

HEALTH AND HUMAN RIGHTS RESOURCE GUIDE



FXBCENTER
FOR HEALTH & HUMAN RIGHTS

HARVARD SCHOOL OF PUBLIC HEALTH | HARVARD UNIVERSITY

HEALTH AND HUMAN RIGHTS RESOURCE GUIDE

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Health and Human Rights Resource Guide

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Cover photograph courtesy of Sven Torfinn - Panos for the Open Society Foundations, "A paralegal nurse named Mercy and a lawyer named Johnson, both with Nyeri Hospice in Nyeri, Kenya talk with Elizabeth (center) about her health and property. She has cancer and is cared for by her granddaughter Caroline (to her left). She wants to ensure her granddaughters can inherit her property even though other relatives are trying to claim it."

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CHAPTER 2



HIV, AIDS AND HUMAN RIGHTS

“ The face of HIV has always been the face of our failure to protect human rights. ”

— Navi Pillay, UN High Commissioner for Human Rights – July 23, 2012

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Cover photograph courtesy of Sven Torfinn – Panos, Open Society Foundations, “William conducts a sensitization workshop about the rights of people living with HIV in Gayaza, Uganda.”

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INTRODUCTION

This chapter will introduce you to key issues and resources in HIV, AIDS, and human rights. In addition, this chapter will help you understand why, more now than ever, HIV and AIDS must be understood and approached as a human rights issue.

The chapter is organized into six sections that answer the following questions. Some of these issues are also addressed in Chapter 3 on Tuberculosis and Human Rights, Chapter 4 on Harm Reduction and Human Rights, Chapter 5 on Palliative Care and Human Rights, and Chapter 8 on LGBTI, Health and Human Rights.

1. How are HIV and AIDS a human rights issue?
2. What are the most relevant international and regional human rights standards related to HIV and AIDS?
3. What is a human rights-based approach to advocacy, litigation, and programming?
4. What are some examples of effective human rights-based work in the area of HIV and AIDS?
5. Where can I find additional resources on HIV, AIDS, and human rights?
6. What are some of the key terms related to HIV, AIDS, and human rights?

I. HOW ARE HIV AND AIDS A HUMAN RIGHTS ISSUE?

What are HIV and AIDS?

What do the acronyms HIV and AIDS stand for?¹

“HIV” stands for human immunodeficiency virus, which is a virus that affects the human immune system. It results in a deterioration of the immune system, causing an individual to become more vulnerable to other infections. “AIDS” stands for acquired immunodeficiency syndrome, which is an advanced stage of HIV defined by the demonstration of certain symptoms, infections, and cancers. An individual with HIV infection may not have developed any of the illnesses that constitute AIDS and the terms should be kept distinct.² As UNAIDS notes:

The expression HIV/AIDS should be avoided whenever possible because it can cause confusion. Most people with HIV do not have AIDS. The expression ‘HIV/AIDS prevention’ is even more unacceptable because HIV prevention entails correct and consistent condom use, use of sterile injecting equipment, changes in social norms, etc., whereas AIDS prevention entails cotrimoxazole, good nutrition, isoniazid prophylaxis (INH), etc.³

There is currently no cure for AIDS. However, people living with HIV can live healthy and productive lives with antiretroviral therapy.⁴

- 1 For basic information on HIV/AIDS, please see the following resources: UNAIDS, *Fast Facts about HIV*. www.unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2008/20080519_fastfacts_hiv_en.pdf; Center for Disease Control, *Basic Information about HIV and AIDS*. www.cdc.gov/ncphi/diss/nndss/print/aidscurrent.htm; World Health Organization (WHO), *HIV/AIDS: Fact Sheet No. 360* (July 2012). www.who.int/mediacentre/factsheets/fs360/en/index.html.
- 2 UNESCO, *UNESCO Guidelines on Language and Content in HIV- and AIDS -Related Materials* (October 2006). <http://unesdoc.unesco.org/imag-es/0014/001447/144725e.pdf>.
- 3 UNAIDS, *Terminology Guidelines* (October 2011). http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf.
- 4 World Health Organization (WHO), *HIV/AIDS: Fact Sheet No. 360* (July 2012). www.who.int/mediacentre/factsheets/fs360/en/index.html.

How is HIV spread?⁵

HIV can be transmitted through unprotected and close contact with certain body fluids, such as blood, semen, breast milk, and vaginal secretions from infected individuals. However, transmission is not possible through air or water, shaking hands, kissing, saliva, tears, or mosquitoes. Common routes of transmission include:

- Unprotected vaginal or anal sex with an HIV-positive partner. The risk of contracting HIV from sexual encounters increases if the person has other sexually transmitted infections (STIs) and if the male is uncircumcised.⁶ Unprotected anal sex has a higher risk factor than vaginal sex, and unprotected receptive anal sex has a higher risk factor than unprotected insertive anal sex.⁷ Transmission can, in some instances with specific conditions, occur through oral sex.
- Passage from an HIV-positive mother to a child during pregnancy, birth, or breastfeeding.
- Sharing contaminated equipment used for injection drug use, including needles, syringes, and wash water.

How are HIV and AIDS treated?

Antiretroviral therapy (ART) is “the combination of at least three antiretroviral drugs to maximally suppress the HIV virus and stop the progression of the HIV disease.”⁸ ART is effective both as life-saving treatment and as protection against HIV AIDS.⁹ According to the Global Commission on HIV and the Law, “Legal strategies, together with global advocacy and generic [drugs], resulted in a 22-fold increase in ART access between 2001 and 2010.” Nevertheless, coverage remains unequal, and in 2011, just 54% of people indicated for ART in low- and middle-income countries received treatment. Globally, just 28% of children in need of treatment received ART.¹⁰ Although there is not yet universal access in many countries, treatment has been successful in extending life expectancy, decreasing HIV transmission,¹¹ and promoting community activism and empowerment around HIV.¹²

5 More detailed information on transmission is available from the Center for Disease Control, *Basic Information about HIV and AIDS*. www.cdc.gov/ncphi/diss/nndss/print/aidscurrent.htm; Center for Disease Control, *HIV Transmission*. www.cdc.gov/hiv/resources/qa/transmission.htm; and World Health Organization, *HIV/AIDS: Fact Sheet No. 360* (July 2012). www.who.int/mediacentre/factsheets/fs360/en/index.html.

6 Canning D, “The Economics of HIV/AIDS in Low-Income Countries: The Case for Prevention,” *Journal of Economic Perspectives* 20 (2006): 121. <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.20.3.121>.

7 Center for Disease Control, “Basic Information about HIV and AIDS.” <http://www.cdc.gov/hiv/topics/basic/>.

8 WHO, “HIV/AIDS: Antiretroviral Therapy.” www.who.int/hiv/topics/treatment/en/.

9 Ibid.

10 UNAIDS, *Global AIDS epidemic facts and figures*, Fact Sheet (July 18, 2012). http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf.

11 Tanser et al, “High Coverage of ART Associated with Decline in Risk of HIV Acquisition in Rural KwaZulu-Natal, South Africa,” *Science* (2013). <http://www.sciencemag.org/content/339/6122/966.short>; Bor J et al, “Increases in Adult Life Expectancy in Rural South Africa: Valuing the Scale-Up of HIV Treatment,” 339, 961 *Science* (2013). <http://www.sciencemag.org.ezp-prod1.hul.harvard.edu/content/339/6122/961.full.pdf>.

12 Robins, S. 2006. “From ‘Rights’ to ‘Ritual’”: AIDS Activism in South Africa.” *American Anthropologist* 108(2):312-323. <http://onlinelibrary.wiley.com.ezp-prod1.hul.harvard.edu/doi/10.1525/aa.2006.108.2.312/pdf>.

How is HIV a global epidemic?

The UN General Assembly notes that the HIV epidemic constitutes “an unprecedented human catastrophe inflicting immense suffering on countries, communities and families around the world.”¹³ More than 30 million people have died of AIDS¹⁴ and there are approximately 34.2 million people living with HIV today. Each year, some 2.5 million people become infected with HIV and around 1.7 million people die of AIDS-related causes, mostly in low- and middle-income countries.¹⁵ Over 16 million children have been orphaned because of AIDS.¹⁶ In the three decades since HIV was first reported, global infection and death rates have declined due to improved access to antiretroviral therapy, which increases life expectancy and reduces the likelihood of transmission. These gains, however, are fragile. HIV and AIDS continue to pose “formidable challenges to the development, progress and stability”¹⁷ of human society and must remain a global priority.¹⁸

What is the connection between HIV, AIDS, and tuberculosis?

Tuberculosis (TB), a disease caused by the *Mycobacterium tuberculosis* bacterium that attacks the lungs, is the leading cause of death for people with HIV worldwide.¹⁹ HIV compromises the immune system and thus increases the likelihood of TB infection, progression, and relapse. People living with HIV are estimated to have between 20-37 times greater risk of developing TB than those not living with HIV. In 2009, 1.2 million (13%) of the 9.4 million new cases of TB were among people living with HIV, and 400,000 (24%) of the 1.7 million people who died from TB were living with HIV.²⁰ It is estimated that one-third of the 40 million people living with HIV worldwide are co-infected with TB.

Unlike AIDS, however, TB can be cured. Studies show that anti-TB drugs can prolong the lives of people living with HIV by at least two years. Therefore, offering TB tests and treatment to people with HIV—and vice versa—greatly increases the manageability of both diseases; indeed, due in large part to the scale-up of joint HIV and TB services, TB deaths in people living with HIV declined by 10% between 2009 and 2010.²¹

Inadequate and inconsistent treatment practices, on the other hand, can cause drug-resistant strains of TB. Multi-drug resistant tuberculosis (MDR-TB) is difficult and costly to treat and can be fatal. The emergence of MDR-TB poses a grave threat not only to people with TB, but to overall progress in the global response to HIV and AIDS.

For more information on TB and health and human rights, please see Chapter 3.

13 UN General Assembly, *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, A/RES/65/277 (June 10, 2011). www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf.

14 Ibid.

15 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

16 UN General Assembly, *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, A/RES/65/277 (June 10, 2011). www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf.

17 Ibid.

18 UN Office of the High Commissioner for Human Rights, “HIV/AIDS and Human Rights.” www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx.

19 The Henry J. Kaiser Family Foundation, *US Global Health Policy Fact Sheet: The Global HIV/AIDS Epidemic* (July 2012). www.kff.org/hiv/aids/upload/3030-17.pdf.

20 WHO, “The Three I’s for HIV/TB.” www.who.int/hiv/topics/tb/3is/en/index.html.

21 Kaiser Family Foundation, *US Global Health Policy Fact Sheet: The Global HIV/AIDS Epidemic* (July 2012). www.kff.org/hiv/aids/upload/3030-17.pdf.

How are HIV and AIDS a human rights issue?

Human rights and HIV are inextricably linked. As the Inter-Parliamentary Union's (IPU) *Handbook for Legislators on HIV/AIDS, Law and Human Rights* notes:

*A lack of respect for human rights fuels the spread, and exacerbates the impact, of the disease. At the same time, HIV undermines progress in the realization of human rights. This link is apparent in the disproportionate incidence and spread of the disease among key populations at higher risk, and particularly those living in poverty. It is also apparent in the fact that the overwhelming burden of the epidemic today is borne by low- and middle-income countries. AIDS and poverty are now mutually reinforcing negative forces in many of these countries.*²²

Human rights are relevant to the response to HIV in at least three ways. First, lack of human rights protection creates vulnerability to HIV,²³ particularly among marginalized and underserved groups such as women, children, and young persons; sex workers; people who use drugs; migrants; men who have sex with men (MSM); transgendered persons; and prisoners.²⁴ The IPU states:

*[These groups] are more vulnerable to contracting HIV because they are unable to realize their civil, political, economic, social and cultural rights. For example, individuals who are denied the right to freedom of association and access to information may be precluded from discussing issues related to HIV, participating in AIDS service organizations and self-help groups, and taking other preventive measures to protect themselves from HIV. Women, and particularly young women, are more vulnerable to infection if they lack access to information, education and services necessary to ensure sexual and reproductive health and prevention of infection. The unequal status of women also means that their capacity to negotiate in the context of sexual activity is severely undermined. People living in poverty often are unable to access HIV care and treatment, including antiretrovirals.*²⁵

Second, lack of human rights protection fuels stigma, discrimination, and violence against persons living with and affected by HIV.²⁶ These harmful attitudes and practices are rooted in a lack of understanding of HIV, misconceptions about how HIV is transmitted,²⁷ and “fears and prejudices surrounding sex, blood, disease, and death—as well as the perception that HIV is related to ‘deviant’ or ‘immoral’ behaviors such as sex outside marriage, sex between men, and drug use.”²⁸ The IPU notes:

22 Inter-Parliamentary Union (IPU), *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007), www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

23 UNAIDS and the UN Office for the High Commissioner for Human Rights, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

24 Ibid. See also Piot P, Greener R, Russell S, “Squaring the Circle: AIDS, Poverty, and Human Development,” *PLOS Medicine* 4, no. 10 (2007): e314. www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040314, and World Health Organization, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2010 (2010). http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf.

25 Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

26 Ibid.

27 UNAIDS, *HIV – Related Stigma, Discrimination, and Human Rights Violations: Case Studies of Successful Program* (April 2005). http://data.unaids.org/publications/irc-pubo6/jc999-humrightsviol_en.pdf.

28 Open Society Institute, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org.

The rights of people living with HIV often are violated because of their presumed or known HIV-positive status, causing them to suffer both the burden of the disease and the consequential loss of other rights. Stigmatization and discrimination may obstruct their access to treatment and may affect their employment, housing and other rights. This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourage individuals infected with, and affected by, HIV from contacting health and social services. The result is that those most needing information, education and counselling will not benefit even where such services are available²⁹

Third, lack of human rights protection impedes effective national responses to HIV.³⁰ Discriminatory, coercive, and punitive approaches to HIV increase vulnerability to infection and worsen the impact of the epidemic on individuals, families, communities and countries.³¹ Examples include:

- Ideologically driven restrictions on information about HIV prevention, including safe sex and condom use;
- Criminalization of groups at higher risk of infection, such as men who have sex with men, persons who inject drugs, and sex workers;
- Criminalization of “reckless” or “negligent” HIV exposure or transmission;
- HIV testing without informed consent;
- Limited access to harm reduction measures, such as needle and syringe programs and opioid substitution therapy;
- Limited access to opioid medications for palliative care; and
- HIV-related immigration restrictions on entry, stay, and residence.³²

These measures deter people from coming forward for HIV services and inhibit the ability of organizations to reach vulnerable and at risk groups.³³ Human rights are thus necessary to achieving universal access to comprehensive prevention, treatment and care; to meeting the rights and needs of the most vulnerable and worst affected populations; and to ensuring voluntary, informed and evidence-based policies, programs and practices.³⁴ The following are some examples of key human rights issues related to HIV.

29 Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

30 Ibid.

31 UNAIDS, *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

32 Ibid.

33 Ibid. See also Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007), www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

34 Open Society Foundations, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org/vs3_korax.net/downloads/nmte_20090923_o.pdf.

HIV disproportionately affects persons living in developing countries and persons living in poverty.

HIV is deeply rooted in social, economic, and gender inequalities.³⁵ The burden of the epidemic is disproportionately carried by persons in developing countries. Sub-Saharan Africa remains the worst-affected region, with 69% of all persons living with HIV and 70% of all HIV-related deaths. The Caribbean region has the highest HIV prevalence outside of sub-Saharan Africa and the number of new HIV infections is increasing in Eastern Europe, Central Asia, North Africa, the Middle East, and parts of Asia and the Pacific.³⁶ The disparate burden of HIV across countries and communities requires “an exceptional and comprehensive global response that takes into account the fact that the spread of HIV is often a consequence and cause of poverty.”³⁷

Poverty creates social and legal environments that increase the risk of infection, sickness, and death. Underlying factors include malnutrition, poor health, barriers to accessing health care and other services, and reduced capacity to participate in HIV prevention and care.³⁸ Poverty increases vulnerability to HIV—even as HIV increases vulnerability to poverty. According to Piot et al.:

*AIDS kills people in the prime of their working and parenting lives, with a devastating effect on the lives and livelihoods of affected households. Incomes shrink when employed household members become sick or die, and resources are further depleted by medical and funeral-related costs. The impact on poor households is clearly disproportionate, with many struggling to meet demands for treatment and care.... For example, in India, the financial burden on households living with HIV was 82% of income in the poorest quintile and just over 20% among the richest quintile.... The very poor struggle to afford even heavily subsidized antiretroviral treatment.... Moreover, even if drugs are free, poor families may have insufficient resources to meet basic nutrition needs or the costs of travel to health clinics for care.*³⁹

HIV thus imposes the heaviest toll on persons living in poverty, while impeding human development in high-prevalence countries.⁴⁰ The Joint United Nations Programme on AIDS (UNAIDS) and the UN Office of the High Commissioner for Human Rights (OHCHR) state:

*Where human rights are not protected, people are more vulnerable to HIV infection. Where the human rights of HIV-positive people are not protected, they suffer stigma and discrimination, become ill, become unable to support themselves and their families, and if not provided treatment, they die. Where rates of HIV prevalence are high and treatment is lacking, whole communities are devastated by the impact of the virus.... HIV has spread to every country in the world and, in the hardest-hit countries, it is undoing most of the development gains of the past 50 years.*⁴¹

35 Piot P, Greener R, Russell S, “Squaring the Circle: AIDS, Poverty, and Human Development,” *PLOS Medicine* 4, no. 10 (2007): e314. www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040314

36 UNAIDS, *Report on the global AIDS epidemic 2012*, (2012): 8-12. www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf.

37 UN General Assembly, *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, A/RES/65/277 (Jun. 10, 2011). www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf.

38 Ibid. See also Drimie S, “The Impact of HIV/AIDS on rural households and land issues in Southern and Eastern Africa,” Background Paper, (Food and Agricultural Organization, Sub-Regional Office for Southern and Eastern Africa, 2002). [ftp://ftp.fao.org/docrep/nonfao/ad696e/ad696e00.pdf](http://ftp.fao.org/docrep/nonfao/ad696e/ad696e00.pdf).

39 Piot P, Greener R, Russell S, “Squaring the Circle: AIDS, Poverty, and Human Development,” *PLOS Medicine* 4, no. 10 (2007): e314. www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040314

40 Ibid. See also Drimie S, “The Impact of HIV/AIDS on rural households and land issues in Southern and Eastern Africa,” Background Paper, (Food and Agricultural Organization, Sub-Regional Office for Southern and Eastern Africa, 2002). [ftp://ftp.fao.org/docrep/nonfao/ad696e/ad696e00.pdf](http://ftp.fao.org/docrep/nonfao/ad696e/ad696e00.pdf).

41 UNAIDS and UN Office of the High Commissioner for Human Rights (OHCHR), *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

Stigma, discrimination, and violence violate the human rights of people living with and affected by HIV.

Many countries have yet to significantly address the HIV-related human rights abuses of their citizens. As a result, stigma and discrimination remain pervasive; they are the primary drivers of the HIV epidemic and the main obstacles to effective public action. UN Secretary-General Ban Ki-Moon notes:

[Stigma] is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.⁴²

UNAIDS defines stigma as the process of devaluing an individual based on certain attributes deemed discrediting or unworthy by others. Discrimination, in turn, occurs when stigma is acted on and consists of the actions or behaviors directed against stigmatized individuals.⁴³ In the context of HIV, discrimination can increase vulnerability to infection, particularly among legally and socially marginalized groups such as sex workers, people who use drugs, men who have sex with men, and prisoners. According to UNAIDS and OHCHR:

Discrimination often prevents them from having access to HIV prevention information, modalities (condoms and clean injecting equipment) and services (for sexually transmitted infections and tuberculosis). This, as well as risk-taking behaviour, makes them highly vulnerable to HIV infection.⁴⁴

At the same time, discrimination can also relate to HIV status itself. People with actual or presumed HIV-positive status may be denied the right to health care, employment, education, and freedom of movement, among other rights.⁴⁵

42 Ki-Moon B, *The Stigma Factor*, The Washington Times, (Aug. 6, 2008). www.washingtontimes.com/news/2008/aug/06/the-stigma-factor/.

43 UNAIDS, *HIV – Related Stigma, Discrimination, and Human Rights Violations: Case Studies of Successful Program* (April 2005). http://data.unaids.org/publications/irc-pubo6/jc999-humrightsviol_en.pdf

44 UNAIDS and the UN Office of the High Commissioner for Human Rights, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

45 Ibid

For example, all people have the right to decent work and their HIV status should not influence their ability to find and keep employment. Yet people living with HIV often face stigma and discrimination in the workplace.⁴⁶ This can affect recruitment, salary levels, training opportunities, labor protection, social insurance, welfare, and dismissal.⁴⁷ The Global Network of People Living with HIV found that up to 45% of survey respondents in Nigeria had lost their jobs or their source of income during the previous 12 months, and up to 27% were refused the opportunity to work as a result of their HIV status.⁴⁸ To address HIV and AIDs discrimination in the workplace, the International Labour Organization released a recommendation on HIV/AIDs and work in 2001 (“The Code”) and a standard in 2010 to bolster implementation of the Code at the country level.⁴⁹ The Code guidelines are:⁵⁰

- No mandatory HIV testing for workers under any circumstances or for any purpose.
- No denial of job opportunities for workers with HIV in any area of work.
- No discrimination of workers such as denial of promotions or shifting job responsibilities.
- Guaranteed confidentiality with regard to HIV status in the workplace.

Discrimination on account of HIV status can contribute to poverty, poor health, and further marginalization. For example, lack of employment security contributes to worse health outcomes, since employment status can determine access to health care and social benefits.⁵¹ When people living with HIV cannot find or keep employment, the loss of income and simultaneous loss of benefits exacerbates poverty and makes adherence to HIV treatment more difficult.

To combat HIV-related stigma manifest in social and legal barriers, countries should enact formal laws that prohibit discrimination on the basis of HIV status for purposes of employment, education, social and health care services, or immigration and asylum applications. The Commission on HIV and the Law reports that of 168 reviewed countries, 123 reported that they had laws that prohibited HIV-related discrimination.⁵² However, the Office of the High Commission on Human Rights cautions that many of these anti-discrimination laws may not be effective:

46 Global Network of People Living with HIV (GNP+), *Stigma and Discrimination at Work: Findings from the People Living with HIV Stigma Index*, Evidence Brief, (2012). www.gnpplus.net/images/stories/Rights_and_stigma/SI_WorkBriefing_Online.pdf.

47 National Center for AIDS/STD Control and Prevention, China CDC & International Labour Office for China and Mongolia, *HIV and AIDS Related Employment Discrimination in China*. www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms_150386.pdf.

48 International Labour Organization (ILO), *HIV still a major obstacle to employment security* (July 24, 2012). www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_185826/lang-en/index.htm.

49 International Labour Organization, *Recommendation concerning HIV and AIDS and the World of Work* (No. 200) (2010), www.ilo.org/ids/WCMS_142706/lang-en/index.htm. Available in many languages. See also, ILO, *Code of Practice on HIV/AIDS and the World of Work*, www.ilo.org/ids/Publications/WCMS_113783/lang-en/index.htm.

50 National Center for AIDS/STD Control and Prevention, China CDC & International Labour Office for China and Mongolia, *HIV and AIDS Related Employment Discrimination in China*. www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms_150386.pdf.

51 Rueda SI, “Labour Force Participation and health-related quality of life in people living with HIV”, *AIDS Behavior* 16, no. 8 (2012):2350-60. www.ncbi.nlm.nih.gov/pubmed/22814570.

52 Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>. The Global Commission on HIV and the Law is an independent body, convened by UNDP on behalf of the program Coordinating Board of the Joint United Nations program on HIV/AIDS (UNAIDS).

*When anti-discrimination provisions are in place, they are often not effectively enforced. Fewer than 60 per cent of countries report having a mechanism to record, document and address cases of HIV-related discrimination. In 2010, the vast majority of countries reported that they addressed stigma and discrimination in their national HIV strategies; however, most countries did not have a budget for activities aimed at responding to HIV-related stigma and discrimination.*⁵³

Four organizations have partnered⁵⁴ to document the experiences of people living with HIV-related stigma, discrimination, and rights violations by developing an index called “People Living with HIV Stigma Index.”⁵⁵ The aim of the index is to “broaden our understanding of the extent and forms of stigma and discrimination faced by people living with HIV in different countries[,]” and to use the data as an advocacy tool.⁵⁶ This tool is helpful in understanding and documenting the extent to which discrimination and stigma affect the daily lives of persons living with HIV.

The People Living with HIV Stigma Index demonstrates that stigma and discrimination are widespread. Stigma can lead to social ostracism, loss of income or livelihoods, denial of medical services or poor care within the health sector, loss of marriage and childbearing options, violence and depression/loss of hope (internalized stigma).⁵⁷ Discrimination perpetuates the stigma associated with HIV-positive status and hinders HIV prevention and intervention. HIV-related stigma and discrimination make people afraid to seek information and education about prevention methods, to find out their status, to disclose their status—even to family and sexual partners—and to adhere to treatment schedules.⁵⁸

HIV education plays an important role in reducing discrimination and stigma. It is also important to ensure that services are delivered in a manner that changes negative social norms at the population level.⁵⁹ For example, there is some evidence that HIV-associated stigma is decreasing in some communities due to high rates of social exposure to people who are receiving ART.⁶⁰ Education, outreach, and other mechanisms to reduce social stigma can make people less afraid of HIV, more willing to be tested, to disclose their status, and to seek care when necessary. All these factors contribute to a more open and inclusive environment.⁶¹

53 United Nations High Commissioner for Human Rights, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, A/HRC/19/37 (Dec. 14, 2011). http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.37_en.pdf.

54 The Global Network of People Living with HIV/AIDS (GNP+); The International Community of Women Living with HIV/AIDS (ICW); The International Planned Parenthood Federation (IPPF); and The Joint United Nations Programme on HIV/AIDS (UNAIDS).

55 The People Living with HIV Stigma Index. www.stigmaindex.org/.

56 The People Living with HIV Stigma Index, “User Guide.” www.stigmaindex.org/9/aims-of-the-index/aims-of-the-index.html.

57 AVERT, “HIV and AIDS Stigma and Discrimination.” www.avert.org/hiv-aids-stigma.htm#contentTable1; UNAIDS, *Non-discrimination in HIV responses* (2010). www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf.

58 UNAIDS and OHCHR, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

59 See, e.g., England R, “The Writing is on the wall for UNAIDS,” *BMJ* 336, no. 7652 (2008). <http://www.ncbi.nlm.nih.gov/ezp-prod1.hul.harvard.edu/pmc/articles/PMC2375992/>; Jewkes R, “Beyond Stigma: social responses to HIV in South Africa,” *The Lancet* 368, no. 9534 (August 2006). <http://www.sciencedirect.com/ezp-prod1.hul.harvard.edu/science/article/pii/S0140673606691307>.

60 Bor J et al, *Social exposure to an antiretroviral treatment programme in rural KwaZulu Natal*, (Africa Centre and University of Kwazulu-Natal, 2011).

61 AVERT, “HIV and AIDS Stigma and Discrimination.” www.avert.org/hiv-aids-stigma.htm#contentTable1.

Gender inequality, gender-based violence, and the low status of women and girls remain three of the principal drivers of HIV.

Women and girls are disproportionately affected by the HIV epidemic. It is estimated that about 75% of all women living with HIV are in sub-Saharan Africa.⁶² HIV remains the “leading cause of death of women of reproductive age”⁶³ and a leading cause of maternal death.⁶⁴ In 2011, approximately 1.2 million women and girls were newly infected with HIV.⁶⁵ Young women between 15 to 24 years of age account for 63% of young people living with HIV and have “infection rates twice as high as among men of the same age.”⁶⁶ Despite this, “Less than half (46%) of all countries allocate resources for the specific needs of women and girls in their national response to HIV.”⁶⁷

The manifestation of gender inequality in the HIV epidemic extends beyond infection rates. The International Guidelines on HIV/AIDS and Human Rights notes the extensive impact of gender inequality on the HIV epidemic:

*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.*⁶⁸

As the UN Secretary General noted, “Gender inequality affects women’s experience of living with HIV, their ability to cope once infected and their access to HIV and AIDS services, including treatment.”⁶⁹ Women’s experiences of living with HIV are further influenced by social and economic gender disparities. For example, women are often care givers, which is complicated if the person they care for contracts HIV or they themselves become HIV infected. Their duties as care givers can become significantly more demanding and complex, compounded by additional economic and social burdens. Also, if women lose their partners to HIV, they may face economic insecurity because of discriminatory employment, inheritance, or property laws. Legal and social empowerment, as well as increased education for women, are both important measures to address the manifest gender disparities that exist in the context of HIV.

62 AVERT, “Women, HIV and AIDS.” www.avert.org/women-hiv-aids.htm#contentTableo.

63 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

64 Fried S et al, “Integrating interventions on maternal mortality and morbidity and HIV: A human rights-based framework and approach,” *Health and Human Rights* 14, no. 2 (2012). www.hhrjournal.org/index.php/hhr/article/view/512/776.

65 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

66 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

67 UNAIDS, *Report on the global AIDS epidemic 2010* (2010). www.unaids.org/globalreport/global_report.htm.

68 UN Office of the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version* (2006): 110. www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf.

69 UN Commission on the Status of Women, *Report of the Secretary General on women, the girl child and HIV and AIDS*, E/CN.6/2011/7 (Dec. 3, 2010): 2. www.un.org/womenwatch/daw/csw/csw55/documentation.htm.

Gender in the law

Laws and policies can be an important source of empowerment for women in the context of HIV, but they can also be equally discriminatory. Laws can create barriers for women to access health services or HIV treatment itself and to protect themselves from HIV infection. Laws can also harm women by legalizing genital mutilation or denying inheritance and property rights, causing more risk and vulnerability to the social determinants of HIV and its effects.⁷⁰ For example, the Global Commission noted that, in 2012, 127 countries did not have laws criminalizing marital rape.⁷¹

Economic status

Women are at an increased risk of becoming infected with HIV due to unequal access to resources, including land and income-generating opportunities, as well as economic dependence on men. Unequal access to resources and economic dependence on men increase the probability that women and girls will engage in variety of unsafe sexual behaviors, including transaction sex, coerced sex, earlier sexual debut, and multiple sex partners.⁷² Despite initial concerns that women might face greater barrier to ART access, there is no evidence of socio-economic gradients in ART access, with the exception of distance to the nearest clinic.⁷³ However, a lack of resources can prevent women from accessing necessary health services for prevention, treatment and care.

Gender-based power imbalances in sexual and reproductive decision-making

Gender-based power imbalances in sexual decision-making put women at increased risk to contract HIV and can have grave consequences for women. The majority of HIV transmissions to women occur during heterosexual intercourse, and women are twice more likely than men to acquire HIV from an infected partner during unprotected heterosexual intercourse.⁷⁴ Gender inequality in sexual relationships can range from women not having power to control their sexual relations both in and out of marriage, women who are married to men for whom having multiple partners is encouraged, the genital mutilation of women, and the early or forced marriage of women. Violence against women also puts women at increased risk for HIV and remains a real threat for women worldwide. Gender-based power imbalances also affect women's autonomy and independent decision-making on reproductive issues, including methods of protection against HIV during sexual encounters, methods of contraception, testing for HIV, and treatment and care options.

⁷⁰ World Bank, *Protecting Women's Land and Property Rights in the Context of AIDS*. <http://siteresources.worldbank.org/INTGENAGRLIVSOUBOOK/Resources/AfricalAP.pdf>.

⁷¹ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

⁷² What Works for Women and Girls, *Promoting Women's Employment, Income and Livelihood Opportunities*. www.whatworksforwomen.org/chapters/21-Strengthening-the-Enabling-Environment/sections/63-Promoting-Womens-Employment-Income-and-Livelihood-Opportunities.

⁷³ Cooke et al, "Population uptake of antiretroviral treatment through primary care in rural South Africa," *BMC Public Health* 10 (2010). <http://www.ncbi.nlm.nih.gov/ezip-prod1.hul.harvard.edu/pmc/articles/PMC3091553/pdf/1471-2458-10-585.pdf>.

⁷⁴ AVERT, "Women, HIV and AIDS." www.avert.org/women-hiv-aids.htm#contentTableo.

The rights and needs of children under the age of 15 are largely ignored in the response to HIV.

An estimated 3.4 million children under 15 are living with HIV today. In 2011, 330,000 new children became infected with HIV—91% of whom live in sub-Saharan Africa—and an additional 230,000 children died of AIDS-related causes.⁷⁵ Children and young people are among the worst affected by HIV due to failures to protect their human rights. The UNAIDS and OHCHR *Handbook on HIV and Human Rights for National-Human Rights Institutions* states:

According to the Convention on the Rights of the Child and its optional protocols, children have many of the rights of adults in addition to particular rights for children that are relevant in relation to HIV and AIDS. Children have the right to freedom from trafficking, prostitution, sexual exploitation and sexual abuse; the right to seek, receive and impart information on HIV; and the right to special protection and assistance if deprived of their family environment. They also have the right to education, the right to health and the right to inherit property. The right to special protection and assistance if deprived of their family environment protects children if they are orphaned by AIDS. And the right of children to be actors in their own development and to express their opinions empowers them to be involved in the design and implementation of HIV-related programmes for children.⁷⁶

Nevertheless, progress remains unsatisfactory in the prevention, diagnosis, and treatment of HIV in children. Many children affected by HIV experience poverty, homelessness, school drop-out, discrimination, loss of economic and social opportunity, and early death. Countries are not adequately fulfilling their commitments to provide care and support for vulnerable children, including and especially orphans and children living in AIDS-affected families.

Prevention of mother-to-child transmission of HIV

Preventing mother-to-child transmission of HIV (PMTCT) remains a priority in eliminating HIV in children. More than 90% of HIV-positive children are infected through their mother during pregnancy, labor, delivery, and breastfeeding. Without intervention, there is a 20 to 45% chance that a mother will transmit HIV to her baby.⁷⁷ Moreover, without intervention, half of all infected children will die before their second birthday.⁷⁸

Lack of universal access to PMTCT services highlights inequities that result from a failure to protect human rights. The prescribed strategy requires administering antiretrovirals (ARTs) to the mother before birth and during labor, administering ARTs to the baby following birth, and undertaking preventative measures to avoid HIV transmission through breast milk. These methods are successfully applied in high-income countries, where mother-to-child transmission is rare.

75 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

76 UNAIDS and the UN Office of the High Commissioner for Human Rights, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

77 AVERT, "Preventing Mother-to-child Transmission (PMTCT) in Practice." www.avert.org/pmtct-hiv.htm.

78 UNAIDS, *Children and AIDS: Fifth Stocktaking Report* (2010). http://www.unicef.org/publications/files/Children_and_AIDS-Fifth_Stocktaking_Report_2010_EN.pdf.

Women in resource-poor countries, however, often do not have access to PMTCT services.⁷⁹ Despite concerted efforts to address the issue, in 2011 just 57% of the 1.5 million pregnant women living with HIV in low- and middle-income countries received ARTs to avoid transmission to their child.⁸⁰ Barriers in resource-poor settings include clinic resources, testing methods, fear and distrust, disclosure and discrimination issues, drug effectiveness, treatment for mothers, feasibility of replacement feeding, and male visits to antenatal clinics. Despite these challenges, effective delivery of PMTCT services has been well documented in resource-limited public health systems.⁸¹

Protection, care, and support for children living with or affected by HIV

Many children lack full access to the HIV prevention information, education, and services they are entitled to under international human rights law. They also receive less antiretroviral treatment than adults, with just 28% of those in need receiving treatment,⁸² and they have limited access to pediatric formulations of HIV medicines.⁸³ Moreover, children are highly vulnerable to the impact of AIDS on their family and community environments. An estimated 17.1 million children under 18 have lost one or both parents to AIDS, with around 14.8 million such orphans in sub-Saharan Africa.⁸⁴ In some instances, children may be forced to become child heads of their households. Orphans and children living in AIDS-affected households are denied their right to social protection and face higher risks of poverty, abuse, exploitation, discrimination, property-grabbing, school drop-out, and homelessness.⁸⁵

The rights and needs of young people aged 15 to 24 are largely ignored in the response to HIV.

With 890,000 new infections in 2011, approximately 4.9 million young people are living with HIV—75% of whom are living in sub-Saharan Africa.⁸⁶ Young women make up 63% of all young people living with HIV globally; however, in sub-Saharan Africa, young women make up 72% of young people living with HIV. Young women in sub-Saharan Africa are eight times more likely to be living with HIV than their male peers.

Young people still are not receiving adequate education on HIV and they face barriers accessing information. Many youth do not receive adequate sex education, and those who do are often misinformed on HIV prevention and HIV transmission. For example, UNAIDS reports: “Only 24% of young women and 36% of young men responded correctly when asked five questions on HIV prevention and HIV transmission, according to the most recent population based surveys in low- and middle-income countries.”⁸⁷

79 AVERT, “Preventing Mother-to-child Transmission (PMTCT) in Practice.” www.avert.org/pmtct-hiv.htm.

80 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

81 See, AVERT, “Preventing Mother-to-child Transmission (PMTCT) in Practice.” www.avert.org/pmtct-hiv.htm.

82 UNAIDS, *Report on the global AIDS epidemic 2012* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf.

83 Open Society Foundations, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org; UNAIDS and OHCHR, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

84 UNICEF, “Childinfo: Monitoring the Situation of Children and Women.” www.childinfo.org/hiv_aids.html.

85 Open Society Foundations, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org; UNAIDS and OHCHR, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

86 UNAIDS, *Global AIDS epidemic facts and figures* (July 18, 2012). www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/201207_FactSheet_Global_en.pdf.

87 Ibid.

Young people also face barriers accessing HIV services, including sexual and reproductive health services, HIV treatment, and harm reduction. These barriers include stigma, discrimination, and restrictive laws and policies.⁸⁸ For example, requiring parental approval to receive HIV testing or treatment can be a significant deterrent for youth, running counter to HIV prevention efforts.

In addition to an inability to realize the right to the highest attainable standard of health, young people living with HIV also often face discrimination in accessing the full range of human rights. For example, UNESCO recently released a publication addressing the barriers and discriminatory practices impeding HIV-positive youth from attending school and getting an education.⁸⁹ According to the IPU, “Evidence has demonstrated that getting and keeping young people (particularly girls) in school dramatically lowers their vulnerability to HIV.”⁹⁰

The most vulnerable and worst affected populations often receive the least attention in national responses to HIV.

In most countries, men who have sex with men; people who use drugs; sex workers; and prisoners have a higher prevalence of HIV infection than that of the general population because they engage in behaviors that put them at higher risk of becoming infected, and they are among the most marginalized and discriminated-against populations in society. Punitive approaches to drug use, sex work, and homosexuality fuel stigma and hatred against these populations, pushing them further into hiding and away from services to prevent, treat, and mitigate the impact of HIV. At the same time, the resources devoted to HIV prevention, treatment, and care for these populations are not proportional to the HIV prevalence, which represents “a serious mismanagement of resources and a failure to respect fundamental human rights.”⁹¹

Sex workers

UNAIDS defines sex workers as “consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally.”⁹² Sex workers are particularly vulnerable to HIV because of their multiple sexual partners and inconsistent condom use,⁹³ discrimination and stigma, criminalization of their work, increased risk of violence, lack of education or information, and barriers to accessing health services. For example, in Rwanda, the prevalence of HIV among female commercial sex workers was 51%, which is 17 times the national average of 3%.⁹⁴

88 Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

89 UNESCO and the Global Network of People Living with HIV, *Positive Learning: Meeting the needs of young people living with HIV (YPLHIV) in the education sector*. <http://unesdoc.unesco.org/images/0021/002164/216485E.pdf>.

90 Inter-Parliamentary Union (IPU), *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007), www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

91 UNAIDS, quoted in Open Society Institute, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org.vs3.korax.net/downloads/nmte_20090923_o.pdf.

92 UNAIDS, *UNAIDS Terminology Guidelines* (Oct. 2011). www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf.

93 AVERT, “Sex Workers and HIV Protection.” www.avert.org/sex-workers.htm.

94 IRIN News, *Rwanda: Criminalization of sex work hinders HIV prevention efforts* (Nov. 17, 2011). www.irinnews.org/Report/94231/RWANDA-Criminalization-of-sex-work-hinders-HIV-prevention-efforts.

Criminalization of sex work creates barriers to accessing HIV prevention and treatment services. More than 100 countries criminalize some aspect of sex work, according to the Global Commission on HIV and the Law.⁹⁵ In many countries, including Kenya, Namibia, Russia, South Africa, and the United States, police confiscate condoms from sex workers or use condoms as a justification for arrest, thereby undermining HIV prevention efforts. These practices criminalize condoms and force sex workers to choose between protecting their health or detention.⁹⁶

Sex workers are also vulnerable to violence, which also increases their risk of contracting HIV. Some sex workers face threats and violence from clients, managers, and intimate partners that prevent them from enforcing condom use. Street-based sex workers are at particular risk and may be forced to exchange unpaid and unprotected sex with some police officers in order to prevent arrest, harassment, obtain release from prison or not be deported.⁹⁷

Men who have sex with men

Men who have sex with men are considered a vulnerable or at-risk population for HIV. This is a diverse group that includes men who identify as gay or bisexual, as well heterosexual men who have sex with men. They are particularly vulnerable to HIV because sex between men can involve anal sex, a practice that, when no protection is used, has a higher risk of HIV transmission than unprotected vaginal sex.⁹⁸

Men who have sex with men are also vulnerable to HIV because of social stigma, discriminatory practices, and criminalization of same-sex conduct. Sex between men is taboo in many cultures and, as a result, HIV prevention campaigns only discuss the risks of heterosexual sex. Some countries deny the existence of homosexuality at all and limit research and funding on the health of this population. There is often little information available about sex between men in these contexts, and this can provide a false impression of limited or no risk.⁹⁹

The criminalization or punishment of same-sex conduct also creates barriers to accessing healthcare and HIV prevention measures, which also contributes to the underlying determinants of health. The UN Special Rapporteur on the right to health notes:

*Various criminal laws exist worldwide that make it an offence for individuals to engage in same-sex conduct, or penalize individuals for their sexual orientation or gender identity. ... Other laws also indirectly prohibit or suppress same-sex conduct, such as anti-debauchery statutes and prohibitions on sex work. Many States also regulate extra-marital sexual conduct through criminal or financial sanctions, which affects individuals who identify as heterosexual but intermittently engage in same-sex conduct.*¹⁰⁰

95 Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

96 Open Society Foundations, *Criminalizing Condoms: How Policing Practices Put Sex Workers And Hiv Services At Risk In Kenya, Namibia, Russia, South Africa, The United States, And Zimbabwe* (July 2012). www.Soros.Org/Reports/Criminalizing-Condoms.

97 WHO, *Violence Against Women and HIV/AIDS: Critical Intersection.*, www.who.int/gender/documents/sexworkers.pdf.

98 Avert, "HIV, AIDS, and Men who have sex with men." www.avert.org/men-sex-men.htm.

99 Semugoma P, Nemande S, Baral SD, "The irony of homophobia in Africa," 380, no. 9839 *The Lancet* (July 2012).

100 Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/14/20 (Apr. 27, 2010). <http://www2.ohchr.org/english/bodies/hrcouncil/14session/reports.htm>. Report is on the right to health and criminalization of same-sex conduct and sexual orientation, sex-work and HIV transmission.

Further, “Sanctioned punishment by States reinforces existing prejudices, and legitimizes community violence and police brutality directed at affected individuals.”¹⁰¹ The Global Commission on HIV and the Law notes that 78 countries criminalize sexual conduct between same sex partners,¹⁰² and it is punishable by death in five of these countries (Iran, Mauritania, Saudi Arabia, Sudan, Yemen, and parts of Nigeria and Somalia).¹⁰³

Prisoners

Although many prisoners living with HIV contracted their infections before imprisonment, the risk of infection while in prison is high due to high-risk sexual and other behaviors, like sharing needles. High-risk sexual behaviors, including unprotected sex, sexual violence, rape, and coercion, are common in prison and increase prisoners’ vulnerability to HIV.¹⁰⁴ Unsafe drug injection, blood exchange, and the use of non-sterile needles/cutting instruments for tattooing are also common and increase HIV vulnerability. Poor prison conditions, including overcrowding, poor food and nutrition, poor security, and lack of health facilities and staff contribute to the spread of HIV and violate prisoners’ human rights.

Some prisons create separate or alternative sections for HIV-positive prisoners, segregating them from the rest of the prison population. In parts of Russia, prisoners are tested for HIV and those who test positive are imprisoned together, but separated from the general prison population. Two states in the United States, Alabama and South Carolina, continue to segregate prisoners living with HIV. The American Civil Liberties Union and the AIDS Project recently filed a lawsuit calling the practice discriminatory.¹⁰⁵ Their reports highlight additional human rights violations that are consequences from discriminatory segregation.

People who inject drugs

An estimated 15.9 million people worldwide inject drugs, the majority of whom live in middle- and low-income countries.¹⁰⁶ Drug-dependent people are frequently subjected to laws, policies and practices that violate their human rights. This increases their vulnerability to HIV and HIV-related risk behaviors, negatively affects the delivery of HIV programs and compromises their health, as well as the health of their communities. As a result, people who inject drugs face a disproportionately high risk of infection and injection drug use accounts for an estimated 10% of total HIV infections.¹⁰⁷

The link between human rights abuses experienced by people who use drugs and vulnerability to HIV infection and barriers to accessing is well-documented. Many violations are related to the criminalization of the status of being a drug user, which can result in the imposition of the death sentence for drug offenses, incarceration of drug-dependent people and abusive law enforcement practices (for example, police harassment, arbitrary detention, ill treatment, and torture). Other violations are related to the abusive treatment of people who inject drugs, such as denial of harm-reduction services (including needle and syringe programs and opioid substitution therapy), discriminatory access to antiretroviral therapy, denial of pain relief and palliative care, and coercion in the guise of treatment for drug dependence.¹⁰⁸ According to the Now More Than Ever Campaign:

¹⁰¹ Ibid.

¹⁰² Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁰³ AVERT, “HIV, AIDS, and Men who have sex with men.” www.avert.org/men-sex-men.htm.

¹⁰⁴ WHO, *Effectiveness of Interventions to Address HIV in Prisons* (2007). http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf.

¹⁰⁵ For the copy of the legal documents, news reports, and blog posts on the case, please see American Civil Liberties Union, *Henderson et al. v. Thomas et al.*, www.aclu.org/hiv-aids-prisoners-rights/henderson-et-al-v-thomas-et-al.

¹⁰⁶ Mathers B et al., “The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review,” *Lancet* 372, no. 9651 (2008): 1733–1745.

¹⁰⁷ World Health Organization, *HIV/AIDS: Injecting Drug Use*, <http://www.who.int/hiv/topics/idu/en/index.html>.

¹⁰⁸ Jurgens et al., “People who use drugs, HIV, and human rights”, *Lancet* 376 (2010): 475-485.

*Criminalized populations...are driven from HIV services by discrimination and violence, often at the hands of police officers and judges charged with enforcing sodomy, narcotics and prostitution laws... People who use drugs end up in prison or in a revolving door of ineffective and coercive rehabilitation programs, rarely receiving the services for drug addiction or HIV prevention and treatment they desperately need.*¹⁰⁹

To effectively address HIV in people who use drugs, there must be greater understanding of human rights violations as core features of risk environments, as barriers to care, and as social determinants of poor health and development. HIV prevention and treatment efforts must address the specific needs and rights of people who inject drugs and promote access to harm prevention services. According to Jurgens et al.:

*Protection of the human rights of people who use drugs therefore is important not only because their rights must be respected, protected, and fulfilled, but also because it is an essential precondition to improving the health of people who use drugs. Rights-based responses to HIV and drug use have had good outcomes where they have been implemented, and they should be replicated in other countries.*¹¹⁰

For more detailed information on this topic, please see Chapter 4 on harm reduction and human rights.

HIV testing frequently takes place without the full protection of voluntariness, confidentiality, and informed consent.

HIV testing implicates a broad range of ethical and human rights issues, including the rights to health, education, information, privacy, liberty and security of the person, and non-discrimination and equality before the law.¹¹¹ The 2004 UNAIDS/WHO *Policy Statement on HIV Testing* notes:

*The conditions of the ‘3 Cs’, advocated since the HIV test became available in 1984, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be **confidential**, be accompanied by **counseling**, [and] only be conducted with informed **consent**, meaning that it is both informed and voluntary.*¹¹²

Under international human rights law, individuals have a right to information and education, which entitles them to seek, receive, and impart information relating to HIV testing and treatment. They have the right to bodily integrity and to physical privacy, which entitles them to withhold consent to medical treatment and testing. They also have the right to confidentiality of personal information, which entitles them to control the collection, use and disclosure of information relating to their HIV status.¹¹³ Jurgens further notes:

*The right to be free of discrimination and the right to security of the person, also require that in both HIV testing policy and practice, governments take into account the outcomes of HIV testing for people—including stigma, discrimination, violence and other abuse—and do all that they can to prevent human rights violations associated with this health service.*¹¹⁴

¹⁰⁹ Open Society Foundations, *10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle* (2009). www.hivhumanrightsnow.org.

¹¹⁰ Jurgens et al., “People who use drugs, HIV, and human rights,” *Lancet* 376 (2010): 475-485.

¹¹¹ UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

¹¹² UNAIDS and WHO, “UNAIDS/WHO policy statement on HIV testing” (2004). www.who.int/hiv/pub/vct/statement/en/.

¹¹³ UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

¹¹⁴ Jurgens R, *Increasing Access to HIV Testing and Counseling While Respecting Human Rights* (Open Society Institute, 2007). www.opensocietyfoundations.org/publications/increasing-access-hiv-testing-and-counseling-while-respecting-human-rights-background.

Traditionally, there have been three main approaches to HIV testing in clinical settings. Opt-in approaches require patients to affirmatively agree to HIV testing after receiving pretest information. This client-initiated model has been shown to reduce HIV infection and transmission¹¹⁵ while increasing uptake of testing.¹¹⁶ Opt-out approaches, by contrast, require patients to specifically decline HIV testing after receiving pretest information. This provider-initiated model can result in increased testing,¹¹⁷ but voluntariness may be compromised by poorly designed protocols, inadequate information about consent, and power imbalances between patients and providers.¹¹⁸ The third approach, involuntary or mandatory testing,¹¹⁹ involves no patient consent and is often required for populations such as prisoners, military recruits, migrants, and pregnant women. Where HIV testing is required as a precondition for marriage, this also implicates the right to marry and found a family.¹²⁰ UNAIDS and WHO do not support the mandatory HIV testing of individuals on public health grounds, and require “specific judicial authorization” to perform a mandatory HIV test.”¹²¹

In recent years, an international consensus in favor of expanded HIV testing has led to a reevaluation of HIV testing principles. Many in the public health community now advocate for the relaxing or elimination of counseling and informed consent requirements—such as HIV testing outside medical settings, mass HIV screening programs¹²² and mandatory disclosure of HIV status to sexual partners.¹²³ These ideas are premised on the “right and responsibility” to know one’s HIV serostatus. They are also premised on the 1984 Siracusa Principles on the Limitation and Derogation of Principles, which permit limitations on individual rights “if [public health policies] are sanctioned by law, serve a legitimate public health goal, are necessary to achieve that goal, are no more intrusive or restrictive than necessary, and are non-discriminatory in application.”¹²⁴

115 Amon J, “Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights,” in Sudarshan N, ed., *HIV/AIDS, Health Care and Human Rights Approaches* (Amicus Books, Jan. 2009).

116 Ibid.

117 WHO, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (2007). www.who.int/hiv/pub/guidelines/9789241595568_en.pdf

118 Amon J, “Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights,” in Sudarshan N, ed., *HIV/AIDS, Health Care and Human Rights Approaches* (Amicus Books, Jan. 2009). See also Jurgens R, *Increasing Access to HIV Testing and Counseling While Respecting Human Rights* (Open Society Institute, 2007). www.opensocietyfoundations.org/publications/increasing-access-hiv-testing-and-counseling-while-respecting-human-rights-background.

119 Involuntary measures are those undertaken against the individual’s will. Mandatory or compulsory measures are also undertaken against the individual’s will and may also be required by law.

120 Open Society Foundations, *Mandatory Pre-Marital HIV Testing: An Overview* (2010). <http://www.soros.org/sites/default/files/mandatory-premarital-hiv-testing-20100513.pdf>.

121 Amon J, “Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights,” in Sudarshan N, ed., *HIV/AIDS, Health Care and Human Rights Approaches* (Amicus Books, Jan. 2009).

122 UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf. Also see Jurgens R, *Increasing Access to HIV Testing and Counseling While Respecting Human Rights* (Open Society Foundations, 2007). www.opensocietyfoundations.org/publications/increasing-access-hiv-testing-and-counseling-while-respecting-human-rights-background.

123 Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

124 Amon J, “Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights,” in Sudarshan N, ed., *HIV/AIDS, Health Care and Human Rights Approaches* (Amicus Books, Jan. 2009).

Nevertheless, there is little evidence to suggest that relaxed consent standards meet these rigorous standards, let alone provide adequate safeguards against human rights violations. For example, women are disproportionately affected by coercive and involuntary approaches to HIV testing. According to Amon, studies in sub-Saharan Africa have found between 3.5 percent and 14.6 percent of women report abuse following the disclosure of test results.¹²⁵ Jurgens further notes that women may be exposed to higher risk of “criminalization in instances of not disclosing to a sexual partner and not using precautions—when it is precisely because women too often lack autonomy in their sexual relations as a result of violence, cultural norms, and/or economic subordination that they may be unable to disclose or to negotiate safer sex.”¹²⁶

Expanding access to HIV testing must be accompanied by renewed commitment to voluntariness, confidentiality and informed consent, as well as measures to increase access to HIV treatment and to reduce vulnerability to the disease. As Amon notes:

*HIV testing in particular—as the entry point for access to anti-retroviral drugs and important services—must be accessible to all. But efforts to expand HIV testing, and to put in place “routine” testing, must not become coercive, must recognize the rights of the individuals being tested, and must provide linkages to both prevention and care.*¹²⁷

Criminalizing HIV transmission and exposure inhibits advances in HIV prevention and treatment.

Criminalization of HIV transmission inhibits advances in HIV prevention and treatment, deters people from being tested or disclosing their status and can negatively impact the underlying social determinants of health. The Global Commission on HIV and the Law found that “[i]n more than 60 countries, it is a crime to expose another person to or transmit HIV” and that “[m]ore than 600 HIV-positive people across 24 countries, including the United States, have been convicted of such crimes.”¹²⁸ The UN Special Rapporteur on the right to health notes that criminalization has no impact on changing behavior or limiting the spread of HIV. Furthermore, it undermines public health efforts and has a disproportionate impact on vulnerable communities.¹²⁹ Criminalization also forces individuals to disclose their HIV status, which is a violation of their rights and potentially dangerous to their person. Many individuals, especially women, cannot disclose their status without facing stigma, isolation, or violence.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Jurgens R, *Increasing Access to HIV Testing and Counseling While Respecting Human Rights* (Open Society Institute, 2007). www.opensocietyfoundations.org/publications/increasing-access-hiv-testing-and-counseling-while-respecting-human-rights-background.

¹²⁸ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹²⁹ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/14/20 (Apr. 27, 2010).

Migration policies often discriminate on the basis of HIV status and increase vulnerability to HIV.

There are approximately 214 million international migrants and 740 million internal migrants worldwide.¹³⁰ Migrants are disproportionately vulnerable to HIV. According to the Global Commission on HIV and the Law:

Migration policies—restrictions on entry, stay and residence in a country—split families and isolate people from their peers, friends and known ways. These conditions disempower people, exposing them to exploitation, changing their sexual behaviours and increasing the likelihood of unsafe practices. As a result, migrants face a risk of HIV infection that is as much as 3 times higher than that faced by people with secure homes.

Immigration laws and policies often discriminate on the basis of HIV status. Under international law, it is not permitted to deny an asylum-seeker entry on the basis of their HIV status,¹³¹ nor is it possible to detain or restrict the movement of a person on the basis of their HIV status.¹³² Despite this, some countries still impose mandatory HIV testing for asylum and immigration applications, deny entry based upon HIV status,¹³³ and detain people with HIV indefinitely pending asylum or removal. Noncitizens are also excluded from national health care systems, leaving them without access to medical care and HIV treatment.¹³⁴ This constitutes a violation of their human rights while also impeding efforts to prevent and address HIV.

Why a human rights response to HIV?

Protection of human rights, both of those vulnerable to infection and those already infected, is not only important for individuals, but also produces positive public health results. National and local responses to HIV will not work without the full engagement and participation of those affected by HIV, particularly people living with HIV. The human rights of women, young people, and children must be protected if they are to avoid infection and withstand the impact of HIV. The human rights of marginalized groups, including people who use drugs, sex workers, prisoners, and gay and bisexual men, must also be respected for the response to HIV to be effective.

When human rights principles guide implementation of local and national responses to HIV, the results are tailored to the needs and realities of those affected. Such principles include non-discrimination, participation, inclusion, transparency, and accountability. Where states provide comprehensive HIV prevention, care, and impact mitigation programs to all those in need—supporting vulnerable populations and allowing the full participation of all those affected in the design and implementation of HIV programs—they are fulfilling their HIV-related human rights obligations and mounting an effective response to HIV.

When human rights inform the content of national responses to HIV, vulnerability to HIV infection diminishes and people living with HIV can live with dignity. In contrast, where human rights are not respected, protected, and promoted, the risk of HIV infection is increased, people living with and affected by HIV suffer from discrimination, and an effective response to the epidemic is often impeded.

¹³⁰ Institute of Medicine (IOM), *World Migration Report 2011* (2011): 49. http://publications.iom.int/bookstore/free/WMR2011_English.pdf.

¹³¹ UN Office of the High Commissioner of Human Rights, *10 Key Points on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern*. www.ohchr.org/Documents/Issues/HIV/SummaryHIV.pdf; UNAIDS, *Denying Entry, Stay and Residence Due to HIV Status: Ten Things You Need to Know*. www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2009/jc1738_entry_denied_en.pdf.

¹³² Ibid.

¹³³ International AIDS Society (IAS), HIV-specific entry and residence restrictions, IAS Policy Paper (2009). www.iasociety.org/Web/WebContent/File/ias_policy%20paper.pdf. List of countries with restrictions are provided in the Annex.

¹³⁴ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012): 60-61. <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

What are rights-based interventions and practices in the area of HIV?

The protection of human rights is essential to mounting an effective public health response to HIV and safeguarding human dignity. At the same time, an effective response to HIV requires the realization of all human rights in accordance with international human rights standards. As the IPU states, “A rights-based, effective response to the HIV epidemic involves establishing appropriate government institutional responsibilities, implementing law reform and support services, and promoting a supportive environment for groups vulnerable to HIV and for those living with HIV.”¹³⁵ Programmatic reforms to address human rights violations must be incorporated in national HIV programs, including measures to combat discrimination and violence against people infected and affected by HIV. Equally, there must be new laws and policies to address the human rights violations that place vulnerable and marginalized populations at risk of HIV.¹³⁶

Many of the following interventions and practices are modeled on the OHCHR/UNAIDS *International Guidelines on HIV/AIDS and Human Rights*. These 12 guidelines—issued in 1998 at the request of what is now the UN Human Rights Council and reissued in 2006¹³⁷—are an essential resource for governments, policymakers, activists, institutions, and other stakeholders. Since then, UNAIDS has developed a supplemental framework called the 2011 *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*. Together, the *International Guidelines* and *Key Programmes* represent several decades of best practice and should be included in all national responses to HIV. The following list provides an overview and is not intended to be comprehensive. For additional recommendations, please refer to both documents, as well the resources listed at the end of this chapter.

National Frameworks for HIV Response

Each country’s HIV epidemic has distinctive drivers, vulnerabilities, aggravating factors, and affected populations.¹³⁸ To address these social and epidemiological complexities, states should establish a national HIV framework that mobilizes key actors and institutions and includes national HIV action plans, strategies, and activities. At the same time, they should ensure the integration of HIV and human rights into all public sectors, including health, education, law and justice, social security and housing, employment and public service and immigration, among others. States should also establish and strengthen national mechanisms for addressing HIV-related legal, ethical, and human rights issues. An effective, well-integrated, and coordinated national framework for HIV response can help harmonize national laws and policy priorities, facilitate stakeholder engagement and ensure the protection of human rights.¹³⁹

¹³⁵ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹³⁶ Amon J, “Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights,” in Sudarshan N, ed., *HIV/AIDS, Health Care and Human Rights Approaches* (Amicus Books, Jan. 2009).

¹³⁷ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹³⁸ Ibid.

¹³⁹ UN Office of the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pubo7/jc1252-internguidelines_en.pdf.

Community Partnership and Consultation

National responses to the epidemic should include consultation and partnership with community representatives in all phases of HIV policy, programs and evaluation. Community representation should comprise people living with HIV, community-based organizations, administrative services organizations, human rights NGOs, and representatives of vulnerable groups, since these individuals and organizations have highly relevant knowledge and experience of HIV and human rights. States should establish formal and regular mechanisms to facilitate ongoing dialogue with community partners. States also ensure they have political and financial support for activities relating to HIV, law, ethics and human rights.¹⁴⁰

“Therapeutic Citizenship”, Self-Help, and Empowerment

The experience in some African countries has demonstrated the strengths of “therapeutic citizenship” in promoting access to treatment and improving adherence, particularly in resource-constrained settings. According to Nguyen et al., therapeutic citizenship refers to “the way in which people living with HIV appropriate ART as a set of rights and responsibilities” that is less focused on negotiating biosocial vulnerability than social and institutional relationships.¹⁴¹ Robins describes the efforts of one organization, the Treatment Action Campaign in South Africa:

Whereas public health practitioners report that most of their HIV/AIDS patients wish to retain anonymity and invisibility at all costs, TAC successfully advocates the transformation of the stigma of HIV/AIDS into a “badge of pride.” It is through these activist mediations that it becomes possible for the social reintegration and revitalization of large numbers of isolated and stigmatized HIV/AIDS sufferers into a social movement and a caring community—a HIV/AIDS activist culture.¹⁴²

These collectivist responses to HIV and treatment have created an empowering experience and resulted in a network of informed activists who are better able to navigate the health system and advise others on how to best negotiate the health care system.¹⁴³

¹⁴⁰ Ibid.

¹⁴¹ Robins, S. 2006. “From ‘Rights’ to ‘Ritual’”: AIDS Activism in South Africa.” *American Anthropologist* 108(2):312-323. <http://onlinelibrary.wiley.com.ezp-prod1.hul.harvard.edu/doi/10.1525/aa.2006.108.2.312/pdf>; Nguyen VK, “Chapter 17: Trial Communities: HIV and Therapeutic Citizenship in West Africa,” *Evidence, Ethos and Experience: The Anthropology and History of Medical Research in Africa*, Geissler WP and Molyneux C, eds., (Berghahn Books, 2011).

¹⁴² Robins, S. 2006. “From ‘Rights’ to ‘Ritual’”: AIDS Activism in South Africa.” *American Anthropologist* 108(2):312-323. <http://onlinelibrary.wiley.com.ezp-prod1.hul.harvard.edu/doi/10.1525/aa.2006.108.2.312/pdf>.

¹⁴³ Robins, S. 2006. “From ‘Rights’ to ‘Ritual’”: AIDS Activism in South Africa.” *American Anthropologist* 108(2):312-323. <http://onlinelibrary.wiley.com.ezp-prod1.hul.harvard.edu/doi/10.1525/aa.2006.108.2.312/pdf>; Nguyen VK, “Chapter 17: Trial Communities: HIV and Therapeutic Citizenship in West Africa,” *Evidence, Ethos and Experience: The Anthropology and History of Medical Research in Africa*, Geissler WP and Molyneux C, eds., (Berghahn Books, 2011).

Public Health Legislation

States should review and reform public health legislation and practices so that they support access to HIV and health services.¹⁴⁴ Specifically, legislation should ensure provision of comprehensive HIV prevention and treatment services—such as information and education, voluntary testing and counseling, sexual and reproductive health services, condoms, harm reduction services, drug treatment, antiretroviral therapy, treatment for HIV/AIDS-related illnesses and palliative care.¹⁴⁵ Legislation should also ensure that HIV testing is only performed with an individual’s specific, informed consent, provide for pre-test and post-test counseling and protect against unauthorized collection, use or disclosure of information relating to HIV status. No one should be subjected to coercive measures such as isolation, detention or quarantine based on their HIV status.¹⁴⁶

Criminal Laws and Correctional Systems

Punitive laws, correctional systems, and denial of access to justice for people infected and affected by HIV are fueling the epidemic.¹⁴⁷ States should review and reform criminal legislation, correctional systems and law enforcement practices to ensure they are “consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups.”¹⁴⁸ The following measures are among those recommended:

- **Decriminalize the transmission of HIV.** At most, “criminalization should be considered permissible only in cases involving intentional, malicious transmission.”¹⁴⁹
- **Decriminalize homosexuality and decriminalize same-sex relations.** This is an important step to reducing the stigma, discrimination and inequality increases the vulnerability of men who have sex with men.
- **Decriminalize sex work and provide support to sex workers.** Criminalization exposes sex workers to violence, exploitation and victimization, including from police. Creating safer working environments and ensuring access to health services, advocacy and other forms of support enable sex workers to seek services and protection without fear of criminal penalties.¹⁵⁰
- **Reform approaches to drug use and advocate for non-discriminatory treatment of people who inject drugs.** Harsh and punitive drug laws exacerbate harms associated with drug use. States should offer harm reduction programs and voluntary, evidence-based treatment.¹⁵¹

¹⁴⁴ UNAIDS, *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

¹⁴⁵ UN Office of the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). <http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines>.

¹⁴⁶ Ibid.

¹⁴⁷ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁴⁸ UN Office of the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁴⁹ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/14/20 (Apr. 27, 2010). <http://www2.ohchr.org/english/bodies/hrcouncil/14session/reports.htm>.

¹⁵⁰ UNAIDS, *UNAIDS Guidance Note on HIV and Sex Work* (2009). www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf.

¹⁵¹ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

- **Review laws, policies, and practices that prevent prisoners from accessing HIV-related services.** Prisoners are entitled to the same rights as other individuals, “with the exception of restrictions on liberty directly related to their imprisonment,” and should have access to health information, treatment, care, and support.¹⁵²

A necessary complement to legislative and criminal justice reform is the sensitization of lawmakers and law enforcement agencies and personnel to the role of law, ethics and human rights in the HIV response. Such programs can “help ensure that individuals living with and vulnerable to HIV can access HIV services and lead full and dignified lives, free from discrimination, violence, extortion, harassment, and arbitrary arrest and detention.”¹⁵³

Anti-Discrimination and Protective Laws

Enabling legal, social and policy environments are necessary to eliminate HIV-related stigma, discrimination, and violence, to provide legal protections for people affected by HIV, and to promote and protect the human rights in the context of HIV.¹⁵⁴ States should therefore enact or strengthen anti-discrimination and other protective laws that protect people living with HIV or members of vulnerable populations from discrimination in both the public and private sectors, ensure privacy and confidentiality and provide access to justice for HIV-related right violations.¹⁵⁵ Specific recommendations include, but are not limited to:

- Explicitly prohibit discrimination against people based on actual or perceived HIV status, covering “health care, social security, welfare benefits, employment, education, sport, accommodation, clubs, trades unions, qualifying bodies, access to transport and other services”;¹⁵⁶
- Abolish mandatory HIV-related registration, testing and forced treatment;
- Work with guardians of traditional and customary laws for consistency with anti-discrimination principles and provide legal remedies for misuse;¹⁵⁷
- Enact general privacy and confidentiality laws, including the use of HIV-related information;¹⁵⁸ and
- Promote and protect the rights of vulnerable and at-risk populations, including women, children, young persons, men who have sex with men, sex workers, prisoners, and other people in detention settings and people living with HIV.¹⁵⁹

¹⁵² UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

¹⁵³ UNAIDS, *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

¹⁵⁴ See 2011 Political Declaration

¹⁵⁵ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁵⁶ Ibid.

¹⁵⁷ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf. See also Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁵⁸ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁵⁹ UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

The IPU's *Handbook for Legislators on HIV/AIDS, Law and Human Rights* provides a checklist of key components of anti-discrimination legislation, privacy legislation and employment legislation to help stakeholders develop longer-term, strategic plans and programs to address HIV-related stigma and discrimination.¹⁶⁰

Universal Access to HIV Prevention, Treatment, Care, and Support

Vast inequities in access to HIV prevention, treatment, care, and support violate a number of human rights—including the right to health, the right to non-discrimination and equality before the law, the right to an adequate standard of living and social security, the right to participation in political and cultural life, and the right to enjoy the benefits of scientific progress.¹⁶¹ States should therefore enact legislation, policies and other measures to ensure universal and equal access to appropriate, affordable and quality HIV-related goods, services and information, “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.”¹⁶²

States should make sufficient resources available to meet the commitments outlined in their national HIV strategies, strengthen their health systems and address health-worker shortages. States should also strive to make HIV medicines more affordable for all. A barrier to access is a global intellectual property (IP) protection regime that hinders the production and distribution of low-cost medicines. The IP regulations enforced by the World Trade Organization's TRIPS (“The Agreement on Trade Related Aspects of Intellectual Property Rights”) enable pharmaceutical companies to maintain monopolies on drug patents, resulting in higher costs and “catastrophic” outcomes for resource-poor countries unable to afford HIV medicines.¹⁶³ The IPU recommends the following measures to address the situation:

A number of mechanisms are available to help make HIV medicines more affordable. These include generic competition, local production, differential pricing by research-based and generic pharmaceutical companies, voluntary licensing by innovator to generic companies, high-volume and bulk-purchasing arrangements, elimination of tariffs and taxes on essential medicines, and the use of flexibilities in the international trade and intellectual property rules (through the TRIPS Agreement and other WTO mechanisms) to achieve wider access to affordable generic medicines.

The Global Commission on HIV and the Law thus urges all countries to suspend TRIPS as it relates to essential medicines and adopt a “moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment.”¹⁶⁴

¹⁶⁰ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹⁶¹ UNAIDS and UN Office of the High Commissioner for Human, *Handbook on HIV and Human Rights for National Human Rights Institutions* (2007). http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf.

¹⁶² UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁶³ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁶⁴ Ibid.

Finally, States should also address barriers to equal access by vulnerable populations, such as poverty, migration, rural location, and discrimination.¹⁶⁵ Social protection programs can promote the uptake of HIV services while alleviating the social and economic impacts of HIV.¹⁶⁶ According to UNICEF, “HIV sensitive social protection can be grouped into three broad categories of interventions: financial protection through predictable transfers of cash or food for those HIV-affected and most vulnerable; access to affordable quality services including treatment, health, and education services; and policies, legislation and regulation to meet the needs and uphold the rights of the most vulnerable and excluded.”¹⁶⁷

Legal Support Services

According to OHCHR, “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.”¹⁶⁸ The provision of HIV-related legal services can facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters, including but not limited to “estate planning; breaches of privacy and confidentiality; illegal action by the police; discrimination in employment, education, housing or social services; and denial of property and inheritance rights.” At the same time, legal literacy programs and campaigns (“Know Your Rights”) teach people about human rights and laws relevant to HIV, enabling them to organize around these rights advocate for their needs.¹⁶⁹

Reducing Vulnerability Among Key Groups

Women and Girls

“Gender inequality, gender-based violence, and the low status of women remain three of the principal drivers of HIV.” Addressing the political, social, economic, and sexual subordination of women and girls is therefore critical to reducing their vulnerability to HIV.¹⁷⁰ States should enact or strengthen laws to protect women’s equal rights in a broad range of areas, including:

- **Education.** Education is instrumental in providing information on HIV itself, but also in empowering women and providing a means for their economic and social independence.
- **Inheritance and Property Ownership.** Unequal inheritance and property laws and customs deprive women of the financial and social resources to prevent infection and mitigate the consequences of HIV.¹⁷¹
- **Employment and Compensation.** Equal rights to employment and fair compensation provide the opportunity to offset the costs of care associated with HIV or the loss of an income-earning partner or family member.

¹⁶⁵ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁶⁶ Nolan A, *Social Protection in the Context of HIV and AIDS* (OECD, 2009), www.oecd.org/development/povertyreduction/43280854.pdf.

¹⁶⁷ UNICEF, *Enhancing Social Protection for HIV Prevention, Treatment, Care & Support –The State of Evidence* (2010). www.unicef.org/aids/files/Social_Protection_Brief_LowresOct2010.pdf.

¹⁶⁸ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁶⁹ UNAIDS, *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

¹⁷⁰ Ibid.

¹⁷¹ Strickland R, *To Have and To Hold: Women’s Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa* (International Center for Research on Women, June 2004). www.icrw.org/files/publications/To-Have-and-To-Hold-Womens-Property-and-Inheritance-Rights-in-the-Context-of-HIV-AIDS-in-Sub-Saharan-Africa.pdf.

- **Gender-Based Violence, Domestic Violence, and Spousal Rape.** Measures to eliminate violence against women include: enactment of formal laws, like those that criminalize marital rape; policy and program changes; training programs for police and health care providers; increased health and psychological services; and legal recourse for rights violations.
- **Equitable Budgetary Allotment.** Only 46% of countries allocate resources for the specific needs of women and girls into HIV programs.¹⁷² HIV programs must incorporate women and their needs and countries must demonstrate their commitment through budgetary allotment.
- **Sexual and Reproductive Health Rights.** Providing information and access to reproductive services enables women to protect themselves against HIV and mitigate its consequences. Formal educational efforts, as well as health providers and mediators can provide women with information on HIV.

Children

Less than a quarter of children in need of ART receive treatment,¹⁷³ and children affected by the loss of a caregiver from HIV-related causes are at grave risk of human rights violations. States should therefore reduce the vulnerability of children and to protect their rights through the following measures: laws protecting orphans and other vulnerable children from abuse, violence, exploitation, and discrimination; full implementation of the Convention on the Rights of the Child and its Optional Protocols into national legislation; laws, policies, and practices to prevent mother-to-child transmission and to increase access to affordable HIV treatment for children; and policies and programs to enable children to stay in school.¹⁷⁴ Additional measures aimed at the empowerment of children include ensuring access to health information and education; education about the rights of persons, including children, living with HIV; and access to confidential sexual and reproductive health services.¹⁷⁵

Young People

Young people aged 15 to 24 represent half of all new HIV infections, and young women are disproportionately vulnerable. States should address the specific needs of this population by ensuring that they have full access to HIV prevention, treatment, care and support, including comprehensive sex and health information and education. Programs should also address HIV-related ignorance, fear, and prejudice by empowering young people to discuss and address the social and cultural issues related to the epidemic, including gender-discrimination, violence, exploitation, and rape. Finally, the IPU recommends ensuring that young people have life skills education “to develop healthy attitudes and the negotiating capacity to make informed, healthy choices about sex, drugs, relationships and other issues.”¹⁷⁶

¹⁷² UNAIDS, *Report on the global AIDS epidemic 2010* (2010) www.unaids.org/globalreport/global_report.htm.

¹⁷³ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁷⁴ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹⁷⁵ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁷⁶ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

Men Who Have Sex With Men

Men who have sex with men are frequently marginalized by society, and many HIV programs and policies do not address their specific needs. As a result, they experience high rates of infection. Laws and policies should address the stigma and discrimination experienced by men who have sex with men and increase access to HIV prevention and treatment services. Countries should also enact anti-discrimination laws, implement privacy laws for same-sex relations, create measures to prevent violence and permit gay, lesbian and bisexual groups to organize.¹⁷⁷

Sex Workers

Sex workers are highly vulnerable to infection and often lack access to HIV services “due to exploitation within the industry, as well as widespread police abuse.”¹⁷⁸ OHCHR/UNAIDS recommend that adult sex work that involves no victimization should be decriminalized, and then legally regulated with respect to occupational health and safety conditions. This can protect both sex workers and their clients, including support for safe sex during sex work.¹⁷⁹ Additionally, sex workers should be provided full and equal access to HIV prevention, treatment, care, and support services, tailored to their needs and consistent with their fundamental human rights.

People Who Inject Drugs

In many countries, people who use illicit drugs account for the majority of people living with HIV but they are the least likely to receive ART. To reduce the vulnerability of this population and to eliminate one of the key drivers of the HIV epidemic, states should put in place rights-based and evidence-based programs that are effective in reducing the risk behaviours and vulnerability to HIV of people who use drugs, including needle and syringe programs, voluntary drug treatment programs, sensitization of health care providers and law enforcement personnel, equal access to ART and care services, peer education and outreach, and access to legal assistance and legal remedies for rights violations.¹⁸⁰

Prisoners

Many prisoners have little or no access to voluntary HIV prevention information and tools or to HIV testing or treatment. States should scale up funding as well as access to health services for prisoners, including HIV services. Specific measures to reduce vulnerability include provision of condoms and needles and syringes, as well as criminal justice reform to reduce the number of people in prison—e.g., decriminalizing the status of drug users and limiting pretrial detention.¹⁸¹

¹⁷⁷ Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁷⁸ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹⁷⁹ UN Office of the High Commissioner for Human and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

¹⁸⁰ Inter-Parliamentary Union, *Handbook for Parliamentarians on HIV/AIDS, Law and Human Rights* (2007). http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf.

¹⁸¹ Ibid.

Education, Training, and Media

While many countries outlaw discrimination based on HIV, these laws are routinely ignored, unenforced or flouted. According to the Global Commission on HIV and the Law:

*To make law real on the ground, the state must educate health care workers, legal professionals, employers and trade unionists, and school faculties about their legal responsibilities to guarantee inclusion and equality.*¹⁸²

The goal of education and training is to inform people living with HIV of their rights, as well to challenge beliefs based on ignorance, fear, prejudice, and moral judgment. States should therefore “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.”¹⁸³

Public and Private Sector Standards and Mechanism

OHCHR/UNAIDS recommend that “[s]tates 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.”¹⁸⁴ This includes training health care providers and other professionals in health care settings on human rights and medical ethics related to HIV. As UNAIDS notes:

*Human rights and ethics training for health care providers focus on two objectives. The first is to ensure that health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions, compensation for work-related infection) and to non-discrimination in the context of HIV. The second is to reduce stigmatizing attitudes in health care settings and to provide health care providers with the skills and tools necessary to ensure patients’ rights to informed consent, confidentiality, treatment and non-discrimination.*¹⁸⁵

Monitoring and Enforcement of Human Rights

OHCHR/UNAIDS recommend that “[s]tates should ensure monitoring and enforcement mechanisms to guarantee HIV-related human rights, including those of people living with HIV, their families and communities.”¹⁸⁶

International Cooperation

OHCHR/UNAIDS recommend that “[s]tates 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 the international level.”¹⁸⁷

¹⁸² Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012). <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>.

¹⁸³ UN Office for the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pubo7/jc1252-internguidelines_en.pdf.

¹⁸⁴ Ibid.

¹⁸⁵ UNAIDS, *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses* (2012). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

¹⁸⁶ UN Office for the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). http://data.unaids.org/Publications/IRC-pubo7/jc1252-internguidelines_en.pdf.

¹⁸⁷ Ibid.

2. WHICH ARE THE MOST RELEVANT INTERNATIONAL AND REGIONAL HUMAN RIGHTS STANDARDS RELATED TO HIV?

How to read the tables

Tables A and B provide an overview of relevant international and regional human rights instruments. They provide a quick reference to the rights instruments and refer you to the relevant articles of each listed human right or fundamental freedom that will be addressed in this chapter.

From Table 1 on, each table is dedicated to examining a human right or fundamental freedom in detail as it applies to HIV. The tables are organized as follows:

Human right or fundamental freedom	
Examples of Human Rights Violations	
Human rights standards	<p>UN treaty body interpretation</p> <p>This section provides general comments issued by UN treaty bodies as well as recommendations issued to States parties to the human right treaty. These provide guidance on how the treaty bodies expect countries to implement the human rights standards listed on the left.</p>
Human rights standards	<p>Case law</p> <p>This section lists case law from regional human rights courts only. There may be examples of case law at the country level, but these have not been included. Case law creates legal precedent that is binding upon the states under that court's jurisdiction. Therefore it is important to know how the courts have interpreted the human rights standards as applied to a specific issue area.</p>
<p>Other interpretations: This section references other relevant interpretations of the issue. It includes interpretations by:</p> <ul style="list-style-type: none"> • UN Special Rapporteurs • UN working groups • International and regional organizations • International and regional declarations 	

The tables provide examples of human rights violations as well as legal standards and precedents that can be used to redress those violations. These tools can assist in framing common health or legal issues as human rights issues, and in approaching them with new intervention strategies. In determining whether any human rights standards or interpretations can be applied to your current work, consider what violations occur in your country and whether any policies or current practices in your country contradict human rights standards or interpretations.

Human rights law is an evolving field, and existing legal standards and precedents do not directly address many human rights violations. Through ongoing documentation and advocacy, advocates can build a stronger body of jurisprudence on human rights and HIV.

Abbreviations

In the tables, we use the following abbreviations to refer to the eleven treaties and their corresponding enforcement mechanisms:

Treaty	Enforcement Mechanism
Universal Declaration of Human Rights (UDHR)	None
International Covenant on Civil and Political Rights (ICCPR)	Human Rights Committee (HRC)
International Covenant on Economic, Social, and Cultural Rights (ICESCR)	Committee on Economic, Social and Cultural Rights (CESCR)
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	Committee on the Elimination of Discrimination Against Women (CEDAW Committee)
International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	Committee on the Elimination of Racial Discrimination (CERD)
Convention on the Rights of the Child (CRC)	Committee on the Rights of the Child (CRC Committee)
African Charter on Human and Peoples' Rights and Protocols (ACHPR)	African Commission on Human and Peoples' Rights (ACHPR Commission)
[European] Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)	European Court of Human Rights (ECtHR)
1996 Revised European Social Charter (ESC)	European Committee of Social Rights (ECSR)
American Convention on Human Rights (ACHR)	Inter-American Court of Human Rights (IACHR)
American Declaration of the Rights and Duties of Man (ADRDM)	Inter-American Court of Human Rights (IACHR)

Also cited are the former Commission on Human Rights (CHR) and various UN Special Rapporteurs (SR) and Working Groups (WG).

Table A: International Human Rights Instruments and Protected Rights and Fundamental Freedoms

	UDHR	ICCPR	ICESCR	CEDAW	ICERD	CRC
Life	Art. 3	Art. 6(1)				Art. 6(1)
Torture or Cruel, Inhuman or Degrading Treatment*	Art. 5	Art. 7				Art. 37(a)
Liberty and Security of Person	Art. 3	Art. 9(1)			Art. 5(b)	
Enjoy and Seek Asylum	Art. 14					
Privacy	Art. 12	Art. 17				Art. 16
Expression and Information	Art. 19	Art. 19(2)			Art. 5(d) (viii)	Art. 12, Art. 13, Art. 17
Assembly and Association	Art. 20	Art. 21, Art. 22			Art. 5(d) (ix)	Art. 15
Marry and Found a Family	Art. 16	Art. 23(2)		Art. 16(1)	Art. 5(d) (iv)	
Non-discrimination and Equality	Art. 1, Art. 2	Art. 2(1), Art. 3	Art. 2(2), Art. 3	Art. 2, All	Art. 2, Art. 5, All	Art. 2
Health	Art. 25		Art. 12	Art. 12	Art. 5(e) (iv)	Art. 24
Women and Children	Art 16, Art. 25(2)	Art. 3, Art. 23, Art. 24	Art. 3, Art. 10, Art. 12(2) (a)	All		All

*See also Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Article 2.

Table B: Regional Human Rights Instruments & Protected Rights and Fundamental Freedoms

	UDHR	ICCPR	ICESCR	CEDAW	ICERD	CRC
Life	Art. 3	Art. 6(1)				Art. 6(1)
Torture or Cruel, Inhuman or Degrading Treatment*	Art. 5	Art. 7				Art. 37(a)
Liberty and Security of Person	Art. 3	Art. 9(1)			Art. 5(b)	
Enjoy and Seek Asylum	Art. 14					
Privacy	Art. 12	Art. 17				Art. 16
Expression and Information	Art. 19	Art. 19(2)			Art. 5(d) (viii)	Art. 12, Art. 13, Art. 17
Assembly and Association	Art. 20	Art. 21, Art. 22			Art. 5(d) (ix)	Art. 15
Marry and Found a Family	Art. 16	Art. 23(2)		Art. 16(1)	Art. 5(d) (iv)	
Non-discrimination and Equality	Art. 1, Art. 2	Art. 2(1), Art. 3	Art. 2(2), Art. 3	Art. 2, All	Art. 2, Art. 5, All	Art. 2
Health	Art. 25		Art. 12	Art. 12	Art. 5(e) (iv)	Art. 24
Women and Children	Art 16, Art. 25(2)	Art. 3, Art. 23, Art. 24	Art. 3, Art. 10, Art. 12(2) (a)	All		All

Table I: HIV, AIDS and the right to life

Examples of Human Rights Violations
<ul style="list-style-type: none"> • Police fail to investigate the murder of a person living with HIV. • Government places unjustified legal restrictions on access to life-saving HIV-prevention or treatment measures. • Government imposes a death sentence for intentional transmission of HIV. • Woman is denied access to post-exposure prophylaxis to prevent HIV following rape.

Human Rights Standards	Treaty Body Interpretation
<p>ICCPR 6(1) Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.</p>	<p>HRC General Comment 6: Explaining that Art. 6 of the ICCPR creates positive obligations on States to protect life, and that “the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.” ¶5 (1982).</p> <p>HRC: Interpreting the right to life, the HRC has recommended that Namibia “pursue efforts to protect its population from HIV/AIDS” and “adopt comprehensive measures encouraging and facilitating greater numbers of persons suffering from HIV and AIDS to obtain adequate antiretroviral treatment and facilitate such treatment.” CCPR/CO/81/NAM (July 30, 2004).</p> <p>HRC: Recommending “equal access to treatment” in Kenya. CCPR/CO/83/KEN (April 29, 2005).</p> <p>HRC: Recommending that Uganda “allow greater number of persons suffering from HIV/AIDS to obtain adequate antiretroviral treatment.” CCPR/CO/80/UGA (May 4, 2004).</p>

Human Rights Standards	Case Law
<p>ECHR 2(1): Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.</p>	<p>ECtHR: The applicant argued that the decision to remove him from the U.K. where he receives antiretroviral drugs to control his case of HIV to St. Kitts where he would likely be unable to obtain antiretroviral drugs necessary to prevent his death from HIV/AIDS-related illness would violate Art. 2. The Court found that the complaint under Art. 2 is “indissociable” from the substance of the complaint under Art. 3 (freedom from inhuman or degrading treatment). <i>D.V. v. The United Kingdom</i>, 30240/96 (May 2, 1997).</p>

Table 2: HIV, AIDS and freedom from torture and cruel, inhuman, and degrading treatment, including in prison

Examples of Human Rights Violations
<ul style="list-style-type: none"> • Outreach workers conducting HIV prevention with MSM are detained and beaten by police. • An activist is detained and tortured for exposing State complicity in a HIV blood scandal. • Prisoners are denied HIV-related information, education, means of prevention (e.g., condoms, sterile injection equipment, and bleach) and HIV testing/treatment. • Authorities fail to take steps to prosecute or prevent prison rape.

Human Rights Standards	Treaty Body Interpretation
<p>ICCPR 7: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.</p>	<p>HRC: expressing concern about the “high incidence of HIV/ AIDS and tuberculosis among detainees in facilities of the State party. . . along with absence of specialized care for pre-trial detainees” in Ukraine. The Committee recommended that Ukraine relieve prison overcrowding, provide hygienic facilities, assure access to health care and adequate food and reduce the prison population, including by using alternative sanctions. CCPR/C/UKR/CO (2006).</p>

Human Rights Standards	Case Law
<p>ECHR 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.</p>	<p>ECtHR: finding failure to provide a prisoner with timely and appropriate AIDS and TB treatment to constitute a violation of the right to freedom from torture and inhuman or degrading treatment. <i>Yakovenko v. Ukraine</i>, 15825/06 (October 25, 2007).</p> <p>ECtHR: The applicant applied for and was refused asylum in the U.K. Her claim under Art. 3 was based on her medical condition (HIV/AIDS) and the lack of sufficient treatment in her home country. The Court found that the deterioration that she would suffer involved a certain degree of speculation and that it did not involve exceptional circumstances. Therefore, the Court found no violation of Art. 3. <i>N. v. The United Kingdom</i>, 26565/05 (May 27, 2008).</p>

Other Interpretations

Standard Minimum Rules for the Treatment of Prisoners (1955)

Principle 22(2): Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

Principle 24: The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

Table 3: HIV, AIDS and the right to liberty and security of the person

Examples of Human Rights Violations
<ul style="list-style-type: none"> • Government quarantines people living with HIV or detains them in special colonies. • Penal code imposes explicit prison term for intentional transmission of HIV. • Government requires HIV testing either for all individuals or as a condition of employment, immigration or military service.

Human Rights Standards	Treaty Body Interpretation
<p>ICCPR 9: 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 procedure as are established by law.</p>	<p>None</p>

Human Rights Standards	Case Law
<p>ECHR 5(1): Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save [for those cases enumerated in this article and only in accordance with the law].</p>	<p>ECtHR: The Court held that the involuntary placement in the hospital of an HIV-positive gay man to prevent him from spreading HIV to others violated Art. 5. The Court found that the “compulsory isolation of the applicant was not a last resort in order to prevent him from spreading the HIV virus because less severe measures had not been considered and found to be insufficient to safeguard the public interest. Moreover, the Court considered that by extending over a period of almost seven years the order for the applicant’s compulsory isolation, with the result that he was placed involuntarily in a hospital for almost one and a half years in total, the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant’s right to liberty.” <i>Enhorn v. Sweden</i>, 56529/00 (January 25, 2005).</p>

Other Interpretations

Working Group on Arbitrary Detention: expressed concern at the arbitrary detention of “drug addicts” and “people suffering from AIDS.” Recommended that persons deprived of their liberty on health grounds “must have judicial means of challenging their detention.” (2003)

Code of Conduct for Law Enforcement Officials (1979)

Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (1990)

Table 4: HIV, AIDS and the right to seek and enjoy asylum

Examples of Human Rights Violations	
<ul style="list-style-type: none"> • A State returns an asylum-seeker to a country where she or he faces persecution on the basis of HIV status or HIV activism. • A State excludes persons living with HIV from being granted asylum, or discriminates on the basis of HIV status in the context of travel regulations, entry requirements or immigration and asylum procedures. • Refugees and asylum seekers face discrimination in access to HIV prevention and treatment services. 	
Human Rights Standards	Treaty Body Interpretation
ICCPR 14(1): All persons shall be equal before the courts and tribunals.	HRC: 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. This would include travel regulations, entry requirements, and immigration and asylum procedures.
Human Rights Standards	Case Law
ECHR 14: The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.	ECTHR: Held that refusing a residence permit to a foreign national solely on the basis of their HIV-positive status amounted to unlawful discrimination. <i>Kiyutin v. Russia</i> , 2700/10 (March 10, 2011).

Other Interpretations

Special Rapporteur on Trafficking: Recommending to **Lebanon** that “[p]otential victims of trafficking and exploitation, including women that have contracted HIV/AIDS or other sexually transmitted diseases, must not be immediately deported but given adequate legal, medical and social assistance, including access to interpretation in language they understand.”
E/CN.4/2006/62/Add.3 (SR Trafficking, 2006)

Geneva Convention Relating to the Status of Refugees (as amended by the 1967 Protocol Relating to Status of Refugees). Defining “refugee” and providing rule of non-refoulement.

Convention Against Torture 3(1): No State Party shall expel, return (“refouler”) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

The **United Nations High Commissioner for Refugees** issued policy guidelines in 1988 stating that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening to exclude HIV-positive individuals from being granted asylum.

Declaration of Territorial Asylum, G.A. Res. 2312 (XXII) (December 14, 1967).

Convention Governing the Specific Aspects of Refugee Problems in Africa, adopted September 10, 1969 (entered into force June 20, 1974).

Recommended Guidelines on Human Rights and Human Trafficking

Guideline 2(7): Ensuring that procedures and processes are in place for receipt and consideration of asylum claims from both trafficked persons and smuggled asylum seekers ...

Guideline 6(8): Measures should be taken to ensure the provision of appropriate physical and psychological health care, housing and educational and employment services for returned trafficking victims.

HIV-related restrictions on entry, stay, and residence, UNAIDS Human Rights and Law Team, July 2012, available at: www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120724CountryList_TravelRestrictions_July2012.pdf. Restrictions listed by country.

Table 5: HIV, AIDS and the right to privacy

Examples of Human Rights Violations
<ul style="list-style-type: none"> • A person is tested for HIV without his or her consent. • A hospital or health care worker fails to maintain confidentiality of a patient’s HIV status or medical records. • Government requires registration by name of all people living with HIV. • Government requires disclosure of HIV status on certain forms such as sick-leave certificates, job applications, and medical prescriptions. • Penal code criminalizes certain sexual acts between consenting adults, such as fornication, oral sex, anal sex, or adultery.

Human Rights Standards	Treaty Body Interpretation
<p>ICCPR 17(1): No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation.</p> <p>ICCPR 17(2): Everyone has the right to the protection of the law against such interference or attacks.</p>	<p>HRC [Jurisprudence]: In finding that the right to privacy is violated by laws that criminalize homosexual acts between consenting adults, the Human Rights 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 and AIDS...[B]y 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 and AIDS prevention.” <i>Toonen v. Australia</i>, CCPR/C/50/D/488/1992 (March 31, 1994).</p>
<p>ICESCR 12(1): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.</p>	<p>CESCR: Recommending to Moldova that “the state party ensure the confidentiality of a patient’s HIV status, including through reforming the law on HIV/AIDS, and reform of the data management system on HIV/AIDS. The committee also recommends that the state party take steps to eliminate the mandatory indication of disease codes on all medical sick leave forms.” E/C.12/MDA/CO/2 (CESCR, 2011)</p>
<p>CEDAW 12(1): States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services.</p>	<p>CEDAW Committee General Recommendation No. 24: Explaining that “[t]he issue of HIV/AIDS and other sexually transmitted disease are central to the rights of women and adolescent girls to sexual health. . . . In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designated programmes that respect their rights to privacy and confidentiality.” Para. 18 (20th Session, 1999).</p> <p>CEDAW Committee General Recommendation No. 24: explaining that “States parties should also, in particular . . . (e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice” Para. 31 (20th Session, 1999).</p> <p>CEDAW Committee: recommending to Zambia that it “undertake awareness-raising campaigns throughout the state party and among personnel in multiple sectors of government in respect of the prevention, protection and maintenance of confidentiality in order to systemize and integrate approaches for combating HIV/AIDS.” CE-DAW/C/ZMB/CO/5-6 (CEDAW, 2011)</p>

Table 5 (cont.)

Human Rights Standards	Case Law
<p>ECHR 8(1): Everyone has the right to respect for his private and family life, his home and his correspondence.</p> <p>ECHR 8(2): There shall be no interference by a public authority with the exercise of this right except such is in accordance with the law and is necessary in a democratic in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.</p>	<p>ECtHR: “As the spouse of a Russian national and father of a Russian child, the applicant was eligible to apply for a residence permit by virtue of his family ties to Russia . . . For his application to be completed, he needed to submit to HIV-testing and enclose a certificate showing that he was not infected with HIV . . . After the test revealed his HIV-positive status, his application for a residence permit was rejected on account of the absence of the mandatory HIV clearance certificate.” “Taking into account that the applicant belonged to a particularly vulnerable group, that his exclusion has not been shown to have a reasonable and objective justification, and that the contested legislative provisions did not make room for an individualised evaluation, the Court held that the applicant was a victim of discrimination on account of his health status in violation of Art. 14, taken together with Art. 8. <i>Kiyutin v. Russia</i>, 2700/10 (March 10, 2011).</p> <p>ECtHR: The applicant’s HIV status was published in the newspaper claiming that the diagnosis was confirmed by the local hospital. The Court explained that “the Court has previously held that the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in legal systems of all Contract Parties to the Convention. The above considerations are especially valid as regards the protection of the confidentiality of a person’s HIV status.” The Court found that “State failed to secure the applicant’s right to respect for her private life.” <i>Biriuk v. Lithuania</i>, 23373/03, para. 39 (November 25, 2008).</p> <p>ECtHR: “In her application to the Commission the applicant complained, amongst other things, about the failure of the Finnish authorities to prevent the disclosure by the press of her identity and her medical condition as an HIV carrier . . . The Court thus reaches the conclusions that there has been no violation of Article 8 of the Convention (art. 8)(1) with respect to the orders requiring the applicant’s medical advisers to give evidence or (2) with regard to the seizure of her medical records and their inclusion in the investigation file. On the other hand, it finds (3) that making the medical data concerned accessible to the public as early as 2002 would, if implemented, give rise to a violation of Article (art. 8) and (4) that there has been a violation thereof (art. 8) with regard to the publication of the applicant’s identity and medical condition in the Court of Appeal’s judgment.” <i>Z v. Finland</i>, 22009/93, para. 62 (February 25, 1997).</p>

Other Interpretations

Declaration on the Promotion of Patients’ Rights in Europe, Art. 4.1: All information about a patient’s health status . . . must be kept confidential, even after death.

Declaration on The Promotion of Patients’ Rights in Europe, Art. 4.8: Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy .

European Convention on Human Rights and Biomedicine, Art. 10(1): Everyone has the right to respect for private life in relation to information about his or her health.

Table 6: HIV, AIDS and freedom of expression and information

Examples of Human Rights Violations
<ul style="list-style-type: none"> • Government censors HIV-prevention information directed at LGBT persons, sex workers, or people who use drugs on the grounds that it is obscene or promotes criminalized behavior. • Schools deny young people information about HIV and AIDS, safer sex, sexuality, or condoms. • Media reporting on HIV engages in stigma and stereotyping rather than providing factual information. • Government restricts a newspaper, website, or other communication by activists critical of government AIDS policies.

Human Rights Standards	Treaty Body Interpretation
<p>CRC 13(1): The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child’s choice.</p> <p>CRC 17: States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.</p>	<p>CRC General Comment No. 4: Providing numerous connections between the provisions of art. 13 and the right of children to access information regarding their health. CRC/GC/2003/4 (2003).</p> <p>CRC General Comment No. 3: Has concluded that adolescent’s right to information about HIV and AIDS is part of the right to information. CRC/GC/2003/3, ¶4 (2003).</p> <p>CRC General Comment No. 3: Finding that “[a]dequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected. The most relevant rights in this regard, in addition to those enumerated in paragraph 5 above, are the following: the right to access information and material aimed at the promotion of their social, spiritual and moral well being and physical and mental health (art. 17)”, CRC/GC/2003/3, ¶6 (2003).</p> <p>CRC: Recommending that Panama “provide children with accurate and objective information about substance use, including hard drugs and tobacco, and protect children from harmful misinformation,” as well as to “strengthen its efforts to address adolescent health issues... [including those] to prevent and combat HIV/AIDS and the harmful effects of drugs.” CRC/C/15/Add.233 (2004).</p> <p>CRC: Has expressed concern that Estonia is “increasing number of HIV-infections among injecting drug users” and encouraged the government “to continue its efforts to provide children with accurate and objective information about substance use”. CRC/C/15/Add.196 (2003).</p>

Other Interpretations

SR Education: Has noted the need for sexuality education in schools, as well as the need for schools to ensure the safety of gay and lesbian students.

SR Freedom of Expression and Information: Has commented on the abuse of the rights of sex workers and LGBT persons; noted restrictions on public speech and denial of HIV and AIDS information to these communities; noted the detention of persons in Kuwait because of a letter mentioning a lesbian relationship; and expressed concern in Uganda about the arrests and harassment of two gender-non-conforming women.

Table 7: HIV, AIDS and freedom of assembly and association

Examples of Human Rights Violations
<ul style="list-style-type: none"> • State restricts formation of nongovernmental, community-based, or service organizations working on HIV and AIDS or imposes prohibitive bureaucratic requirements. • Police disperse a peaceful and authorized demonstration by AIDS activists.

Other Interpretations

Charter of Fundamental Rights of the European Union

Art. 12(1): Everyone has the right to freedom of peaceful assembly and to freedom of association at all levels, in particular in political, trade union and civic matters, which implies the right of everyone to form and to join trade unions for the protection of his or her interests.

Art. 12(2): Political parties at Union level contribute to expressing the political will of the citizens of the Union.

Table 8: HIV, AIDS and the right to marry and found a family

Examples of Human Rights Violations
<ul style="list-style-type: none"> • State requires HIV testing or proof of HIV-negative status as a condition of marriage. • State forces woman living with HIV to undergo abortion or sterilization, rather than providing her with information and services to prevent mother-to-child transmission of HIV. • Women are denied equal rights in marriage, divorce, or within families, thus decreasing their ability to negotiate safer sex or leave relationships that pose a risk of HIV. • State denies migrants the right to be accompanied by family members, thus increasing risk of HIV through casual sex. • State denies asylum to HIV-positive claimant while granting asylum to his or her family. • State removes child from household solely because parent(s) have HIV/AIDS.

Human Rights Standards	Treaty Body Interpretation
<p>CEDAW 16: States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations.</p>	<p>CEDAW Committee: Recommending that Kenya “take appropriate action to eliminate all discriminatory laws, practices and traditions and ensure women’s equality with men particularly in marriage and divorce . . .” including through passage of HIV and AIDS legislation. Concluding Observations to Kenya, A/58/38 (2003).</p>

Table 9: HIV, AIDS and the right to non-discrimination and equality

Examples of Human Rights Violations
<ul style="list-style-type: none"> • A person is denied work, housing, medicine, or education due to actual or presumed HIV status. • A child affected by HIV faces discrimination because of his or her parents' HIV status. • Government-sponsored HIV-prevention materials exclude information targeted at certain minorities such as LGBT persons, persons with disabilities, or people who use drugs. • Discrimination in access to property and divorce render women more vulnerable to HIV.

Human Rights Standards	Treaty Body Interpretation
<p>ICCPR 2(1): Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.</p>	<p>HRC: Finding that Jamaica “should also ensure that persons living with HIV/AIDS, including homosexuals, have equal access to medical care and treatment.” CCPR/C/JAM/CO/3 (HRC, 2011)</p> <p>HRC: Recommending to Cameroon that “public health programmes to combat HIV/AIDS should have a universal reach and ensure universal access to HIV/AIDS prevention, treatment, care and support.” CCPR/C/CMR/CO/4 (HRC, 2010)</p> <p>CHR: Confirmed that the term “other status” in anti-discrimination provisions includes health status, including HIV status (1995 and 1996).</p>
<p>CRC 2: States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.</p>	<p>CRC: Explaining the right to non-discrimination: “States parties have the obligation to ensure that all human beings below 18 enjoy all the rights set forth in the Convention without discrimination (art. 2), including with regard to ‘race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status’. These grounds also cover adolescents’ sexual orientation and health status (including HIV/AIDS and mental health). Adolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.” General Comment No. 4, CRC/GC/2003/4, ¶6 (2003).</p> <p>CRC Committee: observing of Ukraine that “the principle of non-discrimination with respect to . . . children living with HIV/AIDS . . . is not fully implemented in practice” and that there is a “lack of an express reference to the principle of non-discrimination with respect to the protection of children’s rights in domestic legislation.” CRC/C/UKR/CO/3-4 (CRC, 2011)</p> <p>CRC Committee: in the context of anti-discrimination, recommended that Kazakhstan undertake awareness-raising and sensitization of legal and other professionals on the impact of HIV and AIDS on children (2006).</p> <p>CRC Committee: Has recommended that States protect children from HIV-based discrimination in Ukraine (2011), Angola (2010), Burundi (2010), Cameroon (2010), Paraguay (2010), Burkina Faso (2010), Tajikistan (2010), Mozambique (2009), Niger (2009), Mauritania (2009), Malawi (2009), Moldova (2009), Chad (2009), Bhutan (2008), Djibouti (2008), Uruguay (2007).</p>

Table 9 (cont.)

Human Rights Standards	Treaty Body Interpretation
<p>CEDAW 1: For the purposes of the present Convention, the term “discrimination against women” shall mean 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.</p>	<p>CEDAW Committee: Has made several recommendations on the elimination of discrimination against women in the context of HIV and AIDS (see Table 12, below).</p> <p>CEDAW Committee: Recommending to Singapore “to review and repeal the law requiring a work - permit holder, including foreign domestic workers, to be deported on grounds of pregnancy or diagnosis of sexually transmitted diseases such as HIV/AIDS.” CEDAW/C/SGP/CO/4 (CEDAW, 2011)</p>
<p>ICERD 5: States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (e)(iv) The right to public health, medical care, social security and social services.</p>	<p>CERD: Expressed concern at the high rate of HIV and AIDS among minorities and ethnic groups and recommended that governments take appropriate action in Estonia (2006) and South Africa (2006 and 2003).</p>

Other Interpretations

Select National Non-Discrimination Laws:

United States: www.ada.gov/aids/ada_aids_discrimination.htm

Australia: www.afao.org.au/_data/assets/pdf_file/0011/4520/BPo6o6_Discrimination.pdf

South Africa: <http://manuals.southernafricalitigationcentre.org/manual/equal-rights-all-litigating-cases-hiv-related-discrimination/chapter-5-comparative-law-releva>

Table 10: HIV, AIDS and the right to the highest attainable standard of health

Examples of Human Rights Violations
<ul style="list-style-type: none"> • State fails to take progressive steps to ensure access to HIV-prevention information and services (e.g., condoms, sterile syringe programs, or voluntary counseling and testing) or imposes restrictions on such services. • State fails to take progressive steps to ensure access to anti-retroviral drugs, treatment for opportunistic infections, opioid pain medications for palliative care, or comprehensive TB care. • State fails to ensure that sex workers, MSM, prisoners, people who use drugs and other vulnerable groups enjoy proportionate access to HIV prevention, treatment, and care services.

Human Rights Standards	Treaty Body Interpretation
<p>ICESCR 12(1): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.</p> <p>ICESCR 12(2): The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: . . . (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases</p>	<p>CESCR: Art. 12 includes “the right to prevention, treatment and control of epidemic... diseases,” including HIV. Recommendations include: Georgia to undertake general HIV-prevention measures (2002); Moldova to “intensify efforts” on HIV (2003); Russia to take “urgent measures to stop the spread of HIV” and related discrimination (2003); Ukraine to provide HIV information to adolescents (2001).</p> <p>CESRC: Recommending that Kenya ensure that “[p]regnant women with HIV/AIDS are not refused treatment, segregated in separate hospital wards, forced to undergo HIV/AIDS testing, and discriminated or abused by health workers, and that they are informed about and have free access to antiretroviral medication during pregnancy, labour and after birth, including for their children.” E/C.12/KEN/CO/1 (CESCR, 2008)</p>

Table 10 (cont.)

Human Rights Standards	Treaty Body Interpretation
<p>CRC 24(1): States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.</p>	<p>CRC Committee: Recommended that Russia study its practice of “segregating children of HIV-positive mothers in hospital wards or separate orphanages and of HIV positive children being refused access to regular orphanages, medical care and educational facilities.” CRC/C/RUS/CO/3 (2005)</p> <p>CRC Committee: Has recommended that States improve HIV-prevention services for children, protect children from HIV-based discrimination, and include children’s rights in HIV strategies. See, for example, comments on Belarus (2011), Panama (2011), Ukraine (2011), Angola (2010), Grenada (2010), Nigeria (2010), Malawi (2009), Bhutan (2008), Eritrea (2008), Mali (2007), Benin (2006), Senegal (2006), Swaziland (2006), Nigeria (2005), Uganda (2005), Armenia (2004), Burkina Faso (2002), Mozambique (2002), Kenya (2001), Georgia (2000), Tajikistan (2000), and South Africa (2000).</p>
<p>CEDAW 12(1): States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.</p>	<p>CEDAW Committee: Recommending that Zambia “improve access to free prevention, treatment and care and support services at the programming level where gender and customary factors contribute significantly to infection rates among women and girls” and “improve access to services for HIV-positive women by incorporating gender-based violence concerns into health-care protocols and introducing measures to effectively respond to gender-based violence and abuse.” CEDAW/C/ZMB/CO/5-6 (CEDAW, 2011)</p> <p>CEDAW Committee: recommending that Ethiopia “provide free antiretroviral treatment for women and men living with HIV/AIDS, including pregnant women, so as to prevent mother-to-child transmission; train technical and administrative staff to implement the national multisectoral strategy/action framework to combat HIV/AIDS and adopt prevention programmes targeting high-risk groups , such as young women, sex workers and internally displaced persons; conduct awareness-raising activities to de stigmatize orphans and vulnerable children affected by HIV/AIDS and strengthen the material and psychological support provided to them.” CEDAW/C/ETH/CO/6-7 (CEDAW, 2011)</p>

Other Interpretations

The Declaration on the Promotion of Patients’ Rights in Europe, Art. 5.3: Patients have the right to a quality of care which is marked both by high technical standards and by a humane relationship between the patient and health care provider.

WHO 1978 Declaration of Alma-Ata: The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

World Health Organization Constitution, Preamble: The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Charter of Fundamental Rights of the European Union, Art. 35: Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT 2001), Para 33: The provision of basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as, in health establishments, appropriate medication.

Table II: HIV, AIDS and the rights of women and children

Examples of Human Rights Violations
<ul style="list-style-type: none"> • Women are denied access to a full range of health services, including reproductive health care, to prevent and mitigate the impact of HIV for themselves and their children. • Children are denied access to comprehensive HIV-prevention services and information. • Children orphaned or affected by AIDS are withdrawn from school, denied their inheritance, and forced into hazardous situations such as forced labor, begging, and sexual exploitation.

Human Rights Standards	Treaty Body Interpretation
<p>CRC 24(1): States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.</p>	<p>CRC: Recommending that Myanmar “increase its efforts to prevent the spread of HIV/AIDS, with an emphasis on prevention among young people, provide protection and support for orphans and vulnerable children, and ensure universal and cost-free access to antiretroviral therapy.” CRC/C/MMR/CO/3-4 (CRC, 2012)</p> <p>CRC: Recommending that Azerbaijan “intensify efforts to provide adolescents with education on sex and reproductive health, particularly with regard to HIV, and improve the accessibility of contraception.” CRC/C/AZE/CO/3-4 (CRC, 2012)</p> <p>CRC: Recommending to Togo “to increase both the coverage and quality of PMTCT services in order to attain the objective of virtually eliminating mother-to-child HIV transmission by 2015” and “to reinforce preventive action among youth, targeting teenagers that belong to the most vulnerable groups, and ensure that the necessary budget is allocated to the HIV/AIDS education programme provided in secondary schools.” CRC/C/TGO/CO/3-4 (CRC, 2012)</p> <p>CRC: recommending to Madagascar and Burundi to improve prevention of mother-to-child transmission. CRC/C/MDG/CO/3-4 (CRC, 2012); CRC/C/BDI/CO/2 (CRC, 2010)</p> <p>CRC: recommending Panama “undertake steps to reduce the greater risk of HIV/AIDS among indigenous children, including through the provision of culturally sensitive sex education and information on reproductive health, reduce the greater risk of HIV/AIDS among teenagers by providing reproductive health services especially aimed at them and by expanding their access to information on prevention of sexually transmitted diseases, and that it direct programmes at children with HIV/AIDS.” CRC/C/PAN/CO/3-4 (CRC, 2011)</p> <p>CRC: Recommending that Ukraine (a) ensure effective implementation of the national HIV/AIDS programme 2009-2013 and the national strategic action plan for HIV prevention among children and by allocating adequate public funding and resources to these programmes; (b) to take all measures to implement the act on prevention of AIDS and social protection of the population, with special focus on respecting human rights of children and youth affected by HIV/AIDS or at risk of HIV/AIDS, including children in street situations and children suffering from substance abuse, and ensure access to confidential and youth-friendly services; and (c) to intensify information and awareness campaigns on HIV/AIDS and other sexually transmitted diseases, aimed at adolescents as well as at the general public. CRC/C/UKR/CO/3-4 (CRC, 2011)</p> <p>CRC: recommending Belarus and Guatemala implement youth-friendly HIV testing and counselling. CRC/C/BLR/CO/3-4 (CRC, 2011); CRC/C/GTM/CO/3-4 (CRC, 2010).</p> <p>CRC: recommending increasing awareness and education about HIV/AIDS to Sudan CRC/C/SDN/CO/3-4 (CRC, 2010); Belarus CRC/C/BLR/CO/3-4 (CRC, 2011); Montenegro CRC/C/MNE/CO/1 (CRC, 2010); Angola CRC/C/AGO/CO/2-4 (CRC, 2010); Sri Lanka CRC/C/LKA/CO/3-4 (CRC, 2010); Burundi CRC/C/BDI/CO/2 (CRC, 2010); Grenada CRC/C/GRD/CO/2 (CRC, 2010); Nigeria CRC/C/NGA/CO/3-4 (CRC, 2010); Japan CRC/C/JPN/CO/3 (CRC, 2010); Cameroon CRC/C/CMR/CO/2 (CRC, 2010); El Salvador CRC/C/SLV/CO/3-4 (CRC, 2010); etc.</p>

Table II (cont.)

Human Rights Standards	Treaty Body Interpretation
<p>CEDAW 12(1): States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.</p> <p>CEDAW 12(2): Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.</p>	<p>CEDAW Committee: Explaining to Zambia that the “Committee is concerned about the impact of HIV/AIDS on women and especially own young girls who are raped due to the belief that intercourse with a virgin cures the infection. In this respect, the Committee is concerned that women and girls may be particularly susceptible to infection owing to gender-specific norms and that the persistence of unequal power relations between women and men and the inferior status of women and girls may hamper their ability to negotiate safe sexual practices, thereby increasing their vulnerability to infection.” CEDAW/C/ZMB/CO/5-6 (CEDAW, 2011)</p> <p>CEDAW Committee: Recommending that Russia “address gender aspects of HIV/AIDS, including power differential between women and men, which often prevents women from insisting on safe and responsible sex practices.” A/57/38(SUPP) (CEDAW, 2002)</p>
<p>ICESCR 2(2): The States Parties to the present Covenant undertake to guarantee that the right enunciated in the present Covenant will be exercised without discrimination of any kind as to . . . sex . . .</p> <p>ICESCR 3: The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.</p>	<p>CESCR: Recommending that Kenya ensure that “pregnant women with HIV/AIDS are not refused treatment, segregated in separate hospital wards, forced to undergo HIV/AIDS testing, and discriminated or abused by health workers, and that they are informed about and have free access to antiretroviral medication during pregnancy, labour and after birth, including for their children.” E/C.12/KEN/CO/1 (CESCR, 2008)</p> <p>CESCR: Noting with concern that children and orphans affected by HIV/AIDS in Kenya are not adequately supported by the State party and that the care for these children and the task of monitoring their school attendance is frequently delegated to their extended families and to community and faith-based organizations, without adequate support and supervision from the State party. E/C.12/KEN/CO/1 (CESCR, 2008)</p>

3. WHAT IS A HUMAN RIGHTS-BASED APPROACH TO ADVOCACY, LITIGATION, AND PROGRAMMING?

What is a human rights-based approach?

“Human rights are conceived as tools that allow people to live lives of dignity, to be free and equal citizens, to exercise meaningful choices, and to pursue their life plans.”¹⁸⁸

A human rights-based approach (HRBA) is a conceptual framework that can be applied to advocacy, litigation, and programming and is explicitly shaped by international human rights law. This approach can be integrated into a broad range of program areas, including health, education, law, governance, employment, and social and economic security. While there is no one definition or model of a HRBA, the United Nations has articulated several common principles to guide the mainstreaming of human rights into program and advocacy work:

- The integration of human rights law and principles should be visible in all work, and the aim of all programs and activities should be to contribute directly to the realization of one or more human rights.
- Human rights principles include: “universality and inalienability; indivisibility; interdependence and interrelatedness; non-discrimination and equality; participation and inclusion; accountability and the rule of law.”¹⁸⁹ They should inform all stages of programming and advocacy work, including assessment, design and planning, implementation, monitoring and evaluation.
- Human rights principles should also be embodied in the processes of work to strengthen rights-related outcomes. Participation and transparency should be incorporated at all stages and all actors must be accountable for their participation.

A HRBA specifically calls for human rights to guide relationships between rights-holders (individuals and groups with rights) and the duty-bearers (actors with an obligation to fulfill those rights, such as States).¹⁹⁰ With respect to programming, this requires “[a]ssessment and analysis in order to identify the human rights claims of rights-holders and the corresponding human rights obligations of duty-bearers as well as the immediate, underlying, and structural causes of the non-realization of rights.”¹⁹¹

¹⁸⁸ Yamin AE, “Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care,” *Health and Human Rights* 10, no. 1 (2008).

¹⁸⁹ For a brief explanation of these principles, see UN Development Group (UNDG), *The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies* (May 2003), available at: www.undg.org/archive_docs/6959-The_Human_Rights_Based_Approach_to_Development_Cooperation_Towards_a_Common_Understanding_among_UN.pdf.

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

A HRBA is intended to strengthen the capacities of rights-holders to claims their entitlements and to enable duty-bearers to meet their obligations, as defined by international human rights law. A HRBA also draws attention to marginalized, disadvantaged and excluded populations, ensuring that they are considered both rights-holders and duty-bearers, and endowing all populations with the ability to participate in the process and outcomes.

What are key elements of a human rights-based approach?

Human rights standards and principles derived from international human rights instrument should guide the process and outcomes of advocacy and programming. The list below contains several principles and questions that may guide you in considering the strength and efficacy of human rights within your own programs or advocacy work. Together these principles form the acronym PANELS.

- **Participation:** Does the activity include participation by all stakeholders, including affected communities, civil society, and marginalized, disadvantaged or excluded groups? Is it situated in close proximity to its intended beneficiaries? Is participation both a means and a goal of the program?
- **Accountability:** Does the activity identify both the entitlements of claim-holders and the obligations of duty-bearers? Does it create mechanisms of accountability for violations of rights? Are all actors involved held accountable for their actions? Are both outcomes and processes monitored and evaluated?
- **Non-discrimination:** Does the activity identify who is most vulnerable, marginalized and excluded? Does it pay particular attention to the needs of vulnerable groups such as women, minorities, indigenous peoples, disabled persons and prisoners?
- **Empowerment:** Does the activity give its rights-holders the power, capacity, and access to bring about a change in their own lives? Does it place them at the center of the process rather than treating them as objects of charity?
- **Linkage to rights:** Does the activity define its objectives in terms of legally enforceable rights, with links to international, regional, and national laws? Does it address the full range of civil, political, economic, social, and cultural rights?
- **Sustainability:** Is the development process of the activity locally owned? Does it aim to reduce disparity? Does it include both top-down and bottom-up approaches? Does it identify immediate, underlying and root causes of problems? Does it include measurable goals and targets? Does it develop and strengthen strategic partnerships among stakeholders?

Why use a human rights-based approach?

There are many benefits to using a human rights-based approach to programming, litigation and advocacy. It lends legitimacy to the activity because a HRBA is based upon international law and accepted globally. A HRBA highlights marginalized and vulnerable populations. A HRBA is effective in reinforcing both human rights and public health objectives, particularly with respect to highly stigmatizing health issues.¹⁹² Other benefits to implementing a human rights-based approach include:

- **Participation:** Increases and strengthens the participation of the local community.
- **Accountability:** Improves transparency and accountability.
- **Non-discrimination:** Reduces vulnerabilities by focusing on the most marginalized and excluded in society.
- **Empowerment:** Capacity building.
- **Linkage to rights:** Promotes the realization of human rights and greater impact on policy and practice.
- **Sustainability:** Promotes sustainable results and sustained change.

How can a human rights-based approach be used?

A variety of human rights standards at the international and regional levels applies to patient care. These standards can be used for many purposes including to:

- Document violations of the rights of patients and advocate for the cessation of these violations.
- Name and shame governments into addressing issues.
- Sue governments for violations of national human rights laws.
- File complaints with national, regional and international human rights bodies.
- Use human rights for strategic organizational development and situational analysis.
- Obtain recognition of the issue from non-governmental organizations, governments or international audiences. Recognition by the UN can offer credibility to an issue and move a government to take that issue more seriously.
- Form alliances with other activists and groups and develop networks.
- Organize and mobilize communities.
- Develop media campaigns.
- Push for law reform.
- Develop guidelines and standards.
- Conduct human rights training and capacity building
- Integrate legal services into health care to increase access to justice and to provide holistic care.
- Integrate a human rights approach in health services delivery.

¹⁹² Gauri V & Gloppen S, *Human Rights Based Approaches to Development: Concepts, Evidence, and Policy*, World Bank Policy Research Working Paper 5938 (Jan. 2012). <http://elibrary.worldbank.org/content/workingpaper/10.1596/1813-9450-5938>.

4. SOME EXAMPLES OF EFFECTIVE HUMAN RIGHTS-BASED WORK IN THE AREA OF HIV, AIDS AND HUMAN RIGHTS?

This section contains **eight examples** of effective activities in the area of HIV, AIDS, and human rights. These are:

1. Litigating for universal access to medicines under the right to health;
2. Combating legislation criminalizing HIV transmission;
3. Documenting effective HIV policies and programs for women and girls;
4. Using litigation to protect HIV-positive women from coerced sterilization;
5. Using medical-legal partnerships to promote the rights of people living with HIV;
6. Using constitutional rights to equal protection to fight against employment discrimination of those living with HIV; and
7. The Now More Than Ever Campaign.
8. Strategic litigation to protect the rights of women forcibly sterilized in Namibia.

Example I: Litigating for universal access to medicines under the right to health

Minister of Health v. Treatment Action Campaign 2002 (5) SA 721 (CC) (S. Afr.).

www.saflii.org/cgi-bin/disp.pl?file=za/cases/ZACC/2002/15.html&query=%20treatment%20action%20campaign

Project Type

Litigation

The Organization

The Treatment Action Campaign (TAC) is a 16,000-member strong civil society organization founded on December 10, 1998 in Cape Town, South Africa. TAC is committed to increasing access to treatment, care and support programs for people living with HIV and also works to spread information and strategies for reduces the transmission of HIV. In 2004, TAC won the Nobel Peace Prize for their efforts.

The AIDS Law Project (ALP), founded in 2007 by dedicated public interest lawyers, is a nongovernmental organization seeking justice and equal treatment for those living with HIV. The AIDS Law Project provides a range of programs and services related to legal services, human rights and health; policy advocacy and communication; and capacity strengthening.

Violations of the South African Bill of Rights

Section 27(1): Everyone has the right to have access to (a) health care services, including reproductive health care.

Section 27(2): The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

Section 28(1): Every child has the right . . . (c) to basic nutrition, shelter, basic health care services and social services.

Southern Africa Legal Information Institute.

www.saflii.org/cgibin/disp.pl?file=za/legis/num_act/cotrosa_1996423/cotrosa1996423.html&query=-constitution

The Problem

Treatment to reduce the likelihood of mother-to-child transmission of HIV was unavailable to the vast majority of women who needed it in South Africa. In 2001, it was estimated that approximately 70,000 children would become infected with HIV through mother-to-child transmission. Although treatment with azidothymidine (AZT) or Nevirapine can significantly reduce the risk of HIV transmission from mother to child, in 2001 the South African government was restricting this treatment to two pilot sites in each province.

Procedure

In 2001, Treatment Action Campaign (TAC) and the AIDS Law Project (ALP) brought a suit in the High Court in Pretoria to secure access to medication for pregnant women to reduce mother-to-child transmission of HIV. The high court found for TAC and held that the South African Constitution required the government to make Nevirapine available to HIV-positive pregnant women who give birth in public health facilities; the women's babies were also to receive the medication. The Court also held that the Constitution required the Government to formulate and implement a national health program to reduce the transmission of HIV from mother to child. The Government appealed the decision of the high court to the Constitutional Court.

Arguments and Holdings

TAC challenged the Government based on section 27 of the South African Bill of Rights, which protects "the right to have access to health care services." TAC claimed that the Government could not refuse to make Nevirapine, a registered drug, available to pregnant women with HIV who give birth in a public hospital or clinic. Moreover, TAC claimed that the government had a constitutional duty to create and implement a national program to prevent mother-to-child transmission of HIV.

The Constitutional Court set aside the orders of the high court and ordered the government to remove restrictions on Nevirapine to permit its use in public health facilities. The Court also held that counsellors should be provided at public hospitals and clinics for training and use of Nevirapine, if necessary. Finally, the Court held that the government should take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public sector.

Commentary and Analysis

In addition to a strong litigation strategy, there were several other factors that contributed to the success of the litigation. These included:

- A broad social movement accompanying the litigation;
- Charismatic and committed leadership on the part of people living with HIV;
- Alliances with treatment activists around the world;
- The existence of a constitutional democracy with independent courts and a constitution protecting health rights; and
- A legacy of public interest litigation dating back to the post-apartheid era.

This victory was a significant achievement for activists advancing social and economic rights. Traditionally, claims based on the right to health have not been successful in litigation and so this case marked a new era in health and human rights litigation. Health rights activists are now strategically using constitutional provisions to secure health right victories to instigate legal and policy changes.

Additional Resources

There are several wonderful resources to aide health right activists to understand the advances in right to health litigation and to help develop litigation strategies:

Yamin AEY and Gloppen S, eds., *Litigating Health Rights: Can Courts Bring More Justice to Health?* (2011)

Meier BM and Yamin AEY, *Right to Health Litigation and HIV/AIDS Policy*, 39 *Journal of Law, Medicine & Ethics* (Spring 2011).

Gloppen S, *Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health*, 10 *Health and Human Rights: An International Journal*, no. 2, 2008. www.hhrjournal.org/index.php/hhr/article/viewFile/79/145.

Example 2: Combating legislation criminalizing HIV transmission

Project Type

Advocacy

The Organization

The Canadian HIV/AIDS Legal Network is an international organization that promotes the human rights of people living with and vulnerable to HIV through research, analysis, advocacy, litigation, public education, and community mobilization.

Africa National statutes criminalizing the spread of HIV

Adopted: Burundi (2005), Djibouti (2007), Kenya (2006), Madagascar (2005), Mozambique (2009) and Tanzania (2008), Cameroon (2002), Chad (2007), Congo (2009), Democratic Republic of Congo (2008), Equatorial Guinea (2006), Benin (2006), Burkina Faso (2008), Cape Verde (2008), Guinea (2005), Guinea-Bissau (2007), Liberia (2008), Mali (2006), Mauritania (2007), Niger (2007), Sierra Leone (2007), Togo (2005), Lesotho (2003), Zimbabwe (2001).

Proposed: Malawi, Uganda, Botswana. Status Unclear: Angola (2004), Central African Republic (2006), Senegal (2010).

Africa: National statutes criminalizing the spread of a deadly disease

Adopted: Ethiopia, Botswana.

Proposed: Rwanda.

Source: NAM: www.aidsmap.com/

The Problem

A model law on HIV transmission was drafted following a meeting held in N'Djamena, Chad in 2004 by Action for West Africa Region—HIV/AIDS (AWARE), with funding from the United States Agency for International Development (USAID). The model law expands criminal liability for intentional transmission of HIV. Over 25 African countries now criminalize wilful transmission of HIV, including twelve countries in Western Africa that have adopted legislation based on the model law.

The model law allows for radically expanded criminal liability for wilful transmission of HIV by setting out a broad definition of “wilful transmission” and by demanding punishment for all wilful transmissions of the virus. Article 36 of the model law sets out that “any person who is guilty of wilful transmission of HIV shall be sanctioned” The article broadly defines “wilful transmission” as “transmission of the HIV virus through any means by a person with full knowledge of his/her HIV/AIDS status to another person.” Therefore, the model law would expand criminal liability to include, inter alia, mother-to-child transmission; transmission between consenting parties engaging in safe sex; and the transmission that results from the sharing of needles for injection drug use, even after attempts have been made to disinfect.

Actions Taken

The Canadian HIV/AIDS Legal Network (CHLN), along with other concerned NGOs, worked to raise public awareness of the effects of this model law. In addition, the CHLN pressed UNAIDS to publish an alternative model law. CHLN provided legal analysis and aided the drafting of various provisions of the alternative model law. UNAIDS later published the alternative model law as part of its materials, and domestic NGOs used the alternative model law to try to reform criminalization provisions that had passed or were pending adoption. The alternative model law was designed for policy makers and advocates in developing countries where legislative drafting resources may have been scarce.

Results & Lessons Learned

HIV prevention, care and treatment services operate best within a clear legal framework. Law reform is not a complete solution, but it is a necessary and often neglected step. Reforming law and policy around the issue of HIV can be especially challenging given the stigma and discrimination in the general population against those living with HIV and competing demands on the time and energy of local advocates.

Additional Resources

Richard Pearshouse, *Canadian HIV/AIDS Legal Network, A Human Rights Analysis of the N'Djamena Model Legislation on AIDS and HIV-specific Legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo* (September 2007). www.aidslaw.ca/publications/publicationsdocEN.php?ref=967.

Cécile Kazatchkine et al, *Canadian HIV/AIDS Legal Network, Criminalizing HIV Transmission or Exposure in the Context of West and Central French-speaking Africa* (2010). www.aidslaw.ca/EN/aids2010/documents/AIDS10_CK_Africa.pdf.

Legislation contagion: building resistance, 13 *Canadian HIV/AIDS Legal Network: HIV/AIDS Policy & Law Review*, no. 2/3 (December 2008). www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1412.

NAM, *The 'Legislation Contagion' of the N'Djamena Model Law*. www.aidsmap.com/page/1442068/.

Pearshouse R., *Legislation contagion: the spread of problematic new HIV laws in Western Africa*. *HIV/AIDS Policy & Law Review* 12 (2/3), 2007.

Pearshouse R., *Legislation contagion: building resistance*. *HIV/AIDS Policy & Law Review* 12 (2/3), 2008.

Canadian HIV/AIDS Legal Network
 Toronto, Canada
 Website: <http://www.aidslaw.ca>
 E-mail: info@aidslaw.ca

Example 3: Documenting effective HIV policies and programs for women and girls

Project Type

Advocacy

The Organization

What Works for Women & Girls is a comprehensive website documenting the evidence for effective HIV interventions to guide donors, policymakers, and program managers in planning effective HIV policies and programs for women and girls. The resource spans nearly 3,000 reports and articles with more than 450 interventions in nearly 100 countries. (www.whatworksforwomen.org)

What Works has been a collaborative effort. It was originally funded by the Open Society Foundations' Public Health Program. Currently, it is supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Open Society Foundations. It is carried out under the auspices of the United States Agency for International Development (USAID)-supported Health Policy Project at the Futures Group, in collaboration with the Public Health Institute.

The three primary authors of the *What Works* report bring a unique set of research, gender and communication expertise that enable the resource to be both technically rigorous and widely accessible. Moreover, each of the sections of *What Works* underwent extensive peer review from experts in the respective areas, ensuring that all of the key literature was included and put into context. The massive undertaking of creating *What Works* across the spectrum of HIV topics would not have been possible without the more than 100 experts in research, programming and advocacy.

The Problem

Women are disproportionately affected by the HIV epidemic. For example, women make up more half or more of those living with HIV and young women 15-24 years old are as much as eight times as likely as men to be living with HIV in sub-Saharan Africa – the region most affected by HIV (UNAIDS, 2010). In the context of HIV, women face unique risks and have diverse needs influenced by their physical and social environment. Transforming gender norms; advancing education, employment and women's legal rights; and reducing stigma, discrimination, and violence against women remain urgent priorities in HIV programming.

Awareness of the vulnerability of women and girls to HIV is only the first step. Identifying and implementing HIV programs that address the particular vulnerabilities of women and girls is the next step. When designing HIV and AIDS programs, policymakers and program planners have scarce resources and encounter a wide array of statistics, recommendations, best practices, scientific studies, and public health interventions. Policymakers and programmers have been forced, at best, to undertake their own research to identify effective programming and, at worst, to base policies and programs on unquestioned practices. Until now, there has not been one central location to obtain been a clear universal understanding of what works for women and girls.

Actions Taken

What Works makes gender sensitive HIV resources more widely available by providing a one-stop resource center. Through a comprehensive literature review of published work and gray literature, the *What Works* team reviews the evidence and distils successful interventions from that evidence. Written in clear language with policymakers and program planners in mind, *What Works* outlines the interventions that have been proven to work for women and girls, thus providing the evidence base for those designing policies and programs. It also demonstrates the significant gaps in programming for which there are few, if any, evaluated data, thus serving to spur researchers and implementers to design and evaluate additional programming for women and girls. *What Works for Women and Girls* helps maximize the efficiency and effectiveness of HIV programs by providing, in one place, evidence of successful and promising approaches and interventions. In the words of one advocate, “*What Works is absolutely the bottom line...*”

What Works for Women & Girls is available free online, with flash drives of static copies available for those with unreliable internet service, thus putting the evidence into the hands of those who cannot access or afford costly database subscriptions. Outreach efforts to provide technical assistance are underway to achieve the goal of becoming the leading go-to source of evidence on HIV interventions for women and girls, with health and gender ministries, implementing agencies, NGOs, and advocates using the evidence to develop women-friendly, gender transformative HIV policies and programs around the world.

Lessons Learned

HIV programs and policies must be based on evidence and *What Works for Women and Girls* provides the available evidence. *What Works* points out clear interventions that work for women and girls and highlights the supporting evidence. The interventions were not pre-defined with supporting evidence sought. Instead, interventions emerged from the literature reviews. Both authors and experts were at times surprised that almost 30 years into the epidemic, numerous studies do not disaggregate data by sex or consider gender. *What Works* also demonstrates the need for more evaluation and measurement of innovative programs to add to the list of what works for women and girls. As a resource, *What Works for Women & Girls* can guide effective, evidence-based programming, and highlight what remains to be done to address the needs of women and girls.

Website: <http://www.whatworksforwomen.org/>

Example 4: Using litigation to protect HIV-positive women from coerced sterilization

L M and Others v. The Government of the Republic of Namibia (July 30, 2012).

Project Type

Litigation

The Organization

Southern Africa Litigation Centre (SALC) provides technical assistance and financial backing to public and private lawyers, civil society organizations and community-based organizations pursuing the public interest through impactful litigation. Strategic litigation, like that undertaken by SALC, can help level the playing field. Through litigation, the SALC challenges existing laws and regulations and pursues progressive legal reform through judicial decision-making. In addition to securing justice for their clients and others similarly situated, the SALC's efforts draw public attention to the issues faced by those they represent.

The Problem

Discrimination against people living with HIV stymies efforts to reduce morbidity and increase access to HIV prevention and treatment. Many people living with HIV often face economic hardship, violence and social stigma, contributing to an increased risk of human rights abuses. Legal remedies for discrimination against people living with HIV are often difficult to obtain. In Namibia, people living with HIV do not have full access to justice, due in part to a lack of access to legal services, a legal system with pervasive corruption and lack of knowledge of individual rights.

“I have been taught to be quiet. It would be helpful if someone could come and speak on my behalf.”
– **Esther K. of Chilumba, Malawi** (Chi Mgbako et al, *We Will Still Live*, 31 *Fordham International Law Journal* 528, 583 (Jan. 2008)).

Coerced sterilization is a common practice in countries with high rates of HIV infection. Coerced sterilization is defined as any procedure performed on a man or women without their informed consent that eliminates their ability to have children. Doctors at government hospitals in Namibia continue to sterilize HIV-positive women without their informed consent. A 2009 study by the International Community of Women Living with HIV/AIDS found that, of those surveyed, nearly one out every five women living with HIV in Namibia has been subjected to coerced sterilization. Coerced sterilization violates a women's bodily integrity and reproductive rights. Moreover, for women in Namibia, sterilization can lead to additional exclusion, social stigma and restricted marriage prospects.

Actions Taken

With the help of the SALC, three HIV-positive Namibian women who were victims of coerced sterilization at a government hospital brought a common law and constitutional tort action against the government for money damages and injunctive relief.

Results and Lessons Learned

On July 30, 2012, the Namibian High Court ruled that the three women had been sterilized without their consent and therefore coerced into sterilization. Although the court did not rule on the constitutional claim or whether the women were selected for sterilization based on their HIV-positive status, the court did determine that the government owed the plaintiffs money damages. As noted by Nicole Fritz, director of SALC, “The court’s detailed ruling as to what constitutes informed consent upholds the rights of the plaintiffs, recognises their entitlement to redress and lessens the vulnerability to which women especially are likely to be subject [to coerced sterilization].” Priti Patel, the deputy director of SALC, noted that this case means that authorities in Namibia “must [now] meaningfully investigate all the other cases to ensure justice for every woman who has been coercively sterilised.”

Additional Resources

The Guardian (U.K.): Namibia court rules HIV-positive women sterilised without consent.

www.guardian.co.uk/global-development/2012/jul/30/namibia-hiv-women-sterilised-without-consent

Mindy Roseman: The Day After Victory: More Work Needed to Protect Rights of Namibian Women Living with HIV. <http://harvardhumanrights.wordpress.com/2012/07/1/the-day-after-victory-more-work-needed-to-protectrights-of-namibian-women-living-with-hiv/>

The International Community of Women Living with HIV/AIDS (ICW), *The Forced and Coerced Sterilization of HIV Positive Women in Namibia* (2009). www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf

South African Litigation Centre (SALC)

Johannesburg, South Africa

E-mail: Enquiries@salc.org.za

Website: <http://www.southernafricalitigationcentre.org/>

Example 5: Using medical-legal partnerships to promote the rights of people living with HIV

Project Type

Advocacy

The Organizations

The Legal Aid Centre of Eldoret (LACE) and the Christian Health Association of Kenya (CHAK) are closely related in purpose and organization. Founded in 2008 by Kenyan attorneys and judges, LACE works to provide access to justice for those living with HIV in Western Kenya. In similar fashion, the Christian Health Association of Kenya (CHAK) comprises 435 member health facilities throughout Kenya, 15 of which provide not only health services but also rights awareness and legal services to their clients. Both organizations work to provide health and human rights to those living with HIV in western Kenya.

The Problem

An estimated 1.4 million people live with HIV in Kenya and they face stigmatization, discrimination, derogatory stereotypes, and pervasive prejudice. As a result, people living with HIV experience legal issues related to the denial of property rights, criminal charges, unfair dismissal, breach of confidentiality, physical and sexual abuse, and child support payment disputes.

Actions Taken

LACE (The Legal Aid Centre of Eldoret): Health care workers at the Academic Model Providing Access to Healthcare (AMPATH) office in western Kenya have training to recognize legal problems expressed by their patients. When a legal issue arises, the medical workers refer their patients to LACE, which occupies an office directly across the street from the AMPATH office. The LACE attorneys refer the patients to pro bono attorneys practicing in the area or the pro bono legal clinic at Moi University School of Law. Clients also receive referrals for psychosocial support services. Once their legal needs are addressed, they are referred back to AMPATH social workers.

CHAK (Christian Health Association of Kenya): CHAK and the Kenya Episcopal Conference health facilities account for approximate 40% of all health service providers in Kenya. CHAK's attorney travels regularly to 15 of CHAK's health facilities to train health care workers to recognize human right violations. The lawyer also works with community leaders to foster the creation of community organizations that monitor and report human rights violations.

Results and Lessons Learned

LACE: LACE combats the so-called “third epidemic” of HIV—the economic, social, and cultural effects HIV has on a community and on individuals. By working closely with AMPATH, an established health care provider, LACE receives a high volume of clients and is able to address the health and human rights abuses of those often-marginalized people who live with HIV. In 2009, LACE counselled 336 HIV-positive clients.

CHAK: In 2011, CHAK received 198 cases, most of which they referred to lawyers at partner organizations. CHAK’s legal officer emphasizes the need to work closely with community opinion leaders, as they are critical in responding to most HIV-related human rights violations. She also recommends carrying out an initial needs assessment and identifying stakeholders for partnership because it is not possible for one organization to address all of the community’s needs.

Legal Aid Center of Eldoret (LACE)

Eldoret, Kenya

E-mail: info@lancelaw.org

Website: lancelaw.org

Christian Health Association of Kenya (CHAK)

Nairobi, Kenya

Website: www.chak.or.ke

Example 6: Using constitutional rights to equal protection to fight against employment discrimination of those living with HIV

India: *MX v. ZY*, AIR 1997 Bom 406 (High Court of Judicature, 1997).

<http://indiankanoon.org/doc/1264404/>.

South Africa: *Hoffman v. South African Airways*, Constitutional Court of South Africa, Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC). www.saflii.org/za/cases/ZACC/2000/17.html.

Project Type

Litigation

The Organization

These two separate cases are both examples of individuals bringing successful human rights actions against their respective governments.

The Problem

With the largest and second largest population of HIV-positive individuals in the world, South Africa and India experience high rates of employment discrimination on the basis of HIV status. However, both the South African and Indian constitutions provide for equal protection under the law. The two litigation case studies here show how equal protection—a constitutional guarantee in many countries—can protect individuals living with HIV from discrimination in the workplace.

In both cases, a public company terminated its relationship with an employee because of that employee's HIV-positive status. In *MX v. ZY* (India), the employer terminated its relationship with plaintiff-employee once it learned of that employee's HIV-positive status. In *Hoffman* (South Africa), the employer withdrew its offer of employment once it learned of the employee candidate's HIV-positive status.

Arguments and Holdings

Both employees sued their public-corporation employer for violations of their respective country's constitutional equal protection provisions. In both cases, the public-corporation employer argued that it had "legitimate" reasons for terminating their relationship with their HIV-positive employee. In *MX v. ZY*, the employer argued that medical requirements were legitimate because of the added financial and administrative burdens associated with hiring an HIV-positive individual. In *Hoffman*, the public-employer also made business strategy arguments, including the undue cost of training an individual with a shorter lifespan and the unfair advantage that its private competitors—who may discriminate against individuals, unlike their government counterparts—would gain if they were forced to treat HIV-positive individuals equally. In both cases, the court rejected business strategy arguments, finding that the equal protection guarantees of the constitution trumped profit interests of the business.

In addition to business strategy arguments, the defendant in Hoffman argued that the ability of HIV-positive individuals may not be capable of performing essential job responsibilities. First, the defendant airline argued that the court should allow it to reject an applicant based on its HIV-positive status because the National Department of Health required international air cabin attendants to receive yellow fever vaccinations, which may be dangerous for HIV-positive individuals to receive. Second, the airline defendant argued that HIV-positive individuals may not be able to perform the responsibilities of an air cabin attendant during an emergency. The court rejected both these arguments, finding that equal protection demands that the employer perform individual assessments of each candidate's ability to perform essential job functions.

Equal Protection

Indian Constitution. Article 14:

The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

South African Constitution. Section 9:

(1) Everyone is equal before the law and has the right to equal protection and benefit of the law. (2) Equality includes the full and equal enjoyment of all rights and freedoms . . . (3) The state may not unfairly discriminate directly or indirectly against any on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (4) No person may unfairly discriminate directly or indirectly against anyone on one or more ground in terms of subsections (3) . . . (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Analysis and Commentary

Many of the world's constitutions provide for equal protection under the law. The two cases profiled here show how domestic equal protection guarantees can protect those living with HIV. In both cases, the courts found that a public corporation, bound by constitutional equal protection provisions, must assess individual candidates; a blanket rejection of HIV-positive individuals is in violation of an HIV-positive candidate's constitutional right to equal protection under the law.

People living with HIV are among the world's most vulnerable populations, facing widespread stigma and discrimination. Equal treatment requires government and state actor employers to individually assess each candidate. Policies discriminating on the basis of HIV status are not allowed.

Example 7: Now More than Ever Campaign

Project Type

Advocacy

The Organization

The Now More than Ever Campaign represents hundreds of AIDS activists worldwide who believe that human rights should be at the center of the response to HIV. It is their belief that if governments and organizations base their efforts upon human rights, the response will be more inclusive and effective.

“That virus is just as smart at exploiting social weakness as it is at exploiting the weaknesses of the immune system.” – **Jonathan Cohen**, Deputy Director, Open Society Public Health Program

The Problem

Those most affected by HIV are often those who are marginalized by society. They include women and girls, children, people who use drugs, sex workers, men who have sex with men, transgender persons, prisoners, people needing palliative care, and others whose voices are rarely heard. The Now More Than Ever Campaign places particular emphasis on protecting members of these marginalized groups and believes that a human rights-based approach is necessary to the global response.

Actions Taken

The campaign developed a joint statement on 10 reasons why human rights should occupy the center of the global HIV response. Since first publishing the joint statement, the Campaign has organized and led events at each successive International AIDS Conference. Information related to those events may be found at www.hivhumanrightsnow.org/about-us/#overview.

Results and Lessons Learned

Over 650 organizations and networks worldwide have endorsed the joint statement, which is also supported by the United Nations Office of the High Commissioner for Human Rights (OHCHR), the United Nations Development Programme (UNDP), and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Additionally, tens of thousands of people participated in the campaign's protest march and rally for human rights in Vienna at the 2010 International AIDS Conference to call for human rights for all in the face of HIV—often expressing opinions that they could not legally express in their home country.

The Now More Than Ever Campaign brings together thousands of AIDS activists worldwide who believe that human rights should be at the center of the response to HIV. The campaign offers them a unique platform aimed at ensuring that governments move from rhetoric to real action on HIV and human rights, including by investing in key human rights initiatives as part of national HIV programs.

Human Rights and HIV: Now More Than Ever

www.hivhumanrightsnow.org/

Ten Reasons Why Human Rights Should Occupy the Center of the Global AIDS Struggle

1. Universal access will never be achieved without human rights;
2. Gender inequality makes women more vulnerable to HIV, most women and girls now have the highest rates of infection in heavily affected countries;
3. The rights and needs of children and young people are largely ignored in the response to HIV, even though they are the hardest-hit in many places;
4. The worst-affected receive the least attention in national responses to HIV;
5. Effective HIV-prevention, treatment, and care programs are under attack;
6. AIDS activists risk their safety by demanding that governments provide greater access to HIV and AIDS services;
7. The protection of human rights is the way to protect the public's health;
8. AIDS poses unique challenges and requires an exception response;
9. Rights-based" responses to HIV are practical, and they work;
10. Despite much rhetoric, real action on HIV/AIDS and human rights remains lacking.

Twenty-four HIV/AIDS and human rights organizations worldwide jointly developed the declaration, and hundreds of other organizations endorsed it. The declaration is also available in Arabic, Bulgarian, Chinese, French, German, Portuguese, Romanian, Russian, and Spanish.

Human Rights and HIV: Now More Than Ever

Website: <http://www.hivhumanrightsnow.org/>

5. WHERE CAN I FIND ADDITIONAL RESOURCES ON HIV/AIDS AND HUMAN RIGHTS?

The most comprehensive collection of resources on HIV and human rights is contained in an e-Library at AIDSLEX: www.aidslex.org. This resource is available online and in six different languages. This e-Library is a comprehensive repository of materials on HIV, law, and human rights. UNAIDS also has a large collection of UN and WHO documents available for download on its website, www.unaids.org. Resources are categorized according to the 2011 Political Declaration targets and elimination commitments.

A list of commonly used resources on HIV, AIDS and human rights follows organized according to key topics highlighted within the text. It is organized into the following categories:

- A. International Instruments
- B. Regional Instruments
- C. Other Statements and Declarations
- D. General Resources
- E. Non-Discrimination and Equality
- F. Right to Marry and Right to Found a Family
- G. Right to Privacy
- H. Freedom of Liberty of Movement
- I. Freedom of Expression and Information
- J. Right to Health and Right to the Enjoyment of the Benefits of Scientific Progress
- K. Right to Adequate Standard of Living and Social Security
- L. Right to Work
- M. Women and HIV
- N. Children and HIV
- O. Criminalization of HIV Exposure and Transmission
- P. Key Populations – People who use drugs
- Q. Key Populations – Sex Workers
- R. Key Populations – LGBTQ & MSM
- S. Key Populations – Prisoners
- T. Key Populations – People with Disabilities
- U. Key Populations – Refugees and Internally Displaced Persons\
- V. Journals
- W. Blogs and Listservs
- X. Training Manuals
- Y. Websites

A. International Instruments

All resources in this section available at OHCHR, “Publications and Documents on HIV and AIDS”, (www.ohchr.org/EN/Issues/HIV/Pages/Documents.aspx), unless otherwise indicated. Available in multiple languages.

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- WHO, *A Declaration on the Promotion of Patients' Rights in Europe*, ICP/HLE 121 (1994). www.who.int/genomics/public/eu_declaration1994.pdf
- WHO, *Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property*, WHA61.21 (2008). http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R21-en.pdf

B. Regional Instruments

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- Health and Human Rights. www.hhrjournal.org.
A journal dedicated to studying the relationship between human rights and health. Three issues of the journal have focused on HIV/AIDS and human rights.
 - HIV/AIDS Policy and Law Review. www.aidslaw.ca.
Provides analysis and summaries of current developments in HIV/AIDS-related policy, law, and human rights.
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W. Blogs and Listservs

- AIDS and Rights: A Collaborative Blog Focused on HIV and AIDS and Human Rights. www.eliminateaids.blogspot.com.
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- AIDS Law Unit of the Legal Assistance Centre (Namibia): www.lac.org.na.
- AIDS Legal Network (South Africa): www.aln.org.za.
- AIDSLEX: www.aidslex.org.
- AVERT: www.avert.org/.
- Botswana Network on Ethics, Law, and HIV (BONELA): www.bonela.org.
- Canadian HIV/AIDS Legal Network: www.aidslaw.ca/.
- Center for HIV Law and Policy: www.hivlawandpolicy.org.
- Center for Reproductive Rights: <http://reproductiverights.org/en/our-issues/hiv/aids>.
- Global Commission on HIV and the Law: www.hivlawcommission.org.
- Human Rights Watch: www.hrw.org/topic/health/hivtb.
- Hungarian Civil Liberties Association: www.tasz.hu
- International Council of AIDS Service Organizations (ICASO): www.icaso.org.
- Lawyers Collective HIV/AIDS Unit (India): www.lawyerscollective.org.
- Office of the United Nations High Commissioner for Human Rights, HIV/AIDS and Human Rights: www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx.
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- Southern African Litigation Centre: www.southernafricalitigationcentre.org/our-programmes/hivaids/.
- The People Living with HIV Stigma Index: www.stigmaindex.org/.
- Uganda Network on Law, Ethics, and HIV: www.uganet.org.
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6. WHAT ARE KEY TERMS RELATED TO HIV, AIDS AND HUMAN RIGHTS?

A

ARV, ART

Acronyms for anti-retroviral and anti-retroviral treatment. Anti-retroviral drugs inhibit various phases of the life-cycle of the human immunodeficiency virus (HIV), thus reducing HIV-related symptoms and prolonging life-expectancy of people living with HIV. Treatment with ARVs is also used to prevent transmission of HIV from mother to child and to prevent HIV infection following exposure.

D

DOC

Acronym for the *Declaration of Commitment on HIV/AIDS*, adopted by the United Nations General Assembly in a special session in June 2001. The DOC recognizes that “realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS” (paragraph 58).

G

GIPA

Abbreviation for “greater involvement of people living or affected by HIV/AIDS.” The importance and benefits of involving people living with HIV or AIDS in formulating policy and delivering services has been widely recognized, first at the 1994 Paris AIDS Summit and more recently in the *Declaration of Commitment on HIV/AIDS*.

Global Fund

Abbreviation for the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the central global mechanism for channeling funds between rich and poor countries to finance national responses to HIV and AIDS.

Guidelines

Abbreviation for the *International Guidelines on HIV/AIDS and Human Rights*, an authoritative set of non-binding legal and policy recommendations issued by UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) in 1998.

P

PEPFAR

Acronym for the President’s Emergency Plan for AIDS Relief, a 5-year, US\$15 billion AIDS package authorized by U.S. President George W. Bush and enacted by the U.S. Congress in 2003 under the *U.S. Global Leadership on HIV/AIDS, Tuberculosis and Malaria Act*. PEPFAR is the largest program to combat HIV and AIDS financed by a single donor government.

PMTCT

Acronym for prevention of mother-to-child transmission of HIV, or transmission during pregnancy, labor and delivery, or breastfeeding. Without treatment, approximately 15-30% of babies born to mothers living with HIV will be infected during pregnancy and delivery, and a further 5-20% will become infected through breastfeeding.

PWA, PLWA, PLWHA

Acronyms for person living with HIV or AIDS.

S***Stigma and discrimination***

The United Nations has called **stigma** and **discrimination** associated with HIV and AIDS “the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact.” **Stigmatization** leads to **discrimination**.

1. **Stigma** is “a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons.” People who are stigmatized are usually considered deviant or shameful for some reason or other, and as a result are shunned, avoided, discredited, rejected, restrained or penalized. As such, stigma is an expression of social and cultural norms, shaping relationships among people according to those norms. Stigma marks the boundaries a society creates between “normals” and “outsiders,” between “us” and “them.”
2. **Discrimination** in the context of HIV and AIDS has been defined as “any measure entailing any arbitrary distinction among persons depending on their confirmed or suspected HIV serostatus or state of health.” Discrimination can be **legitimate** and **illegitimate**.

Illegitimate discrimination is unjustified, disproportionate, and arbitrary. A measure or an action is *unjustified* if it lacks rational and objective reasons. It is *disproportionate* if the means employed and their consequences far exceed or do not achieve the aims pursued. It is *arbitrary* if it seriously infringes the rights of the individual and is not necessary to protect the health of others.

U**UNAIDS**

Acronym for the Joint United Nations Programme on HIV/AIDS, a consortium of eight United Nations agencies addressing various aspects of the global AIDS epidemic. UNAIDS has a small program dedicated to address the legal, ethical, and human rights aspects of HIV and AIDS.