Judging the epidemic

A judicial handbook on HIV, human rights and the law

UNAIDS

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Acronyms

ADA	Americans with Disabilities Act
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BMS	Bristol-Myers Squibb
CCTV	Closed-circuit television
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CDSA	Controlled Drugs and Substances Act
CEJIL	Center for Justice and International Law
CFS	Commission fédérale pour les problèmes liés au sida
CLADEM	Caribbean Committee for the Defense of Women's Rights
CPS	Crown Prosecution Service [United Kingdom]
DDI	Didanosine
ESC	Economic, Social and Cultural
GPO	Government Pharmaceutical Organization [Thailand]
HAART	Highly Active Antiretroviral Therapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICJ	International Commission of Jurists
ICTR	International Criminal Tribunal for Rwanda
ICTY	International Criminal Tribunal for the former Yugoslavia
INCB	International Narcotics Control Board
IOM	International Organization for Migration
IVSS	Instituto Venezolano de los Seguros Sociales [Venezuelan Social Security Institute]
LGBT	Lesbian, Gay, Bisexual and Transgender
MMT	Methadone maintenance treatment
MSM	Men who have sex with men

OHCHR	Office of the High Commissioner for Human Rights
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PCP	Pneumocystis pneumonia
PMTCT	Prevention of mother-to-child transmission
RITA	Recent Infection Testing Algorithm
STARHS	Serological Testing Algorithm for Recent HIV Seroconversion
STI	Sexually transmitted infection
TB	Tuberculosis
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
TAC	Treatment Action Campaign
VANDU	Vancouver Area Network of Drug Users
WHO	World Health Organization
WTO	World Trade Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime

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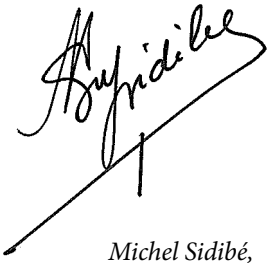
Message

The global AIDS response is yielding unprecedented results. Worldwide, new HIV infections were down 20% in 2012 compared to 2001. For the first time, a majority of people eligible for lifesaving HIV treatment in low- and middle-income countries is now receiving it.

In 2011, UNAIDS promoted a vision of "Zero new HIV infections, Zero AIDS-related deaths and Zero Discrimination" — a vision that seems increasingly possible to achieve. However, "Zero Discrimination" appears the most difficult zero to attain. Stigma, discrimination and punitive approaches against people living with or at risk of HIV remain highly prevalent. They not only hurt those who suffer them, but they also threaten effective responses to the epidemic. Ending HIV requires enabling legal and social environments that guarantee the health, dignity and security of all people living with or at risk of HIV. This is the only way to ensure that all those in need of HIV prevention, treatment, care and support have access to these services without fear of discrimination. Courts are often the last avenue for redress for those who suffer HIV-related discrimination or those whose health and rights have been overlooked. From the South African Constitutional Court to the Delhi High Court, we see examples of bold judicial leadership upholding the rights of people living with or at risk of HIV, and speaking out for their inclusion and dignity. These judges are also transforming the AIDS response.

Addressing HIV-related stigma and discrimination is not an easy challenge. It requires action from all branches of government and all quarters of society. The judiciary is an essential partner in this quest for justice, equality and redress for harm.

It is my hope that this handbook will assist members of the judiciary and other legal professionals in their important work, enabling them to make HIV what it should be — a manageable health condition, not a source of discrimination or recrimination.



Michel Sidibé,
Executive Director, UNAIDS

Foreword: A judge's perspective

Edwin Cameron, Justice of the Constitutional Court of South Africa

It seems right that a judges' handbook on HIV, human rights and law should have a contribution by a judge — and I am very happy to contribute this short chapter. I do so as a judge in South Africa's highest court who was diagnosed with HIV in 1986 and had my life restored to me because I was privileged to have access to antiretroviral (ARV) treatment when I fell severely ill with AIDS in 1997. I therefore feel immensely fortunate to be living, working and contributing to my country and my continent when many millions of others have died in this vast epidemic of suffering and death.

It is against this background that my short contribution is intended to appeal to you, my fellow judges.

In all my travels in Asia, Europe, America and Africa, it has been my experience that judges share common commitments, concerns and pursuits. We are devoted to the independence and integrity of the judiciary. We are committed to the importance of independent institutions supporting the rule of law. We are heartfelt about rights-protection, equality, non-discrimination and social justice. And we realise that corruption, whether in government or the private sector, eats away at the heart of the rule of law and of human rights.

Given this profound shared commitment, the AIDS epidemic should present no unique or even very difficult problems for us as judges. The court in which I now sit (although I was not then part of it) gave an early ruling that outlawed irrational discrimination against persons living with AIDS or HIV. In *Hoffmann v. SA Airways* 2000 (1) SA 1 (CC), the Constitutional Court ruled that South Africa's national flag carrier could not deny a man living with HIV employment as a cabin attendant. The Court's judgment, in moving terms, described the impact of stigma on persons living with HIV. The judgment said that stigma and discrimination could not be countenanced.

This major decision was preceded by a ruling of the Supreme Court of Appeal, in *Jansen von Vuuren v. Kruger* 1993 (4) SA 842 (A). A young man's doctor told his two golfing companions, who were also doctors, that the young man, whom they all knew socially, had been diagnosed with HIV. The news spread like wildfire, and the appeal court held that the young man's right to confidentiality had been violated. In reaching this conclusion, the appeal court closely examined the evidence to determine whether the other two doctors had any need to be informed that the young man had HIV. The answer was No.

In *Hoffmann*, the Constitutional Court also adopted a rigorously lawyerly approach to the evidence. It examined in detail the medical evidence South African Airways proffered for refusing Mr. Hoffmann employment. The Court found that evidence entirely insufficient. There was no basis for barring Mr. Hoffmann from working. The airline was ordered to employ him.

Indeed, a rigorously lawyerly approach to evidence is all those living with AIDS and HIV have ever needed to get fair treatment. Look at the facts about AIDS and HIV. HIV is a fragile virus. It is extremely difficult to transmit. It is non-contagious. It can be transmitted only through a significant injection of virally active material; this can occur only through sexual intercourse, blood transfusion or shared syringes. In addition, a young infant may get HIV from a mother during birth or breast-feeding. But these circumstances rarely occur during the casual engagements of everyday life.

So, irrational fear about contamination with HIV is entirely unjustified. What is more, AIDS is now a fully medically manageable condition. When I was desperately sick with AIDS in 1997, I thought I would certainly die. I thought I would die soon. But I did not die. My life and energies and vitality were restored to me. And I have been living a full, vigorous and joyful life for 15 years because of successful ARV treatment.

Medical studies suggest that my life span is probably equal to a person in my position who does not have HIV. How extraordinary. Because I take my tablets regularly, I have the same life expectation as a person without HIV.

Even more remarkably, the benefits of ARV treatment in Africa are increasingly open to more than only the privileged few. My country, South Africa, has the largest publicly provided ARV treatment programme in the world. More than 1.7 million South Africans are receiving free treatment through the public health service. Over 10 million South Africans have been tested for HIV in the last few years.

These are significant achievements. In fact, given the ghastly past — where, under a previous president, the government refused to deal rationally with the epidemic — they are spectacular. And the success of South Africa's AIDS programme is due in large part to yet another decision of the Constitutional Court (also before I joined it), *Treatment Action Campaign v. Minister of Health* 2002 (5) SA 721 (CC). There, the Court ordered President Thabo Mbeki's government to start making ARV treatment available. This was in the deepest, darkest and most desperate days of the Mbeki government's denial of the causes of, and treatment for, AIDS. The *Treatment Action Campaign* judgment was a stunning reversal for irrational attitudes and government obstructionism on AIDS.

The law and the Constitution spoke clearly, truthfully and bravely. And to the Mbeki government's credit, it complied with the Court's order. The rule of law — and good sense, backed by medical and scientific evidence — prevailed. Yet stigma, discrimination and irrational attitudes persist. This is where we as judges come in. It is our duty, in fidelity to the principles and craft of our calling, to ensure that injustice and irrationality do not triumph.

In cases dealing with HIV, we have the opportunity to make evidence-informed findings and to apply the highest principles to which our legal systems aspire. That is what this handbook is about. And that is why I am so proud to contribute to it.

Note to the reader

In the context of HIV, the judiciary is confronted with new and complex scientific, legal and medical issues that they are not always equipped to consider and adjudicate. While some jurisdictions have seen the emergence of protective jurisprudence on issues such as employment, access to education, medical insurance, treatment in prisons, segregation, confidentiality and access to medicines, others have seen few jurisprudential developments that guarantee the rights of people living with or vulnerable to HIV.

Enhancing the capacity of the judiciary to address HIV-related legal and human rights issues therefore becomes fundamental to creating an enabling legal environment that supports national responses to HIV.

Judging the epidemic has therefore been prepared as a resource to help judges, magistrates, arbitrators and other judicial officers throughout the world adjudicate cases involving HIV-related issues. This handbook may also be used by judicial trainers and ministries of justice to deliver educational programmes to judges and magistrates on legal issues related to HIV and human rights. It may also be relevant to advocates, lawyers and other legal practitioners, and civil society organisations (including people living with HIV) that seek to gain specific understanding of HIV-related legal issues and the potential role of the courts in advancing human rights in the context of the epidemic. Based on international legal and human rights standards, the handbook contains examples of decided cases from different jurisdictions, good-practice advice and judicial rulings on HIV-related issues.

Given the diverse legal systems, rules of evidence and procedures that exist in different countries and jurisdictions, it is nearly impossible to provide a detailed reference book on HIV-related legal and human rights issues with universal applicability. Moreover, a handbook of this sort cannot possibly provide comprehensive coverage of all of the relevant jurisprudence; it cannot compare and contrast different treatments of the issue, nor can it critique decisions that are flawed from a legal or human rights perspective. This handbook instead aims to provide practical guidance, examples and evidence-informed reasoning that judges, magistrates and other judicial officers can use within their own work.

Judging the epidemic can be read in its entirety or consulted selectively as necessary. The 10 chapters contained in this handbook have been written to "stand alone", so there is some repetition between chapters. The chapters are divided into two Parts. The chapters in Part 1, "The science and medicine of HIV", provide background information relevant to understanding the context of the issues-oriented chapters addressed in Part 2.

Part 2, "Legal decisions that promote human rights in the context of HIV", contains seven chapters, each addressing a particular issue area. The chapters begin with a short introduction summarising key considerations that judges should take into account, including references to pertinent studies, examples and illustrative statistics. The chapters go on to provide an overview of relevant legal provisions, including international and regional human rights conventions, as well as domestic laws. Each chapter then addresses a series of factors that are relevant to the adjudication of cases. Finally, each chapter includes summaries of court cases from different jurisdictions that address issues discussed in the chapter. Readers may want to refer to more than one chapter, depending on the facts and legal issues at play in the case they are considering or adjudicating. In addition, several appendices are included to provide further information.

Introduction

Human immunodeficiency virus (HIV) is a blood-borne virus that attacks the immune system. If untreated, a person infected with HIV can develop acquired immunodeficiency syndrome (AIDS), which is a group of potentially life-threatening infections and cancers. The first cluster of AIDS cases appeared in the United States of America in 1981, and the virus known as HIV was identified in 1985. From those first mysterious cases, HIV has spread around the world, and it continues to affect individuals of all sexes, classes, sexual orientations and ethnicities. Today, an estimated 34 million people around the world are living with HIV.[1] While there is still no cure for HIV or AIDS, there has been significant progress in understanding how HIV is transmitted and how HIV-related disease develops. The discovery and rollout of effective antiretroviral treatment (ART) have turned HIV infection into a manageable chronic condition for those who have access to treatment.

"Around various medical conditions there can gather elements of prejudice and stigma. It is found in community attitudes to various venereal conditions, inherited disabilities, and even to cancer. But HIV/AIDS in the courtroom is especially sensitive. In part, this is because of its still significant association with death. In part, it is also because the modes of transmission are frequently by sexual intercourse and injecting drug use. The association of HIV/AIDS with drugs, sex, and in particular, groups which have been (and sometimes still are) the subject of stigma and even criminalisation (homosexuals, drug-addicted persons, sex workers, etc.) makes community responses to the epidemic highly sensitive, and sometimes over-reactive. Lawyers are members of their communities. They cannot be entirely free from the attitudes, fears and prejudices of the societies they live in. But it behoves judges and legal practitioners to be better informed, and especially to so perform their functions as to reduce unnecessary burdens upon those who come before them who are living with HIV/AIDS".

—The Hon. Justice Michael Kirby, "HIV/AIDS — Implications for Law & the Judiciary", Fiji Law Society, 50th Anniversary Convention, 27 May 2006

Apart from the scientific and medical issues and considerations raised by HIV, the epidemic has also had profound interpersonal, social and legal impact across the world. More than 30 years into the epidemic, living with HIV still carries a heavy burden of stigma and moral judgment; it can also result in discrimination, poverty and rejection. HIV-related stigma and discrimination continue to compromise efforts by individual who are living with HIV to lead full and dignified lives, and they also fuel societal prejudices and rejection, ultimately hindering an effective response to the epidemic.

Individuals' and governments' reactions to HIV have often resulted in the adoption of restrictive and negative measures, attitudes and practices against people living with HIV or those considered to be most at risk of HIV infection. For example, people living with HIV have sometimes been refused access to schools or denied employment due to an irrational fear of HIV. Moreover, the enforcement of laws prohibiting sex work, same-sex relationship, and the possession of illegal drugs can affect the ability of key populations at higher risk of HIV from accessing HIV prevention, care, treatment and support services.

Faced with stigma, discrimination, denial of HIV services and other violations of their human rights, people living with HIV have turned to the courts for redress. People living with HIV have challenged their governments in courts and tribunals for failing to make antiretroviral therapies available to them. Courts in various countries have been called on to protect and promote the equal rights of women through the adjudication of matters related to violence against women, family and property.

HIV has been an issue in a variety of court cases, including:

- discrimination on the grounds of HIV status, sexual orientation, gender, disability, drug use or sex work;
- access to treatment, care and support services;
- breaches of privacy;
- violence against women, men who have sex with men, and people living with HIV;
- guardianship of children;
- forced sterilisation and abortion;
- criminal law with respect to HIV exposure or transmission;
- criminal laws that affect men who have sex with men, sex workers and people who use drugs;
- prisoners' access to treatment and prevention interventions;
- employment issues;
- land tenure and housing rights;
- property and inheritance;
- education;
- informed consent for HIV testing, treatment or participation in research studies;
- drug patents and the right to affordable medicine; and
- immigration and asylum.

The role of the judiciary as interpreter of the law and protector of human rights is therefore critical to creating an enabling legal environment that supports the response to HIV.[2] An evidence-informed and protective judicial application of the law is essential to HIV because it:

- protects people living with or vulnerable to HIV against violations of their human rights;
- helps to address fears, misconceptions and prejudices against people living with or vulnerable to HIV;
- generates a sense of dignity and justice among people living with or vulnerable to HIV; and
- supports access to HIV prevention, treatment, care and support services for all.

Experience and research from around the world clearly demonstrate that evidence-informed and rights-based approaches are most effective and critical to addressing health issues (particularly HIV). As explained by the late Jonathan Mann — a key figure in the early response to HIV and AIDS, and a former head of the World Health Organization's Global Programme on AIDS — promoting and protecting human rights is inextricably linked with promoting and protecting health, because human rights offer a societal-level framework for identifying and responding to the underlying social determinants of health.[3] More specifically, the HIV epidemic "has shown a consistent pattern through which discrimination, marginalization, stigmatization and, more generally, a lack of human rights and dignity of individuals and groups heighten their vulnerability to becoming exposed to HIV".[4]

By facilitating access to justice for people living with HIV, ensuring that court procedures are sensitive to HIV (see box below, "HIV in the courtroom") and delivering evidence-informed and rights-based judicial decisions on HIV-related issues, members of the judiciary can challenge stigma, uphold human rights and dignity for all, and contribute to ending the HIV epidemic.

HIV in the courtroom: A few things to consider[5]

1. **Do not change your courtroom procedures because parties to the case are HIV-positive or the case is HIV-related, unless the parties request a change.**
   - HIV is not casually transmitted. There is no infection-control justification to change procedures, such as requiring witnesses to wear masks or handle evidence with gloves.
   - HIV is a disability. It should be normalised within judicial practice.
2. **If you are aware that a party to the case or a witness has a disability, including living with HIV, ask them if they want you to conduct the hearing in a different manner.** For example, you might ask, "Is there anything we can do differently to allow you to participate fully?"
   - For example, a person living with HIV may feel more comfortable if the hearing room is closed to the public and/or the records are sealed in order to protect their privacy.
   - As another example, the medications that a person is taking may mean that they need to take frequent breaks or that they are more alert in the afternoon.
   - Design hearing procedures to accommodate the people before you. Speak plainly; make a straightforward statement describing what you are observing and specifically ask what they need. For example, you might say, "I notice that you have missed several of the hearing dates related to this case. Is there anything I can do to make the hearing process more accessible for you?"
   - You do not need to know a person's prognosis or diagnosis in order to design the hearing process in a way that accommodates their disability. However, you do need to know the symptoms of the disability, because it is the symptoms that create barriers to a person's participation.
   - Concurrent disabilities (e.g. HIV-positive status plus mental health issues) may create particular barriers to participation.
3. **Judicial officers should maintain control of the proceedings. HIV-related threats, breaches of privacy and other abuses of process should be handled the same way as any other potentially inflammatory issue in the Court.**
   - Some parties have tried to use the other party's HIV-positive status to their advantage, such as by revealing their HIV-positive status in open court or by delaying proceedings knowing that the person living with HIV is ill. Such conduct should not be tolerated.
4. **Third-party interveners can provide important and relevant social information, human rights arguments and scientific research to the Court.**
   - On a range of issues — including HIV-related travel restrictions, drug policy issues, and employment discrimination[6] — non-governmental organisations, researchers and other stakeholders have intervened in cases in order to advance the rights of people living with HIV and assist the Court to come to the most just outcome based on up-to-date and contextualised information.

PART 1

The science and medicine of HIV

In adjudicating cases related to HIV, it is important for judges to have an accurate understanding of HIV — including its modes of transmission and treatment — in order to make decisions that are based on best available evidence and that uphold the rights of people living with HIV and those at risk of HIV.

Part 1 of this handbook therefore synthetises the key scientific and medical facts about HIV. Chapter 1 provides a concise account of how HIV can be transmitted from one person to another, while Chapter 2 discusses HIV disease and treatment. Chapter 3 describes the scientific research on the risk of sexual transmission of HIV and on HIV as a chronic, manageable condition. Sexual intercourse is the primary mode of HIV transmission globally, and it raises specific legal issues, in particular with respect to criminalisation of HIV non-disclosure, exposure or transmission.

The science and knowledge around HIV transmission, progression and treatment has greatly evolved in the past 30 years. The information provided herein reflects the most up-to-date and available evidence at the time of writing. Given that new advances in the understanding and treatment of HIV that may result in the refinement (or the invalidation) of previous conclusions are sure to be made, it is important for judges and magistrates to remain abreast of the most recent medical and scientific knowledge on HIV.

Chapter 1
How is HIV transmitted?

The human immunodeficiency virus (HIV) can be transmitted from one person to another through the following bodily fluids:

- blood;
- semen (including pre-ejaculate);
- vaginal secretions and anal fluids; and
- breast milk.

HIV transmission takes place when:

- a bodily fluid containing HIV (from the above list) enters in contact with an area of the body through which transmission can occur, such as a mucosal membrane (i.e. the lining in the vagina, rectum or parts of the penis), a lesion, or a break in the skin;
- sufficient virus to establish infection enters into the body; and
- initial infection is established, which subsequently spreads to other immune cells in the body.

Predominant means of HIV transmission include:

- unprotected sexual contact (i.e. without the use of condoms or latex barriers);
- direct blood contact, including drug injection using contaminated needles, blood transfusions, or accidents in health-care settings; and
- vertical transmission (i.e. mother to foetus or baby, before or during birth, or through breastfeeding).

It is important to note that:

- blood contains the highest concentration of HIV, followed by semen, then vaginal fluids and breast milk;
- saliva, tears, sweat, faeces and urine do not contain sufficient HIV to transmit the virus to another person; and
- HIV does not survive well outside the body.

Chapter 2
HIV disease and treatment

HIV infection and progression

Left untreated, HIV continues to infect CD4 cells and other types of cells in the body. CD4 cells, a particular kind of white blood cell known as "T-cells", play a key role in the immune system by coordinating the body's response to infections. HIV uses host cells to replicate itself; millions of new copies of the virus then infect other cells, continuing the process. The greater the level of virus actively circulating and replicating in a person's body — known as "viral load" — the more damage the virus does. Without treatment, a person's immune system becomes increasingly weakened by HIV and unable to defend against other opportunistic infections and some cancers, ultimately resulting in a diagnosis of AIDS (acquired immunodeficiency syndrome) when certain clinical criteria are satisfied, and then death.

During the initial period of "acute HIV infection", the infection causes a significant drop in a person's CD4 count and an increase in viral load. After this initial phase, some equilibrium is reached between the replication of the virus and the response of the person's immune system. During this period — which may last many years, depending on the individual — there may be little or no clinical manifestation of the HIV infection. During this time however, the virus will continue replicating rapidly, and it will increasingly damage CD4 cells, weakening the immune system. How quickly the damage is done to a person's immune system, and hence how soon they begin to experience other opportunistic infections or other manifestations of HIV, varies from person to person based on their own innate characteristics and external factors (such as exposure to certain infections). The lower the person's CD4 count and the higher the viral load, the likelier they will experience a more rapid progression to developing AIDS, which in the absence of treatment leads to death.

HIV treatment

There is currently no cure for HIV infection and no vaccine to protect against infection.[7] Since HIV was first identified in the early 1980's however, some two dozen effective antiretroviral medications (ARVs) have been approved for use in treating people with HIV.[8] By 1996, researchers had established that combining different medications from different classes, and thereby simultaneously disrupting HIV's viral cycle at different points, could produce dramatic results for the health of people living with HIV. When successful, highly active antiretroviral therapy (HAART) — usually involving the combination of at least three different medications — practically stops HIV from replicating, allowing the immune system to maintain or recover its strength and keep people healthy.

One ideal outcome of HAART is that it reduces a person's viral load to the point that it is below the limits of detection with commercially available assays (usually about 40–50 copies of the virus per millilitre of blood plasma). When a person starts HAART for the first time, the right combination of medications can reduce their viral load to an undetectable level within 12–24 weeks. How quickly this "virologic suppression" occurs depends on factors such as the potency of the ARV regime, the person's adherence to that regimen, and how high the person's viral load and CD4 cell counts were at the start of treatment.

HAART, however, does not eradicate HIV. When a person is first infected with HIV, the virus very quickly manages to penetrate into long-lived CD4 cells in the immune system and into some organs (such as the brain).

ARVs do not always get into these parts of a person's system, so HIV persists at low levels in these "reservoirs", even when ARVs greatly reduce the overall amount of virus present in a person's system. An "undetectable" viral load in the blood does not mean that the person no longer has HIV. HIV is a lifelong infection. If treatment is stopped, the viral load will rebound and the damage to the immune system will resume.

Because existing treatments do not eradicate HIV, a primary goal of treatment is to suppress the viral load in a person's system as much, and for as long, as possible.[9] This helps to restore and preserve the function of the person's immune system, including an increase in CD4 cells. With a stronger immune system, the risk of serious infections is lessened, preventing illness associated with HIV infection, and prolonging the duration and quality of a person's life. Suppressing HIV through antiretroviral medications is also thought to reduce inflammation in the body, thereby helping to prevent damage to the cardiovascular system and other organs (such as the kidneys, heart and brain). If not successfully clinically managed, HIV remains a serious infection with the potential for serious consequences. But with access to HAART and other quality health care, the lifespan of people newly diagnosed with HIV at this point in the epidemic now approximates that of people who are HIV-negative.[10]

HIV treatment and the reduction of HIV transmission

More recently, researchers have confirmed through multiple studies that successful treatment with ARVs is not only beneficial for people living with HIV, but that it also has a major role to play in preventing further transmission of HIV. By reducing the amount of virus present in a person's bodily fluids, successful HAART dramatically reduces the likelihood of transmitting HIV to another person who may be exposed to those fluids through sexual activity or during pregnancy, labour and breastfeeding.

This was first established most definitively through giving women ARV treatment during pregnancy and labour. In fact, where a pregnant woman living with HIV has adequate access to quality prenatal care — including HAART — the chance that her baby will contract HIV are reduced to less than 2%.[11] More recent research has established the effectiveness of HAART in reducing the risk of HIV infection through sexual contact. In 2011, a landmark study showed that the use of ARVs by people living with HIV reduced the risk of transmission to their sexual partners by 96%.[12] This adds to the growing body of scientific research indicating that people who are on HAART and who have a low viral load have a very low risk of transmitting HIV to partners through unprotected sex.[13]

Importance of adherence to treatment and monitoring treatment effectiveness

The successful and sustained suppression of HIV's replication also reduces the likelihood of mutations in the virus that could render it resistant to medications. This is important for the longer-term success of treatment, including preserving future treatment options (e.g. switching to another class of ARVs that works in a different way should the virus become resistant to one class). Where the technology is available, quality clinical care of a person living with HIV includes regular monitoring of clinical status, CD4 levels and viral load, among other factors. If a given medication regimen is not working to suppress and control the viral load, then other regimens using different medications, if available, should be considered.

Adhering to the prescribed antiretroviral therapy regimen is important for it to be successful in reducing HIV viral load, improving quality of life and increasing the survival of people on treatment. Not adhering to the treatment schedule means a greater likelihood that the virus will develop resistance to one or more of the medications, rendering them less effective. Antiretroviral therapy must be taken on a daily basis for the rest of an HIV-positive person's life (given current treatment options available). Unsurprisingly, adherence to a prescribed regimen can

sometimes be a challenge; nevertheless, high levels of adherence can be achieved, including in resource-limited settings. Many antiretroviral therapy regimes have been simplified in recent years, including the development of fixed-dose combination treatments. Various interventions to support people in adhering to their antiretroviral therapy regimen — including psychosocial supports and addressing factors ranging from lack of housing and nutrition, to mental health issues and addiction or problematic substance use — have been shown to be effective.

Many things can affect adherence, including both economic issues and external factors that can interrupt a person's access to treatment or impede them from adhering to their treatment regimen. For example, the stigma surrounding HIV can be a powerful barrier not only to seeking HIV testing and treatment in the first place, but also to adhering to a treatment regime.[14] Being identified as someone who is regularly taking medicine will naturally prompt questions and suspicions about a person's health condition. Other structural factors can also interfere with adherence. For example, being detained and held in custody by police can result in interruptions in treatment for HIV and other health conditions. Access to adequate medical care is also often deficient or completely lacking in prisons and other closed settings.

Other health care needs of people living with or vulnerable to HIV

People living with HIV have treatment and health care needs beyond ARVs and antiretroviral therapy (ART).

- People with weakened immune systems are more vulnerable to various **opportunistic infections** and some cancers.[15] These include bacterial infections (e.g. tuberculosis), fungal infections (e.g. Pneumocystis jiroveci pneumonia — or "PCP" — and candidiasis), other viral infections (e.g. cytomegalovirus), parasitic infections (e.g. toxoplasmosis, cryptosporidiosis and malaria), as well as Kaposi's sarcoma, lymphoma, and cervical and anal cancer. People living with HIV need access to treatment for these conditions.
- A significant number of people with HIV also have **co-infection with hepatitis C virus (HCV) or hepatitis B virus (HBV)**, blood-borne viruses that can cause liver failure, liver cancer and death.[16] In particular, people who have received improperly screened blood or blood products (e.g. via transfusion), who have been exposed through the use of non-sterile medical equipment, or who have a history of sharing non-sterile equipment to inject or inhale drugs, have a high prevalence of infection. For a significant number of people, HCV treatment with antiviral drugs can eradicate the hepatitis virus. Given the damage done to the liver by HCV, liver transplantation may be required for some people to prevent premature death; emerging evidence shows that there is no good clinical justification for denying solid organ transplants to patients with HIV.
- People living with HIV may need access to **other medications or complementary therapies to manage some side effects of ART**. While they save lives, ARVs can also come with adverse side effects. These can include fatigue, loss of appetite, nausea, diarrhoea, aches, neurologic problems, skin problems, loss of bone density, lipodystrophy (distortion of fat distribution around the body), sexual difficulties, cardiac effects, liver toxicity and others.
- **Dental care** is increasingly recognised as an important element of treatment and care for people living with HIV. A high percentage of people with HIV will have some manifestation of their disease show up in their mouths. Anti-HIV medications can also produce changes in oral health that can contribute to tooth decay and gum disease (gingivitis); the latter is connected to a higher risk of heart disease and stroke. Recognising the importance of good oral health for overall health, particularly for people with compromised immune systems, some jurisdictions have included access to oral health care in the health services covered under public medical insurance programmes.
- Access to a range of **rehabilitation services** can also be critical for preventing and managing health-related challenges or disabilities affecting people living with HIV. For example, physiotherapists can help reduce or

manage pain, numbness, fatigue, musculoskeletal problems and mobility issues. Occupational therapists can assist with accommodating physical limitations or neurological challenges. Psychosocial supports can help individuals cope with mental health issues such as depression, problematic substance use and relationship issues, and they can also assist them with gaining access to available income support and similar programmes (e.g. public or private disability benefits, social assistance programmes and affordable housing).

- Like all people, people living with HIV have a right to satisfying, safe and healthy sexuality, and to reproductive health. Access to **sexual and reproductive health care** — including accurate sexuality and sexual health education, screening for sexually transmitted infections, comprehensive family planning services and maternal health care — protects and promotes the health and well-being of people living with HIV. It also helps prevent further onward transmission of HIV (e.g. to sexual partners, and from mother to child during pregnancy and delivery).[17] Certain populations — including women living with HIV, men who have sex with men, sex workers, and adolescents — may have particular sexual and reproductive health concerns that require particular attention.
- Access to **adequate nutrition and clean water** is critical to protecting and promoting the health of people living with HIV. Certain ARVs or other medications may have to be taken with or without food in order to maximise their effectiveness, and some foods can interact with ARVs, resulting in too much or too little absorption of the drug. HIV and related conditions may cause weight loss and make it difficult to maintain a healthy body weight. Some medications may produce loss of appetite, nausea or diarrhoea, which may complicate getting and retaining the nutrients needed for good health. It also may cause fat redistribution in the body (lipodystrophy), which can complicate maintaining a healthy body weight. People with HIV may be more susceptible to disease-causing bacteria, meaning access to uncontaminated food and water becomes all the more important to preserve health and avoid possibly life-threatening illness.
- The advent of HAART has dramatically transformed HIV for those who have access to medication. Yet for those now living longer with HIV, new medical issues have arisen, including the longer-term impacts of both HIV and ARVs on the body's organs and systems, as well as the interactions between HIV and conditions associated with ageing. And for various reasons, the transformative benefits of HAART still remain out of reach for a minority of people living with HIV in high-income countries and the large majority of people living with HIV in low- and middle-income countries. Therefore, there is still a need for **palliative care** to relieve suffering and improve quality of life at the end of life — including managing pain and other symptoms, psychosocial and spiritual support, and hospice care (where required).
- Access to **other medications and health services** for populations at particular risk of HIV infection, or populations particularly affected by the virus, also need to form part of comprehensive care for purposes of both effective prevention and treatment of HIV.
  - For people with dependence on opioids (e.g. heroin), access to **opioid substitution therapy** (OST) using medications such as methadone and buprenorphine plays a key role in preventing HIV (by reducing risky sharing of equipment to inject opioids), increasing adherance to ARV therapy, and managing other behaviours in order to protect and promote health. The World Health Organization has recognised these as "essential medicines",[18] and UN agencies have repeatedly highlighted the importance of access to OST as part of the response to HIV among injecting drug users.[19]
  - If they are administered soon after exposure, ARVs have been shown to reduce the risk of actually becoming infected with HIV. In particular, it is now recommended that people who have had certain kinds of occupational exposures to HIV (e.g. a needle-stick injury in the health-care setting) be counselled about possibly taking a short course of ARVs (for several weeks) if the medications can be started within 72 hours of the exposure.[20] This is known as **"post-exposure prophylaxis" (PEP)**, and it has been estimated to reduce the risk of infection for the exposed person by about 80%. Practice is more variable when it comes to making PEP available to people following non-occupational exposures (e.g. sexual exposures, whether voluntary or as a result of sexual assault, or exposure through sharing drug-injection equipment).[21]

Chapter 3

Sexual transmission of HIV and living with HIV[22]

Introduction

In the context of sex, only four bodily fluids — blood, semen (including pre-ejaculate), and vaginal and anal fluids — contain enough HIV to potentially infect another person.[23] Transmission can only occur when HIV contained in one of these bodily fluids enters the body of another person. This generally occurs when the virus comes in contact with the other person's mucosal membranes – such as those lining the vagina or rectum – or through breaks in the skin. Even then transmission is not guaranteed, as the virus must infect a sufficient number of target cells to establish an infection. If the amount of virus in the fluid from the HIV-positive person is low, the risk of infection is lower. Since HIV is a fragile virus that can survive outside the body for only a few minutes, transmission usually requires intimate contact. During sex, this most often means unprotected anal or vaginal intercourse. HIV can also be transmitted through sharing equipment used to inject drugs, the transfusion of blood products infected with HIV and vertical transmission between mother and child.

For sexual transmission of HIV, the risk of transmission is not constant for all sexual encounters. In understanding the risk of the sexual transmission of HIV, researchers often consider two broad categories: 1) the type of sex act, namely oral versus vaginal versus anal sex, and 2) biological and other factors, such as the level of virus in the HIV-positive partner or the presence of other sexually transmitted infections (STIs) that can decrease or increase risk.

The risk of sexual transmission of HIV depends, among other factors, on the type of sexual activity. Experts generally agree that our ability to precisely or accurately quantify the per-act risk of HIV transmission during any sexual activity is limited. Research has identified the potential for HIV transmission through oral sex (fellatio, cunnilingus, analingus), vaginal sex and anal sex.

The sexual transmission of HIV

The sexual transmission of HIV from one person to another requires the following four conditions:

- a **fluid known to transmit HIV** — in the case of sex, the fluids are blood, semen (including pre-ejaculate) and vaginal and anal fluids;
- the **fluid makes contact with an area of the body through which transmission can occur**, such as a mucosal membrane (e.g. the lining of the vagina, rectum or parts of the penis), a lesion or a break in the skin;
- entry into the body of **sufficient virus** to establish infection; and
- an **initial infection** within immune cells of the mucosal membranes is established and a **subsequent spread of the infection** to other immune cells in the body.

While unprotected vaginal or anal intercourse may be the most risky sexual activity for HIV transmission, extensive research clearly confirms that not every unprotected act between an HIV-positive person and his or her HIV-negative partner leads to transmission of the virus. In fact, the per-act risk of transmission

is low, commonly quoted as 0.1% (i.e. one transmission in 1000 sex acts) for unprotected heterosexual intercourse.[24, 25, 27]

Many other sexual activities carry little to no risk of transmission. Sweat, saliva and tears do not contain enough HIV to transmit the virus. So, for example, kissing — even deep kissing (in the absence of oral sores or bleeding) — pose virtually no risk of transmission.[29, 31, 33] Masturbation or any other activity that does not expose the uninfected partner to an HIV-carrying fluid also poses no risk. HIV is fragile and able to persist outside the body only for minutes. Unbroken skin is an effective barrier to the virus, and so contact between an HIV-containing fluid and healthy, intact skin is considered safe.[30] Note, however, that lesions, even if microscopic, can provide an entry point for HIV. As well, HIV can pass through the mucosal membrane lining the rectum, vagina, urethra and, in uncircumcised men, the inside of the foreskin, even if the membrane is intact. Thus, the sexual activities that carry the greatest risk of transmission are unprotected vaginal and anal intercourse.

Heterosexual sex

Estimates of the risk of HIV transmission come from four types of studies.[24, 25]

- The first type involves cohorts of "serodiscordant couples" (couples in which, at the outset of the study, one partner is infected with HIV and the other is not). Generally, the couples in these studies report that they were monogamous and engaged in vaginal sex as their only form of sexual intercourse. The couples were followed over time to find out if the HIV-negative partner became infected with HIV during the study. Using data on frequency of intercourse, per-risk estimates can be calculated.
  Serodiscordant cohort studies provide the advantage of controlling many variables, which permits a better estimation of the per-act risk. One criticism of these studies is that they likely miss transmissions that occur during the early phase of HIV infection during which HIV is more easily transmitted (because couples for which this happened would no longer be serodiscordant and thus not eligible for the study). Therefore, these studies may underestimate the overall per-act risk of transmission.
- The second type of study tracks seroconversion over time in a cohort of HIV-negative individuals who do not have steady HIV-positive partners, but who are presumed to be at risk of exposure to HIV (e.g. sex workers).
- The third type of study, cross-sectional partner studies, tests the HIV status of the partners of a group of people who are known to be HIV-positive.
- The fourth type of study is also cross-sectional, but it assesses the HIV status of a group of people presumed to have been exposed to HIV.

All four study types are included in the following discussion.

The value of 0.1% per act is commonly cited as the risk of HIV transmission during unprotected vaginal intercourse. However, a 2009 analysis of existing published studies provided a slightly lower, and perhaps more precise, estimate of 0.08% per act. In other words, if 10 000 serodiscordant heterosexual couples had unprotected sex once, there would be eight transmissions of HIV among them. This figure represents the average transmission risk per act of unprotected vaginal intercourse, and according to the Canadian researchers who published the estimate, indicates "a low risk of infection in the absence of antiretrovirals".[25]

Taken together, the literature is equivocal about whether the probability of transmitting HIV from a man to a woman is higher than the probability of transmitting HIV from a woman to a man. Some studies have found no difference, while others suggest that the probability of HIV passing from a man to a woman is about twice

that of it passing from a woman to a man.[24, 25, 31] A number of biological factors, such as increased surface area of the vaginal lining and greater degree of disruption of the lining during intercourse, could support a difference in the risk based on direction of transmission.[32] Other factors known to influence transmission risk, such as being uncircumcised (which increases the risk for HIV-negative male partners), may have influenced results from studies that did not show a significant difference in risk of transmission.

Oral sex

Oral sex has been associated with a much lower HIV transmission risk than unprotected vaginal or anal intercourse.[30, 34, 35] A lack of sufficient data has made it impossible to calculate a statistically sound estimate of the risk. However, a scientific consensus has developed that the risk of HIV transmission during oral sex is extremely low, albeit non-zero.

A systematic review of the literature identified three estimates of per-act risk based on results from three studies involving 2497 people. Two studies reported no new HIV infections resulting from oral sex. The 0.04% value quoted in the table is from a single study of almost 2200 men who have sex with men (MSM) and involved oral sex where a man who is HIV-positive or of unknown status ejaculated in the mouth of the HIV-negative partner.[36] However, the value of 0.04% per act may misrepresent the risk of transmission from oral sex. It is derived from applying complex data to a statistical model in order to estimate per-contact risk for each type of sex. This modelling may have resulted in an overestimation of the risk associated with oral sex alone since there were no seroconversions among study participants who reported only performing unprotected fellatio to ejaculation.[36]

Anal intercourse

Studies show that unprotected anal intercourse is associated with a higher HIV transmission risk than unprotected vaginal intercourse[28, 37] and that the risk is higher when the HIV-positive person is the insertive rather than receptive partner.[36, 38, 39]

While anal intercourse is part of both heterosexual and homosexual sexual activity, much of the data on HIV transmission risk during anal intercourse comes from studies of MSM. Estimates of per-act risk of HIV transmission for unprotected anal sex derive from individual studies and range widely, from 0.01% to over 3%.[25, 36, 39–41] A 2010 systematic review and analysis that included four studies (two including MSM and two including heterosexual participants) reported a pooled estimate of 1.4% per act for unprotected receptive anal sex (that is, when then HIV-negative person is the receptive partner).[115] There was no significant difference between the risk associated with heterosexual and homosexual activity. Because of the significant heterogeneity between estimates from the different studies, the authors urge caution when using the pooled estimate.

Two studies of MSM (one in Australia and one in the United States) have reported risks of transmission to an HIV-negative receptive partner in the range of 0.65% to 1.43% per contact.[36, 39] For an HIV-negative man who is the insertive partner, the range was 0.06% to 0.62%. The study of MSM in the United States found that the risk of infection associated with being the receptive HIV-negative partner was about tenfold higher than with being the insertive partner (0.82% versus 0.06%).[36] The Australian study found that withdrawal before ejaculation reduced the risk to the receptive HIV-negative partner by over 50%, from 1.43% with ejaculation to 0.65% if withdrawal occurred before ejaculation.[39]

Factors modifying the risk of transmission

Researchers have identified several factors, such as condom use and concurrent STIs, that can affect the risk of HIV transmission during a sexual act. The transmission risk is dependent upon the interaction among these factors, some of which lower the risk of transmission and others of which increase the risk. While it is extremely difficult to quantify the HIV transmission risk for a single sex act between two people at one particular moment given the many contributing and interacting factors, it is important to recognize that certain factors are known to reduce HIV transmission risk.

Factors that reduce the risk of transmission

The factors associated with a reduction in the risk of transmission are condom use, circumcision and lower viral load in the HIV-positive partner.

Condoms

There is significant data supporting the role of condoms in reducing the risk of HIV transmission during sex, and health organizations worldwide promote condom use as a primary means of reducing HIV transmission.[42–45] When used consistently for vaginal intercourse, condoms reduce the transmission of HIV by an estimated 80%, on average.[46]

A finding of an 80% reduction in HIV transmission does not mean that 80% of people using condoms are protected from HIV, while 20% of people using condoms will become infected. Rather, it means that condoms prevent 80% of the transmissions that would have occurred if a condom had not been used. For example, assume a per-act risk of 0.08% for receptive vaginal sex and no other HIV risk factors in a group of 10 000 women who had unprotected vaginal intercourse once with an HIV-positive man. If all 10 000 did not use a condom, about eight women would become infected with HIV. If all 10 000 used a condom, one or two women would become infected with HIV.

Condoms are also generally considered effective in reducing transmission of HIV during anal intercourse, though there are considerably less data supporting this claim.[47] Unprotected receptive anal intercourse has been associated with increased risk of HIV transmission compared with intercourse with a condom.[38, 48] As well, among a cohort of 2915 MSM followed in the United States during the 1980s, consistent condom use was associated with decreased risk of HIV transmission.[49] In a separate study, the per-act risk of transmission to an HIV-negative receptive partner during protected anal sex was 0.2%, about one quarter the risk during unprotected anal sex (0.8%).[36]

Circumcision

Male circumcision is a well-studied factor that reduces HIV acquisition among men who have sex with women. Trials in Africa have validated the effectiveness of circumcision in reducing HIV acquisition by men from their HIV-positive female partners, with an approximately 60% reduction in risk for circumcised men compared to their uncircumcised counterparts.[50]

The impact of circumcision on sexual transmission of HIV among MSM remains unclear, though a 2011 systematic review concluded that it might be protective for men who are primarily the insertive partner.[116]

A 2010 observational study of 1136 MSM in Australia reported a more than 80% reduction in the per-contact risk of transmission to the HIV-negative insertive partner if the insertive partner was circumcised versus uncircumcised (0.11% versus 0.62%).[39] However, other observational studies have produced conflicting results.[51]

Antiretroviral therapy and undetectable viral load

Early studies showed an association between viral load and sexual HIV transmission risk. Among people who were not on therapy, lower levels of HIV in the blood were associated with lower rates of sexual HIV transmission.[52–54] Since antiretroviral drugs lower blood viral load, it was postulated that HIV-positive people on therapy might also be less sexually infectious. Using antiretroviral treatment to inhibit transmission of HIV has been borne out by the use of antiretroviral therapy during pregnancy and delivery. Antiretroviral therapy has been shown to reduce the risk of HIV passing between mother and baby to less than 2%.[55, 57] In Canada from 1997 to 2004, only 15 infants (1.6%) were born HIV-positive to 931 HIV-positive mothers who received antiretroviral therapy.[58]

It is generally accepted that effective antiretroviral therapy, which reduces HIV viral load in the blood and slows disease progression, reduces the risk of sexual transmission of HIV. This is an area of intense study among researchers, and 2011 saw a significant advance in our understanding of the extent of risk reduction: the first prospective, randomized, controlled trial of the impact of early antiretroviral treatment on sexual transmission of HIV provided the most reliable data so far on the impact of antiretroviral treatment on the sexual transmission of HIV.

The study from the United States, called HPTN052, enrolled 1763 serodiscordant couples (97% of whom were heterosexual) from sites in both the developing and developed world.[61] The study evaluated the risk of sexual transmission of HIV in a group in which the HIV-positive partner started antiretroviral treatment right away and compared it to a group in which the HIV-positive person delayed treatment until it was medically necessary.

The clinical trial was slated to end in 2015, but the results were released ahead of schedule when analysis of early data showed that early initiation of treatment led to a 96% decrease in sexual transmission of HIV. These results are based on a clinical trial design that is considered "gold standard", and so they are regarded as the most solid data available on this issue.

To better understand this 96% reduction in risk, let us return to our group of 10 000 serodiscordant heterosexual couples who have no other risk factors and a per-act transmission risk of 0.08% for unprotected vaginal intercourse. If all 10 000 HIV-positive partners were **not** on antiretroviral therapy, about eight of the HIV-negative partners would become infected with HIV. If all HIV-positive partners were on antiretroviral therapy, less than one person would become infected with HIV. The group would have to be at least doubled before we would expect to see a transmission event. This reduction is associated with being on antiretroviral therapy, irrespective of whether the HIV-positive person had an undetectable viral load.

In late 2009, a European team published the first systematic review and meta-analysis of data on the relationship between antiretroviral therapy, blood viral load and the sexual transmission of HIV.[59] This analysis included 11 cohorts comprising 5021 serodiscordant heterosexual couples. The individual studies used different ways of defining their cohorts. Some studies only evaluated whether the participants were on antiretroviral therapy, while others evaluated whether participants on therapy had an undetectable viral load. Overall, the analysis found that antiretroviral therapy (without considering viral load) reduced heterosexual

transmission by 92%. A second systematic review, published in 2011 and including seven observational trials with 9755 serodiscordant couples, reported risk reductions ranging from 66% to 98%, depending on the analysis.[117]

One would expect an undetectable viral load to be associated with at least an equal, and perhaps even a greater, reduction in the risk of HIV transmission. However, the data regarding the effect of an undetectable viral load on HIV transmission are incomplete and, therefore, must be viewed with caution. The European team notes that studies have found no transmission of HIV when blood viral load has been kept below 400 copies/mL by antiretroviral therapy, but they also note that the two studies that did report transmission in the presence of antiretroviral therapy did not report viral load.[59] Also, information about other factors that can increase the risk of transmission (such as STIs) was not consistently reported across the studies examined in the systemic review and meta-analysis.

Due to the limited statistical power of the numerous studies involving a small number of participants, members of the European team stated they could not confidently conclude that sexual transmission is impossible when viral load is undetectable. They go on to state that the amount and statistical power of published data do not permit an accurate estimation of the per-act risk of transmission for people with an undetectable viral load.[59, 60] Based on current data and the studies' statistical limitations, the HIV transmission risk estimate could be as high as 0.013% per act of sexual intercourse, or about 1.3 seroconversions among 10 000 acts.[59]

There is a paucity of data on the association between viral load, antiretroviral therapy and the risk of sexual transmission of HIV among MSM populations. Designing transmission risk studies in this population has proven difficult.[62, 63] Two epidemiologic studies in MSM populations — in the United States and in Denmark — present indirect evidence that antiretroviral therapy may be effective in decreasing risk of transmission, at least when viewed from a broader population perspective.[118, 119] An Australian study found little impact, but its design contained flaws.[39]

While HTPN052 contained a small number of same-sex couples, it is not clear whether the study results apply equally to the MSM population.[61] However, the basic principle remains applicable that being on antiretroviral therapy will translate into a reduced risk of transmission in any given encounter. Nonetheless, because anal sex seems to carry a higher absolute risk of transmission compared to vaginal sex, any benefit in relative risk reduction associated with antiretroviral therapy could still result in a higher absolute risk with anal sex.

Factors that increase the risk of transmission

Any factor that increases one of the required conditions of HIV transmission potentially increases the risk of transmission. For example, ejaculation by an HIV-positive partner who is the insertive partner during penetrative intercourse likely increases the risk of transmission because of the introduction of a larger volume of HIV-containing fluid than would otherwise be the case. Having lesions or abrasions at the site of exposure would also increase risk. Two other factors known to increase the risk of transmission are stage of HIV infection and the presence of other sexually transmitted infections.

Stage of infection

It is generally agreed that the risk of sexual HIV transmission is higher during "primary infection", defined as the first two to three months of infection. Estimates range from an 8- to 43-fold increase in per-act risk of HIV transmission during primary infection when compared with the chronic phase of

infection.[25, 37, 85–87] Advanced HIV disease has also been associated with a 7- to 20-fold increase in risk of HIV transmission.[25, 37, 86] These periods of high blood viral load may partly explain the increased infectivity, although the level of infectivity is higher than would be expected for a given viral load versus other factors that increase the risk of HIV infection (such as STIs).[86]

Sexually transmitted infections (STIs)

There is considerable evidence that having a STI or another infection of the genitourinary tract increases the risk of transmission of HIV, regardless of whether the STI is in the HIV-positive or HIV-negative partner.[24, 88, 126, 127] Several infections have been implicated, including herpes simplex virus (HSV), bacterial vaginosis, gonorrhoea, Chlamydia and vaginal candidiasis.[62, 88–91] The risk is generally in the range of 1.5 to five times higher than that seen in the absence of STIs.[25, 62, 89–92]

Rates of STIs vary with time, over geographic areas and among populations. In groups with increasing rates of STIs, such as rates of syphilis among MSM in some urban centres in the Canadian provinces of Ontario and Quebec during the early to mid-2000s,[114] STIs may play an important role in increasing the risk of sexual transmission of HIV.

To investigate how STIs may be increasing the risk of transmission, researchers are evaluating changes in viral load in genital fluids in the presence of STIs. So far, results have been mixed, with some studies reporting a correlation between the two,[128–131] while others have not.[132, 133]

Living with HIV: A chronic, manageable infection

Thanks to advances in therapy, HIV infection has changed from a terminal disease to a chronic, manageable condition in the eyes of many experts and people living with the virus.[26, 93] Antiretroviral therapy blocks the virus' ability to reproduce, which lessens the deleterious effect on the immune system. While the virus is not eliminated, it is controlled. When HIV is under control, the progression to the more serious stages of HIV disease, including AIDS, is slowed, if not halted. Combination antiretroviral therapy has been available only since 1996 and there is no reason to suspect that it will not continue to suppress the virus in the decades to come.

This shift to an understanding of HIV as a chronic, manageable infection is supported by scientific research focused on changes in the rate of death, the cause of death and the life expectancy of people living with HIV. The introduction of effective combination antiretroviral therapies in 1996 was associated with a dramatic decrease in death due to HIV/AIDS.[94–98] Data collected by the Public Health Agency of Canada show that the reported deaths due to AIDS dropped from 1063 in 1996 to 473 in 1997. In 2008, 45 people died of AIDS in Canada, representing 3% of the 1501 deaths in 1995, the peak of AIDS deaths in the Canadian epidemic.[99] Two large studies from the United States have reported a rate of seven to 10 deaths per 100 person-years in the pre-1996 era. By the mid-2000s, that rate had dropped to less than two deaths per 100 person-years.[97, 98] Recent studies suggest that the death rate among some groups of people with HIV may be approaching that of the general population.[100]

In addition to fewer deaths among people with HIV, there has also been a shift in the causes of death away from the traditional AIDS-defining illnesses — infections such as pneumocystis pneumonia (PCP), or cancers such as Kaposi's sarcoma — towards non-HIV-related causes. In one U.S. study, deaths at least partially attributable AIDS-related causes decreased tenfold, from 3.79 per 100 person-years in 1996

to 0.32 per 100 person-years in 2004. At the same time, the proportion of people with HIV dying from non-HIV-related causes rose from 13% in 1996 to over 40% in 2004.[97] Similar figures have been obtained in another study from the United States.[98] These non-HIV-related causes of death are very similar to those affecting the general population, and they include heart, liver and lung disease and non-AIDS-related cancers, although the incidence of these conditions is greater among people with HIV than among the general population. Both HIV infection and the long-term toxicities associated with antiretroviral therapy may be involved in this increased incidence.[97, 101]

Life expectancy for people living with HIV has greatly increased with the introduction of effective antiretroviral therapy. A 2007 Canadian study found that average life expectancy for someone who became infected with HIV at age 20 increased from nine years in 1993–1995 to 23.6 years in 2002–2004. This means that in 2004, a person who was 20 years old and newly infected with HIV could have expected to live another 23.6 years on average, or to the age of about 44.[102] A 2008 study estimated the average life expectancy for someone infected with HIV at age 20 to be almost 50 years, while preliminary results from a 2010 modelling study suggest that life expectancy for people with HIV in Holland who receive proper care could match that of the general population.[93,103]

With increased life expectancy, people with HIV are facing opportunities and challenges associated with long life. The medical community has increasingly recognized the importance of managing both HIV and health issues associated with aging, from menopause to cardiovascular disease.[97, 98, 104–106] As well, with the prospect of a long life and the knowledge that it is possible to prevent mother-to-child transmission, HIV-positive people are having children.[107, 108] Some are also accessing fertility services if they have trouble conceiving.[109] A 2009 study of HIV-positive women of reproductive age in Ontario reported that 69% desired to give birth and 57% intended to give birth in the future.[110]

PART 2

Legal decisions that promote human rights in the context of HIV

HIV-related issues arise in a wide array of legal proceedings. Courts in different jurisdictions have had mixed records in their response to HIV. Some court decisions have contributed to an environment that protects human rights and advances effective HIV prevention, care, treatment and support; others have resulted in injustices and fueled stigma.

Part 2 of this handbook examines substantive issue areas where HIV is frequently a significant factor. It highlights how the judiciary can help create the type of legal and social environment necessary to respond to the HIV epidemic, provide access to justice for those affected and support national commitments to attain universal access to HIV prevention, treatment, care and support.

The chapters comprising this section relate to:

- discrimination on the basis of actual or presumed HIV-positive status;
- the criminal law and HIV non-disclosure, exposure and/or transmission;
- sexual assault and domestic violence;
- drug laws, harm reduction and the rights of people who use drugs;
- women's rights with respect to family and property;
- HIV treatment and health care; and
- human rights and the criminalisation of key populations at higher risk of HIV exposure.

Each chapter begins with a summary of key considerations. The issue area is then described, with particular focus on the types of HIV-related cases that are coming before the courts. Next, applicable human rights standards (both international and national laws) are enumerated, followed by critical factors for judges and magistrates to consider in adjudicating cases. Each chapter concludes with case summaries illustrating positive examples of application of the law and human rights standards in the context of HIV.

Chapter 4

Discrimination on the basis of actual or presumed HIV-positive status

Summary

People living with or presumed to be living with HIV experience stigma, exclusion, abandonment and even physical violence. They are excluded from access to housing, employment, health-care services, immigration and education (among other things).

HIV-related stigma affects all people living with HIV in some fashion, but the experience and impact is not homogeneous. People who belong to groups that are already marginalised tend to experience the most severe forms of stigma, and they also are most likely to experience discrimination when diagnosed with HIV.

Understanding HIV-related stigma helps judges and magistrates to adjudicate a wide range of cases that come before them, including cases related to employment, access to services, immigration, inheritance, child custody, marriage and divorce, and discriminatory treatment by police, health-care workers or social service providers.

Redressing HIV-related discrimination promotes equal access of people living with HIV to opportunities and services, and it reduces barriers to HIV prevention, testing and treatment.

Relevant laws that may be considered in addressing HIV-related discrimination in different jurisdictions include universal and regional human rights law, national constitutions, anti-discrimination laws, disability-related laws and HIV-specific statutes.

Adjudicating HIV-related discrimination cases : Factors to consider

1. **Robust and meaningful protection against discrimination**

   Substantive anti-discrimination analysis with respect to HIV should take into account both the medical and social aspects of HIV infection and of living with HIV, as well as common stereotypes and misinformation about HIV and people living with HIV.

   It is also important to consider the relation between HIV-related stigma/discrimination and stigma/discrimination that is based on gender, sexuality, age, race, family status, socioeconomic background, religion, immigration status, and other status.

   The principle of "reasonable accommodation" should always be taken into account when considering and deciding on HIV-related discrimination cases.

2. **Protecting public health seldom justifies blanket exclusions of people living with HIV**

   Excluding or limiting people living with HIV as a category is seldom justifiable.

   HIV is not transmitted through casual contact. Restricting the rights of people living with HIV in order to protect public health is therefore only justifiable in very limited situations. Any restriction based on HIV-related status should comply with human rights standards.

3. **An individual assessment is required before disqualifying a person living with (or perceived to be living with) HIV from employment or educational opportunities**

   Only an individualised health assessment can determine if a person living with HIV is medically fit to perform the essential duties of a job or educational programme.

   Military service is an area where exclusion based on HIV-positive status (and/or sexual orientation) has been widespread. Various courts, however, have ruled that such blanket exclusion from military service constitutes prohibited discrimination.

Introduction

Discrimination is arguably the most developed area of jurisprudence with respect to HIV and human rights. From the early days of the epidemic, people living with HIV, people presumed to be living with HIV and even people associated with someone living with HIV have been subjected to gossip, exclusion, abandonment, verbal harassment and even physical violence. They have been excluded from housing, employment, health-care services, immigration and education.

Discrimination based on HIV status often emanates from HIV-related stigma, which remains prevalent throughout the world.[134] Much of the stigma attached to HIV infection is related to the fact that HIV is a sexually transmitted infection, meaning it is already laden with discomfort and moral judgments about sex and sexuality. Similarly, given that the use of non-sterile equipment to inject drugs has worsened the HIV epidemic, HIV stigma has been partially rooted in the stigma surrounding drug dependence and drug use.[135] Thus, individuals belonging to key populations[136] who also live with HIV are doubly stigmatised, both because of their behaviours and/or identities, as well as their HIV status.

Misinformation and fear about both HIV and people living with HIV contributes to HIV-related discrimination. HIV infection is a serious medical condition that can be life-threatening, especially without appropriate treatment. Yet it is not easily transmitted and certainly not transmitted through casual contact, so attempts to isolate, exclude and avoid contact with HIV-positive people in order to avoid infection are unnecessary and unjustified. Similarly, restrictions put on employment and educational opportunities for people living with HIV because of the perception that their HIV status automatically renders them incapable are also unfounded. Most people living with HIV who have access to treatment may experience some periods of ill health, but with proper care and support, most are able to undertake regular daily activities, such as working, studying and parenting.

(See Part 1: The science and medicine of HIV, for further information on HIV transmission and disease progression.)

HIV-related stigma affects all people living with HIV in some fashion. Yet the experience and impact of HIV-related stigma may vary depending on social, economic, cultural and other contexts and considerations. People who belong to groups that are already marginalised tend to experience the most severe forms of stigma, and they are also most likely to experience discrimination when diagnosed with HIV.[137] For example, women living with HIV are more likely than men to report violence, loss of property and abandonment by partner or family because of their HIV-positive status, and they also are more likely to experience discrimination in the context of reproductive health services.[138]

As noted by the Inter-American Commission on Human Rights, the persistent stigma and discrimination suffered by people living with HIV has multiple adverse impacts:

> Generally speaking, it should be mentioned that persons living with HIV/AIDS very often suffer discrimination in a variety of forms. This circumstance magnifies the negative impact of the disease on their lives and leads to other problems, such as restrictions on access to employment, housing, healthcare, and social support systems. There can be no doubt that the principle of non-discrimination must be very strictly observed

"From the first diagnosis [...] of what eventually came to be called AIDS, HIV has carried a mountainous burden of stigma. Stigma has, in fact, been the predominant feature of the social and political response to AIDS. No other infectious disease is viewed with as much fear as is HIV. In fact, diseases far more infectious than HIV are treated with less repugnance".

—Justice Edwin Cameron of the Constitutional Court of South Africa[139]

to ensure the human rights of persons affected by HIV/AIDS. Public health considerations must also be taken into account since the stigmatization of, or discrimination against, a person who carries the virus can lead to reluctance to go for medical controls, which creates difficulties for preventing infection.[140]

When allegations of HIV-related discrimination come before the courts, judges and magistrates have the opportunity to do more than just adjudicate the issue in the case at bar, providing redress to the victim if appropriate. The responses of judges and magistrates to cases of HIV-related discrimination are critical pronouncements, with implications for the rights of people living with HIV and for the overall response to the epidemic. By correcting inaccurate information about HIV transmission, renouncing stigma and clearing the way for people living with HIV to have equal access to opportunities and services, courts can reduce barriers to HIV prevention, testing and treatment. They can help break the cycle of marginalisation associated with HIV, and they can help prevent future rights violations.

Understanding HIV-related discrimination

Arbitrary discrimination[141] against people living with HIV, or suspected of it, can have three devastating public health consequences:

1. Arbitrary discrimination tends to instil fear and intolerance. It creates a climate that interferes with effective prevention by discouraging individuals from coming forward for testing and from seeking information on how to protect themselves and others, thus deepening the adverse impact of living with HIV. Since the effectiveness of a prevention policy depends on reaching those who are at risk and encouraging them to adopt safe behaviour, it is essential to combat the discrimination that drives people away from these types of programmes.
2. Arbitrary discrimination may engender a dangerous complacency in individuals and groups who are not targeted, and who therefore assume that they are not at risk. For example, if a State treats HIV and AIDS as a problem related to foreigners visiting or residing in the country, it may increase the vulnerability of its own citizens.
3. Arbitrary discrimination against people living with HIV, or suspected of it, tends to exacerbate existing forms of marginalisation, such as racism, gender-based discrimination, homelessness, and discrimination against children. It deepens the already-increased vulnerability of marginalised groups to HIV infection, and obstructs their ability to deal with the impact of their own infection and/or infection in their family or associates.

—UNAIDS, *Protocol for the identification of discrimination against people living with HIV*[142]

Common fact patterns coming before the courts

Much of the case law looking specifically at HIV-related discrimination deals with discrimination in the context of employment (including pre-employment testing to exclude HIV-positive job applicants and dismissal of existing employees when it is discovered that they are HIV-positive). Perhaps this is not surprising, given that employment discrimination is quite obvious and deliberate, and that it is most often completely without justification. However, courts should be alive to the discrimination that people living with HIV experience in other realms of their lives, which although it may be less evident, can be equally harmful.

For example:

- When HIV-positive women are denied family-planning services or are given delayed or substandard care in relation to labour and delivery, the results can be both humiliating for the women and potentially life-threatening for both the women and their infants.[143]

- When a child living with HIV (or whose parent is living with HIV) is denied access to child care, a school programme or a sports team, the child is unjustifiably denied an opportunity and their dignity undermined.

HIV-related stigma and discrimination can be issues in a whole range of legal proceedings, including:

- immigration
- inheritance
- child custody
- treatment at the hands of police, health-care workers and social service providers
- marriage and divorce
- assault

For justice to be done, the HIV-related stigma and discrimination must be named and addressed in these cases, even if it is indirect, subtle or unintentional.

Human rights standards and discrimination based on actual or presumed HIV-positive status

International law

a) HIV as "health status"

International and regional human rights standards offer a significant amount of guidance and support to denounce and remedy discrimination related to HIV status. Non-discrimination and equality are foundational principles of international human rights law and essential to the exercise and enjoyment of all human rights.[144] Although there is no binding international instrument that expressly prohibits discrimination on the basis of HIV status, the general non-discrimination provisions of the key universal and regional human rights treaties have been interpreted to include this ground. In both the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, Article 2 guarantees that the rights recognised in the covenants are to be enjoyed "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". This provision has consistently been interpreted as prohibiting discrimination on the basis of HIV or AIDS status, actual or presumed.

The United Nations Commission on Human Rights (predecessor of the current Human Rights Council) has repeatedly confirmed that the term "other status" should be interpreted to cover health status, including HIV and AIDS.[145] Furthermore, in its General Comment on non-discrimination, the Committee on Economic, Social and Cultural Rights explicitly enumerated health status in its list of additional grounds of discrimination that are included under the category "other status". The Committee noted that:

> States parties should ensure that a person's actual or perceived health status is not a barrier to realizing the rights under the Covenant. The protection of public health is often cited by States as a basis for restricting human rights in the context of a person's health status. However, many such restrictions are discriminatory, for example, when HIV status is used as the basis for differential treatment with regard to access to education, employment, healthcare, travel, social security, housing and asylum. States parties should also adopt measures to address widespread stigmatization of persons on the basis of their health status…[146]

Similarly, the reference to "other status" in Article 2 of the *Convention on the Rights of the Child* has been interpreted to include the HIV status of the child and their parent(s).[147]

The existence of a general prohibition of discrimination against people living with HIV is further reflected in both the *Declaration of Commitment on HIV/AIDS*, adopted by the UN General Assembly in 2001, and the 2006 and 2011 *Political Declarations on HIV/AIDS*, also adopted by the UN General Assembly, where member states expressed their commitment to adopt and enforce legislation and other measures aimed at eliminating all forms of discrimination against people living with HIV.[148] The *International Guidelines on HIV and Human Rights*, adopted by the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, also recognise an obligation to protect against discrimination on grounds of HIV status.[149] Most recently, the Global Commission on HIV and the Law has recommended that States explicitly prohibit discrimination on the basis of actual or perceived HIV status, and that they ensure that existing human rights commitments and constitutional guarantees are enforced.[150]

Within Europe, the Parliamentary Assembly of the Council of Europe (consisting of representatives appointed by the national parliaments of all 47 member states of the Council) called upon parliaments and governments of the Council of Europe to "protect people living with HIV/AIDS from all forms of discrimination in both the public and private sectors".[151] Moreover, the European Court of Human Rights has held that HIV status constitutes a prohibited ground of discrimination ("other status") under Article 14 of the *European Convention on Human Rights*.[152] The Inter-American Commission on Human Rights has also recognised the prohibition of discrimination on the basis of HIV status.[153]

b) HIV as a disability

There is no universally accepted definition of "disability" in international law, yet protections against discrimination on the basis of disability may be useful for people living with HIV. Most prominently, Article 5 of the *Convention on the Rights of Persons with Disabilities* states: "State Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds".[154] The Convention does not include a definition of "disability" or "persons with disabilities", nor does it mention HIV or AIDS. The definition of discrimination on the basis of disability contained in the Convention is based on the "social model" of disability, which is broad enough to include HIV or AIDS.[155]

Furthermore, the definition of "disability" in the 1999 *Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities* is also broad enough to encompass HIV and AIDS: "a physical, mental, or sensory impairment, whether permanent or temporary, that limits the capacity to perform one or more essential activities of daily life, and which can be caused or aggravated by the economic and social environment".[156]

National law

At the national level, discrimination against people based on their real or presumed HIV-positive status has been prohibited and condemned by way of a variety of statutes, policies and legal decisions. According to UNAIDS' *Report on the Global AIDS Epidemic 2010*, non-governmental sources in 71% of countries reported the existence of laws protecting people living with HIV from discrimination.[157] These laws take the form of anti-discrimination provisions in national constitutions and human rights laws, anti-discrimination legislation and labour statutes, and/or national HIV legislation and disability laws. Some contain "health status" or "disability" in a list of prohibited grounds of discrimination, both of which can be interpreted to include HIV

status and health conditions related to HIV. Some list HIV and/or AIDS as a specific prohibited ground of discrimination or outline specific protections for people living with HIV in various pieces of legislation.

For example, the Kenya *HIV and AIDS Prevention and Control Act* of 2006 includes a section on "discriminatory acts and practices" that includes prohibitions on discrimination based on actual, perceived or suspected HIV status in the workplace, schools, travel and habitation, public service, credit and insurance services, health institutions, and burial services.[158] The Bahamas has included explicit mention of HIV in its *Employment Act of 2001*: "No employer or person acting on behalf of an employer shall discriminate against an employee or applicant for employment on the basis of race, creed, sex, marital status, political opinion, age or HIV/AIDS".[159] In New South Wales, Australia, the *Anti-Discrimination Act* makes it unlawful for a person "by a public act, to incite hatred towards, serious contempt for, or severe ridicule of" anyone living with HIV or thought to be HIV-positive.[160]

In various countries, court decisions have confirmed that people living with HIV are covered by laws that prohibit discrimination based on "disability" and, furthermore, that this includes both *actual* and *perceived* disability. The Supreme Court of Canada, for example, has stated:

> Whatever the wording of definitions used in human rights legislation, Canadian courts tend to consider not only the objective basis for certain exclusionary practices (i.e. the actual existence of functional limitations), but also the subjective and erroneous perceptions regarding the existence of such limitations. Thus, tribunals and courts have recognised that even though they do not result in functional limitations, various ailments such as congenital physical malformations, asthma, speech impediments, obesity, acne and, more recently, being HIV positive, constitute grounds of discrimination.[161]

Similarly, the Supreme Court of the United States has confirmed that the *Americans with Disabilities Act* protects people living with HIV against discrimination based on HIV status.[162]

Adjudicating HIV-related discrimination cases: Factors to consider

1. Robust and meaningful protection against discrimination

Courts can play a vital role in identifying discrimination against people living with HIV and putting remedies in place to enable the full enjoyment of all human rights by everyone, including people living with or affected by HIV. In the words of the Constitutional Court of Colombia in an HIV-related employment discrimination case, discrimination against HIV-positive individuals cannot be permitted for two reasons:

> Firstly, because human dignity prevents any legal subject from being the object of discriminatory treatment because discrimination is an unjust act per se and the rule of law is founded in justice, the basis of the social order. Secondly, because the right to equality, in accordance with Article 13 [of the Constitution of Colombia], places an obligation on the State to especially protect those who are in a position of manifest weakness.[163]

With respect to HIV, a robust, substantive anti-discrimination analysis necessarily must take into account both the medical aspects of HIV infection and the social aspects of living with HIV. It must also take into consideration the common stereotypes and assumptions that may be tacitly or overtly applied to people living with or perceived to be living with HIV. This includes assumptions that they must be promiscuous,

homosexual, sex workers, or drug users in order to be have contracted the virus, and that they are weak, sickly, unable to work, and will soon die. As noted in a decision of the Supreme Court of Canada considering the prohibition against discrimination in the national constitution,

> The objectives of the [*Canadian Charter of Rights and Freedoms*], namely the right to equality and protection against discrimination, cannot be achieved unless we recognize that discriminatory acts may be based as much on perception and myths and stereotypes as on the existence of actual functional limitations. Since the very nature of discrimination is often subjective, assigning the burden of proving the objective existence of functional limitations to a victim of discrimination would be to give that person a virtually impossible task. Functional limitations often exist only in the mind of other people…[164]

Understanding the real difficulties, barriers and inequalities faced by people living with HIV also requires recognition of how HIV-related stigma plays out when it combines with stigma based on gender, sexuality, age, race, family status, socioeconomic background, religion, or immigration or other statuses.

The Committee on Economic, Social and Cultural Rights comments on non-discrimination

> Discrimination constitutes any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing recognition, enjoyment or exercise, on an equal footing, or Covenant rights. Discrimination also includes incitement to discriminate and harassment.[165]

The Committee instructs that it is not sufficient to eliminate *formal* discrimination; guaranteeing human rights also requires addressing substantive discrimination. *Substantive* discrimination is the actual differential, detrimental treatment which people experience even if the laws and policies appear to be neutral.

> The effective enjoyment of Covenant rights is often influenced by whether a person is a member of a group characterized by the prohibited grounds of discrimination. Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations.[166]

The principle of "reasonable accommodation", a feature of disability-related legislation in numerous jurisdictions, is a helpful concept to employ in discrimination cases where an employer, education facility, service provider or other agency would need to take specific or additional measures in order to provide equal access to a person living with HIV or other disability. Based in human rights, reasonable accommodation is the duty to take positive action to ensure that members of disadvantaged groups benefit equally from services offered to the general public.[167] The extent of this duty to accommodate is generally expressed as "to the point of undue hardship" or a similar standard. In assessing whether reasonable accommodation must be provided, courts have looked at factors such as:

- financial cost
- safety
- the effects on the business or programme of providing the accommodation
- the effect of the disability on the person concerned
- the nature of the benefit or detriment likely to accrue
- the benefits or detriments of the accommodation on other employees, students or service users[168]

2. Protecting public health seldom justifies blanket exclusions of people living with HIV[169]

Rights can be justifiably restricted in certain circumstances. For example, all major treaties that protect civil and political rights recognise that "the protection of public health" is a legitimate reason for government interference with certain rights.[170] The *Siracusa Principles* provide guidance on weighing public policy objectives against human rights guarantees, noting that public health policies can infringe rights if they are sanctioned by law, aimed at a legitimate public health goal, necessary to achieve that goal, no more intrusive or restrictive than necessary, and non-discriminatory in application.[171]

Simply justifying a discriminatory measure (e.g. compulsory HIV testing or denying a person living with HIV access to a service or entrance into a country) as "necessary to protect public health", as is often done in the context of HIV, is usually not sufficient to meet these legal standards for restricting rights. In assessing a measure restricting a person's rights in order to protect public health, courts can benefit from awareness of the limited modes of transmission of the virus (i.e. sexual transmission, by blood and vertical transmission from mother to child). Scientific studies and medical expert opinions are helpful to evaluate the actual risk of transmission in the given circumstances.

For example, restricting blood or organ donations from people who have been confirmed as HIV-positive is a legitimate measure to protect potential recipients from HIV infection because of the risk of HIV transmission inherent in blood transfusions and organ transplants. Excluding people living with HIV from emergency shelter or from rental housing, however, is not a justifiable restriction to protect other residents from HIV infection, since there is no real risk of HIV transmission from casual contact; therefore, such a measure would not be proportionate or effective in terms of safeguarding public health. Generally, measures that stigmatise people living with HIV are ineffective in promoting public health.[172]

HIV-specific migration restrictions are a typical example of blanket exclusions. Numerous countries continue to deny entry to HIV-positive people,[173] often claiming that this is necessary to protect the health of residents.

The European Court of Human Rights examined this issue in the case of *Kiyutin v. Russia.* Mr. Kiyutin, a national of Uzbekistan with a Russian spouse, was required to undergo a medical exam in conjunction with his application for a residence permit in Russia. He tested positive for HIV and his residence permit was refused.[174] As Mr. Kiyutin had been subjected to different treatment on account of his health status, the Court proceeded to examine whether the State's justification was objective and reasonable. The Court rejected Russia's public health rationale for excluding people living with HIV as residents, finding that:

> The mere presence of a HIV-positive individual in a country is not in itself a threat to public health: HIV is not transmitted casually but rather through specific behaviours that include sexual intercourse and sharing of syringes as the main routes of transmission.[175]

The Court also noted that not only are the travel restrictions unnecessary and ineffective from the perspective of HIV prevention, but they might in fact be detrimental to the Russian public by encouraging migrants to avoid HIV testing and reinforcing a false sense of security that HIV is a "foreign" problem.[176]

The Court's rejection of the blanket exclusion of people living with HIV is consistent with international recommendations. For example, UNAIDS and the International Organization for Migration (IOM) issued a joint statement on HIV- and AIDS-related travel restrictions, noting that "HIV/AIDS should not be considered to be a condition that poses a threat to public health in relation to travel because, although it is

infectious, the human immunodeficiency virus cannot be transmitted by the mere presence of a person with HIV in a country or by casual contact".[177]

"Public health is most often cited by States as a basis for restricting human rights in the context of HIV. Many such restrictions, however, infringe on the principle of non-discrimination, for example when HIV status is used as the basis for differential treatment with regard to access to education, employment, health care, travel, social security, housing and asylum…"

—International Guidelines on HIV/AIDS and Human Rights[178]

Other examples of concern are cases of people living with HIV being excluded from various services and facilities — including swimming pools, restaurants, schools, child care centres and health services — in the belief that doing so is necessary to protect others from HIV. Many courts have been instrumental in renouncing such unjustified exclusions (including those put in place by both public and private agencies), defending human dignity and equality, and enabling people living with HIV to fully participate in their communities.

One example of this sort of case is a 2010 decision from a New York district court, which ruled against a basketball camp that excluded a boy because of his HIV-positive status.[179] While the camp did not have a policy on HIV-positive campers, it excluded this boy, not based on any personal limitations that he had, but ostensibly to protect other campers from a theoretical risk of transmission, a form of blanket exclusion that would presumably apply to any applicant living with HIV.

Having found that the *Americans with Disabilities Act* (ADA) applied to this situation, the Court turned to the camp's "direct threat" defence (i.e. that the camp was not required to permit an individual to participate where such individual posed a direct threat to the health or safety of others).[180] The Court affirmed that the ADA does not sanction deprivations of equal treatment based on prejudice, stereotypes or unfounded fears, and that the camp's assessment of the significance of the risk had to be "objectively reasonable" (in other words, based on medical evidence from public health authorities).[181] The Court ruled against the camp, noting that public health publications stated that HIV could not survive in a swimming pool or on a toilet seat, and that HIV was highly unlikely to be transmitted through contact sports (the hypothetical means of transmission considered in the camp's decision to reject the boy's application): "The court agrees that Defendants were obligated to protect other campers from a very serious, life-threatening viral infection. But this obligation does not excuse Defendants' actions when based on unsubstantiated fears".[182]

The dispositive factor in these cases of blanket exclusions that were put in place ostensibly to protect others from infection has been the courts' reliance on the medical community's increased understanding of HIV and its modes of transmission. The widely accepted conclusion among medical researchers is that there is no risk of HIV infection through casual contact or sharing household functions. It is therefore arbitrary, disproportionate and ineffective to deny people living with HIV access to schools, child care facilities or sports and recreational activities, or to restrict their custody or visitation rights, employment opportunities, or other activities in order to protect public health.

Early school case recognises no risk of HIV transmission through non-sexual personal contact

In 1987, the Middle District Court of Florida ruled on a case in which the DeSoto County School District prohibited three haemophiliac boys, the Ray brothers, from attending public school due to their HIV-positive status. While the Court recognised the concern that flowed from the small community, it also refused to allow the school system to be guided by community fear, parental pressure and the possibility of lawsuits.

> The reality is that the Ray boys have already been dealt a hand not to be envied by anyone. The boys at their young ages are having to face two potentially life-threatening diseases. This is more than most people face in their entire adult lives. Denial of the opportunity to lead as normal an educational and social life as possible is adding insult to injury. *Unless and until* it can be established that these boys pose a real and valid threat to the school population of DeSoto County, they shall be admitted to the normal and regular classroom settings, to which they are respectively educationally entitled.
> …
> Defendants assert future theoretical harm that may occur to Defendants and/or to the school population of DeSoto County, including transmission of the disease in the classroom setting and liability of the Board for allowing the Ray boys in the classroom. Such theoretical harm as to transmission is not supported by the evidence in this case. The clear weight of the expert medical evidence and opinion is in favor of returning these children to the integrated classroom, as long as the guidelines are followed and proper care is maintained.
>
> —*Ray v. School Dist. of Desoto County* (U.S.A., 1987)[183]

3. An individual assessment is required before disqualifying a person living with (or perceived to be living with) HIV from employment or educational opportunities

Particularly in employment and education contexts, medical assessments or documentation — including HIV tests — remain a requirement for acceptance in some situations. People living with HIV may be excluded (i.e. dismissed from or refused employment, or expelled from an educational institution) based on their HIV status because they are presumed to be unable to perform the required tasks (often alongside concerns that they will transmit HIV to others at the school or place of employment). HIV-positive status alone, however, is seldom sufficient to justify excluding an employee or student living with HIV. HIV infection should be treated in the same manner as any other chronic medical condition. Only an individualised health assessment — not a stereotype or generalisation — can determine if a person, including someone living with HIV, is medically fit to perform the essential duties of a job. Rather than dismissal, providing reasonable accommodation is generally the most appropriate response.

In this regard, it is important to note the impressive advances that have been made with respect to HIV treatment, including antiretroviral therapies that impede disease progression and allow many people living with HIV to lead long and productive lives. *(See Part 1. The Science and Medicine of HIV).* In employment cases, numerous courts have asked whether employers have had legitimate reasons for denying or terminating employment. In making these assessments, many have relied heavily on medical and scientific evidence regarding modes of HIV transmission, treatment and how HIV infection affects an individual. Informed by this evidence, they have generally held that HIV status alone cannot be a reason for denying or terminating employment.[184]

For example, in the Indian case of *MX v. ZY*, MX was a casual labourer with a public-sector corporation who was denied permanent employment after testing HIV-positive. The High Court rejected the company's arguments that it was legitimate to insist that candidates meet medical requirements in order to be eligible for employment and to refuse candidates whose medical examinations showed them to be suffering from a serious disease.

The Court found that:

> The impugned rule which denies employment to the HIV-infected person merely on the ground of his HIV status irrespective of his ability to perform the job requirements and irrespective of the fact that he does not pose any threat to others at the workplace is clearly arbitrary and unreasonable and infringes the wholesome requirement of Article 14 [equality before the law] as well as Article 21 [protection of life and personal liberty] of the Constitution of India. Accordingly, we hold that the [employer's policy...] in so far as it directs that if the employee is found to be HIV-positive by ELISA test, his services will be terminated is unconstitutional, illegal and invalid and, therefore, is quashed.[185]

The Court went on to stress the importance of non-discrimination in responding to HIV:

> In our opinion, the State and public corporations like [ZY] cannot take a ruthless and inhuman stand that they will not employ a person unless they are satisfied that the person will serve during the entire span of service from the employment till superannuation. As is evident from the material to which we have made detailed reference in the earlier part of this judgment, the most important thing in respect of persons infected with HIV is the requirement of community support, economic support and non-discrimination of such persons. This is also necessary for prevention and control of this terrible disease. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn the victims of HIV infection, many of whom may be truly unfortunate, to certain economic death. It is not in the general public interest and is impermissible under the Constitution. The interests of the HIV-positive persons, the interests of the employer and the interests of the society will have to be balanced in such a case. If it means putting certain economic burdens on the State or the public Corporations or the society, they must bear the same in the larger public interest.[186]

Military service is an area where exclusion because of HIV-positive status (and/or sexual orientation) has been widespread. Various courts, however, have ruled that the same principles regarding discrimination apply in the military context. In a 1994 case in Canada, for example, an HIV-positive man was awarded damages for being discriminated against by the Canadian Armed Forces, which failed to accommodate his disability or assess his individual capabilities, and released him from employment.[187] Similarly, in May 2008, the High Court of South Africa ruled against the South African National Defence Force's discriminatory policy of excluding HIV-positive persons from recruitment, external deployment and promotion in the military.[188]

Different treatment is discriminatory if based solely on the fact that a person is HIV-positive. This is a fundamental guiding principle to judge whether decisions taken because of a person's HIV-positive status are discriminatory in a whole range of circumstances.

- Is there any real reason to deny an HIV-positive parent custody of their child, for example?
- Is a student living with HIV truly unable to succeed in the educational programme? Will they actually be putting other students at risk of infection?
- Is the accommodation required to enable an HIV-positive employee to perform their duties unreasonably onerous?

In adjudicating any HIV-related discrimination matter, courts should distinguish between actual limitations and justifiable restrictions, and those based on stigma, stereotypes, mistaken assumptions and/or overly broad general policies.

International Labour Organization's handbook on HIV and AIDS for judges and legal professionals

The International Labour Organization's (ILO) "Recommendation concerning HIV and AIDS and the world of work, 2010" (No. 200) highlights the importance of strong, independent judicial institutions to ensure that national rights-based policies and legislation are vigorously enforced in domestic courts and through other applicable dispute-resolution mechanisms. *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals* (2013) was subsequently developed by the ILO to promote implementation of national, regional and international human rights law with the aim of eliminating HIV-related stigma and discrimination, protecting human rights and facilitating access to HIV-related services in and through the workplace.

The handbook is both a reference and a training manual. As a reference for judges and legal practitioners in labour-related cases, it provides:

- comprehensive information on the modes of HIV transmission;
- an overview of international and regional law and other international instruments relevant to HIV and AIDS and the world of work, including United Nations and ILO instruments;
- examples of cases showing how international law, including international labour standards, has been and can be applied by national courts under different legal systems, whether monist, dualist or mixed;
- an overview of the ILO and international labour standards relevant to HIV and AIDS and the workplace, focusing on the key human rights principles contained in Recommendation No. 200;
- copies of relevant case law from courts around the world applying the key principles of Recommendation No. 200;
- information on key groups affected by the epidemic;
- an overview of the instrumental roles that judges and legal professionals can play in national HIV responses; and
- a range of procedural safeguards that could be put in place in national courts or dispute-resolution mechanisms for the handling of HIV-related cases.

As a training manual, the handbook offers a flexible three-day training programme, supported by a range of interactive group activities, exercises and case studies. It may be used as a stand-alone training tool or as part of a broader training course or workshop on HIV and AIDS and human rights law.

Highlighted cases

South Africa: Court prohibits HIV-based employment discrimination

Hoffmann v. South African Airways, Constitutional Court of South Africa, Case CCT 17/00 (2000)

Parties

The appellant was a man living with HIV who had applied for a job with South African Airways, a corporate enterprise of the Republic of South Africa. South African Airways had a policy under which it refused to hire people living with HIV as airplane cabin attendants.

Remedy sought

The appellant sought a court order that South African Airways employ him as a cabin attendant.

Outcome

The Constitutional Court ordered South African Airways to employ Hoffman as a cabin attendant. South African Airways was also ordered to pay Hoffman's court costs.

Background and material facts

In September 1996, Hoffmann applied for employment as a cabin attendant with South African Airways. The airline interviewed him and found him to be a suitable candidate for employment and, he underwent a pre-employment medical examination that included an HIV test. He was found to be clinically fit and suitable for employment. The HIV antibody test returned a positive result, and the medical report was altered to say that he was unsuitable for employment because of his HIV-positive status.

South African Airways had a policy prohibiting the employment of people living with HIV as cabin attendants, supposedly because cabin attendants had to be fit for worldwide duty, which required them to be vaccinated against yellow fever. South African Airways stated that people living with HIV could react negatively to this vaccine. Further, South African Airways stated that HIV-positive people could be prone to contracting opportunistic infections and therefore would not be able to perform emergency and safety procedures. Finally, the airline stated that the life expectancy of people living with HIV was too short to warrant the costs of training them.

The medical evidence provided by AIDS Law Project, which intervened in the case, and South African Airways' medical expert demonstrated that asymptomatic HIV-positive persons can perform the work of a cabin attendants. According to the medical expert, there was nothing to indicate that at the time of his medical examination, Hoffmann had either reached the immuno-suppressed stage of HIV infection or had developed AIDS.

Legal arguments and issues addressed

Before the High Court, Hoffmann challenged the constitutionality of the refusal to hire him. He alleged that the refusal constituted unfair discrimination and violated his rights to equality, human dignity and fair labour practices. South African Airways argued that the decision not to hire Hoffmann was based on its policy, and its policy was justified by medical, safety and operational considerations. The airline also argued that if it were obliged to hire people living with HIV, the public perception of the airline would be impaired and it would be seriously disadvantaged against its competitors (private corporations to whom the Constitution did not apply). The High Court accepted South African Airways' arguments, finding that its policy did not unfairly discriminate against people living with HIV.

On appeal to the Constitutional Court, South African Airways conceded that its practice of refusing to employ cabin attendants because of their HIV status was medically unjustified and thus unfair. Instead, South African Airways argued that its "true" policy was to refuse employment to HIV-positive cabin attendants where their HIV infection had progressed such that the airline believed the person unsuitable for employment.

The Constitutional Court refused to consider the legality of the airline's allegedly "true" policy. The Constitutional Court considered Hoffmann's constitutional claims. The Constitution applied to South African Airways because it was owned by a statutory body under control of the State. The Court based its judgment on the right to equality under the Constitution (section 9). In assessing equality rights claims, the Court had to engage in three enquiries:

1. Does the challenged law make a differentiation that bears a rational connection to a legitimate government purpose? Where there is no rational connection, then section 9 has been breached.

2. Where there is a rational connection, does the differentiation amount to unfair discrimination?

3. If the differentiation does amount to unfair discrimination (and if it is found in a law of general application), can the differentiation be justified under the provision in the Constitution that permits limitations on constitutional rights (section 36)?

With respect to the first enquiry, the Court found that South African Airways' employment practice was irrational; the fact that some people living with HIV may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify the exclusion of all people who are living with HIV from that position.

With respect to the second inquiry, the Court found that the airline's policy discriminated unfairly against Hoffmann because of his HIV status. It stated that people living with HIV were one of the most vulnerable groups in South African society and they faced prejudice and stereotypes despite medical evidence about how HIV is transmitted. Thus, any discrimination against HIV-positive people was a "fresh instance of stigmatisation" and an "assault on their dignity". The Court further remarked that people living with HIV enjoy special protection from discrimination under the *Employment Equity Act* because of the impact of employment discrimination on their ability to earn a living.

The Court also considered the commercial interests of South African Airways, given that other airlines had similar policies. It found that South African Airways' commercial interest argument was not legitimate. It was based on fear, ignorance and stereotypes of the supposed dangers posed by HIV-positive people, regardless of their individual circumstances. It stated that "the constitutional right of the appellant not to be unfairly

discriminated against cannot be determined by ill-informed public perception of persons with HIV", nor determined by policies of other airlines that are not subject to the Constitution.

Because the policy in question was not a "law of general application", the Court did not undertake the third enquiry.

Having found that South African Airways had engaged in unfair discrimination, the Constitutional Court turned to the issue of the remedy. The Court ordered the airline to offer Hoffmann employment forthwith, but if Hoffmann did not accept employment within 30 days of the offer, the order would lapse. The airline was also ordered to pay Hoffmann's costs in both the High Court and in the Constitutional Court.

Commentary

This ruling affirms that the blanket exclusion of people living with HIV from employment infringes the constitutional guarantee of equality. Individual job applicants should be evaluated in terms of their individual circumstances, including their ability to perform the essential duties of a job. As the Constitutional Court pointed out, people living with HIV cannot be "condemned to economic death" by the denial of equal opportunity in employment. In the words of the Constitutional Court, the ruling is a validation of the principle of *ubuntu* — a Zulu word conveying the recognition of human worth and respect for the dignity of every person.

The Constitutional Court's mention of the *Employment Equity Act* was also significant because relatively few employers in South Africa are subject to the Constitution. HIV-positive South Africans who do not work for the state or state-owned businesses must rely on the *Employment Equity Act* for protection from discrimination in employment. The Court's analysis of discrimination in the Hoffmann case provided guidance to the Labour Court and other courts deciding cases under the Act.

This case also highlights the importance of remedial issues for people living with HIV to defend their rights. In this case, the Court refused to order South African Airways to compensate the applicant for any income he may have lost as a result of the denial of employment as a cabin attendant, because there was no evidence before the Court on this point. While the legal principles developed through court decisions may have far-reaching impact, the interests at stake for each individual litigant also must be protected and specific evidence in support of an individual's claims also must be introduced. Compensation for lost wages may be an appropriate remedy for some litigants. A job offer may be an appropriate remedy for some. Employment situation, privacy concerns and other factors will dictate in each situation.

Note that this summary of Hoffmann is adapted from the case summary in *Courting Rights: Case studies in Litigating the Human Rights of People Living with HIV,* UNAIDS Best Practice Collection, (Canadian HIV/AIDS Legal Network and UNAIDS, 2006), pp. 35–38.

European Court of Human Rights: Court finds that refusal to grant a residence permit because of HIV-positive status is unjustifiable discrimination

Case of Kiyutin v. Russia, European Court of Human Rights, 10 March 2011, app. 2700/10

Parties

The plaintiff, Viktor Kiyutin, was a national of Uzbekistan seeking a Russian residence permit. Interights (International Centre for the Legal Protection of Human Rights) was granted leave to intervene.

Remedy sought

The applicant alleged that he had been a victim of discrimination on the basis of his health status in his application for a residence permit. He sought non-pecuniary damages, plus costs and expenses.

Outcome

The Court found that the applicant had been a victim of discrimination on account of his health status, a breach of Article 14 (non-discrimination) taken together with Article 8 (respect for private and family life) of the *European Convention on Human Rights*. The plaintiff was awarded 15 000 euros in non-pecuniary damages and 350 euros in costs, to be paid to him by Russia.

Background and material facts

The plaintiff, a national of Uzbekistan, married a Russian national in 2003 and went to live in Russia. They had a child in 2004. In 2003, Kiyutin applied to obtain a Russian residence permit. He was required to undergo an HIV test and tested positive; his application was therefore denied. Under Russian law, foreign nationals and stateless persons who are in Russia are to be deported if it is discovered that they are HIV-positive. In addition, applications for residence permits are refused if the applicant is unable to produce a medical certificate demonstrating that they are HIV-negative.

In April 2009, Kiyutin filed a new application for a temporary residence permit. In May 2009, the Federal Migration Service determined that he had been residing unlawfully in Russia and imposed a fine. In June 2009, the Federal Migration Service again rejected his application because of his HIV-positive status. Confronted with an order to leave Russia, Kiyutin challenged the decision. His complaint and appeal were rejected by the courts.

In late 2009, Kiyutin's HIV disease was progressing such that he was prescribed highly active antiretroviral therapy (HAART); he was also diagnosed with hepatitis B and C.

Legal arguments and issues addressed

The European Court of Human Rights had to determine whether the decision to refuse Kiyutin authorisation to reside in Russia was disproportionate to the legitimate aim of protection of public health, and if it had disrupted his right to live with his family. The Court considered it appropriate to examine his grievances from the standpoint of Article 14 (non-discrimination) of the *European Convention on Human Rights*, in conjunction with Article 8 (respect for private and family life).

The Court noted that international law does not recognise a right to settle in a foreign country and that some travel restrictions are permissible. However, restrictions will be in breach of anti-discrimination standards if they single out people living with HIV without an objective justification.

The jurisprudence of the Court established that discrimination means treating differently, without an objective and reasonable justification, persons in analogous situations. In order for a difference in treatment to be justifiable, it must be shown by the State to be objective and reasonable. It must pursue a legitimate aim and have a reasonable relationship of proportionality between the means and the ends. Considering the practice of other countries, the Court found that the exclusion of HIV-positive applicants from residence does not reflect an established European consensus, and that it has little support among Council of Europe member states. Russia therefore must provide a particularly compelling justification to deny residence permits on the basis of HV-positive status.

The Court acknowledged that travel restrictions can help protect the public against some contagious diseases, but that in the case of HIV, travel restrictions are a disproportionate and discriminatory response**.** The Court found that:

> [T]he mere presence of a HIV-positive individual in a country is not in itself a threat to public health: HIV is not transmitted casually but rather through specific behaviours that include sexual intercourse and sharing of syringes as the main routes of transmission. This does not put prevention exclusively within the control of the HIV-infected non-national but rather enables HIV-negative persons to take steps to protect themselves against the infection (safer sex and safer injections). Excluding HIV-positive non-nationals from entry and/or residence in order to prevent HIV transmission is based on the assumption that they will engage in specific unsafe behaviour and that the national will also fail to protect himself or herself. This assumption amounts to a generalisation which is not founded in fact and fails to take into account the individual situation, such as that of the applicant.

In addition, the Court noted that not only is the Russian policy of denying residence permits to HIV-positive individuals ineffective at preventing HIV transmission, it may actually be harmful in terms of HIV prevention. Such legislation might encourage migrants to remain illegally in Russia and not take an HIV test. They may then be unaware of their HIV-positive status and therefore may not adopt safe behaviours to avoid HIV transmission. Also, this legislation might create a false sense of security by encouraging the Russian population to consider HIV as a foreign problem that can be addressed by excluding foreigners who carry the virus. The Russian public might then feel that they need not adopt safe behaviour.

Commentary

This case represents an important international legal condemnation of discrimination against people living with HIV. It is notable in several regards.

First, the Court took guidance from international experts on the issue of HIV-related travel restrictions and discrimination against people living with HIV. It looked to the United Nations Commission on Human Rights, the Committee on Economic, Social and Cultural Rights, the Parliamentary Assembly of the Council of Europe, the *Convention on the Rights of Persons with Disabilities*, the UNAIDS/IOM statement on HIV/AIDS-related travel restrictions (from 2004), the *International Guidelines on HIV/AIDS and Human Rights*, and the *Report of the International Task Team on HIV-related Travel Restrictions* (convened in 2008). This reliance on international jurisprudence and expert opinion is a positive example of a court taking into consideration the latest practice and evidence on an HIV-related issue.

Second, the Court disapproved of the blanket, indiscriminate manner of the exclusion in this case. The Court clearly felt that an individualised assessment based on the particular facts was necessary. Without considering Kiyutin's health and behaviours, Russia could not assume that he posed a risk of transmission to Russian citizens. The Court acknowledged that protecting public health was a legitimate aim, but it set a high standard in terms of demonstrating an actual risk to public health.

Finally, the Court acknowledged that people living with HIV have suffered a history of stigma and discrimination. Understanding that people living with HIV constitute a vulnerable group, and therefore requiring that any legislation that excludes people living with HIV be given close consideration, is both realistic and pragmatic. Anti-discrimination provisions can be given life by acknowledging how significant past discrimination can structure current policies and practices.

For additional summaries of cases regarding HIV-related discrimination, see *Courting Rights: Case studies in Litigating the Human Rights of People Living with HIV*, UNAIDS Best Practice Collection, (Canadian HIV/AIDS Legal Network and UNAIDS, 2006).

Chapter 5

The criminal law and HIV non-disclosure, exposure and/or transmission

Summary

In many jurisdictions throughout the world, it is considered a crime to engage in certain sexual acts with another person without disclosing one's HIV-positive status, to expose another person to HIV, or to transmit HIV to another person, especially through sex. Some jurisdictions have enacted HIV-specific legislation while others have applied existing criminal laws to HIV cases.

Proponents of criminalisation of HIV non-disclosure, exposure or transmission often assert that invoking the criminal law promotes public health by deterring and punishing behaviour that exposes others to the risk of HIV transmission.

There is no evidence that criminal prosecutions help prevent new HIV infections. Rather, there are indications that overly broad criminalisation of HIV non-disclosure, exposure or transmission undermines public health and can result in miscarriage of justice.

Adjudicating cases of HIV non-disclosure, HIV exposure and/or transmission: Factors to consider

1. **The science on HIV and HIV transmission risk**

   Judges and/or juries should consider the level of HIV transmission risk in the specific circumstances of the case and the degree of harm resulting from the prohibited conduct (if any). An overview of key scientific information is provided in this chapter, including an overview of how HIV transmission happens, factors that reduce or increase the risk of transmission, and key facts about HIV infection.

   In HIV transmission cases, judges/juries should require a proof that HIV was transmitted by the accused in order to secure a conviction. Judges/juries must note that available scientific techniques — including phylogenetic analysis and Recent Infection Testing Algorithm (RITA) testing — have significant limitations and alone cannot definitively prove the source or timing of an HIV infection.

2. **Evidence of a culpable mind**

   Some legislation criminalising HIV exposure or transmission expressly requires that the accused acts with the intention to transmit HIV. Wilful, purposeful or intentional exposure or transmission should not be presumed merely because a person living with HIV has engaged in unprotected sex or has had sex without disclosing their HIV-positive status to the sex partner.

In jurisdictions where a person living with HIV can be convicted for HIV non-disclosure, exposure and/or transmission even if they did not intend to infect anyone, the required level of culpability will depend on the applicable offence and jurisprudence in the jurisdiction. For example, some jurisdictions may require evidence of recklessness or negligence. Often, proving that the accused knew that they had HIV, and that they understood how HIV is transmitted is critical to the determination of legal culpability. Similarly, whether measures to prevent HIV transmission were taken (e.g. condoms or avoiding certain type of sexual activities) should also be a critical element in determining the required mental culpability.

3. Defences

Judges should consider, as defences to charges of HIV non-disclosure, exposure and transmission, the elements below:

- Consent to sex by the sexual partner of the HIV-positive person.
- The use of reasonable precautions to protect a partner from HIV infection. This may include the use of a condom and other measures to significantly reduce the risk of transmission (e.g. engaging in oral sex). Maintaining a low or undetectable viral load could also be considered a reasonable safeguard against transmission, given its dramatic impact on HIV transmission risks.
- Fear of violence, abandonment or abuse, especially for women in abusive relationships.

4. Prosecutions for vertical transmission of HIV

In some jurisdictions, HIV-related criminal provisions could be interpreted to include prosecutions of women for vertical transmission (i.e. mother-to-child transmission). From the perspective of preventing vertical transmission and protecting the rights of women, it is problematic to predicate criminal prosecutions on a woman having transmitted HIV to an infant or having failed to take "reasonable" measures to prevent vertical transmission. There are many reasons why a woman may not be able to prevent the transmission of HIV to her child.

5. Sentencing in HIV exposure or transmission cases

Sentencing in cases of HIV exposure and transmission varies greatly from one jurisdiction to another.

Sentences that are imposed in some jurisdictions in relation to HIV exposure and transmission are particularly onerous and are often higher that those applied for similar risks or harms.

When imposing sentences in prosecutions for HIV non-disclosure exposure or transmission, judges may take into account the negative impact that imprisonment may have on the health of a person living with HIV.

Introduction

In many jurisdictions throughout the world, it is considered a crime to engage in certain sexual acts with another person without disclosing one's HIV-positive status, to expose another person to HIV or to transmit HIV to another person, especially through sex. Some jurisdictions have enacted HIV-specific legislation, while others have applied existing criminal laws to HIV cases.[189]

The first known prosecutions for HIV exposure occurred in the United States in 1987; the first HIV-specific laws were enacted that same year.[190] In the intervening years, the criminalisation of HIV non-disclosure, exposure and transmission (hereinafter sometimes referred to as "criminalisation") has spread throughout the world. Africa is the region of the world with the most legislation specifically criminalising HIV non-disclosure, exposure or transmission.[191] Many of these laws are based on a model law developed at a workshop held in N'Djamena, Chad in 2004.[192] These newer laws usually embody a "rights and responsibilities" approach, providing protection for the rights of people living with HIV, while making it their responsibility (punishable by the criminal law) to protect others from infection.

Most prosecutions and HIV-specific criminal penalties relate to HIV non-disclosure, exposure and/or transmission in the context of sexual relations. HIV status can, however, be taken into account in relation to other offences. For example, where a person prosecuted for rape is living with HIV, the fact that the complainant was exposed to the risk of HIV transmission as a result of the assault may be considered as an aggravating factor.[193] Criminal charges have also been brought in relation to non-sexual exposure, such as vertical (i.e. mother-to-child) transmission, spitting or biting.

> *"There will be calls for 'law and order' and a 'war on AIDS'. Beware of those who cry out for simple solutions, for [in] combating HIV/AIDS there are none. In particular, do not put faith in the enlargement of the criminal law".*
>
> *—Justice Michael Kirby, High Court of Australia, "The Ten Commandments",* [Australian] National AIDS Bulletin, *March 1991*

The criminalisation of HIV non-disclosure, exposure and/or transmission is controversial. Proponents often assert that criminalisation promotes public health by deterring and punishing behaviour that risks transmitting HIV. But there is little evidence that criminal prosecutions help prevent new infections by increasing safer sex practices or disclosure to sexual partners.[194] On the other hand, many critics have raised concerns that an overly broad use of the criminal law undermines public health by:

- contradicting public-health messages encouraging everyone to take responsibility for their own sexual health (i.e. criminalisation instead assigns responsibility for HIV prevention to people who know they are HIV-positive);
- contributing to misconceptions about HIV and how it is transmitted, especially where low- to negligible-risk activities are being criminalised (e.g. vaginal sex with a condom or oral sex);
- creating a false sense of security in those who are HIV-negative or who do not know their HIV status by encouraging people to believe that the law can protect people from exposure to HIV;
- undermining the trust between health professionals, service providers and their patients, and deterring people from talking openly about their sexual practices and seeking advice to minimise risk for fear that what they say could be used against them in a criminal investigation;
- deterring people from accessing HIV testing, care and treatment for fear of legal ramifications; and
- reinforcing stigma and discrimination against people living with HIV.[195]

Critics have also warned that criminalisation can be a source of great injustice and unfairness[196] for a variety of reasons, including:

- many police, prosecutors and judges misunderstand the risk of HIV transmission and the realities of living with HIV;[197]
- very serious charges are being laid and harsh sentences imposed, even where there is no intention of harm, the risk of transmission is minimal, and no transmission occurred;[198]
- cases of HIV non-disclosure, exposure and transmission are often determined solely on the basis of the credibility of the witnesses, which makes people living with HIV particularly vulnerable to false accusations by vindictive partners; and
- racialised communities and marginalised groups may be disproportionally affected by criminalisation.[199]

Criminalisation and women

Criminalisation is often perceived as a necessary tool to protect women, especially monogamous wives, from the risk of HIV infection by male sexual partners. Many advocates are concerned, however, that rather than protecting women, the burden of criminalisation may fall unfairly on them because:

- in many countries, women are generally the first, if not the only, partner of a couple to test for HIV, because of pre-natal screening;
- some HIV-positive women risk violence, abuse or abandonment if they reveal their HIV status to their partners and cannot negotiate safer sex practices; and
- if women disclose their HIV-positive status to their partners, such information can be used by a vindictive partner as a tool for revenge or coercion, especially against women in abusive or dependent relationships.[200]

The numerous human rights and public health concerns associated with the criminalisation of HIV non-disclosure, exposure and/or transmission have led UNAIDS and the United Nations Development Programme (UNDP) to urge States to limit the use of the criminal law to cases of *intentional transmission of HIV (i.e. where a person knows their HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it).* [201] The 2008 policy brief on criminalisation of HIV non-disclosure, exposure and transmission adopted by UNAIDS and UNDP further stated that the criminal law should never be applied where there is no significant risk of HIV transmission, or where the accused:

- did not know that they were HIV-positive;
- did not understand how HIV is transmitted;
- disclosed their HIV-positive status to the person at risk (or honestly believed the other person was aware of their status through some other means);
- did not disclose their HIV-positive status because of fear of violence or other serious negative consequences;
- took reasonable measures to reduce risk of transmission (e.g. using a condom); or
- previously agreed on a level of mutually acceptable risk with the other person.[202]

To support further consideration of the issues raised by overly broad criminalisation of HIV non-disclosure, exposure and transmission, UNAIDS has developed a guidance note on the scientific, medical and legal considerations involved.[203] The guidance note provides critical considerations and recommendations regarding the scientific and medical facts and developments relating to HIV, as well as the legal principles that are essential to assessing:

- what level of harm, if any, has been caused to another person as a result of HIV non-disclosure, exposure and transmission;
- whether the nature/level of risk of HIV transmission from particular sexual acts warrants criminal liability;
- what elements should be recognised as defences to charges of HIV non-disclosure, exposure and transmission; and
- the merits and limitations of methods of proof used in the context of HIV non-disclosure, exposure and transmission.[204]

The guidance note also discusses and draws on recent legal, judicial and policy developments in a number of jurisdictions on the application of the criminal law to HIV non-disclosure, exposure and transmission. The guidance note is the result of the project described below.

A project to marshal the latest scientific and medical evidence and best legal practices on HIV and criminal law

Between 2010–2012, UNAIDS implemented a project involving research, policy dialogue, and evidence and consensus-building on criminalisation of HIV non-disclosure, exposure and transmission. This was done to ensure that any application of criminal law in the context of HIV achieves justice and does not jeopardize public health objectives. The project consisted of the following:

- the development of background and technical papers on current laws and practises, as well as recent medical and scientific developments, that are relevant to the criminalisation of HIV non-disclosure, exposure and transmission;[205]
- an expert meeting (convened on 31 August–2 September 2011 in Geneva, Switzerland) that brought together scientists, medical practitioners and legal experts in order (i) to consider the latest scientific and medical facts about HIV that should be taken into account in the context of criminalisation, and (ii) to explore how to best address issues of harm, risk, intent and proof — including alternative responses to criminalisation — in light of this science and medicine;[206] and
- a high-level policy consultation, jointly convened by the Government of Norway and UNAIDS in Oslo on 14–15 February 2012, that gathered policy-makers from around the world to discuss options and recommendations for addressing the criminalisation of HIV non-disclosure, exposure and transmission.[207]

Adjudicating cases of HIV non-disclosure, HIV exposure and/or transmission in a sexual context: Factors to consider

Legal provisions and jurisprudence on this issue vary greatly from one jurisdiction to another. This section is not intended to cover all the criminal issues that may arise in relation to HIV; rather, it highlights some critical factors to consider when adjudicating cases of HIV non-disclosure, HIV exposure and/or transmission in the context of sexual relations.

1. The science on HIV and HIV transmission risk

In order to adjudicate cases of HIV non-disclosure, exposure and/or transmission, courts often need to consider the science on HIV and HIV transmission risk. The science helps establish the level of risk involved in a particular case and the degree of harm resulting from the prohibited conduct (if any). What follows is a synopsis of the best available science on HIV and HIV risks of transmission at the time of writing.

(See Part 1. The science and medicine of HIV, for further information.)

a) HIV transmission

Conditions required to transmit HIV from one person to another

- presence of a bodily fluid known to transmit HIV (i.e. blood, semen — including pre-ejaculate — vaginal and anal fluids, and breast milk);
- fluid makes contact with an area of the body through which transmission can occur (i.e. mucosal membrane, lesion, or break in the skin);
- entry into the body of sufficient virus to establish infection; and
- initial infection is established, which subsequently spreads to other immune cells in the body.[208]

Factors affecting the level of risk of HIV infection from various sexual acts

- the type of sexual activity (i.e. whether it is non-penetrative and/or penetrative, vaginal, anal and/or oral intercourse)
- the roles of sexual partners during penetrative sex (i.e. insertive or receptive)
- the frequency and overall number of sexual events
- whether or not a condom (male or female) or other barrier that is effective at preventing HIV exposure during penetrative sex was used correctly and consistently
- whether or not the insertive partner was circumcised
- the presence or absence of other STIs in the individuals involved
- the concentration of HIV (viral load) in the bodily fluid to which the at-risk person has been exposed
- whether or not the HIV-positive person was on antiretroviral therapy that significantly reduced the concentration of HIV in bodily fluids to non-infectious levels[209]

Transmission routes

- **Unprotected vaginal intercourse**
  - The per-act risk of transmission is commonly quoted as 0.1% (i.e. one transmission in every 1000 acts).[210]
- **Unprotected anal intercourse**
  - The risk of transmission is higher when the HIV-positive person is the insertive partner rather than the receptive partner.
  - In men who have sex with men, when the insertive partner is HIV-positive, the per-act risk of transmission is commonly quoted as 0.82% (i.e. one transmission in 122 acts),[211] but one study found a 1.43% per-act risk estimate with ejaculation (i.e. one transmission in 70 acts).[212]
- **Sharing contaminated syringes, needles or other sharp instruments**
  - Using non-sterile or previously used drug-injection equipment is a highly efficient route of HIV transmission because infected blood can enter directly into the bloodstream.
  - No specific quantification of the risk level is available.
- **From an HIV-positive mother to a foetus or infant ("vertical transmission")**
  - In the absence of any intervention, the chance of transmitting the virus during pregnancy, delivery or breastfeeding is 15-45%.
  - With effective HIV treatment and a managed delivery, this risk can be reduced to levels below 5%.[213]

Activities with negligible or no risk of HIV transmission

- **Kissing, spitting or biting (in the absence of oral sores or bleeding)**[214]
- **Masturbation**[215]
- **Oral sex**[216]

Factors known to reduce the risk of sexual transmission

- **Condom use**
  - Condom use reduces the risk of sexual transmission considerably. Using condoms consistently, though not necessarily perfectly (i.e. breakage and slippage sometimes occurs), reduces the risk of HIV transmission by at least 80% compared to not using condoms.[217]
- **Antiretroviral treatment**
  - Effective antiretroviral therapy, which reduces viral load and slows disease progression, can reduce the risk of transmission by over 90%.[218]
- **Post-exposure prophylaxis**
  - Post-exposure prophylaxis (PEP) is a course of HIV medication following HIV exposure that is highly effective at blocking HIV infection. PEP is most commonly used by health-care workers after needle-stick injuries. In some settings, PEP is also available to people who were exposed to HIV as a result of sexual assault, condom failure or unprotected sex.[219]

Factors known to increase the risk of sexual transmission

- **Primary infection and end-stage AIDS**
  - The risk of sexual HIV transmission is higher during the stage of "primary infection" (i.e. the first two or three months of infection) and later, if HIV disease has advanced to AIDS.[220]

- **Other sexually transmitted infections**
  - The presence of another sexually transmitted infection (STI) in either partner (HIV-positive or HIV-negative) may increase the risk of HIV transmission.
  - Depending on the other STI and its manifestation (e.g. open sores), the risk of transmission is generally in the range of 1.5 to five times higher than that seen in the absence of other STIs.[221]
- **Sexual and domestic violence**
  - Violence can increase the risk of HIV transmission directly, through forced sex, and indirectly, by constraining the ability to negotiate the circumstances and ways in which sex takes place (including condom use).[222]

Courts in several jurisdictions have interpreted and applied differently the above scientific and medical facts about the risk of HIV infection. A court in New Zealand was faced with evaluating the level of transmission risk in the case of an HIV-positive man who was charged with criminal nuisance for not disclosing his HIV status to a sexual partner before having unprotected oral sex and protected vaginal intercourse.[223] The evidence introduced at trial showed that "the risk of transmission of the virus as a result of oral intercourse without a condom is not zero because it is biologically possible but it is so low that it does not register as a risk".[224] Moreover, the evidence regarding the risk of transmission during protected vaginal sex showed that "condoms are 80%–85% effective, thus significantly reducing the risk, which, even using the prosecution figures, is low".[225] In light of the scientific and medical evidence relating to the limited risk of HIV transmission, the Court acquitted the accused.[226]

In Switzerland, a Court of Justice (Penal Division), with the support of the prosecution, overturned an HIV-positive man's conviction for having unprotected vaginal sex because of the negligible risk of transmission.[227] Factors considered included that he was on treatment, had an undetectable viral load and did not have any other STIs. The prosecutor's medical expert stated that the risk of transmission was "too low to be scientifically quantified".[228] In its decision, the Court referred to a statement issued in 2008 by the Swiss Federal Commission on HIV/AIDS.

> After a review of the scientific data[...] the *Commission fédérale pour les problèmes liés au sida* (CFS) resolves that: [a]n HIV-positive individual not suffering from any other STD and adhering to antiretroviral therapy with a completely suppressed viremia does not transmit HIV sexually, i.e. he/she cannot pass on the virus through sexual contact.[229] [unofficial translation]

In contrast, a 2008 case before the Supreme Court of Idaho (U.S.A.) illustrates a different approach, where the science on HIV transmission risks was not considered relevant to criminal liability. In *State v. Mubita,* a man living with HIV was convicted of 11 counts of transferring body fluids containing HIV. Some of the charges were based on the act of oral sex.[230] The defence asserted that the purpose of the legislation was to punish and deter those who "knowingly expose another person to AIDS" (referring to the legislation) and that his conduct fell outside the reach of the statute because HIV cannot be transmitted through saliva. The Court rejected this argument and held that his actions were specifically prohibited under the plain language of the law. The Court reasoned that the statute prohibited in "unambiguous terms" an HIV-positive person from transferring or attempting to transfer body fluids, including saliva, to another person, and it therefore did not consider defence evidence on the unlikelihood of HIV transmission through male-to-female oral sex.[231]

b) HIV infection

Depending on the formulation of the criminal offence, courts may have to determine the level of harm resulting from HIV transmission (in other words, how harmful is HIV infection?). The level of harm associated with HIV might be determinative of which offence is applicable, if any, or it might be a factor in sentencing. For instance, in Canada, most people charged in relation to HIV exposure have been charged with the offence of aggravated sexual assault — an offence that requires "endangerment of life".[232]

Key facts

- The majority of people infected with HIV, if not treated, develop signs of HIV-related illness within 5–10 years, but the time between infection with HIV and being diagnosed with AIDS can be 10–15 years, or sometimes longer.[233]
- If people begin taking antiretroviral therapy at the recommended time (before significant damage has been done to the immune system), they are likely to have a normal or near-normal lifespan.[234]
- HIV remains an incurable infection and the treatments can have side effects.[235] Some people may also develop resistance to certain treatments, which can limit the efficacy and the variety of treatment options available to that person.[236]
- An HIV-positive diagnosis may be a source of great psychological distress.
- Unfortunately, treatments remain unavailable or unaffordable for the majority of people living with HIV in the world today.[237]

(See Part 1: The science and medicine of HIV, for further information on HIV disease progression and living with HIV).

c) Proving HIV transmission

When actual transmission of HIV is alleged (or is an element of the offence), courts may need to establish that the accused has infected the complainant. But proving transmission can be challenging. First, it would need to be established that the defendant is the source of the complainant's HIV infection. It should not be assumed that, because a former or current sexual partner is HIV-positive, the complainant's infection necessarily originated with that partner. Second, the direction of transmission must be established. It could be that the complainant transmitted HIV to the accused, rather than the reverse.[238]

To rule on transmission, courts may need to use a combination of scientific evidence about HIV itself ("virological evidence"), medical records (including evidence of diagnosis, symptoms, treatment and viral load) and testimony.[239] In some jurisdictions, like England and Wales, phylogenetic analysis has been used. Phylogenetics is a scientific process used by experts to analyse the genetic code of individual strains of HIV. By undertaking HIV gene-sequencing, they are able to identify small differences and establish whether two samples may be genetically related.[240] Such analysis has important limitations.

- It can only determine the degree of relatedness of two samples. It cannot create a definitive "match" between two samples.
- It can *exclude* the possibility that a defendant was responsible for HIV transmission to a particular complainant, by showing that the two strains are not closely related. However, it cannot prove that transmission occurred directly between two individuals, even if the strains are closely related, because their strains of HIV will not be unique to the two individuals, but could extend to other people who are part of the same transmission network.

- Phylogenetic analysis that suggests one person's virus is closely related to another person's virus also does not provide any information on the direction of transmission.[241]

Another available tool is the Recent Infection Testing Algorithm (RITA) test. RITA testing is used in some countries to estimate the likelihood of recent HIV infection for public health purposes. Caution has been urged with respect to using RITA testing to establish the timing of transmission for individual criminal court cases for several reasons.

- RITA is designed to estimate recency and calculate incidence rates at the population level, not the individual level.
- The immune responses of individuals vary, but the RITA test for recency corresponds to an "average" response, leading to unreliability at the individual level.
- Significant rates of false results indicating recent infection have been documented.[242]

Results of RITA tests must therefore be interpreted with caution and only used in the context of all available evidence. They should not be considered dispositive in establishing when one person was infected.

2. Evidence of a culpable mind

As in any criminal proceeding, the intent of the accused (sometimes referred to as the *mens rea* or mental element, depending on the legal system) can be a critical element in HIV exposure and transmission cases. The type or level of intent required to secure a conviction will depend on the specific offence in each jurisdiction. What follows are some critical factors to consider.

a) Malicious intent to transmit HIV

Some legislation criminalising HIV exposure or transmission expressly requires that the accused act with the intention to transmit HIV**.** For instance, in Cambodia, Article 18 of the *Law on the Prevention and Control of HIV/AIDS* provides that "any practice or acts of those who are HIV-positive, *which have the intention to transmit HIV to other people*, shall be strictly prohibited" [emphasis added].[243] In jurisdictions where there is no HIV-specific legislation, it may be necessary to prove intent to transmit in order to convict under the most serious general criminal offences (e.g. attempted murder).

Canada's sole first-degree murder prosecution in relation to HIV transmission involved a man who allegedly did not disclose his HIV-positive status before having unprotected sex; two complainants later died of cancers allegedly related to their HIV infection.[244] Under Canadian criminal law, culpable homicide is murder where the person who causes the death of a human being:

- means to cause death; or
- means to cause bodily harm that the person knows is likely to cause death, and is reckless whether death ensues or not.[245]

Because of the specific intent required for a murder conviction, the judge instructed the jurors to decide "whether [the accused] did in fact form this intent or whether his intent was merely to have sex with the complainants without regard to the consequences".[246] The latter would be the basis for a finding of manslaughter, but insufficient to find him guilty of murder.[247]

In England and Wales, the prosecutorial guidelines with respect to cases of transmission of STIs call for caution when dealing with alleged intentional transmission. The guidelines state that "the intentional infliction of grievous bodily harm by one person on another is one of the most serious crimes under the law",

and establishing a conviction of intentional infection requires solid evidence.[248] Specifically, the guidance states that the fact that the defendant says that they infected the complainant and that they intended so to do is not sufficient, on its own, to meet the evidential test. Additional evidence is required to prove that the suspect's account is compatible with the contention that they intentionally infected the complainant.[249]

In an exceptional case in Australia, the court did find that the accused acted with the purpose of transmitting HIV.[250] The evidence on which the court relied included the testimony of two complainants. They alleged that the accused did not disclose his status (or lied about it), and that he engaged in unprotected sex; he later told them that he wanted to infect other men with HIV in order to have a larger pool of partners for unprotected sex. The complainants also testified that he had organised "conversion" parties for HIV-negative men who wanted to become HIV-positive. The accused was found guilty of attempted intentional HIV transmission.[251]

Wilful, purposeful or intentional exposure or transmission should not be presumed merely because a person living with HIV has engaged in unprotected sex or has had sex without disclosing their HIV-positive status to their partner. While some HIV-specific laws are ambiguously worded, suggesting that intent to infect could be inferred from such circumstances is doctrinally problematic and factually incorrect.

There are many reasons why people may not disclose their HIV-positive status and/or may engage in unprotected sex, but those reasons do not indicate an "intent to infect". For example, some people living with HIV choose to engage in lower-risk sexual activities (e.g. using condoms for intercourse or only engaging in oral sex) in order to prevent passing the virus on to sex partners. Some people living with HIV may understand that there is no appreciable risk of them transmitting HIV through sex because of their treatment and/or low viral load.[252] A fear of rejection, violence, abandonment and loss of privacy also affect disclosure practices and condom use.[253] Concerns that condom use signals a lack of trust or infidelity, along with the desire to conform to social and cultural norms, affect people's sexual and disclosure practices, as does the desire to have children.[254] Finally, people living with HIV may engage in higher-risk behaviours and/or not disclose their status as a result of denial, mental health or substance abuse issues.[255] As a result, the fact that a person living with HIV has engaged in unprotected sex and/or has not disclosed their HIV-positive status to a sexual partner should not, on its own, be taken as proof of intent to transmit the virus. Similarly, while active deception, including lying about one's HIV-positive status, may be taken into account when assessing an accused's state of mind, it should not be dispositive. Again, there are many reasons why a person may lie about their HIV-positive status, including possible coercion, fear of violence or denial.

b) No intent to transmit HIV

In many countries, people living with HIV can be convicted for HIV non-disclosure, exposure and/or transmission even if they did not intend to infect anyone. The required level of culpability will depend on the applicable offence and jurisprudence in the jurisdiction. Some jurisdictions may require establishing a *mens rea* of recklessness, while others may only require proving negligence. In some jurisdictions, offences related to HIV are strict liability offences; therefore, there is no need to prove any specific state of mind.[256] In cases of non-intentional HIV exposure or transmission, proving that the accused knew that they had HIV, and that they understood how HIV is transmitted, becomes critical. Similarly, whether measures to prevent HIV transmission were taken (e.g. condoms or avoiding certain type of sexual activities) may also be critical to establish the required mental culpability.

A medical diagnosis of HIV-positive status, accompanied by post-test counselling regarding HIV transmission, is usually necessary to establish mental culpability for HIV exposure or transmission. It should be noted, however, that even if a person living with HIV has been advised on the risks of HIV transmission,

challenges such as language barriers, shock about the diagnosis or other issues may prevent them from completely understanding the transmission risks associated with different activities. A single counselling session or reference document might not be sufficient to inform a person living with HIV adequately about transmission risks.[257]

The use of precautions to reduce the risks of HIV transmission may be an indicator of mental culpability, or lack thereof. For instance, the prosecutorial guidelines developed in England and Wales provide that "[e]vidence that the suspect took appropriate safeguards to prevent the transmission of their infection throughout the entire period of sexual activity, and evidence that those safeguards satisfy medical experts as reasonable in light of the nature of the infection, *will mean that it will be highly unlikely that the prosecution will be able to demonstrate that the suspect was reckless*" [emphasis added].[258] Relevant factors may include condom use or engaging in lower-risk sexual activities (e.g. oral sex),[259] having unprotected sex knowing that one's viral load is low or undetectable,[260] and having only isolated incidents of unprotected sexual intercourse.[261]

3. Defences

a) Consent and disclosure

Some jurisdictions may explicitly provide that the criminal law only applies to cases of HIV non-disclosure (i.e. where a person living with HIV does not disclose their status to their partner before engaging in sexual activities). For instance, the law in Benin provides that it is a crime for a person living with HIV to engage in unprotected sex *without previous disclosure*.[262] This means that the criminal law does not apply where it can be established that a person consented to engage in sex knowing their partner's HIV-positive status. In other jurisdictions, disclosure (or consent) might be raised as a defence where the law criminalises exposure or transmission of HIV rather that HIV non-disclosure per se.

This issue confronted a United Kingdom court in a 2004 case. The Court of Appeal of England and Wales ruled in the landmark decision *R. v. Dica* that the complainant's consent to the risk of infection was a defence available to the defendant in cases of reckless transmission of HIV.[263] *(For more information about this case, see the summary below.)*

From a human rights perspective, this approach is preferable because it is respectful of the individual's right to private life and autonomy. It respects the personal decisions of consenting adults. Moreover, it is respectful of the sexual and reproductive rights of people living with HIV. Failing to accept disclosure or consent as a valid defence would *de facto* deprive people living with HIV of their right to have a sexual life and children.

The Supreme Court of Kansas (U.S.A.) had to address issues of consent in an HIV-related case in 2009.[264] Whether the defendant had disclosed his status was not directly at issue in this case. One of the key issues was whether the Kansas legislation requires a specific intent to expose a partner to HIV, or simply a general intent to engage in sexual intercourse knowing one is HIV-positive. The prosecutor argued that since there is always some risk of HIV transmission, the specific intent to expose another to HIV is inherently included in the defendant's general intent to engage in sexual intercourse. The Court found this interpretation to mean that "a person infected with HIV must be totally abstinent or risk being prosecuted for a felony each and every time he or she engages in sexual intercourse or sodomy, regardless of whether the act is between consenting (perhaps married) adults with full knowledge of the virus and utilizing prophylactic measures". The Court strongly rejected this interpretation and ruled that the legislation required a specific intent. But more interestingly, the Court expressly questioned the constitutionality of the prosecutors' interpretation, reaffirming that "a person's decision to engage in private, consensual sexual conduct is protected by the United States Constitution".[265]

While the availability of a defence of consent is a positive development, disclosure of one's HIV-positive status in the context of intimate sexual relationships is a difficult thing to prove because there is usually no witness or documentary evidence to support it. For this reason, many people living with HIV fear prosecutions, even if they have disclosed their status. For example, charges have been used as a retaliation tool or a threat by vindictive partners.[266]

Disclosure is also an emotional and difficult undertaking for people living with HIV who may fear violence, abandonment, rejection or loss of privacy. The ability to disclose might also depend on one person's acceptance and understanding of their diagnosis. Moreover, disclosure is not necessarily a simple one-step process. The decision to disclose and the timing for disclosure may differ depending on the context and the nature of the sexual relationship.[267]

Where a person living with HIV has not disclosed their HIV-positive status to a sexual partner, they may still be able to demonstrate that the complainant consented to the risk of HIV exposure. Even in the absence of disclosure, some would argue that a person knowledgeable of the risks associated with unprotected sex may be found to have consented to the risk of being exposed to HIV by engaging in it.[268] Although general knowledge of the risks associated with unprotected sex might not be considered sufficient to establish consent to exposure, knowledge of a partner's HIV status might not necessarily require prior disclosure by the person living with HIV. A person might learn about their partner's HIV-positive status through a friend or by discovering their partner's medication.[269]

b) Use of reasonable precautions to protect a partner

The use of reasonable precautions to protect a partner from HIV infection can be a critical piece of evidence in prosecutions for HIV non-disclosure, exposure and/or transmission. It can be taken into account when assessing the mental culpability of the accused — taking precautions may demonstrate a sense of responsibility and concern for the complainant's safety. It can also be taken into account to assess risk of transmission involved in a particular case and whether such risk warrants a conviction.

An HIV-positive person's use of reasonable precautions to protect a partner may include the use of a condom and other measures to significantly reduce the risk of transmission (e.g. engaging only in oral sex). Maintaining a low or undetectable viral load could also be considered a reasonable safeguard against transmission, given its dramatic impact on HIV transmission risks.

In many jurisdictions, the use of precautions is a valid defence provided by the law or existing jurisprudence, or described in prosecutorial guidelines. For instance, in Senegal, the law expressly provides that "[n]o one may be prosecuted or sentenced under this Act for HIV transmission or exposure that occurs in any of the following cases: the person living with HIV had safe sexual relations, such as sexual relations using a condom" [unofficial translation].[270] The prosecutorial guidance on intentional or reckless transmission of, or exposure to, STIs published in Scotland provides in this regard that:

> [i]n determining whether a person has the necessary recklessness, the totality of all the facts and circumstances must be taken into consideration. Evidence of the following factors will mean that it is unlikely that the requisite degree of recklessness will be established:
> - The person infected is receiving treatment and [has] been given medical advice that there is a low risk of transmission or that there was only a negligible risk of transmission in some situations or for certain sexual acts.
> - The person infected took appropriate precautions such as using a condom or other safeguards throughout the sexual activity.

(...) In cases of exposure alone, and in view of the negligible risk of transmission, there is a very strong presumption against prosecution in these circumstances.[271]

c) *Fear of violence, abandonment or other abuse*

Fear of violence can impede HIV disclosure or the use of precautions to reduce the risks of HIV transmission. This is particularly true for women living with HIV in abusive relationships. From a human rights perspective, it is important to take such contextual elements into account. It would be unjust to hold someone criminally responsible for HIV non-disclosure, exposure and/or transmission when that person had valid reasons for not disclosing their status and/or not taking precautions to prevent transmission.

4. Prosecutions for vertical transmission of HIV

To date, the focus of criminal prosecutions for HIV non-disclosure, exposure and/or transmission has been cases involving sexual exposure. However HIV can also be transmitted from a woman to a foetus or infant through pregnancy, delivery or breastfeeding. It is therefore possible that in some jurisdictions, HIV-related criminal provisions could be interpreted to include prosecutions of women for vertical transmission.

Some HIV-specific legislation is drafted in such a way that vertical transmission could be caught in the net. For instance, the N'Djamena model law and many of the African statutes based on it make "wilful transmission of HIV" an offence, but define "wilful transmission" very broadly as "the transmission of HIV virus through any means by a person with full knowledge of his/her HIV/AIDS status to another person".[272] This could logically be interpreted as including vertical transmission. Sierra Leone's 2007 HIV statute explicitly criminalised vertical transmission, but it has since been amended.[273]

HIV-specific statutes have not yet been applied to cases of vertical transmission, but women have faced criminal charges, restrictions to their autonomy and intervention by child protection services in relation to their HIV-positive status in various circumstances.[274] Given the possibility of criminal prosecutions for vertical transmission, however, the issue merits consideration. From the perspective of preventing vertical transmission and protecting the rights of women, it is problematic to predicate criminal prosecutions on a woman having transmitted HIV to an infant or having failed to take "reasonable" measures to prevent vertical transmission.

> *"Countries must amend or repeal any law that explicitly or effectively criminalizes vertical transmission".*
>
> *—Global Commission on HIV and the Law, Recommendation 2.3 (July 2012)*

There are many reasons why a woman may not be able to prevent the transmission of HIV to her child. Those factors may also vary depending on the social, economic and cultural context of each country and the individual woman's situation. Relevant considerations include:

- **Ability to access information**
  - Women's ability to make informed decisions about their reproductive life and prevent unintended pregnancies depends on their access to information, counselling and support. Yet many women do not have access to reproductive and sexual health information or to effective contraception, and they may face considerable social pressure to bear children.[275] As a result, women may lack understanding of contraceptive options, the implications of an HIV-positive test, the risks of transmission associated with pregnancy, delivery and breastfeeding, and the different available options to reduce the risks of transmission.

- **Inability to negotiate sexual relations**
  - Many women are not able to control the conditions under which their sexual relations take place, including whether condoms are used.
- **Access to health-care services**
  - Many women, especially in poor and rural areas, do not have access to health services, including prenatal care and medical assistance during labour and following delivery. Many have to give birth without medical assistance and do not have access to effective prevention of mother-to-child transmission programmes (PMTCT).[276] PMTCT programmes include antiretroviral treatment, counselling and psychological support. In 2010, the estimated coverage of most effective antiretroviral regimens for preventing the mother-to-child transmission of HIV in low- and middle-income countries was 48%.[277]
- **Access to HIV tests**
  - Many women continue to lack access to voluntary HIV testing in prenatal care.[278]
- **Discrimination and stigmatisation**
  - Some women are unable to disclose their status to their sexual partner or spouse and to health-care providers without experiencing discrimination or abuse.[279] Some HIV-positive women experience delays and mistreatment when seeking pregnancy-related health care, or they are denied health-care in emergency situations.[280]
- **Transmission risks during breastfeeding**
  - Reducing HIV-related risk when breastfeeding is not straightforward and the decision will depend on whether breast-milk substitute ("formula") for infant feeding is affordable and whether clean water is available; whether she can maintain exclusive breastfeeding for six months; as well as the social cost of possibly being exposed as HIV-positive by formula-feeding in cultural environments where breastfeeding is the norm.[281] There is not one appropriate or reasonable standard for all HIV-positive women.
- **Failure of interventions**
  - Despite best efforts, contraception and PMTCT interventions do fail.
- **Violence and abuse**
  - Women are also frequently victims of violence and coercion. Women do become pregnant against their wishes, and they may transmit HIV to a foetus or infant despite their best prevention efforts.

Is incarcerating the mother in the best interests of the child?

In Florida, a woman was charged with felony child neglect in 2008 for failing to take action to prevent HIV transmission to her second child, who was born HIV-positive. She faced up to 15 years in prison on the felony charge, but in the end, she was sentenced to two years of probation and mandatory health and parenting classes so as not to hinder her ability to provide for her child. The Court recognised that incarceration of a mother for reckless transmission was not in the best interests of the child.[282]

5. Sentencing in HIV exposure or transmission cases

Sentencing in cases of HIV exposure and transmission varies greatly from one jurisdiction to another, depending on the applicable criminal charges. It has been noted, however, that the sentences imposed can also be particularly onerous, especially when compared to other conduct that may result in much greater harm.

When imposing sentences in prosecutions for HIV non-disclosure, exposure or transmission, judges may wish to take into account the impact imprisonment may have on the health of a person living with HIV. For example:

- prison is usually a source of stress, depression and fatigue, which in turn increases the likelihood of opportunistic infections;[283]
- the conditions of imprisonment may expose people living with HIV to opportunistic infections, which can have devastating consequences on their health;[284] and
- HIV-related treatment is not always available within prisons, which can lead to serious illness and even death for a person living with HIV.[285]

Some courts have taken these factors into consideration. For example, in an unreported decision, the New South Wales Court of Criminal Appeal (Australia) affirmed that AIDS is a "special circumstance" and that the period in detention should be reduced to account for the harsher effects of imprisonment.[286] Similarly, in Canada, a woman living with HIV who was convicted in an HIV non-disclosure case received a 12-month conditional sentence to be served in the community. The judge noted in the sentencing decision that the woman's health had seriously deteriorated and that her life would be endangered if she did not have proper access to a new medication requiring regular follow-up by her doctor. She was also suffering from depression and was considered by an expert to be suicidal.[287]

Highlighted case and guidance

England:
Court rules that informed consent to the risk of HIV transmission is valid defence

R v. Dica [2004] EWCA Crim 1103, Court of Appeal (England and Wales)

Parties

The appellant (accused) Mohamed Dica was a man living with HIV. He had been convicted of two counts of causing grievous bodily harm under section 20 of the *Offences against the Person Act 1871* and subsequently appealed the conviction.

Outcome

The appeal was allowed and the Court ordered a new trial.

Background and material facts

The accused was diagnosed with HIV in December 1995 and began treatment. Following his diagnosis, he had unprotected sexual intercourse with two women, allegedly without disclosing his HIV-positive status. The accused testified that both women were aware of his HIV infection and were nonetheless willing to have sexual intercourse with him. The complainants later tested positive for HIV.

Legal arguments and issues addressed

The Crown prosecutors alleged that when the accused had consensual sexual intercourse with the complainants knowing he was HIV-positive, he was reckless as to whether they might become infected. They positioned this argument under section 20 of the *Offences against the Person Act 1871* (reckless infliction of grievous bodily harm).[288] According to the Court, "[r]ecklessness as such, was not an issue. If protective measures had been taken by the appellant that would have provided material relevant to the jury's decision whether, in all the circumstances, recklessness was proved".

One of the main issues in this case was whether the complainants' consent to have sex with the accused, knowing of his condition, should have been left to the jury. The trial judge had decided that, whether or not the complainants knew of the appellant's condition, their consent, if any, was irrelevant and provided no defence. Accepting the Crown's argument, the trial judge held that complainants were deprived "of the legal capacity to consent to such serious harm".[289]

The Court of Appeal, however, ruled that consent to the risk of transmission through consensual sex is a valid defence to a charge of reckless transmission. Consent to the risk of infection, however, would not provide a defence in cases of deliberate infection or spreading of HIV with intent to cause grievous bodily harm (cases that would be prosecuted under section 18 of the *Offences against the Person Act 1871).*

Based on the existing jurisprudence, the Court found that for public policy reasons, violent conduct involving the deliberate and intentional infliction of bodily harm is and remains unlawful, notwithstanding that its purpose is the sexual gratification of one or both participants. Referring to the case, the Court went on to find that:

> It does not follow from them, and they do not suggest, that consensual acts of sexual intercourse are unlawful merely because there may be a known risk to the health of one or other participant. These participants are not intent on spreading or becoming infected with disease through sexual intercourse. They are not indulging in serious violence for the purposes of sexual gratification. They are simply prepared, knowingly, to run the risk — not the certainty — of infection, as well as all the other risks inherent in and possible consequences of sexual intercourse, such as, and despite the most careful precautions, an unintended pregnancy.

Although it would be unlikely that consent can be established unless the complainant was informed about the risk of a sexually transmitted infection, the Court indicated that the ultimate question is not knowledge but consent and that, in every case where this issue arises, the question of whether the complainant did or did not consent to the risk of a sexually transmitted infection is one of fact and case specific.

Commentary

From a human rights perspective, the ruling that consent to the risk of a sexually transmitted infection is a valid defence to HIV transmission charges in the context of consensual sex (unless there is a deliberate intention to spreading disease) sets an important precedent that is respectful of not only individuals' private lives and autonomy, but also the sexual and reproductive rights of people living with HIV.

What remains uncertain from the Court of Appeal decision is how consent could be established if the HIV-positive partner has not disclosed their status. Some may argue that consenting to unprotected sex may equate to consenting to the risk of a sexually transmitted infection. However, this argument was rejected by the Court of Appeal in the case *R v. Konzani* (2005), where a distinction was drawn between "running the risk of transmission" and "willingly" or "consciously" consenting to the risk of transmission of a particular infection, thus establishing that consent must be informed.[290]

With regard to the application of section 20 of the *Offences against the Person Act 1871,* it is interesting to note that no charges for intentional transmission (section 18 of the *Offences against the Person Act 1861*) have proceeded to trial. As of the time of this writing, all HIV exposure cases in the United Kingdom have proceeded under section 20, which criminalises the reckless infliction of grievous bodily harm.

United Kingdom:
Crown Prosecution Service (CPS) issues guidance for criminal prosecutions related to HIV transmission

The Crown Prosecution Service (CPS), *Legal Guidance on Intentional or Reckless Sexual Transmission of Infection*: Key provisions (England and Wales)

Note: The provisions reproduced below were excerpted in September 2012 from *Legal Guidance on Intentional or Reckless Sexual Transmission of Infection* issued by the Crown Prosecution Service of England and Wales.

Introduction

This guidance sets out how prosecutors should deal with cases where there is an allegation that the suspect/defendant has passed an infection to the complainant during the course of consensual sexual activity. It excludes other methods of transmission, such as shared needle usage.

Prosecutors will appreciate that this area of the criminal law is exceptionally complex.

The criminality of this offending lies in the *mens rea*. This means that the relevant offences will be difficult to prove to the requisite high standard, to satisfy the evidential stage of the Code test and in the court itself.

There are other sensitivities: the relationship between the criminal law and consensual sexual behaviour is delicate. The use of the criminal law in the most intimate of physical exchanges is always going to attract publicity and will invite strongly held and differing views.

…

Relevant offences

The courts have recognised that person-to-person transmission of a sexual infection that will have serious, perhaps life-threatening, consequences for the infected person's health can amount to grievous bodily harm under the *Offences against the Person Act 1861: R v Dica [2004] 2 Cr. App. R. 28*. Therefore, the transmission of that infection can constitute the offence of inflicting or causing grievous bodily harm, which when intentional can attract a sentence of life imprisonment.

The relevant offences for a prosecutor to consider are under sections 18 and 20 of the *Offences against the Person Act 1861*.

…

Reckless transmission: Section 20 *Offences against the Person Act 1861*

Recklessness in this context means that a defendant foresaw that the complainant might contract the infection via unprotected sexual activity but still went on to take that risk. Once the prosecutor is satisfied that the suspect had foreseen the risk of infection, the reasonableness of taking such a risk must be considered. Reasonableness is dependant upon the circumstances known to that person at the time he or she decided to take the risk.

Prosecutors should ensure that in those cases where sexual intercourse between the suspect and the complainant is restricted to occasions few in number, they are satisfied that, taking all the circumstances together, the necessary recklessness of the suspect has been established to the required standard. Relevant to recklessness is the level of risk of transmission and this can vary based on the number of exposures and the nature and status of the infection. One exposure to a highly infectious condition could be regarded as being reckless; conversely, for a condition where there is a low risk of transmission, the level of recklessness increases with the number of exposures since this will increase the possibility of transmission.

…

The informed consent of the complainant to the assumption of risk of infection by engaging in sexual activity with a person who is infectious — in cases where the defendant cannot be shown to intend to pass on the infection — is a defence available to the defendant in cases of section 20 grievous bodily harm: *R. v. Dica*.

Informed consent does not necessarily mean that the suspect must disclose his or her condition to the complainant. A complainant may be regarded as being informed for the purposes of giving consent where a third party informs the complainant of the suspect's condition, and the complainant then engages in unprotected sexual activity with the suspect. Similarly, a complainant may be regarded as being informed if he/she becomes aware of certain circumstances that indicate that the suspect is suffering from a sexually transmitted infection, such as visiting the suspect while he or she is undergoing treatment for the infection in hospital, or the appearance of sores on the suspect's genitalia.

Whether the complainant gave his or her informed consent is a matter for the jury.

…

Scientific and/or medical evidence

Ideally both scientific and medical evidence should be relied upon but depending upon the facts of the case, there may not always be the need for both to be adduced. Scientific/ medical evidence can exist in a number of forms, and the precise nature of any such evidence that is gathered will depend to some degree on the nature of the infection in question and the overall facts of the case. Each case must be considered on its own facts and on its own merits.

…

The first issue to be addressed is the need for scientific and/or medical evidence. In the case of some infections, the scientific and/or medical evidence can demonstrate with certainty that the suspect **did not** infect the complainant because the two people concerned have different strains of the infection. In particular, for a virus such as HIV, phylogenetic analysis can exclude the possibility of transmission between two persons where there is no relevant match between the two samples. However, scientific and/or medical evidence cannot prove that the suspect **did** infect the complainant. In such circumstances, at best, any match would simply show that it is possible that the suspect passed on the infection to the complainant. Phylogenetic analysis may also demonstrate that the strain of the infection in the complainant is consistent with the strain in the suspect. Additional factual evidence is essential to make the case that the suspect was in fact responsible for the complainant's infection. Phylogenetic or medical evidence alone is insufficient.

Prosecutors should also bear in mind that there may be varying degrees of infectiousness during the cycle of infection and during any anti-retroviral therapy. Therefore the scientific evidence is extremely helpful

here and it should also include specific information on the degree of infectiousness of the suspect at the time of the alleged offence. Prosecutors should consider the need for scientific evidence namely clinical and epidemiological evidence regarding duration of infection, the possible incubation period of the infection and a strong likelihood that the suspect infected the complainant as opposed to any possibility that the complainant may have infected the suspect. The proximity of the strain(s) of infection in the complainant and suspect and the extent to which the scientific evidence supports other factual evidence in terms of when the infection was allegedly passed will be critical in helping to determine the weight that may be placed on the scientific evidence.

In the case of HIV transmission, new tests, known as RITA (Recent Infection Testing Algorithm) tests, are sometimes being used to assess rates of recent infection in the population, and it is possible that a RITA test result for an individual sample might be offered as evidence of the timing of infection. These tests are sometimes also known as STARHS (Serological Testing Algorithm for Recent HIV Seroconversion) tests. Prosecutors should be aware that there are limitations on the reliability of such evidence at an individual level and any claim of evidence of recency of infection should be referred to any prosecution expert witness.

Prosecutors will always have in their minds the fact that the scientific evidence will only be evidence of the fact of infection — not of the identity of the person who infected. Prosecutors will need to discuss with their expert witness all the ramifications of their findings and have clearly in their minds exactly how far they are able to rely on the scientific and/or medical evidence to support their case against the defendant and what additional factual evidence is necessary to satisfy the evidential stage of the Code.

…

Sexual history

Prosecutors will be alert to the need to proceed most carefully here. The prosecutor will need to be satisfied that the complainant did not receive the infection from a third party or that the complainant did not infect the suspect or defendant. This means that the prosecutor will need to know about any factual possibility which is compatible with the scientific and/or medical evidence that points to the complainant having been infected by a third party. This means enquiries will have to be made about the relevant sexual behaviour and relevant sexual history of the complainant. This is extremely sensitive and prosecutors must take enormous care to ensure that the complainant is treated with respect and dignity and is not made to feel any more victimised than they are likely to already. Complainants will need to be made aware of the need to rule out the possibility that he/she became infected in a different way or by a person other than whom he/she alleges. Not to rule out such a possibility will mean that there will be insufficient evidence to proceed.

Prosecutors must ensure that expert evidence is sought at an early stage in order to determine the likelihood of transmission in any given case, and the possibility of alternative sources of infection, in order to minimise unnecessary and protracted investigations and distress to all parties concerned. In particular, prosecutors must be fully aware of the ways in which the particular infection can be passed between two people.

Recklessness

Once a prosecutor is satisfied that he/she is in possession of sufficient factual evidence to show that the suspect is responsible for passing on the relevant infection and (where available for the decision as to charge) that the scientific and/or medical evidence is compatible with the allegation, he/she will need to move on to consider the way in which the element of recklessness may be proved.

In this regard, prosecutors will look for evidence that the suspect knew that he/she had a sexually transmissible infection and were potentially infectious to others if they engaged in unprotected sexual activity. Knowledge is a matter for the prosecution to prove to the criminal standard of proof and for the jury to decide. Evidence will have to be called and the best, and usual, evidence will be medical diagnosis, that is evidence to prove that the suspect had been tested and had been told of his/her infection and advised about ways of reducing the risk of transmission to others, and that he or she had understood such advice. But it is possible that, on rare occasions, a person can know that he or she is infected without undergoing the necessary medical tests. This will depend on all the circumstances and will be a matter for the jury to decide. Those who choose not to be tested will not necessarily avoid prosecution for the reckless transmission of a sexually transmissible infection if all the circumstances point to the fact that they knew that they were infected.

…

Safeguards against transmitting infection

Prosecutors will need to be aware that proof of knowledge is likely to be difficult. Even in cases where the suspect can be shown to have been told that they carry an infection, prosecutors will need further evidence to show that the suspect understood that he or she too was infectious to other people. Prosecutors will need to have a thorough understanding of the means by which people can protect themselves either from passing on an infection during sexual activity or from being infected during sexual activity.

Prosecutors will also want to bear in mind that people who are informed that they have an infection which may possibly be life-shortening are likely to be in a state of shock at that time, and any further information that is given at the same time may be unlikely to have registered fully with the suspect. In such cases, prosecutors will need to be satisfied that the suspect really did understand that he/she was infectious to other people, and how the particular infection concerned could be transmitted.

…

Whilst in consensual sexual activity, public health considerations demand that it is the responsibility of both individuals to ensure safeguards are taken to mitigate the risk of transmitting infection. Ultimately it is the responsibility of the person who is infectious to ensure that those safeguards are taken and, so far as they are aware, remain operative throughout the entire period of sexual activity when it remains a possibility that their infection might be transmitted.

Evidence that the suspect took appropriate safeguards to prevent the transmission of their infection throughout the entire period of sexual activity, and evidence that those safeguards satisfy medical experts as reasonable in light of the nature of the infection, will mean that it will be highly unlikely that the prosecution will be able to demonstrate that the suspect was reckless.

Where someone who is HIV-positive is receiving treatment, one of the effects is a reduction of the amount of the virus in their system (in some cases this may result in an undetectable viral load). In these circumstances, the prospect of the infection being transmitted to another is potentially significantly reduced. It may be argued that taking medication may, in some circumstances, be as effective a safeguard as, for example, the use of a condom in reducing risk and therefore negating recklessness. Prosecutors should take great care with such cases however, as medical opinion on the reduction of the risk of infection is not settled, and evidence of the actual taking of medication in accordance with medical instructions may not be as clear-cut as evidence of the use of other safeguards such as condoms.

…

Intentional transmission: Section 18 *Offences against the Person Act 1861*

The deliberate infliction of grievous bodily harm by one person on another is one of the most serious crimes under the law.

Consequently, where the evidential stage of the test set out in the Code is satisfied, it is likely that the public interest will require a prosecution.

However, prosecutors should never proceed to trial in a case in which a defendant is charged contrary to section 18 unless there is scientific and/or medical **and** factual evidence which proves the contention that the defendant intentionally and actually transmitted the infection to the complainant. The mere fact that the suspect or defendant says that he/she did and that he/she intended so to do is not sufficient on its own to meet the evidential stage in the Code test. There has to be other evidence to demonstrate that the suspect or defendant's account is at least compatible with the contention that he/she intentionally infected the complainant.

…

Rape

A person who does not disclose the fact that they have a STI and then has consensual sexual intercourse with another without informing that person of their infectious state, is not guilty of rape (*R v. B* [2006] EWCA Crim 2945, CA).

…

Chapter 6

Sexual assault and domestic violence

Summary

Sexual assault and domestic violence increase the risk of HIV infection, particularly for women. Violence heightens the risk of HIV infection, through forced sex, by constraining the ability of a survivor to negotiate the circumstances and ways in which sex takes place, including whether condoms are used.

Violence against women is recognised as a human rights violation and a form of discrimination. In particular, the *Convention on the Elimination of all Forms of Discrimination against Women* affirms that States parties must take all appropriate measures to eliminate discrimination against women by any person or organisation. States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.

Adjudicating cases involving domestic violence and sexual assault: Factors to consider

1. **A range of situations covered by domestic violence legislation**

   Courts should be mindful of the many different types of violence that are covered by the relevant statute(s) and the range of tools at their disposal to stop and punish acts of domestic violence.

2. **Protection orders: Legal interventions to prevent domestic violence**

   In many jurisdictions, courts have the power to issue protection orders or injunctions related to domestic violence in the civil or criminal realm. These orders are designed to stop violent behaviour and to protect the survivor of domestic violence and their family from the perpetrator of violence. In issuing protective orders, courts should consider of the desires of the survivor.

3. **A range of situations covered by sexual violence legislation**

   Most jurisdictions have definitions of crimes of sexual violence that are based on either consent or "coercive circumstances". A wide range of coercive and violent sexual acts can be captured under these statutes.

4. **Marital rape**

   In many jurisdictions, a rape committed by one's spouse is not included within the legal definition of rape or sexual assault. This is in violation of international human rights principles. Both human rights and public health mandate the end of marital rape exceptions, and courts increasingly are overruling such exemptions, where they still exist.

5. **Evidentiary considerations**

Cautionary rules and corroboration requirements violate the human rights of complainants and are increasingly being set aside, where they still exist.

Legislatures and courts are restricting the admissibility of evidence of a complainant's previous sexual conduct or experience, because such inferences can be prejudicial and irrelevant to the case at bar.

Where a complainant or a witness finds it distressing to be in the same room as the accused, it might mean that they are unable to give evidence effectively or that the complainant or witness suffers further stress and trauma from testifying. Courts should consider various alternative options for providing evidence, such as allowing complainants and witnesses to give evidence from a remote location through closed-circuit television (CCTV) or changing the typical courtroom seat arrangements.

6. **Privacy concerns**

Courts should be sensitive to the privacy concerns and vulnerabilities of complainants and witnesses in sexual and domestic violence cases. HIV status and other personal information may come into evidence during a trial, and efforts must be made to protect the complainant and allow them some degree of control over the public discussion of their personal information.

Introduction

Violence against women and girls arises from and perpetuates gender inequality, and it has a devastating impact on the lives of women and girls worldwide. In recognition of the severity of the harms caused by gender-based violence, governments and international entities around the world have unequivocally condemned violence against women and are pursuing various law reform and programmatic interventions. Despite this international attention, however, all too often violence perpetuated against women is overlooked, or its significance is diminished, by police, judicial officers, community and religious leaders, and other authority figures.[291] By refusing to be swayed by myths, stereotypes and "cultural" justifications for violence against women — and by providing effective redress to survivors of domestic violence and sexual assault — courts are setting a course for a more just future. Today, violence against women remains commonplace around the world and many survivors do not turn to police and courts; legal action has an important role to play in changing this reality.

> *"[Violence against women is] a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women".*[292]
>
> —Declaration on the Elimination of Violence against Women, *1993*

Violence against women takes many forms; the focus of this chapter is domestic violence and sexual assault. Domestic violence is a pattern of abusive behaviour by one or more people in an intimate relationship (including marriage, dating, family, friends or cohabitation). Domestic violence has many forms, including physical aggression (e.g. hitting, kicking, restraining, throwing objects, etc.), sexual abuse, emotional abuse, intimidation and threats, stalking, neglect and economic deprivation. Sexual assault includes forcing, threatening or coercing a person to engage in involuntary sexual acts against their will, or any sexual touching of a person who has not consented. Sexual assault therefore includes rape (such as forced vaginal, anal or oral penetration), unwanted sexual touching, forced kissing, child sexual abuse, and sexual torture.

In settings with high HIV prevalence, when cases of sexual and/or domestic violence come before the courts, judges and magistrates are very often presiding over HIV-related issues. This is because violence increases an individual's risk of HIV infection. Violence can elevate the risk of HIV infection directly, through forced sex, and indirectly, by constraining the ability of a survivor[293] to negotiate the circumstances and ways in which sex takes place, including whether condoms are used.[294] Coerced or non-consensual sex increases the risk of HIV transmission because of abrasions and tearing occurring when the vagina or anus is dry or when force is used. This is particularly true for younger women and girls, whose genital tracts are still immature. The risks of transmission are higher still if the survivor is subjected to gang rape, given the exposure to multiple assailants.

People who experience forced sex or other sorts of violence in intimate relationships often find it difficult to negotiate condom use (or other sorts of risk reduction, such as lower-risk sexual activities or abstinence). Using a condom (or requesting the use of a condom) could be interpreted as a sign of mistrust of their partner, or as an admission of promiscuity, or it may provoke a violent reaction from their partner.[295] Where violent sexual contact is between strangers, negotiating condom use is rarely an option.

Further, there may be a correlation between experiencing sexual violence and behaviours in later stages of life that may increase the risk of HIV.[296] For example, forced sex in childhood or adolescence has been linked with increases in the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work, perpetrating sexual violence and using illegal substances later in life. Each of these activities can present heightened risks of HIV transmission.[297]

Young women and violence

Worldwide, one in five women are estimated to experience rape or attempted rape in their lifetime, and one in three women will be beaten, coerced into sex or otherwise abused, most commonly by a family member or an acquaintance.[298]

The targets of sexual violence are often young women and girls.[299] In South Africa, for example, police statistics show that more than 40% of rape survivors who reported their assaults to the police in 2002–03 were girls under 18 years of age, and 14% of those girls were 12 years old or younger.[300]

The international community has increasingly recognised that violence against women is a human rights violation that intersects with HIV, and that combatting sexual and domestic violence requires the empowerment of women.[301] For example, the United Nations Commission on Human Rights emphasised that violence against women and girls increases their vulnerability to HIV, that HIV infection further increases women's vulnerability to violence, and that violence against women contributes to the conditions fostering the spread of HIV.[302] Most recently, the Global Commission on HIV and the Law recommended that countries act to end all forms of violence against women and girls, including through the enactment and enforcement of laws that prohibit domestic violence and sexual assault, including marital rape.[303]

Human rights standards and protecting women from violence

International law

While there is scant mention of sexual or domestic violence in the texts of the main international human rights treaties, international law has come to recognise violence against women as a human rights violation and as a form of discrimination. The international human rights framework can therefore provide important guidance for legal avenues of protection and redress. Of particular relevance with respect to cases regarding sexual and domestic violence are the following human rights:

- right to life[304]
- right to the highest attainable standard of health[305]
- right to freedom from cruel, inhuman or degrading treatment or punishment[306]
- right to be free from slavery and servitude[307]
- right to liberty and security of the person[308]
- right to non-discrimination and equal protection of the law[309]
- right to equality in the family[310]
- right to just and favourable conditions of work[311]

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) — the United Nations expert panel that oversees the implementation of the *Convention on the Elimination of all Forms of Violence against Women* (CEDAW) — has advanced the understanding of violence against women as a human rights issue and provided critical guidance on a human rights–based response, in particular through its *General Recommendation No. 19*.[312] Of particular consequence for judges and judicial officers are several key points recognised by the Committee.

- Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.[313]
- Discrimination under CEDAW is not restricted to action by or on behalf of governments. The Convention calls on States parties to take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise. States may also be responsible for private acts if they

fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, as well as for providing compensation.[314]

- Family violence is one of the most insidious forms of violence against women and is prevalent in all societies. It puts women's health at risk and impairs their ability to participate in family life and public life on a basis of equality.[315]

Some regional treaties also set out specific obligations with respect to protecting women from violence. For example, Article 4 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* sets out that, among other things, States parties:

> shall take appropriate and effective measures to:
>
> a. enact and enforce laws to prohibit all forms of violence against women, including unwanted or forced sex, whether the violence takes place in private or public;
> b. adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women; and
> c. identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence.

National laws

The protection of women from domestic and sexual violence is accomplished through diverse legal methods. Applicable domestic legislation may include domestic violence acts, assault provisions in the criminal law, constitutional non-discrimination guarantees and other statutes and/or common law. While the laws vary in form, the underlying principles are similar. Moreover, the urgency to enforce them in a manner that promotes substantive equality and the full enjoyment of all human rights by women and girls is universal.

Adjudicating cases involving domestic violence and sexual assault: Factors to consider

1. A range of situations covered by domestic violence legislation

Policy-makers pass anti-violence legislation and devise "strategies of action" and programmatic priorities, but it is in courtrooms that individual women seek justice and redress. Each day, judges and magistrates around the world enforce laws that afford protection and redress to women and children who have been victims of violence. Applying these laws requires an understanding of the range of situations addressed by the legislation. Courts should be mindful of the different types of violence that are covered by the relevant statute(s) and the various tools at their disposal to stop and punish acts of domestic violence.

a) Types of domestic relationships

The definition of domestic violence varies among different jurisdictions. While the majority of domestic violence continues to be perpetrated by men against women,[316] many jurisdictions have adopted a gender-neutral definition to ensure that no survivors of domestic violence are excluded.[317] Moreover, there is a growing understanding that violence in the domestic realm can apply to many types of relationships. A wide range of relationships can be considered "domestic", including spouses, live-in partners, former wives or partners, girlfriends and boyfriends, live-in domestic workers, and relatives such as sisters, daughters and mothers. Household workers who are not live-in domestics, but are employed within the household and suffer violence, may also appropriately be considered survivors of "domestic violence".[318] Unless a statute is

specifically limited to spousal relationships, the legislative intent may have been to address a broader range of relationships — the harms of domestic violence are certainly not confined to marriage.

b) *Forms of domestic violence*

Domestic violence can take many forms, including (but not limited to):

- rape and other forms of sexual assault;
- physical abuse (e.g. physical assault, forcible confinement, physically depriving a person of adequate food, water, clothing, shelter or rest);
- economic abuse (e.g. unreasonably depriving a person of any economic resources to which they are entitled under law, destroying, hiding or hindering the use of property);
- emotional, verbal or psychological abuse (e.g. any pattern of conduct that seriously degrades or humiliates a person or deprives them of privacy, liberty, integrity or security);
- intimidation (e.g. intentionally inducing fear in a person, threatening to assault or exhibiting a weapon to frighten or coerce);
- harassment or stalking (repeatedly following, contacting, pursuing or accosting a person); and
- entry into a person's residence without consent.[319]

Further, the threat of committing any of the acts listed above may also constitute an act of domestic violence.

Post-exposure prophylaxis (PEP) for survivors of rape

If administered soon after exposure, antiretroviral medications (ARVs) can reduce the risk that an exposure to HIV will result in actual HIV infection. In particular, it is now recommended that people who have had certain kinds of *occupational exposures* to HIV (e.g. a needle-stick injury in the health-care setting) be counselled about possibly taking a short-course of ARVs for several weeks, provided the medications can be started within less than 72 hours of exposure.[320] This is known as "post-exposure prophylaxis" (PEP) and has been estimated to reduce the risk of the exposed person becoming infected by about 80%. In some jurisdictions, PEP is also available for non-occupational exposure or possible exposure (e.g. sexual exposure, or exposure through use of non-sterile injecting equipment).[321]For survivors of rape, access to PEP can be a critical concern.

2. Protection orders: Legal interventions to prevent domestic violence

Under international human rights law, the state has an obligation to act with due diligence to protect people's human rights. The United Nations Commission on Human Rights concluded that in order to fulfil its due diligence obligation, a state has the responsibility to prevent, investigate and punish acts of violence against women and girls.[322] One judicial tool that can be used to prevent incidences of domestic violence from continuing or reoccurring is a court-issued protection order.

In many jurisdictions, courts have the power to issue protection orders or injunctions related to domestic violence in the civil or criminal realm.[323] A protection order is a court order designed to stop violent behaviour and to protect the survivor of domestic violence and their family from the perpetrator of violence. A protection order may instruct the perpetrator to stop the violent behaviour, stay away from the person or people who are being abused, or leave the family home.[324]

The CEDAW Committee has clearly articulated that protection orders are a critical element in the state response to violence against women and are required under international human rights law. In the case

of *A.T. v. Hungary*, for example, the CEDAW Committee reviewed the legal response within Hungary to domestic violence.[325] A.T. was a Hungarian national. She had been the victim of violence at the hands of her spouse for several years. At the time that she brought a communication to the CEDAW Committee, there were no protection orders for domestic violence available under Hungarian law. She had brought civil proceedings in an attempt to restrict her abusive spouse's access to the family's residence, but the Budapest Regional Court authorised him to return to the apartment, reportedly basing its decision in part on the ground that his right to property, including possession, could not be restricted.[326]

The CEDAW Committee found that Hungary's response to the abuse A.T. was suffering constituted a violation of articles 2(a), (b) and (c) of the Convention, noting that "[w]omen's human rights to life and to physical and mental integrity cannot be superseded by other rights, including the right to property and the right to privacy".[327] Among the CEDAW Committee's recommendations to Hungary was a recommendation to implement a specific law prohibiting domestic violence against women, and providing not only protection and exclusion orders, but also support services (including shelters).[328]

Legislation providing for protection orders varies from jurisdiction to jurisdiction — including provisions for temporary and permanent orders, and penalties for breaching the conditions of the order — but the underlying rationale common to all is to prevent imminent violence from occurring. Some national domestic violence laws specifically allow third parties to apply for a protection order on behalf of the complainant (for example, when a woman is not in a position to access the justice system herself). For instance, Article 4 of the Republic of Namibia's *Combating of Domestic Violence Act* stipulates that "an application may be brought on behalf of a complainant by any other person who has an interest in the well-being of the complainant, including but not limited to a family member, a police officer, a social worker, a health care provider, a teacher, traditional leader, religious leader, or an employer".[329]

In issuing protective orders, courts should remain cognisant of the desires of the survivor. For example, some experts have recommended caution in allowing certain third parties to apply for protection orders without the consent of the survivor:

> [A]uthorizing third parties to apply for protection orders, independent of the survivor's wishes, may compromise her interests and safety. One of the original purposes of the protection order remedy was to empower the complainant/survivor.… Further, survivors of violence are often the best judges of the danger presented to them by a violent partner and allowing others to apply for such orders removes control over the proceeding from them.[330]

An order is said to be *ex parte* when it is granted without the party being present in court to contest it.[331] Some jurisdictions give courts the power to issue temporary protection orders on an *ex parte* basis. In balancing the right of the accused to respond to the allegations against them and the right of the survivor to an effective response in a potentially urgent situation, courts may wish to consider granting a temporary protection order, even if the respondent has not yet been served or cannot be present for a hearing, in order to make that protection available until a hearing can be held.

While issuing a protection order may suffice to protect the victim, courts should be prepared to issue subsequent orders ensuring that their order is obeyed. Courts should not underestimate the seriousness of breaching a protection order, and they may consider having the perpetrator arrested, taking into consideration the risk to the safety of the complainant if the arrest is not made, the seriousness of the alleged breach, the length of time since the alleged breach occurred and other relevant circumstances.[332] In addition to offering protection to an individual survivor through their decisions, judges and magistrates also have the opportunity to make clear that violence against women is a serious offence that will not be tolerated.

In light of the HIV epidemic, some judges have reported being asked to issue protective orders requiring a spouse (generally, though not always, the husband) to use condoms for sexual intercourse. Obviously, such an order would be difficult to enforce, at least prospectively. Nevertheless, some judges have reported issuing the orders. They recognise that a ruling to deny the order is as much a decision on the merits as a ruling to grant it. While judges cannot send police into bedrooms to monitor whether such orders are obeyed, the existence of the order may strengthen the position of the weaker party in the marriage. If the order is ignored, its existence may help the weaker power obtain PEP from sceptical medical authorities, especially in legal systems that do not criminalise marital rape.[333]

"The Committee notes that the State party has established a comprehensive model to address domestic violence that includes legislation, criminal and civil-law remedies, awareness-raising, education and training, shelters, counselling for victims of violence and work with perpetrators. However, in order for the individual women victim of domestic violence to enjoy the practical realization of the principle of equality of men and women and of her human rights and fundamental freedoms, the political will that is expressed in the aforementioned comprehensive system of Austria must be supported by State actors, who adhere to the State party's due diligence obligations".

—Committee on the Elimination of Discrimination against Women in Sahide Goekce v. Austria *(2005)*

3. A range of situations covered by sexual violence legislation

Although most countries in the world criminalise rape and other forms of sexual assault, some parliaments have chosen to define these crimes in ways that are not consistent with international human rights standards. For example, some national laws define the crime of rape narrowly, such that certain non-consensual or coerced sexual acts are not captured. In some jurisdictions, gendered definitions exclude the possibility of charging someone with raping a boy or a man.[334] Furthermore, many statutes define marriage as an exemption or defence to the crime of rape.[335]

In addition to being commonplace in peaceful settings, sexual violence is also a well-documented instrument of terror in conflict situations.[336] International jurisprudence on rape and other forms of sexual violence has arisen largely out of the prosecution of war crimes and other crimes against humanity committed in conflict environments in the 1990s. This body of case law takes a broad, purposeful and contextualised approach to understanding sexual violence. This approach can be adopted within national jurisdictions.

The International Criminal Tribunal for Rwanda (ICTR) and the International Criminal Tribunal for the former Yugoslavia (ICTY) were the first international courts to comprehensively deal with the crimes of rape and other forms of sexual violence in international law. The courts undertook surveys of national legislation on rape and other forms of sexual assault in order to articulate the definition of the crimes. In the significant case *Prosecutor v. Jean-Paul Akayesu*, the ICTR found that sexual violence is "any act of a sexual nature which is committed on a person under circumstances which are coercive. Sexual violence is not limited to physical invasion of the human body and may include acts which do not involve penetration or even physical contact".[337] The ICTR defined rape broadly, as a physical invasion of a sexual nature, committed on a person under circumstances that are coercive. Note that this definition goes beyond non-consensual intercourse to include acts that involve insertion of objects or bodily orifices not considered to be intrinsically sexual.[338]

Based on its survey of national legislation, the Trial Chamber of the ICTY, in the case of *Prosecutor v. Kunarac, Kovac and Vukovic,* found that the common element in the various definitions of rape was the principle that "serious violations of sexual *autonomy* are to be penalized".[339] Further, "[s]exual autonomy is violated wherever the person subjected to the act has not freely agreed to it or is otherwise not a voluntary

participant".[340] The Appeal Chamber settled the international definition of rape by endorsing the Trial Chamber's articulation:

> The *actus reus* of the crime of rape in international law is constituted by the sexual penetration, however slight: (a) of the vagina or anus of the victim by the penis of the perpetrator or any other object used by the perpetrator; or (b) the mouth of the victim by the penis of the perpetrator; where such sexual penetration occurs without the consent of the victim. Consent for this purpose must be consent given voluntarily, as a result of the victim's free will, assessed in the context of the surrounding circumstances. The *mens rea* is the intention to effect this sexual penetration, and the knowledge that it occurs without the consent of the victim.[341]

Note that there is no requirement of force or active resistance in the definition. Lack of consent is the *sine qua non* of the definition.

Most jurisdictions have definitions of crimes of sexual violence that are based on either consent or "coercive circumstances". In the former, whether or not the complainant genuinely and voluntarily consented to the sexual act is the key question. In the latter, sex "under coercive circumstances" is the crime and therefore the actions of the perpetrator are the focus, including the use by the perpetrator of force, threat of force or other coercive circumstances (such as abuse of authority, unlawful detention or the presence of another person who is used to intimidate, etc.).

"[A]ny rigid approach to the prosecution of sexual offences, such as requiring proof of physical resistance in all circumstances, risks leaving certain types of rape unpunished and thus jeopardizing the effective protection of the individual's sexual autonomy".

—M.C. v. Bulgaria,
European Court of Human Rights[342]

4. Marital rape

Another critical element in the definitions of rape and other forms of sexual assault relates to the marital relationship of the parties. In many jurisdictions, so-called marital rape — that is, a rape committed by one's spouse, whether the couple is married, co-habiting or separated — is not included within the legal definition of rape or sexual assault. Sexual violence against wives, however, is prevalent and causes severe and long-lasting physical and emotional traumas for women.[343] Exemptions for rape within marriage reinforce the view that wives are the property of their husbands and that women do not have the right to make independent choices about their actions, bodies and sexuality. The UN General Assembly specifically identified marital rape as an act of gender-based violence in its 1993 *Declaration on the Elimination of Violence against Women*.[344] The *Beijing Declaration and Platform for Action* similarly lists marital rape and sexual violence occurring in the family as a form of violence against women that States have a duty to combat.[345] The European Court of Human Rights has stated that the abolition of the marital rape exemption conforms not only with "a civilised concept of marriage but also, and above all, with the fundamental objectives of the Convention, the very essence of which is respect for human dignity and human freedom".[346]

The principle of common law that a man cannot be guilty of rape upon his wife is widely acknowledged to originate in a proposition by Sir Matthew Hale in his book *History of the Pleas of the Crown* (1736). In 1991, the House of Lords ruled that the Hale proposition was no longer the law England.[347] Courts in various parts of the world have been faced with adjudicating cases of alleged rapes inflicted upon wives by their husbands, ex-husbands or cohabiting partners, and in recent years increasingly have been looking to constitutional and human rights principles of equality to oust this principle from national laws.

For example, the High Court of Uganda at Masaka was faced with a rape case in 2002 where the defence argued that the accused could not be convicted of raping the complainant, whom the accused believed to be his customary wife.[348] In this case, a man ("A1") and woman were to be married, but the woman learned that A1's previous wife may have died of AIDS. The wedding was therefore postponed; the couple would be married only after they had been tested on three separate occasions for HIV.[349] A1, however, proceeded to abduct the complainant and force intercourse upon her.

In disposing of the case, the judge rejected the assertion that A1 genuinely believed that he was customarily married to the complainant.

> No sane person who regards any woman as his wife would wish to have her exposed to such shame as A1 put the complainant in this case to by inviting two men to hold her while he was having sexual intercourse with her. No husband, worth the name, would leave his bride lying in dirt on the floor of his bedroom crying and dejected, on the first day of their marriage which normally marks the peak of their love. No husband would lock up his loving bride in his bedroom like a prisoner of war on their first day of their marriage.
>
> That strange conduct, on the part of A1, renders it clear to me that A1 did not believe, deep in his heart, that the complainant was his bride. For after treating her in that savagery manner, he could never hope to have any love from her. His having sex with her, at such a time of the day and in such a fashion, was a mere release of vengeance upon her for having refused to get married to him. He did not care what would follow.[350]

The judge did not stop there, however, but went on to explain why the accused would still be guilty of the offence of rape even if he had honestly believed that the complainant was his customarily wedded wife. Considering articles 31(1) [equal rights in marriage], 31(3) [consent to marriage], 33(1) [women shall be accorded full and equal dignity with men], 33(6) [laws, cultures, customs or traditions against the dignity, welfare or interest of women are prohibited] and 273(1) [existing law shall be constituted with such modifications, adaptations, qualifications and expectations as necessary to bring into conformity with the Constitution] of the Constitution of 1995, the judge ruled that the presumption of consent to sex on the part of a wife is invalidated by the Constitution.

> The presumption of consent, even where a man and woman are validly married, in my humble view, appears to be wiped out by the provisions of the Constitution which I have mentioned above. Husband and wife enjoy equal rights in marriage. They enjoy equal human dignity. No activity on the part of any of the two which is affront to those rights in relation to the other, can be sustained by a court of law; For the existing law, whether written or not, must, by virtue of section 273(1) of the Constitution, be interpreted to conform with the provisions of the Constitution.[351]

The accused was thus convicted of the offence of rape, contrary to sections 123 and 124 of the *Penal Code Act*.

Similarly, in a 2012 decision, the High Court of Solomon Islands rejected the proposition that a husband cannot be convicted of rape upon his wife.[352] In this case, the complainant and the accused were legally married, but the complainant had left the husband and was living with another man. The husband grabbed her on the street, forced her into a car and took her to a remote location. He then forced her to perform oral sex on him and to have sexual intercourse.[353] The accused submitted that since he and the victim were still legally married at the time of the alleged rape, it was not possible in law for him to be convicted of rape.

The Court however ruled that:

> 49. … the Hale proposition (*where a husband cannot be guilty of rape upon his wife*) has run its course and is no longer applicable nor appropriate in the circumstances of Solomon Islands. The proposition should now be confined to its grave.
>
> 50. The time when women are considered as sex objects or as subservient chattel of the husband in Solomon Islands has gone.
>
> 51. In this modern time, marriage is now regarded as a partnership of equals and this principle of equality has been reflected, not only in international conventions to which Solomon Islands is a party, but also in the entrenched provisions of the Constitution.
>
> 52. One of the international conventions to which Solomon Islands is a part is the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) which, in article 15, calls on all state parties to accord women equality with men before the law and, in article 16, calls for the same personal rights between husband and wife.
>
> 53. As for the Constitution, sections 3 and 15 of the Constitution guarantees women equal rights and freedoms as men and affords them protection against all forms of discrimination, including discrimination on the ground of sex.
>
> 54. Furthermore, judicial decisions regarding rape and similar offences against women have also reflected the judicial approach to offences affecting women.
>
> 55. The courts have stated time and again that rape is an offence which is often committed out of a selfish desire to gratify a man's own sexual desires, appetite and fantasies in disregard for the right, dignity and feelings of the victim.
>
> 56. A husband raping his own wife does so for no other reason that to satisfy his own selfish desires at the expense of the wife's dignity and feelings. Such behaviour must come to an end.
>
> 57. All these instances show the changing attitude in Solomon Islands towards the status of women and the recognition that women are equal partners with men in nearly all things, including marriage.
>
> 58. In my view the time has come for this court to take a hard look at this old marital exception rule
> and see whether its terms accord with what is now regarded generally in these modern times as acceptable behaviour.
>
> 59. If the court considers the rule as no longer applicable then in my view it has a duty to change it. That is what I now do.
>
> 60. This is not the creation of a new offence against husbands. What is being done here is, in the words of Lord Keith, who delivered the judgment of the House of Lords in *RvR*, removing a "*common law fiction which has become anachronistic and offensive*".
>
> 61. Hence, to the question whether or not a husband can be criminally liable for raping his wife, the answer must now be "yes".

As these two decisions recognise, marriage vows are not an agreement to have intercourse at any time under any circumstances. From a human rights perspective, these decisions — and others that recognise the criminality of marital rape — are to be applauded for protecting the dignity, autonomy and equality of women. Moreover, women's ability to negotiate the terms of sex, including condom use, without fear of violence is critical in order to prevent HIV transmission. The failure to recognise rape by a husband or partner as rape may also impede access to health services for survivors, including post-exposure prophylaxis for HIV. For all of these reasons, both human rights and public health mandate the end of marital rape exceptions.

5. Evidentiary considerations

Some rules of evidence may undermine successful prosecution of sexual assault or rape cases, re-victimise complainants or result in them withdrawing their cases. Furthermore, some rules of evidence violate human rights standards.

a) Cautionary rules and corroboration requirements

Cautionary rules require the court to exercise special caution when considering the evidence of certain witnesses — such as complainants in sexual assault cases, women and children — on the grounds that the evidence of such witnesses is inherently potentially unreliable.[354] The requirement for corroboration is a rule found in some jurisdictions that prohibits a criminal conviction upon the uncorroborated testimony of a complainant. Sexual assault cases are particularly affected by these two rules of evidence because sexual violence is often perpetrated in private, where the complainant is the only witness to the offence.

Common justifications for these two rules are that accusations of rape or sexual assault are relatively easy to make and difficult to disprove, and that women and children are prone to lie and to fantasise about sexual matters. However, courts are increasingly challenging the validity of such claims. The Supreme Court of Appeal of South Africa, for example, rejected these claims unequivocally.[355] It dismissed the claim regarding the ease of making accusations, finding that complainants in sexual assault cases, particularly women, often encounter significant risks of secondary victimisation when pursuing legal recourse against the perpetrators.[356] The contention that women and children lie and fantasise about sexual matters was similarly dismissed in the face of growing empirical evidence that "refutes the notion that women lie more easily or frequently than men, or that they are intrinsically unreliable witnesses."[357] The Court went on to state: "[T]he cautionary rule in sexual assault cases is based on an irrational and out-dated perception. It unjustly stereotypes complainants in sexual assault cases (overwhelmingly women) as particularly unreliable".[358]

The credibility of testimony by children has also been affirmed. The Supreme Court of Canada, for example, has adopted the position that the evidence of children is not inherently unreliable.[359]

Furthermore, a growing body of case law has found that these rules of evidence violate complainants' human rights. The Supreme Court of Namibia, for example, found that cautionary rules violate the constitutional prohibition on discrimination against women.[360] Similarly, the Kenya Court of Appeal found the requirement for corroboration in sexual assault cases unconstitutional because it discriminated against women and girls.[361]

b) Complainant's previous sexual conduct

Historically, in many jurisdictions, a complainant's previous sexual conduct or experience has been admissible evidence in sexual assault cases. Studies have shown that many complainants found the admission of such evidence to be an invasion of their privacy, and that a significant number of complainants either chose to not report or to withdraw their cases as a result.[362] Oftentimes, this evidence relating to previous

sexual conduct is used by the defence to suggest that the complainant is more likely to have consented to the sexual interaction and is less worthy of belief.[363]

Various courts have dismissed such inferences as prejudicial, and evidence of previous sexual conduct or experience has been prohibited in many jurisdictions when adduced for the purpose of discrediting the complainant.[364] Numerous jurisdictions have also enacted legislation to restrict the admissibility of evidence of a complainant's previous sexual conduct.[365]

In many jurisdictions, courts are now likely to encounter one of two forms of prohibition on evidence of a complainant's previous sexual conduct — a mandatory regime that imposes a blanket ban on the admission of such evidence, or a discretionary model that allows judges to determine the admissibility of such evidence in defined circumstances. If presiding within a discretionary regime, judges should be sensitive to the possibility of prejudice and stereotypes influencing how the evidence is interpreted (especially in jury trials).

> *"The fact that a woman has had intercourse on other occasions does not in itself increase the logical probability that she consented to intercourse with the accused. Nor does it make her a liar".*[366]
>
> —R. v. Seaboyer, *Supreme Court of Canada*

c) Alternative arrangements for giving evidence

Complainants and witnesses of sexual offences may find being in the same room as the accused one of the most difficult aspects of the trial process. Where a complainant or a witness finds it distressing to be in the same room as the accused, it might mean that they are unable to give evidence effectively or that the complainant or witness suffers further stress and trauma from testifying. Increasing recognition of the trauma related to giving evidence in cases of sexual violence has led a number of legal systems to take steps to make the criminal justice system more sensitive to the needs of complainants.[367]

When adjudicating cases of sexual or domestic violence, courts should consider various alternative options that are possible for giving evidence. For example, with technological advancements, courts are increasingly equipped to allow complainants and witnesses to give evidence from a remote location (usually a room within the court precincts) through closed-circuit television (CCTV). Where CCTV is unavailable, a mobile screen, for example, can be used to ensure that the witness does not have direct eye contact with the accused. Other physical arrangements, such as special seating arrangements, may also be used to facilitate this. Through such measures, courts have the opportunity not only to help complainants and witnesses, but to also advance the interests of justice by ensuring that evidence is provided in as unhindered a manner as possible.[368]

The constitutionality of alternative provisions has been upheld in response to challenges related to the fair trial rights of the accused. For example, the South African High Court (Cape of Good Hope Provincial Division) upheld the constitutionality of a witness testifying by CCTV and giving an *in camera* hearing of the testimony of the complainant.[369] Similarly, the Supreme Court of Canada upheld the constitutionality of section 486(2.1) of the *Criminal Code*, which permits complainants and witnesses under the age of 18 years or those who have a disability that affects their ability to communicate, to testify outside the courtroom or from behind a screen.[370]

6. Privacy concerns

Courts should be sensitive to the privacy concerns and vulnerabilities of complainants and witnesses. HIV status and other personal information may come into evidence during a trial, and efforts must be made to protect the complainant and allow him or her some degree of control over the public discussion of their personal information.

In sexual and domestic violence cases, the defence may, for a number of reasons, seek access to private information relating to the complainants and witnesses, particularly counselling records.[371] Information contained in these records is often taken out of context and misused in an attempt to cast doubt on the moral character and credibility of complainants and witnesses.[372] In some jurisdictions where evidence of complainants' sexual reputation and previous sexual conduct has been barred, the use of complainants' personal information records in court allows the defence to circumvent such legislative prohibition.[373] Further, complainants' records from post-assault counselling have sometimes been introduced as evidence of facts surrounding the incident in question.[374]

Many legal scholars have challenged such use of private records in sexual assault trials, arguing that this information is seldom relevant to the case and that its quality as admissible evidence is questionable for several reasons.[375] First, most personal information records are not prepared with the intention of detailing what has transpired and therefore do not represent faithful documentations of the incidents at issue. Second, documents such as medical charts and counsellors' notes are not reviewed by the complainants and may contain inaccurate descriptions of facts. Third, it is not uncommon for survivors of rape or sexual assault to blame themselves for what has occurred. To introduce such personal feelings contained in private records as evidence does not contribute to fact-finding.[376]

Compelled disclosure of personal information records in court also invades the right to privacy of complainants and witnesses.[377] Oftentimes, complainants face public humiliation, stigmatisation and disruption of social and family life consequent to such disclosure.[378] Studies have found that some survivors of rape and sexual assault may refrain from reporting their cases due to the fear of private information becoming a matter of public record.[379] With respect to the use of counselling records at trials, there is ample empirical evidence that shows the efficacy of therapy being undermined as a result.[380] For instance, complainants and counsellors alike may be hesitant to discuss certain sensitive issues that are integral to the therapeutic process due to the fear of them being disclosed in court.[381] Complainants also may terminate treatment prematurely or avoid seeking necessary support altogether.[382]

Highlighted case

Brazil:
The Inter-American Commission on Human Rights found that the state failed to meet its due diligence obligation to tackle domestic violence

Inter-American Commission on Human Rights, Report No. 54/01, Case 12.051, Maria da Penha (Brazil), 16 April 2001

Parties

Maria da Penha Maia Fernandes was a survivor of domestic violence. Together with the Center for Justice and International Law (CEJIL) and the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), she filed a petition before the Inter American Commission on Human Rights alleging wrongdoing on the part of the Federative Republic of Brazil (the state).

Remedy sought

The petitioners sought for the state to take preventative action to reduce incidences of domestic violence within its borders. In addition, the petitioners sought for the state to investigate, prosecute and punish perpetrators of domestic violence within a reasonable time period to protect the human rights of women.

Outcome

The Inter-American Commission found that the state violated the petitioner's right to a fair trial and judicial protection, guaranteed by articles 8 and 25 of the *American Convention on Human Rights*. Furthermore, the state failed to perform its duties under Article 7 of the *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women* "to pursue, by all appropriate means and without delay, policies to prevent, punish and eradicate" violence against women.[383]

The Commission made a number of recommendations to the State.

1. Complete, rapidly and effectively, criminal proceedings against the person responsible for the assault and attempted murder of Mrs. Maria da Penha Maia Fernandes.

2. In addition, conduct a serious, impartial and exhaustive investigation to determine responsibility for the irregularities or unwarranted delays that prevented rapid and effective prosecution of the perpetrator, and implement the appropriate administrative, legislative and judicial measures.

3. Adopt, without prejudice to possible civil proceedings against the perpetrator, the measures necessary for the state to grant the victim appropriate symbolic and actual compensation for the violence established herein, in particular for its failure to provide rapid and effective remedies, for the impunity that has surrounded the case for more than 15 years, and for making it impossible, as a result of that delay, to institute timely proceedings for redress and compensation in the civil sphere.

4. Continue and expand the reform process that will put an end to the condoning by the state of domestic violence against women in Brazil and discrimination in the handling thereof. In particular, the Commission recommends:

    a. Measures to train and raise the awareness of officials of the judiciary and specialized police so that they may understand the importance of not condoning domestic violence.

    b. The simplification of criminal judicial proceedings so that the time taken for proceedings can be reduced, without affecting the rights and guarantees related to due process.

    c. The establishment of mechanisms that serve as alternatives to judicial mechanisms, which resolve domestic conflict in a prompt and effective manner and create awareness regarding its serious nature and associated criminal consequences.

    d. An increase in the number of special police stations to address the rights of women and to provide them with the special resources needed for the effective processing and investigation of all complaints related to domestic violence, as well as resources and assistance from the Office of the Public Prosecutor in preparing their judicial reports.

    e. The inclusion in teaching curriculums of units aimed at providing an understanding of the importance of respecting women and their rights recognized in the Convention of Belém do Pará, as well as the handling of domestic conflict.

    f. The provision of information to the Inter-American Commission on Human Rights within sixty days of transmission of this report to the State, and of a report on steps taken to implement these recommendations, for the purposes set forth in Article 51(1) of the American Convention.[384]

Background and material facts

Fernandes was subjected to over a decade of aggressive and violent behaviour at the hands of her husband without receiving adequate and timely judicial intervention to stop the violence. At the time the Commission heard the petition, almost two decades had elapsed since the petitioner had approached legal authorities to investigate allegations of domestic violence; no final judicial ruling had been delivered. The perpetrator had remained free throughout this period, and no remedies had been provided for the consequences of the attempted murder of the petitioner.

Legal arguments and issues addressed

The facts of this case did not represent an isolated incident in Brazil. The Commission cited abundant evidence demonstrating the state's pattern of impunity in cases of domestic violence against women in Brazil: "[R]eports indicate that 70% of the criminal complaints pertaining to domestic violence are put on hold without any conclusion being reached. Only 2% of the criminal complaints for domestic violence against women lead to conviction of the aggressor".[385]

The Commission found that the state's judiciary showed a general pattern of negligence and lack of effectiveness in prosecuting and convicting perpetrators of domestic violence. Consequently, the Commission found that the state failed to fulfil its obligation under international law to engage in due diligence to prevent violence against women. The Commission acknowledged some of the policy reform measures passed to tackle domestic violence in Brazil. Yet the Commission found "[t]hat general and discriminatory judicial ineffectiveness also creates a climate that is conducive to domestic violence, since society sees no evidence of willingness by the State, as the representative of the society, to take effective action to sanction such acts".[386]

Commentary

The Commission's findings emphasise the important role of the judiciary in implementing laws that address violence against women. Failure to effectively prosecute the perpetrator of domestic violence in a timely manner represents an indication that the state condones violence against women. The *Fernandes* decision, by contrast, gives life to the due diligence doctrine: under both domestic and international law, the state has a legal duty to act positively to prevent violent crime, including crimes of domestic violence.

Chapter 7

Drug laws, harm reduction and the rights of people who use drugs

Summary

The use of illegal drugs is associated with a wide range of health, social and community problems, and people who use drugs are stigmatised and marginalised in most societies. Most countries have therefore adopted a range of laws in an attempt to curtail drug use.

Illicit drug use — and especially risky drug injection — is one of the primary means of HIV transmission globally. Given the prevalence of HIV among people who use drugs, and the direct link between risky drug-use practices and HIV infection, effectively addressing the epidemic necessarily requires programmes, services and initiatives that reduce the risks of HIV transmission associated with drug use.

Criminal justice actors have a significant role to play in creating an enabling environment for HIV prevention, care and treatment among people who use drugs. Key considerations are the high risk of transmission of HIV and other blood-borne infections in prison, the impact of drug-related prosecutions on the availability of services to people who use drugs, and providing redress for abuse and mistreatment suffered by people who use drugs.

The contemporary international drug control system consists of three UN conventions:

- *Single Convention on Narcotic Drugs* (1961)
- *Convention on Psychotropic Substances* (1971)
- *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988)

Many changes have occurred since their adoption, including the appearance of infectious diseases such as HIV. International and regional human rights treaties provide important avenues for improving the legal environment in the context of drug use.

Adjudicating cases involving drug use/possession: Factors concerning HIV to consider

1. The proportionality test and incarceration for drug offences

Long prison sentences for drug-related offences may be disproportionate. The legitimate aims of drug control can often be achieved while also respecting human rights through consideration of the full range of relevant factors, rather than arbitrarily imposing a mandatory sentence of imprisonment.

Key questions regarding the appropriateness of a sentence of imprisonment include:

- Is incarceration a necessary response for drug-related offences?

- To what extent can incarceration result in the achievement of the desired objectives?
- Does the response go beyond what is needed?

2. **Drug dependence treatment considerations related to sentencing**

   In many jurisdictions, drug dependence treatment is an alternative to criminal justice sanctions. Treatment substantially increases recovery, reduces crime and criminal justice costs, and is appropriate from a public health perspective, including in the prevention of HIV, tuberculosis and other infectious diseases.

   Given that drug dependence is a chronic disease, treatment that does not require complete abstinence tends to be more effective as an alternative or addition to punishment for drug-dependent offenders.

3. **Prosecutions in relation to harm reduction services**

   In some contexts, charges of "inciting" drug use, possession of illicit drugs, or possession of drug paraphernalia could theoretically be applied against harm reduction organisations and their workers. Prosecuting harm reduction services, however, could seriously impede the provisions of essential health services and information to people who use drugs, and it generally is not within the legitimate aims of drug law enforcement.

4. **How is the criminal law enforced against people who use drugs?**

   Abuses by law enforcement officers against people who use drugs are well documented, and they include physical abuse, illegal searches, harassment, extortion and sexual violence.

   Judges and magistrates have a critical role to play in preventing abuse and injustice by examining the full range of circumstances and thoroughly assessing investigation methods and any confessions made by people who use drugs, especially in cases of limited access to quality legal aid services.

Introduction

The use of illegal drugs is often associated with a wide range of health, social and community problems. In response, policy-makers have relied heavily on law enforcement in an attempt to curtail drug use. The combined impact is that people who use drugs are highly stigmatised and marginalised in most societies.

At the same time, illicit drug use — and especially risky drug injection — is one of the primary means of HIV transmission globally.[387] People who use drugs are considered one of the "key populations" in the HIV response.[388] Given the prevalence of HIV among people who use drugs and the direct link between risky drug-use practices and HIV infection, effectively addressing the epidemic necessarily requires programmes, services and initiatives that reduce the risks of HIV transmission associated with drug use.

Data on HIV and drug use

Injection drug use is a significant factor in the HIV epidemic in all regions of the world, although there is significant regional variation.

- **Sub-Saharan Africa:** Injection drug use is increasingly a factor in the HIV epidemics of various countries, including Kenya, Mauritius, South Africa and Tanzania.
- **Asia:** 16% of the 4.5 million people who inject drugs in Asia are living with HIV.
- **Eastern Europe and Central Asia:** Approximately one quarter of the 3.7 million people who inject drugs in this region are living with HIV.
- **Central America and South America:** As many as two million people inject drugs, more than one quarter of whom may be living with HIV.
- **Middle East:** Exposure to contaminated drug-injection equipment features in the epidemics of Iran, Algeria, Egypt, Lebanon, Libya, Morocco, Oman, Syria, and Tunisia.
- **Oceania:** Injection drug use features prominently in the HIV epidemic among Aboriginal people; in French Polynesia and Melanesia (excluding Papua New Guinea), people who inject drugs comprise 12% and 6%, respectively, of HIV infections.
- **Caribbean:** Injection drug use contributes significantly to the spread of HIV in Bermuda and Puerto Rico.
- **North America and Western Europe:** Rates of new infections among people who inject drugs have been falling, largely due to the availability of harm reduction services. In several localized epidemics, however, (e.g. Aboriginal people in Canada and sex workers in U.S.A.–Mexico border towns), injection drug use remains a critical factor.

—UNAIDS, *Report on the Global AIDS Epidemic*, 2010

Criminal justice actors have a significant role to play in creating an enabling environment for HIV prevention, care and treatment among people who use drugs.[389] When judges and magistrates preside over drug cases, they can affect the course of the HIV epidemic in several ways. First, by handing down non-custodial sentences, they may be able to divert a person who uses drugs away from prison, which is a high-risk environment for the transmission of HIV and other blood-borne infections. Second, their rulings can affect the services available to people who use drugs, because the implementation of drug laws in an aggressive or overly broad manner may impede HIV prevention programmes, including harm reduction programmes. Third, judges and magistrates can provide meaningful redress for the abuse, marginalisation and mistreatment faced by people who use drugs. This abuse increases the vulnerability of drug users to HIV and continuing drug use, and limits opportunities for employment, education and addiction treatment.

What is harm reduction?

"Harm reduction" or "harm minimisation" refers to policies, programmes and practices aimed at reducing the harms associated with the use of illegal drugs. The defining features of harm reduction are the focus on:

- the prevention of the harms associated with drug use (rather than on the prevention of drug use itself); and
- people who continue to use drugs.[390]

Harm reduction programmes are critical health interventions for people who use drugs, enabling them to protect their own health and the health of others. Many people are unwilling or unable to stop using drugs for a variety of reasons (including drug dependence), even when they are aware of the harms related to continuing drug use. A comprehensive package for the prevention, treatment and care of HIV among people who use injection drugs has therefore been recommended by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and UNAIDS, including:

- needle and syringe programmes
- opioid substitution therapy and other evidence-based drug dependence treatment
- HIV testing and counselling
- antiretroviral therapy
- prevention and treatment of sexually transmitted infections
- condom programmes
- targeted information and education
- vaccination, diagnosis and treatment of viral hepatitis
- prevention, diagnosis and treatment of tuberculosis[391]

Available data demonstrates that a large number of prisoners in the world either use drugs or have a history of drug use.[392] In virtually all low- and middle-income countries, there are more people who inject drugs in prisons, pre-trial detention facilities, police lock-ups and forced rehabilitation centres than in health centres.[393] The adverse consequences of far-reaching punitive drug policies that result in the imprisonment of people who use drugs — including the impact of incarceration on the spread of blood-borne diseases, such as HIV — are well documented.[394] Therefore, with the objective of effectively responding to the HIV epidemic while respecting human rights, this chapter focuses on how to avoid unnecessary incarceration, particularly for people who use drugs who have been charged with drug possession.

Human rights standards and drug laws

International law

The contemporary international drug control system consists of three UN conventions.

- The *Single Convention on Narcotic Drugs* of 1961 mandates that narcotic drugs (e.g. opium, coca, marijuana and their derivatives) only be produced, distributed, possessed and used for medical and scientific purposes.[395]
- The 1971 *Convention on Psychotropic Substances* mandates similar restrictions for primarily synthetic psychotropic substances (e.g. amphetamines, barbiturates, benzodiazepines and psychedelics) and their precursor chemicals.[396]

- Finally, the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* promotes co-operation between states to address the international dimension of trafficking, establishing measures against drug trafficking (including criminalisation at the domestic level), provisions against money laundering, the diversion of chemical precursors, mutual legal assistance and extradition.[397]

Together, these conventions aim to control illicit drugs by reducing their supply, in particular through criminal sanctions. The conventions do not require criminalisation of drug use per se,[398] and they allow for treatment, after-care, rehabilitation and social reintegration, as opposed to penal punishment, for persons with drug dependence who commit drug trafficking-related offences.[399]

The Commission on Narcotic Drugs and the International Narcotics Control Board (INCB) monitor these conventions and assist states in implementing them.[400] Some of the official documents of these bodies provide useful guidance on the contemporary interpretation of the conventions (e.g. a 2002 legal opinion about the legality of harm reduction programmes according to the conventions).[401] Moreover, many changes have occurred since their adoption, including the appearance of infectious diseases such as HIV, which need to be taken into consideration in order to implement the conventions today.

Commission on Narcotic Drugs calls for removing obstacles to HIV services

- *Reiterating* the commitments made in the *Single Convention on Narcotic Drugs* of 1961, in the preamble to which States parties expressed concern for the health and welfare of mankind; …
- *Reaffirming* that all countries should strive to achieve the highest attainable standard of physical and mental health for their people, as recognized in the relevant international instruments; …
- *Urges* Member States to remove obstacles to the achievement of the goal of universal access to HIV prevention, treatment, care and related support services so that people living with HIV, or at elevated risk of contracting HIV, including drug users, may use available services.

"Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV" (*Commission on Narcotic Drugs Resolution*, March 2010)[402]

In addition to the UN drug conventions, international and regional human rights treaties also provide important context for the legal environment for the control of illicit drugs.[403] In particular, the right to health is directly relevant because "health is at the core of drug policy".[404] The *International Covenant on Economic, Social and Cultural Rights* includes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[405] Similarly the *African Charter on Human and Peoples' Rights* includes the right of every individual to "enjoy the best attainable state of physical and mental health".[406] Interrelated with the right to health are the rights to life, liberty and personal security, to be free from ill treatment and discrimination, and to enjoy other human rights as embodied in treaties such as the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social and Cultural Rights*, the *International Covenant on Civil and Political Rights* and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.

The application of drug laws in a manner that results in the spread of HIV and other communicable diseases among people who use drugs could amount to a violation of the right to health.[407] This principle was recognised by a group of European and Latin American judges in the 2009 *Porto Declaration*, in which they explicitly prioritised the rights to human dignity, health and life over punitive policies with respect to illicit drug use.[408] Similarly, the UN Special Rapporteur on the right to health has indicated that the right to health prevails in cases of conflict between the goals and approaches of the international drug control regime

and the international human rights regime.[409] Moreover, the UN commentary to the *Convention against Illicit Trafficking* says that parties shall observe the norms of public international law, in particular norms protecting human rights, when adopting stricter measures than those mandated by the conventions.[410]

In every one of its resolutions on "international cooperation against the world drug problem", the UN General Assembly has reaffirmed that the drug problem must be addressed with full respect for all human rights and fundamental freedoms.[411] Member States of the Commission on Narcotic Drugs have similarly endorsed this principle.[412] Such repeated statements by the international community are important in understanding and interpreting the international drug control treaties so that they do not impede effective, evidence-based measures to address HIV and otherwise protect and promote health among people who use drugs.

National laws

Domestic drug laws vary from country to country. Most contain some criminal penalties for violating prohibitions on producing, possessing and/or distributing drugs. Many include alternatives to conviction and punishment, particularly for people who are addicted to prohibited substances. Public health and public safety are often dual objectives of national legislation related to drugs.[413]

States may incorporate the right to health into their national laws through specific constitutional provisions, as the extension of other human rights (such as the right to life, the protection of dignity, the right to non-discrimination, and the right to be free from ill treatment), or in other domestic legislation relating to health care and/or human rights.[414]

Courts also adjudicate cases where drug use and/or drug dependence are at issue, but where the person is not charged specifically with a drug offence. These cases involve what is often referred to as "drug-related crime" and could include theft and other criminal offences committed in order to obtain money to obtain drugs, offences committed while under the influence of psychoactive substances, and those committed as part of the business of supplying drugs within an illicit drug market.[415] In addition, courts may adjudicate cases involving drug laws where the accused is charged in relation to the provision of harm reduction services. For example, a service provider may be charged with possession of a controlled substance for possessing used needles that have been collected from people who use drugs for safe disposal, but still contain trace amounts of drugs.[416]

Adjudicating cases involving drug use/possession: Factors concerning HIV to consider

1. The proportionality test and incarceration for drug offences

In many courts around the world, a significant amount of time is dedicated to sentencing people who use drugs who have been convicted on possession charges, as well as those convicted in relation to drug production or trafficking. Some countries dictate mandatory minimum sentences for drug offences, while judges in other jurisdictions have a significant amount of discretion.[417]

Canada provides an example of mandatory minimum sentences in relation to some drug crimes. These provisions were challenged before the Supreme Court of Canada in the case of *R. v. Smith*.[418] Smith had pleaded guilty to importing 7.5 ounces of cocaine into Canada, contrary to the *Narcotic Control Act*. Before sentencing submissions were made, Smith challenged the constitutionality of the seven-year minimum sentence of imprisonment mandated by the law, arguing it was in violation of his constitutional rights to life, liberty and security of the person, right against arbitrary detention, and right against cruel and unusual treatment or punishment.

Noting that a constitutionally valid purpose does not necessarily guarantee the constitutional validity of the law, the Court examined the purpose and effect of the relevant provisions.[419] The Court found that the mandatory minimum sentence was "grossly disproportionate" because the provision encompassed a broad range of circumstances without differentiating according to the type of substance imported, the quantity, the purpose (e.g. for personal consumption or for trafficking) and whether the accused has had previous convictions. The certainty of the sentence, irrespective of the circumstances, amounts to a *prima facie* violation of the Charter prohibition on cruel and unusual treatment or punishment.[420]

Having found a violation, the Court considered whether the provision could be justified, highlighting the issue of proportionality. Relying on prior Canadian jurisprudence, the Court explains:

> Although the nature of the proportionality test will vary depending on the circumstances, in each case courts will be required to balance the interests of society with those of individuals and groups. There are three important components of a proportionality test. First, the measures adopted must be carefully designed to achieve the objective in question… Second, the means, even if rationally connected to the objective in this first sense, should impair "as little as possible" the right or freedom in question. Third, there must be a proportionality between the effects of the measures which are responsible for limiting the right or freedom, and the objective which has been identified as of "sufficient importance".[421]

The Court ruled that the mandatory sentence of seven years of imprisonment failed the proportionality test; the objective could be achieved with less impairment of rights.[422]

From a human rights perspective, the judgment is very positive. It demonstrates how the legitimate aims of drug control can be achieved while also respecting human rights through consideration of the full range of relevant factors rather than arbitrarily imposing a compulsory sentence.[423] The issue of arbitrariness was not specifically considered in the majority judgment, although two judges from the panel highlighted in their concurring opinions that considerations of arbitrariness are part of the proportionality test: imposition of the punishment regardless of the circumstances of the offence or the offender might result in a disproportionate sentence.[424] Note that the proportionality analysis presented in the Canadian context mirrors the basic elements of the *Siracusa Principles*, internationally applicable guidelines that are helpful in assessing the validity of a punishment.[425]

The principle of proportionality: Fundamental to the rule of law

Applying the principle of proportionality to sentencing ensures not only that the punishment matches the gravity of the offence, but it also ensures that the state's infringement on fundamental rights shall be "narrowly tailored" to serve a "compelling state interest".[426] The principle of proportionality is effective for avoiding the overuse of incarceration for drug-related crimes because it allows the adjudicator to consider multiple factors related to drugs and drug use, including the public health perspective and the spread of HIV and other communicable diseases.

The Supreme Court of the United States has also considered proportionality in a case about the arbitrariness of sentencing. In *Kimbrough v. the U.S.,* the Supreme Court upheld a lower court's judgment about the disproportionate and unjust effect of federal sentencing guidelines with respect to crack cocaine.[427] The lower court had imposed a sentence lower than the range advised by the *Federal Sentencing Guidelines*, a decision that was overturned on appeal on the grounds that a sentence outside of the range of the Guidelines is per se

unreasonable when based on disagreement with the Guidelines. The Guidelines recommended much harsher punishments for offences involving crack cocaine than those involving powder cocaine.[428]

The Supreme Court held that the Guidelines were advisory only and that the trial judge's sentence was reasonable and based on consideration of the appropriate factors. In coming to this decision, the Court noted that the Sentencing Commission had itself reported that the crack/powder disparity produces disproportionately harsh sentences.[429] This decision highlights how applying the proportionality test might depend on both the individual circumstances of the accused and the specific scientific evidence regarding the particular circumstances of the case.[430] This regard for science is very helpful from a public health perspective. Research studies often shed light on the relevant circumstances of the case, allowing for the formulation of an appropriately tailored sentence based on objective facts.

According to the International Narcotics Control Board (INCB):

> Whether or not a State's response to drug-related offences is proportionate depends in turn on how its legislative, judicial and executive arms of government respond in both law and practice. For example:
>
> a. Is the particular response necessary?
>
> b. To what extent can the response result in the achievement of the desired objectives?
>
> c. Does the response legitimately go beyond what is needed?
>
> d. Does the response comply with internationally accepted norms concerning the rule of law?[431]

When engaging in a proportionality analysis with respect to sentencing for a drug-related offence, courts may take into considerations the following factors related to the first three guiding questions suggested by the INCB.

a) Is incarceration a necessary response for drug-related offences?

The UN drug conventions provide safeguards against the disproportionate use of incarceration:

- There is no requirement to criminalise personal consumption nor to make offences related to personal consumption punishable with incarceration. Criminalisation of possession for personal consumption is subject to "constitutional principles and the basic concepts of legal system" (*Convention against Illicit Traffic*, Article 3(2)).
- Drug treatment, education, aftercare, rehabilitation or social reintegration of the offender are legitimate alternatives to conviction or punishment, in "appropriate cases of a minor nature" and for offences related to personal consumption, or as additional measures to conviction or punishment for other drug-related offences (*Convention against Illicit Traffic*, Article 3(4)(b),(c) & (d)).[432]

b) To what extent can incarceration result in the achievement of the desired objectives?

Controlling drug possession, production and distribution could be in pursuit of multiple objectives. Those suggested in the preamble to the *Single Convention* include combatting drug addiction and promoting health and welfare. The prevention, treatment and care of HIV, hepatitis and other blood-borne diseases transmitted in relation to drug use are necessarily implicated.[433] The prevention of, and retribution for, drug-related crime would logically also be considered an objective of drug policy.

The extent to which incarceration contributes to these objectives is influenced by several factors.

- The drug–crime relationship is complex and there are multiple paths that lead to drug use and crime.[434] Incarceration does not address many of the underlying factors that lead to drug use and to possible drug-related criminal behaviour.
- Available studies suggest that incarceration has very limited deterrent effects on people who use drugs.[435]
- Because drugs are widely available within prisons (despite extensive efforts at interdiction) and people continue to use drugs while incarcerated, incapacitation and rehabilitation are often not achieved.[436]
- Prison is a high-risk environment for the transmission of HIV and hepatitis because of the high prevalence of HIV, hepatitis and drug dependence among prisoners, and the use of non-sterile drug use equipment.[437]
- Prison is also a high-risk environment for tuberculosis (TB).[438] TB infection can constitute a "death sentence" for those already in poor health (including poor health resulting from drug use, HIV and hepatitis). HIV, hepatitis and TB infections in prisons also contribute to morbidity and mortality in the communities to which prisoners return on their release.

c) *Does the response go beyond what is needed?*

A sentence of imprisonment may go beyond what is legitimately needed in order to accomplish the goals of the drug policy. As noted, the UN drug control conventions provide for alternatives to incarceration. In assessing whether alternatives are appropriate in a given case, and whether they may better satisfy the desired objectives, the courts should consider the following:

- The specific circumstances of the case may indicate that custodial measures are necessary, for instance when public safety concerns outweigh public health concerns (e.g. violent crimes, high-level drug trafficking offences, offences with engagement of firearms);
- Research shows that public health responses (rather than the imprisonment of people who use drugs) are better at achieving a reduction in the offences committed by people who use drugs (as well as other goals such as HIV prevention);[439]
- Drug treatment in the community is generally more effective than that offered in prison;[440] and
- Diversion programmes for people who use drugs — which refer drug users to medical services as an alternative to prosecution, sentencing or custodial sanctions — may satisfy both the requirements of the criminal justice system and public health objectives.[441]

> *"[T]he use of non-custodial measures and treatment programmes for offences involving possession for personal use of drugs offer a more proportionate response and the more effective administration of justice. Moreover, the criminal justice response should not be considered proportionate if it results in the denial of another individual human right. Where imprisonment for possession/use offences precludes access to appropriate drug-dependence treatment, for example, this may constitute a denial of the right to the highest attainable standard of health or even the right to freedom from cruel, inhuman or degrading treatment, rendering the criminal justice response de facto disproportionate".*[442]
>
> —*Commission on Narcotic Drugs,* Drug control, Crime Prevention and Criminal Justice: A Human Rights Perspective, *March 2010*

2. Drug dependence treatment considerations related to sentencing

Drug dependence is a chronic but treatable multifactor health disorder. In many jurisdictions, sentences in relation to drug offences are not strictly punitive, but may also involve drug dependence treatment. It has been demonstrated that drug dependence treatment as an alternative to criminal justice sanctions substantially increases recovery and reduces crime and criminal justice costs. Treatment is also more appropriate from a public health perspective, including in the prevention of HIV, TB and other infectious diseases.[443]

Relapses are common rather than exceptional for drug dependence. Given that dependence is a chronic disease, treatment that does not require complete abstinence tends to be more effective as an alternative or addition to punishment for drug-dependent offenders.[444] Overreliance on abstinence-based programmes has been one of the criticisms of drug treatment courts in the U.S.A.[445] Imposing punitive measures for relapses or prohibiting opioid substitution treatment may amount to discriminatory punishment; often, relapse is a symptom of dependence.

Illustrative in this regard is the 1962 decision of the Supreme Court of the United States in the case of *Robinson v. California*. Lawrence Robinson had been sentenced to 90 days' imprisonment on a misdemeanour charge of being "addicted to the use of narcotics".[446] The Court ruled that drug dependence is a disease and punishing someone for being ill constituted cruel and unusual punishment. Justice Stewart delivered the majority judgment.

> It is unlikely that any State at this moment in history would attempt to make it a criminal offence for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. … in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an affliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendment (Citizenship Rights) [...] narcotic addiction is an illness. … To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be a cruel and unusual punishment for the "crime" of having a common cold.[447]

The decision is noteworthy for its recognition that drug dependence is an illness and that punishment for illness is a rights violation. The Court did not go so far as to extend its judgment to every aspect of criminalising drug use (i.e. purchasing, possessing, making solutions, etc.). However, the reasoning could be extended to recognise that for people who are dependent on drugs, the use of drugs and the related activities are part of their dependence. Punishing them for such activities, therefore, would be similarly suspect as a matter of human rights. Moreover, if relapsing into drug use is an element of the illness, by the logic of this decision, the appropriate response is treatment, not punishment.

It should be noted, however, that although drug dependence is an illness, and treatment is therefore an appropriate response, people with drug dependence must consent to treatment. From a human rights perspective, the involuntary imposition of non-evidence-informed or experimental treatment (for any condition, including drug dependence) constitutes torture or otherwise cruel, inhuman or degrading treatment or punishment.[448]

"Forced labour, solitary confinement and experimental treatments administered without consent violate international human rights law and are illegitimate substitutes for evidence-based measures such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent".[449]

—The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the UN General Assembly, *2010*

3. Prosecutions in relation to harm reduction services

In some jurisdictions, "drug propaganda" laws may be used against harm reduction organisations for providing drug users with information about safer methods of consuming drugs, ways to prevent and respond to drug overdoses, and alternatives to injecting drugs. In some contexts, charges of "inciting" drug use, possession of illicit drugs, or possession of drug paraphernalia could theoretically be applied against harm reduction organisations and their workers, depending on the wording of certain laws and how broadly police and prosecutors choose to interpret them. Prosecuting harm reduction services, however, could seriously impede the provision of essential health services and information to people who use drugs, and it generally is not within the legitimate aims of drug law enforcement.[450]

If such a case comes before a court, it is fundamental to consider the intent of the individual or organisation providing the drug use equipment or information. Is the equipment or information provided in order to encourage or facilitate drug use, or is it provided in order to prevent the transmission of communicable diseases and other harms among people who use drugs? Indeed, harm reduction workers know that the materials they distribute will be used to consume illicit drugs — their intent is to reduce the adverse consequences of illicit drug use among people who are already using drugs and, for whatever reason, are unwilling or unable to stop. Prosecuting harm reduction workers and services would be particularly perverse when:

- they are doing what is recommended by UN health agencies to address HIV among people who use drugs;
- harm reduction activities go directly toward achieving the public health objectives that drug control laws supposedly espouse; and
- the programmes are often supported by government funds.

An analogous situation arose in the case of *Open Door and Dublin Well Woman v. Ireland* regarding the distribution of health information (on accessing safe abortions). At the time, it was contrary to Irish law to distribute information related to accessing abortion services abroad. The organisations *Open Door Counselling Ltd.* and *Dublin Well Woman Centre Ltd.* challenged the injunction preventing them from distributing information about abortion clinics in Great Britain. The European Court of Human Rights held that the injunction violated Article 10 [freedom of expression] of the Convention.[451] The Court found that the injunction interfered with the right of the applicants by preventing them from providing information about pregnancy-related options, and with the ability of women to receive information. Even if Ireland had a legitimate interest in protecting the foetus, the injunction had a disproportionate impact because it prohibited counselling in all circumstances, regardless of the circumstances, and posed a health risk to women.[452] Similar reasoning could be applied to the situation of providing harm reduction services and information to people who use drugs.[453]

In some jurisdictions, the threshold quantities of drugs for the purposes of criminal or administrative liability are so small that charges of possession could be brought against outreach workers or clients of harm reduction services who are in possession of used syringes with trace amounts of illicit drugs. However, prosecution in such circumstances would contradict the public health goals usually prioritised in drug laws. Recognising this reality, the U.K. Crown Prosecution Service's manual on drug offences notes that "[t]he need to prevent the spread of serious infections outweighs the normal requirement for prosecution".[454]

Considerations with respect to "threshold quantities"

In many jurisdictions, prosecution and sentencing for drug offences is based on a system of "threshold quantities": if the amount of drugs is below a certain threshold amount, then the charge is a lesser offence and the sentence is reduced. If the amount is above the prescribed threshold, then it is a more serious offence, with a longer mandatory sentence.[455]

Note that:

- Threshold quantities can help distinguish between cases of possession for personal use and cases of drug trafficking. However, where the amount of drugs exceeds the threshold quantity, caution should be taken to avoid reversing the burden of proof such that the accused has to prove that they did not intend to traffic.
- Threshold quantities can trigger exemptions or diversions away from the criminal justice system as part of a health-oriented approach.[456]
- The purity of street drugs can vary drastically. Therefore, an assessment of the purity of the seized drugs is necessary in order to apply the threshold quantity accurately.[457]
- Drug-dependent users may have a higher tolerance to drugs and therefore use a larger amount or higher purity. These circumstances should be taken into account to avoid applying harsher repercussions based solely on the threshold quantity, which could amount to discrimination, particularly against those whose dependence is more pronounced.[458]

4. How is the criminal law enforced against people who use drugs?

People who use drugs may be vulnerable in ways that affect their access to justice and equal treatment before the law. For example, they may be susceptible to self-incrimination or incrimination of fellow drug users as a result of acute withdrawal symptoms during police interrogation. Moreover, abuses by law enforcement officers against people who use drugs are well documented and they can include physical abuse, illegal searches, harassment, extortion and sexual violence.[459] Judges and magistrates therefore have a critical role to play in preventing injustice by examining the full range of circumstances and thoroughly assessing investigation methods and any confessions made by people who use drugs, especially in cases of limited access to quality legal aid services.[460]

Similarly, because drug crime investigations often employ undercover police agents, at times it is not clear how the evidence against the accused was obtained. In order to guard against instances of entrapment or unfair arrests in drug trafficking cases, the European Court of Human Rights looks to whether there is additional evidence beyond mere possession of drugs. For example:

- Was there a preliminary investigation indicating that trafficking was going on?
- Does the accused have a previous criminal record for trafficking?
- Was there a substantial quantity of illicit drugs or drug-making paraphernalia found in the accused's residence?
- Were the drugs found on the accused purchased from somebody else in order to fulfil the request of the undercover police agent?
- Was the undercover police operation pre-authorised by the independent authority, or was it authorised by the same forces that carried out the operation?[461]

Highlighted cases

United States: Supreme Court upholds significant deviation from the sentencing guidelines

Brian Gall v. United States of America, S. Ct. No 06–7949 (2007), Supreme Court of the United States, 2007

Parties

The applicant, Brian Gall, had been convicted of drug trafficking. At the trial level, the district court had imposed a sentence of probation. The appellate court vacated this judgment and imposed a sentence of imprisonment.

Remedy sought

The applicant further challenged the appellate court's judgment, asking the Supreme Court to restore the original trial court's decision imposing probation instead of imprisonment.

Outcome

The Supreme Court overturned the appellate court's judgment and held that the probationary sentence imposed by the District Judge in this case was reasonable.

Background and material facts

While in college, Gall was engaged in a conspiracy for trafficking ecstasy and netted about 30 000 U.S. dollars in seven months. Three and half years after withdrawing from the conspiracy, Gall pled guilty to his participation.

The recommended sentence for his offence under federal sentencing guidelines was 30 to 37 months' imprisonment. However, the trial judge sentenced him to 36 months' probation. The judge determined that probation adequately reflected the seriousness of his offence and that imprisonment was unnecessary because his voluntary withdrawal from the conspiracy and post-offence conduct showed that he would not return to criminal behaviour and was not a danger to society.

The appellate court overturned this sentence on the ground that a sentence outside the range of the Federal Sentencing Guidelines must be supported by "extraordinary circumstances", which it said did not exist in this case. On a further appeal, the Supreme Court reinstated the probationary sentence originally imposed by the trial judge.

Legal arguments and issues addressed

The Supreme Court held that deviation from the *Federal Sentencing Guidelines* was permitted, but a judge must explain the appropriateness of any departure from the Guidelines with sufficient justification. In reviewing cases where the sentence imposed by the trial court was outside the recommended range, the appellate court may not require "extraordinary" circumstances or employ a rigid mathematical formula based on a departure's percentage as the standard for determining the strength of the justification required for a specific sentence. Such approaches come too close to creating an impermissible presumption that sentences outside the Guidelines' range are unreasonable.

The Court explained that for the trial judge, the Guidelines represent a starting point and initial benchmark for determining an appropriate sentence, but they are not the only consideration. The judge should pay attention to all the factors to be considered in imposing the sentence.[462] The judge must make an individualised assessment based on the facts presented, must consider the extent of the deviation from the Guidelines and must ensure that the justification is sufficiently compelling to support the degree of variation. The judge also must adequately explain the chosen sentence to allow for meaningful appellate review and to promote the perception of fair sentencing. The Court further clarified that at the level of appellate review, abuse of discretion is the appropriate standard.

Commentary

From a human rights perspective, this decision provides important direction as to good practice in judicial discretion with respect to sentencing. Individualised assessment, as opposed to a formalised application of guidelines, allows for an individual's personal circumstances to be assessed and an appropriate and proportional sentence to be crafted. The formulaic application of sentencing guidelines without individual assessment can result in disproportionate sentences amounting to cruel and unusual punishment since the individual circumstances of people convicted of drug-related offences are so diverse and because drug dependence, a complex health issue, is often a key factor.

Argentina:
Supreme Court declares criminalisation of drug possession for personal consumption unconstitutional

Arriola, Sebastian and Others, Case No. 9080, Supreme Court of Argentina, 2009[463]

Parties

The initial appeal was brought to the Supreme Court by several people who used drugs and who had been convicted on charges of drug possession for personal use and/or drug trafficking. Subsequently, the Supreme Court dismissed the appeal for two of the appellants who had been charged with drug trafficking and restricted its decision to those appellants who had only been convicted of drug possession for personal use.

Remedy sought

The appellants requested that their convictions be set aside and further sought a declaration that the prohibition on drug possession for personal use was unconstitutional.

Outcome

The Supreme Court granted the appeal and declared that Argentina's criminal prohibition on drug possession for personal consumption (Article 14, second paragraph, of Law 23,737) was unconstitutional. The Court urged all public authorities to ensure a state policy against illicit drug trafficking and to adopt preventive health measures, including the provision of information and education to dissuade drug consumption, in order to comply with international human rights treaties.

Background and material facts

The criminal case was initiated in 2006 after police charged eight people with possession of drugs. Three accused were subsequently sentenced for drug trafficking and the rest for drug possession for personal consumption.

Legal arguments and issues addressed

The defence argued that Article 14, second paragraph, of Law 23,737 (prohibiting drug possession for personal consumption) ran contrary to Article 19 of the National Constitution, which provides that:

> The private actions of men that in no way offend public order or morality, nor injure a third party, are reserved only to God, and are exempt from the authority of the magistrates. No inhabitant of the Nation shall be compelled to do what the law does not order, or be deprived of what it does not forbid.

The Court agreed, unanimously holding that criminalising people in the absence of harm to others violates constitutional protections. The Court found that each individual adult is responsible for making decisions freely about their desired lifestyle without state interference. Private conduct is allowed unless it constitutes a real danger or causes damage to property or the rights of others. The state cannot establish morality.

On the negative consequences of criminal approaches to people who use drugs, Supreme Court Justice Zaffaroni noted:

> … prosecuting users becomes an obstacle for the recovery of those few who are dependent, since it only stigmatises them and reinforces their identification as drug users, blocking the possibility of any detoxification therapy and behavioural change that, in fact, has the opposite objective because it seeks to remove that identification in order to promote their self-esteem based on other values. [unofficial translation]

The judgment also considered the requirements of the international drug control system. In this regard, Justice Lorenzetti pointed out that:

> … none of the international conventions signed by Argentina on this matter (*United Nations Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* of 1988; the *Convention on Psychotropic Substances* of 1971; and the *Single Convention on Narcotic Drugs* of 1961) compels it to criminalise the possession of narcotic drugs for personal use. On the contrary, it is established that such a question remains "subject to its constitutional principles and the fundamental concepts of its legal system" (Article 3, section 21; Article 22 and Articles 35 and 36 of the previously mentioned conventions, respectively), and therefore it is evident that the conventions respect Article 19 of the Constitution. [unofficial translation]

Referring to drug use, justices Fayt and Petracchi made the following comments:

> … it is clear that definitive responses to these considerations cannot be found through criminal action without hindering the possibility of solutions through other areas of the law. It is, without a doubt, inhumane to criminalise the individual by subjecting him to criminal proceedings that will stigmatise him for life and, in his case, sentencing him to prison. [unofficial translation]

Commentary

Noteworthy in this decision is the Court's assessment of the national drug laws in light of human rights and international treaties. The decision affirms that drug dependence is a health problem and that solutions are best found within the health sphere. The conclusion that personal drug use is a public health issue, rather than a criminal justice issue, is in keeping with the contemporary development of international drug policy.

The subsequent application of the Court's reasoning will depend on how lower courts determine what shall be considered possession for personal consumption. It will also depend on how the term "harm to others" is understood with respect to personal drug use. Nonetheless, from a public health and HIV prevention perspective, it represents a positive development. Recognising that criminalisation further marginalises people who use drugs and may drive them away from treatment and other health-related services, presents an opening for prioritising harm reduction and treatment for drug dependence over prosecution. It is also a powerful statement to policy-makers and law enforcement about the appropriate allocation of resources.

Similar judgments have been issued by high courts in Brazil[464] and Colombia.[465]

Canada:
Supreme Court holds that the federal government must grant a supervised injection facility an exemption from criminal liability under national drug laws

Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, Supreme Court of Canada, 2011

Parties

The plaintiffs in this case were two people who use drugs, Dean Wilson and Shelly Tomic, together with the PHS Community Services Society (PHS), which operates the supervised injection facility, Insite, in Vancouver, Canada. The Vancouver Area Network of Drug Users (VANDU) also brought a separate action to defend Insite's continued operation, but on somewhat different grounds. The two cases were ultimately heard and decided together.

Remedy sought

The plaintiffs alleged that the application to Insite of criminal prohibitions on the possession and trafficking of illicit drugs (ss. 4(1) and 5(1)) in the *Controlled Drugs and Substances Act* (CDSA) violated their constitutional rights to life, liberty and security of the person under the *Canadian Charter of Human Rights and Freedoms*.[466] They sought a declaration that any decision by the federal Minister of Health to refuse to grant or extend Insite's exemption constituted a violation of these constitutional rights.

Outcome

The Supreme Court found that the Health Minister's refusal to grant an exemption to Insite violated the constitutional rights to life, liberty and security of the person, and that such violations could not be justified.[467] The Court ordered the Minister to grant an exemption to Insite under the CDSA.

Background and material facts

Insite opened in 2003 to provide medical services to injection drug users in Vancouver after receiving an exemption from the federal Minister of Health from two specific provisions of the CDSA.[468] The exemption allowed PHS to operate Insite without putting clients or staff at risk of criminal prosecution for possession of prohibited drugs (which are brought into the facility by clients and injected on the premises using sterile equipment while under medical supervision) or for trafficking (since staff would be in possession of small amounts of drugs on used injection equipment). A new government elected in 2006 was publicly opposed to the continued operation of Insite. Fearing that the exemption would be discontinued once it expired, the plaintiffs brought proceedings before the courts seeking various remedies that would allow the health service to continue operating without risk of prosecution.

The trial judge found that to deny access to the health services provided at Insite would violate Charter rights. He found that many of the health risks of injection drug use are caused by improper injection practices and non-sterile equipment, not by the drugs themselves. He held that the violation of constitutional rights could not be saved under the "justification" provision of the Charter. He therefore declared sections 4(1) and 5(1) [criminal prohibitions on possession and trafficking of illicit drugs] of the CDSA unconstitutional. The British Columbia Court of Appeal upheld the trial judge's conclusion that Insite should continue to operate legally. The government appealed to the Supreme Court.

Legal arguments and issues addressed

The Supreme Court held that the claimants' constitutional rights to life, liberty and security of the person were engaged by the prohibitions on possession of drugs and trafficking when those prohibitions were applied in the context of Insite. The health professionals working at Insite would be unable to offer medical supervision and counselling to clients without risking criminal prosecution, unless an exemption from the application of the CDSA was granted. As a result, Insite clients would be denied potentially lifesaving medical care, thus violating their rights to life and security of the person.

The Supreme Court did not strike-down the implicated provisions in the CDSA entirely, because the CDSA gave the Minister the power to grant exemptions from the law. However, the Minister's decision to refuse a further exemption to Insite did violate the claimants' constitutional rights. The discretion vested in the Minister of Health was not absolute; it needed to be exercised in accordance with the Charter.

The Court found that the government's refusal to grant the exemption was arbitrary. As stated in the unanimous ruling:

> The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.[469]

And further:

> The Minister made a decision not to extend the exemption from the application of the federal drug laws to Insite. The effect of that decision, but for the trial judge's interim order, would have been to prevent injection drug users from accessing the health services offered by Insite, threatening the health and indeed the lives of the potential clients. The Minister's decision thus engages the claimants' s. 7 [rights to life, liberty and security of person under the *Canadian Charter of Human Rights and Freedoms*] interests and constitutes a limit on their s. 7 rights. Based on the information available to the Minister, this limit is not in accordance with the principles of fundamental justice. It is arbitrary, undermining the very purposes of the CDSA, which include public health and safety. It is also grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises.[470]

In conclusion, the Court stated that this decision is not a licence for people who use drugs to possess drugs wherever and whenever they want, nor is it a general approval of supervised injection facilities. The result in this case rests on the trial judge's conclusions based on the specific facts about Insite. However, where the Minister is considering an application for an exemption for a supervised injection facility, they must aim to strike the appropriate balance between achieving public health and public safety goals. Where the evidence indicates that a supervised injection site will decrease the risk of death and disease – and there is little or no evidence that it will have a negative impact on public safety – the Minister should generally grant an exemption.

Commentary

This case is an important recognition of the benefits of harm reduction services. Principles articulated in the judgment with regard to public health, drug laws and human rights are applicable not only to supervised injecting facilities, but also to needle and syringe programmes, as well as overdose prevention programmes.

Drug laws must provide appropriate flexibility to accommodate a broad range of public health considerations related to different groups of people, taking into account the factual circumstances of each particular case. Exemptions from the application of drug laws in certain cases may serve public health and public safety goals more than their overly broad implementation would, and such exemptions are in line with the principle of protection from arbitrary and disproportionate use of the criminal law.

Chapter 8
Women's rights with respect to family and property law

Summary

Gender inequality and violations of women's human rights are pervasive with respect to family and property law issues, and they are also decisively linked to the HIV epidemic. Factors such as social and economic inequalities between spouses, pressure for married women to bear children, laws that codify gender inequality, domestic violence, inequitable division of property on divorce, and insecurity of land tenure also contribute to women's HIV risk.

Inequalities in marriage, divorce and inheritance laws and practices are not new issues, but the HIV epidemic has dramatically aggravated their discriminatory effects.

Because their legal, social and economic subordination renders women vulnerable to HIV infection, protecting and promoting the human rights of women is critical to an effective response to the HIV epidemic. Under both international and regional human rights treaties, states have specific obligations with respect to combatting discrimination against women.

National laws relevant to women's rights with respect to family and property are diverse and encompass a range of statutes, regulations and other forms of subsidiary law, common law, customary law and constitutional provisions. This complicated legal terrain can result in inconsistencies and injustices.

Adjudicating cases involving marriage, divorce, property and inheritance: Factors concerning HIV to consider

1. **Gender equality and women's rights**

   Gender disparities with regard to property are often based in notions of men being the sole stakeholders. Presumptions that women are incapable of managing land and that men and communities will take care of women have proven untrue and are inconsistent with women's diverse roles in contemporary society.

   Recognising women's diverse contributions to family property is consistent with human rights. It acknowledges the different types of contributions that different members of the family make, and that one partner's ability to engage in paid employment or advance their career may only be possible because the other partner takes responsibility for domestic labour and childcare. It also respects the autonomy and dignity of each spouse, and it can help alleviate women's poverty and vulnerability, both during and at the dissolution of a marriage.

   The HIV epidemic has led to more women, especially widows and orphans, being threatened with the dispossession of their land and property rights. Property-grabbing is an obvious human rights violation and exacerbates the already devastating consequences of HIV on families.

In some countries, civil or customary laws support "marital powers", whereby a husband gains legal control over his wife and any marital property. Marital powers are not consistent with equal rights and responsibilities in the family, and they are an overt example of gender discrimination in marriage.

Granting a divorce on the basis of HIV status is likely to reinforce discrimination against people living with HIV and potentially impede voluntary testing and disclosure. Similarly, mandatory pre-marital HIV testing not only violates individuals' rights to privacy and to marry and found a family, but it also reinforces discrimination against people living with HIV and is ultimately not helpful in terms of HIV prevention.

2. Administrative procedures

Administrative procedures – such as the process for registering a marriage and the requirements to transfer title to a piece of land – are an essential consideration in terms of access to justice and fair outcomes for all parties. In some jurisdictions, men continue to enjoy greater rights and access in terms of administrative procedures related to family and property.

Judges, magistrates and judicial officers should facilitate women's full participation in various administrative processes.

Introduction

Gender inequality and violations of women's human rights are pervasive with respect to family and property law issues, and they are also decisively linked to the HIV epidemic. While HIV may not be raised specifically in property and family law cases involving, for example, marriage, divorce, property and inheritance, it is implicitly a backdrop to many cases.

For many women around the world, their greatest risk of contracting HIV is through sexual intercourse with their husbands. The terms of the marriage relationship and the conditions for its dissolution are thus critically important with respect to both promoting women's equality and preventing HIV transmission.[471] Furthermore, gender inequalities in the context of marriage play a complex role in spreading the epidemic among women. Social and economic power imbalances make it difficult for many married women to request safer sex with their husbands, to refuse sex, or to leave abusive relationships.[472] Where there is significant pressure to bear children, married women may believe that they do not have any right to refuse sex.[473] So-called "marital powers" — still a component of the law in some countries — are a particularly severe example of gender discrimination within marriage, authorising a husband to take legal control over his wife and any marital property. Moreover, the prevalence of domestic violence in marriage and cohabitation, as well as some customary practices, put women at risk of HIV infection.[474]

Similarly, lack of access to divorce on fair terms puts women at greater risk of HIV infection leaving women – especially women living with HIV – vulnerable to economic destitution. The prospect of imminent or worsening poverty upon divorce leads some women to remain in marriages, despite their worries about HIV infection as a result of their husbands' sexual activity outside the marriage. It also impedes their ability to demand safer sex, and it may constrain their ability to seek appropriate HIV treatment and support.[475] Gender inequality with respect to divorce includes inequitable division of property upon divorce, lack of provision for spousal maintenance, different grounds for divorce available to men as compared to women, lengthier or more onerous divorce proceedings when initiated by the wife, and assumptions that children "belong to" the husband.

> *"Women have tended to suffer economic disadvantages and hardships from marriage or its breakdown because of the traditional division of labour within that institution. Historically, or at least in recent history, the contributions made by women to the marital partnership were non-monetary and came in the form of work at home, such as taking care of the household, raising children, and so on. Today, though more and more women are working outside the home, such employment continues to play a secondary role and sacrifices continue to be made for the sake of domestic considerations. These sacrifices often impair the ability of the partner who makes them (usually the wife) to maximize her earning potential because she may tend to forego educational and career advancement opportunities. These same sacrifices may also enhance the earning potential of the other spouse (the husband) who, because his wife is tending to such matters, is free to pursue economic goals".*
>
> —Moge v. Moge, *Supreme Court of Canada, 1992*[476]

Inequality with respect to property rights is a result of laws and practices that limit women's ability to buy, administer, inherit or sell land, as well as their opportunities to acquire credit on equal footing with men. It has been noted that protecting women's property rights can have both preventive and mitigating impacts in the context of the HIV epidemic.[477] On the preventive side, secure tenure over housing and land provide women with economic security, livelihoods, dignity and independence. Numerous studies have demonstrated how poverty and insecurity drive women to remain in violent relationships or to engage in behaviours that put them at risk of HIV.[478] Women with access to resources (including land, financial resources and supportive networks) are better able to negotiate condom use in their sexual relationships, to leave abusive partners and to provide for their own and their children's needs. In terms of mitigation, property rights can help ease the impact of HIV and AIDS on individuals and families. Impoverished families have less capacity to cope with the disease if members are

infected. Secure property rights also provide livelihoods and assets to pay school fees, buy medication and access the nutrition, clean water and shelter that are necessary in order to stay healthy.[479]

Inequalities in inheritance laws and practices are not new issues, but the HIV epidemic has dramatically aggravated the discriminatory effects of inheritance by increasing the number and vulnerability of widows and orphans. More women are becoming heads of households or widows, often in the context of family resources already depleted because of illness. These women often lack independent property rights or livelihoods.[480]

The HIV epidemic has also amplified pre-existing discrimination against women and added new dimensions to human right abuses against women. When misunderstanding of HIV and discrimination against women merge, for example, it can result in distrust and mistreatment of widows whose husbands have died of AIDS-related causes. A widow may be blamed for her husband's HIV infection and death, and subsequently she may be driven from her home by her in-laws.[481] If a widow is showing signs of illness, her family may refuse to take her in, she may face eviction or she may find it difficult to secure adequate housing. One specific and disturbing manifestation of women's inequality with respect to inheritance in the context of HIV is the phenomena referred to as property dispossession, disinheritance or property-grabbing, whereby property that a person should own or have rightfully inherited is taken from them. Instances of property-grabbing have been reported in many countries, and qualitative studies confirm that the practice has been widespread.[482] In many instances, the property is taken because the woman who should inherit it is (or is presumed to be) HIV-positive.

As a result, when judges and magistrates adjudicate cases about family and property — especially marriage, marital property, divorce, inheritance and related matters — they are playing a role in the fight against HIV, whether or not HIV seems to be a central issue in the case. They can affect the course of the HIV epidemic by refusing to endorse the social, cultural and legal inequalities that entrench women's subordination to male partners, but also by protecting women's rights and implementing the international human rights norm against gender discrimination. Women (and children) with economic and food security are better equipped to refuse unwanted intercourse and leave abusive relationships, and they are less likely to resort to transactional sex. Pressure on girls to enter into early marriages or engage in transactional sex with older men will also be diminished.[483]

Human rights standards and women's rights with respect to family and property law

International law

Because their legal, social and economic subordination renders women vulnerable to HIV infection, protecting and promoting their human rights of women is critical to an effective response to the HIV epidemic. Under both international and regional human rights treaties, states have specific obligations with respect to combatting discrimination against women.

The *International Covenant on Civil and Political Rights* (ICCPR) and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) guarantee equality between men and women and the right to non-discrimination.[484] The ICCPR also protects the family and equality of spouses in marriage and at the dissolution of marriage.[485] The ICESCR provides that "the widest possible protection and assistance should be accorded to the family", and recognises the right of everyone to an adequate standard of living (including adequate food, clothing and housing).[486]

In addition, the *Convention on the Elimination of all Forms of Discrimination against Women* (CEDAW) outlines specific measures that States parties must take to address discrimination against women, including embodying the principles of equality in national constitutions, adopting appropriate legislation and taking measures to modify or abolish laws, customs and practices that constitute discrimination against women.[377] It also requires that States take all appropriate measures to "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women…"[488] and to "eliminate discrimination against women in all matters relating to marriage and family relations…".[489] Moreover, CEDAW requires states to ensure that both spouses enjoy the same rights with respect to the ownership, acquisition, management, administration, enjoyment and disposition of property.[490]

Regional human rights treaties also recognise women's rights to equality and non-discrimination. For example, the *Protocol to the African Charter on Human Rights and People's Rights on the Rights of Women in Africa* specifically:

- protects the right to "equal access to housing and to acceptable living conditions";
- requires states to "grant to women, whatever their marital status, access to adequate housing";[491] and
- guarantees to widows "an equitable share in the inheritance of the property of her husband" and "the right to continue to live in the matrimonial home".[492]

The Protocol also provides that women and men enjoy equal rights and are regarded as equal partners in marriage. Similarly, the *American Convention on Human Rights* includes articles that protect equality in marriage, guarantee everyone the right to property and recognise that all people are equal before the law.[493] The *European Convention for the Protection of Human Rights and Fundamental Freedoms* also includes an article on the right to marry and a prohibition of discrimination.[494]

National laws

National laws relevant to women's rights with respect to family and property are diverse and encompass a range of statutes, regulations and other forms of subsidiary law, common law, customary law and constitutional provisions. This complicated legal terrain can result in inconsistencies and injustices, as gains made on one front may be undermined or limited in effect by contradictory rules and processes in other laws. In many countries, customary laws are also critically important with respect to family and property-related issues. While the diversity, on-going evolution and differing interpretations of customary laws make it difficult to draw any broad conclusions, many customary laws (or practices justified on the grounds that they are based on customary or religious laws) violate basic principles of equality reflected in international, regional and domestic human rights laws.[495] Where applicable statutes, customs and regulations conflict, courts play a critical role in protecting women's rights.

Adjudicating cases involving marriage, divorce, property and inheritance: Factors concerning HIV to consider

1. Gender equality and women's rights

a) Gender-based discrimination concerning property and inheritance

While gender-based discrimination is prohibited in international, regional and domestic laws worldwide, a great number of laws with respect to marriage, divorce, property and inheritance continue to be in force despite containing provisions that fail to treat men and women equally. Gender disparities with regard to property are often based in notions of men being the sole stakeholders. This is for multiple reasons, including presumptions that land given to women is lost to another family in the event of marriage or divorce, that women are incapable of managing property, and expectations that the men in the family or community will support the women.[496] These notions have proven untrue and out of line with women's diverse roles in contemporary society.

United Nations Commission on Human Rights, *Women's equal ownership, access to and control over land and the equal rights to own property and to adequate housing*, Human Rights Resolution 2005/25

…

Reaffirming that all human rights are universal, indivisible, interdependent and interrelated and that women's equal ownership, access to and control over land and the equal right to own property and to adequate housing contribute to the full realization of human rights,

…

Recognizing that the Secretary-General has linked the growing prevalence of HIV/AIDS in women with laws that inhibit the full enjoyment of women's rights to land ownership and inheritance, and that he has called for positive change and attention to women's empowerment and protection of women's housing and land rights to make women less vulnerable to HIV/AIDS,

Reaffirming the Declaration of Commitment on HIV/AIDS, agreed to at the twenty-sixth special session of the General Assembly convened in 2001, which calls for all Governments to strengthen or enforce legislation, regulations and other measures to eliminate all forms of discrimination and to ensure the full enjoyment of all human right and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular, to ensure their access to inheritance and legal protections,

Recognizing that laws, policies, customs, traditions and practices that act to restrict women's equal access to credit and loans also prevent women from owning and inheriting land, property and housing and exclude women from participating fully in development processes, are discriminatory and contribute to increasing the poverty of women and girls,

…

- *Affirms* that discrimination in law and practice against women with respect to having access to, acquiring and securing land, property and housing, as well as financing for land, property and housing, constitutes a violation of women's human rights to protection against discrimination and may affect the realization of other human rights;
- *Reaffirms* Commission on the Status of Women resolution 42/1, which, inter alia, urges States to design and revise laws to ensure that women are accorded full and equal rights to own land and other property, and the right to adequate housing, including through the right to inheritance, and to undertake administrative reforms and other necessary measures to give women the same right as men to credit, capital, appropriate technologies, access to markets and information;
- *Encourages* Governments to support the transformation of customs and traditions that discriminate against women and deny women security of tenure and equal ownership of, access to and control over land and equal rights to own property and to adequate housing, to ensure the

> right of women to equal treatment in land and agrarian reform as well as in land resettlement schemes and in ownership of property and in adequate housing, and to take other measures to increase access to land and housing for women living in poverty, particularly female heads of household, including through access to housing subsidies; …

Many courts throughout the world have faced laws relating to property and/or inheritance that privilege the interests of men. Frequently, disputes arise as to the ownership of property acquired during marriage, division of such property upon the dissolution of the marriage, and the duty to pay support or maintenance to an ex-spouse. Women may retain virtually no property after marriage dissolution where property must either be registered in their own name or they must prove that they made a contribution to its acquisition or maintenance in order to demonstrate that they have a proprietary interest in it (especially in an "out of community of property" marital property system). Since property acquired in the marriage is usually registered in the husband's name, and women are often unable to provide courts with records of their possessions and contributions to the family's property, women in such situations have little to claim as their own upon marriage dissolution. Moreover, because women's domestic and caregiving work is not often recognised as an economic activity and is difficult to quantify, husbands can more often claim ownership of assets.

In Tanzania for example, once a marriage is dissolved, courts have the power to divide assets jointly acquired by the couple during the course of the marriage (pursuant to section 114 of the *Law of Marriage Act of 1971*). The two main factors the court considers in making this determination are the customary norms of the community to which the parties belong and the "contributions made by either party in money, property, or work towards the acquiring of the assets".[497] This latter provision has proven contentious, as it does not specify what kinds of activities constitute work done in contribution to the acquisition of marital assets. In the case of *Zawadi Abdallh v. Ibrahim Iddi*, for example, the Tanzanian High Court held that a wife's domestic services did not factor into economic contributions because the drafters of the *Law of Marriage Act* did not positively acknowledge their applicability in the division of assets.[498]

In contrast, the Supreme Court of Canada has recognised that "domestic services", including housework and childcare, provided by a spouse or domestic partner are a valuable contribution and should be recognised in the division of property and determination of support payments upon the dissolution of a relationship. In the leading case of *Pettkus v. Becker*, a majority of the Court held that although the property was registered in the man's name and had been purchased primarily with his employment income, Ms. Becker's contribution of labour and income to the household entitled her to a one-half interest in the lands and a share of the business.[499] For the first five years of their relationship, Ms. Becker paid the rent, bought the food and clothing, and took care of other living expenses, enabling Mr. Pettkus to save his entire income, money that was later used to buy properties that were the basis of their beekeeping business. Both spouses worked in the beekeeping business over the years.

In upholding the ruling that Ms. Becker's contributions entitled her to a share of the property and the business, the Supreme Court of Canada quoted Wilson J.A.'s comments from the Court of Appeal:

> With all due respect to the learned trial judge I think he has vastly underrated the contribution the appellant made to the acquisition of the assets held in the respondent's name. The parties lived together as husband and wife, although not married, for almost twenty years during which period she not only made possible the acquisition of their first property in Franklin Centre by supporting them both exclusively from her income during "the lean years", but worked side by side with him for fourteen years building up the bee-keeping operation which was their main source of livelihood. The respondent did not deny that she supported him for the first five or six years of their lives together while he put away all earnings in the bank.[500]

Recognising women's diverse contributions to family property is consistent with human rights because it applies the lens of substantive equality to the adjudication. It acknowledges the different types of contributions that different members of the family make, how that one partner's ability to engage in paid employment or advance their career may only be possible because the other partner takes responsibility for domestic labour and childcare. It also respects the autonomy and dignity of each spouse, and it can help alleviate women's poverty and vulnerability, both during and at the dissolution of a marriage. As discussed above, alleviating women's poverty is an essential component in an effective response to HIV.

The Matrimonial Home: Special consideration

All too often, when marriages come to an end (whether because of separation, divorce or the death of a spouse), women lose their homes. The matrimonial home is central to family life and is often the primary asset of a couple. If a woman loses access to the matrimonial home, she may well become homeless and destitute, losing custody of her children. Allowing women to be evicted from their homes (whether by an ex-spouse, the ex-spouse's family or others) subjects them to insecurity, poverty and sexual violence. Specifically protecting women's access to the marital home during and at the dissolution of a marriage, therefore, is a tangible way for legislatures, judges and magistrates to empower women and reduce HIV-related vulnerability.

Another set of rules being increasingly challenged relate to intestate inheritance rules that restrict the ability of women and girls to inherit. Primogeniture, for example, refers to the common law or customary law right of the first-born son to inherit all of the assets of the deceased to the exclusion of all siblings. Such rules exclude women from inheriting and thus raise human rights, inequality and poverty concerns.

A similar inheritance rule came before the High Court of Botswana, which was asked to rule whether a customary law of inheritance that permitted only males to succeed in intestate succession violated section 3(a) of the Constitution by violating women's rights to equal protection.[501] Botswana's Constitution specifically provides that discrimination, through application of customary law, is permissible.[502] The applicants — four daughters who had been ordered to vacate the home, which under the customary law rule now belonged to the nephew — therefore relied on the right to equal protection before the law. The Court canvassed international human rights treaties, comparative jurisprudence, and jurisprudence of Botswana (including the key cases *Attorney General v. Dow* 1992 BLR 199 and *The Student's Representative Council of Molepolole College of Education v. Attorney General* 1995 BLR 178).

Having reviewed the applicable law, the Court notes that:

> It is axiomatic that by ratifying the above international legal instruments, states parties commit themselves to modify the social and cultural patterns of conduct that adversely affect women through appropriate legislative, institutional and other measures, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.[503]

In analysing the effect of the customary law, the Court asked several questions. First, does the customary law differentiate between males and females? To this question, the answer was that yes, it did differentiate.[504] Second, with respect to whether the differentiation is unfair, the Court found that it was unfair because sex was one of the prohibited grounds.[505] Finally, the Court considered whether the discrimination was justifiable. The Court found that neither the respondents nor the Attorney General offered a justification for discriminating against the applicants. One argument put forward was that it would be absurd to declare the

rule unconstitutional because it is recognised or practised by the majority of the population of Botswana. In rejecting this argument, the Court noted the impacts of the rule:

> It seems to me that the reason proffered by the learned Attorney General cannot be a valid reason to discriminate against the applicants. In my mind, there is no legitimate government purpose to be served by the discriminatory rule; and the fact of the matter is that the rule sought to be impugned is not only irrational but amounts to an unjustifiable assault on the dignity of the applicants and or women generally. The effect of the Ngwaketse customary law, sought to be impugned, is to "subject women to a status of perpetual minority, placing them automatically under the control of male heirs, simply by virtue of their sex". I do not think it can be credibly argued that discrimination alluded to above serves any worthy or important societal purpose. It is a matter of record that the government is concerned about this discrimination and its wish to see it ended, if what it proclaims at International forums is anything to go by. Speaking for myself, I am unable to reconcile the rule under discussion with the equality provisions captured by Section 3 (a) of our Constitution.
>
> This court also rejects outright any suggestion, no matter how remote, that the court must take into account the mood of society in determining whether there is violation of constitutional rights as this undermines the very purpose for which the courts were established.[506]

"[C]ustom which discriminates against a person solely on the basis of sex has outlived its usefulness and is not in conformity with public policy; if customs are to survive they must change with the times".

—Akrofi v. Akrofi *[1965] GLR 13*

"[T]he children of a deceased person, both male and female, have a right to inherit their deceased mother's property; this is regardless of whether the woman came from a matrilineal or patrilineal family".

—Fianko v. Aggrey (2007–2008) SC, GLR 1135

The court concluded that the customary law, which provided that the last-born son was to inherit the family home, was biased against women and had adverse effects on women, including that daughters living in their parents' homes could be evicted by the heir upon the death of the parents.[507] It found that such discrimination could not be allowed to continue; customary law must yield to the constitutional provisions, spirit and values.[508] The Court affirmed its role as a protector of human rights, without being inhibited by aspects of culture that are "no longer relevant".[509]

b) Property disinheritance or dispossession

The HIV epidemic has led to more women, especially widows and orphans, being threatened with the dispossession of their land and property rights. As a result of HIV and AIDS, there has been an exponential growth in the number of young women who are widowed or left without parents to care for them. More women are becoming heads of households, often in the context of family resources having been depleted because of illness. Widows may be blamed for their husband's HIV infection and death, and it may be assumed that a widow is living with HIV herself. This may be used as a justification to withdraw social support from a woman and even to usurp her property. Moreover, as a result of stigma against people living with HIV, a woman who is believed to be living with HIV may find it difficult to maintain employment and rent housing or land, or she may face eviction from her home.[510] Property dispossession or property-grabbing is an obvious human rights violation and exacerbates the already devastating consequences of HIV on families. As such, judges and magistrates will want to be aware of this issue when adjudicating property and inheritance cases.

Judicial action against property dispossession

1. Who used the property prior to the death of the deceased? What uses were made of the property (e.g. as a residence, livelihoods from livestock, crops, microenterprises, etc.)?
2. Who is now asserting a proprietary interest in the property? On what basis? Who else may have an interest in the property?
3. What will happen to those who resided on the property or used the property prior to the death of the deceased if property rights are granted to the applicants?
4. What options are available, within the applicable legal framework, to protect the rights of the spouse, children and other dependants of the deceased? For example, can maintenance payments be ordered or the property be held in trust?
5. How can the court be sure that the rightful heir peacefully enjoys their property and that the needs of the deceased's dependants are considered? What supervisory powers does the court have? What other resources (such as police, a community council, a trustee) can be called on? What remedies are available to return property that has been unlawfully taken? What sanctions are available against anyone who has illegitimately taken property?

c) Gender-based discrimination concerning marriage and divorce

For many family courts around the world, daily work revolves around cases related to marriage and its dissolution (including issues of domestic violence, child custody and related property issues). For example, courts may be asked to rule on whether a marriage should be voided because the bride was younger than the minimum legal age to marry or because she did not fully and freely consent to the marriage, or court may be asked to rule on disputes regarding returning marriage payments. Laws and practices that favour the husband's interests are therefore continually before judges and magistrates, with potential ramifications for women's HIV risk.

In some countries, civil or customary laws support "marital powers", whereby a husband gains legal control over his wife and any marital property. The United Nations Commission on Human Rights stated that, "[d]uring marriage, the spouses should have equal rights and responsibilities in the family. This equality extends to all matters arising from their relationship, such as choice of residence, running of the household, education of the children and administration of assets".[511] Marital powers are not consistent with equal rights and responsibilities in the family, and they are an overt example of gender discrimination in marriage, condoned by law.

CEDAW *General Recommendation No. 21: Equality in marriage and family relations*

A woman's right to choose a spouse and enter freely into marriage is central to her life and to her dignity and equality as a human being. An examination of States parties' reports discloses that there are countries which, on the basis of custom, religious beliefs or the ethnic origins of particular groups of people, permit forced marriages or remarriages. Other countries allow a woman's marriage to be arranged for payment or preferment and in others women's poverty forces them to marry foreign nationals for financial security. Subject to reasonable restrictions based for example, on a woman's youth or consanguinity with her partner, a woman's right to choose when, if, and who she will marry must be protected and enforced at law.

An examination of States parties' reports discloses that many countries in their legal systems provide for the rights and responsibilities of married partners by relying on the application of common law principles, religious or customary law, rather than complying with the principles contained in the Convention. These variations in law and practice relating to marriage have wide-ranging

> consequences for women, invariably restricting their rights to equal status and responsibility within marriage. Such limitations often result in the husband being accorded the status of head of household and primary decision maker and therefore contravene the provisions of the Convention.
>
> Moreover, generally a de facto union is not given legal protection at all. Women living in such relationships should have their equality of status with men both in family life and in the sharing of income and assets protected by law. Such women should share equal rights and responsibilities with men for the care and raising of dependent children or family members.[512]

When the South Africa Constitutional Court was confronted with the issue of the equality of spouses within a marriage in the 2008 case of *Elizabeth Gumede (born Shanga) v. President of the Republic of South Africa and Others*, the Court held that the codified customary law of marriage of KwaZulu-Natal, which subjected a woman married under customary law to the marital power of her husband, was discriminatory on the ground of gender.[513] *(See case summary below.)* This decision is an excellent example of a court using human rights principles (i.e. non-discrimination) to inform its interpretation and application of a law.

Under a number of divorce law regimes, husbands are able to divorce their wives for a host of reasons that are not available to wives. For example, some countries' laws focus on grounds related to a wife only (particularly on an alleged fault or failing on her part) as the basis for a divorce, while having little regard for the grounds on which a husband's fault or failing may give rise to a woman's right to divorce.[514] When confronted with this issue, the Ugandan Constitutional Court found that the provisions of the *Divorce Act*, which established different grounds of divorce for men and women, were discriminatory (on the basis of sex) and therefore in violation of the Constitution.[515] The Court held that women, like men, should have the right to divorce for the sole reason of adultery, and that provisions related to compensation for adultery, maintenance and settlement should apply to both sexes. This case is another progressive example of the principles of non-discrimination prevailing.

In some countries, the HIV-positive status of a spouse has been construed as a ground of divorce. It should be noted, however, that even in those countries with enumerated lists of grounds upon which a person may petition for divorce, health status is generally not included. Granting a divorce on the basis of HIV status is likely to reinforce discrimination against people living with HIV and potentially impede voluntary testing and disclosure. In Kenya, a man was reported to have argued that his wife's HIV-positive status put his life in danger, and that it was tantamount to "cruelty" as a ground for divorce. The Kenya Court of Appeal rejected this argument.[516]

In the same vein, a number of jurisdictions have implemented mandatory pre-marital HIV screening legislation, and a number of faith-based organisations have instituted mandatory pre-marital HIV testing among couples seeking to be married. Where such testing has been implemented, however, there is little evidence demonstrating its effectiveness with respect to HIV prevention.[517] Mandatory pre-marital HIV testing violates individuals' rights to privacy, to marry and to found a family; it also reinforces discrimination against people living with HIV and is ultimately not helpful in terms of HIV prevention.[518]

When divorce regimes discriminate against women in terms of child custody, the risk of losing access to their children may hinder some women's ability to end their marriage. Separating children from the parent who has been their primary caregiver can also be traumatic for children.

Notwithstanding any customary or religious laws or practices, a human rights approach to child custody determinations prioritises the best interests of the child. Factors to consider are the wishes of the child; the

physical, emotional and educational needs of the child; the capabilities of each parent; and the desirability of giving custody of the child to the child's primary caregiver in order to provide continuity and stability.

In all matters regarding marriage, divorce, property and inheritance, recognising women's autonomy and promoting their equality is consistent with international human rights norms and supportive of HIV prevention, care, treatment and support. By assessing marriage and divorce provisions through the lens of substantive equality, judges and magistrates can put conditions in place that support women's autonomy, reducing their vulnerability to HIV infection and enabling them to cope more effectively with HIV-related illness. By refusing to condone the impulse toward requiring HIV testing before marriage or accepting HIV infection as a reason to dissolve a marriage, judges and magistrates likewise counteract stigma against people living with HIV and make a positive intervention in the epidemic. Upholding equality principles in family law jurisprudence is therefore a powerful tool.

Presiding over cases of marriage and divorce

1. What laws apply in this case? Are there relevant statutory provisions, customary laws and/or constitutional provisions? What sort of marital property regime applies?
2. Do the applicable rules treat women and men equally? Are women's contributions fully recognised (including reproductive roles, caregiving and household work)? Is the applicable law consistent with international, regional and constitutional equality provisions?
3. What remedies are available? Which remedies will be most effective, considering all relevant factors (including poverty, HIV, violence, the needs of dependants, etc.)?

2. Administrative procedures

With respect to family and property law, administrative procedures are an essential consideration in terms of access to justice and fair outcomes for all parties. Whether it be the process for registering a marriage, the paperwork required to process a divorce, or the requirements to transfer the title to a piece of land, administrative procedures can exacerbate inequalities and prevent parties from enjoying the full benefit of the law meant to protect their rights. Consider estates, for instance: in some countries, the manner in which estates are administered continues to deprive women of procedural rights and exclude women from participation. For example, some statutory laws continue to include explicit limitations on women's ability to administer an estate, while some customary laws also exclude women from the role of administrator, often because the customary successor (usually a man) is the first choice for the role of administrator.[519] In practice, this often means that women cannot claim their rightful inheritance. As noted by the Tanzanian Law Reform Commission, how estates are administered is as important as having a good law of succession; even if the law is good, poor administration — including undue delay — can cause many injustices.[520]

Judges and magistrates have played an instrumental role in ensuring that women are able to administer estates in appropriate cases, particularly where the deceased is the husband. For example, in the case of *Re Kibiego*, the Kenya High Court observed: "A widow is the most suitable person to obtain representation to her deceased husband's estate. In the normal course of events she is the person who would rightfully, properly and honestly safeguard the assets of the estate for herself and her children".[521] Similarly, in the Tanzanian case of *Ndossi v. Ndossi*, a widow successfully challenged the appointment of her deceased husband's brother as administrator of the estate in the district appellate court. On appeal, the court held that the widow was entitled to administer the estate on behalf of her children under the *Constitution of Tanzania*, which provides that "every person is entitled to own property and has a right to the protection of that property held in

accordance with the law".[522] Citing CEDAW articles 2(b) [obligation to adopt appropriate legislation and other measures prohibiting discrimination against women] and (f) [obligation to take measures to modify or abolish laws and customs that discriminate against women] and Article 3 of the *Convention on the Rights of the Child* [best interests of the child], the judge held that these provisions protect widows and children from "uncouth relatives prying and/or attempting to alienate the estate of the deceased fathers and mothers under the shield of custom".[523]

In addition to the issue of who is to administer the estate, other administrative issues can have significant ramifications with respect to women's rights, including:

- whether an inventory of the property comprising the estate is promptly and accurately produced;
- fees and administrative requirements;
- administrative processes resulting in lengthy delays; and
- obstacles to accessing magistrate or court offices.

To the extent that they can facilitate processes that are clear, efficient, accessible and respectful of the rights of all concerned parties — all while striking a balance between the need for efficient process and sufficient oversight and safeguards — judges and magistrates play an important, albeit indirect, role in reducing women's vulnerability to poverty and HIV.

Highlighted cases

South Africa: Court strikes down rule of male primogeniture as unconstitutional

Bhe and Others v. Khayelitsha Magistrate and Others, Case CCT 49/03, [2004] ZACC 17 (Constitutional Court of South Africa, 2004)

Parties

Three cases were heard together. First, Ms. Bhe — the spouse of the deceased — and the Women's Legal Centre brought a case on behalf of the couple's two minor daughters, in the public interest, and in the interest of the female descendants, descendants other than eldest descendants and extra-marital children. The respondent is the Magistrate of Khayelitsha, who appointed the father of the deceased as representative of the estate, along with the President and the Minister for Justice and Constitutional Development. The Commission for Gender Equality was admitted as *amicus curiae*.

In the second case, the applicant is Ms. Shibi, whose brother died intestate. The two respondents in the case were cousins of the deceased, his closest male relatives.

The third case was an application brought by the South African Human Rights Commission and the Women's Legal Centre Trust. The respondents were the President of South Africa and the Minister for Constitutional Development.

Remedies sought

In the first case (*Bhe*), the applicants sought interdicts pending the outcome of the case to prevent the selling of the immovable property and further harassment of Bhe by the father of the deceased. The applicants challenged the appointment of the deceased's father as heir and representative of the estate.

In the second case (*Shibi*), the applicant challenged the decision of the Magistrate in appointing the representatives of the deceased's estate. She sought an order declaring her the sole heir of the estate.

In the third case, the applicants sought a declaration that section 23 of the *Black Administration Act 38 of 1927*, which explicitly separated Black Africans from "people of European descent", was unconstitutional and invalid.

Outcomes

The majority of the Court found that the exclusion of women, female children and extra-marital children from inheritance violates the equality protection in section 9(3) of the Constitution, which prohibits unfair discrimination by the state "directly or indirectly against anyone" on grounds that include race, gender and sex, and the right of women to human dignity (section 10 of the Constitution). Section 23 of the *Black Administration Act* (the Act), the rule of male primogeniture (as it applies in customary law to the

inheritance of property), and section 1(4)(b) of the *Intestate Succession Act* were declared to be inconsistent with the Constitution and invalid. Section 1 of the *Intestate Succession Act*, which governs general principles of intestate succession, will apply to estates that would formerly have been governed by section 23 of the Act.

The daughters of Ms. Bhe are declared the sole heirs of their father's estate. Ms. Shibi is declared the sole heir of her brother's estate.

Background and material facts

In the first matter, Ms. Bhe and the deceased had a relationship and had lived together since 1990. They were poor and lived in an informal shelter. The deceased obtained state housing subsidies, which he used to purchase the property on which they lived, as well as building materials to build a house. However, he died before the house was built. The estate comprises the informal shelter, the property on which it stands, and miscellaneous items of movable property, including the building materials.

The Magistrate appointed the father of the deceased as representative and sole heir in accordance with section 23 of the Act and the regulations. The deceased's father stated that he intended to sell the immovable property.

In the second matter, Ms. Shibi's brother had died intestate in 1995. He was not married or party to any customary union. He had no children and was not survived by any parent or grandparent. His nearest male relatives were two cousins. The Magistrate appointed Mantebi Sithole (one of the male cousins) as representative of the estate. Relatives complained that Mr. Sithole was misappropriating estate funds, so the appointment was withdrawn and an attorney, Mr. Nkuna, was appointed to administer the estate and distribute the assets according to customary law. The estate was distributed to Jerry Sithole as the sole heir.

Legal arguments and issues addressed

The Court noted that section 23 was part of the *Black Administration Act* that was specifically crafted to separate and exclude Africans from "people of European descent"; it provides a scheme whereby the legal system that governs intestate succession is determined simply by reference to skin colour. As such, the Court concluded that section 23 of the Act and its regulations are manifestly discriminatory and in breach of section 9(3) of the Constitution. They concluded that such a racist framework intent on entrenching division and subordination could not be justified in any open and democratic society, and they invalidated that provision.

The effect of invalidating section 23 of the Act was that the rules of customary law governing succession were applicable, namely the customary rule of primogeniture. Both *Bhe* and *Shibi* challenged this rule.

The Court notes that it is important to examine the context in which rules of customary law operated and the kind of society served by them. The heir did not merely succeed to the assets of the deceased, but stepped into the shoes of the family head and acquired all the attendant rights and obligations. Women did not participate in the intestate succession of deceased's estates.

> The exclusion of women from heirship and consequently from being able to inherit property was in keeping with a system dominated by deeply embedded patriarchy which reserved for women a position of subservience and subordination and in which they were regarded as perpetual minors under the tutelage of the fathers, husbands, or the head of the extended family.

The Court looked at the effect of changing circumstances.

> The setting has however changed. Modern urban communities and families are structured and organised differently and no longer purely along traditional lines. The customary law rules of succession simply determine succession to the deceased's estate without the accompanying social implications which they traditionally had. Nuclear families have largely replaced traditional extended families. The heir does not necessarily live together with the whole extended family which would include the spouse of the deceased as well as other dependants and descendants. He often simply acquires the estate without assuming, or even being in a position to assume, any of the deceased's responsibilities.

The Court notes that the customary rules of succession have not been given the space to adapt and keep pace with changing social conditions and values, in part because they were captured in legislation. In effect, therefore, they have become increasingly out of step with the real values and circumstances of the societies they were meant to serve.

The basis of the constitutional challenge to the official customary law rule of succession was that the rule of primogeniture precludes:

- widows from inheriting as the intestate heirs of their late husbands;
- daughters from inheriting from their parents;
- younger sons from inheriting from their parents; and
- extra-marital children from inheriting from their father.

The Court held that the exclusion of women from inheritance on the grounds of gender is a clear violation of section 9(3) of the Constitution. It also violates section 10, which guarantees human dignity, in that it implies that women are not fit or competent to own and administer property, and it also subjects them to the status of perpetual minor, automatically placing them under the control of male heirs, simply by virtue of their sex and gender. It also discriminates by preventing all female children from inheriting and significantly curtailing the rights of male extra-marital children from inheriting. The limitation male primogeniture imposes on the rights of those subject to it is not reasonable and justifiable in an open and democratic society founded on values of equality, human dignity and freedom.

Note: There was a separate opinion issued in this case, concurring with the outcome. The dissenting judge limited his consideration to the rights of daughters and sisters to succeed a deceased male. He did not consider the right of widows to succeed their deceased husbands.

Commentary

This ruling set an important precedent, both in terms of how to interpret customary law under the new *Constitution of South Africa* and with respect to women's equality. It represented a significant step forward for women's right to inherit, demonstrating sensitivity to culture, yet recognising the harmful impacts of continuing discrimination against women. The analysis recognises changes in economic and social conditions, which offers an opening to consider the impact of the HIV epidemic on societies in future cases.

South Africa:
Court places husbands and wives on equal footing, invalidating "marital power" in customary marriages

Gumede (born Shange) v. President of the Republic of South Africa & Others, Case CCT 50/08, [2008] ZACC 23, Constitutional Court of South Africa

Parties

Ms. Gumede was a spouse in a customary marriage. The respondents include the President of South Africa, the Minister for Justice and Constitutional Development, the Premier of Kwazulu-Natal, the Kwazulu-Natal MEC [Member of the Executive Council] for Traditional and Local Government Affairs, and the Minister of Home Affairs. Ms. Gumede's husband is a named respondent but did not join issue with his wife's claim. Women's Legal Centre Trust was admitted as *amicus curiae*.

Remedy sought

Ms. Gumede sought confirmation from the Constitutional Court of an order, made in her favour by the High Court, of constitutional invalidity for the distinction made between marriages entered into before and those entered into after the *Recognition of Customary Marriages Act, 1998*.

Outcome

The order of constitutional invalidity made by the High Court was confirmed. No longer is there to be a distinction made between marriages entered into before and marriages entered into after the commencement of the Act.

Background and material facts

Ms. Gumede and her husband entered into a customary marriage in 1968. They remained married for more than 40 years and had four children. During the marriage, Ms. Gumede was not in formal employment; she maintained the household and was the primary caregiver to the children. Mr. Gumede received an employment income. Over time, the family acquired two homes. Ms. Gumede acquired the furniture and appliances for one of the homes.

At the time of the proceeding, Ms. Gumede and her husband lived separately; divorce proceedings were pending. Mr. Gumede received a pension from his employment. Ms. Gumede lived off a government pension and the occasional financial support received from her children.

Before a divorce was granted, Ms. Gumede approached the High Court to procure an order invalidating the statutory provisions of the Act that dictated that the proprietary consequences of her marriage be governed by customary law (according to the Act, marriages entered into before the commencement of the Act in November 2000 would be governed by customary law; those entered into after that date would be in community of property, except where the parties agree otherwise). She considered that this regime was unfairly discriminatory to customary law wives on grounds of gender and race.

In KwaZulu-Natal, where the Gumedes are domiciled, customary law has been codified in the *KwaZulu Act* and the *Natal Code*. These pieces of legislation provide that in a customary marriage, the husband is the family head and owner of all family property, which he may use in his exclusive discretion. Therefore, the wife will not have any claim to the family property.

The High Court found that the impugned provisions offend the equality protections afforded by sections 9(3) and (5) of the Constitution because they unfairly discriminate on the grounds of gender and race.

Legal arguments and issues addressed

The government contended that the legislative measures are constitutionally defensible because the Constitution obliges courts to apply customary law when it is applicable. The government further argued that the relief Ms. Gumede sought was premature and unnecessary because a decision on the proprietary consequences of her marriage was within the power of the divorce court.

In the decision, the Court provided a historical overview, noting that the Act represents a belated but welcome legislative effort to remedy the lack of recognition previously accorded to marriages that were entered into in accordance with the law and culture of the African people of this country. The legislation also entrenches the equal status and capacity of spouses, and it regulates the proprietary consequences of these marriages.

The impugned provisions fall into two categories: the provisions of the Act — sections 7(1) and (2) — that differentiate between the proprietary consequences of marriages entered into before and after the commencement of the Act, and the codified customary law in KwaZulu-Natal, which subjects a woman married
under customary law to the marital power of her husband, who is the exclusive owner and has control of all family property.

The Court notes that the provisions are self-evidently discriminatory on the ground of gender between the wife and the husband. The discrimination is on a listed ground and is therefore unfair unless it is established that it is fair (sections 9(3) and (5) of the Constitution). Within the class of women married under customary law, the legislation differentiates between a woman who is party to marriage entered into before the Act and a woman who is party to a marriage entered into after the Act. This differentiation is unfairly discriminatory.

The Court considered whether the discrimination could be justified. The Court recognised that the jurisdiction conferred on a divorce court by section 8(4)(a) of the Act means that every divorce court granting a divorce decree relating to a customary marriage has the power to order how the assets of the customary marriage should be divided between the parties, having regard to what is just and equitable in each case. That, however, is no answer to or justification for the unfair discrimination based on the listed ground of gender. The provisions of section 8(4)(a) of the *Recognition Act*, read together with sections 7(3), (4), (5), (6) and (7) of the *Divorce Act*, apply only upon dissolution of the customary marriage. This does not cure the discrimination that a spouse in a customary marriage has to endure during the course of the marriage. Further, if Ms. Gumede approached the divorce court relying on section 8(4)(a) of the *Recognition Act*, she might be severely prejudiced, because under the codified customary law, all the family property belongs to her husband.

In the words of the Court:

> This patriarchal domination over, and the complete exclusion of, the wife in the owning or dealing with family property unashamedly demeans and makes vulnerable the wife concerned and is thus discriminatory and unfair. It has not been shown to be otherwise, nor is there any justification for it.[524]

The retrospective effect of the order of invalidity was not limited.

Commentary

By terminating the husband's "marital power" over his wife and the couple's property, the Court put an end to blatant discrimination on the ground of gender. The Court helpfully articulated the vulnerability and poverty of women and children that resulted from the unequal position of spouses, having examined the substantive equality of the spouses within the contemporary social and economic system. The Court's reasoning is supportive of women's right to equality in marriage and has important potential to reduce poverty suffered by women and their children.

Chapter 9

HIV treatment and health care

Summary

In order to protect their health, people living with HIV need access to quality and comprehensive care. Central to effective HIV care is access to antiretroviral (ARV) medicines, which have transformed HIV disease from a rapidly progressing, fatal illness to one that is manageable (albeit still very challenging and chronic).

Currently, there is no cure for HIV infection and no preventive vaccine to protect against infection.

There are multiple barriers to ensuring access to antiretroviral treatment and other needed medications and health services. Some of these are the result of particular laws, policies or practices that may end up being contested before the courts.

The right to health is the most directly applicable human right with respect to HIV and AIDS-related treatment and health care.

Attention must also be paid to the right to privacy with respect to personal health information, the right to give informed consent (or refusal) to medical interventions, and the rights that more generally protect against mistreatment in a health-care setting.

Adjudicating cases involving access to HIV- and AIDS-related treatment and care: Factors to consider

1. **Applying the right to health: The question of justiciability**

   Some governments and commentators have maintained the position that economic, social and cultural (ESC) rights — such as the right to health — are not justiciable.

   Strong counter-arguments have been advanced, however, and numerous courts around the world have successfully adjudicated cases involving economic, social and cultural rights.

2. **Cost of treatment and intellectual property issues**

   One key factor affecting access to treatment is the cost to the purchaser. The high cost of medications can result in part from various legal sources, including whether international and domestic laws on intellectual property encourage or impede competition that lowers medicine prices.

   Access to lower-cost, generic medicines has been central to efforts to scale up access to ARVs and other medicines and diagnostics globally. Of primary concern with respect to patent protection that affects

access to generics is the World Trade Organization's *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS).

The TRIPS Agreement includes some flexibility that governments can use so that their intellectual property laws take health concerns into account. In 2001, World Trade Organization members adopted the *Doha Declaration*, in which they agreed that TRIPS should not prevent members from taking measures to protect the public health of their citizens.

3. Other factors in the social and/or legal environment affecting access to treatment

There are multiple factors that affect access to treatment. Some of these factors arise, in part or in whole, from law and policy.

Key impediments to access to treatment include:

- criminalisation of certain medication or treatment;
- stigma and discrimination; and
- insurance coverage of HIV-related treatment and care.

Introduction

In order to protect their health, people living with HIV need access to quality comprehensive care. Central to effective HIV care is access to antiretroviral medicines (ARVs), which have transformed HIV disease from a rapidly progressing, fatal illness to one that is manageable (albeit still very challenging and chronic). Access to care for opportunistic infections and HIV-related malignancies (e.g. tuberculosis, fungal infections, helminthic infections and cancers), as well as other infections and health conditions (e.g. sexually transmitted infections [STIs], reproductive health services, mental health services, rehabilitation services, palliative care, addiction treatment, etc.) are also essential components of care and contribute to effective HIV prevention efforts.

Left untreated, HIV continues to infect CD4 cells (part of the immune system) and other cells in the body. Without treatment, a person's immune system becomes increasingly weakened by HIV and unable to defend against opportunistic infections and some cancers, ultimately resulting in a diagnosis of acquired immune deficiency syndrome (AIDS) when certain clinical criteria are satisfied and, eventually, in death. Treatment for opportunistic infections and malignancies is therefore also a key element of HIV-related care and treatment.

Currently, there is no cure for HIV infection and no preventive vaccine to protect against infection.[525] However, since HIV was first identified in the early 1980s, some two dozen effective antiretroviral medications have been developed, tested through clinical trials, and approved for use in treating people with HIV.[526] By 1996, researchers had established that combining different medications and disrupting HIV's viral cycle at different points simultaneously could produce dramatic results for the health of people living with HIV. When successful, highly active antiretroviral therapy (HAART) — usually involving the combination of at least three different medications — practically stops HIV from replicating, thereby lowering the person's viral load (i.e. the amount of virus circulating) and allowing their immune system to maintain or recover its strength and keep them healthy. The success of antiretroviral treatment depends on factors such as:

- the potency of the particular regimen;
- whether the person's virus already has some resistance, or becomes resistant to, certain drugs being used;
- how high the person's viral load and CD4 cell counts were when starting treatment; and
- the person's adherence to their regimen.

If treatment is stopped, viral load will rebound and the damage to the immune system will resume and increase.[527]

With a stronger immune system, the risk of serious infections is lessened, reducing the morbidity associated with HIV infection and prolonging the duration and quality of a person's lifespan. Suppressing HIV through antiretroviral medications is also thought to reduce inflammation in the body's systems, thereby helping prevent the damage to the cardiovascular system and other organs that is sometimes seen over time with HIV replication and disease progression. HIV infection obviously remains a serious infection with the potential for serious consequences if not successfully clinically managed. However, with access to HAART and other quality health care, the lifespan of those newly diagnosed with HIV at this point in the epidemic approximates that of people who are HIV-negative.

Having access to appropriate health care and treatment represents the difference between life and death for many people living with HIV. Therefore, when cases regarding access to treatment come before them, courts, judges and magistrates are challenged to apply human rights standards and the best available evidence so as to maximise the benefits of life-saving medications and care.

There are multiple barriers to ensuring access to antiretroviral treatment and to other needed medications and health services. Some of these are the result of particular laws, policies or practices that may end up being contested before the courts. Other barriers may be extra-legal in nature; nonetheless, the law, and its interpretation and application, may have a role to play in addressing them. It is therefore useful for judges and magistrates to understand the basics of HIV-related treatment and to appreciate some of the ways in which the law can promote or hinder access to treatment.

(See Part 1: The science and medicine of HIV, for further information.)

In addition to the question of rights to health care, there are key human rights issues that arise in the context of seeking and receiving health care, both for people living with HIV and for populations at greater risk of HIV. In particular, attention must be paid to the right to privacy with respect to personal health information, the right to give informed consent (or refusal) to medical interventions, and the rights that more generally protect against mistreatment in a health-care setting. These human rights are of concern per se, but whether or not they are respected also will have a significant impact on the ability and willingness of HIV-positive people to seek care. While not the primary focus of this chapter, judges and magistrates may also be called upon to adjudicate cases in which these human rights are engaged.

Access to treatment and other health care: Human rights standards

International law

What is commonly referred to in abbreviated form as "the right to health" finds expression in numerous legal instruments adopted within the UN system, beginning with the *Universal Declaration of Human Rights*. The *International Covenant on Civil and Political Rights* (ICCPR) recognises the right to life. This has been interpreted as requiring states to adopt positive measures "to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate [...] epidemics".[528] In the context of HIV, this obviously requires access to ARVs and other forms of care and treatment. Particularly significant is the *International Covenant on Economic, Social & Cultural Rights* (ICESCR), which broadly recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[529] As the most encompassing treaty setting out governments' obligations regarding the right to health, it is discussed in more detail below.

Numerous declarations and treaties concluded at a regional level also recognise and create a right to health in international law.[530]

International Covenant on Economic, Social and Cultural Rights: Leading treaty on health

International Covenant on Economic, Social and Cultural Rights: The right to health

Article 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.

(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:

(a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 2 (1) Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

(2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

In its *General Comment No. 14*, adopted in 2000, the Committee on Economic, Social and Cultural Rights laid out the most authoritative interpretation by expert jurists of the right to the health. Noting that "health is a fundamental human right indispensable for the exercise of other human rights",[531] the Committee clarified that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".[532] In particular, the Committee explains that the right to health requires that these facilities, goods and services be available, accessible, acceptable and of good quality.[533] With respect to the element of "accessibility", there are four overlapping dimensions.

- Non-discrimination: "[H]ealth facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds".[534]
- Physical accessibility: Health facilities, goods and services must be within safe physical reach for all sections of the population, and they must also be accessible for persons with disabilities. In addition, the underlying determinants of health (e.g. potable water and adequate sanitation facilities) must be accessible.
- Economic accessibility (affordability): "[H]ealth facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households".[535]

- Information accessibility: "[A]ccessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality".[536]

Furthermore, with respect to the obligation to prevent, treat and control diseases as set out in ICESCR Article 12(2)(c), the Committee notes that this requires "States' individual and joint efforts to, *inter alia*, make available relevant technologies",[537] such as medicines and related diagnostic tools. With respect to the obligations to ensure universal access to medical service and attention as set out in ICESCR Article 12(2)(d), the Committee notes that this "includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care".[538]

The Committee has also clarified, in its *General Comment No. 3*, that states have different sorts of obligations under the ICESCR, including those of "progressive realization".[539] Specifically with regard to realising the right to health, in its *General Comment No. 14*, the Committee notes that states have "immediate obligations in relation to the right to health, such as ... the obligation to take steps (article 2(1)) towards the full realization of article 12 [the right to health]. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health".[540] Furthermore, states "have a specific and continuing obligation to move as expeditiously as possible toward the full realization" of the right to health,[541] and "as with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible".[542] This includes "the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health"[543] — this would obviously preclude the adoption of legislation that it will foreseeably hinder equitable access to medicines or other forms of care. This "principle of non-retrogression" is an important factor for consideration by courts when considering actions taken by government and possible challenges to them.

Access to medication has been recognised specifically as a fundamental component of fully achieving the highest attainable standard of health, by international and regional human rights tribunals, the UN's expert human rights committees, UN agencies, and states themselves.[544] For example, international treaties such as the ICCPR and ICESCR, as well as regional treaties and domestic constitutional expressions of human rights to life and/or health (or some variant thereof), have been the bases on which numerous courts have ordered government action to ensure, or at least promote, access to HIV and AIDS medications.[545]

Adjudicating cases involving access to HIV- and AIDS-related treatment and care: Factors to consider

1. Applying the right to health: The question of justiciability

Human rights, such as the right to health, have formed part of international law for at least 60 years, and they appear in the national constitutions of at least 60 countries.[546] Yet some governments and commentators have maintained the position that economic, social and cultural (ESC) rights — such as the right to health — are not justiciable. Several of the arguments and counter-arguments about the question of justiciability of such rights are outlined below.

The primary objection is that such rights are "so vague or uncertain in character that their content cannot be adequately defined".[547] A report published by the International Commission of Jurists (ICJ) addresses this objection as follows:

> The merits of this argument need careful examination…. Without clear requirements for the content and scope of a right, combined with a failure to identify rights-bearers and duty-bearers, judicial enforcement would be difficult…. However … many legal rules are expressed in broad terms and, to a certain extent, unavoidably general wording. Thus, "classic" rights such as the right to property, freedom of expression, equal treatment or due process face this hurdle to the same extent as ESC rights. Yet this has never led to the conclusion that these "classic" rights are not rights, or that they are not judicially enforceable. On the contrary, it has resulted in ongoing efforts to specify the content and limits of these rights, through a series of mechanisms aimed at defining their meaning (for instance, the development of statutory law-making, administrative regulation, case law and jurisprudence).[548]

In defining the content of ESC rights, such as the right to health, courts may have regard to a variety of sources, including statutory definitions, international or regional bodies established under human rights treaties, international experts (such as UN Special Rapporteurs or working groups, as well as leading jurists), and jurisprudence from international tribunals or treaty bodies and domestic courts.

For example, the Constitutional Tribunal of Ecuador looked to multiple sources when faced with interpreting the rights to health and life when four people living with HIV in need of medications brought an application against the Minister of Public Health and the Director of the National Programme on HIV/AIDS and Sexually Transmitted Infections.[549] The Constitutional Tribunal's analysis began with the proposition that the State of Ecuador must protect the right to health of its people, as recognised in the 1948 *American Declaration of the Rights and Duties of Man* (Article XI) and in the 1988 *Protocol of San Salvador* that supplements the original 1969 *American Convention on Human Rights*. The Constitutional Tribunal also expressly noted that Ecuador had adopted the *Declaration of Commitment on HIV/AIDS* from the 2001 UN General Assembly Special Session on HIV/AIDS, in which all Member States of the Assembly committed to ensuring access to treatment for all and to establishing or strengthening effective systems for supervising, promoting and protecting human rights of people living with HIV.

The Tribunal also noted the obligation of the state under Ecuador's Constitution to guarantee the promotion and protection of health (Article 42), and the constitutional declaration that public health programmes and measures shall be free for all, while public medical care services will be for those who need them (Article 43). The Tribunal also considered a number of statutes dealing with HIV and AIDS and with health, including the 2002 *Ley Orgánica del Sistema Nacional de Salud* (Organic Law of the Health System) the *Código de la Salud* (Health Code), the 2000 *Ley para la Prevención y Asistencia Integral del VIH-SIDA* (HIV/AIDS Prevention

and Comprehensive Care Act) and the 2002 *Reglamento para las personas que viven con el VIH-SIDA* (Regulation applicable for persons living with HIV/AIDS).

Having surveyed the applicable legal provisions, the Tribunal found that the state had positive obligations in relation to social rights; these norms gave rise to immediate obligations, had "full juridical force", and could be applied by the courts. Based on the record before it, the Tribunal concluded that the Ministry of Health had not met its obligation to ensure the supply of needed antiretroviral drugs, which had caused grave harm to the applicants with HIV and violated their rights as protected by the national constitution and international instruments ratified by Ecuador. The Ministry had breached the fundamental rights to life and to health of the applicants. The Tribunal therefore ordered the Ministry to take immediate steps to ensure access to the necessary antiretroviral drugs whose supply had been interrupted and to ensure access to related testing services to inform the use of these treatments.

A second objection is that ESC rights (such as the right to health) should not be considered justiciable because:

- courts are ill-equipped to adjudicate matters of social policy; and
- such matters are properly in the domain of other branches of the state (i.e. the legislative and executive branches) that should not be subject to review or interference by the judiciary.

In response to this argument, the ICJ report points out:

> The issue is not whether the judiciary should have the leading role in the implementation of public policies intended to comply with constitutional or international ESC rights obligations. Such a proposition would be difficult to support. Rather, the fundamental question is what role the courts should have to supervise the implementation of these policies, according to constitutional, international human rights or legal standards.[550]

For some, one area of particular concern with courts adjudicating ESC rights claims is the question of judicial interference with budgetary allocations by the state. The counter-argument is that judicial decisions regarding civil and political rights also have cost implications. Breaches of such rights may lead to financial compensation, and remedying or preventing breaches may require the adoption of legislation or regulations, or the expenditure of funds (e.g. to ensure fair trials in a functioning criminal justice system, minimum standards of detention, or free and fair elections). The mere fact that courts' rulings may affect the state's budgetary allocations is not thought to be a sufficient reason to deny the enforceability of civil and political rights.[551] The Committee on Economic, Social and Cultural Rights has also underscored the particular importance of courts when it comes to protecting ESC rights:

> While the respective competences of the various branches of government must be respected, it is appropriate to acknowledge that courts are generally already involved in a considerable range of matters which have important resource implications. The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.[552]

For example, the Supreme Court of India has ruled against the state for its failure to provide emergency medical treatment as required by the Constitution, ordering it to take corrective measures, notwithstanding that this would necessarily require the expenditure of public funds.

> It is no doubt true that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the constitutional obligation of the State to provide adequate medical services to the people…. In the context of the constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints…. The said observations would apply with equal, if not greater, force in the matter of discharge of a constitutional obligation of the State to provide medical aid to preserve human life. In the matter of allocation of funds for medical services the said constitutional obligation of the State has to be kept in view. It is necessary that a time bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by us and steps should be taken to implement the same.[553]

Finally, a third argument against the justiciability of rights (such as the right to health) is that the judicial process itself is inherently ill-suited to address ESC rights because the judiciary lacks the knowledge or expertise to adjudicate properly complex social policy matters, because it has limited capacity to enforce decisions related to such rights, and because courts' procedural mechanisms are limited or inadequate to protect such rights effectively.[554] In response, the ICJ report offers a number of observations on these points.

First, it is worth noting that judges appropriately and competently adjudicate cases in many fields that are technically complex (e.g. telecommunications, antitrust law, or environmental law)[555] — indeed, many civil litigation and criminal proceedings can involve complex scientific or other technical evidence. Second, while there are legitimate concerns about the limited ability of the courts to ensure that other branches of government comply with their orders, this is not a concern restricted to ESC rights such as the right to health: "the same argument would apply to any decision regarding State obligations in any other field of law".[556] Third, there are indeed limitations to what court procedures can accommodate procedurally and remedies that may be fashioned to address infringements of human rights.[557] Experience to date suggests that some courts adjudicating these sorts of human rights cases have risen to this challenge, making findings regarding states' obligations and fashioning remedies that seek to protect effectively and contribute to the achievement of human rights. As noted by the ICJ report in its review:

> Judges usually assess the course of action undertaken by the duty-bearer in terms of legal standards such as "reasonableness", "proportionality", "adequacy", "appropriateness" or "progression". Such standards are not unknown to courts when they carry out judicial reviews of other types of decisions taken by the political branches.[558]

In the event of finding a breach by the state of its obligations to respect, protect and fulfil human rights, many established and commonly used remedies can be equally applicable in the context of ESC rights — including ordering monetary compensation to an injured party, imposing administrative or criminal penalties on the party responsible for the violation (with due regard to considerations of proportionality), or various other orders aimed at preventing further or future violations in the case of a particular individual or a broader group of affected persons (e.g. injunctions prohibiting or mandating certain conduct).

Courts may also order remedies that are more "structural" than individual and that may, in some cases, include a greater degree of on-going "supervisory" involvement by judges. Various courts have crafted remedies that would not only address the situation of a particular plaintiff before the court, but would also hold the potential for redressing a systemic situation resulting in identical or similar violations affecting many others.

One example is the South African case of *Minister of Health and Others v. Treatment Action Campaign and Others.*[559] In this case, the Court considered that the government's refusal to make the antiretroviral drug nevirapine available to pregnant women outside certain pilot sites as a means of reducing the risk of transmission of HIV from mother to child during pregnancy and birth. The Court found that the state had not satisfied its legal obligation to take "reasonable measures" within its available resources to achieve progressively the highest attainable standard of health. The Court held that the government was constitutionally obliged "to devise and implement within its available resources a comprehensive and coordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV".[560]

Human rights in health-care settings

In addition to the question of rights to health care (the focus of this chapter), there are key human rights issues that arise for people living with HIV, and for those vulnerable populations at greater risk of HIV, in the context of seeking and receiving health care. These human rights in health care are obviously of concern per se, but respecting or disrespecting them will also have a significant impact on the ability and willingness of people to seek care (and, depending on the circumstances, they also may have an effect on public health more broadly). Judges and magistrates may be called upon to decide cases in which the following human rights are engaged:

a. The right to give informed consent (or refusal) to medical interventions

The requirement to obtain informed consent for any medical interventions (including diagnostic tests and treatments) derives from the right to security of the person, as well as the right to information. Article 12 of the *International Covenant on Economic, Social and Cultural Rights* includes the right to be free from "non-consensual medical treatment" and to receive full information about health and health procedures.[561] With few, very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment.

Fully informed consent for HIV testing has long been considered good health practice and respectful of human rights. Nonetheless, calls for compulsory or forced HIV testing continue to emerge in instances of occupational and non-occupational exposure to blood or body fluids, and legislation to this effect has been adopted in some jurisdictions despite human rights concerns. Moreover, some now suggest that testing procedures and policies should be modified to reduce emphasis on "the three Cs" (that is, informed consent, pre- and post-test counselling, and confidentiality) and the human rights protections they represent. For example, some countries have adopted policies on HIV testing for pregnant women that place the onus on the woman to refuse or "opt-out" of an HIV test that will otherwise be done. Similarly, "routine testing" initiatives (sometimes also referred to as "provider-initiated testing") are being pursued in some settings. These risk infringing human rights if informed consent — which should be aided by good-quality counselling, the length and detail of which can be varied to suit the patient — is not guaranteed by explicit law or institutional policy, encouraged by proper training of testing providers and respected by them in their practice. Judges may be called upon to ensure that health policy and health-care providers respect the legal and ethical requirement of informed consent in all settings, including those where programmes and practices are aggressively encouraging or pursuing HIV testing as a "routine" part of health care.

Informed consent applies not only to HIV testing, but to all medical interventions, including HIV treatment, drug dependence treatment or sexual and reproductive health services.[562] It follows that compulsory or coercive treatment must be used only as measures of last resort, and it always requires justification according to established principles for human rights derogations, such as the *Siracusa Principles* and any applicable statutory or constitutional requirements under domestic law.[563] Only in exceptional circumstances — such as necessity to prevent imminent harm to oneself or to others — would the possibility of involuntary treatment being justified even arise.

b. The right to privacy with respect to personal health information

Privacy rights are particularly pertinent with respect to HIV testing and treatment. Personal health information is considered to be one of the most sensitive categories of information and deserving of special protection. The right to privacy is guaranteed in several international and regional human rights treaties, including the *International Covenant on Civil and Political Rights* (Article 17), the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (Article 8), and the *American Convention on Human Rights* (Article 11). Except in narrow circumstances that must be legally and ethically justified, all people should have the power to decide how, when, to whom and to what extent their personal health information is shared. Moreover, a breach of the right to privacy often leads to breaches of other human rights, such as the rights to life, liberty, security of the person, to work and free choice of employment, and to adequate housing and medical care.

In the *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and the United Nations High Commissioner for Human Rights note specific concerns about intrusions upon both bodily integrity and privacy in the context of HIV testing.

> The individual's interest in his/her privacy is particularly compelling in the context of HIV, firstly, in view of the invasive character of a mandatory HIV test and, secondly, by reason of the stigma and discrimination attached to the loss of privacy and confidentiality if HIV status is disclosed. The community has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV prevention and care services. The interest in public health does not justify mandatory HIV testing or registration, except in cases of blood/organ/tissue donations where the human product, rather than the person, is tested before use on another person. All information on HIV sero-status obtained during the testing of donated blood or tissue must also be kept strictly confidential.[564]

c. Protection against abuse, mistreatment and discrimination in health-care settings

In addition to violations of personal integrity through testing or treatment without informed consent, people living with HIV and members of the key populations at higher risk of HIV have at times been denied appropriate, compassionate and ethical care from health-care providers. Abusive or inappropriate health care may amount to discrimination, a violation of reproductive and family rights or even, depending on the circumstances, torture or other cruel, unusual or degrading treatment or punishment.[565] The prohibition on torture or other cruel, unusual or degrading treatment or punishment is a peremptory norm of customary international law, binding on every state.[566] Courts may be called upon to remedy such abuses and, through their judgments, to reduce the likelihood of further violations.

For example, women living with HIV report being mistreated by nurses and doctors when they present at health-care facilities for labour and delivery, and coerced sterilisation of HIV-positive women has been documented in multiple countries.[567] Other examples of particular relevance in the context of HIV, and for key populations affected by HIV, can be identified. These include being subjected to experimental or unscientific treatments, as well as physical abuse, in the name of "treatment" — something that has been observed in the context of compulsory detention for "rehabilitation" of people who use drugs,[568] and enforced psychiatric "treatment" because of a person's real or perceived sexual orientation or gender identity.[569] People with disabilities or mental health problems may be particularly vulnerable to involuntary "treatment" violating human rights.[570] In other cases, the state may withhold health services unjustifiably from certain groups, such as denying those in detention access to HIV prevention services or adequate medical care,[571] notwithstanding the well-established legal principles that those detained by the state have the right to receive health care and treatment equivalent to that available in the community.[572] Some health-care providers may also deny treatment on discriminatory grounds (e.g. by refusing to treat people because of their HIV-positive status, race or ethnicity, religion, migrant status, sexual orientation, gender identity or presentation, involvement in sex work, etc.).

2. Cost of treatment and intellectual property issues

One key factor affecting access to treatment is, of course, the cost to the purchaser, whether it is the individual paying for medications out of pocket or a government or private insurer covering the cost. The high cost of medications can result in part from various legal sources, including whether international and domestic laws on intellectual property encourage or impede competition that lowers medicine prices. Patents and other intellectual property rights are not absolute; governments commonly legislate in relation to pricing, licensing and distribution of drugs. Courts may be called upon to rule in cases challenging patents (or patent applications) on antiretroviral drugs or other technologies, challenging anti-competitive behaviour or other abuse of patent rights by patent-holders, or seeking licences to enable the production of generic formulations of pharmaceutical products (for domestic sale or export).

Access to lower-cost generic medicines has been central to efforts to scale up access to ARVs and other medicines and diagnostics globally. The available global data demonstrates that competition by generic producers, where feasible, has had the most significant and sustained effect in lowering prices for ARVs for developing countries.[573]

This means that rules on intellectual property (including on patents and other "industrial property") are an important dimension of the law affecting access to health goods such as medicines, depending on the extent to which they constrain or facilitate generic competition. Such rules are to be found in international law and domestic intellectual property law. Of primary concern globally is the WTO's *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS).[574] Other bilateral or regional trade and investment agreements, however, may also contain provisions on intellectual property rights — in some cases, these are more stringent than the TRIPS provisions and raise additional questions about the impact on access to medicines and other health goods. Courts may be called upon to interpret the significance in domestic law of those provisions, including in light of other obligations binding on the state (e.g. constitutional or other obligations to ensure or promote equitable access to medicines).

One issue that may arise in front of courts that has implications for access to medicines is the validity and scope of patents. Depending on the applicable law, such disputes may arise when an application for the grant of a patent is made (which could include a pre-grant opposition from someone other than the patent holder) or after a patent has been granted (a post-grant challenge). While the exact wording of domestic patent law and its interpretation will vary across jurisdictions, the gist of three common criteria for patentability can be summarised as follows. In order to get a patent, the applicant needs to demonstrate that the product or process:

- is novel;
- reflects some inventive step (i.e. it was not obvious); and
- is capable of industrial application (i.e. is not merely abstract knowledge).[575]

How liberally or strictly courts interpret these requirements for patentability will affect the degree to which medicines or other pharmaceutical products and processes are tied up by patents or are able to be reproduced by competitors. How the product or process is described, and the coverage of the patents claimed, determines the extent of the patent-holder's monopoly and hence the space open to competitors. Therefore, courts' interpretation of patent claims will have an impact on access to medicines.

The case summarised below, brought before the Thai courts by the AIDS Access Foundation and others, is one illustration of the importance of careful scrutiny of patent claims — the case involved a claim to wide patent coverage over a particular ARV medication (didanosine) by the brand-name pharmaceutical company

Bristol-Myers Squibb. As a result of the court's findings in favour of the plaintiff, a potential barrier to the domestic, and much cheaper, production of a generic ARV was removed, thereby enabling access to an important medication for a much greater number of Thai people living with HIV.

Interpretation of other laws can also have a direct impact on access to medicines. For example, Kenyan courts have been called upon to address the validity of legislation with a definition of "counterfeit" products that was deemed overly broad, such that it misleadingly and inaccurately treated approved generic medicines as "counterfeits". In 2012, the High Court of Kenya held that the Kenyan *Anti-Counterfeit Act*, as it affects accessibility to and affordability of essential generic drugs, violates the rights to life, dignity and health that are enshrined in the country's constitution.[576] The petition was originally brought by three people living with HIV who had been receiving free first-line antiretroviral medication for themselves or for family members.[577] The petitioners could not afford the price being charged by the originator, a brand-name pharmaceutical company, and they argued that the Act jeopardised their ability to access antiretrovirals, as its enforcement would deny petitioners the opportunity to obtain generic medication.[578] The High Court of Kenya agreed with the petitioners, finding that while intellectual property rights should be protected, this should not be done at the expense of jeopardising "fundamental rights such as the right to life of others".[579]

Similarly, at this writing, litigation proceeds before the Indian courts in which patients' rights groups and generic manufacturers are challenging the patent claimed by the pharmaceutical company Novartis on the anti-cancer drug imatinib mesylate (marketed as "Gleevec" or "Glivec"). The outcome of the case will determine not only the patenting of this particular drug, but also the scope of provisions in India's *Patent Act* that, in the interests of safeguarding public health, attempt to prevent "evergreening" of patents (and hence the on-going monopolies on medicines of a patent-holder).[580] The provisions of Indian law that are being challenged limit the ability of a pharmaceutical company to obtain patents on "new" forms of already-known drugs unless those new forms represent a significant therapeutic advancement.[581]

Flexibilities in limiting exclusive rights under patents are another significant aspect of the law where courts play an important role. As a general rule, it is illegal to copy or sell any drug that is still under patent. However, the TRIPS Agreement does include some flexibility that governments can use in making and implementing their intellectual property laws in ways that take health concerns into account. The World Health Organization has recognised that TRIPS rules can adversely affect public health and has supported full use of the crucial safeguards to mitigate this impact.[582] In 2001, WTO members adopted the *Doha Declaratio*n in which they agreed that TRIPS should not prevent members from taking measures to protect the public health of their citizens.[583] The Declaration reaffirms that countries may use "flexibilities" in TRIPS to overcome the barriers posed by patents.

One important "flexibility" is the practice of "compulsory licensing" (allowed under Article 31), which authorises a generic drug manufacturer to make a therapeutically equivalent version of a patented product without the consent of the company holding the patent. In exchange, as specified in TRIPS Article 31(h), the patent-holder must be paid "adequate remuneration in the circumstances of each case, taking into account the economic value of the authorization" (e.g. a royalty). The patent-holder retains all other rights over the patented product (including, of course, the right to continue to sell the product), but now they face a competitor in the market. Under TRIPS Article 31(i), decisions about issuing a compulsory licence must be subject to "judicial review or independent review by a distinct higher authority". Therefore, how courts interpret applicable provisions about compulsory licensing will have an impact on whether this policy tool can be used effectively to promote "access to medicines for all", as agreed unanimously by WTO members in the Declaration.

In 2003, WTO members agreed on a mechanism that would permit compulsory licensing to be used primarily or exclusively for the purposes of exporting or importing generic versions of patented medicines across national boundaries.[584] The objective of this decision was to enable countries with insufficient capacity to manufacture their own generic medicines to "make effective use" of compulsory licensing by securing more affordable medicines from generic producers in other countries. While a number of countries have adopted domestic legislation, regulations or similar instruments based on this agreement at the WTO level, to date there has been little use of such mechanisms. Courts may be called upon in future to interpret provisions of such laws, if and when attempts are made to use them, should such efforts provoke litigation by patent-holders challenging their use. Those decisions will affect the degree to which such laws or regulations are seen as viable mechanisms for cross-border supply of lower-cost, generic pharmaceutical products.

Competition laws may also be invoked before courts in an effort to secure greater access to medicines. For example, the Competition Commission of South Africa addressed the issues of abusive pricing and anti-competitive practices in a complaint filed by the Treatment Action Campaign (TAC) and others against two multinational pharmaceutical companies in 2002.[585] South Africa's *Competition Act* of 1998 prohibits a firm that is dominant in the marketplace from charging "an excessive price to the detriment of consumers".[586] The complainants alleged that the companies had engaged in excessive pricing of several antiretrovirals to the detriment of consumers, with the direct consequence of premature, predictable and avoidable deaths from AIDS. The complaints put forward detailed evidence comparing the prices available in South Africa from the patent-holders for the originator, brand-name product to the best prices offered by generic manufacturers.

The complainants outlined how the high prices charged by the pharmaceutical companies in question limited access to life-saving and life-enhancing treatment in both the public and private sectors. This included creating a further barrier to government adopting a comprehensive public sector HIV and AIDS treatment plan. In the case of those who had to pay for their own medicines in the private sector or those who had limited coverage under medical insurance plans (e.g. through their employment), such high prices also resulted in a lack of treatment, substandard treatment or limited appropriate treatment options.[587]

Under South Africa's *Competition Act*, the price being charged by the dominant firm must not only be to the detriment of consumers but must also be shown to be "excessive". The statute defines an "excessive price" as one that bears "no reasonable relation to the economic value" of the good or service in question. The complainants argued that the prices charged by the two companies were "grossly disproportionate to the economic value of the goods, even when taking into account the cost of production, research and development costs and an appropriate rate of profit".[588]

On 16 October 2003, the Competition Commission (the agency tasked with investigating competition concerns) issued its decision, which found merit to the complaint, but which also went further. Not only did the Commission agree that the two companies had engaged in excessive pricing, it also reported that it had found evidence of two other contraventions of the *Competition Act* in the companies' refusal to grant licences to generic manufacturers. The Commission indicated that it would put the results of its investigation before the Competition Tribunal (the adjudicative body) and request that the Tribunal grant compulsory licences to generic competitors to facilitate access to a sustainable supply of less expensive antiretrovirals for South Africans.[589] As a result of the Commission's findings, GlaxoSmithKline and Boehringer Ingelheim came under intensified pressure to reduce the prices of their medicines in the South African market and to grant licences to generic manufacturers to produce these products. On 10 December 2003, TAC and the other complainants announced they had reached agreements with the two companies to settle the Competition Commission complaints. The effect of the agreements was to allow a previous deal negotiated by the Clinton Foundation, announced a week after the Commission's decision in October 2003, to be implemented,

meaning that four generic pharmaceutical companies would sell triple-drug antiretroviral therapy to governments in sub-Saharan Africa at US$140 per patient per year, representing a reduction of approximately 90% in the cost of treatment.

3. Other factors in the social and/or legal environment affecting access to treatment

There are multiple factors that affect access to treatment. These include the cost of medications, the infrastructure that delivers that medication, the social environment and practices of health-care providers, and the legislation that prohibits or restricts access to certain forms of care. Some of these factors arise, in part or in whole, from law and policy; others may not be primarily legal in origin, but, may be amenable to possible remedies through legal proceedings, depending on the legal tools available to be applied under international or domestic law and the judicial approach to using those tools. Some of the key factors affecting access to treatment are noted below (and some are discussed in more detail elsewhere in this handbook); in addition, a number of case summaries illustrate how some courts have handled these issues.

a) Criminalisation of medication or treatment

One important consideration is criminal (or other) laws, regulations or policies that prohibit or heavily restrict the provision of certain kinds of medications or treatment. In the context of HIV, this issue arises in relation to access to medications such as methadone for pain management or substitution therapy (in the case of persons with opioid dependence). Access to a controlled substance such as marijuana for medicinal purposes is another example of particular relevance, given its potential therapeutic benefits for some people living with HIV.

Courts in Canada have grappled with the criminal prohibitions against certain controlled substances with medicinal uses. In the case of *R. v. Parker*, for example, the Ontario Court of Appeal found that the prohibition on the possession and cultivation of marijuana violated the accused's rights to liberty and security of the person.[590] He used marijuana to treat his epilepsy and therefore the blanket prohibition, without an exception for medical use, interfered with his right to make choices concerning his own body and did not accord with the principles of fundamental justice. It was therefore found to be unconstitutional.

Human rights concerns were also raised in a 2003 Canadian case regarding the provision of methadone maintenance treatment (MMT) in prison.[591] The applicant sought to continue his MMT while serving a prison sentence, but the correctional facility did not have a methadone programme. The Court ordered that he be provided with MMT on an interim basis until the application could be heard.[592] The judge remarked that the denial of MMT was wrong, stating "they have no right to torture your client, none whatsoever. It's almost like keeping food away from him, starving him. He needs this. It's a medical necessity".[593]

b) Stigma and discrimination

A social environment that stigmatises HIV and people living with (or perceived to be living with) HIV, as well as various populations particularly affected by HIV (e.g. men who have sex with men, sex workers, people who use drugs, prisoners or people with disabilities) is one powerful barrier to HIV treatment and care. When prejudices and stigmatising attitudes manifest in discriminatory conduct and policies, this further impedes access. Discrimination is an underlying factor in many cases of failure to provide appropriate HIV-related health care or treatment.

Various populations may face distinct obstacles in accessing care and treatment, but all raise questions about how legal standards may be applied to remedy and prevent unjustified discrimination in the provision of care. For example, people in prison should have the same rights to health as people in the general population, yet in many prisons, HIV-related treatment and health care is not available. Similarly, people who use drugs may be denied access to HIV-related treatment and care under the assumption that they will not be able to adhere properly or because they are seen to be responsible for their own infection and therefore not worthy of expensive treatments.

Treatment access for prisoners

The High Court in Durban, South Africa, ruled on the issue of access to HIV treatment while in prison in a 2006 case brought on behalf of 15 people serving prison sentences in Westville Correctional Centre.[594] The Court accepted that the authorities were legally and constitutionally bound to provide adequate medical treatment to prisoners who need it and that the applicants thus had the right to antiretroviral treatment. As the applicants did not have access to HIV-related health care in accordance with the National Department of Health's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*, the Court ruled that the respondents had not fulfilled their constitutional obligations.

c) Insurance coverage of HIV-related treatment and care

The extent of coverage of HIV-related medications and other forms of treatment under private and public health insurance plans is a key factor in determining, for a majority of people living with HIV, the degree to which they can have access to HIV-related care. When a government or other insurer is not supplying or covering the costs of obtaining ARVs or other HIV-related care, most often the justification is the high costs of these medications and the lack of resources to provide them to everyone in need. Courts should thus consider whether financial constraints can justify denying treatment to people living with HIV. In so doing, courts will need to consider any applicable laws against discrimination (and the extent to which those laws may limit insurers' freedom to exclude or cap coverage), as well as any applicable obligations on the state to ensure access to adequate coverage under public or quasi-public health insurance plans (or through the regulation of the private insurance sector). Some of the cases below (e.g. *Bermudez* and *Lopez*) explore these issues in the context of challenges to remedy the exclusion of HIV treatments from such plans.

Highlighted cases

Venezuela: Supreme Court orders government and social security institute to ensure universal access to antiretroviral medications and other HIV-related diagnostics and treatment

Cruz del Valle Bermudez et al. v. Ministerio de Sanidad y Asistencia Social, Supreme Court of Venezuela, Decision No. 916, Court File No. 15.789 (1999)

López et al. v. Instituto Venezolano de los Seguros Sociales, Supreme Court of Venezuela, Judgment No. 487-060401 (2001)

Background

Before ruling in the two cases summarised here, Venezuelan courts, including the highest court in the country, had repeatedly recognised that the government must take positive action to ensure that people living with HIV have access through various social insurance schemes, including antiretroviral drugs, medicines for the treatment of opportunistic infections and specialised laboratory tests necessary for the effective treatment of HIV and opportunistic infections.

For example, in *NA v. Ministerio de Sanidad y Asistencia Social* [Ministry of Health and Social Assistance], the Supreme Court ruled against the Ministry of Health, which had failed to ensure coverage for HIV medications through the public health-care system. (This system is the option of last resort in the sense that it provides care for those who are not eligible for coverage under the national "social security" scheme, which is tied to contributions based on employment earnings.) The Court ordered the public health system to provide the medications.[595]

***Cruz del Valle Bermudez et al. v. Ministerio de Sanidad y Asistencia Social* (1999)**

Parties and remedy sought

The parties were almost 170 people living with HIV who needed antiretroviral medication and accompanying clinical examinations, but who lacked coverage under the employment-linked national "social security" scheme of the *Instituto Venezolano de los Seguros Sociales* (IVSS) [Venezuelan Social Security Institute]. They brought the proceeding against the Ministry of Health and Social Assistance, which is responsible for the provision of health care through the public system to those not covered by the IVSS. Cruz Bermudez and the other applicants brought an *amparo*[596] action alleging that, by failing to supply prescribed antiretroviral drugs, the Ministry was infringing various human rights. They sought a court order instructing the government to take the steps necessary to respect and fulfil those rights.

Outcome

The Supreme Court ruled in favour of the applicants. It set out a number of specific steps required of the government that went beyond simply supplying medications, and it further ordered the Ministry to seek the necessary budget allocations. The Court also declared that its remedy was not limited to the individual applicants named in the proceedings, but extended to all Venezuelans in a similar situation.

Legal arguments and issues addressed

The applicants founded their claim in both international and Venezuelan law. They argued that the failure of the public health-care system to provide needed medicines to those who were not eligible for social security benefits from the IVSS constituted a violation of their rights to life, health, liberty and security of the person, freedom from discrimination, and access to the benefits of science and technology.

The Court dismissed the claims invoking the rights to liberty and security of the person, as well as the equality rights argument, citing its earlier decision on similar arguments in the case of *NA et al v. Ministerio de Sanidad y Asistencia Social* (noted above). The Court reiterated the view that the personal liberty protected by the constitution is "physical liberty", such as protection against arbitrary detention or confinement, and that it does not extend so far as to compel the government to ensure access to health care. It took a similarly narrow view of "security of the person", simply saying that it did not see anything in the government's conduct that affected this right. The Court also rejected the applicants' claim based on non-discrimination. The Court declared that the health system as a whole was suffering from inadequate resources; it was not proved that people living with HIV were being treated differently from those with other conditions.

However, the Court did find in favour of the applicants on the closely linked rights to life, health and the benefits of science and technology, affirming its approach in the 1998 *NA* case. It declared that the right to life is a "positive right" and, therefore, the state must have public health policies aimed at guaranteeing this right, including measures for both HIV prevention and treatment.

> We believe that all the citizens — including the plaintiffs in this case — have the right to receive protection of their health, and that there is a correlative duty on the State to oversee that such right is realized accordingly, especially when the citizen lacks sufficient means to afford health care.[597]

The Ministry did not deny that the applicants were not receiving their prescribed medications, but argued that because of the cost, "it is evident that we cannot satisfy all the necessities of the HIV/AIDS patient".[598] The Court recognised this challenge, but it did not accept it as sufficient justification for the violation of the applicants' rights.

By way of remedy, the Supreme Court ordered the Minister to seek the necessary budget allocations to comply with its legal obligations as set out in the judgment. It also went on to order that, for all Venezuelan citizens and residents, the Ministry must:

- regularly supply antiretroviral drugs as prescribed and take measures necessary to ensure uninterrupted supply;
- cover all tests necessary for using antiretroviral drugs and treating opportunistic infections;
- provide medications necessary for treating opportunistic infections;
- develop a policy of information, treatment and comprehensive medical assistance for people living with HIV or AIDS who are eligible for social assistance; and
- undertake research on HIV and AIDS in Venezuela for the purpose of developing programmes and infrastructure to prevent HIV transmission and provide care for those infected.

Commentary

This case came after repeated actions against the state for failing to include the medicines needed by people living with HIV in its benefits programmes. Given this history, the Court decided in *Cruz Bermudez* that the remedy granted in an *amparo* action need not be limited to the specific petitioners, but that could be extended to benefit all those in a similar situation. In this respect, this case advanced access to care and treatment not only for people living with HIV, but also set a precedent in Venezuelan law regarding the protection of constitutional rights more generally. The Court's approach seemingly reflects a frustration with continuing to address the same issues repeatedly in a series of individual applications, and a preference to issue a more proactive decision that anticipates problems and sets out clearly the extent of actions required by the state to adequately respond to the treatment needs of people living with HIV.

***López et al. v. Instituto Venezolano de los Seguros Sociales* (2001)**

Parties and remedy sought

The parties were 29 people living with HIV who were eligible for coverage under the social security system administered by the *Instituto Venezolano de los Seguros Sociales* (IVSS).

López et al. brought an *amparo* action against the IVSS alleging that it not only had failed to supply prescribed antiretroviral medications, but that it had failed to do so in a regular manner as required by the specialists (raising concerns about the negative effects of interrupting ARV treatment) and/or it had supplied only certain ARVs and not others needed for effective combination therapy. They also alleged that the IVSS had failed to pay disability pensions to which they were entitled, with serious consequences for emotional and physical health, and for the health and economic well-being of their family members, some of whom were also HIV-positive. Finally, they alleged that the IVSS had refused to cover the costs of specialised laboratory tests (e.g. CD4 counts or viral load testing) necessary for the proper administration of combination therapy. They sought a court order compelling the IVSS to supply these medications and cover the costs of these services.

Legal arguments and issues addressed

As in previous cases, the applicants invoked a number of human rights, both in the Venezuelan constitution and in international law. They argued that the failure to provide uninterrupted treatment results in deterioration of the immune system, drug resistance, opportunistic infections, mental suffering and death, and that it was in breach of their rights to life, health, and liberty and security of the person. They also alleged the IVSS had breached their right to social security by denying access under the programme to the health-care services needed. Finally, they alleged the IVSS had breached their right to the benefits of scientific progress and its applications — which they alleged was an inherent right of the human person (although not expressly stated in the Constitution) and guaranteed by the *International Covenant on Economic, Social and Cultural Rights* (Article 15) — by failing to provide medications and cover necessary laboratory tests for effective treatment of persons living with HIV.

Noting, among other sources, the language of the Constitution (Article 83), the Supreme Court concluded that the right to health was constitutionalised as a fundamental social right, and not simply as a state objective. The Court ruled that the failure to provide an uninterrupted supply of the necessary medications, and to cover specialised laboratory tests needed for the use of antiretroviral drugs and the treatment of opportunistic infections, was not only in violation of the applicants' rights to health, but that it also threatened their rights to life, to the benefits of science and technology, and to social security.

Having found that the IVSS had infringed the applicants' human rights, the Supreme Court issued a remedy that, as in the previous *Cruz Bermudez* case, applied beyond the individual applicants to protect all those people living with HIV eligible for coverage by the IVSS. It ordered the IVSS to:

- provide transcriptase and protease inhibitors to patients as prescribed by medical specialists;
- pay for specialised tests (e.g. viral load testing) reasonably available in the country and necessary for treatment of HIV, AIDS and opportunistic infections; and
- provide medications for the treatment of opportunistic infections.

South Africa:
Court orders government to implement plan for antiretroviral drugs to reduce mother-to-child transmission of HIV

Minister of Health and Others v. Treatment Action Campaign and Others, Constitutional Court of South Africa, CCT 8/02 (2002), [2002] ZACC 15; 2002 (5) SA 721

Parties and remedy sought

The Treatment Action Campaign (TAC), the Children's Rights Centre, and a physician initiated the proceeding. The respondents were the national Minister of Health and the provincial ministers of health from each province (except one). The applicants sought a court order compelling the government to take steps to ensure access to the antiretroviral drug nevirapine for all pregnant women with HIV in South Africa, so as to reduce the risk of vertical (i.e. mother-to-child) transmission of HIV.

Outcome

The Constitutional Court ordered the South African government to make the antiretroviral drug nevirapine available in all public hospitals and clinics for the purposes of preventing vertical transmission of HIV. The Court also ordered the government to develop and implement a comprehensive programme to reduce the risk of vertical transmission of HIV.

Background and material facts

The South African government had chosen not to roll out a national programme to reduce the risk of transmission of HIV from mother to child. Instead, it had identified two sites per province that were to participate in a study that would test various aspects of the programme. It refused to make nevirapine available to sites that did not fall within the study, and it prohibited hospitals outside the pilot sites from prescribing and administering nevirapine to mothers with HIV. TAC and the other applicants brought their application to the High Court in Pretoria in August 2001, challenging these restrictions and seeking to compel the government to ensure access to nevirapine for all HIV-positive pregnant women and their newborn children at public hospitals and clinics where appropriate testing and counselling was available and the use of the drug was medically indicated. The High Court found in favour of the applicants at first instance; the case was appealed further to the Constitutional Court, which upheld the original ruling.

Legal arguments and issues addressed

The judgment focused on two rights under the national constitution: the right to have access to health-care services, including reproductive health care (section 27) and children's right to basic health-care services (section 28).

The Court framed the issues as follows:

> The question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are. The question is whether the applicants have shown that the measures adopted by the government to provide access to health care services for HIV-positive mothers and their newborn babies fall short of its obligations under the Constitution.[599]

Reaffirming that "[t]he state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflict our society",[600] the Court looked to criteria it had developed in the earlier *Grootboom* decision on the government's obligation, under international law and the Constitution, to take reasonable legislative and other measures to achieve progressively the realisation of human rights, within available resources.[601] The Court reduced the dispute between TAC and the government to two key issues — namely:

- whether it was reasonable for the government to confine the supply of nevirapine to the pilot sites by prohibiting its supply at other facilities; and
- whether the government had in fact a "comprehensive policy for the prevention of mother-to-child transmission".[602]

On the first issue, the government advanced four reasons for its refusal to allow nevirapine to be prescribed outside the pilot sites:

1. concerns about the efficacy of nevirapine where the so-called comprehensive package of care provided at the pilot sites was not available;
2. the question of whether the provision of the single dose of nevirapine to mother and child would lead to resistance to nevirapine and other antiretrovirals at a later stage;
3. the safety of the drug itself; and
4. whether capacity existed in the public sector to provide the full package of care.

Dealing first with the question of efficacy, the Court found unequivocally that it was clear "from the evidence that the provision of nevirapine will save the lives of a significant number of infants even if it is administered without the full package and support services that are available at the research and training sites".[603] The Court found that even where mothers did not have access to breast-milk substitutes (which are provided at the pilot sites) or elected to breastfeed, there were still benefits to the use of nevirapine.

The Court also rejected the argument concerning drug resistance, saying that this risk was well worth taking, given the alternative of suffering and death because of HIV infection.

On the evidence, the Court also found that concerns about the safety of the drug were no more than hypothetical, with the drug recommended without qualification by the World Health Organization for the purpose of preventing vertical transmission and registered for this purpose by the South African Medicines Control Council.

With respect to the question of capacity, the Court acknowledged that limited resources and a lack of adequately trained personnel were relevant to the government's ability to make a full package of care available throughout the public sector. However, this was not relevant to the question of whether nevirapine should be used at public hospitals and clinics outside the research sites, where the necessary testing and counselling facilities existed.

Having reviewed this evidence, the Court considered whether the policy of confining nevirapine to the pilot sites was unreasonable. It found that the policy was not reasonable and amounted to a violation of the state's constitutional obligations.

> In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of

> nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences.[604]
>
> […]
>
> Government policy was an inflexible one that denied mothers and their newborn children at public hospitals and clinics outside the research and training sites the opportunity of receiving a single dose of nevirapine at the time of birth of the child. A potentially lifesaving drug was on offer and where testing and counselling facilities were available it could have been administered within the available resources of the state without any known harm to mother or child. In the circumstances we agree with the finding of the High Court that the policy of government in so far as it confines the use of nevirapine to hospitals and clinics which are research and training sites constitutes a breach of the state's obligations under [section 27] of the Constitution.[605]

On the second issue of whether a comprehensive plan existed to combat vertical transmission of HIV, the Court concluded that the current programme did not meet the constitutional standard, as it failed to include some women to whom the treatment is medically indicated to prevent vertical transmission. The government had argued vehemently that the Court had no power to make an order that would have the effect of requiring it to pursue a particular policy, because that would undermine the doctrine of separation of powers, a fundamental concern of a constitutional democracy. In dealing with this argument, the Court found that "although there are no bright lines that separate the roles of the legislature, the executive and the courts from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not the others".[606] This did not preclude the Court from making a decision that would have an impact on policy.

> It is essential that there be a concerted national effort to combat the HIV/AIDS pandemic. The government has committed itself to such an effort. We have held that its policy fails to meet constitutional standards because it excludes those who could reasonably be included where such treatment is medically indicated to combat mother-to-child transmission of HIV. That does not mean that everyone can immediately claim access to such treatment, although the ideal … is to achieve that goal. Every effort must, however, be made to do so as soon as reasonably possible.[607]

The Court therefore ordered the government to remove without delay the restrictions preventing nevirapine from being made available for preventing vertical transmission at public hospitals and clinics other than the pilot sites, and to facilitate and expedite the use of nevirapine for this purpose, including extending testing and counselling services via facilities throughout the public health sector. Furthermore, the Court ruled that the government was constitutionally obliged to:

> devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV. The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.[608]

Commentary

Standards of care for HIV treatment and prevention have evolved since this judgment in 2002. Yet the decision is still noteworthy. It provides a clear example of a court giving effect to government's obligations to take positive steps to protect and promote health. In the specific case of South Africa, this obligation is codified in the Constitution. But it is also articulated in international treaties ratified by many states — in particular the ICESCR — and the analysis applied in this case, as set out in the earlier *Grootboom* decision cited by the Court, draws heavily on those obligations under international law. This case is one of many that illustrates that it is well within the abilities of courts to interpret and apply socio-economic rights to particular contexts, to reach conclusions about whether government's actions have satisfied or breached those legal obligations, and to fashion appropriate remedies where required. In particular, the judgment demonstrates that, with the benefit of evidence, courts are able to assess the reasonableness of government's actions in providing access to health-care services. Moreover, it explicitly notes the importance of ensuring access for those without the resources to pay for such care personally.

Thailand:
Court invalidates company's claim to broader patent on ARV medication, enabling production of lower-cost generic product

AIDS Access Foundation et al. v. Bristol-Myers Squib Company & Department of Intellectual Property, Central Intellectual Property and International Trade Court (Thailand), Case No. 334/2544 (Black Case), No. 92/2545 (Red Case) (2002)[609]

Parties and remedy sought

The plaintiffs were two people living with HIV and the AIDS Access Foundation, a Thai non-governmental organisation, seeking access to a lower-cost, generic version of the antiretroviral medication, didanosine (DDI). The complaint was brought against both the multinational pharmaceutical company Bristol-Meyers Squibb (BMS), which held the patent on the drug in Thailand, and the federal Department of Intellectual Property. The plaintiffs sought to have BMS' patent claim on DDI invalidated, at least in part, to permit the production and distribution of a less expensive generic version of this medicine in Thailand.

Outcome

The court ruled for the plaintiffs. It found that BMS and the Department of Intellectual Property had unlawfully extended a broader patent for BMS on DDI than BMS had originally claimed and been granted. The intended and actual effect was to inhibit generic production of the product and ensure its monopoly on DDI in Thailand. The Court ordered the Department to restore the patent scope to what had been originally claimed and granted. The Court also ordered BMS to pay the plaintiffs' costs of bringing the proceeding.

Background and material facts

Through the state-run Government Pharmaceutical Organization (GPO), the Thai Ministry of Public Health provided high-quality, generic versions of a few antiretroviral drugs at a reasonable cost. However, where such production was blocked by patents on antiretroviral drugs, the GPO was not able to legally produce a lower-cost generic version. The Thai government had been reluctant to issue compulsory licences or authorise government use of these patents to expand the range of medicines available from the GPO. Because of their price, antiretroviral drugs other than those supplied by the GPO remained out of reach for most people living with HIV in Thailand.

BMS held a number of Thai patents on the drug, thereby enjoying the exclusive right to manufacture, import or sell it in Thailand. This included a patent claim covering the buffered tablet formulation of the drug. At the time of the proceeding, BMS was charging 44 Thai baht per 100 milligrams buffered tablet of DDI (42 Thai baht = 1 U.S. dollar at the time). Thai people living with HIV who could not afford the patented DDI tablet resorted to taking generic DDI produced in powder form by the GPO. This product was more difficult for people to take for several reasons, including the fact that it was more awkward to carry than tablets. It was also harder to take a powder formulation discreetly, as it required mixing with a liquid and carried greater side effects, such as diarrhoea. This added complexity interfered with people's adherence to the treatment regimen.

Starting in 1999, activists called on the government to grant a compulsory licence to permit the GPO to produce buffered DDI in generic form. Such a measure is permitted under the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS) of the World Trade Organization (WTO). Specifically, TRIPS allows for compulsory licensing of patented inventions, subject to certain conditions, including the payment

of "adequate remuneration" to the patent-holder (Article 31). However, Thai Public Health and Commerce ministry officials declined to respond officially to the activists' request or to issue a compulsory licence.

When the original patent claim on this product had been filed, BMS specified that the patent was in relation to a buffered tablet that contained "from about 5–100mg per dose" of the active ingredient. Subsequently, BMS and the Department of Intellectual Property removed this limitation for the entry in the patent register, thereby purporting to extend BMS's patent to also cover any formulation containing more than 100 mg per dose. Such a patent blocked a generic producer, such as the GPO, from producing any buffered tablet version of DDI.

Legal arguments and issues addressed

The plaintiffs claimed that the patent registration for its buffered tablet formulation of DDI was illegally amended in an attempt to claim a wider monopoly than the patent description justified. BMS and the Department of Intellectual Property argued that because the plaintiffs were not drug manufacturers and/or competitors of BMS, they could not be recognised under the law as parties who had been injured by the extended patent claim, and therefore had no basis to initiate the legal proceeding. The Court rejected this argument. The Court stated that "medicine is essential for human life, as distinct from other products that consumers may or may not choose to consume", and "the treatment of life and health transcends the importance of any other property". The Court noted that "this was recognized internationally" in the *Declaration on the TRIPS Agreement and Public Health* (the *Doha Declaration* adopted unanimously by all WTO Members in November 2001). The Court concluded that the parties injured by the illegal amendment of the patent could not be limited to just competing manufacturers or vendors of the medicine protected by the patent.

Having resolved this preliminary (but nevertheless important) issue, the Court considered the merits of the allegation. It found that BMS and the Department of Intellectual Property had unlawfully deleted the phrase "from about 5–100mg per dose" from the patent claim, which was the basis on which they then purported to block the entry into the market of any generic competitors selling lower-cost versions of buffered DDI. The Court ordered that the limiting phrase regarding the dosage be restored. The Court ordered BMS to pay the plaintiffs' costs of bringing the lawsuit.

Commentary

This case was the first proceeding in Thai legal history to challenge excessive patent protection that was blocking access to a needed medicine for most Thai people living with HIV. It was significant that the court directly cited the WTO's *Doha Declaration* and explicitly interpreted it as support for the conclusion that the rights to life and to health can take precedence over property rights. Some states and commentators have suggested that the *Doha Declaration* is of no legal significance and is "merely political", but this characterisation is disputed — and this case provides an example of the Declaration's relevance to judicial decision-making.

Following the decision, activists in Thailand called on the government to order the state-owned pharmaceutical organisation to immediately start producing generic buffered DDI in tablet form containing more than 100 mg. GPO representatives said they could manufacture the drug in a buffered tablet form at half the price charged by BMS. On 16 October 2002, the GPO announced that it would produce a generic version of the buffered tablet in dosage ranges outside those covered by BMS's patent, if it was certain that BMS would not be appealing the ruling.[610] BMS did not launch an appeal.

Chapter 10

Human rights and the criminalisation of key populations at higher risk of HIV exposure

Summary

In the context of HIV, "key populations at higher risk of HIV exposure" ("key populations") refer to those individuals most likely to be exposed to HIV or to transmit it. They are often the individuals least likely to access HIV prevention and treatment services because they face the most societal marginalisation and discrimination. The following groups are often considered key populations:

- men who have sex with men (MSM)
- transgender people
- people who inject drugs
- sex workers
- prisoners
- mobile and migrant populations

This chapter focuses on sex workers and MSM.

Several law, policies and practices have a direct impact on the access of key populations to HIV prevention, care, treatment and support, and they often increase the vulnerability of key populations to violence and poor health.

Many international organisations, human rights advocates and affected communities have called for the decriminalisation of key populations — including sex workers and MSM — and advocated for human rights-based approaches to HIV prevention, care, treatment and support for all key populations.

The criminalisation of — and violence against — sex workers hampers their ability to negotiate safer sex and puts them at greater risk of HIV infection. Physical and sexual violence perpetrated by police, clients and others against sex workers is rampant.

Punitive legal environments towards MSM reduces uptake of HIV testing and treatment, and it undermines the relationship between MSM and health-care providers. Criminalisation of same-sex relationships leads to police harassment of HIV prevention workers and restricts HIV prevention education and resources.

International human rights treaties obligate states to protect and promote the human rights of all people. These human rights include the rights to life, privacy, liberty and security of the person (which encompass protection against threats of physical violence), the right to be protected from arbitrary arrest or detention, torture, inhuman and degrading treatment, as well as freedoms of expression, association, peaceful assembly and information.

Adjudicating cases involving sex work: Factors concerning HIV to consider

1. **How is the criminal law enforced against sex workers?**

   Sex workers have few avenues to seek protection or redress when violence is perpetrated against them.

   Sex workers may be arbitrarily arrested even when they have not violated any laws. In some jurisdictions, the possession of condoms is taken as evidence that a person is engaged in illegal prostitution. Sex work is also conflated with human trafficking.

   Irrespective of whether sex work is criminalised or regulated in a country, all people engaged in sex work retain the right not to be subjected to violence and to receive the full protection of the law if they are assaulted or arbitrarily arrested.

2. **How are specific criminal provisions against sex work applied?**

   The criminalisation of procuring (or facilitating) sex work or living on the proceeds of sex work may force sex workers to work in isolation, resulting in them having less control over their working conditions and facing a higher risk of violence.

   The criminalisation of living on the proceeds of sex work may have the unintended impact of exposing to prosecution family members and others who may be supported by someone who engages in sex work, thus alienating sex workers from their networks of support.

   Provisions against keeping a brothel or "bawdy house" force sex workers to work in isolation, on the street or in clients' homes, rather than in safer indoor environments.

   The prohibition of solicitation or communication for the purpose of prostitution forces sex workers to hastily conclude transactions, leaving them with inadequate time to screen potential clients and negotiate safer sex, including condom use. It also displaces sex workers to more secluded areas, rendering them vulnerable to violence and diminishing their ability to enforce condom use.

   Some courts have struck down provisions criminalising sex work. Short of striking down a law, courts may consider the underlying rationale for a provision and restrict its application appropriately.

Adjudicating cases involving sexual orientation and gender identity: Factors concerning HIV to consider

1. **Redress for individuals who are subject to assault and extortion**

   Many LGBT people are physically or sexually assaulted because of their sexual orientation, yet they do not report such attacks for fear of reprisals, exposure to police abuse, and/or criminal liability where same-sex relations are prohibited.

   Whether or not same-sex relations are criminalised, all people have the right not to be subjected to violence and to receive the full protection of the law if they are assaulted.

2. **Prosecution of HIV prevention activities**

   The staff of non-governmental organisations providing HIV prevention interventions to LGBT people have been subject to police harassment, extortion, arbitrary detention and arrest for alleged violations of criminal laws prohibiting homosexuality, as well as laws that are intended to protect morality and decency.

   These prosecutions have a detrimental impact on public health. Where there is evidence of abuse of power, courts must also hold police accountable for their conduct.

3. **Impact of criminalisation on HIV prevention, care, treatment and support**

   The criminalisation of same-sex relations has a detrimental impact on public health, including the alienation from health-care services of men who have sex with.

   A number of courts around the world have invalidated laws criminalising homosexuality on the basis of human and constitutional rights. If same-sex relations remain criminalised, it is likely that HIV interventions for men who have sex with men will continue to be inadequate, LGBT people will continue to be marginalised from health services, and HIV epidemics will escalate.

Introduction

In the context of HIV, "key populations at higher risk of HIV exposure" (herein after "key populations") refer to those individuals most likely to be exposed to HIV or to transmit it. They are also often the individuals least likely to access HIV prevention and treatment services because they face the most societal marginalisation and discrimination. The following groups with elevated HIV prevalence are often categorised as key populations: men who have sex with men (MSM),[611] transgender people,[612] people who inject drugs, sex workers,[613] prisoners, and mobile and migrant populations. This list is not exhaustive and which populations are "key" in each country will depend on the epidemiological and social context. Significantly, being a member of a key population(s) does not, in itself, place individuals at risk. However, behaviours of key populations (e.g. unprotected sex or the use of non-sterile injection equipment) and the resulting health inequities are greatly influenced by the policy and legal environment in which they live. Therefore, focusing on key populations is critical to addressing the HIV epidemic. While various groups may be categorised as key populations, this chapter will focus on the legal issues related to sex work and men who have sex with men.[614]

Regardless of one's personal views on the behaviours of key populations, addressing the laws and policies that have a detrimental impact on their health and human rights is crucial to tackling the epidemic. There is increasing evidence linking the stigmatisation, marginalisation and criminalisation of key populations with poor health and higher HIV prevalence. For example, although migration itself is not a risk factor for HIV, women migrants are more vulnerable to HIV due to the physical and sexual abuse they may experience during unregulated migration and their time in the host country (through exploitative living and working conditions).[615] Similarly, in prisons where access to health care (including HIV treatment) is minimal or non-existent, prisoners have significantly higher rates of HIV than in the general population, and a number of outbreaks of HIV infection have occurred behind bars.[616]

Because laws and policies relating to a key population have a direct impact on both the access of its members to HIV prevention, care, treatment and support, as well as their vulnerability to violence and poor health, judges and magistrates who adjudicate criminal matters related to key populations are necessarily affecting the course of the epidemic. Whether the case involves criminal prohibitions on harm reduction tools for people who use drugs, communication for the purposes of sex work or sexual relations between men, the outcome can shape the HIV risk of the parties to the case, and the greater community itself by driving others in similar situations away from HIV prevention services. Criminalising behaviours of key populations also results in the incarceration of people living with or at risk of HIV, which can have fatal repercussions because many prisons lack an adequate supply of accessibility condoms, other HIV prevention methods, and essential medications to treat HIV. Judges and magistrates benefit from an understanding of this larger social context in order to apply existing laws for legitimate aims without unnecessarily trampling on human rights and inadvertently exacerbating the HIV epidemic.

Sex workers as a key population

Sex workers are considered a key population at higher risk of HIV exposure because of the higher HIV prevalence among sex workers in many countries and the condemnation, marginalisation, and violence that they experience, which hinders their access to basic services (such as police protection and health care). In particular, the criminalisation of — and violence against — sex workers hampers their ability to negotiate safer sex and puts them at greater risk of HIV infection.

Responses to sex work generally fall under one of two approaches. One approach advances the rights of sex workers and promotes the decriminalisation of sex work. This approach does not focus on how or why a person came to be engaged in sex work, instead focusing on promoting the safety and human rights of all people. In line with this approach, calls for the repeal of criminal laws prohibiting sex work have come from UN Secretary-General Ban-Ki Moon,[617] the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on the Right to Health),[618] the Independent Commission on AIDS in Asia,[619] and the Global Commission on HIV and the Law.[620] Furthermore, the *International Guidelines on HIV/AIDS and Human Rights* urges states to review laws that prohibit commercial sex between consenting adults in private, "with the aim of repeal",[621] and the *Handbook for Legislators on HIV/AIDS, Law and Human Rights* recognises that criminal regulation of prostitution impedes the provision of HIV prevention and care by driving sex workers underground, and it urges states to review those laws with a view towards decriminalisation.[622]

The second approach favours the elimination of sex work altogether, based on the notion that prostitution is immoral or a form of violence against women. An example of this approach is the United States government's "anti-prostitution pledge", a policy that requires all organisations that receive HIV and AIDS funding from the United States government to explicitly oppose prostitution.[623] Some of the non-governmental organisations working from this approach acknowledge that vulnerability to HIV is a critical issue for those engaged in sex work. They propose law reform to "discourage the demand for prostitution" as a solution.[624]

While many sex workers take precautions to reduce their risk of contracting sexually transmitted infections,[625] widespread public disapproval of sex work on moral or other grounds, and criminal prohibitions on sex work, lead to a greater risk of HIV infection for sex workers by creating barriers to HIV testing, sexual health education, harm reduction services, the negotiation of safer sex and HIV-related treatment, care and support.[626] The stigmatisation of sex workers manifests itself in their experiences of hostility and discrimination at the hands of health-care workers, other service providers, landlords and others, and it is a significant barrier to accessing health care and housing.[627] Consequently, HIV prevalence is high among sex workers in some regions of the world.[628]

In particular, violence perpetrated by police, managers, clients and others against sex workers is a key factor in HIV transmission. Violence, or the threat of violence, may be used to coerce unprotected or risky sexual services, thereby increasing the risk of HIV transmission. Sex workers who fear violence may also be less able to negotiate condom use with their clients. In one study of female sex workers in South Africa, researchers found that women were at a higher risk for physical violence when they insisted on condom use with customers.[629] In another study, 45% of female sex workers in the United States stated that clients became abusive if they insisted on the use of condoms.[630] Increasingly, research suggests that when violence against sex workers is pervasive and largely unaddressed, sex workers are forced to prioritise their immediate physical safety over condom use with clients.[631]

Violence against sex workers

- In a 2009 survey of sex workers in Central and Eastern Europe and Central Asia, 42% reported physical abuse by police, and 37% reported having been sexually assaulted by police.[632]
- In a study of 1000 female and transgender sex workers in Phnom Penh, Cambodia, half of those surveyed reported being beaten by police, one third had been gang-raped by police, and three quarters had been gang-raped by clients in the past year. In total, over 90% of those surveyed had been raped at least once in the past year.[633]
- A study conducted in Washington, D.C., reported that 61% sex workers who work on the street had been physically assaulted since entering sex work, with 75% of assaults having been perpetrated by clients.[634]
- In a study of 267 female and transgender sex workers who work on the street in Vancouver, Canada, 57% reported having experienced at least one incident of violence within an 18-month period, with over half of these perpetrated by clients.[635]
- In a study of 815 female sex workers in Thailand, approximately one in seven had experienced violence in the week before the survey.[636]

There is a growing body of evidence linking various sex work-related criminal provisions to health risks for sex workers. Condom use is one of the most effective HIV prevention technologies available. Yet enforcing criminal prohibitions related to sex work has been shown to force sex workers to hastily conclude transactions for fear of police intervention, leaving them with inadequate time to screen potential clients and negotiate safer sex, which includes condom use.[637] It can also displace sex workers to more secluded areas to avoid detection by police and prevent sex workers from working indoors, which increases their vulnerability to violence and diminishes their ability to practice safer sex.[638] Laws that prohibit sex workers from working in association with others may force them to work in isolation and prevent them from hiring bodyguards or drivers, measures that enable sex workers to better screen clients and lessen the risk of violence, especially if they request condom use.[639] More broadly, criminalisation institutionalises an adversarial relationship between sex workers and police, impeding sex workers' ability to report violence directed against them. This creates a climate of impunity, which fosters and fuels further violence.[640]

"Criminalisation represents a barrier to accessing services, establishing therapeutic relationships and continuing treatment regimes, leading to poorer health outcomes for sex workers, as they may fear legal consequences or harassment and judgment. This is particularly concerning given that HIV has been noted to disproportionately affect sex workers in many regions".

—Anand Grover, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [641]

Human rights standards and sex work

International law

There are some international treaties that treat sex work as a form of exploitation. The primary international instrument addressing trafficking and sex work, the *Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others* (Trafficking Convention), which dates back to 1950, describes sex work as being "incompatible with the dignity and worth of the human person".[642] The Convention thus requires states to punish any person who exploits another person in sex work, or who procures or entices another person into sex work, even with the consent of that person.[643] Persons who engage in prostitution are conceived of as victims, regardless of whether the individual chose to be a sex worker.

Other international human rights treaties present a different approach. The *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) urges states to "take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women".[644] While the language of this provision echoes the Trafficking Convention, CEDAW is not based on the premise that sex work should be eradicated, but instead on the need to protect women from all forms of discrimination, including violence.[645] As the CEDAW Committee has elaborated: "Prostitutes are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence".[646] Human rights set out in numerous other international conventions – including the *International Covenant on Civil and Political Rights* (ICCPR),[647] and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) [648] – further affirm every human being's (including sex workers') right to equal protection of the law.

National laws

Domestic laws approach sex work in diverse ways. Some jurisdictions regulate sex work through criminal prohibitions of the sale of sexual services, while others criminalise practices linked to sex work (including, but not limited to, keeping a brothel, recruiting or arranging for the prostitution of others, living off the proceeds of sex work, communicating or soliciting for sex work in public spaces, and facilitating sex work through the provision of information or assistance).[649] In the latter framework, the sale of sex is not in itself illegal, but it is severely limited by the criminalisation of associated activities. Some jurisdictions also use other laws (e.g. vagrancy or public nuisance laws) to detain or arrest sex workers who work on the street.

In a few jurisdictions, sex work is legal and regulated (e.g. subject to licensing, registration, taxation and rigid codes determining what is permissible), while certain practices associated with sex work (e.g. street solicitation) remain illegal.[650] In New Zealand, for example, the *Prostitution Reform Act, 2003*, makes it legal to enter into contracts for commercial sexual services. The law regulates the business of prostitution, including through provisions requiring condom use for penetrative sex and making explicit that sex workers are covered by New Zealand's *Health and Safety in Employment Act 1992*.[651]

In yet other countries, those who attempt to or have purchased a sexual service are criminalised. This is commonly referred to as the "Nordic model".[652] Under the Nordic model, sex workers are themselves not criminally liable for selling sex, although all other activities associated with sex work remain criminalised (including keeping a brothel, acting as a security guard and working in association with others). This legal framework has been adopted in Sweden, Norway and Iceland, among other countries,[653] and it has been criticised for worsening, rather than improving the lives of sex workers.[654]

Adjudicating cases involving sex work: Factors related to HIV to consider

1. How is the criminal law enforced against sex workers?

a) Lack of redress for violent crimes

As discussed above, there is ample research documenting physical and sexual violence perpetrated by police, clients and others against sex workers. Public condemnation of sex work fuels, in part, violence against sex workers, and their criminal status and lack of legal protection discourages them from going to police when they have been victimised. For sex workers, reporting a violent experience may mean that they not only incriminate themselves, but also their employers, colleagues and clients, potentially leading to a loss of work

and income. It may also result in police harassing and targeting sex workers and the individuals with whom they have personal relationships (believing those individuals to be clients). Moreover, the police are often unwilling to take seriously the complaints of sex workers who do seek help. These factors create conditions of impunity for perpetrators of violence.[655] Sex workers have reported that their lack of access to police protection has made them easy and frequent targets of violent attacks.[656]

Irrespective of whether sex work is criminalised or regulated in a country, all people engaged in sex work retain the right not to be subjected to violence and to enjoy the full protection of the law if they are assaulted. Yet there are numerous instances in which sex workers have been denied equal protection of the law, particularly with respect to physical and sexual assault.[657] An Australian appellate court recognised this shortcoming and held in *R. v. Leary* that it is wrong to sentence on the assumption that the psychological effect of sexual assault on a sex worker or the gravity of the offence would be less than that experienced by others. The appellate court approved the lower court's statement that "prostitutes, male or female, were entitled to the same protection of the law as any other citizen. They have their human dignity and their privacy and ought not unconsensually to have that invaded by fellow citizens".[658]

This decision diverged from the earlier case of *R. v. Hakopian*, in which the judge at first instance observed that "the likely psychological effect on the victim [a sex worker] of the forced oral intercourse and indecent assault is much less a factor in this case and lessens the gravity of the offences".[659] From a human rights perspective, the *Hakopian* approach violates the victim's right to equal protection of the law. Moreover, from a public health perspective, it does little to deter sexual assault and further marginalises sex workers, who may consequently be less inclined to pursue criminal charges against those who assault them and more likely to experience future violence, which in turn presents further risks of HIV infection.

> *"[S]ex workers are also human beings and no one has a right to assault or murder them. [...] They are also entitled to a life of dignity in view of Article 21 of the [Indian] Constitution".*
>
> —Budhadev Karmaskar v. State of West Bengal, *Supreme Court of India*[660]

b) Unlawful arrest and detention

Even when sex workers have not violated any laws, they may be arbitrarily arrested, detained and charged with a criminal offence.[661] Moreover, in a number of jurisdictions, possession of condoms — a highly effective HIV prevention intervention for all sexually active people — has been seen as evidence of involvement in sex work and probable cause for an arrest for sex work, thus deterring sex workers and outreach workers from carrying or using them.[662]

Some sex workers are also detained because of the conflation of all sex work with sex trafficking.[663] In Cambodia, for example, this approach has resulted in sex workers being sent to "forced rehabilitation", displacing them from the brothels where they were working and disrupting HIV prevention services.[664] While forced prostitution merits criminal prohibition, the conflation of sex work with sex trafficking can result in unlawful detentions and drive sex workers further underground (and away from health services) as they attempt to evade police and immigration authorities.

In South Africa, where prostitution is illegal, police harassment of sex workers in Cape Town was so persistent that a sex worker organisation sought a court order to stop it.[665] Sex workers had been systematically arrested on numerous occasions but never prosecuted.[666] The Cape Town High Court held that a police officer "who arrests a person, knowing with a high degree of probability that there will not be

a prosecution, acts unlawfully even if he or she would have preferred a prosecution to have followed the arrest" and issued an interdict ordering members of the Cape Town police service to refrain from arresting sex workers unless they would be brought before a court of law to face prosecution.[667] Courts should thus be aware of the unlawful arrest and detention of sex workers, and, where there is evidence of abuse of power, hold police accountable for such crimes.

2. How are specific criminal provisions against sex work applied?

a) Procuring or living on the proceeds of prostitution

The criminalisation of procuring (or facilitating) sex work or living on the proceeds of sex work may force sex workers to work in isolation, prevent them from working for people who coordinate, organise or supervise their labour, and preclude the hiring of bodyguards, drivers or assistants. As a result, these sex workers have less control over their working conditions and face a higher risk of violence, especially if they request condom use.[668] Moreover, an overly broad definition of procurement that includes activities that assist the "prostitution of others", may risk criminalising sex worker advocates or HIV outreach activities (including condom distribution).[669] At the same time, the criminalisation of living on the proceeds of sex work may have the unintended impact of capturing family members and others who may be supported by someone who engages in sex work, thus alienating sex workers from their networks of support.

One court faced with this issue looked to the underlying concern motivating the criminalisation of living on the avails of prostitution. In the Canadian case of *R. v. Grilo*, an appellate court held that an individual did not live on the avails of prostitution when the individual acted "solely … as [the sex worker's] protector" and held her earnings safely for the sex worker until she next returned home.[670] The Court noted that the law in controversy intended to criminalise the "parasitic aspect" of the relationship, which contains "an element of exploitation which is essential to the concept of living on the avails of prostitution".[671] The Court concluded that this "parasitic aspect" did not exist in the case.[672] From a public health perspective, this is a progressive decision. To require an element of "parasitism" imposes punishment on those who coerce or exploit sex workers. However, it does not impede sex workers' ability to organise and work collectively and with security personnel, which lessens the risk of violence that they face and — directly and indirectly — their risk of HIV infection.

b) Brothel-keeping

Provisions against keeping a brothel or "bawdy house" also force sex workers to work in isolation, on the street or in clients' homes by prohibiting the establishment of facilities where sex workers can bring their clients, including indoor venues where sex workers can work in a clean and supportive space with effective security measures in place. The threat of prosecution (and fear of tipping-off police about the nature of what they do) also deters those working in bawdy houses from making available large quantities of condoms, and other safer-sex materials or violence-prevention resources available.[673] Research has indicated that, in some contexts, the risk of HIV infection is higher for sex workers who work on the street than for sex workers working indoors, due in part to the disproportionate impact of criminalisation on sex workers who work on the street and their clients.[674] Moreover, a familiar space enables sex workers to better enforce condom use and protect themselves from violence (e.g. have colleagues on the premises or access available exits and telephones, etc.).[675] In a 2005 study of legalised brothels in Las Vegas, Nevada, only one of 40 sex workers interviewed reported experiencing violence at work, leading researchers to conclude that "the legalisation of prostitution brings a level of public scrutiny, official regulation and bureaucratization to brothels" that decreases violence.[676]

This issue of brothel-keeping was before a U.K. court in 2010.[677] The jury acquitted a woman of keeping a brothel in Bedfordshire County after a trial in which she testified that she had worked from her home with friends for safety, and neighbours testified that they were aware of what the accused did for a living and considered her a welcome member of their community.[678] Evidence was also introduced about the nearly 20 000 sexual and other violent attacks reported against women in the County during the preceding five years, including many attacks against sex workers. In directing the jury, the judge outlined that if they found the accused was a brothel-keeper, the jury could consider the defence of "duress of circumstances" — that the accused was compelled to work with other women for fear of assault if she worked alone — which the jury ostensibly did when it acquitted her.[679]

In another 2010 case, a Canadian judge held that the objective of the country's "bawdy house" provision was "combating neighbourhood disruption or disorder and safeguarding public health and safety".[680] Because the law imposed a blanket prohibition on indoor prostitution without regard for whether there was actually neighbourhood disruption or a threat to public health and safety, the court struck down the provision as an overbroad and unjustifiable violation of sex workers' security of the person.[681]

Short of striking down a law, a court may opt to consider the underlying rationale for a provision prohibiting brothels and, if warranted, require an additional element of exploitation or public nuisance in light of the grave health and safety ramifications of such a prohibition.

c) Communication or solicitation for the purpose of prostitution

The prohibition of solicitation or communication in public for the purpose of prostitution forces sex workers to hastily conclude a transaction for fear of police intervention and leaves them with inadequate time to screen a potential client and negotiate the terms of a transaction, including condom use.[682] At the same time, such provisions displace sex workers to more secluded areas to avoid detection by police, which further renders sex workers more vulnerable to violence and diminishes their ability to enforce condom use.[383] In several jurisdictions, a prohibition on solicitation or communication is intended to address the perceived "nuisance" associated with public solicitation.[684] Nevertheless, sex workers have been convicted for solicitation, even when their behaviour is not persistent or aggressive, or when they have not been soliciting customers actively at the time.[685]

In light of the significant risks to health and life posed by the criminalisation of communication or solicitation for the purposes of sex work, limiting prosecutions to cases of persistent or aggressive solicitation would have positive public health and human rights implications. It would enable sex workers to take time to screen clients and negotiate the terms of a transaction, including safer sex, while still ensuring that the "nuisance" the provision is intended to address is captured in appropriate cases.[686] In terms of HIV and violence prevention, this would be a positive outcome.

Key questions to consider on HIV and sex work

- What specific offence is alleged? Does the evidence support this specific offence?
- If the accused is a sex worker, have their rights been fully protected? Whether or not the court needs to impose a sentence under the criminal law, a sex worker has the same human and constitutional rights as every other citizen.
- What is the appropriate remedy or punishment, in order to protect rights and not impede HIV prevention, care, treatment and support?

Men who have sex with men as a key population

Sexual minorities,[687] particularly men who have sex with men and transgender people, have significantly higher rates of HIV than the population as a whole in nearly every country reliably collecting HIV surveillance data.[688] The broader public health implications are profound when one considers that many men who have sex with men also have sex with women.[689] At the same time, same-sex relations are illegal in many countries and sexual minorities face condemnation and persecution globally, irrespective of the legality of their conduct.

Research confirms that punitive legal environments towards men who have sex with men lead to a range of adverse consequences in the context of HIV.[690] Where same-sex relations are criminalised, men who have sex with men may not seek HIV testing, care, support and treatment for fear of being identified as homosexual and prosecuted,[691] and when treatment is sought, men who have sex with men may be concerned about health-care professionals divulging their same-sex conduct, thus undermining the doctor–patient relationship.[692] The access of men who have sex with men to health care is further impeded by the reproachful attitudes of health care professionals who are not trained to meet the needs of MSM patients, refuse to treat men who have sex with men altogether or respond with hostility when compelled to do so.[693]

Other consequences of the criminalisation of same-sex relations on HIV prevention activities include police harassment of HIV outreach workers (many of whom are peer educators), police raids on events and venues where HIV education takes place (including peer-based support groups), restriction of HIV prevention education on the grounds that the activities encourage illegal same-sex activity, police confiscation of condoms and lubricants as evidence of illegal same-sex activity, and restriction or censorship of health promotion information concerning safer sex practices on the grounds that they breach obscenity laws.[694] These actions restrict the access of men who have sex with men to key HIV prevention information and technologies (i.e. condoms and lubricant), thus undermining critical responses to the HIV epidemic.

As with sex work, these collateral impacts have led to calls for the decriminalisation of same-sex activity from UN Secretary-General Ban Ki-Moon,[695] the Commission on AIDS in Asia,[696] the UN Special Rapporteur on the right to health[697] and the Global Commission on HIV and the Law.[698] The *International Guidelines* recommend the review of laws that prohibit sex between consenting adults (including "sodomy") in private, "with the aim of repeal". *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* calls for the repeal of laws that criminalise same-sex acts between consenting adults in private, as well as the repeal of laws and policies that have been used to harass men who have sex with men or to prevent crucial public health information from reaching them.[699]

> *"[T]here are those who argue that because sexual orientation or gender identity are not explicitly mentioned in any of the conventions and covenants, there would be no protection. My response is that such a position is untenable in legal terms, which is confirmed by the evolving jurisprudence. The principle of universality admits no exception. Human rights truly are the birth right of all human beings".*[700]
>
> *—UN High Commissioner for Human Rights Navanethem Pillay*

Human rights standards, and sexual orientation and gender identity

International law

Although "sexual orientation" is not specifically enumerated as a category of protection (as are, for example, race, colour and sex) in core international human rights treaties, it can be addressed under the category of "other status".[701] This has been affirmed by jurisprudence recognising sexual orientation as a ground of protection under international human rights instruments,[702] emerging recognition of sexual orientation as a prohibited ground of discrimination among international bodies,[703] and the explicit integration of sexual orientation in the list of prohibited grounds of discrimination in new international instruments.[704]

International human rights treaties obligate states to protect and promote the human rights of all people, and to provide the conditions necessary for the realisation of human rights. These human rights include the rights to life, privacy, liberty and security of the person (which encompass protection against threats of physical violence), the right to be protected from arbitrary arrest or detention, torture, inhuman and degrading treatment, as well as freedoms of expression, association, peaceful assembly and information.

Specific to sexual orientation and gender identity, the *Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity,* although not binding on states, provide recommendations on how existing human rights statutes are to be applied in specific situations relevant to sexual minorities. Among the recommendations comprising Principle 17 are calls on states to:

- take all necessary measures to ensure that all persons have access to health-care facilities, goods and services, and that these improve the health status of, and respond to the needs of, all persons without discrimination;
- ensure that medical records are treated with confidentiality;
- develop and implement programmes to address discrimination and prejudice that undermine the health of sexual minorities; and
- ensure that all health-service providers treat clients and their partners without discrimination on the basis of sexual orientation or gender identity.[705]

The United Nations Working Group on Arbitrary Detention, in expressing its views on individuals who had been detained or imprisoned solely on the basis of their sexual orientation, has stated that "detention was arbitrary because it violated articles 2(1) and 26 of the *International Covenant on Civil and Political Rights*, which guarantee equality before the law and the right to equal legal protection against all forms of discrimination, including that based on sex".[706]

National laws

In almost 80 countries, same-sex sexual activity is a criminal offence, and in some countries, it is punishable by death.[707] Even in jurisdictions where same-sex relations are not criminalised, a number of countries stipulate a lower age of consent for "heterosexual" versus "homosexual" sexual acts, and there is no legal protection from discrimination on the grounds of sexual orientation.[708] However, courts around the world have increasingly applied both international and domestic law and standards to protect the human rights of sexual minorities, striking down laws criminalising same-sex activity.[709] A number of countries also prohibit discrimination on the basis of sexual orientation.[710]

Adjudicating cases involving sexual orientation and gender identity: Factors concerning HIV to consider

1. Redress for individuals who are subject to assault and extortion

There are numerous documented accounts of gay men being subject to physical and sexual violence on the basis of their sexual orientation, but choosing not to report such attacks for fear of reprisals, exposure to police abuse, criminal liability where same-sex relations are prohibited,[711] or police and judicial inaction. This contributes to a culture of impunity where violence based on sexual orientation is allowed to continue.[712] Blackmail and extortion of gay men because of their sexual orientation is also prevalent, and it is a rights violation that has been linked to barriers in accessing housing and health care.[713]

When allegations of violence and abuse because of a person's sexual orientation are brought before courts, human rights law offers an important recourse: all individuals are entitled to equal protection of the law, regardless of their sexual orientation. The High Court of Uganda affirmed this principle in 2010, when it found a violation of the constitutional rights to privacy, human dignity and protection from inhuman treatment of three gay and lesbian applicants after a local newspaper had published a defamatory article about them.[714] The respondents had contended that since homosexuality was a criminal offence in Uganda, the applicants had not come to court with clean hands and equity should deny them the relief they sought. The Court rejected this argument and held that this case was not about homosexuality per se, but about the fundamental rights and freedoms of individuals. Therefore, the respondents' argument concerning "clean hands" was invalid, as the relevant criminal provision required an individual to actually commit one of the prohibited acts in order to be considered a criminal.[715]

From an HIV prevention perspective, condemning assault and extortion of gay men, men suspected of having sex with other men, and service providers is essential in the response to HIV. As men who have sex with men are a key population at higher risk of HIV infection, ensuring that they are able to access HIV prevention information and tools (e.g. condoms and lubricant), as well as treatment for those who are infected, can curb the HIV epidemic in countries where infection rates among men who have sex with men are high. When adjudicating allegations of assault and extortion because of sexual orientation, judges and magistrates can make important pronouncements regarding the security of all people, regardless of their sexual orientation or other traits. Assault and extortion are not to be tolerated in any circumstances, and by upholding the rule of law, the judiciary both protects individual rights and enables an effective HIV response.

2. Prosecution of HIV prevention activities

The staff of non-governmental organisations providing HIV prevention interventions to gay men have been subject to police harassment, extortion, arbitrary detention and arrest for alleged violations of criminal laws prohibiting homosexuality, as well as laws that are intended to protect morality and decency (e.g. laws against "anti-social" or "immoral" behaviour or the "promotion of homosexuality"). Some have also been charged with public nuisance or breach of censorship laws (which may restrict the publication of images or messages relating to homosexuality, including safer sex materials).[716]

For example, in December 2008, police arrested and charged nine members of AIDES Senegal (an organisation carrying out HIV education and outreach among men who have sex with men) with engaging in homosexual conduct contrary to Senegal's *Criminal Code*.[717] At trial, prosecutors apparently used condoms and lubricants found in their house — tools used for HIV prevention work — as evidence of homosexual conduct. The men received the maximum five-year sentence, as well as an additional three years for being

found guilty of forming a "criminal association".[718] The ruling was reported to have produced widespread panic among organisations addressing HIV and AIDS in Senegal, particularly those working with gay men and other marginalised populations.[719]

Similarly, in Lucknow, India, police arrested four HIV outreach workers and charged them with possession of obscene materials and conspiracy to commit sodomy following police raids on their offices in 2001.[720] As a result, the HIV prevention work of the organisations was suspended for more than five months.[721]

An overzealous application of laws prohibiting same-sex relations has significant implications for HIV prevention. The harassment, detention, arrest and prosecution of those involved in HIV prevention work (including gay men involved in peer outreach) impair the access to crucial HIV prevention information and materials for men who have sex with men. As illustrated by the case in Senegal (discussed above), this has broader consequences for HIV prevention work as a whole, especially when HIV organisations serving gay men are criminalised by mere virtue of possession of condoms and lubricant. Judges and magistrates adjudicating allegations of "immoral" or "anti-social" behaviour should be aware of the detrimental public health ramifications of convicting individuals for doing HIV outreach work. Where there is evidence of abuse of power, courts must also hold police accountable for their conduct.

3. Impact of criminalisation on HIV prevention, care, treatment and support

The criminalisation of same-sex relations has a detrimental impact on public health, including the alienation from health-care services of men who have sex with men. This is particularly so where the death penalty is imposed for same-sex activity — doubtless a considerable deterrent to seeking HIV education, treatment, care or support.

The provision of the *Indian Penal Code* pursuant to which HIV outreach workers had previously been charged (see above) was considered by the Delhi High Court in 2009 in the case of *Naz Foundation v. Government of NCT*. In that instance, a lawsuit was brought claiming that the provision that criminalised those who have "carnal intercourse against the order of nature" obstructed HIV prevention efforts and perpetuated negative and discriminatory beliefs towards same-sex conduct. Evidence was introduced describing how people were reluctant to reveal same-sex sexual activity due to their fear of law enforcement agencies, making it difficult for public health workers to access them. In its decision, the Court accepted that criminalisation is harmful to HIV responses and read down the provision to exclude consensual sex between adults, effectively decriminalising homosexuality in India's National Capital Territory.[722]

Similarly, in *Toonen v. Australia*, in which Tasmanian law criminalising consensual sex between adult men was challenged, the United Nations Human Rights Committee rejected the Tasmanian authorities' submission that the laws were justified on public health grounds (namely, that they prevent the spread of HIV in Tasmania) and accepted that criminalisation tended "to impede public health programmes 'by driving underground many of the people at the risk of infection'".[723] The Commission consequently held that there had been a violation of Toonen's rights and that an effective remedy would be the repeal of the impugned provisions of the Tasmanian *Criminal Code*.[724]

While some may argue that criminal laws relating to same-sex conduct should be left to legislators, a number of courts around the world have invalidated laws criminalising homosexuality on the basis of human and constitutional rights.[725] *(See the case summary at the end of this chapter for one example.)* The European Court of Human Rights addressed this issue, and when confronted with arguments pertaining to the right to religious and cultural freedom as justifications for the criminal provisions, that Court found (while acknowledging the legitimate aims of the protection of morals) no "pressing social need" for the retention of

legislation criminalising same-sex sexual behaviour. It concluded that even if there were justification for their retention, the detrimental effects of such legislation outweighed the aim pursued in the retention of the laws.[726]

When the difficult question of the constitutionality of laws criminalising same-sex conduct comes before a court, the impact of criminalisation on the right to health (and specifically HIV) is a relevant consideration. Based on current evidence, if same-sex relations remain criminalised, it is likely that HIV interventions for men who have sex with men will continue to be inadequate, gay men will continue to be marginalised from health services, and HIV epidemics will escalate.

Moreover, although HIV prevalence in prisons around the world is generally higher than in the community, few prison systems provide condoms to prisoners, in spite of the common occurrence of both consensual sex and sexual violence behind bars, as well as the fact that coerced or non-consensual sex poses a significant risk of HIV transmission.[727] This has potentially fatal consequences for prisoners, especially in jurisdictions where HIV treatment is not available in prison.[728] Courts may thus consider alternative sentences such as "house arrest" and community service, as appropriate, in order to protect key populations from an escalated HIV risk in prison.[729]

Key questions to consider on HIV and sexual minorities

- What specific offence is alleged? Does the evidence support this specific offence?
- If the accused is a sexual minority, have their rights been fully protected? Whether or not the court needs to impose a sentence under the criminal law, sexual minorities have the same human and constitutional rights as every other citizen.
- For any charged offence, what is the appropriate remedy or punishment that will protect the rights and not impede HIV prevention, care, treatment and support for individuals living with and vulnerable to HIV?

Highlighted cases

Canada:
Court strikes down criminal provisions prohibiting activities related to prostitution

Bedford v. Canada, 2010 ONSC 4264, Ontario Superior Court of Justice

Parties

The applicants — Terri Jean Bedford, Amy Lebovitch and Valerie Scott — were former and current sex workers. The respondent was the Attorney General of Canada.

Remedy sought

The applicants sought an order to strike down three provisions of the Canadian *Criminal Code* dealing with adult prostitution.

1. keeping a common bawdy-house;
2. living on the avails of prostitution; and
3. communicating in a public place for the purpose of engaging in prostitution.

Outcome

The Ontario Superior Court of Justice found the impugned provisions had the effect of forcing sex workers to choose between their constitutional rights to liberty (by virtue of the threat of incarceration upon conviction) and personal security, and thus were not in accordance with the principles of fundamental justice. The Court also found the communicating provision was "overbroad" in achieving its legislative purpose and had the effect of increasing the risk of violence faced by sex workers. Therefore, the impugned provisions were ordered struck down. [The Government of Canada appealed this decision, and in 2012, the Ontario Court of Appeal upheld the lower court's decision to strike down the prohibition on common bawdy houses, revising the prohibition regarding "living on the avails" of prostitution by limiting criminalisation to situations where there are demonstrated "circumstances of exploitation", and maintaining the prohibition on communication. At the time of writing, both parties had appealed the decision to the Supreme Court of Canada.]

Background and material facts

Prostitution is not illegal in Canada, although various aspects of prostitution are criminalised. The applicants had personally endured or witnessed physical, verbal and sexual abuse while working on the street. In the hopes of increased security, Ms. Bedford, a former sex worker, had worked indoors but was convicted of operating and working at a bawdy house. Ms. Lebovitch and Ms. Scott wished to work indoors for increased security, but they feared conviction for themselves and their partners, who could have been charged with living on the avails of prostitution.

Legal arguments and issues addressed

The applicants submitted that the impugned provisions were unconstitutional since they prevented sex workers from conducting lawful business in a safe environment, thereby violating their rights both to freedom of expression and to life, liberty and security of the person as guaranteed by the *Canadian Charter of Rights and Freedoms*.

The respondents submitted that Parliament had chosen to criminalise the most harmful and public aspects of sex work to protect both the individuals involved and society at large. They also argued that sex work is associated with other harmful activities, including physical violence, drug addiction, trafficking and organised crime, and they referred to a 1990 decision by the Supreme Court of Canada that found the impugned provisions to be a reasonable limit on the constitutional rights of sex workers. [730]

While acknowledging the 1990 Supreme Court of Canada decision, the Court recognised the need to revisit the constitutionality of the impugned provisions given a) the breadth of new evidence that had emerged in the intervening 20 years, and b) the changes in Canada's socio-political and economic landscape and the legal reforms to decriminalise various aspects of sex work in other western democracies.

The Court conducted an analysis of the legislative objectives behind each provision.

1. Prohibition of bawdy houses: reducing neighbourhood disruptions, safeguarding public health and safety, and reducing public nuisance.
2. Prohibition of living on the avails of prostitution: preventing the exploitation of sex workers and the parasitic profiting of "pimps" from prostitution.
3. Prohibition on communicating for the purposes of prostitution: eradicating social nuisances that arise from public displays of the sale of sex.

The Court held that the provisions deprived the applicants of their right to liberty through the possibility of imprisonment upon conviction. In considering whether there was a sufficient causal connection between the provisions and the violation of the Applicants' right to personal security, it concluded that two factors affected the level of violence faced by sex workers: work location (with sex workers who work on the street facing a higher risk of danger) and individual working conditions.

The Court accepted that the impugned provisions made many of the methods for conducting prostitution in a safer manner illegal. For example, the evidence demonstrated a significant reduction in the risk of violence faced by sex workers who worked indoors (i.e. in a bawdy house), where sex workers can collect credit card numbers, screen potential clients, enforce condom use and develop a regular clientele. In its effect, the bawdy house provision forced sex workers to work in remote, secluded areas, where they were more prone to face danger. The "living on the avails" provision made it illegal for sex workers to hire managers, drivers or bodyguards who could offer protection. The communicating provision compelled outdoor sex workers to rush transactions without properly screening for dangerous individuals posing as clients or negotiating the terms of sex, including safer sex, thereby increasing their risk of danger. Although it was the client who ultimately inflicted violence on the sex worker, the Court held that the law played a strong contributory role in preventing sex workers from taking steps that could increase their personal security.

These deprivations were not in accordance with principles of fundamental justice, as they were grossly disproportionate to their legislative purposes and placed sex workers at greater risk of experiencing violence. The bawdy house and living on the avails provisions were also broader than necessary, as they assigned

criminal liability to individuals who could assist in ensuring the safety of a sex worker, thus exceeding the state's objective of criminalising those who exploited sex workers.

The communicating provision was also held to infringe the applicants' right to free expression, because it curtailed all communication for the purpose of engaging in sex work, including expression necessary for personal security. Furthermore, the evidence submitted at trial proved that the impugned provision did not effectively curtail social nuisance and merely increased the risk of harm faced by sex workers.

Commentary

The Ontario Superior Court of Justice's decision in this case is notable in that it rejects the simplistic assumption that criminalising something will make all of the harms associated with it disappear. The Court did a comprehensive analysis of the evidence regarding how the laws were enforced and what the impacts were, revealing that harms such as physical violence, drug addiction, human trafficking and organised crime were not eradicated because sex work was criminalised; in fact, sex workers were less able to protect themselves from these harms as a result of the law. In this way, the Court did not allow religious, moral or ideological positions to nullify the human rights of individuals involved in sex work, and it put the government on notice that it needed to legislate in order to protect the rights of all Canadians, irrespective of their occupation.

High Court of Delhi, India: Court strikes down provision criminalising homosexuality

Naz Foundation v. Government of NCT of Delhi and Others, High Court of Delhi, 2009 (160) DLT 277

Parties

The applicant Naz Foundation is a non-governmental organisation working in the field of HIV intervention and prevention. The respondents were the Government of the National Capital Territory of Delhi and the Union of India.

Remedy sought

The applicant sought an order declaring section 377 of the *Indian Penal Code* unconstitutional, to the extent that it criminalised the private same-sex activities of consenting adults.

Outcome

The High Court ruled in favour of the applicant. The impugned provision, insofar as it criminalised the private, consensual sexual acts of adults, was declared unconstitutional. [At the time of writing, this decision had been appealed to India's Supreme Court, which heard arguments in 2012. A decision is pending.]

Background and material facts

Section 377 of the *Indian Penal Code* criminalised "unnatural offences", including "carnal intercourse against the order of nature with any man, woman, or animal".[731] The impugned provision had historically been interpreted to include oral sex, anal sex and penetration of other non-vaginal orifices under the ambit of "unnatural" sex.

The Naz Foundation brought the action after their HIV prevention efforts were severely impaired by the discriminatory attitudes of state agencies towards India's gay community. The applicant observed state agencies subjecting members of the gay community to harassment, questioning, extortion, forced sex and payments of hush money — largely through the enforcement of section 377. Individuals, including MSM, consequently hid their same-sex activity, along with any illnesses, from health providers for fear of criminal sanction. The applicant argued that section 377 was a major impediment to safely conducting HIV prevention, treatment, care and support.

Legal arguments and issues addressed

The applicant argued that section 377 arbitrarily targeted members of the gay community and conveyed the message that its members were of less value, thereby infringing their rights to equal treatment, life, liberty and free expression.

The Court held that in order to be meaningful, the rights to life and liberty must include the concepts of individual privacy, dignity and autonomy, of which sexual intimacy was at the core; it therefore must be afforded protection.[732] The Court also held that the impugned provision was archaic and inconsistent with international law and values of dignity, inclusion and respect for all.

In examining whether the impugned provision also infringed on the right to equality, the Court found that section 377 did not distinguish between public and private acts, or between consensual and non-consensual acts. It also did not consider relevant factors such as age, consent or the absence of harm. Criminalisation in the absence of evidence of harm was thus arbitrary and irrational. The Court further dismissed the respondents' submission that the objective of section 377 was to protect against sexual abuse.

Although "sexual orientation" is not explicitly enumerated as a prohibited ground of discrimination in the Indian Constitution, the Court considered the ICCPR, the *Yogyakarta Principles*, the *European Convention on Human Rights*, and comparative case law that either had evolved to include "sexual orientation" as a prohibited ground of discrimination or had interpreted "sex" to also include "sexual orientation" as an analogous prohibited ground of discrimination. The Court agreed with these interpretations and held that in its operation, section 377 targeted members of the gay community, subjecting them to extensive prejudice and persecution.

Having established that constitutional rights to life, liberty, equality and non-discrimination of the gay community had been infringed, the Court considered the respondents' submissions that section 377 should nevertheless be upheld as it served the compelling state interests of a) public safety and health, and b) the protection of Indian sexual values and morals.

Evidence submitted by the National AIDS Control Organization showed that section 377 not only rendered men who have sex with men and gay individuals vulnerable to police harassment and isolation, but that it effectively made them inaccessible for the purposes of HIV prevention. Moreover, no scientific study or reputable research supported the respondents' assertion of a causal connection between the decriminalisation of homosexuality and the spread of HIV. The Court thus held that, contrary to the respondents' submission, the evidence showed the compelling state interest of public health would be best served through decriminalising same-sex activity.

The Court also disagreed with the respondents' second submission regarding social mores and values, and it held that moral disapproval alone was not a legitimate state interest for the purpose of upholding a statute that infringes on the constitutional rights of individuals.

Commentary

This case sets a very positive precedent in Indian law for the rights of sexual minorities. The Delhi High Court looked to international human rights law on the question of whether sexual orientation is a prohibited ground of discrimination, finding that contemporary interpretations favoured the prohibition of discrimination on the basis of sexual orientation. This recognition of the evolution of human rights promotes greater inclusion and dignity for all people.

It is noteworthy that the Court looked at evidence of the impacts of criminalising same-sex conduct, rejecting the notion that moral disapproval or public values were sufficient grounds upon which to limit rights. Given the well-documented adverse impacts of criminalising homosexuality, the careful consideration of this evidence allowed the Court to make a ruling that both protected individual rights and was supportive of evidence-based public health interventions.

Supreme Court of the United States: Court strikes down provision criminalising same-sex sexual activity

John Geddes Lawrence and Tyron Garner, Petitioners v. Texas, United States Supreme Court, 539 U.S. 558 (2003)

Court and date of decision

The decision was delivered by the Supreme Court of the United States on 26 June 2003.[733]

Parties

The applicants were John Geddes Lawrence and Tyron Garner. The respondent was the State of Texas.

Remedy Sought

The applicants challenged the constitutional validity of section 21.06(a) of the *Texas Penal Code,* which stated that "a person commits an offense if he engages in deviate sexual intercourse with another individual of the same sex".[734] The applicants argued that the impugned provision violated the guarantee of "Equal Protection" under the Fourteenth Amendment of the *United States Constitution*[735] because the same sexual conduct was permissible between heterosexual couples. The applicants also argued that criminal conviction for adult consensual sexual acts in private violated the liberty and privacy protections under the "Due Process Clause" of the Fourteenth Amendment.

Outcome

The majority of the Court held that the impugned provision be struck down, for being in violation of the applicants' constitutional rights to equality and liberty, as seen through the equality and due process clauses of the Constitution.

Background and Material Facts

The applicants were arrested when police officers entered the private residence of one of the applicants to investigate an allegation of weapon disturbance. Upon entering the apartment, the officers witnessed the applicants, both adult men, engaging in consensual anal sex. The applicants were arrested, held in custody overnight, and charged and convicted of engaging in "deviate sexual intercourse" under the impugned provision.[736]

The applicants appealed their conviction, but the Texas Criminal Court rejected the applicants' request. The case was heard by the Texas Court of Appeals, Fourteenth District, but the applicants' arguments were rejected; the Court upheld their conviction on the basis of the leading precedent in *Bowers v. Hardwick*, a decision of the U.S. Supreme Court.[737] The applicants then requested a review of the decision by the Texas Court of Criminal Appeals, but their request was denied. On 2 December 2002, the Supreme Court granted a writ of *certiorari* to hear the applicants' arguments.

Legal arguments and issues addressed

The Court began by addressing whether *Bowers* should still be considered binding precedent. *Bowers* was similar to the present case on its facts, but the impugned provision in *Bowers* criminalised specific sexual conduct for all forms of sexuality, including heterosexual sex. The Court recognised the importance of *stare decisis* and the particular need for exercising caution when reversing precedent that interprets a constitutional right.[738]

The Court noted the various criticisms of the ruling in *Bowers* within the United States, as well as the European Court of Human Rights' rejection of its reasoning.[739] The Court stated that the *Bowers* ruling failed to properly articulate the issue for consideration. In *Bowers*, the issue was reduced to a question of the moral appropriateness of particular sexual conduct, without appreciating the full implications of the impugned provision on the constitutional rights to liberty and privacy. Thus, the majority decision in *Bowers* was determined through a consideration of the historic attitudes towards homosexuality, which were based on the religious and moral views of a majority of society.

The Court held that equality and due process rights are closely linked to the liberty guarantee, and it further recognised that the criminalisation of conduct common to a same-sex lifestyle invites discrimination towards members of the lesbian, gay, bisexual and transgender (LGBT) community.

Thus, the Court considered the dissenting opinion in *Bowers*, which analysed the effects of the impugned provision on the right to liberty. The dissent held that it was insufficient to uphold a law prohibiting a practice, simply because the majority of a society viewed the practice as immoral. The dissent also argued that individual decisions regarding the sexual relationships of unmarried or married persons are a form of the liberty interest, protected by the due process clause of the Fourteenth Amendment. The Court stated that the dissenting opinion should have been the controlling ruling in *Bowers* and overruled *Bowers*.

The applicants challenged the central reasoning of *Bowers,* stating its continuance as precedent demeans the lives of gay and lesbian people, thereby infringing on their constitutional rights to equality and due process. The applicants urged the Court to strike down the impugned provision, following the same reasoning used by the Supreme Court in *Romer v. Evans,* which found a provision directed at same-sex activity to be "born of animosity toward the class of persons affected" and struck it down for violating the Equal Protection Clause.[740]

The majority concluded by stating that the applicants, both consenting adults, engaged in sexual practice common to a LGBT lifestyle, were entitled to their fundamental right to privacy. Thus, the state could not demean or attempt to control their lives by making their private, consensual sexual conduct a crime.

A concurring decision of the Court further highlighted that the State of Texas had previously acknowledged the collateral effects of its sodomy law, stating that the law "legally sanction[ed] discrimination against [homosexuals] in a variety of ways unrelated to the criminal law, [such as] employment, family issues, and housing".[741] The Court held that the majority ruling in *Bowers* never established that moral disapproval of a class of society is a rational basis, under the Equal Protection Clause, to criminalise sexual activity between same-sex couples that was allowed between heterosexual couples. Furthermore, the argument proposed by the State of Texas, that the law discriminated against same-sex conduct rather than same-sex individuals, was dismissed. The Court stated that the conduct targeted by the law was so closely correlated with LGBT sexual expression, that the law targeted LGBT persons as a class.

Commentary

This decision demonstrates another approach to decriminalising same-sex sexual conduct — through the right to privacy. The Court recognised that rights protections should not be subordinated to laws criminalising private, consensual sexual activities. In that way, the Court recognised that sexuality is diverse and also fundamental to human nature. This is a positive development from human rights and public health perspectives.

Appendices

Appendix A
HIV statistics and facts

Global Snapshot, 2011

People living with HIV	34 million
AIDS-related deaths	1.7 million
People newly infected with HIV	2.5 million
People eligible for HIV treatment (in low- and middle-income countries)	14.8 million
People on HIV treatment (in low- and middle-income countries)	8 million
People living with HIV by region	
Sub-Saharan Africa	23.5 million
Asia	4.9 million
North America, Western and Central Europe	2.3 million
Eastern Europe and Central Asia	1.4 million
Latin America	1.4 million
Middle East and North Africa	300 000
Caribbean	230 000
Oceania	53 000

Source: UNAIDS *World AIDS Day Report 2012*, "At a glance", pp. 6–7.

Regional data and facts

The information below is adapted from UNAIDS "Regional Fact sheets 2012",[742] and from WHO, UNAIDS and UNICEF, *Global HIV Report: Epidemic Update and Health Sector Progress Towards Universal Access, 2011 Progress Report*, 2011[743].

Sub-Saharan Africa

- In 2011, there were an estimated 1.8 million new HIV infections in sub-Saharan Africa compared to 2.4 million new infections in 2001 — a 25% decline.
- In 2011, an estimated 23.5 million people living with HIV resided in sub-Saharan Africa, representing 69% of the global HIV burden.
- Women in sub-Saharan Africa remain disproportionately impacted by the HIV epidemic, accounting for 58% of all people living with HIV in the region in 2011.
- In 2011, 92% of pregnant women living with HIV resided in sub-Saharan Africa.
- The vast majority of new HIV infections occurred through unprotected heterosexual intercourse or through mother-to-child transmission. Having unprotected sex with multiple partners and having other sexually transmitted diseases are the greatest risk factors for HIV. Increasing proportions of newly infected people are in cohabiting HIV-discordant relationships. Unprotected paid sex and sex between men are significant factors in several countries in the region.
- Injecting drug use is a relatively recently reported phenomenon in sub-Saharan Africa; high HIV prevalence has been documented among people who use drugs in some cities in the region.
- According to data collected through the People Living with HIV Stigma Index between 2008 and 2011, more than half of people living with HIV in Zambia (52%), Rwanda (53%) and Kenya (56%) reported being verbally abused as a result of their HIV status.
- In Nigeria and Ethiopia, one in five people living with HIV (20%) reported feeling suicidal because of their HIV status.

Asia and the Pacific

- Nearly 5 million people were living with HIV in South, South-East and East Asia combined in 2011.
- In Oceania, an estimated 53 000 people were living with HIV in 2011, compared to 38 000.
- Oceania and South and South-East Asia have made progress in reducing new HIV infections and AIDS-related deaths. In East Asia, new HIV infections and AIDS-related deaths are increasing.
- Country-level progress in reducing new HIV infections varies throughout the Asia Pacific region. For example:
  - In Cambodia, India, Malaysia, Myanmar, Nepal, Papua New Guinea and Thailand, the rate of new HIV infections fell by more than 25% between 2001 and 2011.
  - In Bangladesh, Indonesia, the Philippines and Sri Lanka, the rate of new HIV infections increased by more than 25% between 2001 and 2011.
- In Oceania, an estimated 69% of people eligible for antiretroviral therapy were accessing it in 2011, compared to a global average of 54%. That same year, coverage of antiretroviral therapy was 47% in South and South-East Asia and 18% in East Asia.
- In 2011, only one country in the Asia Pacific region (Cambodia) reached more than 80% coverage of antiretroviral therapy.
- HIV epidemics in Asia and the Pacific remain largely concentrated among injecting drug users, men who have sex with men and sex workers.

- Across the region, wide variations in HIV prevalence among key populations have been documented, as well as significant variations in coverage of HIV prevention services.
- In many countries, stigma and discrimination impeded effective HIV responses. In Myanmar, for example, about 18% of people living with HIV were verbally insulted and 10% were physically assaulted as result of their HIV status, according to surveys collected through the People Living with HIV Stigma Index. In Nepal, about 12% of people living with HIV reported losing a job or income on the basis of their HIV status.

Eastern Europe and Central Asia

- Between 2001 and 2011, the estimated number of people living with HIV in Eastern Europe and Central Asia increased from 970 000 to 1.4 million.
- New HIV infections in the region increased from 130 000 in 2001 to 140 000 in 2011.
- There was a 21% increase in AIDS-related deaths in the region between 2005 and 2011: from 76 000 to 92 000.
- In Eastern Europe and Central Asia, coverage of HIV treatment remains low: an estimated 25% of people eligible for HIV treatment are receiving it. Two countries in the region have achieved more than 60% treatment coverage: Georgia and Romania.
- The HIV epidemics in Eastern Europe and Central Asia are typically driven by unsafe drug injection and by onward transmission to the sexual partners of people who inject drugs.
- According to 2012 country progress reports and UNAIDS estimates, more than 15% of people who inject drugs in Belarus and Tajikistan are living with HIV; more than 20% in Ukraine; and more than 50% in Estonia.
- A number of countries in Eastern Europe and Central Asia reported a low coverage of needle and syringe programmes, including Albania, Armenia, Azerbaijan, Belarus, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Tajikistan and Ukraine. One country in the region, the Czech Republic, reported high coverage of needle and syringe programmes.

Caribbean

- After sub-Saharan Africa, the Caribbean is one of the most heavily affected regions in the HIV epidemic.
- Adult HIV prevalence in 2011 was about 1%, higher than in any other world region outside of sub-Saharan Africa.
- The number of people living with HIV in the Caribbean remains relatively low — 230 000 in 2011 — and has varied little since the late 1990s.
- The region has seen a sharp decline (42%) in new HIV infections since 2001, from 22 000 in 2001 to 13 000 in 2011.
- AIDS-related deaths fell from an estimated 20 000 in 2005 to 10 000 in 2011. Unprotected sex — including paid sex — is the key driver of the epidemic in this region.
- Unprotected sex between men and women — especially paid sex — is thought to be the main mode of HIV transmission in the region.
- According to recent surveys, HIV prevalence among sex workers is considerably higher than in the general population. For example, in the Dominican Republic, HIV prevalence among sex workers is 4.7% compared to a national prevalence of 0.7%.

Latin America

- The HIV epidemics in Latin America are generally stable. The total number of people living with HIV continues to increase, having reached 1.5 million in 2010, in part because of increased access to antiretroviral treatment.
- 36% of adults living with HIV are women.
- There has been a considerable decrease in the number of children newly infected with HIV, from 6300 in 2001 to 3900 in 2010.
- HIV is spreading predominantly in and around networks of men who have sex with men.
- Few national HIV programs focus sufficiently on preventing and treating HIV among men who have sex with men. Countries have generally been more inclined to address HIV transmission during paid sex, with apparent success in some regions.
- Injecting drug use is another significant route of HIV transmission, especially in the Southern Cone and in Mexico. The interplay of drug and sex work is an important factor in some countries.

North America and Western and Central Europe

- The total number of people living with HIV in North America increased from an estimated 1.1 million in 2001 to 1.4 million in 2011.
- In Western and Central Europe, an estimated 900 000 people were living with HIV in 2011, up from 640 000 in 2001.
- In North America and Western and Central Europe, the rate of new HIV infections is relatively stable:
  - About 51 000 people were newly infected with HIV in 2011, compared to 50 000 in 2001.
  - In Western and Central Europe, an estimated 30 000 people were newly infected with HIV in 2011, compared to 29 000 in 2001.
- In Western and Central Europe, the number of people dying from AIDS-related causes fell from 7800 in 2005 to 7000 in 2011.
- In North America, there were approximately 21 000 AIDS-related deaths in 2011 compared to 20 000 in 2001.
- HIV infection trends are showing significant racial, ethnic and socioeconomic disparities. In the United States, young black men who have sex with men have had a marked increase in diagnoses. In Canada, Aboriginal people continue to be overrepresented in the epidemic, accounting for 13% of people newly represented in 2008. Immigrants living with HIV have become growing features in the epidemics of several European countries.
- In North America and Western and Central Europe, HIV prevalence among men who have sex with men (MSM) plays a substantial role in national HIV epidemics:
  - France, the Netherlands and Canada reported an HIV prevalence of 15% or more among MSM compared to a national HIV prevalence in the general population of less than 0.5% in all three countries.
  - Germany, Greece, Belgium, Switzerland, Spain and Portugal reported an HIV prevalence among MSM of at least 10% compared to a national HIV prevalence of 0.6% or lower in all six countries.
- In Western and Central Europe, less than 1 in 3 men who have sex with men were tested for HIV in the past 12 months, according to 2012 country progress reports.
- Reported levels of condom use among MSM were less than 50% in the United States, Netherlands, Sweden and Switzerland. Canada, Belgium, France, Germany, Portugal, Spain and the United Kingdom reported condom use coverage among MSM of 50–74%.
- The decline in infection rates in people who inject drugs in Western Europe and parts of Central Europe are attributed to harm reduction services.

Middle East and North Africa

- Between 2001 and 2011, the estimated number of people living with HIV in the Middle East and North Africa increased from 210 000 to 300 000.
- Since 2001, the number of people newly infected with HIV in the Middle East and North Africa has increased by more than 35% — from 27 000 to 37 000.
- Between 2005 and 2011, there was a significant increase (17%) in AIDS-related deaths in this region — from 20 000 to 23 000.
- Coverage of HIV treatment remains low across the Middle East and North Africa, at 15%. However, between 2009 and 2011, the number of people accessing HIV treatment in the region more than doubled, from 8700 to 17 000.
- In 2011, an estimated 7% of HIV-positive pregnant women in the region received services to prevent mother-to-child transmission (PMTCT) of HIV. The Middle East and North Africa is the only region that has yet to see a reduction in the number of children newly infected with HIV.
- Unprotected sex, including between men, and sharing non-sterile drug injection equipment are the primary drivers of the epidemic in the region. Most people newly infected are men living in urban areas.
- Sex between men is highly stigmatised and criminalised in all countries in the region. High-risk sexual practices, low levels of condom use and generally low levels of HIV knowledge have been observed in several countries among men who have sex with men.

Appendix B
Statement of principles on HIV, the law and the judiciary in sub-Saharan Africa

Meeting of Eminent African Jurists on HIV and the Law in the 21st Century

10–12 December 2009

Johannesburg, South Africa

Background

1. We, judges from more than 15 sub-African countries, met in Johannesburg from 10 to 12 December 2009 to review the role that judges could play to deal constructively with, and mitigate, the harsh impact of the HIV epidemic.

2. We underline that HIV is having a severe impact on the economic, social and cultural fabric of our societies, with adverse effects on the health, human rights and development gains made in the region.

3. We are deeply concerned that sub-Saharan Africa remains the region most severely affected by HIV.

4. We affirm that HIV is fundamentally a human rights issue. We also recognise the universality of the human rights of all persons, including those living with and/or affected by HIV.

Role of the law in responding to the epidemic

5. We note that the law, and the manner in which it is interpreted, applied and developed, has the potential both to mitigate and aggravate the impact of the epidemic. Some laws afford protection whilst others may exacerbate vulnerability to HIV.

6. We recognise that, where no specific legislation relating to HIV exists, other sources of law, including the common law, comparative jurisprudence and/or international law where appropriate, should be expansively and purposively interpreted and developed to ensure the realisation of the human rights of all, including those vulnerable to HIV infection and living with HIV.

Evidence-informed decision-making

7. We recognise the importance of understanding the science of HIV transmission, prevention, treatment, care and support in order to ensure evidence-informed adjudication on all matters related to HIV.

8. We stress the importance of developing guidelines for, and within, our respective judiciaries, aimed at empowering all judicial officers to deliver evidence-informed and rights-based judgments on all matters relating to HIV. In this regard, judicial education should be aimed at the entire hierarchy of the judiciary, including the use of internationally accepted non-stigmatising language. This will help to eliminate myths, misconceptions and prejudices related to HIV and to AIDS.

Stigma and discrimination

9. We are acutely aware of, and concerned about, the continued stigma and discrimination that is experienced by those vulnerable to and living with HIV. Such stigma and discrimination undermine their inherent dignity.

10. We are particularly concerned by the absence of protective anti-discrimination legislation in a number of African countries. We call for a review of all laws to ensure consistency with the *International Guidelines on HIV/AIDS and Human Rights*. Furthermore, laws should be developed, where necessary, to ensure full and effective protection against unfair discrimination on the basis of HIV status.

Protecting and empowering women: the links between HIV, gender-based violence and property rights

11. We recognise that gender inequalities fuel the epidemic in sub-Saharan Africa.

12. We understand that gender-based violence, discrimination against women, inequitable distribution of property and other goods, combined with lack of access to the legal system increase vulnerability to HIV infection.

13. We urge judges to implement widows' inheritance rights, as these rights support food security, economic empowerment and the ability to mitigate the impact of the epidemic.

14. We note the existence of various initiatives aimed at alleviating court backlogs and overcoming barriers to justice, in particular in cases that disproportionately affect women. These measures include specialised courts for issues that affect women, the allocation of particular days to deal with backlogs and barriers, and programmes to cut the costs of access.

15. We call on judiciaries to experiment with these and other initiatives aimed at addressing these barriers.

Protecting and empowering children

16. We recognise that many children are left vulnerable by the HIV epidemic and that this manifests in many ways, including large numbers of orphans, child-headed households, children born with HIV, children vulnerable to trafficking and high HIV prevalence among adolescents.

17. We stress the importance of taking these facts into account when determining the best interests of the child in all relevant HIV-related juridical matters such as guardianship, adoption, inheritance, education, social security, and access to health care services, including voluntary testing and counselling, and prevention, support and treatment services.

Protecting and empowering marginalised and criminalised communities

18. We note that the *Declaration of Commitment on HIV/AIDS*, adopted at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) on 27 June 2001, recognises the existence of "identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection".

19. We stress the importance of enforcing, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of, all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and to developing strategies to combat stigma and social exclusion connected with the epidemic, as agreed by Governments in the *Political Declaration on HIV/AIDS* (2006) at the UNGASS.

Ensuring proper application of criminal law

20. We are mindful of the negative impact that laws that expressly criminalise HIV transmission have on HIV prevention, treatment, care and support programmes. In this regard, we understand that the criminalisation of HIV transmission refers to laws that impose criminal penalties on people living with HIV for not disclosing their HIV status or for exposing others to the virus or for transmitting it, as well as special, HIV-focused prosecutions.

21. We recognise that the use of criminal law to target vulnerable groups undermines prevention, treatment, care and support and increases stigma. It also prevents vulnerable communities from accessing services such as HIV prevention, treatment, care and support.

Court proceedings and access to justice

22. We recognise that the ability to claim human rights relevant in the context of HIV depends on knowledge of rights, access to courts and affordability of legal services.

23. We call on all judicial officers to work towards increasing access to justice by educating the public about the legal process. This will improve transparency of the legal system.

24. We stress the importance of ensuring that the judiciary is able to harness the experience and expertise of civil society in order to enhance access to justice. Mindful of the imperative to respect the separation of powers, we recognise the need for the judiciary to work with the other branches of government to ensure access to justice.

Access to HIV treatment

25. We note the importance of securing, expanding and sustaining access to treatment of proven quality, safety and efficacy, mindful of the fact that for those with access to highly active antiretroviral therapy, HIV infection is ordinarily a chronic manageable condition.

26. We recognise that the judiciary may have an important role to play in relation to a wide range of treatment-related issues such as the provision, expansion, suspension or termination of health services, equal access to such services, public procurement of medicines, and the relationship between intellectual property rights and access to affordable medicines.

The way forward

27. We call upon members of the judiciary to use their positions of power and influence to act as role models by providing leadership on the HIV epidemic in their communities.

28. We commit to upholding the rule of law so that governments fulfil their national and international obligations relevant to HIV.

29. We call upon UNAIDS to establish, as a matter of urgency, a Commission on AIDS and the Law that includes jurists and assists countries to align their laws with the *International Guidelines on HIV/AIDS and Human Rights*.

Appendix C
Selected sources for further information

People living with HIV and key populations: Rights, advocacy and lived experience

AIDES
www.aides.org

Global Forum on MSM and HIV (MSMGF)
www.msmgf.org

Global Network of People Living with HIV (GNP+)
www.gnpplus.net

Global Network of Sex Work Projects (NSWP)
www.nswp.org

International Community Women Living with HIV/AIDS (ICW)
www.icwglobal.org/en

Harm Reduction International (formerly known as International Harm Reduction Association (IHRA))
www.ihra.net

International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)
http://ilga.org

HIV, human rights and law

AIDS and Rights Alliance of Southern Africa (ARASA)
www.arasa.info

AIDSLEX
www.aidslex.org

Canadian HIV/AIDS Legal Network
www.aidslaw.ca

The Centre for HIV Law and Policy
www.hivlawandpolicy.org

Global Commission on HIV and the Law
www.hivlawcommission.org

International Development Law Organization, Health Law
www.idlo.int

Open Society Foundations, Law and Health Initiative
www.opensocietyfoundations.org

Southern Africa Litigation Centre
www.southernafricalitigationcentre.org

Treatment Action Campaign
www.tac.org.za

HIV prevention, treatment, and disease progression

Aidsmap
www.aidsmap.com

Centres for Disease Control and Prevention
www.cdc.gov

Global HIV Prevention Working Group
www.globalhivprevention.org

HIV InSite
http://hivinsite.ucsf.edu/InSite

United Nations organizations and entities

International Labour Organization
www.ilo.org

Joint United Nations Programme on HIV/AIDS (UNAIDS)
www.unaids.org

Office of the High Commissioner for Human Rights (OHCHR)
www.ohchr.org

Office of the United Nations High Commissioner for Refugees (UNHCR)
www.unhcr.org

United Nations Children's Fund (UNICEF)
www.unicef.org

United Nations Development Programme (UNDP)
www.undp.org

United Nations Educational, Scientific and Cultural Organization (UNESCO)
www.unesco.org

United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

www.unwomen.org

United Nations Office on Drugs and Crime (UNODC)

www.unodc.org

United Nations Population Fund (UNFPA)

www.unfpa.org

World Bank

www.worldbank.org

World Food Programme (WFP)

www.wfp.org

World Health Organization (WHO)

www.who.int

Notes

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5. Special thanks to Ruth Carey, an arbitrator with the Landlord and Tenant Board (Ontario, Canada) for sharing her insights. Personal communication, September 2011.
6. See *Kiyutin v. Russia* (European Court of Human Rights, 10 March 2011, app. 2700/10); *Canada (Attorney General) v. PHS Community Services Society,* [2011] S.C.J. No. 44, (Supreme Court of Canada); and *Hoffmann v. South African Airways,* Case CCT 17/00 (2000), (Constitutional Court of South Africa).
7. At the time of this writing, there is no cure for HIV that is generally available. There has been a small handful of highly unusual cases in which specific techniques (e.g., a complete bone marrow transplant) have led to what clinicians have described as a "functional cure". None of these techniques are easily replicable on a mass scale. Research is still in progress.
8. Several well-established guidelines exist for the clinical management of HIV disease, including recommendations about ARV treatment. Some resources also exist that tailor these recommendations for the needs of specific populations (e.g. infants and children, pregnant women, men who have sex with men, and transgender people) and specific contexts (e.g. resource-limited settings). These guidelines are updated regularly as the available evidence about various medications evolves. A compilation is found online at the University of California, San Francisco's *HIV InSite* (found at http://hivinsite.ucsf.edu/global?page=cr-00-04, accessed 24 June 2013). Key among them are the following guidelines from the World Health Organization: *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach* (July 2010); *Antiretroviral Therapy for HIV Infection in Infants and Children* (July 2010); and *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants in Resource-Limited Settings: Towards Universal Access – Recommendations for a Public Health Approach* (July 2010).
9. A very small percentage – less than 1% – of people with HIV appear to have lived for years without taking ARV treatment and without experiencing disease progression. Researchers speculate that there may be some genetic factors that allow these "long-term non-progressors" to keep the virus in check without medication. However, for the vast majority of people, HIV will progress if left untreated, ultimately leading to serious infections, organ damage and death.
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135. Parker R and Aggleton P, *HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action* (The Population Council Inc., 2002), p. 2.
136. Key populations – or key populations at higher risk, as they are often known – are groups of people who are more likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients are at higher risk of HIV exposure than other groups. Prisoners and migrants are also considered key populations in some countries. Each country should define the specific populations that are crucial to its epidemic and response, based on the epidemiological and social context. See UNAIDS, *2011–2015 Strategy: Getting to Zero* (Geneva: UNAIDS, 2010) and Chapter 10 of this handbook, "Human rights and the criminalization of key populations at higher risk of HIV exposure".

137. UNAIDS, *26th Meeting of UNAIDS Programme Coordinating Board: Non-discrimination in HIV Responses*, UNAIDS/PCB(26),10.3, 3 May 2010, p. 5. Citing Morrison K and Negroni M, "A stigma reduction program for health professionals in Mexico: MoKexteya", presented at PEPFAR Annual Meeting, Durban, South Africa, 2006 (abstract 294). See also Visser M, Makin J and Lehobye K, "Stigmatizing attitudes of the community towards people living with HIV/AIDS", *Journal of Community & Applied Social Psychology*, 2006, 16(1):42–58.
138. UNAIDS, *26th Meeting of UNAIDS Programme Coordinating Board: Non-discrimination in HIV Responses*, UNAIDS/PCB(26), 10.3, 3 May 2010, pp. 5–6.
139. Cameron E, "Criminalization of HIV transmission: Poor public health policy", *HIV/AIDS Policy & Law Review*, 14(2), (2009):1, 63–74.
140. *Jorge Odir Miranda Cortez et al. v. El Salvador*, Inter-American Commission on Human Rights, Report No. 29/01, Case 12.249 (2001), at para. 70.
141. For the purposes of this chapter, the term "discrimination" is generally being used to encompass what in various jurisdictions may be referred to as "unfair discrimination", "arbitrary discrimination", or simply "discrimination". While the terminology may vary, the basic concept is the same across jurisdictions: some different treatment is permitted, but prejudicial or distinguishing treatment of an individual based on their actual or perceived membership in a certain group or category (such as their race, gender, sexual orientation, ethnicity, national origin, health status or religion) is not permissible.
142. UNAIDS, *Protocol for the Identification of Discrimination against People living with HIV* (Geneva: UNAIDS, 2000), p. 6.
143. For examples, see Human Rights Watch, *Positively Abandoned: Stigma and Discrimination against HIV-Positive Mothers and their Children in Russia* (2005) and Center for Reproductive Rights, *Rights Violations of HIV-Positive Women in Kenyan Health Facilities* (2008).
144. Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights* (article 2, para. 2, of the *International Covenant on Economic, Social and Cultural Rights*), E/C.12/GC/20, 2 July 2009, para. 2.
145. *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)*, United Nations Commission on Human Rights, Resolution 1995/44, 3 March 1995, para. 1. See also Commission on Human Rights, Resolutions 1996/43, 19 April 1996; 1999/49, 27 April 1999; 2001/51, 24 April 2001; 2003/47, 23 April 2003; and 2005/84, 21 April 2005.
146. Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights* (article 2, para. 2, of the *International Covenant on Economic, Social and Cultural Rights*), E/C.12/GC/20, 2 July 2009, para. 33.
147. Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, CRC/GC/2003/3, 2003, para. 9.
148. *Declaration of Commitment on HIV/AIDS*, UN General Assembly, Res/S-26/2, 27 June 2001, paras. 37 and 58; UN General Assembly, *Political Declaration on HIV/AIDS*, A/RES/60/262, June 2006; and *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, A/65/l.77 June 2011.
149. OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), Guideline 5, pp. 17, 31–21, 83–84.
150. Global Commission on HIV and the Law, *Risks, Rights & Health*, July 2012, Recommendation 1.2.
151. Council of Europe Parliamentary Assembly, *HIV/Aids in Europe*, Resolution 1536, 2007, para. 9.2.
152. *Kiyutin v. Russia* (European Court of Human Rights, 10 March 2011, app. 2700/10), at para. 56.
153. *Rolando Luis Cuscul Privaral and Others affected by HIV/AIDS v. Guatemala*, petition 642-03, 7 March 2005, report no. 32/05 and *Jorge Odir Miranda Cortez and Others v. El Salvador*, case 12.249, 20 March 2009, report no. 27/09.
154. *Convention on the Rights of Persons with Disabilities*, UN Doc. A/61/611 (entered into force 3 May 2008).
155. Article 1 of the Convention states
Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
Article 2 defines discrimination on the basis of disability as:
[A]ny distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. See Elliott R, Utyasheva L and Zack E, "HIV, disability and discrimination: Making the links in international and domestic human rights law", *Journal of the International AIDS Society*, 2009, 12 (available from http://www.biomedcentral.com/1758-2652/12/29/, accessed 24 June 2013).
156. *Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities*, OAS AG/RES 1999:1608, Article 1.
157. UNAIDS, *Report on the Global AIDS Epidemic 2010* (Geneva: UNAIDS, 2010), pp. 127–128.
158. *HIV and AIDS Prevention and Control Act*, Act No. 14 of 2006, sections 31–37.
159. *Employment Act, Bahamas, 2001*, Section 6. As cited in Gable L *et al.*, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington, D.C.: The World Bank, 2007), p. 47.
160. *Anti-Discrimination Act*, New South Wales, Australia, 1977, Section 49ZXB & C. cited in Gable L *et al.*, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington, D.C.: The World Bank, 2007), p. 47.
161. *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Québec (Commission des droits de la personne et des droits de la jeuness) v. Boisbriand (City)*, 2000 SCC 27 [2000] 1 SCR 665 (Supreme Court of Canada), at para. 48.
162. *Bragdon v. Abbott*, 524 U.S. 624 (U.S. Supreme Court, 1998).

163. *XX. V. Gun Club Corporation et al.,* Constitutional Court, Judgment No. SU-256/96 (1996), as quoted in Canadian HIV/AIDS Legal Network and UNAIDS, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV* (Geneva: UNAIDS and Canadian HIV/AIDS Legal Network, 2006), p. 15.
164. *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Québec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, 2000 SCC 27 [2000] 1 SCR 665 (Supreme Court of Canada), at para. 39.
165. Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights* (article 2, para. 2, of the *International Covenant on Economic, Social and Cultural Rights*), E/C.12/GC/20, 2 July 2009, para. 7.
166. *Ibid*., para. 8.
167. Article 2 of the *Convention on the Rights of Persons with Disabilities* defines reasonable accommodation as: [N]ecessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.
168. *The Concept of Reasonable Accommodation in Selected National Disability Legislation: Background Conference Paper prepared by the Department of Economic and Social Affairs*, Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 7th Sess., 2006, UN Doc. A/AC.265/2006/CRP.1. This document provides an overview of the concept of "reasonable accommodation" in legislation in Australia, Canada, the European Union, Ireland, Israel, New Zealand, Philippines, South Africa, Spain, the United Kingdom, the United States of America, and Zimbabwe.
169. The term "blanket exclusion" is used here to refer to a policy, regulation or law that excludes an entire category of people without individual assessment.
170. Fidler D, *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence* (Ardsley: Transnational Publishers, 2000), p. 290.
171. UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex, 1985. While originally drafted with respect to provisions of the *International Covenant on Civil and Political Rights*, *the Siracusa Principles* have been used more broadly and, in particular, with respect to health issues. Many domestic constitutions, human rights acts and jurisprudence contain principles with respect to justifications for rights restrictions, and they prohibit discrimination by private parties as well as governments.
172. UNAIDS, *Protocol for the Identification of Discrimination against People living with HIV* (Geneva: UNAIDS, 2000), p. 8.
173. See www.hivtravel.org for a database of countries' restrictions (accessed 24 June 2013). See also UNAIDS Human Rights and Law team, *HIV-related Restrictions on Entry, Stay and Residence* (updated June 2011), available via www.unaids.org (accessed 24 June 2013).
174. *Kiyutin v. Russia* (European Court of Human Rights, 10 March 2011, app. 2700/10), at para. 9.
175. *Ibid*., at para. 68.
176. *Ibid*., at para. 71.
177. UNAIDS and IOM, *Statement on HIV/AIDS-related Travel Restrictions*, 1 June 2004, para. 1.
178. OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), para 105.
179. *Doe v. Deer Mountain Day Camp, Inc*., 07 Civ. 5495 (United States District Court – Southern District of New York, 2010).
180. *Ibid*., at p. 33.
181. *Ibid*., at p. 35.
182. *Ibid*., at p. 43.
183. *Ray v. School District of DeSoto County*, 666 Federal Supplement 1524 (United States District Court, MD Florida, 1987), at p. 1535.
184. See *Diau v. Botswana Building Society* (BBS), Case No IC 50/2003, Industrial Court of Botswana, 2003; *Canada (Attorney General) v. Thwaites*, [1994] 3 FC 38 (Federal Court of Canada – Trial Division, 1994); *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); and *XX v. Gun Club Corporation et al.*, Constitutional Court, Judgement No. SU-256/96 (1996).
185. *MX v. ZY*, AIR 1997 Bom 406 (High Court of Judicature at Bombay, 1997), at para. 54.
186. *Ibid*., at para. 56.
187. *Thwaites v. Canada (Canadian Armed Forces)*, [1993] CHRD No. 9 (Canadian Human Rights Tribunal, Decision No. 9/93) affirmed in *Canada (Attorney General) v. Thwaites*, [1994] 3 FC 38 (Federal Court of Canada – Trial Division, 1994).
188. *S.A. Security Forces Union v. Surgeon General A.O.,* High Court of South Africa (Transvaal Provincial Division) Case No. 18683107 (20058).
189. Countries that apply general criminal law offences include Canada (sexual assault), the United Kingdom (reckless infliction of grievous bodily harm), New Zealand (criminal nuisance), France (administration of a noxious substance), and the U.S.A. (attempted homicide). At least 63 countries have criminal provisions relating to HIV non-disclosure, exposure and/or transmission in at least one jurisdiction.
190. Bernard E, *HIV and the Criminal Law* (London: NAM, 2010).
191. Global Network of People Living with HIV (GNP+), *The Global Criminalisation Scan Report 2010*, July 2010 (available online at www.gnpplus.net, accessed 24 June 2013).
192. The relevant provision in the model law criminalizes the wilful transmission of HIV, which is defined as "the transmission of HIV virus through any means by a person with full knowledge of his/her HIV/AIDS status to another person". The model provisions also impose specific obligations on people living with HIV, including the duty to disclose their status to their sexual partner(s) within six weeks: AWARE-HIV/AIDS, *Regional Workshop to Adopt a Model Law for STI/HIV/AIDS for West and Central Africa – General Report*, September 2004 (on file with author), articles 1, 26 and 36. Also see Pearshouse R, "Legislation contagion: Building resistance", *HIV/AIDS Policy & Law Review, 2008,* 13(2/3):1–10.

193. For example, in Botswana, section 142 of the *Penal Code* provides higher minimum sentences when a person convicted of rape is HIV-positive. Note that in *Makuto v. State* [2000] 2 BLR 130, the Botswana Court of Appeal interpreted the law to provide for higher minimum sentences only if a convicted offender was proven to be HIV-positive at the time of the commission of the offence. Several concerns have been raised with respect to considering HIV-positive status as an aggravating factor for other offences, including: the passage of time between the commission of the offence and HIV testing (meaning that the offender's status at the time of the commission of the offence remains uncertain); the possibility that the complainant could have infected the alleged perpetrator with HIV, or that both were HIV-positive when the crime occurred; and that it may lead to the use of mandatory testing against alleged sexual offenders, which constitutes a violation of the right to privacy and security. See Patel P, "African case law on HIV", 2010, pp. 13–14 (on file with author).

194. See Burris S *et al.*, "Do criminal laws influence HIV risk behavior? An empirical trial", *Arizona State Journal*, 2007(39):467–520; Galletly C *et al.*, "New Jersey's HIV exposure law and the HIV-related attitudes, beliefs, and sexual and seropositive status disclosure behaviors of persons living with HIV", *American Journal Public Health*, 2012, 102(11):2135–2140.

195. Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV", *AIDS and Behavior,* 2006, 10(5):451–461; Mykhalovskiy E, "The problem of 'significant risk': Exploring the public health impact of criminalizing HIV non-disclosure", *Social Science & Medicine*, 2011, 73(5):668–675; Dodds C *et al.*, "Responses to criminal prosecutions for HIV transmission among gay men with HIV in England and Wales", *Reproductive Health Matters*, 2009, 17(34):135–145; O'Byrne P, "Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?" *Sexuality Research and Social Policy*, 2012, 9(1):70–79; O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results From an Ottawa-based gay men's sex survey", *Journal of the Association of Nurses in AIDS Care*, 2013, 24(1):81–87; and O'Byrne P and Gagnon M, "HIV criminalisation and nursing practice", *Aporia*, 2012, 4(2):5–34.

196. Burris S and Cameron E, "The case against criminalization of HIV transmission", *Journal of the American Medical Association,* 2008, 300(5):578–581 and Jürgens R *et al.*, "Ten reasons to oppose the criminalization of HIV exposure or transmission", *Reproductive Health Matters*, 2009, 17(34):163–172.

197. UNAIDS, *Expert Meeting on the Scientific, Medical, Legal and Human Rights Aspects of Criminalization of HIV Non-disclosure, Exposure and Transmission*, Meeting Report, (Geneva: 3 August to 2 September 2011), p. 9.

198. For example, in Canada, the offence of aggravated sexual assault applies to people living with HIV who do not disclose their HIV-positive status to partners before engaging in sex that poses a "significant risk" of HIV transmission. This offence carries a maximum penalty of life imprisonment. In the United States, some people have been charged for terrorist threats and attempted murder. See UNAIDS, *Expert Meeting on the Scientific, Medical, Legal and Human Rights Aspects of Criminalization of HIV Non-disclosure, Exposure and Transmission*, Meeting Report, (Geneva: 3 August to 2 September 2011), p. 7.

199. Mykhalovskiy E and Betteridge G, "Who? What? Where? When? And with what consequences? An analysis of criminal cases of HIV non-disclosure in Canada", *Canadian Journal of Law and Society*, 2012, 27(1):31–53. Also see examples provided in UNDP, *Global Commission on HIV and the Law:Risks, Rights and Health* (New York: UNDP, 2012), pp. 22–23.

200. UN General Assembly, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover,* Human Rights Council, Fourteenth session, Agenda item 3, A/HRC/14/20, 27 April 27 2010; Athena Network, *Ten Reasons why Criminalisation of HIV Exposure of Transmission Harms Women* (Athena Network, 2009); and Canadian HIV/AIDS Legal Network, *Women and the Criminalization of HIV Non-Disclosure*, Info Sheet (Toronto: Canadian HIV/AIDS Legal Network, 2012).

201. UNAIDS and UNDP, *Policy Brief: Criminalization of HIV Transmission* (Geneva: UNAIDS, August 2008).

202. *Ibid*.

203. UNAIDS, *Ending Overly Broad Criminalisation of HIV Non-disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations* (Geneva: UNAIDS, 2013).

204. *Ibid*.

205. See UNAIDS, *Criminalisation of HIV Non-disclosure, Exposure and Transmission: Background and Current Landscape*, revised version (Geneva: UNAIDS, 2012) and UNAIDS, *Criminalisation of HIV Non-disclosure, Exposure and Transmission: Scientific, Medical, Legal and Human Rights Issues*, revised version (Geneva: UNAIDS, 2012).

206. UNAIDS, *Report of the Expert Meeting on the Scientific, Medical, Legal and Human Rights Aspects of the Criminalisation of HIV Non-disclosure, Exposure and Transmission* (31 August–2 September 2011).

207. UNAIDS, *Report of the High-level Policy Consultation on Criminalisation of HIV Non-disclosure, Exposure and Transmission* (14–15 February 2012).

208. Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44.

209. UNAIDS, *Ending overly Broad Criminalisation of HIV Non-disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations* (2013).

210. Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44. Note that a review analysis of scientific studies found the risk to be slightly lower in high-income countries: 0.08% per unprotected vaginal intercourse from male-to-female in the absence of antiretroviral therapy (i.e. one transmission in 1250 acts). The same review stated the risk level for in low-income countries to be 0.30%: Boily MC *et al.*, "Heterosexual risk of HIV-1 infection per sexual act: Systematic review and meta-analysis of observational studies", *The Lancet Infectious Diseases*, 2009, 9(2):118–129.

211. Vittinghoff E *et al.*, "Per-contact risk of human immunodeficiency virus transmission between male sexual partners", *American Journal of Epidemiology*, 1999, 150(3):306–311.

212. Jin F *et al.*, "Per-contact probability of HIV transmission in homosexual men in Sydney in the era of HAART", *AIDS*, 2010, 24(6):907–913. See also Baggaley R, White R and Boily MC, "HIV transmission risk through anal intercourse: Systematic review, meta-analysis and implications for HIV prevention", *International Journal of Epidemiology*, 2010, 39(4):1048–1063.

213. World Health Organization (WHO), *Mother-to-Child Transmission of HIV* (webpage) (available online at http://www.who.int/hiv/topics/mtct/en/index.html, accessed 24 June 2013).

214. Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44, citing notably UNAIDS, *HIV Prevention Fast Facts* (available online at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/brochurepamphlet/2009/20090401_prevention_fast_facts_en.pdf, accessed 24 June 2013). See also Centers for Disease Control and Prevention, *HIV/AIDS: Questions and Answers* (March 2010) (available online at http://www.cdc.gov/hiv/resources/qa/transmission.htm, accessed 24 June 2013).

215. *Ibid*.

216. Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44, citing notably Vittinghoff E *et al.*, "Per-contact risk of human immunodeficiency virus transmission between male sexual partners", *American Journal of Epidemiology*, 1999, 150(3):306–311. See also NAM, *HIV Transmission and Testing* (2009).

217. Weller SC and Davis-Beaty K, "Condom effectiveness in reducing heterosexual HIV transmission (Review)", *Cochrane Database of Systematic Reviews*, 2002:1.

218. Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44; Attia S *et al.*, "Sexual transmission of HIV according to viral load and antiretroviral therapy: Systematic review and meta-analysis", *AIDS*, 2009, 23(11):1397–1404; and Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy", *The New England Journal of Medicine*, 2011, 365(6):493–505. "Viral load" is the term used to describe the amount of HIV circulating in the body and is usually measured in the blood. Viral load is measured in terms of the number of copies of HIV per millilitre (ml). When viral load is below the level that a test can detect, it is considered "undetectable". This level varies from country to country depending on the available testing technology. In some countries it may be 400 copies/ml; in others 20 or 40 copies/ml. Effective antiretroviral therapy reduces viral load to the undetectable level.

219. NAM, *Post-exposure Prophylaxis (PEP)*, Factsheets (April 2011)(available online at http://www.aidsmap.com/Post-exposure-prophylaxis-PEP/page/1044883, accessed 24 June 2013) and Bernard E, *HIV and the Criminal Law* (London; NAM, 2010).

220. See diverse studies cited in Mykhalovskiy E, Betteridge G and McLay D, *HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario* (August 2010), pp. 26–44 .

221. *Ibid*., and studies cited in NAM, *HIV Transmission and Testing* (London: NAM, 2009).

222. World Health Organization (WHO), *Violence Against Women and HIV/AIDS: Setting the Research Agenda* (Geneva: WHO, 2000). See also Chapter 6 of this handbook, "Sexual assault and domestic violence".

223. *New Zealand Police v. Dalley,* [2005] 22 C.R.N.Z. 495.

224. *Ibid*., at para. 39.

225. *Ibid*., at para. 45.

226. *Ibid*., at paras. 50–51.

227. *"S" v. Procureur-General*, Judgment, 23 February 2009, Court of Justice (Penal Division) (Geneva).

228. *Ibid*.. Description of facts. [Unofficial translation]

229. Vernazza P *et al.*, "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle", *Bulletin des médecins suisses*, 2008, 89(5):165–169. "Effective ART" is defined in the statement as HIV treatment that stably renders the viral load in blood undetectable (viral load below detection limits, <40 copies/ml) for at least six months.

230. *State v. Mubita, 188 P.3d 867 (Idaho 2008)*, as summarized by the Center of HIV Law and Policy (available at http://www.hivlawandpolicy.org/resources/view/544, accessed 24 June 2013). In Idaho (U.S.A.), people living with HIV can be convicted for the transfer of bodily fluids that may contain HIV. The law stipulates that "[a]ny person who exposes another in any manner with the intent to infect or, knowing that he or she [has HIV], transfers or attempts to transfer any of his or her body fluid, body tissue or organs to another person is guilty of a felony". For the purpose of the law, "body fluid" is defined as semen (with or without sperm), blood, saliva, vaginal secretion, breast milk, and urine; "transfer" is defined as engaging in sexual activity by genital-genital contact, oral-genital contact or anal-genital contact, with respect to sexual activities. See IDAHO CODE ANN. § 39-608.

231. *Ibid*.

232. *Criminal Code of Canada*, section 268.

233. UNAIDS, *Fast Facts about HIV* (Geneva: UNAIDS, 2008).

234. Harrison KM *et al.*, "Life expectancy after HIV diagnosis based on national surveillance data from 25 states, United States", *Journal of Acquired Immune Deficiency Syndromes*, 2010, 53(1):124–130; Lewden C and the Mortality Working Group of COHERE, "Time with CD4 count above 500 cells/mm3 allows HIV-infected men, but not women, to reach similar mortality rates to those of the general population: A 7-year analysis", presented at the Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, 2010, abstract 527; and Van Sighem A *et al.*, "Life expectancy of recently diagnosed asymptomatic HIV-infected patients approaches that of uninfected individuals", presented at the Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, 2010, abstract 526.

235. NAM, *Side-Effects,* Fact Sheet (available online at http://www.aidsmap.com/Side-effects/page/1283597, accessed 24 June 2013).

236. GNP+, *Living with HIV* (June 2010) (available online at www.aidslaw.ca/lawyers-kit, accessed 24 June 2013).

237. By the end of 2010, more than six million people in low- and middle-income countries had access to antiretroviral therapy. But despite exceptional progress, the estimated global coverage in low- and middle-income countries is still less than 50% (based on the 2010 WHO guidelines on initiating treatment). UNAIDS, UNICEF and WHO, *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access. Progress Report* (Geneva: WHO, 2011).

238. See Bernard EJ (ed.), *HIV and the Criminal Law* (London: NAM, 2010), pp. 115–118 and Bernard EJ *et al.*, *The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission* (February 2007).

239. Crown Prosecution Service for England and Wales (CPS), *Legal Guidance on Intentional or Reckless Transmission of Sexual Infection* (originally published 2008; updated 15 July 2011) (available online at http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/, accessed 24 June 2013).

240. GNP+, *The Global Criminalisation Scan Report 2010* (July 2010) (available via www.gnpplus.net/criminalisation, accessed 24 June 2013) and Bernard EJ *et al.*, *The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission (*February 2007).

241. See Bernard EJ (ed.), *HIV and the Criminal Law* (London: NAM, 2010), pp. 115–118; and Bernard EJ *et al.*, *The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission*, February 2007.

242. See Bernard EJ *et al.*, *Estimating the Likelihood of Recent HIV Infection – Implications for Criminal Prosecution (2011), p. 3 (available online at* http://www.nat.org.uk/Media%20library/Files/Policy/2011/RITA%20Testing%20Report.pdf*, accessed 24 June 2013).*

243. *The Law on the Prevention and Control of HIV/AIDS 2002, No. NS/RKM/0702/015*, Cambodia. See GNP+, *Global Criminalisation Scan* (available *online at* www.gnpplus.net/criminalisation, accessed 24 June 2013).

244. See Chu S and Elliott R, "Man convicted of first-degree murder sets disturbing precedent", *HIV/AIDS Policy & Law Review*, 2009, 14(2):42–43.

245. *Criminal Code*, section 229.

246. *R. v. Aziga*, Charge to the Jury (1–2 April 2009) Court File No. CR-08-1735 (Ontario Superior Court of Justice), pp. 197–198, as cited in Chu S and Elliott R, "Man convicted of first-degree murder sets disturbing precedent", *HIV/AIDS Policy & Law Review*, 2009, 14(2):42–43, at p. 43.

247. The accused was convicted by a jury of first-degree murder related to the two complainants who had died. It is the first murder conviction for HIV transmission in the world. The accused was also convicted of 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault in relation to sexual encounters he had with a total of 11 women without disclosing his HIV-positive status. Chu S and Elliott R, "Man convicted of first-degree murder sets disturbing precedent", *HIV/AIDS Policy & Law Review*, 2009, 14(2):42–43.

248. Crown Prosecution Service for England and Wales (CPS), *Legal Guidance on Intentional or Reckless Transmission of Sexual Infection* (originally published 2008; updated 15 July 2011) (available online at http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/, accessed 24 June 2013).

249. *Ibid*.

250. *The Queen v. Neal* (Unreported, County Court of Victoria, Judge Parsons, 16 January 2009); *Neal v. The Queen* [2011] VSCA 172.

251. As described in Bernard EJ (ed.), *HIV and the Criminal Law* (London; NAM, 2010), p. 12.

252. GNP+, *The Global Criminalisation Scan Report 2010* (July 2010) (available online at www.gnpplus.net/criminalisation, accessed 24 June 2013) and Galletly CL and Dickson-Gomez J, "HIV seropositive status disclosure to prospective sex partners and criminal law that require it: Perspectives of persons living with HIV", *International Journal of STD and AIDS*, 2009, 20(9):613–618.

253. Siegel K, Lekas HM and Schrimshaw EM, "Serostatus disclosure to sexual partners by HIV-infected women before and after the advent of HAART", *Women & Health*, 2005, 41(4):63–85.

254. Woodsong C and Koo HP, "Two good reasons: Women's and men's perspectives on dual contraceptive use", *Social Science & Medicine*, 1999, 49(5):567–580; studies cited in Wagner GJ *et al.*, "Factors associated with condom use among HIV clients in stable relationships with partners at varying risk for HIV in Uganda", *Aids and Behavior*, 2010, 14(5):1055–1065; and Amnesty International, *Giving Life, Risking Death: Maternal Mortality in Burkina Faso* (London: Amnesty International, 2009). This report describes how opposition to contraception, including condom use, remains widespread in Burkina Faso because it is often rooted in traditional gender roles and the fact that children are generally considered a source of wealth.

255. Bernard E, *HIV and the Criminal Law* (London; NAM, 2010).

256. UNAIDS, *Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Scientific, Medical, Legal and Human Rights Issues,* background paper, revised version (February 2012), p. 23.

257. The prosecutorial guidelines developed in England and Wales call for particular caution when there is no medical diagnosis of HIV; prosecutions will be exceptional. *Crown Prosecution Service for England and Wales (CPS), Legal Guidance on Intentional or Reckless Transmission of Sexual Infection* (originally published 2008; updated 15 July 2011) (available online at http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/, accessed 24 June 2013). See the provisions on knowledge of HIV-positive status.

258. *Ibid*.

259. See *New Zealand Police v. Dalley,* [2005] 22 C.R.N.Z. 495.

260. See the provisions on recklessness in the prosecutorial guidelines developed in England and Wales. Similarly, the law in the state of Idaho (U.S.A.) allows a defence that a licensed physician had advised that the accused was non-infectious. IDAHO CODE ANN. § 39-608.

261. The risk associated with unprotected sex being generally low, the number of incidents of sexual intercourse is a factor to be taken into account. See the provisions on recklessness in the prosecutorial guidelines developed in England and Wales, excerpted below.

262. Loi portant prévention, prise en charge et contrôle du VIH/sida en République du Bénin, n. 2005-31, April 5 2006, article 27: « toute personne se sachant infectée par le virus du SIDA, et qui entretient sciemment des rapports sexuels non protégés avec un ou une partenaire *non informé(e) de son état sérologique* même si celui-ci ou celle-ci est séropositif(ve) ». [emphasis added]

263. *R v. Dica* [2004] EWCA Crim 1103.

264. *State v. Richardson*, 209 P.3d 696 (Kansas Supreme Court, 2009).

265. *Ibid*.

266. See the case of "D.C.", a Canadian woman living with HIV who was charged by her ex-partner for not disclosing her status after she complained to the police for domestic abuse. *R. v. D.C.*, [2008] J.Q. 994 (QL); *R. v. D.C.*, 2010 QCCA 2289; 2012 SCC 48.

267. For a discussion of the challenges associated with HIV disclosure, see Bernard EJ (ed.), *HIV and the Criminal Law* (London; NAM, 2010), p. 70.

268. That argument was rejected in *R. v. Konzani*, where the Court of Appeal of England and Wales held that consent to the risk of transmission must be informed. [2005] EWCA Crim 706.

269. See Crown Prosecution Service for England and Wales (CPS), *Legal Guidance on Intentional or Reckless Transmission of Sexual Infection* (originally published 2008; updated 15 July 2011) (available online at http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/, accessed 24 June 2013). The guidelines describe circumstances of "informed consent" in the absence of disclosure.

270. *Loi n° 2010-03 du 9 avril 2010 relative au VIH SIDA,* section 36: « Personne ne pourra être poursuivi ni jugé aux termes de cette loi pour transmission VIH, ou pour exposition au VIH, lorsque ladite transmission ou exposition se produit dans l'un des cas suivants: la personne vivant avec le VIH a pratiqué des relations sexuelles sans risque y compris avec l'usage du préservatif. »

271. Crown Office and Procurator Fiscal Service of Scotland, "Guidance on intentional or reckless sexual transmission, or exposure to, infection", May 2012, p. 6.

272. AWARE-HIV/AIDS, *Regional Workshop to Adopt a Model Law for STI/HIV/AIDS for West and Central Africa – General Report, September 2004* (on file with author), Article 1.

273. GNP+, *The Global Criminalisation Scan Report 2010* (July 2010) (available online at www.gnpplus.net/criminalisation, accessed 24 June 2013).

274. Csete J, Pearshouse R and Symington A, "Vertical HIV transmission should be excluded from criminal prosecution", *Reproductive Health Matters*, 2009, 17(34):154–192 at 158–159.

275. According to the Center for Reproductive Rights, 215 million women worldwide don't have access to modern contraceptive technologies. In the United States, approximately half of the over six million annual pregnancies are unplanned. See "Celebrating World Contraception Day", September 2010 (available online at http://reproductiverights.org/en/feature/celebrating-world-contraception-day, accessed 24 June 2013). See also Amnesty International, *Giving Life, Risking Death: Maternal Mortality in Burkina Faso* (London: Amnesty International, 2009).

276. Amnesty International, *Giving Life, Risking Death: Maternal Mortality in Burkina Faso* (London: Amnesty International, 2009) and UNICEF, *Factsheets on the Status of National PMTCT Responses in the Most Affected Countries* (2010) (available online at http://uni.cf/7dWbtX, accessed 24 June 2013).

277. UNAIDS, UNICEF and WHO, *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access. Progress Report* (Geneva: WHO, 2011), p. 150.

278. For example, in 2010, an estimated 35% of the estimated 123 million pregnant women in low- and middle-income countries received an HIV test. In eastern and southern Africa, only 61% of pregnant women were tested for HIV. *Ibid.*

279. Center for Reproductive Rights, *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities* (New York and Santiago: Center for Reproductive Rights, 2010).

280. *Ibid*.

281. Coovadia HM *et al.*, "Mother-to-child transmission of HIV-1 infection during exclusive breastfeeding in the first 6 months of life: An intervention cohort study", *Lancet*, 2007, 369(9567):1107–1116. As the World Health Organization notes, "the most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances". World Health Organization, "Consensus statement from the WHO HIV and infant feeding technical consultation" (Geneva, 2006) available online at http://www.who.int/maternal_child_adolescent/documents/if_consensus/en/index.html, accessed 24 June 2013).

282. Csete J, Pearshouse R and Symington A, "Vertical HIV transmission should be excluded from criminal prosecution", *Reproductive Health Matters,* 2009, 17(34):154–162.

283. HIV/AIDS Legal Centre New South Wales (HALC), *HIV/AIDS Sentencing Kit,* 3rd ed. (2000).

284. See, for instance, UNODC, UNAIDS and World Bank, *HIV and Prisons in Sub-Saharan Africa* (2007).

285. *Ibid*.

286. *R. v. Dwyer* (unreported, NSW CCA, February 23, 1994), cited in HIV/AIDS Legal Centre New South Wales (HALC), *HIV/AIDS Sentencing Kit*, 3rd ed. (2000).

287. *R. v. D.C.*, (July 8, 2008), Longueuil 505-01-058007-051.

288. Another issue on appeal was whether section 20 of the *Offences against the Person Act 1871* (reckless infliction of grievous bodily harm) could be applied in cases of HIV transmission. The Court of Appeal ruled in *R. v. Clarence* (1989) that "suggest[ing] that consensual sexual intercourse of itself was to be regarded as consent to the risk of consequent disease … [and is] no longer authoritative". As a result, prosecutions of people living with HIV accused of recklessly transmitting HIV during consensual sexual intercourse without having disclosed their HIV status would no longer be limited by what the Court described as "outdated restrictions" and could be pursued under section 20.

289. Based on the decision in the case of *R. v. Brown & ors* [1994] 1 AC 212 (House of Lords).

290. On this issue, the prosecutorial guidance developed in England and Wales states that informed consent to take the risk of being infected by engaging in sexual activity with a person who is infectious if the complainant is knowledge of the defendant's specific infected status. However, this does not necessarily require that the person living with HIV has disclosed their HIV status to the complainant; the complainant could have been informed by a third party or aware from other circumstances. Crown Prosecution Service for England and Wales (CPS), *Policy on Prosecuting Cases Involving the Intentional or Reckless Sexual Transmission of Infection* (originally published 2008; updated 15 July 2011) (available via www.cps.gov.uk, accessed 24 June 2013).

291. Although gender-based violence primarily harms women and girls, men, boys and transsexual/transgender people also suffer from domestic violence and sexual assault. See Dunkle KL *et al.*, **"***Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa", Lancet*, 2004, 363:1415–*1421;* Dunkle KL *et al.*, *"Perpetration of partner violence and HIV risk behavior among young men in the rural Eastern Cape, South Africa", AIDS*, 2006, 20(16):2017–*2114; Sivakumaran S, "Sexual violence against men in armed conflict", European Journal of International Law, 2007, 18(2):253–276; and Stotzer R, "Violence against transgender people: A review of United States data", Aggression and Violent Behaviour, 2009, 14(3):170–179.* Note that some of the content of this chapter is adapted from Pearshouse R and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS—Volume One: Sexual and Domestic Violence* (Toronto, Canada: Canadian HIV/AIDS Legal Network, 2009) (available online at www.aidslaw.ca/women, accessed 24 June 2013).
292. UN General Assembly, *Declaration on the Elimination of Violence against Women,* A/RES/ 48/104, 20 December 1993, preamble.
293. The term "survivor" is used in throughout this text to refer to a person who has experienced rape, sexual assault or domestic violence.
294. World Health Organization (WHO), *Violence Against Women and HIV/AIDS: Setting the Research Agenda* (Geneva: WHO, 2000) and UNAIDS, *Facing the Future Together: Report of the Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa* (Geneva: UNAIDS, 2004).
295. WHO, *World Report on Violence and Health* (Geneva: WHO, 2002).
296. *Ibid.* See also UNAIDS and Global Coalition on Women and AIDS, *Violence Against Women and HIV/AIDS: Critical Intersections,* Information Bulletin Series, 1–9 (Geneva: UNAIDS, 2004).
297. WHO, *World Report on Violence and Health* (Geneva: WHO, 2002).
298. United Nations Population Fund (UNFPA), *State of World Population 2005 — The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*, Chapter 7 (available online at http://www.unfpa.org/swp/2005/english/ch7/index.htm, accessed 24 June 2013).
299. The UNFPA reports that nearly 50% of all sexual assaults worldwide are against girls 15 years old or younger: United Nations Population Fund (UNFPA), *State of World Population 2005 — The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*, Chapter 7
(available online at http://www.unfpa.org/swp/2005/english/ch7/index.htm, accessed 24 June 2013).
300. Human Rights Watch, *Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence* (2004).
301. See UN General Assembly, *Intensification of Efforts to Eliminate All Forms of Violence Against Women*, Resolution 63/155, 30 January 2009.
302. United Nations Commission on Human Rights, *Elimination of Violence Against Women*, Resolution 2005/41, para. 9.
303. Global Commission on HIV and the Law, *Risks, Rights & Health* (July 2012), Recommendation 4.1.
304. *International Covenant on Civil and Political Rights*, 16 December 1966, 999 U.N.T.S. 171 (entered into force 23 March 1976), Article 6; *Protocol on the Rights of Women in Africa*, Article 4.
305. *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976), Article 12; *Conventional on the Elimination of all Forms of Discrimination against Women*, 13 September 2000, O.A.U. Doc. CAB/LEG/66.6 (entered into force 25 November 2005, Article 14.
306. *International Covenant on Civil and Political Rights*, Article 7; *Protocol on the Rights of Women in Africa*, Article 4.
307. *Ibid.,* Article 8.
308. *Ibid.,* articles 9 and 10; *Protocol on the Rights of Women in Africa,* Article 4.
309. *International Covenant on Civil and Political Rights,* Article 26; *Protocol on the Rights of Women in Africa,* Article 8.
310. *Convention on the Elimination of all forms of Discrimination against Women*, Article 16.
311. *International Covenant on Economic, Social and Cultural Rights*, Article 7.
312. CEDAW Committee, *General Recommendation No. 19: Violence Against Women (Eleventh Session, 1992)*, UN Doc A/47/38, 1993.
313. *Ibid.*, para. 1.
314. *Ibid.,* para. 9. Similarly, the 1993 *Declaration on the Elimination of Violence against Women* directs that states should "[e]xercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons". General Assembly Resolution 48/108, 20 December 1993, Article 4(c).
315. *Ibid.*, para. 23.
316. Statistics show that women bear the brunt of domestic violence. For example, the WHO estimates that the proportion of women per country who have experienced physical or sexual violence, or both, by an intimate partner in their lifetime ranges from 15–71%: WHO, *WHO Multi-Country Study on Women's Health and Violence Against Women: Initial Responses on Prevalence, Health Outcomes and Women's Responses* (Geneva: WHO, 2005).
317. For example, [U.S.A.] National Council of Juvenile and Family Court Judges, *Model Code on Domestic Violence*; South Africa, *Domestic Violence Act of 1998.*
318. See *Combating of Domestic Violence Act, No. 4 of 2003,* Namibia, Article 3.
319. Pearshouse R and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS—Volume One: Sexual and Domestic Violence* (Toronto, Canada: Canadian HIV/AIDS Legal Network, 2009), at pp. 2–6 (available online at www.aidslaw.ca/women, accessed 24 June 2013). This list was compiled with reference to domestic legislation of Namibia, South Africa, Ghana and India. See also the UN General Assembly, *Declaration on the Elimination of Violence against Women*, Res. No. 48/104, 20 December 1993.
320. Centers for Disease Control and Prevention, "Updated U.S. public health service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis", *Morbidity and Mortality Weekly Report*, 54 (RR09):1–17.
321. Centers for Disease Control and Prevention, "Antiretroviral post-exposure prophylaxis after sexual, injection-drug use, or other non-occupational exposure to HIV in the United States", *Morbidity and Mortality Weekly Report* 54 (RR02):1–20.

322. United Nations Human Rights Commission, *Elimination of Violence Against Women*, Resolution 2003/45, para. 14.

323. Alternatively, restraining orders, non-molestation orders or ouster orders. For the purposes of this chapter, the term "protection order" will be used in relation to all such orders.

324. The standard conditions of protection orders are that the violence must cease and the perpetrator must surrender their firearm, where applicable. Further conditions may include:
• prohibiting the respondent from contacting the applicant, any child or person in the care of the applicant, or specified members of the applicant's family;
• prohibiting the respondent from loitering near or preventing access to the applicant's place of residence or work, following the applicant, or entering or remaining on land occupied by the applicant;
• granting the applicant and dependents of the applicant exclusive occupation of a joint residence, regardless of whether the residence is owned or leased jointly by the parties or solely by one of them;
• directing the respondent to pay rent for the applicant or otherwise make arrangements for the accommodation or shelter of the applicant and dependents;
• granting temporary sole custody of a child; or
• any other provisions that the court deems reasonably necessary to ensure the safety of the complainant or any child or other person who is affected.
On legislative provisions for protection orders, see Pearshouse R and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS—Volume One: Sexual and Domestic Violence* (Toronto, Canada: Canadian HIV/AIDS Legal Network, 2009), Module 2 (available online at www.aidslaw.ca/women, accessed 24 June 2013).

325. *A.T. v. Hungary*, Communication No. 2/2003, (CEDAW, 2005).

326. *Ibid*., at para. 2.4.

327. *Ibid*., at para. 9.3.

328. *Ibid*., at para. 9.6.

329. Except in limited, enumerated circumstances, applications made by a third party under this provision of Namibia's *Combating of Domestic Violence Act* must be made with the written consent of the complainant. See also *Domestic Violence Act of 2006*, Republic of Zimbabwe, Article 7; *Domestic Violence Act of* 2007, Republic of Ghana, Article 12; Victoria, Australia, *Crimes (Family Violence) Act of 1987*, section 7; and Schollenberg E and Gibbons B, "Domestic violence protection orders: a comparative review", *Canadian Journal of Family Law*, 1992, 10:191–238, at p. 211.

330. United Nations Division for the Advancement of Women and United Nations Office on Drugs and Crime, *Good Practices in Legislation on Violence Against Women: Report of the Expert Group Meeting* (2008), p. 55.

331. See the definition of *ex parte* in Black H, *Black's Law Dictionary*, 8th ed., (St. Paul: West Publishing Co., 2004).

332. Pearshouse R and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS—Volume One: Sexual and Domestic Violence* (Toronto, Canada: Canadian HIV/AIDS Legal Network, 2009), pp. 2–26 (available online at www.aidslaw.ca/women, accessed 24 June 2013).

333. Tierney Goldstein A, Human Rights Education Director of the International Association of Women Judges, personal communication.

334. For example, Zimbabwe, *Criminal Law (Codification and Reform) Act No., 23 of 2004*, defines rape in the following way: "[W]here a male person knowingly has sexual intercourse or anal sexual intercourse with a female person and at the time of the intercourse (a) the female person has not consented to it; and b) he knows that she has not consented to it or realizes that there is a real risk or possibility that she may not have consented to it".

335. See "Country Pages" of The Advocates for Human Rights website for relevant national laws and policies (available online at http://www.stopvaw.org/Country_Pages, accessed 24 June 2013).

336. See Human Rights Watch, *Global Report on Women's Human Rights* (1995); Security Council Resolution 1820, S/RES/1820 (2008); and Neill K, "Duty, honor, rape: Sexual assault against women during war", *Journal of International Women's Studies*, 2000, 2 (available online at http://www.bridgew.edu/soas/jiws/nov00/index.htm, accessed 24 June 2013).

337. *Prosecutor v. Jean-Paul Akayesu*, Case No. ICTR-96-4-T, Decision of 2 September 1998 (Chamber 1), para. 688.

338. *Ibid*., at para. 686.

339. *Prosecutor v. Dragoljub Kunarac, Radomir Kovac and Zoran Vukovic*, Decision of 22 February 2001 (International Criminal Tribunal for the former Yugoslavia Trial Chamber), at para. 457.

340. *Ibid*.

341. *Ibid*., at para. 460.

342. *M.C. v. Bulgaria*, Application No. 39272/98 [2003] XII ECHR at para. 166.

343. Burgen R, "Marital rape", National Electronic Network on Violence Against Women, Applied Research Forum (March 1999), pp. 1 and 4.

344. UN General Assembly, *Declaration on the Elimination of Violence against Women,* A/RES/ 48/104, 20 December 1993, Article 2(a).

345. *Beijing Declaration and Platform for Action*, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995).

346. *C.R. v. U.K.*, (1995) 335-C ECHR (Ser A) at para. 42.

347. *R. v. R.,* [1991] 4 All ER 481.

348. *Uganda v. Hamidu*, *et al.*, Criminal Session Case 0055 of 2002 (9/2/2004).

349. *Ibid*.

350. *Ibid.*, at pp. 14–15.

351. *Ibid*., at pp. 18–19.

352. *R. v. Gua*, [2012] SBHC 188.

353. *Ibid*., paras. 2, 4, 18–21.
354. South African Law Reform Commission, *Project 107: Sexual Offences Report* (2002), c. 6.
355. *S. v. Jackson*, [1998] ZASCA 13 (Supreme Court of Appeal of South Africa).
356. *Ibid*., pp. 15–16.
357. *Ibid.,* p. 13.
358. *Ibid,* p. 18.
359. *R. v. W. (R.)*, [1992] S.C.R. 122 (Supreme Court of Canada), paras. 24–26. The Court cited the following text from Wilson J.'s decision in *R. v. B. (G.),* [1990] 2 S.C.R. 30 (Supreme Court of Canada), with approval: "While children may not be able to recount precise details and communicate the when and where of an event with exactitude, this does not mean that they have misconceived what happened to them and who did it".
360. *S. v. D.*, [1992] 1 SA 509 (High Court of Namibia), at 516H, cited with approval in *S. v. K* [1999] NR 348 (Supreme Court of Namibia).
361. *Mukungu v. Republic*, [2003] AHRLR 175 (Kenya Court of Appeal).
362. Kelly L, Temkin J and Griffiths S, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* ([U.K.] Home Office, 2006), pp. 61–69; Schwikkard PJ, "A critical overview of the rules of evidence relevant to rape trials in South African law", in Jagwanth S *et al.* (eds.), *Women and the Law* (Pretoria, South Africa: HSRC Publishers, 1994), pp. 98–218, at 204.
363. Pithey B. *et al.*, *Discussion Document: Legal Aspects of Rape in South Africa*, commissioned by the Deputy Minister of Justice, Rape Crisis (Cape Town), Women & Human Rights Project (University of the Western Cape), Institute of Criminology (University of Cape Town) (1999), c. 1 (available online at http://www.ghjru.uct.ac.za/parl-submissions/Legal-Aspects.pdf, accessed 24 June 2013).
364. *R. v. Seaboyer*, [1991] 2 S.C.R. 577 (Supreme Court of Canada). This decision was reaffirmed in *R. v. Darrach*, [2000] 2 S.C.R. 443 (Supreme Court of Canada). See also, *S. v. Johannes Myeni,* [2002] 2 S.A.C.R. 411 (Supreme Court of Appeal of South Africa).
365. See the United States Federal Rules of Evidence, rule 412, often referred to as "the rape shield rule". See also International Criminal Court, *Rules of Procedure and Evidence*, Rule 71.
366. *R. v. Seaboyer*, [1991] 2 S.C.R. 577 (Supreme Court of Canada), para. 38.
367. Examples of national laws that include alternative arrangements for vulnerable witnesses include South Africa, *Criminal Procedure Act of 1977*, ss. 158(2) and (3); the United Kingdom, *Youth Justice and Criminal Evidence Act of 1999*, ss. 23–30; Namibia, *Criminal Procedure Act of 1977, s. 158A*; Canada, *Criminal Code* s. 486; and New South Wales, Australia, *Criminal Procedure Act of 1986*, ss. 290–294C. Both the ICTY and the ICTR have similar relevant provisions: *Rules of Procedure and Evidence*, Rule 75.
368. See, for example, Hamlyn B, Phelps A and Sattar G, *Key Findings from the Surveys of Vulnerable and Intimidated Witnesses, 2000/2001 and 2003* ([U.K.] Home Office), 2204 and Kebbell M, O'Kelly C and Gilchrist E, "Rape victims' experiences of giving evidence in English courts: A survey", *Psychiatry, Psychology and Law*, 2007, 14(1):111–119.
369. *S. v. Staggie and Another*, [2003] 1 BCLR 43 (C), the South African High Court (Cape of Good Hope Provincial Division).
370. *R. v. Levogiannis*, [1993] 4 S.C.R. 475 (Supreme Court of Canada). See also *Klink v. Regional Court Magistrate NO and Others* [1996] 3 BCLR 402 (SE) and *R. v. Ngo* [2001] NSWSC 339 [Supreme Court of New South Wales, Australia].
371. Temkin J, "Digging the dirt: Disclosure of records in sexual assault cases", *Cambridge Law Journal*, 2002, 61(1):126–145, at p. 126.
372. For example, counselling records of complainants, particularly women, before the alleged incident of rape or sexual assault have often been used to suggest that the complainants are incapable of telling the truth about what had happened. See Bronitt S and McSherry B, "The use and abuse of counselling records in sexual assault trials: Reconstructing the 'rape shield'?" *Criminal Law Forum*, 1997, 8(2):259–291, at p. 262.
373. *R. v. O'Connor*, [1995] 4 S.C.R. 411 (Supreme Court of Canada), para. 123, L'Heureux-Dubé J., dissenting. See also Bronitt S and McSherry B, "The use and abuse of counselling records in sexual assault trials: Reconstructing the 'rape shield'?" *Criminal Law Forum*, 1997, 8(2):259–291, at pp. 260–261.
374. For example, in *R. v. O'Connor*, the Supreme Court of Canada allowed post-assault counselling records to be used in court as they may contain, *inter alia*, information concerning the unfolding of events underlying the criminal complaint.
375. Temkin J, "Digging the dirt: Disclosure of records in sexual assault cases", *Cambridge Law Journal*, 2002, 61(1):129–130. See also *R. v. Osolin*, [1993] 4 S.C.R. 595 (Supreme Court of Canada), para. 189, L'Heureux-Dubé J., dissenting.
376. In *R. v. O'Connor,* at para. 110, L'Heureux-Dubé J. stated in dissent: "[T]hese records may very well have a greater potential to derail than to advance the truth-seeking process".
377. The European Court of Human Rights has considered the protection of medical data of fundamental importance to an individual's right to respect for private life, which is guaranteed by Article 8 of the *European Convention on Human Rights*. See *Z. v. Finland* (1998) 25 E.H.R.R. 371.
378. Kelly L, Temkin J and Griffiths S, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* ([U.K.] Home Office, 2006), pp. 64–67; Cossins A, "Tipping the scales in her favour: The need to protect counselling records in sexual assault trials", in Easteal P (ed.), *Balancing the Scales: Rape, Law Reform and Australian Culture* (Sydney, Australia: Federation Press, 1998), pp. 94–106.
379. South African Law Reform Commission, *Project 107: Sexual Offences Report* (2002), c. 6, pp. 212–213. See also, Kelly L, Temkin J and Griffiths S, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* ([U.K.] Home Office, 2006), pp. 61–69.
380. For a summary of research on this topic, see American Psychological Association, *Brief Amicus Curiae of the American Psychological Association in Support of Respondents: Jaffee v. Redmond* [Supreme Court of United States] (1996), pp. 14–15 (available online at http://www.apa.org/about/offices/ogc/amicus/jaffee.pdf)

381. Shuman D, Weiner M and Pinard G, "The privilege study (part III): Psychotherapist–patient communications in Canada", *International Journal of Law and Psychiatry*, 1986, 9:393–429; Pithey B *et al.*, *Discussion Document: Legal Aspects of Rape in South Africa*, commissioned by the Deputy Minister of Justice, Rape Crisis (Cape Town), Women & Human Rights Project (University of the Western Cape), Institute of Criminology (University of Cape Town) (1999), c. 1, p. 126 (available online at http://www.ghjru.uct.ac.za/parl-submissions/Legal-Aspects.pdf, accessed 24 June 2013).
382. Shuman D, Weiner M and Pinard G, "The privilege study (part III): Psychotherapist–patient communications in Canada", *International Journal of Law and Psychiatry*, 1986, 9:393–429; Lindenthal J and Thomas C, "Psychiatrists, the public and confidentiality", *Journal of Nervous and Mental Disease*, 1982, 170: pp. 319–323, at p. 321.
383. Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, Organisation of American States, 1994, Article 7.
384. Report No. 51/01, para. 61.
385. *Ibid*., at para. 49.
386. *Ibid*., at para. 56.
387. When drug-use equipment (e.g. needles and materials for preparing drug solutions such as spoons, etc.) that has already been used by a person living with HIV is used by someone else, the risk of transmitting the virus is high because blood containing HIV may go directly into the blood stream of the subsequent user.
388. "Key populations", or "key populations at higher risk", are groups of people who are more likely to be exposed to HIV or to transmit it. Their engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men (MSM), transgender people, people who inject drugs, and sex workers and their clients are at higher risk of HIV exposure than other groups. Prisoners and migrants are also considered key populations in some countries. See UNAIDS, *2011–2015 Strategy: Getting to Zero* (Geneva: UNAIDS, 2010) and Chapter 10 of this handbook, "Human rights and key populations at higher risk of HIV exposure".
389. Rhodes T, "Risk environments and drug harms: A social science for harm reduction approach", *International Journal of Drug Policy*, 2009, 20(3):193–201.
390. Harm Reduction International, *What is Harm Reduction? A Position Statement from the International Harm Reduction Association* (2010) (available online at www.ihra.net, accessed 24 June 2013).
391. World Health Organization, United Nations Office on Drugs and Crime and UNAIDS, *Technical Guide for Countries to set up Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (2009).
392. Bewley-Taylor D, Hallam C and Allen R, *The Incarceration of Drug Offenders: An Overview* (The Beckley Foundation, March 2009), pp. 5–9. The International Narcotics Control Board observed that for drug crimes, imprisonment often is used not as a last resort, but as a first one. Prisons can become markets for illicit drugs and consequently increase the scale and severity of drug abuse in a population, as well as the incidence of HIV and other diseases. *Report of the International Narcotics Control Board for 2007*, E/INCB/2007/1.
393. Wolfe D and Saucier R, "In rehabilitation's name? Ending institutionalized cruelty and degrading treatment of people who use drugs", *International Journal of Drug Policy*, 2010, 21(3):145–148.
394. See Wolfe D and Malinowska-Sempruch K, *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches* (Open Society Institute, 2004); Barrett D *et al.*, *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy* (The Beckley Foundation, 2008); Wolfe D and Saucier R (eds.), *At What Cost?: HIV and Human Rights Consequences of the Global "War on Drugs"* (Open Society Institute, 2009); Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy* (2011) (available online at www.globalcommissionondrugs.org, accessed 24 June 2013); Jürgens R *et al.*, "People who use drugs, HIV, and human rights", *The Lancet*, 2010, 376(9739):475–485; and Open Society Institute, *The Effect of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia, and Ukraine* (2009).
395. United Nations, *Single Convention on Narcotic Drugs*, 30 March 1961, entered into force 13 December 1964, as amended by the 1972 Protocol amending the *Single Convention on Narcotic Drugs*, 1961, 25 March 1972, entered into force 8 August 1975 [hereinafter *Single Convention*].
396. United Nations, *Convention on Psychotropic Substances*, 21 February 1971, entered into force 16 August 1976 [hereinafter *Convention on Psychotropic Substances*].
397. United Nations, *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 20 December 1988, entered into force 11 November 1990 [hereinafter *Convention against Illicit Traffic in Narcotic Drugs*].
398. Possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption shall be treated as a criminal offence only if such acts run contrary to the provisions of the *Single Convention* or the *Convention on Psychotropic Substances*. According to the UN Commentary on the *Single Convention*, Article 4(c) and Article 36(1) only require penalization of possession, purchase and cultivation when it is part of illicit drug trafficking, not for personal consumption. Commentary to the *Single Convention on Narcotic Drugs*, 1961, Prepared by the UN Secretary-General in accordance with paragraph 1 of the *Economic and Social Council Resolution 914 D (XXXIV)*, 3 August 1962.
399. *Single Convention*, Article 38; *Convention on Psychotropic Substances*, Article 22; *Convention against Illicit Traffick in Narcotic Drugs,* Article 14.
400. See "Mandate and functions of the Commission on Narcotic Drugs" (available from www.unodc.org, accessed 24 June 2013) and "Mandate and functions of the International Narcotics Control Board" (available from www.incb.org, accessed 24 June 2013). In addition, Article 14(4) of the *Convention against Illicit Traffic in Narcotic Drugs* directs states to adopt measures aimed at reducing the demand for illicit drugs, making specific reference to the recommendations of the United Nations, specialized agencies of the United Nations such as the World Health Organization, and other competent international organizations. Recommendations of UNAIDS and United Nations Office on Drugs and Crime (UNODC) may be used in this context.
401. International Narcotics Control Board, *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches* (Decision 74/10), 30 September 2002, paras. 6, 26.

402. Commission on Narcotic Drugs, *Achieving Universal Access to Prevention, Treatment, Care and Support for Drug Users and People living with or affected by HIV*, Resolution 53/9, March 2010.

403. United Nations Office on Drugs and Crime, *Drug Control, Crime Prevention and Criminal Justice: A Human Rights Perspective*, March 2010, E/CN.7/2010/CRP.6–E/CN.15/2010/CRP.1; Barrett D and Nowak M, "The United Nations and drug policy: Towards a human rights-based approach", in Constantinides A and Zaikos N (eds.), *The Diversity of International Law: Essays in Honour of Professor KalliopiI K. Koufa* (Brill/Martinus Nijhoff, 2009), pp. 449–477.

404. United Nations Office on Drugs and Crime, *World Drug Report* (2010), p. 4.

405. *International Covenant on Economic, Social and Cultural Rights*, United Nations General Assembly, Resolution 2200 (XXI), 16 December 1966, entry into force 3 January 1976, Article 12(1). [For further information on the right to health, see Chapter 9, "HIV treatment and health care".]

406. *African Charter on Human and People's Rights*, Organization of African Unity, 27 June 1981, entry into force 21 October 1986, Article 16(1).

407. The Committee on Economic, Social and Cultural Rights lists among the violations of the right to health, "state actions, policies or laws that result in unnecessary morbidity and preventable mortality" (Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*: Article 12 E/C.12/2000/4, August 2000, para. 50).

408. Acuna M *et al.*, *Porto Declaration 2009: Latin Judges' Statement on Drugs and Human Rights Policies* (3 July 2009) (available from www.druglawreform.info, accessed 24 June 2013).

409. The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report to the UN General Assembly*, 65th Session, 6 August 2010, A/65/255, para. 10, 17.

410. United Nations, *Commentary on the UN Convention Against Illicit Trafficking of Narcotic Drugs and Psychotropic Substances (1988)*, 1998, para. 3.3.

411. UN General Assembly Resolutions A/RES/65/233; A/RES/64/182; A/RES/63/197; A/RES/62/176; A/RES/61/183; A/RES/60/178; A/RES/60/178; A/RES/59/163; A/RES/58/141; and similar resolutions for earlier years.

412. United Nations Office on Drugs and Crime: Commission on Narcotic Drugs, *Strengthening Cooperation between the United Nations Office on Drugs and Crime and other United Nations Entities for the Promotion of Human Rights in the Implementation of the International Drug Control Treaties*, Resolution 51/12, March 2008.

413. See *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (Supreme Court of Canada) interpreting the objectives of the *Controlled Drugs and Substances Act*; *On Narcotic Drugs and Psychotropic Substances*, Russian Federation, No. 3-FZ, 8 January 1998; *On Narcotic Drugs, Psychotropic Substances, Precursors and Measures Against Illicit Trafficking and Drug Misuse*, Republic of Kazakhstan, No. 279, 10 July 1998; and *EU Drugs Strategy (2005–2012)*, Council of the European Union, 2004, para. 2.

414. Kinney E and Clark B, "Provisions for health and health care in the constitutions of the countries of the world", *Cornell International Law Journal* 2004, 37:285–355.

415. European Monitoring Centre for Drugs and Drug Addiction, "Defining drug-related crime", *Drugnet Europe* 59, July–September 2007; Goldstein P, "The drugs/violence nexus: A tripartite conceptual framework", *Journal of Drug Issues*, 1985, 15(4) 493–506.

416. Note that such prosecutions can have a chilling effect on the provision of these health services, which are critical HIV prevention interventions.

417. Note that mandatory minimum sentences for drug offences have been shown to be ineffective at reducing drug use and the problems associated with drug use. See Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses* (Toronto, Ontario: Canadian HIV/AIDS Legal Network, 2006) (available from www.aidslaw.ca/drugpolicy, accessed 24 June 2013).

418. *R. v. Smith,* [1987] 1 S.C.R. 1045 (Supreme Court of Canada).

419. *Ibid*, para. 49.

420. *Ibid.*, para. 66–67. Section 12 of the *Canadian Charter of Rights and Freedoms* provides that "everyone has the right not to be subjected to any cruel and unusual treatment or punishment". The standard for judicial review under this provision is gross disproportionality. As explained in *R. v. Smith*:
In assessing whether a sentence is grossly disproportionate, the court must first consider the gravity of the offence, the personal characteristics of the offender and the particular circumstances of the case in order to determine what range of sentences would have been appropriate to punish, rehabilitate or deter this particular offender or to protect the public from this particular offender. The other purposes which may be pursued by the imposition of punishment, in particular the deterrence of other potential offenders, are thus not relevant at this stage of the inquiry. This does not mean that the judge or the legislator can no longer consider general deterrence or other penological purposes that go beyond the particular offender in determining a sentence, but only that the resulting sentence must not be grossly disproportionate to what the offender deserves. … (para. 56).

421. *Ibid*, para. 71, quoting from *R. v. Oakes*, [1986] 1 S.C.R. 103 (Supreme Court of Canada).

422. *Ibid.*, para. 73.

423. Writing for the majority of the Supreme Court of Canada, Justice Lamer referred to the tests synthesized by Walter Tarnopolsky in "Just deserts or cruel and unusual treatment or punishment? Where do we look for guidance?" *Ottawa Law Review*, 1978, 10(1):1–34 at 32–33. Although addressed to a broader issue of cruel and unusual punishment, these tests might also be useful guidelines for a proportionality analysis, providing indicators to evaluate the state's response in light of human rights standards and social expectations. The tests include the following criteria:
    1) Is the punishment such that it goes beyond what is necessary to achieve a legitimate penal aim?
    2) Is it unnecessary because there are adequate alternatives?
    3) Is it unacceptable to a large segment of the population?
    4) Is it such that it cannot be applied upon a rational basis in accordance with ascertained or ascertainable standards?
    5) Is it arbitrarily imposed?
    6) Is it such that it has no value in the sense of some social purpose such as reformation, rehabilitation, deterrence or retribution?
    7) Is it in accord with public standards of decency or propriety?
    8) Is the punishment of such a character as to shock general conscience or as to be intolerable in fundamental fairness?
    9) Is it unusually severe and hence degrading to human dignity and worth?
424. *R. v. Smith,* [1987] 1 S.C.R. 1045 (Supreme Court of Canada), paras. 113–114.
425. United Nations Economic and Social Council, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, UN Doc E/CN.4/1984/4 (1984).
426. Ristroph A, "Proportionality as a principle of limited government", *Duke Law Journal*, 200555(2):263–332, at p. 293.
427. *Kimbrough v. United States*, 552 U.S. 85 (United States Supreme Court, 2007).
428. "A drug trafficker dealing in crack cocaine is subject to the same sentence as one dealing in 100 times more powder cocaine". *Ibid.*, at p. 1. See also U.S. News, *Crack vs. Powder Cocaine: A Gulf in Penalties*, 1 October 2007 (available online at www.usnews.com, accessed 24 June 2013).
429. *Kimbrough v. United States*, 552 U.S. 85 (United States Supreme Court, 2007), at p. 23.
430. More recently, a similar decision was taken on with respect to the drug known as "ecstasy". See *United States v. McCarthy*, Southern District Court of New York, 09 Cr.1136 (WHP), Second Supplemental Sentencing Memorandum Addressing the Appropriate Guideline, 12 July 2010.
431. United Nations, *Report of the International Narcotics Control Board for 2007*, E/INCB/2007/1, para. 9. A fifth question relates specifically to offences with international aspects, which are beyond the scope of this chapter.
432. The international drug control bodies have asserted on numerous occasions that complete alternatives to conviction and punishment can be applied for offences involving the possession, purchase or cultivation of illicit drugs for the offender's personal use. See United Nations, *Report of the International Narcotics Control Board for 2007*, E/INCB/2007/1, para. 18 and United Nations Office on Drugs and Crime, *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*, March 2009, section 6, para. 16(a), p. 23 (adopted by the High Level Segment of the Commission on Narcotic Drugs, and later adopted by the UN General Assembly's Resolution 64/182 of 18 December 2009). See also United Nations Office on Drugs and Crime, *From Coercion to Cohesion: Treating Drug Dependence through Health Care, not Punishment* (2010), p. 1:
    The [UN Drug] conventions encourage the adoption of a health-oriented approach to both illicit drug use and drug dependence rather than relying solely upon a sanction-oriented approach. In the case of nondependent drug users, a health-oriented approach may involve: providing education, reliable information, brief motivational and behavioral counseling, and measures to facilitate social reintegration and reduce isolation and social exclusion. In the case of drug dependent individuals it may also involve more comprehensive social support and specific pharmacological and psychosocial treatment, and aftercare.
433. From 2002 onwards, the agenda of every session of the Commission on Narcotic Drugs included the issue of HIV prevention among drug users with reference to the United Nations *Millennium Declaration* and the Millennium Development Goals, the 2001 *Declaration of Commitment on HIV/AIDS*, the 2006 *Political Declaration on HIV/AIDS*, and a particular emphasis that "all countries should strive to achieve the highest attainable standard of physical and mental health for their people, as recognized in the relevant international instruments". See also the United Nations Office on Drugs and Crime, *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem* (March 2009), para. 20 (adopted by the High Level Segment of the Commission on Narcotic Drugs and later adopted by the UN General Assembly's Resolution 64/182 of 18 December 2009).
434. White H and Gorman D, "Dynamics of the drug–crime relationship", *Criminal Justice Volume 1: The Nature of Crime: Continuity and Change* (Washington, D.C.: U.S.A. Department of Justice, 2000), pp. 151–218.
435. Bewley-Taylor D, Hallam C and Allen R, *The Incarceration of Drug Offenders: An Overview* (The Beckley Foundation, March 2009), p. 15; Mackenzie D, *Sentencing and Corrections in the 21st Century: Setting the Stage for the Future* (2001), at pp. 21–22; Friedman S *et al.*, "Relationships of deterrence and law enforcement to drug-related harms among drug injectors in U.S. metropolitan areas", *AIDS*, 2006, 20(1):93–99; Friedman S *et al.*, "Drug arrests and injecting drug deterrence", *American Journal of Public Health*, 2011, 101(2):344–349; Degenhardt L *et al.*, "Toward a global view of alcohol, tobacco, cannabis, and cocaine use: Findings from the WHO World Mental Health Surveys", *PLOS Medicine*, 2008, 5(7):1053–1067; U.K. Drug Policy Commission, *Consultation Paper on Sentencing for Drug Offences* (July 2009); and Reuter P, "Ten years after the United Nations General Assembly Special Session (UNGASS): Assessing drug problems, policies and reform proposals", *Addiction*, 2009, 104(4):510–517.
436. European Monitoring Centre for Drugs and Drug Addiction, *Prevalence of Drug Use within Prison among Prisoners, 2000–09 (Table DUP-3),* Statistical bulletin (2011) and World Health Organization, United Nations Office on Drugs and Crime and UNAIDS, *Effectiveness of Interventions to Address HIV in Prisons* (Geneva: WHO, 2007).
437. United Nations Office on Drugs and Crime, World Health Organization and UNAIDS, *HIV and AIDS in Places of Detention: A Toolkit for Policymakers, Programme Managers, Prison Officers and Health Care Providers in Prison Settings* (New York: UN, 2008), p. 7.
438. *Ibid*, p. 10.

439. United Nations Office on Drugs and Crime and World Health Organization, *Principles of Drug Dependence Treatment* (2008), p. 14; Costa AM, *Preface to the UNODC World Drug Report* (2009), p. 2; and The National Treatment Agency for Substance Misuse (England), *Breaking the Link: The Role of Drug Treatment in Tackling Crime* (2009), p. 4.

440. United Nations Office on Drugs and Crime, *Handbook of Basic Principles and Promising Practices on Alternatives to Imprisonment* (2007), p. 63.

441. Diversion programmes exist in different formats, such as arrest referral schemes (Russia and Scotland), drug intervention programmes (England and Wales), and drug treatment courts (U.S.A., Canada and Australia). A central component of diversion programmes is collaboration between the criminal justice system and medical services. Portugal provides a notable example, in that pre-trial diversion is promoted by a national policy and has had significant benefits in terms of public health and human rights with no escalation in crime. (European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles: Portugal* [2011]).

442. Commission on Narcotic Drugs, *Drug Control, Crime Prevention and Criminal Justice: A Human Rights Perspective*, March 2010, E/CN.7/2010/CRP.6–E/CN.15/2010/CRP.1, para. 23.

443. United Nations Office on Drugs and Crime, *From Coercion to Cohesion: Treating Drug Dependence through Health Care, not Punishment* (2010); United Nations Office on Drugs and Crime and World Health Organization, *Principles of Drug Dependence Treatment* (2008); National Institute of Drug Abuse (U.S.A.), *Treating Offenders with Drug Problems: Integrating Public Health and Public Safety: A Research Update* (2011); The National Treatment Agency for Substance Misuse (England), *Breaking the Link: The Role of Drug Treatment in Tackling Crime* (2009), p. 4; and Gossop M, Marsden J and Stewart D, *The National Treatment Outcome Research Study: Changes in Substance Use, Health and Criminal Behaviour during the Five Years after Intake* (London: National Addiction Centre, 2001).

444. "…Chronic drug abuse alters the brain's anatomy and chemistry and…these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicts are at a high risk of relapse to drug abuse even after long periods of abstinence, and why they persist in seeking drugs despite deleterious consequences". National Institute on Drug Abuse (U.S.A.), *Principles of Drug Abuse Treatment for Criminal Justice Populations* (2006), p. 2.

445. Drug Policy Alliance, *Drug Courts Are Not the Answer: Toward a Health Centered Approach to Drug Abuse* (2011), p. 12.

446. *Robinson v. California*, 370 U.S. 660 (United States Supreme Court, 1962).

447. *Ibid*, pp. 667–668.

448. Open Society Foundations, *Treatment or Torture: Applying International Human Rights Standards to Drug Detention Centers* (2011), p. 37.

449. The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report to the UN General Assembly* (2010), para. 31.

450. Note the Legal Opinion of the United Nations Drug Control Programme (prepared at the request of the INCB) that various harm reduction programmes do not contravene the drug control conventions, in particular the provisions on incitement. (International Narcotics Control Board, *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches* (Decision 74/10), 30 September 2002, paras. 6, 26).

451. Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950.

452. *Open Door and Dublin Well Woman v. Ireland*, 64/1991/316/387-388, European Court of Human Rights, 23 September 1992.

453. See also *Iorfida v. MacIntyre*, [1994] 21 OR (3d) 186 (Ontario Supreme Court), where the Canadian *Criminal Code* prohibition on distributing "literature for illicit drug use" was struck down as an unjustified restriction on freedom of expression.

454. The Crown Prosecution Service (U.K.), *Drug Offences: Incorporating the Charging Standard* (available from www.cps.gov.uk, accessed 24 June 2013).

455. European Monitoring Centre for Drugs and Drug Addiction, *The Role of the Quantity in the Prosecution of Drug Offences* (European Legal Database on Drugs Comparative Study, 2003).

456. Transnational Institute and International Drug Policy Consortium, *Conviction by Numbers: Threshold Quantities for Drug Policy* (2011).

457. For instance, the reported purity of street heroin in Romania (2003) varies from 0.2 to 95%, and in Bulgaria (2003) from 9 to 55% (UNODC, *World Drug Report, Volume 2: Statistics* [2005], p. 346); in Germany (2007), from 0.03 to 73.8%, and in the U.K. (2008) from 1.0 to 85% (UNODC, *World Drug Report: Statistics* [2011] [available online at http://www.unodc.org/documents/data-and-analysis/WDR2011/WDR_Final_Prices_crop.pdf, accessed 24 June 2011]).

458. Golichenko M and Merkinaite S, *In Breach of International Law: Ukrainian Drug Legislation and the European Convention for the Protection of Human Rights and Fundamental Freedoms* (Toronto: Eurasian Harm Reduction Network and Canadian HIV/AIDS Legal Network, 2011), pp. 32–39.

459. See UN General Assembly, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (A/HRC/7/3), 15 January 2008; Csete J and Cohen J, "Lethal violations: Human rights abuses faced by injection drug users in the era of HIV/AIDS", in Malinowska-Sempruch K and Gallagher S (eds.), *War on Drugs, HIV/AIDS and Human Rights* (New York: International Debate Education Association, 2004), pp. 212–226; Human Rights Watch, *Fanning the Flames: How Human Rights Abuses Are Fuelling the AIDS Epidemic in Kazakhstan* (2003); Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS* (2006); Sarang A *et al.*, "Policing Drug Users in Russia: Risk, Fear, and Structural Violence", *Substance Use & Misuse*, 2010, 45(6):813–864; Human Rights Watch, *Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver* (2003); and Rhodes T, "Street policing, injecting drug use and harm reduction in a Russian city: A qualitative study of police perspectives", *Journal of Urban Health*, 2006, 83(5):911–925.

460. Drug users often lack of access to legal counsel. See Csete J and Cohen J, "Health benefits of legal services for criminalized populations: The case of people who use drugs, sex workers and sexual and gender minorities", *Journal of Law, Medicine & Ethics*, 2010, 38(4):816–831. When a lawyer is engaged in the criminal cases, there are fewer chances that human rights violations would be left unchallenged during pre-trial procedures. See Gefter V and Levinson L, *Monitoring of Appeals during the Pre-trial Proceedings* (Moscow: Human Rights Institute, 2004), p. 21.

461. *Teixeira de Castro v. Portugal*, 44/1997/828/1034, European Court of Human Rights, 9 June 1998; *Vanyan v. Russia*, 53203/99, European Court of Human Rights, 15 December 2005; and *Khudobin v. Russia*, 59696/00, European Court of Human Rights, 26 October 2006.

462. *United States Code*, Title 18 USC section 3553 (a) Factors To Be Considered in Imposing a Sentence: (1) the nature and circumstances of the offense and the history and characteristics of the defendant; (2) the need for the sentence imposed (A) to reflect the seriousness of the offense, to promote respect for the law, and to provide just punishment for the offense; (B) to afford adequate deterrence to criminal conduct; (C) to protect the public from further crimes of the defendant; and (D) to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner.

463. Note that this summary is based on a translation from the original Spanish by Arturo Marcano (MIA Translations) and David Cozac (Canadian HIV/AIDS Legal Network). [On file with author.]

464. In 2008, the Sixth Appellate Court of the High Court of Justice in São Paulo, Brazil, declared the unconstitutionality of criminalization of "drug possession for personal consumption". See Rodrigues Torres JH, *Drug Policy and the Courts: A Brazilian Experience* (Transnational Institute, 2009).

465. In 1994, the Constitutional Court of the Republic of Colombia declared unconstitutional the provisions of anti-drug law which 1) prohibited consumption and possession of narcotic in quantities considered as doses for personal use; and 2) provided for compulsory treatment of addiction: *Constitutional Court Sentence No. C-221/94*. Record No. D-429, Constitutional Court Gazette 1994 Special Edition. In December 2009, the Congress of the Republic of Colombia again passed a law prohibiting possession and consumption of drugs or psychotropic substances except for medical prescriptions. In August 2011, the Supreme Court again held that the prohibition of drug use and possession for personal consumption was unconstitutional. The Court referred to the Constitutional Court ruling of 1994 and set up a threshold quantity of 20 grams of marijuana or cocaine that shall be considered for personal consumption (*Corte Suprema defiende el porte de dosis mínima de droga*. 24 August 2011 [available via www.eltiempo.com, accessed 24 June 2011).

466. *Canadian Charter of Human Rights and Freedoms*, R.S. Q. c.C-1, section **7: "**Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice".

467. Section 1: **"**The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".

468. The exemptions were granted in accordance with section 56 of the CDSA, which reads: **"**The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest".

469. *Canada (Attorney General) v. PHS Community Services Society*, at para. 133.

470. *Ibid*., at para. 136.

471. UNAIDS, United Nations Population Fund (UNFPA) and United Nations Development Fund for Women (UNIFEM), *Women and HIV/AIDS: Confronting the Crisis* (2004); Smith D, "Modern marriage, men's extramarital sex, and HIV risk in Southeastern Nigeria", *American Journal of Public Health*, 2007, 97(6):997–1005; Hirsch J *et al.*, "The inevitability of infidelity: Sexual reputation, social geographies, and marital HIV risk in rural Mexico", *American Journal of Public Health*, 2007, 97(6):986–996; Mayer K *et al.*, "Marriage and monogamy and HIV: A profile of HIV-infected women in south India", *International Journal of STD & AIDS*, 2007, 11(4):250–253; and Carpenter L *et al.*, "Rates of HIV-1 transmission within marriage in rural Uganda in relation to HIV serostatus of the partners", *AIDS*, 1999, 13(1):1083–1089. Note that some of the content of the chapter is adapted from Chu S and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS—Volume Two: Family and Property Issues* (Toronto: Canadian HIV/AIDS Legal Network, 2009) (available online at www.aidslaw.ca/women, accessed 24 June 2013).

472. For example, a survey of women in Swaziland found that married women were twice as likely to report that they lacked control over whether and when to have sex, and whether or not to have unprotected sex, when compared with their unmarried counterparts. See Physicians for Human Rights*, Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland* (2007), pp. 100–101.

473. Preston-Whyte E, "Reproductive health and the condom dilemma: Identifying situational barriers to HIV protection in South Africa", in Caldwell J *et al.* (eds.), *Resistances to Behavioural Change to Reduce HIV/AID Infection in Predominantly Heterosexual Epidemics in Third World Countries* (Canberra, Australia: Australian National University, 1999), pp. 139–155, at p. 143; Clark S, "Early marriage and HIV risks in sub-Saharan Africa", *Studies in Family Planning*, 2004, 35(3):149–160, at p. 151; Deller Ross S, *Women's Human Rights: The International and Comparative Law Casebook* (Philadelphia: University of Pennsylvania Press, 2008), p. 630; and Physicians for Human Rights*, Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland* (2007), p. 59.

474. See also Chapter 6, "Sexual assault and domestic violence". Customary practices vary around the world, but particular attention has been drawn to practices such as forced marriages, betrothal and widow inheritance as posing particular risks in terms of HIV. See Clark S, "Early marriage and HIV risks in sub-Saharan Africa", *Studies in Family Planning*, 2004, 35(3):149–160; Luginaah I, *et al.*, "Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows", *Social Science and Medicine*, 2005, 60(6):1219–1228; and Okeyo T and Allen A, "Influence of widow inheritance on the epidemiology of AIDS in Africa", *African Journal of Medical Practice*, 1994, 1(1):20–25.

475. Smith K and Watkins S, "Perceptions of risk and strategies for prevention: Responses to HIV/AIDS in rural Malawi", *Social Science & Medicine*, 2005, 60(3):649–660; Kenyega-Kayondo S *et al.*, "Risk perception and HIV-1 prevalence in 15 000 adults in rural south-west Uganda", *AIDS*, 1999, 13(16):2295–2302; Lindgen T *et al.*, "Malawi women and HIV socio-cultural factors and barriers to prevention", *Women & Health*, 2005, 41(1):69–86; and Human Rights Watch, *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (2007), p. 21.

476. *Moge v. Moge*, [1992] 3 S.C.R. 813, (Supreme Court of Canada), at para. 70.

477. 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* (ICRW), working paper (2004), p.10. Note that "property" can include land, housing and other buildings, livestock, productive equipment, household items, personal items, and financial instruments such as stocks, bonds, etc.

478. See White S, "Extreme poverty and its impact on women's vulnerability to HIV transmission: A rights issue", *The International Journal of Human Rights*, 2010, 14(1):75–91; Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (2003), p. 32; Lindgen T *et al.*, "Malawi women and HIV socio-cultural factors and barriers to prevention", *Women & Health*, 2005, 41(1):69–86; Simmons J *et al.*, "A global perspective", in Farmer P *et al.* (eds.), *Women, Poverty and AIDS* (Monroe: Common Courage Press, 1996), p. 73; Hattori M and Ni-Amoo Dodoo F, "Cohabitation, marriage and 'sexual monogamy' in Nairobi's slums", *Social Science & Medicine*, 2007, 64(5):1067–1078; and United Nations Commission on Human Rights, *Women's Equal Ownership, Access to and Control over Land and the Equal Rights to Own Property and to Adequate Housing*, Resolution 2005/25, UN Doc. E/CN.4/2005/RES/25, 15 April 2005.

479. 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* (ICRW), working paper (2004), p.1; Whiteside A, "Poverty and HIV/AIDS in Africa", *Third World Quarterly*, 2002, 23(2):313–332; and Drimie S, *The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa*, Food and Agricultural Organization of the United Nations (FAO), Integrated Rural and Regional Development, Human Sciences Research Council (2002), p.4.

480. Scholz B, "Linkage between HIV/AIDS and human rights to housing, land and inheritance for women within urban and rural contexts", presented at the Technical Consultation on Gender, Property Rights and Livelihoods in the Era of AIDS, Food and Agriculture Organization (FAO), 2007, Rome, Italy.

481. See Ezer T, "Inheritance law in Tanzania: The impoverishment of widows and daughters", *Georgetown Journal of Gender and the Law*, 2006, 7 (Special Issue):599–662, at p. 627; Izumi K (ed.), *The Land and Property Rights of Women and Orphans in the Context of HIV and AIDS: Case Studies from Zimbabwe* (Cape Town: HSRC Press, 2006), p. v; and Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (2003), p. 38.

482. See Human Rights Watch, *Double Standards: Women's Property Rights Violations in Kenya* (2003), pp. 16–23; Izumi K (ed.), *The Land and Property Rights of Women and Orphans in the Context of HIV and AIDS: Case Studies from Zimbabwe* (Cape Town: HSRC Press, 2006), pp. 30–34; and Werner W, *Protection for Women in Namibia's Communal Land Reform Act: Is It Working?*(Namibia: Legal Assistance Centre, 2008), p. 25.

483. See Tierney Goldstein A, "Judging in a time of AIDS: The role of the judiciary in finding justice for both women and men in the HIV epidemic in Africa", paper presented at the High-Level Judicial Conference on HIV in Johannesburg, 10–12 December 2009 (on file with author).

484. United Nations General Assembly, *International Covenant on Civil and Political Rights* (ICCPR), 16 December 1966, 999 U.N.T.S. 171, articles 2(1) and 3.

485. ICCPR, articles 23 and 26.

486. United Nations General Assembly, *International Covenant on Economic, Social and Cultural Rights* (ICESCR), 16 December 1966, articles 10 and 11.

487. *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW), United Nations General Assembly, 18 December 1979, 1249 U.N.T.S. 13, Article 2.

488. CEDAW, Article 5.

489. CEDAW, Article 16.

490. CEDAW, Article 16(1)(h).

491. *Protocol to the African Charter on Human Rights and People's Rights on the Rights of Women in Africa*, (Protocol on the Rights of Women) African Commission on Human and People's Rights, 11 July 2003, Article 16.

492. Protocol on the Rights of Women, Article 21.

493. *American Convention on Human Rights*, Organization of American States, 22 November 1969, articles 17, 21 and 24.

494. Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, articles 12 and 14.

495. See Chu S and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS, Volume Two: Family and Property Issues* (Toronto: Canadian HIV/AIDS Legal Network, 2009); Whitehead A and Tsikata D, "Policy discourses on women's land rights in sub-Saharan Africa: The implications of the return to the customary", *Journal of Agrarian Change*, 2003, 3(1–2):67–112; and Center on Housing Rights and Evictions, *Bringing Equality Home: Promoting and Protecting the Inheritance Rights of Women* (2004), p. 79.

496. See Sweetman C, "How title deeds make sex safer: Women's property rights in an era of HIV", *From Poverty to Power*, Background Papers (Oxfam International, 2008); Farha L, *Women and Housing Rights* (Centre on Housing Rights and Evictions, 2000), p.11; and Bennett V, *et al.*, "Inheritance law in Uganda: The plight of widows and children", *Georgetown Journal of Gender and Law* 7 (2006):451–520 at 457.

497. *The Law of Marriage Act,* United Republic of Tanzania, 1971, Section 114.

498. *Zawadi Abdallah v. Ibrahim Iddi,* High Court (United Republic of Tanzania) Civil Appeal No. 9, 1980. Similarly, in the Nigerian case of *Amadi v. Nwosu*, [1992] 5 NWLR 273 (Supreme Court of Nigeria), the Court held that in a marriage concluded under customary law, where a wife does not have the right to property ownership, she must prove her monetary contribution to family property before she can invoke other laws to claim joint ownership of property.

499. *Pettkus v. Becker*, [1980] 2 S.C.R. 834 (Supreme Court of Canada). Note that Mr. Pettkus and Ms. Becker were not formally married, but the Court did not see that as a legally relevant factor: "I see no basis for distinction, in dividing property and assets, between marital relationships and those more informal relationships which subsist for a lengthy period. This was not an economic partnership nor a mere business relationship, nor a casual encounter. Mr. Pettkus and Miss Becker lived as man and wife for almost twenty years. Their lives and their economic well-being were fully integrated". (at p. 850).

500. *Pettkus v. Becker*, (1978) 87 D.L.R. (3d) 101 (Ontario Court of Appeal), at para. 14. In the case of *Peter v. Beblow*, the Supreme Court of Canada also recognized the value of the domestic labour that the female partner contributed to the relationship, noting:
[I]n today's society it is unreasonable to assume that the presence of love automatically implies a gift of one party's services to another. Nor is it unreasonable for the party providing the domestic labour required to create a home to expect to share in the property of the parties when the relationship is terminated. Women no longer are expected to work exclusively in the home. It must be recognized that when they do so, women forgo outside employment to provide domestic services and child care. The granting of relief in the form of a personal judgment or a property interest to the provider of domestic services should adequately reflect the fact that the income earning capacity and the ability to acquire assets by one party has been enhanced by the unpaid domestic labour of the other.
Peter v. Beblow, [1993] 1 S.C.R. 980 (Supreme Court of Canada) at para. 78.

501. *Mmusi & Others v. Ramantele & another*, Case MAHLB-000836-10, in the High Court of Botswana held at Gaborone, 12 October 2012. Section 3 of the *Constitution of Botswana* reads:
a) Whereas every person in Botswana is entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, place of origin, political opinions, colour, creed or **sex**, but subject to respect for the rights and freedoms of others and for the public interest to each and all of the following, namely—
life, liberty, security of the person **and the protection of the law**;
b) freedom of conscience, of expression and of assembly and association; and
c) protection for the privacy of his home and other property and from deprivation of property without compensation, the provisions of this Chapter shall have effect for the purpose of affording protection to those rights and freedoms subject to such limitations of that protection as are contained in those provisions, being limitations designed to ensure that the enjoyment of the said rights and freedoms by any individual does not prejudice the rights and freedoms of others or the public interest. [emphasis added]

502. See section 15(4).

503. *Mmusi & Others v. Ramantele & another, Ibid.,* at para. 187.

504. *Ibid.*, para 189.

505. *Ibid.,* para 190. On the authority of the case of *Harken v. Lane*, 1998 (1) SA 300 [South African Constitutional Court], if discrimination has been found to be on a prohibited specified ground, then unfairness is presumed.

506. *Ibid.,* at paras. 196–197.

507. The Court further found that:
The Ngwaketse Customary law is an unacceptable part of the system of male domination that was emphatically rejected in the case of **Dow**. In my view, the exclusion of women from heirship is consistent with the logic of patriarchy which reserves for women positions of subservience and subordination. Such exclusion does not only amount to degrading treatment but constitute an offence against human dignity. Discrimination against women or denying or limiting their equality with men is fundamentally unjust.
Ibid., at para. 205.

508. *bid.,* paras. 200–201.

509. *Ibid*., at para. 211.

510. See Ezer T, "Inheritance law in Tanzania: The impoverishment of widows and daughters", *Georgetown Journal of Gender and the Law*, 2006, 7 (Special Issue):599–662; Izumi K (ed.), *The Land and Property Rights of Women and Orphans in the Context of HIV and AIDS: Case Studies from Zimbabwe* (Cape Town: HSRC Press, 2006); 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 (ICRW) Working Paper, 2004; Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (2003), p. 38; and Izumi K (ed.), *Reclaiming Our Lives: HIV and AIDS, Women's Land and Property Rights and Livelihoods in Southern and East Africa* (Cape Town: HSRC Press, 2006), p.4.

511. United Nations Human Rights Committee, *General Comment No. 19: Protection of the Family, the Rights to Marriage and Equality of the Spouses (Article 23)*, 27 July 1990, para. 8.

512. Committee on the Elimination of Discrimination against Women, *General Recommendation No. 21: Equality in Marriage and Family Relations*, adopted at the 13th Session, 1994 (contained in Document A/49/38).

513. *Elizabeth Gumede (born Shanga) v. President of South Africa and Others*, [2008] CCT 50/08 ZACC 23, 8 December 2008 (Constitutional Court of South Africa).

514. For example, in Sierra Leone, a husband can divorce his wife for numerous reasons not available to wives: CEDAW Committee, "Consideration of reports submitted by States Parties under Article 18 of the CEDAW, combined Initial, Second, Third, Fourth and Fifth Periodic Report of States Parties: Sierra Leone", CEDAW/C/SLE/5, 14 December 2006. Numerous other countries have similar unequal divorce laws.

515. *Uganda Association of Women Lawyers and Others v. Attorney General,* (Constitutional Petition No. 2 of 2003) [2004] UGCC 1, 10 March 2004 (Constitutional Court of Uganda).

516. "Kenyan HIV ruling hailed", BBC News, 3 August 2000.

517. See Uneke C, Alo M and Ogbu O, "Mandatory pre-marital HIV testing in Nigeria: The public health and social implications", *AIDS Care*, 2007, 19(1):116–121; Turnock B and Kelly C, "Mandatory premarital testing for human immunodeficiency virus, the Illinois experience", *Journal of the American Medical Association*, 1989, 261:3415–3418; and Luginaah I *et al.*, "From mandatory to voluntary testing: Balancing human rights, religious and cultural values, and HIV/AIDS prevention in Ghana", *Social Science & Medicine*, 2005, 61:1689–1700.

518. Chu S and Symington A, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS — Volume Two: Family and Property Issues* (Toronto: Canadian HIV/AIDS Legal Network, 2009), pp. 1-26.

519. See *Administration of Estates Act of 1974* of Botswana, which includes the following provisions:
28(5) Letters of administration may be issued to a woman, but shall not, without the consent in writing of her husband, be granted to a woman married in community of property, or to a woman out of community of property when the marital power of the husband is not excluded.
Under the customary laws of the United Republic of Tanzania, a woman can only become an administrator if the deceased has absolutely no male relatives who could assume the role. See Ezer T, "Inheritance law in Tanzania: The impoverishment of widows and daughters", *Georgetown Journal of Gender and the Law*, 2006, 7 (Special Issue):599–662, at pp. 617–618.
520. Tanzania Law Reform Commission (TLRC), *Report on the Law of Succession* (2002), p. 55.
521. *Re Kibiego*, Probate Cause 15 of 1972, 6 March 1972 (High Court of Kenya).
522. Article 24(1) of the Constitution of the United Republic of Tanzania, 1977 (available online at http://www.judiciary.go.tz/downloads/constitution.pdf).
523. *Ndossi v. Ndossi*, [2001] Civil Appeal No. 13, 13 February 2002 (High Court of Tanzania at Dar Es Salaam).
524. *Gumede (born Shange) v. President of the Republic of South Africa & Others, Case CCT 50/08, [2008] ZACC 23*, at para 46.
525. Note that, at the time of this writing, there is no cure for HIV that is generally available. There has been a small handful of a few highly unusual cases in which specific techniques (e.g. a complete bone marrow transplant) have led to what clinicians have described as a "functional cure". None of these techniques are easily replicable on a mass scale. Research is still in progress.
526. Several well-established guidelines exist for the clinical management of HIV disease, including recommendations about ARV treatment. Some resources also exist that tailor these recommendations for the needs of specific populations (e.g. infants and children, pregnant women, men who have sex with men, and transgender people) and specific settings (e.g. resource-limited settings). These guidelines are updated regularly as the available evidence about various medications evolves. A compilation of such guidelines is to be found via HIV InSite (available online at http://hivinsite.ucsf.edu/global?page=cr-00-04, accessed 24 June 2013). Key among them are the following guidelines from the World Health Organization: *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach* (July 2010); *Antiretroviral Therapy for HIV Infection in Infants and Children* (July 2010); and *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants in Resource-Limited Settings: Towards Universal Access – Recommendations for a Public Health Approach* (July 2010).
527. If treatment is interrupted, a person can also develop resistance to specific antiretrovirals. For more information, see Bennett D *et al.*, "The World Health Organization's global strategy for prevention and assessment of HIV drug resistance", *Antiretroviral Therapy*, 2008, 13(Suppl. 2):1–13 and World Bank*, HIV/AIDS Medicines and Related Supplies: Contemporary Context and Procurement*, technical guide (2004).
528. Human Rights Committee, *General Comment No. 6: The Right to Life (Article 6)*, HRI/GEN/1/Rev.1 at 6 (1994).
529. *International Covenant on Economic, Social and Cultural Rights*, 993 U.N.T.S. 3 (1967), Article 12.
530. In the Americas, see Article 11 of the *American Declaration of the Rights of Man*, OAS Res. XXX (2 May 1948), reprinted in *Basic Documents Pertaining to Human Rights in the Inter-American System*, OEA/Ser.L.V./II.82 doc 6 rev. 1 at 17 (1992). Note that this Declaration is binding on all States parties to the OAS *Charter: Protocol of Amendment to the Charter of the Organization of American States*, O.A.S. Treaty Series No. 1-A. See also Article 26 of the *American Convention on Human Rights*, 1144 U.N.T.S. 123, O.A.S. TS 36. In Africa, see Article 16 of the *African Charter on Human and Peoples' Rights*, OAU Doc. CAB/LEG/67/3 rev. 5 (1981), (1982) 21 I.L.M. 58. With respect to women's health, see also Article 14 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, AU Doc. CAB/LEG/66.6 (2000), and with respect to children's health, see Article 14 of the *African Charter on the Rights and Welfare of the Child*, OAU Doc. CAB/LEG/24.9/49 (1990). In Europe, see Part I of the *European Social Charter*, 529 U.N.T.S. 89, E.T.S. No. 35 for statement of principles including the right to health and Part II, articles 11 and 13, for more detailed provision on states' obligations.
531. Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12)*, UN Doc. E/C.12/2000/4 (2000), at para. 1.
532. a*Ibid.*, para. 9.
533. *Ibid.*, para. 12.
534. *Ibid.*
535. *Ibid.*
536. *Ibid.*
537. *Ibid.,* para. 16.
538. *Ibid.*, para. 17 [emphasis added].
539. Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The Nature of States Parties' Obligations* (Article 2, par. 1), UN Doc. E/1990/23, annex III at 86 (1990) at para. 2. ["*CESCR General Comment 3*"]. For further elaboration by leading human rights jurists of the nature of economic, social and cultural rights, see *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights,* (1998) 20 *Human Rights Quarterly* 691 (available online at http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html, accessed 24 June 2013).
540. *General Comment No. 14*, para. 30.
541. *Ibid.,* para. 31.
542. *Ibid.,* para. 32.
543. *Ibid.,* para. 48.
544. See *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version*, Guideline 6: Access to Prevention, Treatment, Care and Support (UN High Commissioner for Human Rights and UNAIDS); "Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria", UN GA Res. 58/179, UN Doc. A/RES/58/179(2003), adopted with 181 votes in favour, 1 vote against (United States) and no abstentions; and *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS,* UN GA Res. 65/277, UN Doc. A/RES/65/277 (2011).

545. For example, see *Muñoz Ceballos v. Instituto de Seguros Sociales* (1992), Judgment No. T-484-92 (Colombia, Corte Constitucional); *García Alvarez v. Caja Costarricense de Seguro Social* (1997), Decision No. 5934-97 (Costa Rica, Sala Constitucional de la Corte Suprema de Justicia); *Murillo Rodríguez v. Caja Costarricense de Seguro Social* (1997), Decision No. 6096-97 (Costa Rica, Sala Constitucional de la Corte Suprema de Justicia); *Van Biljon & Others v. Minister of Correctional Services & Others* (1997), 50 B.M.L.R. 206 (High Court of South Africa, Cape of Good Hope Provincial Division); *Cruz del Valle Bermudez et al. v. Ministerio de Sanidad y Asistencia Social* (1999), Case No. 15.789, Decision No. 916 (Venezuela, Corte Suprema de Justicia), (and for a discussion of this case, see Torres MA, "The human right to health, national courts, and access to HIV/AIDS treatment: A case study from Venezuela", *Chicago Journal of International Law*, 2002(3):105–114); *Moreno Alvarez v. Estado Colombiano* (1999), Decision No. SU.819/99 (Colombia, Corte Constitucional); *Odir Miranda Cortez et al. v. El Salvador* (2001), Case 12.249, Report No. 29/01, Inter-American Commission on Human Rights, *Annual Report 2000*, OEA/Ser./L/V/II.111, Doc. 20 Rev. (2001); *Lopez v. Instituto Venezolano de Seguros Sociales* (2001), Judgment No. 487-060401 (Venezuela, Sala Constitucional de la Corte Suprema de Justicia); *Minister of Health & Others v. Treatment Action Campaign & Others* (5 July 2002), Judgment No. CCT 8/02 (South Africa, Constitutional Court); and *Castro et al. v. Programa Nacional del SIDA-VIH-ITS y Ministerio de Salud Pública* (2004), Decision No. 0749-2003-RA, Tribunal Constitucional del Ecuador. For summaries of some of these cases, see Elliott R *et al.*, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV* (Geneva: UNAIDS & Canadian HIV/AIDS Legal Network, 2006). In *General Comment No. 14*, the Committee on Economic, Social and Cultural Rights specifically recognized that a state's minimum core obligations under the ICESCR include ensuring access to "essential drugs, as defined by the WHO Action Programme on Essential Drugs" (at para. 43). See the most recent version of the WHO's Model List of Essential Medicines (available at www.who.int/medicines/publications/essentialmedicines, accessed 24 June 2013).

546. For details of individual country legislation, see "International Digest of Health Legislation", maintained online by the World Health Organization (available at http://apps.who.int/idhl-rils/frame.cfm?language=english, accessed 24 June 2013). See also *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur to the United Nations Commission on Human Rights*, UN Doc. E/CN.4/2003/58 (2003) and Toebes B, *The Right to Health as a Human Right in International* Law (Amsterdam: Hart/Intersentia, 1999).

547. International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability*, Human Rights and Rule of Law Series, No. 2 (Geneva: ICJ, 2008), p. 15.

548. *Ibid*., pp. 15–16.

549. *Edgar Mauricio Carpio Castro et al. v. Programa Nacional del SIDA-VIH-ITS y Ministerio de Salud Publica*, Constitutional Tribunal, Decision No. 0749-2003-RA (2004).

550. *Ibid*., p. 73.

551. *Ibid*., pp. 83–84. For an example of a court further elaborating on this point, see *Certification of the Constitution of the Republic of South Africa*, Constitutional Court of South Africa, Case CCT 23/95 (1996).

552. Committee on Economic, Social and Cultural Rights, *General Comment No. 9: The Domestic Application of the Covenant*, UN Doc. E/C.12/1998/24 (1998), para. 10.

553. *Paschim Banga Khet Samity v. State of West Bengal*, Supreme Court of India, Case No. 169 (6 May 1996), para. 16.

554. For a more detailed discussion, see International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability*, Human Rights and Rule of Law Series, No. 2 (Geneva: ICJ, 2008), p. 89ff.

555. *Ibid*., p. 90.

556. *Ibid*., p. 91.

557. *Ibid*., pp. 92, 94–95.

558. *Ibid*., p. 21. For additional examples of judgments in which courts have found it possible to determine whether ESC rights, including the right to health, have been violated by state action or inaction, see the database maintained by the International Network on Economic, Social and Cultural Rights (available at www.escr-net.org, accessed 24 June 2013).

559. *Minister of Health and Others v. Treatment Action Campaign and Others*, Constitutional Court of South Africa, CCT 8/02 (2002), [2002] ZACC 15; 2002 (5) SA 721.

560. *Ibid*., at para. 135.

561. *General Comment No. 14*, paras. 8 and 14.

562. For example, see *L.M., M.I. & N.H. v. Namibia*, Cases No. I 1603/2008, 3518/2008 & 3007/2008 High Court of Nambia (30 July 2012). In this case, the High Court of Namibia found against the Namibian Government for the coerced sterilization of three HIV-positive women at public hospitals in Namibia. As noted by the Court, "[t]he issue in each claim is whether the defendant had obtained not only the plaintiffs' written consent but the plaintiffs' informed consent prior to the respective sterilisation procedures performed on them" (para. 6). Further, the patients must be provided with adequate information to enable them to make informed decisions (para. 16). However, the Court, without further comment, found that the claim of discrimination based on HIV status was not made out. At the time of this writing, the trial judgment with respect to one of the plaintiffs was under appeal.

563. United Nations Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4.

564. *International Guidelines on HIV/AIDS and Human Rights,* (2006 Consolidated Version), para. 120.

565. In the case of *V.C. v. Slovakia*o (Application No. 18968/07, 8 November 2011), for example, the European Court of Human Rights ruled that forced sterilization is a violation of the *European Convention on Human Rights* (specifically Article 3, which prohibits torture or inhuman and degrading treatment, and Article 8, which protects the right to private and family life).

566. *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc. A/39/51 (1984), *entered into force* 26 June 1987, articles 1, 2 and 16; Nowak M & McArthur E, *The United Nations Convention Against Torture: A Commentary* (Oxford: Oxford University Press, 2008), p. 8.

567. See Center for Reproductive Rights, *Dignity Denied: Violations of the rights of HIV-positive Women in Chilean Health Facilities* (2010) and Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).

568. See Open Society Foundations, *Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centres* (2011); Open Society Foundations, *Treated with Cruelty: Abuses in the Name of Drug Rehabilitation* (June 2011); and Human Rights Watch, *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia and Lao PDR* (2012).

569. *Pitcherskaia v. [U.S.] Immigration and Naturalization Service*, 118 F.3d 641 (9th Circuit, 1997).

570. Nowak M, *Interim Report of the Special Rapporteur on Torture and Cruel, Inhuman or Degrading Treatment or Punishment*, UN General Assembly, 63rd Session, UN Doc. A/63/175 (2008), para. 59.

571. *Estelle v. Gamble*, 429 US 97 (U.S. Supreme Court, 1976); Nowak M, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN General Assembly, 62nd Session, UN Doc. No. A/62/221 (13 August 2007), para. 9; Nowak M, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Report to the UN Human Rights Council, UN Doc. A/HRC/10/44 (14 January 2009), para. 58 (e.g. referring to the practice of some states withholding from people in detention access to substitution maintenance therapy as a treatment option for opioid dependence).

572. UN General Assembly, *Basic Principles for the Treatment of Prisoners*, United Nations General Assembly Official Records (UNGAOR), 45th Sess., Supp. No. 49A, UN Doc. A/45/49 (1990), Principle 5; Lines R, "The right to health of prisoners in international human rights law", *International Journal of Prisoner Health*, 2008, 4(1):3–53.

573. Médecins Sans Frontières, *Untangling the Web of Antiretroviral Price Reductions* (14th ed., July 2011), regularly updated online (available at http://utw.msfaccess.org, accessed 24 June 2013). See also data regularly collected and reported via the WHO's Global Price Reporting Mechanism (available at http://www.who.int/hiv/amds/gprm/en, accessed 24 June 2013).

574. *Agreement on Trade-Related Aspects of Intellectual Property Rights* (Annex 1C to the *Agreement Establishing the World Trade Organization*) (1994), 1867 U.N.T.S. 299. UNDP, UNAIDS and WHO, *Policy Brief: Using TRIPS Flexibilities to Improve Access to HIV treatment* (2011).

575. Some countries may also exclude certain things from being the subject of a patent claim for various public policy reasons (e.g. because it would be morally objectionable to allow the patenting and commercialization of the subject matter in question). International treaties generally recognize this flexibility to some degree.

576. Republic of Kenya, *Judgment of the High Court of Kenya (in Nairobi)*, Petition no. 409 (2009).

577. *Ibid.* at paras. 9–10.

578. *Ibid.* at para. 14.

579. *Ibid.* at paras. 85–86.

580. The term "evergreening" is generally used to describe a range of strategies through which patent-holders seek to preserve their patent monopoly on a product when an original patent is about to expire (e.g. by obtaining a new patent based on a minor modification).

581. See Lawyers Collective HIV/AIDS Unit, "Novartis case: Background and update" (New Delhi, 5 September 2011) and subsequent updates online (available at www.lawyerscollective.org, accessed 24 June 2013). On opposing patents, see Médecins Sans Frontières' Access Campaign's Patent Opposition Database (available at http://patentoppositions.org, accessed 24 June 2013).

582. WHO, *Globalization, TRIPS and Access to Pharmaceuticals*, WHO Policy Perspectives on Medicines No. 3 (Geneva: WHO, 2011), WHO/EDM/2001.2.

583. WTO Ministerial Conference, *Declaration on the TRIPS Agreement and Public Health*, WTO Doc. WT/MIN(01)/DEC/2 (14 November 2001).

584. WTO General Council, *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, Decision of the General Council of 30 August 2003, WTO Doc. IP/C/W/405.

585. See full background and description of proceedings in Treatment Action Campaign, *The Price of Life: Hazel Tau and Others vs GlaxoSmithKline and Boehringer Ingelheim* (Johannesburg: Treatment Action Campaign, 2003).

586. Article 8(a) of the Competition Act of South Africa, No 89 of 1998, available at http://www.saflii.org/za/legis/num_act/ca1998149.pdf.

587. *Ibid*.

588. *Ibid*.

589. Competition Commission of South Africa, Media Release (No. 29 of 2003): "Competition Commission finds pharmaceutical firms in contravention of the Competition Act" (16 October 2003).

590. *R. v. Parker*, [2000] 49 O.R. (3d) 481 (Court of Appeal for Ontario).

591. *Cardinal v. The Director of the Fort Saskatchewan Correctional Centre and The Director of the Edmonton Remand Centre* (Action No 021531397PI) (Alberta Court of Queen's Bench).

592. Right before the case went to trial, a new policy was brought into force, under which prisoners in Alberta's correctional institutions who had been receiving MMT prior to their incarceration would be permitted to continue treatment while in prison. As a result, the case did not proceed to trial. See Whitling N, "New policy on methadone maintenance treatment in prisons established in Alberta", *Canadian HIV/AIDS Policy & Law Review*, 2003, 8(3):45–47.

593. *Ibid*.

594. *EN and Others v. Government of RSA and Others*, (2006) AHRLR 326 (SAHC 2006) [Durban High Court].

595. *N.A. et al. v. Ministerio de Sanidad y Asistencia Social*, Supreme Court of Justice of Venezuela, Case No. 14.625 (14 August 1998).

596. The *amparo* action is a remedy in some Latin American civil law systems best described as a "constitutional injunction" — that is, an injunction obtained urgently to redress an existing, or prevent an imminent, breach of constitutional rights. In some other jurisdictions, it is referred to as a *tutela* action.

597. As translated by M.A. Torres and reproduced in Fidler DP, *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence* (Ardsley, NY: Transnational Publishers, 2000), p. 321.

598. *Ibid.*

599. *Minister of Health and Others v. Treatment Action Campaign and Others,* Constitutional Court of South Africa, CCT 8/02 (2002), [2002] ZACC 15; 2002 (5) SA 721 at para. 25. [*Minister of Health v. TAC*]
600. *Ibid*., at para. 36.
601. *Government of the Republic of South Africa and Others v. Grootboom and Others*, 2001 (1) SA 46 CC; 2000 (11) BCLR 1169 (CC).
602. *Minister of Health v. TAC*, at para. 47.
603. *Ibid*., at para. 57.
604. *Ibid*., at para. 70.
605. *Ibid*., at para. 80.
606. *Ibid*., at para. 98.
607. *Ibid*., at para. 125.
608. *Ibid*., at para. 135.
609. This summary is adapted from Elliott R *et al.*, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV* (Toronto: Canadian HIV/AIDS Legal Network and UNAIDS, March 2006), pp. 92–94. [Unofficial English translation of the original Thai judgment on file with authors.]
610. Thepgumpanat P, "Thailand takes on US giant over AIDS drug", *Reuters*, 9 October 2002; "Thai government to begin producing didanosine", *Kaiser Daily HIV/AIDS Report*, 18 October 2002 (with reference to *Financial Times*, 17 October 2002); and Sivaram S, "Patient rights win over patent rights", *Inter Press Service*, 20 October 2002.
611. The phrase "men who have sex with men" (MSM) emphasizes sexual practices rather than identities, and it includes not only self-identified gay and bisexual men, but also men who have sex with men and self-identify as heterosexual (or do not self-identify at all), as well as transgender males.
612. A transgender person has a gender identity that is different from their sex at birth. Transgender people may be male to female, in that she has a gender identity that is predominantly female, even though she was born with a male body, or female to male, in that he has a gender identity that is predominantly male, even though he was born with a female body.
613. While the term "prostitution" is regarded by some to be pejorative, virtually all legal systems use the term "prostitution" to describe the activity that is being regulated. In this chapter, the terms "sex work" and "prostitution" are used interchangeably to refer to the consensual sale of sexual services by adults.
614. For issues specific to people who use drugs, see Chapter 7, "Drug laws, harm reduction and the rights of people who use drugs".
615. UNAIDS, *UNDP: Bangladeshi Women Migrants Abroad Vulnerable to HIV* (*November 2009)* (available online at www.unaids.org, accessed 24 June 2013).
616. WHO, UNAIDS and United Nations Office on Drugs and Crime (UNODC), *Interventions to Address HIV in Prisons: HIV Care, Treatment and Support, Evidence for Action Technical Papers* (2007), p. 5.
617. United Nations in China, *Report of the Independent Commission on AIDS in Asia* (March 2008) (available online at www.un.org.cn, accessed 24 June 2013).
618. Grover A. and United Nations 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, 14th Session, Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the Right to Development*, UN Doc. A/HRC/14/20, 27 April 2010.
619. Commission on AIDS in Asia, *Redefining AIDS in Asia – Crafting an Effective Response* (26 March 2008).
620. Global Commission on HIV and the Law, *Risks, Rights & Health*, Recommendation 3.2.1 (July 2012).
621. Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), Guideline 4, para. 21(b).
622. UNAIDS and the Inter-Parliamentary Union (IPU), *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (1999), p. 56. Note that the Global Commission on HIV and the Law endorsed this approach, stating: "Countries must reform their approach towards sex work. Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients access to effective HIV and health services and commodities". *Risks, Rights & Health*, Recommendation 3.2. (July 2012).
623. This approach has been criticized (and successfully challenged in a U.S.A. court) for making it extremely difficult to provide necessary health services to sex workers. In 2011, the U.S.A. 2nd Circuit Court of Appeals in Manhattan held that the U.S.A. cannot force its partners in the global response to AIDS to denounce prostitution as a condition to get funding, citing the First Amendment. *Alliance for Open Society International v. U.S. Agency for International Development*, U.S.A. Court Of Appeals for the Second Circuit, 6 July 2011, Docket No. 08-4917-cv. See also Center for Health and Gender Equity, *Policy Brief: Implications of U.S. Policy Restrictions for HIV Programs Aimed at Commercial Sex Workers* (August 2008).
624. See Coalition Against Trafficking in Women (CATW), *Theme 1: Why are We So Behind Key Areas?* (United Nations Non-governmental Liaison Service, 18 June 2010) (available online at www.un-ngls.org, accessed 24 June 2013). See also CATW, *Prostitution Law Reform* (undated) (available via www.catwinternational.org, accessed 24 June 2013).
625. See Abel G, *Decriminalisation: A Harm Minimisation and Human Rights Approach to Regulating Sex Work, A Thesis Submitted for the Degree of Doctor of Philosophy of the University of Otago, Dunedin, New Zealand* (June 2010), pp. 62, 248 and Ward H. *et al.*, "Prostitution and risk of HIV: Female prostitutes in London", *British Medical Journal*, 1993, 307(7):356–358.
626. See Asia Pacific Network of Sex Workers, UNFPA and UNAIDS, *Building Partnerships on HIV and Sex Work: Report and Recommendations from the First Asia and the Pacific Regional Consultation on HIV and Sex Work* (2010), p. 14 and Aids2031, *Sex, Rights and the Law in a World with AIDS* (2009).

627. Scorgie F *et al.*, *"I Expect To Be Abused and I Have Fear": Sex Workers' Experiences of Human Rights Violations and Barriers to Accessing Health Care in Four African Countries* (African Sex Worker Alliance, April 2011), pp. 9–10; Abel G, *Decriminalisation: A Harm Minimisation and Human Rights Approach to Regulating Sex Work, A Thesis Submitted for the Degree of Doctor of Philosophy of the University of Otago, Dunedin, New Zealand* (June 2010), p. 84; Rekart ML, "Sex-work harm reduction", *Lancet*, 2005, 366(9503):2123–2134, at p. 2129; Shaver F *et al.*, "Rising to the challenge: Addressing the concerns of people working in the sex industry", *Canadian Review of Sociology*, 2011, 48(1):47–65, at p. 49; Pivot Legal Society Sex Work Subcommittee, *Voices for Dignity: A Call to End the Harms of Canada's Sex Trade Laws* (2004), p. 20; and Fick N, *Coping With Stigma, Discrimination And Violence: Sex Workers Talk About Their Experiences* (Sex Worker Education & Advocacy Taskforce Cape Town, 2005), p. 28.

628. Consider, for example, the following statistics:
• India: five percent of female sex workers are living with HIV (over 15 times higher than the adult HIV prevalence). UN General Assembly Special Session, *Country Progress Report: India* (2010);
• Spain: HIV prevalence among male sex workers is 12.2 percent. Belza MJ, "Risk of HIV infection among male sex workers in Spain", *Sexually Transmitted Infections*, 2005, 81(1):85–88;
• Benin, Burundi, Cameroon, Ghana, Guinea-Bissau, Mali, Nigeria: over 30 percent of sex workers are living with HIV. UNAIDS, *2009 AIDS Epidemic Update, Fact Sheet: Sub-Saharan Africa* (2009);
• Guyana: HIV prevalence among sex workers is 16.6 percent. UNAIDS, *UNAIDS Report on the Global AIDS Epidemic* (2010), p. 207;
• Argentina: HIV prevalence among male sex workers is 22.8 percent versus 1.8 percent among female sex workers. UNAIDS, *2009 AIDS Epidemic Update, Fact Sheet: Latin America* (2009);
• Kazakhstan: twelve percent of sex workers are HIV-positive and 30 percent have hepatitis C, suggesting both risky sex and drug injecting behaviour. Central and Eastern European Harm Reduction Network, *Sex Work, HIV and Human Rights in Central and Eastern Europe and Central Asia* (2005); and
• Indonesia: HIV prevalence among transgender sex workers is 22 percent and 3.6 percent among male sex workers: Pisani E *et al.*, "HIV, syphilis infection, and sexual practices among transgenders, male sex workers, and other men who have sex with men in Jakarta, Indonesia", *Sexually Transmitted Infections*, 2004, 80(6):536–540.

629. Karim QA *et al.*, "Reducing the risk of HIV infection among South African sex workers: Socioeconomic and gender barriers", *American Journal of Public Health*, 1995, 85:1521–1525. See also Wojcicki JM and Malala J, "Condom use, power and HIV/AIDS risk: Sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg", *Social Science & Medicine*, 2001, 53(1):99–121.

630. Raymond J *et al.*, *Sex Trafficking of Women in the United States: Links between International and Domestic Sex Industries* (Coalition Against Trafficking in Women, 2001).

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632. Sex Workers Action Network, *Arrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia* (2009), p. 20.

633. USAID, *Violence And Exposure To HIV Among Sex Workers In Phnom Penh, Cambodia* (March 2006), p. 5.

634. Valera R *et al.*, "Perceived health needs of inner-city street prostitutes: A preliminary study", *American Journal of Health Behavior*, 2001, 25(1):50–59.

635. Shannon K *et al.*, "Prevalence and structural correlates of gender-based violence among a prospective cohort of female sex workers", *British Medical Journal*, 2009, 339(7718):442–445.

636. Decker M *et al.*, "Violence victimisation, sexual risk and sexually transmitted infection symptoms among female sex workers in Thailand", *Sexually Transmitted Infections*, 2010, 86(3):236–240.

637. Barnard MA, "Violence and vulnerability: Conditions of work for streetworking prostitutes", *Sociology of Health & Illness*, 1993, 15(5):683–705, at p. 700; Pivot Legal Society Sex Work Subcommittee, *Voices for Dignity: A Call to End the Harms of Canada's Sex Trade Laws*, 2004, p. 17; and Alexander P, "Sex work and health: A question of safety in the workplace", *Journal of the American Medical Women's Association*, 1998, 53(2):77–82.

638. See Bruckert C and Chabot F, *Challenges: Ottawa-area Sex Workers Speak Out*, (Prostitutes of Ottawa/Gatineau Work, Educate, Resist [POWER], 2010) and Shannon L *et al.*, "Mapping violence and policing as an environmental–structural barrier to health service and syringe availability among substance-using women in street-level sex work", *International Journal of Drug Policy*, 2008, 19(2):140–147. In a Canadian study, greater clustering of coercive sex in sex work transactions was found in isolated public spaces compared with main streets near services and stores: Shannon K *et al.*, "Structural and environmental barriers to condom use negotiation with clients among female sex workers: Implications for HIV-prevention strategies and policy", *American Journal of Public Health*, 2009, 99(4):659–665; May T and Hunter G, "Sex work and problem drug use in the U.K.: The links, problems and possible solutions", in Campbell R and O'Neill M (eds.), *Sex Work Now* (Cullompton, Devon: Willan Publishing, 2006); Vanwesenbeeck I, "Another decade of social scientific work on sex work: A review of research 1990–2000", *Annual Review of Sex Research*, 2001, 12:242–289; and Lee DM, *et al.*, "The incidence of sexually transmitted infections among frequently screened sex workers in a decriminalised and regulated system in Melbourne", *Sexually Transmitted Infections*, 2005, 81(5):434–436.

639. van der Meulen E., "Ten illegal lives, loves, and work: How the criminalization of procuring affects sex workers in Canada", *Wagadu* 8 (Fall 2010):217–240.

640. See Canadian HIV/AIDS Legal Network, *Women and HIV: "Women, Sex Work and HIV"* (Toronto: Canadian HIV/AIDS Legal Network, 2012).

641. *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, 14th Session, Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the Right to Development*, UN Doc. A/HRC/14/20, 27 April 2010.

642. UN General Assembly Resolution 317 (IV), *Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others*, 2 December 1949 (Trafficking Convention). Note that the Convention is not widely ratified; as of the time of this writing, there were only 82 parties to the convention as per the United Nations Treaty Collection (available at http://treaties.un.org, accessed 24 June 2013).

643. See Article 2 of the Trafficking Convention.

644. 1249 U.N.T.S. 13, entered into force 3 September 1981.

645. The history of the drafting process suggests CEDAW does not embrace the perspective of the *Trafficking Convention*. During negotiations on the wording of CEDAW, Morocco introduced an amendment to Article 6 to include the phrase "suppression of prostitution", in addition to the phrase "suppression of the exploitation of prostitution" and the Netherlands and Italy rejected this move, which signifies that Article 6 does not consider all prostitution as inherently coercive. See Mgbako C and Smith LA, "Sex work and human rights in Africa", *Fordham International Law Journal*, 2011, 33(4):1200–1201.

646. United Nations Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW): *General Recommendation 19*, UN Doc No A/47/38, 1992. The Committee is mandated to monitor and encourage states' compliance with CEDAW.

647. Consider States parties' obligations to guarantee all persons' rights: to life; not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment; to liberty and security of the person; not to be subjected to arbitrary arrest or detention; not to be subjected to arbitrary or unlawful interference with their privacy, family, home or correspondence, nor to unlawful attacks on their honour or reputation; to freedom of expression; to freedom of association with others; to equality before the law and equal protection of the law without any discrimination on any ground; and to an effective remedy for violations of rights or freedoms, notwithstanding that the violation has been committed by persons acting in an official capacity. See articles 6, 7, 9, 17, 19(2), 22, 26 and 2(3), respectively, of the *International Covenant on Civil and Political Rights* (ICCPR), 999 U.N.T.S. 171, entered into force 23 March 1976.

648. States parties are legally obligated to take steps towards the progressive realization of the rights to: work, including the opportunity to work that is freely chosen or accepted; enjoy just and favourable conditions of work; form and join a trade union; social security; special protection for mothers during a reasonable period before and after childbirth; an adequate standard of living for themselves and their families; and the highest attainable standard of physical and mental health. See articles 6(1), 7, 8(1), 9, 10(2), 11(1) and 12(1), respectively, of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), 993 U.N.T.S. 3, entered into force 3 January 1976.

649. See ProCon.org, *100 Countries and Their Prostitution Policies* (available from www.prostitution.procon.org, accessed 24 June 2013).

650. Brock D, *Making Work, Making Trouble: The Social Regulation of Sexual Labour, Second Edition* (Toronto: University of Toronto Press, 2009), p. 7.

651. *Prostitution Reform Act*, New Zealand, 2003, Sections 8–10; *Public Act,* New Zealand, 2003 No. 28.

652. See *Government Bill for the Violence Against Women Act of 1998* (Kvinnofrid 1997/98:55) and Swedish *Penal Code*, section 11, chapter 6: On sexual crimes. See also Dodillet S and Östergren P, "The Swedish sex purchase Act: Claimed success and documented effects", Conference paper presented at the International Workshop, *Decriminalizing Prostitution and Beyond: Practical Experiences and Challenges*, The Hague, March 3–4, 2011.

653. See "New Norway law bans buying of sex", 1 January 2009, *BBC News* and Rogers S, "Ireland eyes the decriminalisation of prostitutes", *Irish Examiner*, 5 January 2011.

654. For a discussion of this criticism, see Global Commission on HIV and the Law, *Risks, Rights and Health* (2012), at p. 38.

655. Sex Workers Action Network, *Arrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia* (2009), p. 42 and Ditmore M and Poulcallec-Gordon C, "Human rights violations: The acceptance of violence against sex workers in New York", in *Research for Sex Work*: *Sex Work, HIV/AIDS, Public Health and Human Rights* (December 2003). In Serbia, a police officer publicly expressed that "sex workers do not deserve to be protected as they are willingly engaging in risky and illegal activities". Report from JAZAS, Serbia, April 2011.

656. See Blankenship K and Koester S, "Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users", *Journal of Law, Medicine & Ethics*, 2002, 30(4):548–559; Barnard M, "Violence and vulnerability: Conditions of work for streetworking prostitutes", *Sociology of Health & Illness*, 1993, 15(5):683–705; Pyett PM and Warr DJ, "Vulnerability on the streets: Female sex workers and HIV risk", *AIDS Care*, 1997, 9(5):539–547; Benoit C and Millar A, *Dispelling Myths and Understanding Realities: Working Conditions, Health Status, and Exiting Experiences of Sex Workers* (Prostitutes Empowerment, Education and Resource Society [PEERS], 2001); and Sex Workers Action Network, *Arrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia* (2009), p. 42.

657. In 2007, for example, a municipal court judge in Philadelphia (U.S.A.) dismissed sexual assault charges against a man accused of raping a sex worker at gunpoint so that his remaining charges were only for "theft of services". Michels S, "Philly judge criticized for rape decision", *ABC News*, 31 October 2007. See also *R. v. Harris* 1981 (unreported), Victorian Supreme Court, Court of Criminal Appeal, August, as referenced in Scutt J, "Judicial vision: Rape, prostitution and the 'chaste woman'", in Weiser Easteal P (ed.), *Without Consent: Confronting Adult Sexual Violence* (Canberra: Australian Institute of Criminology, 1993).

658. *R. v. Leary*, unreported, 8/10/93 (NSWCCA) at 6, as referenced in *Equality before the Law Bench Book*, Judicial Commission of NSW, June 2006, p. 7305.

659. *R. v. Hakopian*, unreported, 11/12/91 (VicCCA), as referenced in *Equality before the Law Bench Book*, Judicial Commission of NSW, June 2006, p. 7305.

660. *Budhadev Karmaskar v. State of West Bengal*, Criminal Appeal No. 135 of 2010, Supreme Court of India, 2 August 2011.

661. Sex Workers Action Network, *Arrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia* (2009), p. 34.

662. See Boynton P and Cusick L, "Sex workers to pay the price", *British Medical Journal*, 2006, 332(7535):190 and Sex Workers Action Network, A*rrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia* (2009), p. 43; and Tucker JD and Ren X, "Sex worker incarceration in the People's Republic of China", *Sexually Transmitted Infections*, 2008, 84(1):34–35.

663. Consider, for example, the dissent of Justice Kirby in *Queen v. Wei Tang* [2008] HCA 39 (High Court of Australia).

664. "CAMBODIA: Human trafficking crackdown also hits HIV prevention", *PlusNews*, 21 October 2008 and Human Rights Watch, *Off the Streets: Arbitrary Detention and Other Abuses against Sex Workers in Cambodia* (2010).

665. *The Sex Worker Education and Advocacy Task Force v. Minister of Safety and Security & Others*, (2009) (2) SACR 417 WCC.

666. *Ibid.*, at para. 13.

667. *Ibid.*, at para. 60.

668. van der Meulen E, "Ten illegal lives, loves, and work: How the criminalization of procuring affects sex workers in Canada", *Wagadu*, Fall 2010, 8:217–240.

669. Human Rights Watch, *Off the Streets: Arbitrary Detention and Other Abuses against Sex Workers in Cambodia* (2010), p. 9 and Kavemann B, *The Act Regulating the Legal Situation of Prostitutes – Implementation, Impact, Current Developments: Findings of a Study on the Impact of the German Prostitution Act* (2007), p. 4.

670. *Regina v. Grilo*, (1991) 2 O.R. (3d) 514 (Ontario Court of Appeal) at para. 3.

671. *Ibid.*, at para. 27.

672. *Ibid.*

673. See Canadian HIV/AIDS Legal Network, *Women and HIV: "Women, Sex Work and HIV"* (Toronto: Canadian HIV/AIDS Legal Network, 2012).

674. Vanwesenbeeck I, "Another decade of social scientific work on sex work: A review of research 1990-2000", *Annual Review of Sex Research*, 2001, 2:242–289;
Canadian HIV/AIDS Legal Network, *Women and HIV: "Women, Sex Work and HIV"* (Toronto: Canadian HIV/AIDS Legal Network, 2012); and Lee DM *et al.*, "The incidence of sexually transmitted infections among frequently screened sex workers in a decriminalised and regulated system in Melbourne", *Sexually Transmitted Infections*, 2005, 81(5):434–436.

675. Bruckert C and Chabot F, *Challenges: Ottawa-area Sex Workers Speak Out* (POWER, 2010); Abel G, *Decriminalisation: A Harm Minimisation and Human Rights Approach to Regulating Sex Work, A Thesis Submitted for the Degree of Doctor of Philosophy of the University of Otago, Dunedin, New Zealand* (June 2010), p. 72.

676. Brents B and Hausbeck K, "Violence and legalized brothel prostitution in Nevada: Examining safety, risk, and prostitution policy", *Journal of Interpersonal Violence*, 2005, 20(3):270–295, at p. 270.

677. Note that this decision was unreported, being a decision of first instance.

678. International Prostitutes Collective, *Victory for Claire Finch, Victory for Sex Workers' Safety! A Malicious Prosecution with a Happy Ending*, undated; Personal communication with counsel, Anna Morris, 9 August 2011 and D. Taylor, "Law on brothels puts prostitutes at risk: Preventing sex workers operating together makes them more vulnerable to attack – we need a more pragmatic approach", *The Guardian*, 3 May 2010.

679. *Ibid.*

680. *Bedford v. Canada*, 2010 ONSC 4264 (Ontario Superior Court of Justice) at para. 242.

681. *Ibid.*, at paras. 397–401.

682. Abel G, *Decriminalisation: A Harm Minimisation and Human Rights Approach to Regulating Sex Work, A Thesis Submitted for the Degree of Doctor of Philosophy of the University of Otago, Dunedin, New Zealand* (June 2010), p. 73; Barnard M, "Violence and vulnerability: Conditions of work for streetworking prostitutes", *Sociology of Health & Illness*, 1993, 15(5):683–705, at p. 700; Pivot Legal Society Sex Work Subcommittee, *Voices for Dignity: A Call to End the Harms of Canada's Sex Trade Laws* (2004), p. 17; and Alexander P, "Sex work and health: A question of safety in the workplace", *Journal of the American Medical Women's Association*, 1998, 53(2):77–82.

683. Bruckert C and Chabot F, *Challenges: Ottawa-area Sex Workers Speak Out* (POWER, 2010); Shannon K *et al.*, "Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work", *Social Science & Medicine*, 2008, 66(4):911–921; Shannon K *et al.*, "Mapping violence and policing as an environmental–structural barrier to health service and syringe availability among substance-using women in street-level sex work", *International Journal of Drug Policy*, 2008, 19(2):140–147; Pivot Legal Society Sex Work Subcommittee, *Voices for Dignity: A Call to End the Harms of Canada's Sex Trade Laws* (2004), p. 17.

684. See the Republic of Ireland, *The Law On Sexual Offences: A Discussion Paper*, Department of Justice, Equality and Law Reform, Dublin, May 1998, p. 95; Canada, *Bedford v. Canada*, 2010 ONSC 4264 (Ontario Superior Court of Justice) at para. 274 and U.K., as affirmed in *Smith v. Hughes*, [1960] 1 W.L.R. 830 (Queen's Bench Division), 16 June 1960: "Everybody knows that this was an Act intended to *clean up the streets*, *to enable people to walk along the streets without being molested or solicited by common prostitutes*" [emphasis added]. See also section 3 of the 1842 U.K. law, *An Act for the Punishment of Idle and Disorderly Persons, and Rogues and Vagabonds*: "every common prostitute wandering in the public street or highway, or in any place of public resort, *and behaving in a riotous or indecent manner*. . . shall be deemed an idle and disorderly person…" [emphasis added]. A virtually identical provision is featured in Sri Lanka's *An Ordinance to Amend and Consolidate the Law Relating to Vagrants, 1842*.

685. National Network of Sex Workers and Lawyers Collective HIV/AIDS Unit, *Sex Workers Meet Law Makers,* 1 March 2011, p. 3 and Laite J, *Paying the Price Again: Prostitution Policy in Historical Perspective* (October 2006).

686. For example, in *Hutt v. R.* (1978), 82 D.L.R. (3d) 95, decided by the Supreme Court of Canada, the Court held that for the activities of a sex worker to be criminal, her conduct must conform to the dictionary definition of "solicit", which requires such communication to be "pressing or persistent" and constitute more than a mere indication that she was willing to provide sexual services.

687. The term "sexual minorities" refers to individuals' whose sexual identity, orientation or practices differ from the majority. It includes MSM, as well as members of the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. For the purposes of this chapter, we are focusing on MSM, although some of the legal issues discussed are also common to other sexual minorities.

688. See UNAIDS, *Report on the Global AIDS Epidemic 2010,* Chapter 2: Epidemic Update (2010); amfAR Aids Research, *MSM, HIV, and the Road to Universal Access — How Far Have We Come?* (August 2008); and Mumtaz G *et al.*, "Are HIV Epidemics among Men Who have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis", *PLoS Medicine*, 2011, 8(8):e1000444.

689. UNAIDS, *Report on the Global AIDS Epidemic 2010* (2010), p. 30 and UNAIDS, IPU and UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* (2007), p. 170.

690. See amfAR Aids Research, *MSM, HIV, and the Road to Universal Access — How Far Have We Come?* (August 2008), p. 6; Arreola S *et al.*, *In Our Own Words: Preferences, Values, and Perspectives on HIV Prevention and Treatment: A Civil Society Consultation with MSM & Transgender People* (Global Forum on MSM and HIV [MSMGF] and WHO, December 2010); and Legrand A *et al.*, "MSM law in francophone Africa and the fight against AIDS: The hypocrisy of certain countries", *HIV/AIDS Policy & Law Review*, 2010, 14(3):13–17.

691. See "Kenya: Rural MSM too afraid to access HIV health services", *IRIN Plus News*, 14 June 2011; Mahon C, "Sexual orientation, gender identity and the right to health", in Clapham A and Robinson M (eds.), *Swiss Human Rights Book*, *Vol. 3*, *Realizing the Right to Health* (Rüffer & Rub: Zurich, 2009), p. 236; UNAIDS, IPU and UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* (2007), p. 172; Nath D, *Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal* (Human Rights Watch, 2010); and Achille Tiedjou J *et al.*, *Criminalizing Identities: Rights Abuses in Cameroon based on Sexual Orientation and Gender Identity* (L'Association pour la Défense des Droits des Homosexuels, L'Association pour la Liberté, la Tolérance, l'Expression et le Respect de Personnes de Nature Indigente et Victimes D'Exclusion Sociale au Cameroun, the International Gay and Lesbian Human Rights Commission [IGLHRC] and Human Rights Watch, 2010), pp. 6 and 13.

692. Consider Uganda's proposed *Anti Homosexuality Bill*, which proposed prosecution for anyone failing to report to authorities a person they knew to be homosexual: "Uganda anti-gay bill 'shelved by parliament'", *BBC News*, 13 May 2011. See also Human Rights Watch, *Hated to Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic* (2004), p. 14.

693. Johnson A, *Off the Map: How HIV/AIDS Programming is Failing Same-sex Practicing People in Africa* (IGLHRC, 2007), pp. 57–58; Godwin J, *Legal Environments, Human Rights and HIV Responses among Men who Have Sex with Men and Transgender People in Asia and the Pacific: An Agenda for Action* (UNDP and Asia Pacific Coalition on Male Sexual Health [APCOM], July 2010), p. 9; and Arreola S *et al.*, *In Our Own Words: Preferences, Values, and Perspectives on HIV Prevention and Treatment: A Civil Society Consultation with MSM & Transgender People* (MSMGF and WHO, December 2010), p. 10.

694. Godwin J, *Legal Environments, Human Rights and HIV Responses among Men who Have Sex with Men and Transgender People in Asia and the Pacific: An Agenda for Action* (UNDP and APCOM, July 2010), p. 4; Tejada V and Tristán E, *Shadow Report for the Human Rights Committee Submitted in Conjunction with Panama's (Third Periodic) Report* (Asociación Hombres y Mujeres Nuevos de Panama, Global Rights, IGLHRC, March 2008), p. 6; and UNAIDS, IPU and UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* (2007), pp. 171–173.

695. "Universal decriminalisation of homosexuality a human rights imperative – Ban", *UN News Centre*, 10 December 2010.

696. Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (2008), p. 203.

697. Grover A. and United Nations 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, 14th Session, Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the Right to Development*, UN Doc. A/HRC/14/20, 27 April 2010.

698. Global Commission on HIV and the Law, *Risks, Rights & Health*, Recommendation 3.3.1 (July 2012).

699. UNAIDS, IPU and UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* (2007), p. 174.

700. Speech given in New York on 18 December 2008 on the occasion of the United Nations Statement, signed by 66 countries from all continents against the criminalization of homosexuality.

701. Consider, for example, Article 2 of the *Universal Declaration of Human Rights*: "Everyone is entitled to all of the rights and freedoms set forth in this Declaration, 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*" [emphasis added]; Article 2 of the *African Charter on Human and Peoples' Rights*: "Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or *any status*" [emphasis added]; and para. 20 of the Explanatory Report accompanying Protocol No. 12 to the European *Convention for the Protection of Human Rights and Fundamental Freedoms*, which specifies that the list of grounds of non-discrimination in Article 14 of the Convention is not exhaustive and notes that the European Court of Human Rights had already applied Article 14 in relation to discrimination on grounds not explicitly mentioned in that provision including, sexual orientation.

702. Consider, for example, *Toonen v. Australia,* in which Toonen argued that Tasmania's *Criminal Code* charging unnatural sexual intercourse and indecent practices between men violated his rights not to be discriminated against (Article 2(1) of the ICCPR), to privacy (Article 17 of ICCPR) and to equal protection under the law (Article 26). The United Nations Human Rights Committee found a violation of articles 2(1) and 17 and interpreted "sex" in articles 2(1) and 26 of the ICCPR to include sexual orientation (Communication No. 488/1992, views adopted on 31 March 1994). In *Young v. Australia*, Young was denied a war veteran's dependant pension because his partner was also male. The United Nations Human Rights Committee found that the state party had violated Article 26 (UN Doc CCPR/C/78/D/941/2000 (12 August 2003).

703. In 2008, the UN General Assembly issued the *Statement on Human Rights, Sexual Orientation and Gender Identity* with the support of 66 countries from all continents. The Statement reaffirmed that the principle of non-discrimination applies to all human beings regardless of sexual orientation or gender identity, condemned human rights violations of sexual minorities and urged all states to decriminalize consensual adult relations between persons of the same sex (18 December 2008). In 2011, the United Nations Human Rights Council passed a resolution on sexual orientation and gender identity "[r]ecalling the universality, interdependence, indivisibility and interrelatedness of human rights as enshrined in the Universal Declaration of Human Rights and consequently elaborated in other human rights instruments". The resolution noted concern about acts of violence and discrimination based on sexual orientation and gender identity, and it requested the High Commissioner for Human Rights to prepare a study on this issue that would be subsequently discussed at the Human Rights Council (A/HRC/17/L.9/Rev.1).

704. See Principle II of the *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, approved by the Inter-American Commission on Human Rights in 2008, Article 21(1) of the *Charter of Fundamental Rights of the European Union* (2007/C 303/01), and Article 10 of the *Andean Charter for the Promotion and Protection of Human Rights*, which includes sexual orientation on the list of prohibited grounds of discrimination (26 July 2002).

705. Principle 17 (right to the highest attainable standard of health). For more information about the *Yogyakarta Principles*, see www.yogyakartaprinciples.org/index.html.

706. The Working Group based its opinion on that of the Committee on Human Rights, according to which the reference to "sex" in Article 2, para. 1 and Article 26 is to be taken as including sexual orientation. *Report of the Working Group on Arbitrary Detention*, UN Doc. E/CN.4/2004/3, of 15 December 2003, para. 73.

707. Ottosson D, *State-sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults* (IGLA 2009); amfAR Aids Research, *MSM, HIV, and the Road to Universal Access — How Far Have We Come?* (August 2008), p. 5; and United Nations Office of the High Commissioner on Human Rights, *Born Free and Equal: Sexual Orientation and Gender Identity in International Human Rights Law* (2012), p. 7.

708. Ottosson D, *State-sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults* (IGLA 2009), pp. 48–52.

709. In the United States, for example, the Supreme Court in 1996 struck down an amendment to the *Constitution of the State of Colorado* that prohibited public measures designed to protect against discrimination against persons based on sexual orientation (*Romer v. Evans*, 134 L Ed 2d 855 (1996)). In 2003, the Supreme Court also struck down the Texan sodomy law on the basis that it infringed on liberty protected under the Fourteenth Amendment to the Constitution through the criminalization of intimate, consensual sexual conduct (*Lawrence v. Texas*, 539 U.S. 558). In Hong Kong, the Court of Appeal confirmed in both *Secretary for Justice v. Yau Yuk Lung Zigo and Lee Kam Chuen* [2007] 3 HKLRD 903(2007) and *Leung T.C. William Roy v. Secretary of Justice* [2006] 4 HKLRD 211(C.A.) that sexual orientation is a proscribed ground of discrimination analogous to race and sex. In Fiji, the High Court ruled that *Penal Code* offences criminalizing consensual sexual acts between adult men in private were in breach of the constitutional guarantees to personal privacy and equality, and that such prosecutions were thus invalid (*Nadan and McCoskar v. State* [2005] FJHC 500).

710. Ottosson D, *State-sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults* (IGLA 2009), pp. 50–52.

711. See *Report of the Special Rapporteur on the Question of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc. A/56/156, July 3, 2001, pp. 6–7; Nath D, *Fear for Life: Violence Against Gay Men and Men Perceived as Gay in Senegal* (Human Rights Watch, 2010); Achille Tiedjou J *et al.*, *Criminalizing Identities: Rights Abuses in Cameroon based on Sexual Orientation and Gender Identity* (L'Association pour la Défense des Droits des Homosexuels, L'Association pour la Liberté, la Tolérance, l'Expression et le Respect de Personnes de Nature Indigente et Victimes D'Exclusion Sociale au Cameroun, IGLHRC and Human Rights Watch, 2010); and Global Rights *et al.*, *The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in Mexico: A Shadow Report Submitted to the Human Rights Committee* (March 2010), pp. 10–11.

712. *Report of the Special Rapporteur on the Question of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc. A/56/156, July 3, 2001 at para. 21; United Nations Office of the High Commissioner on Human Rights, *Born Free and Equal: Sexual Orientation and Gender Identity in International Human Rights Law*, 2012; Sanei F, *We are a Buried Generation: Discrimination and Violence Against Sexual Minorities in Iran* (Human Rights Watch, 2010), pp. 70–72; Gender and Development of Azerbaijan, International Lesbian, Gay, Bisexual, Trans and Intersex Association: Europe (ILGA Europe) and Global Rights, *The Violations of the Rights of Lesbian, Gay, Bisexual, Transgender Persons in Azerbaijan: A Shadow Report Submitted during the Third Periodic Report to the United Nations Human Rights Committee* (July 2009), p. 11; and Global Rights *et al.*, *Violations of the Rights of Lesbian, Gay, Bisexual, and Transgender Persons in Russia: A Shadow Report* (October 2009), pp. 10–13.

713. Achille Tiedjou J *et al.*, *Criminalizing Identities: Rights Abuses in Cameroon based on Sexual Orientation and Gender Identity* (L'Association pour la Défense des Droits des Homosexuels, L'Association pour la Liberté, la Tolérance, l'Expression et le Respect de Personnes de Nature Indigente et Victimes D'Exclusion Sociale au Cameroun, IGLHRC and Human Rights Watch, 2010), pp. 20–21. A survey of MSM in Malawi, Namibia and Botswana found that blackmail was one of the most common human rights abuses they faced, with 18% of MSM in Malawi, 21.3% of MSM in Namibia, and 26.5% of MSM in Botswana having experienced incidents of blackmail. Significantly, those who had been blackmailed because of their sexuality were more afraid than those who had not sought health services, and they also were more likely to have experienced a denial of housing and health care. Thoreson RR, "Blackmail and extortion of LGBT people in sub-Saharan Africa", *International Gay and Lesbian Human Rights Commission*, 14 June 2011.

714. *Kasha Jacqueline v. Rolling Stone Ltd.* (2010), Miscellaneous Cause No. 163, H. Court of Uganda. In October 2010, the respondents had published a story in its newspaper with the headlines "SCANDAL" and "HANG THEM: THEY ARE AFTER OUR KIDS!!!!! Pictures of Uganda's 100 homos leak". The author of the article claimed to have conducted an investigation and found that the gay and lesbian community was "bent on recruiting at least one million members by 2012" and was targeting schoolchildren for this purpose. Twenty-three days after the High Court's ruling, David Kato, one of the applicants, was beaten to death in his home: Pillay N, "What David Kato's death can teach the world", *Africa Renewal Online*, 3 February 2011; Rice X, "Ugandan gay rights activist David Kato found murdered", *The Guardian*, 27 January 2011.

715. *Uganda Penal Code Act 1950,* c. XIV, s. 145.
Any person who—
a) has carnal knowledge of any person against the order of nature;
b) has carnal knowledge of an animal; or
c) permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence and is liable to imprisonment for life.

716. UNAIDS, IPU and UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians* (2007), p. 172; Godwin J, *Legal Environments, Human Rights and HIV Responses among Men who have Sex with Men and Transgender people in Asia and the Pacific: An Agenda for Action* (UNDP and APCOM, July 2010), pp. 24 and 30; and Human Rights Watch, *Bangladesh: Ravaging the Vulnerable: Abuses against Persons at High Risk of HIV Infection in Bangladesh* (2003), pp. 41–42.

717. Nath D, *Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal* (Human Rights Watch, 2010), p. 5.

718. Human Rights Watch, *Senegal: Free AIDS Activists; Eight-Year Sentences in Threatening Conditions for 9 Accused of 'Indecent and Unnatural Acts'*, 9 January 2009.

719. *Ibid. and* Global Commission on HIV and the Law, *Risks, Rights & Health* (July 2012), at pp. 46–47.

720. IGLHRC, *India: Lucknow Four Freed* (17 August 2001).

721. Godwin J, *Legal Environments, Human Rights and HIV Responses among Men who have Sex with Men and Transgender People in Asia and the Pacific: An Agenda for Action* (UNDP and APCOM, July 2010), pp. 29–30.

722. *Naz Foundation v. Government of NCT of Delhi and Others,* 2009 (160) DLT 277, (Delhi High Court).

723. *Toonen v. Australia* (Communication No. 488/1992, views adopted on 31 March 1994) at para. 8.5.

724. *Ibid*., at para. 10.

725. See *Dudgeon v. United Kingdom*, 45 Eur. Ct. H.R. (ser. A) (1981); *Norris v. Republic of Ireland*, 142 Eur. Ct. H.R. (ser. A) (1988); *Modinos v. Cyprus*, 259 Eur. Ct. H.R. (ser. A) (1993); *The National Coalition for Gay and Lesbian Equality v. The Minister of Justice*, [1998] ZACC 15 (Constitutional Court of South Africa); *Lawrence v. Texas*, 539 US 558 (2003) (United States Supreme Court); and *Sunil Babu Pant and Others v. Nepal Government and Others*, [2008] 2 NJA L.J. 261–286 (Supreme Court of Nepal).

726. *Dudgeon v. United Kingdom, Ibid*., at para. 60. Consider also the *African Charter on Human and Peoples' Rights*, which enshrines the right to non-discrimination in articles 2, 3 and 19, but is limited by Article 27(2), stipulating that rights must be exercised "with due regard to the rights of others, collective security, morality and common interest". With respect to this article, the African Commission has applied a proportionality test that requires that limitations pursuant to Article 27(2) are "strictly proportionate with and absolutely necessary for the advantages that are to be obtained" and may not interpret the right in a manner that renders it illusory: *Media Rights Agenda and Others v. Nigeria*, African Commission on Human and Peoples' Rights, Comm. Nos. 105/93, 128/94, 130/94 and 152/96 (1998) at para. 69.

727. See Grenada Caribbean HIV/AIDS Partnership *et al.*, *Sexuality, Gender, HIV Vulnerability & Human Rights in Grenada: A Shadow Report to the United Nations Human Rights Committee* (July 2007), p. 6.

728. In 2006, Alim Mongoche died in Cameroon after being released from prison one year after he was arrested because he was suspected of being gay. Mongoche was living with HIV, and his death was attributed to the lack of HIV-related treatment during his detention. Global Rights, IGLHRC and the Centre for Human Rights at the University of Pretoria and Alternatives Cameroun, *The Status Of Lesbian, Gay, Bisexual and Transgender Rights in Cameroon: A Shadow Report Submitted to the Human Rights Committee* (June 2010), pp. 6–7.

729. Note the inaccessibility of HIV treatment in prisons has been considered by a number of courts. In *Odafe and Others v. Attorney-General and Others* (High Court 2004), for example, a Nigerian court held that the continuous detention of HIV-positive prisoners without medical treatment amounted to mental torture that was in violation of the Constitution, and it ordered the prisoners to be relocated to a hospital for treatment. In *B and Others v. Minister of Correctional Services and Others* (High Court 1997), a South African court held that HIV-positive prisoners were entitled to antiretroviral treatment, and that failure to provide this would be a violation of their right to adequate medical treatment under the Constitution. In particular, the Court took judicial notice of the fact that HIV-positive prisoners are "more exposed to opportunistic viruses than HIV sufferers who are not in prison" and that "tuberculosis and pneumonia are prevalent in prison", exacerbated by overcrowding (para. 45). Recall that prisoners are also considered a "key population".

730. *Reference re ss. 193, 195.1(1)(c) of Criminal Code (Canada)*, [1990] 1 S.C.R. 1123 [*Prostitution Reference*].

731. 1860, c XVI, s. 377: "Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for term which may extend to ten years, and shall also be liable to fine".

732. At para 8.

733. *John Geddes Lawrence and Tyron Garner, Petitioners v. Texas*, 539 U.S. 558 (U.S.S.C. 2003).

734. 2003, c. 5, section 21.06(a).

735. *Constitution of the United States,* 1868, amendment 14, clause 1.

736. Section 21.01(1) of the *Texas Penal Code* defines "deviate sexual intercourse" as:
a) any contact between any part of the genitals of one person and the mouth or anus of another person; or
b) the penetration of the genitals or the anus of another person with an object.

737. *Bowers v. Hardwick*, 478 U.S. 186 (U.S.S.C. 1986) [*Bowers*].

738. *Lawrence*, at 16.

739. *Ibid*.

740. 517 U.S. 620 (1996) at 634.

741. *State v. Morales*, 826 S.W. 2d at 202–203 (Tex. App. 1992).

742. Available online at http://www.unaids.org/en/resources/presscentre/factsheets/.

743. Available online at http://apps.who.int/iris/bitstream/10665/44787/1/9789241502986_eng.pdf.

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