

International Guidelines on **HIV/AIDS** and **Human Rights** 2006 Consolidated Version

**Second International Consultation on
HIV/AIDS and Human Rights**
Geneva, 23-25 September 1996

**Third International Consultation on
HIV/AIDS and Human Rights**
Geneva, 25-26 July 2002

Organized jointly by the Office of the United Nations
High Commissioner for Human Rights and the
Joint United Nations Programme on HIV/AIDS



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¹ **Editor's note:** This version of the International Guidelines on HIV/AIDS and Human Rights consolidates the Guidelines first published in 1998 and revised Guideline 6 first published in 2002. Because of the consolidation, paragraph numbering has changed, and references to the Guidelines should include reference to the consolidated version to avoid confusion as to paragraph numbering. Other minor editorial changes have been made with regard to the introduction, summary and use of some terms. For example, "HIV/AIDS" is usually shortened to "HIV" and is intended to include both conditions, and "PLWHA" has been changed to "PLHIV". Other than that, the content of the Guidelines has not been revised or altered.

CONTENTS

Foreword	4
Glossary	8
Introduction	9
Background and summary of the Guidelines	13
I. GUIDELINES FOR STATE ACTION	20
A Institutional responsibilities and processes	21
B Law review, reform and support services	26
C Promotion of a supportive and enabling environment	52
II. RECOMMENDATIONS FOR DISSEMINATION AND IMPLEMENTATION OF THE GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS	69
A States	69
B United Nations system and regional intergovernmental bodies	71
C Non-governmental organizations	74
III. INTERNATIONAL HUMAN RIGHTS OBLIGATIONS AND HIV	77
A Human rights standards and the nature of State obligations	79
B Restrictions and limitations	81
C The application of specific human rights in the context of the HIV epidemic	83

Annex 1

History of the recognition of the importance of human rights
in the context of HIV 105

Annex 2

List of participants at the Second International Consultation
on HIV/AIDS and Human Rights 112

Annex 3

List of participants at the Third International Consultation
on HIV/AIDS and Human Rights 114

Foreword

It has been ten years since the International Guidelines were adopted by the Second International Consultation on HIV/AIDS and Human Rights in 1996. In terms of the fast and ever-evolving epidemic, much has happened in this decade, both good and bad. Evidence of the effectiveness of a treatment for HIV was first announced in 1996, which for many changed HIV from a situation of hopelessness to a manageable health condition. But as the HIV epidemic cast its glaring light on the vast inequity in health care across the globe, people living with HIV, among others, began to demand that something be done about the fact that millions were dying of a treatable condition. In 2001, the Commission on Human Rights adopted a resolution in which it stated that the right to the highest attainable standard of health includes access to antiretroviral therapy for HIV. Following this, in 2002, OHCHR and UNAIDS sponsored the Third International Consultation on HIV/AIDS and Human Rights in order to revise Guideline 6 (consolidated into this reprint) to reflect the human rights dimensions of access to HIV prevention, treatment, care and support.

Widespread access to antiretrovirals, as well as to HIV prevention, care and support, remains a major global health and human rights emergency for millions in need. Nonetheless, the numbers of those having such access is rising. In this regard, governments and the international community made commitments in 2006 to pursue all necessary efforts towards achieving the goal

of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010. Other time-bound commitments (including on human rights relating to HIV), have been made during the decade in the Millennium Declaration, and in the Declaration of Commitment adopted by the UN General Assembly Special Session on HIV/AIDS in 2001 and confirmed and expanded by the Political Declaration of the 2006 High Level Meeting on AIDS at the General Assembly. These commitments reflect what works in the response to HIV, as well as much greater political commitment to the response. Global funding for HIV programmes has risen almost 30-fold in the course of the decade.

Nevertheless, the situation remains grave, with a doubling of people living with HIV worldwide to over 40 million, with women now comprising half of those living with HIV, with young people, particularly young women, having the fastest rates of infection, and with some 14 million children having been orphaned by AIDS. HIV prevalence has grown among those groups in society most marginalized, such as sex workers, drug users and men having sex with men. Coverage of interventions to educate people about HIV; to provide them with HIV prevention commodities, services and treatment; to protect them from discrimination and sexual violence; and to empower them to participate in the response and live successfully in a world with HIV is unacceptably low in many places in the world.

Since the drafting of the Guidelines, the epidemic continues to confirm that the relationship between HIV and human rights is profound. Vulnerability to HIV infection and to its impact feeds on violations of human rights, including discrimination against women and violations which create and sustain poverty. In turn, HIV begets human rights violations, such as further discrimination, and violence. During the decade, the role of human rights in responding to the epidemic and in dealing with its effects has become evermore clear. The international human rights system explicitly recognized HIV status as a prohibited ground of discrimination. At the same time, the impact of HIV highlighted the inequities and vulnerabilities leading to increased rates of infection among women, children, the poor and marginalized groups, and thereby contributed to a renewed focus on economic, social and cultural rights. In this regard, the content of the right to health has been increasingly defined and now explicitly includes the availability and accessibility of HIV prevention, treatment, care and support for children and adults. Either through legislation or litigation, many countries have recognized that their people have the right to HIV treatment as a part of their human rights, confirming that economic, social and cultural rights are justiciable. HIV has brought to the fore the difficult issues surrounding the human rights of those engaged in illegal activities; and importantly HIV has hammered home the importance of the right to participation of those most affected by the epidemic – people living with HIV and those highly vulnerable to infection. Developments such as these have strengthened the principles of the indivisibility and universality of human rights.

The Guidelines resulted from a request made many years ago by the Commission on Human Rights which underlined the need and the imperative to provide guidance to States on how to take concrete steps to protect human rights in the context of HIV. As the epidemic has evolved, the lessons learned from it confirm that the protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health, and provides for an effective response to HIV. This is the basis for the joint work of OHCHR and UNAIDS, the tenth anniversary of which we also mark in 2006.

We urge governments, non-governmental organizations, the United Nations system, and regional bodies to benefit from and build upon these Guidelines, and continue to find ways to operationalise their commitment to protect human rights in the response to HIV.

July 2006



Louise Arbour
United Nations
High Commissioner
for Human Rights



Peter Piot
Executive Director
Joint United Nations Programme
on HIV/AIDS

Glossary of terms

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
ART	antiretroviral therapy
ASO	AIDS service organization
CBO	community-based organization
HIV	human immunodeficiency virus
IGO	intergovernmental organization
NGO	non-governmental organization
PLHIV	people living with HIV
VCT	voluntary counselling and testing

Introduction

The *International Guidelines on HIV/AIDS and Human Rights* arose because of various calls for their development in light of the need for guidance for Governments and others on how to best promote, protect and fulfil human rights in the context of the HIV epidemic. During the first International Consultation on AIDS and Human Rights, organized by the United Nations Centre for Human Rights, in cooperation with the World Health Organization, in Geneva, from 26 to 28 July 1989, participants discussed the possible elaboration of guidelines to assist policymakers and others in complying with international human rights standards regarding law, administrative practice and policy.² Several years later, in his report to the Commission at its fifty-first session (E/CN.4/1995/45, para.135), the United Nations Secretary-General stated that “the development of such guidelines or principles could provide an international framework for discussion of human rights considerations at the national, regional and international levels in order to arrive at a more comprehensive understanding of the complex relationship between the public health rationale and the human rights rationale of HIV/AIDS. In particular, Governments could benefit from guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS and indicate concrete and specific measures, both in terms of legislation and practice, that should be undertaken”.

The Commission on Human Rights at its fifty-second session in its resolution 1996/43 of 19 April 1996 requested that the United Nations High Commissioner for Human Rights, inter

² Report of an International Consultation on AIDS and Human Rights, Geneva, 26 to 28 July 1989 (HR/PUB/90/2).

alia, continue the efforts, in cooperation with UNAIDS and non-governmental organizations, as well as groups of people living with HIV/AIDS, “towards the elaboration of guidelines on promoting and protecting respect for human rights in the context of HIV/AIDS.” At the same time, the Commission requested that the Secretary-General of the United Nations prepare for the consideration of the Commission at its fifty-third session a report on the above-mentioned guidelines, including the outcome of the second expert consultation on human rights and HIV/AIDS, and on their international dissemination.

In response to the above requests, the United Nations Centre for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened the Second International Consultation on HIV/AIDS and Human Rights in Geneva, from 23 to 25 September 1996. This Consultation brought together thirty-five experts in the field of HIV/AIDS and human rights, comprising Government officials and staff of national AIDS programmes, people living with HIV, human rights activists, academics, representatives of regional and national networks on ethics, law, human rights and HIV, and representatives of United Nations bodies and agencies, non-governmental organizations and AIDS service organizations (ASOs). Participants at the Consultation had before them five background papers that had been commissioned for the purpose of eliciting specific regional and thematic experiences and concerns regarding HIV and human rights. Participants discussed the most important human rights principles and concerns in the context of HIV and AIDS, as well as concrete measures that States could take to protect HIV-related human rights. The result was the *International Guidelines on HIV/AIDS and Human Rights*. The full text, as adopted by the Second

International Consultation, is contained in annex I to the report of the Secretary-General to the Commission on Human Rights in document E/CN.4/1997/37. The Guidelines were published in 1998 by OHCHR and UNAIDS.

Significant developments have taken place with regard to the right to health and access to HIV-related prevention, treatment, care and support, including advances in the availability of diagnostic tests and HIV-related treatments, including antiretroviral therapies. There have been increased commitments at the international, regional and domestic levels towards the full realization of all human rights related to HIV, including improved access to health services for people living with HIV. Key among these are: the Declaration of Commitment on HIV/AIDS;³ the Millennium Development Goals;⁴ general comment 14 of the Committee on Economic, Social and Cultural Rights;⁵ and the Commission on Human Rights resolutions on the right to the highest attainable standard of health⁶ and access to medication.⁷

In light of advances in HIV-related treatment and antiretroviral medication, the current global disparity in access to treatment, as well as political and legal developments since the elaboration of the Guidelines in 1996, the High Commissioner for Human Rights and the Executive Director of UNAIDS decided to convene a Third International Consultation on HIV/AIDS and Human Rights on 25–26 July 2002 in Geneva in order to

³ Declaration of Commitment on HIV/AIDS ('Global Crisis—Global Action'), General Assembly resolution S-26/2 of 27 June 2001.

⁴ United Nations Millennium Declaration, General Assembly resolution 55/2 of 8 September 2000.

⁵ General comment 14 on the right to the highest attainable standard of health, adopted on 11 May 2000 (E/C.12/2000/4).

⁶ Commission on Human Rights resolution 2002/31 of 22 April 2002.

⁷ Commission on Human Rights resolutions 2002/33 and 2002/32 of 22 April 2002.

update Guideline 6. This document consolidates the original Guidelines with revised Guideline 6, together with its related commentary and recommendations for implementation.

Since their original publication in 1998 and that of revised Guideline 6 in 2002, the *International Guidelines on HIV/AIDS and Human Rights* have provided important guidance to Governments, international organizations, non-governmental organizations and civil society groups on the development and implementation of effective national strategies for combating HIV and AIDS. The Commission on Human Rights has asked States to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related human rights as contained in the Guidelines, and has urged States to ensure that their laws, policies and practices comply with the Guidelines.⁸ The Secretary-General has submitted reports to the Commission on steps taken by Governments and United Nations organs, programmes and specialized agencies to promote and implement the Guidelines.⁹

Global resolve to halt and reverse the epidemic continues to strengthen. In the 2005 World Summit Outcome,¹⁰ world leaders committed to a massive scaling-up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it. The political declaration of the 2006 High Level Meeting on AIDS affirmed and expanded these commitments.

⁸ Commission on Human Rights resolutions 1997/33, 1999/49, 2001/51, 2003/47, 2005/84.

⁹ E/CN.4/1999/76, E/CN.4/2001/80, E/CN.4/2003/81, E/CN.4/2005/79.

¹⁰ General Assembly resolution 60/1 of 16 September 2005.

Background and summary of the Guidelines

1. This document consolidates the Guidelines adopted at the Second International Consultation on HIV/AIDS and Human Rights, held in Geneva from 23 to 25 September 1996, and revised Guideline 6 on access to prevention, treatment, care and support adopted at the Third International Consultation on HIV/AIDS and Human Rights held in Geneva from 25 to 26 July 2002. The purpose of these Guidelines is to assist States in creating a positive, rights-based response to HIV that is effective in reducing the transmission and impact of HIV and AIDS and is consistent with human rights and fundamental freedoms.
2. The elaboration of such guidelines was first considered by the 1989 International Consultation on AIDS and Human Rights, organized jointly by the then United Nations Centre for Human Rights and the World Health Organization.¹¹ The United Nations Commission on Human Rights and its Sub-Commission on Prevention of Discrimination and Protection of Minorities repeatedly reiterated the need for guidelines.¹² Increasingly, the international community recognized the need for elaborating further how existing human rights principles apply in the context of HIV and for providing examples of concrete activities to be undertaken by States to protect human rights and public health in the context of HIV.
3. The purpose of these Guidelines is to assist States in translating international human rights norms into practical observance in the context of HIV. To this end, the Guidelines consist

¹¹ Report of an International Consultation on AIDS and Human Rights, Geneva, 26 to 28 July 1989 (HR/PUB/90/2).

¹² For reports and resolutions on HIV/AIDS and human rights of the United Nations Commission on Human Rights and its Sub-Commission on Prevention of Discrimination and Protection of Minorities, see footnotes 62-63.

of three parts: first, Guidelines for State action comprising action-oriented measures to be employed by Governments in the areas of law, administrative policy and practice that will protect human rights and achieve HIV-related public health goals; second, recommendations for dissemination and implementation of the Guidelines; and third, international human rights obligations and HIV, which describes the human rights principles underlying a positive response to HIV.

4. The Guidelines recognize that States bring to the HIV epidemic different economic, social and cultural values, traditions and practices – a diversity which should be celebrated as a rich resource for an effective response to HIV and AIDS. In order to benefit from this diversity, a process of participatory consultation and cooperation was undertaken in the drafting of the Guidelines, so that the Guidelines reflect the experience of people affected by the epidemic, address relevant needs and incorporate regional perspectives. Furthermore, the Guidelines reaffirm that diverse responses can and should be designed within the context of universal human rights standards.
5. It is intended that the principal users of the Guidelines will be States, in the persons of legislators and Government policymakers, including officials involved in national AIDS programmes and relevant departments and ministries, such as health, foreign affairs, justice, interior, employment, welfare and education. Other users who will benefit from the Guidelines include intergovernmental organizations (IGOs), non-governmental organizations (NGOs), networks of persons living with HIV (PLHIV), community-based organizations (CBOs), networks on ethics, law, human rights and HIV and AIDS service organizations (ASOs).

The broadest possible audience of users of the Guidelines will maximize their impact and make their content a reality.

6. The Guidelines address many difficult and complex issues, some of which may or may not be relevant to the situation in a particular country. For these reasons, it is essential that the Guidelines be taken by critical actors at the national and community level and considered in a process of dialogue involving a broad spectrum of those most directly affected by the issues addressed in the Guidelines. Such a consultative process will enable Governments and communities to consider how the Guidelines are specifically relevant in their country, assess priority issues presented by the Guidelines and devise effective ways to implement the Guidelines in their respective contexts.
7. In implementing the Guidelines, it should be borne in mind that achieving international cooperation in solving problems of an economic, social, cultural or humanitarian character and promoting and encouraging respect for human rights and for fundamental freedoms for all, is one of the principal objectives of the United Nations. In this sense, international cooperation, including financial and technical support, is a duty of States in the context of the HIV epidemic and industrialized countries are encouraged to act in a spirit of solidarity in assisting developing countries to meet the challenges of implementing the Guidelines.
8. HIV continues to spread throughout the world at an alarming rate. The widespread abuse of human rights and fundamental freedoms associated with HIV has emerged in all parts of the world in the wake of the epidemic. In response to this situation the experts at the Second International Consultation on HIV/AIDS and Human Rights concluded the following:

- (a) The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards;
- (b) Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and AIDS;
- (c) A rights-based, effective response to the HIV epidemic involves establishing appropriate governmental institutional responsibilities, implementing law reform and support services and promoting a supportive environment for groups vulnerable to HIV and for those living with HIV;
- (d) In the context of HIV, international human rights norms and pragmatic public health goals require States to consider measures that may be considered controversial, particularly regarding the status of women and children, sex workers, injecting drug users and men having sex with men. It is, however, the responsibility of all States to identify how they can best meet their human rights obligations and protect public health within their specific political, cultural and religious contexts;
- (e) Although States have primary responsibility for implementing strategies that protect human rights and public health, United Nations bodies, agencies and

programmes, regional intergovernmental bodies and non-governmental organizations, including networks of people living with HIV, play critical roles in this regard.

9. There are many steps that States can take to protect HIV-related human rights and to achieve public health goals. The 12 Guidelines elaborated by the Consultations for States to implement an effective, rights-based response are summarized below.

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

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

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

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

GUIDELINE 5: *States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living*

with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6 (as revised in 2002): *States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.*

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

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

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

GUIDELINE 9: *States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.*

GUIDELINE 10: *States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.*

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

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

I. Guidelines for State action

10. Recommended Guidelines for implementation by States in order to promote and protect human rights in the context of HIV are set out below. These Guidelines are firmly anchored within a framework of existing international human rights norms and are based on many years of experience in identifying those strategies that have proven successful in addressing HIV and AIDS. The normative principles together with practical strategies provide the evidence and ideas for States to reorient and redesign their policies and programmes to ensure respect for HIV-related rights and to be most effective in addressing the epidemic. States should provide adequate political leadership and financial resources to enable implementation of these strategies.

11. The Guidelines focus on activities by States in view of their obligations under international and regional human rights instruments. This is not to deny, however, the responsibilities of other key actors, such as the private sector, including professional groups such as health-care workers, the media, and religious communities. These groups also have responsibilities not to engage in discrimination and to implement protective and ethical policies and practices.

A. Institutional responsibilities and processes

GUIDELINE 1: NATIONAL FRAMEWORK

12. States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities, across all branches of government.

13. Depending upon existing institutions, the level of the epidemic and institutional cultures, as well as the need to avoid overlapping of responsibilities, the following responses should be considered:
- (a) Formation of an interministerial committee to ensure integrated development and high-level coordination of individual ministerial national action plans and to monitor and implement the additional HIV strategies, as set out below. In federal systems, an intergovernmental committee should also be established with provincial/state, as well as national representation. Each ministry should ensure that HIV and human rights are integrated into all its relevant plans and activities, including:
 - (i) Education;
 - (ii) Law and justice, including police and corrective services;
 - (iii) Science and research;
 - (iv) Employment and public service;
 - (v) Welfare, social security and housing;
 - (vi) Immigration, indigenous populations, foreign affairs and development cooperation;

- (vii) Health;
 - (viii) Treasury and finance;
 - (ix) Defence, including armed services.
- (b) Ensuring that an informed and ongoing forum exists for briefing, policy discussion and law reform to deepen the level of understanding of the epidemic, in which all political viewpoints can participate at national and subnational levels, e.g. by establishing parliamentary or legislative committees with representation from major and minor political parties.
- (c) Formation or strengthening of advisory bodies to Governments on legal and ethical issues, such as a legal and ethical subcommittee of the interministerial committee. Representation should consist of professional (public, law and education, science, bio-medical and social), religious and community groups, employers' and workers' organizations, NGOs and ASOs, nominees/experts and people living with HIV.
- (d) Sensitization of the judicial branch of government, in ways consistent with judicial independence, on the legal, ethical and human rights issues relative to HIV, including through judicial education and the development of judicial materials.
- (e) Ongoing interaction of government branches with United Nations Theme Groups on HIV/AIDS and other concerned international and bilateral actors to ensure that governmental responses to the HIV epidemic will continue to make the best use of assistance available from the international community. Such interaction should, *inter alia*, reinforce cooperation and assistance to areas related to HIV and human rights.

Commentary on Guideline 1

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

15. Most countries already have national AIDS committees. In some countries, there are also subnational committees. However, the persistent lack of coordination in Government policy and the lack of specific attention to human rights issues relating to the HIV epidemic suggest a need to consider possible additional structures or to strengthen and reorient those that exist to include legal and ethical issues. Several models of coordinating committees and multidisciplinary advisory groups exist.¹³ Similar coordination is essential within and between lower levels of government. It is necessary to

¹³ A successful example of an interministerial coordinating committee is the National AIDS Prevention and Control Committee chaired by the Prime Minister of Thailand since 1991. Other models are the Federal Parliamentary Liaison Group in Australia, the National AIDS Coordinating Council in Western Samoa, the Philippine National AIDS Council and the National Commission on AIDS in the United States. Another noteworthy example is the National Anti-AIDS Committee established by the President of Ukraine as a special State authority.

focus such coordination not only in creating specialized HIV bodies, but also in securing a place for HIV human rights issues in existing mainstream forums, such as regular gatherings of Ministers of, e.g. Health, Justice and Social Welfare. A multidisciplinary body with professional and community representation should exist to advise Governments on legal and ethical issues. These bodies at the national level should also ensure coordination with UNAIDS, its cosponsors and other international agencies (donors, bilateral donors and others) to reinforce cooperation and assistance to areas relating to HIV and human rights.

GUIDELINE 2: SUPPORTING COMMUNITY PARTNERSHIP

16. States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the fields of ethics, law and human rights, effectively.

- (a) Community representation should comprise people living with HIV, CBOs, ASOs, human rights NGOs and representatives of vulnerable groups.¹⁴ Formal and regular mechanisms should be established to facilitate ongoing dialogue with and input from such community representatives into HIV-related Government policies and programmes. This could be established through

¹⁴ See section III, Introduction, for a listing of vulnerable groups.

regular reporting by community representatives to the various government, parliamentary and judicial branches described in Guideline 1, joint workshops with community representatives on policy, planning and evaluation of State responses and through mechanisms for receiving written submissions from the community.

- (b) Sufficient Government funding should be allocated in order to support, sustain and enhance community organizations in areas of core support, capacity-building and implementation of activities, in such areas as HIV-related ethics, human rights and law. Such activities might involve training seminars, workshops, networking, developing promotional and educational materials, advising clients of their human and legal rights, referring clients to relevant grievance bodies, collecting data on human rights issues and human rights advocacy.

Commentary on Guideline 2

- 17. Community partners have knowledge and experience that States need in order to fashion effective State responses. This is the case particularly with regard to human rights issues, as community representatives are either directly affected by human rights problems or work directly with those who are affected. States should, therefore, ensure that this knowledge and experience are included in the development of HIV policy, programmes and evaluation by recognizing the importance of such contributions and creating structural means by which to obtain them.
- 18. The contribution of CBOs, NGOs, ASOs and people living with HIV is an essential part of the overall national response to the epidemic, in such areas as ethics, law and human rights. As

community representatives do not necessarily possess organizational ability or skills for advocacy, lobbying and human rights work, this contribution should be enhanced by State funding for administrative support, capacity-building, human resource development and implementation of activities. Collection of complaints data by CBOs and NGOs is vital to inform Governments and the international community where the most serious HIV-related human rights problems are occurring and what effective action should be implemented in response.¹⁵

B. Law review, reform and support services

GUIDELINE 3: PUBLIC HEALTH LEGISLATION

19. States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

20. Public health legislation should include the following components:
- (a) Public health law should fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV and AIDS, including relevant information and education, access to voluntary testing and counselling, STD and sexual and reproductive health services for men and women, condoms and drug treatment,

¹⁵ See Guideline 11, paragraph 66.

services and clean injection materials, as well as adequate treatment for HIV and AIDS-related illnesses, including pain prophylaxis.

- (b) Apart from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual. Exceptions to voluntary testing would need specific judicial authorization, granted only after due evaluation of the important considerations involved in terms of privacy and liberty.
- (c) In view of the serious nature of HIV testing and in order to maximize prevention and care, public health legislation should ensure, whenever possible, that pre- and post-test counselling be provided in all cases. With the introduction of home-testing, States should ensure quality control, maximize counselling and referral services for those who use such tests and establish legal and support services for those who are the victims of misuse of such tests by others.
- (d) Public health legislation should ensure that people not be subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status. Where the liberty of persons living with HIV is restricted, due process protection (e.g. notice, rights of review/appeal, fixed rather than indeterminate periods of orders and rights of representation) should be guaranteed.
- (e) Public health legislation should ensure that HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality.

- (f) Public health legislation should ensure that information relative to the HIV status of an individual be protected from unauthorized collection, use or disclosure in the health-care and other settings and that the use of HIV-related information requires informed consent.
- (g) Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:
 - (i) The HIV-positive person in question has been thoroughly counselled;
 - (ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
 - (iii) The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
 - (iv) A real risk of HIV transmission to the partner(s) exists;
 - (v) The HIV-positive person is given reasonable advance notice;
 - (vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
 - (vii) Follow-up is provided to ensure support to those involved, as necessary.
- (h) Public health legislation should ensure that the blood/tissue/organs supply is free of HIV and other blood-borne diseases.
- (i) Public health law should require the implementation of universal infection control precautions in health-care and other settings involving exposure to blood and other bodily

fluids. Persons working in these settings must be provided with the appropriate equipment and training to implement such precautions.

- (j) Public health legislation should require that health-care workers undergo a minimum of ethics and/or human rights training in order to be licensed to practise and should encourage professional societies of health-care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV-related issues such as confidentiality and the duty to provide treatment.

GUIDELINE 4: CRIMINAL LAWS AND CORRECTIONAL SYSTEMS

21. States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups.

- (a) Criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.
- (b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed,

with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.

- (c) With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients. Criminal law should ensure that children and adult sex workers who have been trafficked or otherwise coerced into sex work are protected from participation in the sex industry and are not prosecuted for such participation but rather are removed from sex work and provided with medical and psycho-social support services, including those related to HIV.
- (d) Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider:
- the authorization or legalization and promotion of needle and syringe exchange programmes;
 - the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes.
- (e) Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should

also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.

GUIDELINE 5: ANTI-DISCRIMINATION AND PROTECTIVE LAWS

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

- (a) General anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face. Disability laws should also be enacted or revised to include HIV and AIDS in their definition of disability. Such legislation should include the following:

- (i) The areas covered should be as broad as possible, including health care, social security, welfare benefits, employment, education, sport, accommodation, clubs, trades unions, qualifying bodies, access to transport and other services;
 - (ii) Direct and indirect discrimination should be covered, as should cases where HIV is only one of several reasons for a discriminatory act, and prohibiting HIV vilification should also be considered;
 - (iii) Independent, speedy and effective legal and/or administrative procedures for seeking redress, including such features as fast-tracking for cases where the complainant is terminally ill, investigatory powers to address systemic cases of discrimination in policies and procedures, ability to bring cases under pseudonym and representative complaints, including the possibility of public interest organizations bringing cases on behalf of people living with HIV;
 - (iv) Exemptions for superannuation and life insurance should only relate to reasonable actuarial data, so that HIV is not treated differently from analogous medical conditions.
- (b) Traditional and customary laws which affect the status and treatment of various groups of society should be reviewed in the light of anti-discrimination laws. If necessary, legal remedies should be made available, if such laws are misused and information, education and community mobilization campaigns should be conducted to change these laws and attitudes associated with them.
- (c) General confidentiality and privacy laws should be enacted. HIV-related information on individuals should be included within definitions of personal/medical data subject to

protection and should prohibit the unauthorized use and/or publication of HIV-related information on individuals. Privacy legislation should enable an individual to see his or her own records and to request amendments to ensure that such information is accurate, relevant, complete and up to date. An independent agency should be established to redress breaches of confidentiality. Provision should be made for professional bodies to discipline cases of breaches of confidentiality as professional misconduct under codes of conduct discussed below.¹⁶ Unreasonable invasion of privacy by the media could also be included as a component of professional codes governing journalists. People living with HIV should be authorized to demand that their identity and privacy be protected in legal proceedings in which information on these matters will be raised.

- (d) Laws, regulations and collective agreements should be enacted or reached so as to guarantee the following workplace rights:
 - (i) A national policy on HIV and the workplace agreed upon in a tripartite body;
 - (ii) Freedom from HIV screening for employment, promotion, training or benefits;
 - (iii) Confidentiality regarding all medical information, including HIV status;
 - (iv) Employment security for workers living with HIV until they are no longer able to work, including reasonable alternative working arrangements;
 - (v) Defined safe practices for first aid and adequately equipped first-aid kits;

¹⁶ See Guideline 10, paragraphs 64-65.

- (vi) Protection for social security and other benefits for workers living with HIV, including life insurance, pension, health insurance, termination and death benefits;
 - (vii) Adequate health care accessible in or near the workplace;
 - (viii) Adequate supplies of condoms available free to workers at the workplace;
 - (ix) Workers' participation in decision-making on workplace issues related to HIV and AIDS;
 - (x) Access to information and education programmes on HIV, as well as to relevant counselling and appropriate referral;
 - (xi) Protection from stigmatization and discrimination by colleagues, unions, employers and clients;
 - (xii) Appropriate inclusion in workers' compensation legislation of the occupational transmission of HIV (e.g. needle stick injuries), addressing such matters as the long latency period of infection, testing, counselling and confidentiality.
- (e) Protective laws governing the legal and ethical protection of human participation in research, including HIV-related research, should be enacted or strengthened in relation to:
- (i) Non-discriminatory selection of participants, e.g. women, children, minorities;
 - (ii) Informed consent;
 - (iii) Confidentiality of personal information;
 - (iv) Equitable access to information and benefits emanating from research;
 - (v) Counselling, protection from discrimination, health and support services provided during and after participation;

- (vi) The establishment of local and/or national ethical review committees to ensure independent and ongoing ethical review, with participation by members of the community affected, of the research project;
 - (vii) Approval for use of safe and efficacious pharmaceuticals, vaccines and medical devices.
- (f) Anti-discrimination and protective laws should be enacted to reduce human rights violations against women in the context of HIV, so as to reduce vulnerability of women to infection by HIV and to the impact of HIV and AIDS. More particularly, laws should be reviewed and reformed to ensure equality of women regarding property and marital relations and access to employment and economic opportunity, so that discriminatory limitations are removed on rights to own and inherit property, enter into contracts and marriage, obtain credit and finance, initiate separation or divorce, equitably share assets upon divorce or separation, and retain custody of children. Laws should also be enacted to ensure women's reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape. The age of consent to sex and marriage should be consistent for males and females and the right of women and girls to refuse marriage and sexual relations should be protected by law. The HIV status of a parent or child should not be treated any differently from any other analogous medical condition in making decisions regarding custody, fostering or adoption.

- (g) Anti-discrimination and protective laws should be enacted to reduce human rights violations against children in the context of HIV, so as to reduce the vulnerability of children to infection by HIV and to the impact of HIV and AIDS. Such laws should provide for children's access to HIV-related information, education and means of prevention inside and outside school, govern children's access to voluntary testing with consent by the child, in line with the evolving capacities of the child, or by the parent or appointed guardian, as appropriate, should protect children against mandatory testing, particularly if orphaned by AIDS, and provide for other forms of protection in the context of orphans, including inheritance and/or support. Such legislation should also protect children against sexual abuse, provide for their rehabilitation if abused and ensure that they are considered victims of wrongful behaviour, not subject to penalties themselves. Protection in the context of disability laws should also be ensured for children.
- (h) Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men, including in the context of HIV, in order, *inter alia*, to reduce the vulnerability of men who have sex with men to infection by HIV and to the impact of HIV and AIDS. These measures should include providing penalties for vilification of people who engage in same-sex relationships, giving legal recognition to same-sex marriages and/or relationships and governing such relationships with consistent property, divorce and inheritance provisions. The age of consent to sex and marriage should be consistent for heterosexual and homosexual relationships. Laws and police practices

relating to assaults against men who have sex with men should be reviewed to ensure that adequate legal protection is given in these situations.

- (i) Laws and regulations that provide for restrictions on the movement or association of members of vulnerable groups¹⁷ in the context of HIV should be removed in both law (decriminalized) and law enforcement.
- (j) Public health, criminal and anti-discrimination legislation should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups.¹⁸

GUIDELINE 6: ACCESS TO PREVENTION, TREATMENT, CARE AND SUPPORT (revised)

23. States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

24. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics

¹⁷ See section III, Introduction, for a listing of vulnerable groups.

¹⁸ In addition to vulnerable groups, specific employment groups should also be protected from such targeted testing, e.g. truck drivers, sailors, hospitality/tourist industry workers and the military.

and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

25. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

Commentary on Guideline 6

26. Prevention, treatment, care and support are mutually reinforcing elements and a continuum of an effective response to HIV. They must be integrated into a comprehensive approach, and a multifaceted response is needed. Comprehensive treatment, care and support include antiretroviral and other medicines, diagnostics and related technologies for the care of HIV and AIDS, related opportunistic infections and other conditions, good nutrition, and social, spiritual and psychological support, as well as family, community and home-based care. HIV-prevention technologies include condoms, lubricants, sterile injection equipment, antiretroviral medicines (e.g. to prevent mother-to-child transmission or as post-exposure prophylaxis) and, once developed, safe and effective microbicides and vaccines. Based on human rights principles, universal access requires that these goods, services and information not only be available, acceptable and of good quality, but also within physical reach and affordable for all.

Recommendations for implementation of Guideline 6

27. States should develop and implement national plans to progressively realize universal access to comprehensive

treatment, care and support for all persons living with HIV, as well as universal access to a full range of goods, services and information for HIV prevention. National plans should be developed in consultation with non-governmental organizations to ensure the active participation of people living with HIV and vulnerable groups.

28. Universal access to HIV prevention, treatment, care and support is necessary to respect, protect and fulfil human rights related to health, including the right to enjoy the highest attainable standard of health. Universal access will be achieved progressively over time. However, States have an immediate obligation to take steps, and to move as quickly and effectively as possible, towards realizing access for all to HIV prevention, treatment, care and support at both the domestic and global levels. This requires, among other things, setting benchmarks and targets for measuring progress.¹⁹
29. Access to HIV-related information, goods and services is affected by a range of social, economic, cultural, political and legal factors. States should review and, where necessary, amend or adopt laws, policies, programmes and plans to realize universal and equal access to medicines, diagnostics and related technologies, taking these factors into account. As one example, duties, customs laws and value-added taxes may hinder access to medicines, diagnostics and related technologies at affordable prices. Such laws should be revised so as to maximize access. States should ensure that national laws, policies, programmes

¹⁹ For example, States could make use of the indicators developed by UNAIDS for measuring follow-up on the United Nations General Assembly's 2001 Declaration of Commitment on HIV/AIDS, in particular the National Composite Policy Index, which assesses a country's progress in developing laws, policies and strategies to address HIV and AIDS at the national level in relation to prevention, treatment, care and support, as well as specific human rights issues.

and plans affecting access to HIV-related goods, services or information are consistent with international human rights norms, principles and standards. States should consider the experience and expertise of other States, and consult with people living with HIV, non-governmental organizations, and domestic and international health organizations with relevant expertise.

30. States should also ensure that their laws, policies, programmes and practices do not exclude, stigmatize or discriminate against people living with HIV or their families, either on the basis of their HIV status or on other grounds contrary to international or domestic human rights norms, with respect to their entitlement or access to health-care goods, services and information.²⁰
31. States' legislation, policies, programmes, plans and practices should include positive measures to address factors that hinder the equal access of vulnerable individuals and populations to prevention, treatment, care and support, such as poverty, migration, rural location or discrimination of various kinds.²¹ These factors may have a cumulative effect. For example, children (particularly girls) and women may be the last to receive access even if treatment is otherwise available in their communities.

²⁰ See also Guideline 5, above, regarding protections against discrimination, including in areas such as health care, social security, welfare benefits and other services.

²¹ Depending on legal, social and economic conditions, which may vary widely within countries and across regions, individuals and groups that may be vulnerable to discrimination and marginalization include women, children, those living in poverty, indigenous people(s), gay men and other men who have sex with men, migrants, refugees and internally displaced persons, people with disabilities, prisoners and other detained persons, sex workers, transgender people, people who use illegal drugs, and racial, religious, ethnic, linguistic or other minorities. See also: Guideline 3, paragraph 20 (j), and Guideline 10, paragraph 64 (a), on measures to address discrimination in the provision of health care; Guideline 4, paragraph 21 (e), on the specific issue of access to HIV-related prevention, treatment and care for prisoners; and Guideline 8, paragraphs 60 (b) and 60 (j), regarding specific attention to the needs of vulnerable groups.

32. States should recognize, affirm and strengthen the involvement of communities as part of comprehensive HIV prevention, treatment, care and support, while also complying with their own obligations to take steps in the public sector to respect, protect and fulfil human rights related to health. Mechanisms should be developed to enable affected communities to access resources to assist families who have lost income earners to AIDS. Particular attention must be paid to gender inequalities, with respect to access to care in the community for women and girls, as well as the burdens that delivering care at the community level may impose on them.
33. To assist caregivers and, where relevant, employers and insurers, States should ensure the availability, use and implementation of sound, scientifically up-to-date guidelines for prevention, treatment, care and support to people living with HIV in respect of available health-care goods, services and information. States should develop mechanisms to monitor and improve, as necessary, the availability, use and implementation of these guidelines.
34. Legislation, policies and programmes should take into account the fact that persons living with HIV may recurrently and progressively experience ill-health and greater health-care needs, which should be accommodated accordingly within benefit schemes in both the public and private sectors. States should work with employers, and employers' and workers' organizations, to adopt or adapt benefit schemes, where necessary, to ensure universal and equal access to benefits for workers living with HIV. Particular attention must also be paid to ensuring access to health care for individuals outside the formal employment sector, who lack work-related health-care benefits.²²

²² See also Guideline 5, paragraph 22 (d), and the *Code of practice on HIV/AIDS and the world of work*, adopted in 2001 by the International Labour Organization.

35. States should ensure that domestic legislation provides for prompt and effective remedies in cases in which a person living with HIV is denied or not provided access to treatment, care and support. States should also ensure due process of law so that the merits of such complaints can be independently and impartially assessed. At the international level, States should strengthen existing mechanisms, and develop new mechanisms where they do not currently exist, enabling persons living with HIV/AIDS to seek prompt, effective redress for breaches of States' international legal obligations to respect, protect and fulfil rights related to health.
36. States should ensure the quality assurance and control of HIV-related products. States should ensure, through legislative and other measures (e.g. functional systems for pre-marketing approval and post-marketing surveillance), that medicines, diagnostics and related technologies are safe and effective.
37. States should take legislative and other measures to ensure that medicines are supplied in adequate quantities and in a timely fashion, and with accurate, current and accessible information regarding their use. For example, consumer protection laws or other relevant legislation should be enacted or strengthened to prevent fraudulent claims regarding the safety and efficacy of drugs, vaccines and medical devices, including those relating to HIV.
38. Laws and/or regulations should be enacted to ensure the quality and availability of HIV tests and counselling. If home tests and/or rapid HIV test kits are permitted on the market, they should be strictly regulated to ensure quality and accuracy. The consequences of loss of epidemiological information, the lack of accompanying counselling and the risk of unauthorized

use, such as for employment or immigration, should also be addressed. Legal and social support services should be established to protect individuals from any abuses arising from HIV testing. States should also ensure supervision of the quality of delivery of voluntary counselling and testing (VCT) services.

39. Legal quality control of condoms should be enforced, and compliance with the International Condom Standard should be monitored in practice. Restrictions on the availability of preventive measures, such as condoms, bleach, clean needles and syringes, should be repealed. Widespread provision of these preventive measures through various means, including vending machines in appropriate locations, should be considered, in light of the greater effectiveness provided by the increased accessibility and anonymity afforded by this method of distribution. Condom promotion initiatives should be coupled with HIV information campaigns for optimal impact.
40. Laws and/or regulations should be enacted to enable widespread provision of information about HIV through the mass media. This information should be aimed at the general public, as well as at various vulnerable groups that may have difficulty in accessing information. HIV information should be effective for its designated audience and not be inappropriately subject to censorship or other broadcasting standards, particularly as this will have the effect of damaging access to information vital to life, health and human dignity.
41. In order to improve prevention and therapeutic options related to HIV, States should increase funds allocated to the public sector for researching, developing and promoting therapies and technologies for the prevention, treatment, care and support of HIV and AIDS and related infections and conditions. The

private sector should also be encouraged to undertake such research and development and to make the resulting options widely and promptly available at prices affordable to those who need them.

42. States and the private sector should pay special attention to supporting research and development that address the health needs of developing countries. In recognition of the human right to share in scientific advancement and its benefits, States should adopt laws and policies, at the domestic and international levels, ensuring that the outcomes of research and development are of national and global benefit, with particular attention to the needs of people in developing countries and people who are poor or otherwise marginalized.
43. States should integrate HIV prevention, treatment, care and support into all aspects of their planning for development, including in poverty eradication strategies, national budget allocations and sectoral development plans. In so doing, States should have particular regard, at a minimum, for internationally agreed targets in addressing HIV.²³
44. States should increase their national budget allocations for measures promoting secure and sustainable access to affordable HIV prevention, treatment, care and support, at both the domestic and international levels. States should, among other steps, make contributions, in proportion to their resources, to mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Developed countries should make concrete commitments of increased official development

²³ Examples include the Millennium Development Goals agreed in 2000 by the United Nations General Assembly, and the specific HIV/AIDS-related goals agreed in the United Nations General Assembly's Declaration of Commitment on HIV/AIDS in 2001.

assistance that will move them without delay towards meeting international targets to which they have agreed, paying particular attention to assistance in realizing access to health-care goods, services and information.²⁴

45. States should ensure that international and bilateral mechanisms for financing responses to HIV/AIDS provide funds for prevention, treatment, care and support, including the purchase of antiretroviral and other medicines, diagnostics and related technologies. States should support and implement policies maximizing the benefit of donor assistance, including policies ensuring that such resources are used to purchase generic medicines, diagnostics and related technologies, where these are more economical.
46. States' international and bilateral financing mechanisms should also provide funding for strengthening health-care systems, for improving the capacity and working conditions of health-care personnel and the effectiveness of supply systems, for financing plans and referral mechanisms to provide access to prevention, treatment, care and support, and for family, community and home-based care.
47. States should collaborate with non-governmental organizations, intergovernmental organizations, and United Nations bodies, agencies and programmes in creating, maintaining and expanding international, publicly accessible sources of information on the sources, quality and worldwide prices

²⁴ For example, in their 2001 Declaration of Commitment on HIV/AIDS, all United Nations Member States urged developed countries that have not done so to meet, as soon as possible, the long-standing target of dedicating 0.7% of their gross national product to overall official development assistance and earmarking 0.15–0.20% of their gross national product as official development assistance for least developed countries. States formally reiterated this call in the outcome document of the 2002 International Conference on Financing for Development (Monterrey, Mexico).

of medicines, diagnostics and related technologies for the preventive, curative and palliative care of HIV and AIDS and related opportunistic infections and conditions.²⁵

48. Creditor countries and international financing institutions should implement debt relief for developing countries more quickly and extensively, and should ensure that resources provided for this purpose do not detract from those made available for official development assistance. Developing countries should use the resources freed up by debt relief (as well as other sources of development finance) in a manner that fully takes into account their obligations to respect, protect and fulfil rights related to health. States should, among other things, dedicate an appropriate proportion of such resources, in the light of domestic conditions, priorities and internationally agreed commitments, to HIV prevention, treatment, care and support.
49. States should support and cooperate with international mechanisms for monitoring and reporting on the measures they have taken for progressively realizing access to comprehensive HIV prevention, treatment, care and support, including antiretroviral and other medicines, diagnostics and related technologies. States should include relevant information in their reports to bodies monitoring their progress in complying with their international legal obligations. The data in these reports should be disaggregated in a manner that helps identify and remedy possible disparities in access to

²⁵ For example, UNICEF, UNAIDS, WHO and the non-governmental organization *Médecins Sans Frontières* jointly produce and update a publication identifying sources and prices of selected drugs and diagnostics used in providing care and treatment to people living with HIV. Similarly, in 2001 the World Health Organization initiated an ongoing project that produces and maintains a list of HIV/AIDS drugs and diagnostics, and their suppliers, who meet WHO quality standards.

prevention, treatment, care and support, and should use existing, or develop new, evaluation tools such as indicators or audits to measure implementation. States should actively involve non-governmental organizations, including those representing people living with HIV/AIDS and vulnerable groups, in preparing such reports and in acting on the observations and recommendations received from such monitoring bodies.²⁶

50. States should pursue and implement international and regional cooperation aimed at transferring to developing countries technologies and expertise for HIV prevention, treatment, care and support. States should support cooperation between developing countries in this regard, and should join international organizations in providing and supporting technical assistance aimed at realizing access to HIV prevention, treatment, care and support.
51. In their conduct in international forums and negotiations, States should take due account of international norms, principles and standards relating to human rights. In particular, they should take account of their obligations to respect, protect and fulfil rights related to health, as well as of their commitments to provide international assistance and cooperation.²⁷ States should also avoid taking measures that would undermine access to HIV prevention, treatment, care and support, including access to antiretroviral and other medicines, diagnostics and related technologies, either domestically or in other countries, and should ensure that medicine is never used as a tool for political pressure. Particular attention must be paid by all States to the needs and situations of developing countries.

²⁶ See also Guideline 11, for further guidance on State monitoring and enforcement of human rights.

52. States should, in light of their human rights obligations, ensure that bilateral, regional and international agreements, such as those dealing with intellectual property, do not impede access to HIV prevention, treatment, care and support, including access to antiretroviral and other medicines, diagnostics and related technologies.
53. States should ensure that, in interpreting and implementing international agreements, domestic legislation incorporates to the fullest extent any safeguards and flexibilities therein that may be used to promote and ensure access to HIV prevention, treatment, care and support for all, including access to medicines, diagnostics and related technologies. States should make use of these safeguards to the extent necessary to satisfy their domestic and international obligations in relation to human rights. States should review their international agreements (including on trade and investment) to ensure that these are consistent with treaties, legislation and policies designed to promote and protect all human rights and, where those agreements impede access to prevention, treatment, care and support, should amend them as necessary.

GUIDELINE 7: LEGAL SUPPORT SERVICES

54. States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of Ministries of Justice, ombudspersons, health complaint units and human rights commissions.

55. States should consider the following features in establishing such services:
- (a) State support for legal aid systems specializing in HIV casework, possibly involving community legal aid centres and/or legal service services based in ASOs;
 - (b) State support or inducements (e.g. tax reduction) to private sector law firms to provide free *pro bono* services to people living with HIV in areas such as anti-discrimination and disability, health-care rights (informed consent and confidentiality), property (wills, inheritance) and employment law;
 - (c) State support for programmes to educate, raise awareness and build self-esteem among people living with HIV concerning their rights and/or to empower them to draft and disseminate their own charters/declarations of legal and human rights; State support for production and dissemination of HIV legal rights brochures, resource personnel directories, handbooks,²⁸ practice manuals, student texts, model curricula for law courses and continuing legal education and newsletters to encourage information exchange and networking should also be provided. Such publications could report on case law, legislative reforms, national enforcement and monitoring systems for human rights abuses;

²⁷ See also Guideline 11, paragraph 66 (e), regarding promotion of HIV-related human rights in international forums and ensuring their integration into the policies and programmes of international organizations.

²⁸ See J. Godwin (et al.), *Australian HIV/AIDS Legal Guide*, (2nd edition), Federation Press, Sydney, 1993; Lambda Legal Defense and Education Fund Inc., *AIDS Legal Guide: A Professional Resource on AIDS-related Legal Issues and Discrimination*, New York.

- (d) State support for HIV legal services and protection through a variety of offices, such as Ministries of Justice, procurator and other legal offices, health complaint units, ombudspersons and human rights commissions.

Commentary on Guidelines 3 to 7

- 56. Since laws regulate conduct between the State and the individual and between individuals, they provide an essential framework for the observance of human rights, including HIV-related human rights. The efficacy of this framework for the protection of human rights depends on the strength of the legal system in a given society and on the access of its citizens to the system. However, many legal systems worldwide are not strong enough, nor do marginalized populations have access to them.
- 57. Nevertheless, the role of law in the response to HIV may also be overemphasized and provide a vehicle for coercive and abusive policies. Although law may have an educative and normative role and may provide an important supportive framework for human rights protection and HIV programmes, it cannot be relied upon as the only means by which to educate, change attitudes, achieve behavioural change or protect people's rights. Guidelines 3 to 7 above are, therefore, meant to encourage the enactment of meaningful and positive legislation, to describe the basic legal components necessary to provide support for the protection of HIV-related human rights and effective HIV prevention and care programmes and to be supplemented by all other Guidelines set out in this document.
- 58. Guidelines 3 to 6 encourage law and law reform which would bring national HIV-related laws into conformity with international and regional human rights standards. Although the content of the strategies primarily addresses formal law, law reform

should also encompass traditional and customary laws. The process of HIV law review and reform should be incorporated into the State's general activities regarding the observance of human rights norms and be integrated into the national AIDS response, whilst involving the affected communities, ensuring that existing legislation does not act as an impediment to HIV prevention and care programmes (for the general population, as well as for vulnerable groups) and protecting individuals against discrimination by both Government actors and private individuals or institutions. It is recognized that some of the recommendations for law and law reform, particularly those concerning the status of women, drug use, sex work and the status of men having sex with men, might be controversial in particular national, cultural and religious contexts. However, these Guidelines are recommendations to States: they are based on existing international human rights standards and designed to achieve a pragmatic approach to public health goals relative to HIV. It is the obligation of States to establish how they can best meet their international human rights obligations and protect the public health within their political, cultural and religious contexts. The Office of the United Nations High Commissioner for Human Rights, UNAIDS, its relevant co-sponsors and other United Nations bodies and agencies, such as the International Labour Organization, can offer Governments technical assistance in the process of law review and reform.

59. Guideline 7 urges that States (and the private sector) encourage and support specialist and generalist legal services to enable people living with HIV and affected communities to enforce their human and legal rights through the use of such services. Information and research resources on legal and human rights issues should also be made available. Such services should also address the issue of reducing the vulnerability to infection with-

in and the impact of HIV on vulnerable groups. The location and format of the information (e.g. plain and understandable language) provided via such services should render it accessible to members of these groups. Models exist in many countries.²⁹

C. Promotion of a supportive and enabling environment

GUIDELINE 8: WOMEN, CHILDREN AND OTHER VULNERABLE GROUPS³⁰

60. States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

²⁹ Models include the Group for Life (Grupo Pela Vidda) in Rio de Janeiro, Brazil, which offers free legal services, brochures, bulletins, telephone hotline and media campaigns. Legal rights brochures have been produced in the United Kingdom by the Terrence Higgins Trust and Immunity's Legal Centre (D. Taylor (ed.), *HIV, You and the Law*). Resource directories have been produced in the United States by the American Bar Association (*Directory of Legal Resources for People with AIDS & HIV*, AIDS Coordination Project, Washington, D.C., 1991) and the Gay Men's Health Crisis (M. Holtzman (ed.), *Legal Services Referral Directory for People with AIDS*, New York, 1991). Several other organizations in the United States have produced practitioners' or volunteers' training manuals, such as the Whitman-Walker Clinic (Washington, D.C.), the AIDS Project (Los Angeles), the National Lawyers Guild, State AIDS Legal Services Organization (San Francisco) and the American Civil Liberties Union (William Rubenstein, Ruth Eisenberg and Lawrence Gostin, *The Rights of Persons Living with HIV/AIDS* (Southern Illinois Press, Carbondale, Illinois, 1996)). A manual for paralegals is being prepared in South Africa by the Pietermaritzburg branch of Lawyers for Human Rights with the assistance of the AIDS Law Project and with training coordination being provided by the AIDS Legal Network. Other resources include benchbooks for judges (A.R. Rubinfeld (ed.), *AIDS Benchbook*, National Judicial College, American Bar Association, Reno, Nevada, January 1991), the Southern Africa AIDS Information Dissemination Service and newsletters such as the Canadian *HIV/AIDS Policy and Law Newsletter* and Australia's Legal Link (see also *AIDS/STD Health Promotion Exchange*, Royal Tropical Institute, the Netherlands).

³⁰ See section III, Introduction, for a listing of vulnerable groups.

- (a) States should support the establishment and sustainability of community associations comprising members of different vulnerable groups for peer education, empowerment, positive behavioural change and social support.
- (b) States should support the development of adequate, accessible and effective HIV-related prevention and care education, information and services by and for vulnerable communities and should actively involve such communities in the design and implementation of these programmes.
- (c) States should support the establishment of national and local forums to examine the impact of the HIV epidemic on women. They should be multisectoral to include Government, professional, religious and community representation and leadership and examine issues such as:
 - (i) The role of women at home and in public life;
 - (ii) The sexual and reproductive rights of women and men, including women's ability to negotiate safer sex and make reproductive choices;
 - (iii) Strategies for increasing educational and economic opportunities for women;
 - (iv) Sensitizing service deliverers and improving health care and social support services for women; and
 - (v) The impact of religious and cultural traditions on women.
- (d) States should implement the Cairo Programme of Action of the International Conference on Population and Development³¹ and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women. Primary health services, programmes and information

³¹ A/CONF.171/13, chap. I, resolution 1, annex.

campaigns in particular should include a gender perspective. Violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated. Positive measures, including formal and informal education programmes, increased work opportunities and support services, should be established.

- (e) States should support women's organizations to incorporate HIV and human rights issues into their programming.
- (f) States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose.
- (g) States should ensure the access of children and adolescents to adequate health information and education, including information related to HIV prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality. Such information should take into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent and means of prevention, as well as the responsibilities, rights and duties of parents. Efforts to educate children about their rights should include the rights of persons, including children, living with HIV.
- (h) States should ensure that children and adolescents have adequate access to confidential sexual and reproductive health services, including HIV information, counselling,

testing and prevention measures such as condoms, and to social support services if affected by HIV. The provision of these services to children/adolescents should reflect the appropriate balance between the rights of the child/adolescent to be involved in decision-making according to his or her evolving capabilities and the rights and duties of parents/guardians for the health and well-being of the child.

- (i) States should ensure that persons employed to child care agencies, including adoption and foster-care homes, receive training in the area of HIV-related children's issues in order to deal effectively with the special needs of HIV-affected children including protection from mandatory testing, discrimination and abandonment.
- (j) States should support the implementation of specially designed and targeted HIV prevention and care programmes for those who have less access to mainstream programmes due to language, poverty, social or legal or physical marginalization, e.g. minorities, migrants, indigenous peoples, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users.

Commentary on Guideline 8

61. States should take measures to reduce the vulnerability, stigmatization and discrimination that surround HIV and promote a supportive and enabling environment by addressing underlying prejudices and inequalities within societies and a social environment conducive to positive behaviour change. An essential part of this enabling environment involves the empowerment of women, youth and other vulnerable groups to deal with HIV by taking measures to improve

their social and legal status, involving them in the design and implementation of programmes and assisting them to mobilize their communities. The vulnerability of some groups is due to their limited access to resources, information, education and lack of autonomy. Special programmes and measures should be designed to increase access. In many countries, community-based organizations and NGOs have already begun the process of creating a supportive and enabling environment in their response to the HIV epidemic. Governments must recognize these efforts and lend moral, legal, financial and political support to strengthen them.

GUIDELINE 9: CHANGING DISCRIMINATORY ATTITUDES THROUGH EDUCATION, TRAINING AND THE MEDIA

62. States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

- (a) States should support appropriate entities, such as media groups, NGOs and networks of people living with HIV, to devise and distribute programming to promote respect for the rights and dignity of people living with HIV and members of vulnerable groups, using a broad range of media (film, theatre, television, radio, print, dramatic presentations, personal testimonies, Internet, pictures, bus posters). Such programming should not compound stereotypes about these groups but instead dispel myths and assumptions about them by depicting them as friends,

relatives, colleagues, neighbours and partners. Reassurance concerning the modes of transmission of the virus and the safety of everyday social contact should be reinforced.

- (b) States should encourage educational institutions (primary and secondary schools, universities and other technical or tertiary colleges, adult and continuing education), as well as trades unions and workplaces to include HIV and human rights/non-discrimination issues in relevant curricula, such as human relationships, citizenship/social studies, legal studies, health care, law enforcement, family life and/or sex education, and welfare/counselling.
- (c) States should support HIV-related human rights/ethics training/workshops for Government officials, the police, prison staff, politicians, as well as village, community and religious leaders and professionals.
- (d) States should encourage the media and advertising industries to be sensitive to HIV and human rights issues and to reduce sensationalism in reporting and the inappropriate use of stereotypes, especially in relation to disadvantaged and vulnerable groups. A training approach of this kind should include the production of useful resources, such as handbooks containing appropriate terminology, which would serve to eliminate use of stigmatizing language; and a professional code of behaviour in order to ensure respect for confidentiality and privacy.
- (e) States should support targeted training, peer education and information exchange for people living with HIV staff and volunteers of CBOs and ASOs as well as for leaders of vulnerable groups as a means of raising their awareness of human rights and of the means to enforce these rights.

Conversely, education and training should be provided on HIV-specific human rights issues to those working on other human rights issues.

- (f) States should support the use of alternative efforts such as radio programmes or facilitated group discussions to overcome access problems for individuals who are located in remote or rural areas, are illiterate, homeless or marginalized and without access to television, films and videos and specific ethnic minority languages.

Commentary on Guideline 9

63. The use of formal standards and their implementation through Government process and law alone cannot change the negative attitudes and prejudices surrounding HIV into respect for human rights. Public programming explicitly designed to reduce the existing stigma has been shown to help create a supportive environment which is more tolerant and understanding.³² The reach of such programming should be a mixture of general and focused programmes using various media, including creative and dramatic presentations, compelling ongoing information campaigns for tolerance and inclusion and interactive educational workshops and seminars. The goal should be to challenge beliefs based on ignorance, prejudices and punitive attitudes by appealing to human compassion and identifying with visible individuals. Programming based on fear can be counter-productive by engendering discrimination through panic.

³² Professor R. Feachem, *Valuing the Past, Investing in the Future: Evaluation of the National HIV/AIDS Strategy 1993-4 to 1995-6*, Commonwealth Department of Human Services and Health, September 1995, Canberra, pp. 190-192.

GUIDELINE 10: DEVELOPMENT OF PUBLIC AND PRIVATE SECTOR STANDARDS AND MECHANISMS FOR IMPLEMENTING THESE STANDARDS

64. States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

- (a) States should require or encourage professional groups, particularly health-care professionals, and other private sector industries (e.g. law, insurance) to develop and enforce their own codes of conduct addressing human rights issues in the context of HIV. Relevant issues would include confidentiality, informed consent to testing, the duty to treat, the duty to ensure safe workplaces, reducing vulnerability and discrimination and practical remedies for breaches/misconduct.
- (b) States should require that individual government departments devise clear guidelines on the extent to which their policies and practices reflect HIV-related human rights norms and their enforcement in formal legislation and regulations, at all levels of service delivery. Coordination of these standards should occur in the national framework described in Guideline 1 and be publicly available, after involvement of community and professional groups in the process.

- (c) States should develop or promote multisectoral mechanisms to ensure accountability. This involves the equal participation of all concerned (i.e. Government agencies, industry representatives, professional associations, NGOs, consumers, service providers and service users). The common goal should be to raise standards of service, strengthen linkages and communication and assure the free flow of information.

Commentary on Guideline 10

65. The development of standards in and by the public and private sectors is important. First, they translate human rights principles into practice from an insider's perspective and reflect more closely the community's concerns. Second, they are likely to be more pragmatic and acceptable to the sector involved. Third, they are more likely to be "owned" and implemented if developed by the sector itself. Finally, they might have a more immediate impact than legislation.

GUIDELINE 11: STATE MONITORING AND ENFORCEMENT OF HUMAN RIGHTS

- 66. States should ensure monitoring and enforcement mechanisms to guarantee HIV-related human rights, including those of people living with HIV, their families and communities.**

- (a) States should collect information on human rights and HIV and, using this information as a basis for policy and programme development and reform, report on HIV-related human rights issues to the relevant United Nations

treaty bodies as part of their reporting obligations under human rights treaties.

- (b) States should establish HIV focal points in relevant government branches, including national AIDS programmes, police and correctional departments, the judiciary, Government health and social service providers and the military, for monitoring HIV-related human rights abuses and facilitating access to these branches for disadvantaged and vulnerable groups. Performance indicators or benchmarks showing specific compliance with human rights standards should be developed for relevant policies and programmes.
- (c) States should provide political, material and human resources support to ASOs and CBOs for capacity-building in human rights standards development and monitoring. States should provide human rights NGOs with support for capacity-building in HIV-related human rights standards and monitoring.
- (d) States should support the creation of independent national institutions for the promotion and protection of human rights, including HIV-related rights, such as human rights commissions and ombudspersons and/or appoint HIV ombudspersons to existing or independent human rights agencies, national legal bodies and law reform commissions.
- (e) States should promote HIV-related human rights in international forums and ensure that they are integrated into the policies and programmes of international organizations, including United Nations human rights bodies, as well as in other agencies of the United Nations system.

Furthermore, States should provide intergovernmental organizations with the material and human resources required to work effectively in this field.

Commentary on Guideline 11

67. Standard-setting and promotion of HIV-related human rights standards alone are insufficient to address human rights abuses in the context of HIV. Effective mechanisms must be established at the national and community levels to monitor and enforce HIV-related human rights. Governments should see this as part of their national responsibility to address HIV. The existence of monitoring mechanisms should be publicized, particularly among networks of people living with HIV, in order to maximize their use and impact. Monitoring is necessary to collect information, formulate and revise policy, and establish priorities for change and benchmarks for performance measurement. Monitoring should be both positive and negative, i.e. reporting on good practice to provide models for others to emulate, as well as identifying abuses. The non-governmental sector can provide an important means of monitoring human rights abuses, if resourced to do so, since it frequently has closer contact with the affected communities. Formal grievance bodies may be too bureaucratic and their procedures too time-consuming and stressful to attract a representative sample of complaints. Training is necessary for community participants to develop skills so as to be able to analyse and report findings at a level of quality which is credible for States and international human rights bodies.

GUIDELINE 12: INTERNATIONAL COOPERATION

68. States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues, and should ensure effective mechanisms to protect human rights in the context of HIV at the international level.

- (a) The Commission on Human Rights should take note of the present Guidelines and of the report on the Second International Consultation on HIV/AIDS and Human Rights and request States to carefully consider and implement the Guidelines in their national, subnational and local responses to HIV and human rights.
- (b) The Commission on Human Rights should request human rights treaty bodies, special rapporteurs and representatives and its working groups to take note of the Guidelines and include in their activities and reports all issues arising under the Guidelines relevant to their mandates.
- (c) The Commission on Human Rights should request UNAIDS, its co-sponsors (UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank³³) and other relevant United Nations bodies and agencies to integrate the promotion of the Guidelines throughout their activities.

³³ Since the issuing of the Guidelines in 1998, the number of UNAIDS co-sponsors has grown to include the International Labour Organization (ILO), the United Nations Office on Drugs and Crime (UNODC), the World Food Programme (WFP) and the United Nations High Commissioner for Refugees (UNHCR).

- (d) The Commission on Human Rights should appoint a special rapporteur on human rights and HIV/AIDS with the mandate, *inter alia*, to encourage and monitor implementation of the Guidelines by States, as well as their promotion by the United Nations system, including human rights bodies, where applicable.
- (e) The Commission on Human Rights should encourage the Office of the United Nations High Commissioner for Human Rights to ensure that the Guidelines are disseminated throughout that Office and are incorporated into all its human rights activities and programmes, particularly those involving technical cooperation, monitoring and support to human rights bodies and organs.
- (f) States, in the framework of their periodic reporting obligations to United Nations treaty monitoring bodies and under regional conventions, should report on their implementation of the Guidelines and other relevant HIV-related human rights concerns arising under the various treaties.
- (g) States should ensure, at the country level, that their cooperation with UNAIDS Theme Groups includes promotion and implementation of the Guidelines, including the mobilization of sufficient political and financial support for such implementation.
- (h) States should work in collaboration with UNAIDS, the Office of the United Nations High Commissioner for Human Rights and non-governmental and other organizations working in the field of human rights and HIV to:

- (i) Support translation of the Guidelines into national and minority languages;
- (ii) Create a widely accessible mechanism for communication and coordination for sharing information on the Guidelines and HIV-related human rights;
- (iii) Support the development of a resource directory on international declarations/ treaties, as well as policy statements and reports on HIV and human rights, to strengthen support for the implementation of the Guidelines;
- (iv) Support multicultural education and advocacy projects on HIV and human rights, including educating human rights groups with regard to HIV and educating HIV and vulnerable groups in human rights issues and strategies for monitoring and protecting human rights in the context of HIV, using the Guidelines as an educational tool;
- (v) Support the creation of a mechanism to allow existing human rights organizations and HIV organizations to work together strategically to promote and protect the human rights of people living with HIV and those vulnerable to infection, through implementation of the Guidelines;
- (vi) Support the creation of a mechanism to monitor and publicize human rights abuses in the context of HIV;
- (vii) Support the development of a mechanism to mobilize grass-roots responses to HIV-related human rights concerns and implementation of the Guidelines, including exchange programmes and training among different communities, both within and across regions;
- (viii) Advocate that religious and traditional leaders take up HIV-related human rights concerns and become part of the implementation of the Guidelines;

- (ix) Support the development of a manual that would assist human rights and AIDS service organizations in advocating the implementation of the Guidelines;
 - (x) Support the identification and funding of NGOs and ASOs at country level to coordinate a national NGO response to promote the Guidelines;
 - (xi) Support, through technical and financial assistance, national and regional NGO networking initiatives on ethics, law and human rights to enable them to disseminate the Guidelines and advocate their implementation.
- (i) States, through regional human rights mechanisms, should promote the dissemination and implementation of the Guidelines and their integration into the work of these bodies.

Commentary on Guideline 12

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

Conclusion

70. States are urged to implement these Guidelines in order to ensure respect for the human rights of those affected by HIV and to ensure an effective and inclusive public health response to HIV. These Guidelines are based on experience gained from best practices which have proven to be effective over the last 15 years. By implementing these Guidelines, States are able to avoid negative and coercive policies and practices which have had a devastating impact on people's lives and on national HIV programmes.
71. The practical aspects of protecting HIV-related human rights are more likely to be addressed if there is leadership on this issue in the executive and legislative arms of government and if multisectoral structures are established and maintained. Vital to any policy development and implementation is the involvement of affected communities, together with relevant professionals and religious and community leaders, as equal partners in the process.
72. As national legislation provides a critical framework for the protection of HIV-related human rights, many of the Guidelines relate to the need for law reform. Another major instrument of social change is the provision of a supportive and enabling environment within which to conduct HIV-related prevention, care and support activities. Part of this enabling environment can be obtained by changing attitudes through general and targeted education, public information and education campaigns which deal with HIV-related rights, tolerance and inclusion. Another part of this enabling environment involves the empowerment of women and vulnerable groups to deal with HIV by taking measures to

improve their social and legal status and to assist them in mobilizing their communities.

73. HIV and AIDS continue to challenge our societies in many ways. It is incumbent on States, communities and individuals to address extremely difficult and pervasive societal issues which have always been present in our societies, and to identify solutions thereto. With the advent of HIV, we can no longer afford to evade these issues because to do so threatens the lives of millions of men, women and children. These issues relate to the roles of women and men, the status of marginalized or illegal groups, the obligations of States concerning health expenditure and the role of law in achieving public health goals, the content of privacy between individuals and between individuals and their Governments, the responsibility and ability of people to protect themselves and others, as well as the relationship between human rights, health and life. These Guidelines are means for giving guidance on these difficult matters – guidance which has evolved from the international human rights regime and from the courageous and inspiring work of millions the world over who have demonstrated that protecting the human rights of people means protecting their health, lives and happiness in a world with HIV.

II. Recommendations for dissemination and implementation of the Guidelines on HIV/AIDS and Human Rights

74. At the Second International Consultation on HIV/AIDS and Human Rights, the participants considered strategies for dissemination and implementation of the Guidelines. It was considered that there are three groups of key actors who, jointly and separately, are critical to the implementation of the Guidelines, namely States, the United Nations system, regional intergovernmental organizations and non-governmental and community-based organizations. Recommendations for measures that these actors are encouraged to take in order to ensure that the Guidelines are widely disseminated and effectively implemented are set out below.

A. States

75. States, at the highest level of Government (Head of State, Prime Minister and/or relevant ministers), should promulgate the Guidelines and ensure that the political weight of the Government is behind the dissemination and implementation of the Guidelines throughout all branches of the executive, legislature and judiciary.
76. States, at the highest level of Government, should assign appropriate governmental bodies/staff the responsibility to devise and implement a strategy for dissemination and implementation of the Guidelines and establish periodic monitoring of this strategy through, for example, reports to the

Executive Office and public hearings. States should establish within the executive branch a staff member(s) responsible for this strategy.

77. States should disseminate the Guidelines, endorsed by the executive, to relevant national bodies, such as interministerial and parliamentary committees on HIV and national AIDS programmes, as well as to provincial and local-level bodies.
78. States, through these bodies, should give formal consideration to the Guidelines in order to identify ways to build them into existing activities and prioritize necessary new activities and policy review. States should also organize consensus workshops with the participation of non-governmental organizations, community-based organizations and AIDS service organizations (ASOs), networks of people living with HIV, networks on ethics, law, human rights and HIV, United Nations Theme Groups on HIV/AIDS, as well as political and religious groups:
 - (a) To discuss the relevance of the Guidelines to the local situation, to identify obstacles and needs, to propose interventions and solutions, and to achieve consensus for the adoption of the Guidelines;
 - (b) To elaborate national, provincial and local plans of action for implementation and monitoring of the Guidelines within the local context;
 - (c) To mobilize and ensure the commitment of relevant governmental officials to apply the Guidelines as a working tool to be integrated into their individual workplans.
79. States, at national, subnational and local levels, should establish mechanisms to receive, process and refer issues, claims and

information in relation to the Guidelines and to the human rights issues raised therein. States should create focal points to monitor the implementation of the Guidelines in relevant government departments.

80. States, in ways consistent with judicial independence, should disseminate the Guidelines widely throughout the judicial system and use them in the development of jurisprudence, conduct of court cases involving HIV-related matters and HIV-related training/continuing education of judicial officers.
81. States should disseminate the Guidelines throughout the legislative branch of government and particularly to parliamentary committees involved in the formulation of policy and legislation relevant to the issues raised in the Guidelines. Such committees should assess the Guidelines to identify priority areas for action and a longer-term strategy to ensure that relevant policy and law are in conformity with the Guidelines.

B. United Nations system and regional intergovernmental bodies

82. The United Nations Secretary-General should submit the Guidelines to the Commission on Human Rights as part of the report on the Second International Consultation on HIV/AIDS and Human Rights.
83. The Secretary-General should transmit the Guidelines to heads of State:
 - (a) Recommending that the document be distributed nationally through the appropriate channels;

- (b) Offering, within the mandates of UNAIDS and the Office of the United Nations High Commissioner for Human Rights, technical cooperation in facilitating the implementation of the Guidelines;
 - (c) Requesting that compliance with the Guidelines be included in national reports to existing human rights treaty bodies;
 - (d) Reminding Governments of the responsibility to uphold international human rights standards in promoting compliance with the Guidelines.
84. The Secretary-General should transmit the Guidelines to the heads of all relevant United Nations bodies and agencies, requesting that they be widely disseminated throughout the relevant programmes and activities of the bodies and agencies. The Secretary-General should request that all relevant United Nations bodies and agencies consider their activities and programmes on HIV in the light of the provisions of the Guidelines and support the implementation of the Guidelines at national level.
85. The Commission on Human Rights and the Sub-Commission on Prevention of Discrimination and Protection of Minorities, as well as all human rights treaty bodies, should consider and discuss the Guidelines with a view to incorporating relevant aspects of the Guidelines into their respective mandates. Human rights treaty bodies, in particular, should integrate the Guidelines, as relevant, in their respective reporting guidelines, questions to States and when developing recommendations and general comments on related subjects.
86. The Commission on Human Rights should appoint a special rapporteur on human rights and HIV with the mandate,

inter alia, to encourage and monitor implementation of the Guidelines by States, as well as their promotion by the United Nations system, including human rights bodies, where applicable.

87. The Office of the United Nations High Commissioner for Human Rights should ensure that the Guidelines are disseminated throughout that Office and incorporated into its activities and programmes, particularly those involving support for the United Nations human rights bodies, technical assistance and monitoring. This should be coordinated by a staff member with exclusive responsibility for the Guidelines. Similarly, the United Nations Division for the Advancement of Women should ensure the full integration of the Guidelines into the work of the Committee on the Elimination of Discrimination against Women.
88. UNAIDS should transmit the Guidelines throughout the system – to co-sponsors of the UNAIDS Programme Coordinating Board, United Nations Theme Groups on HIV/AIDS, UNAIDS staff, including country programme advisers and focal points – and should ensure that the Guidelines become a framework for action for the work of the United Nations Theme Groups on HIV/AIDS and UNAIDS staff; Theme Groups should use the Guidelines to assess the HIV-related human rights, legal and ethical situation at country level and to elaborate the best means for supporting implementation of the Guidelines at that level.
89. Regional bodies (such as the Inter-American Commission on Human Rights, the Organization of American States, the African Commission on Human and Peoples' Rights, the Organization of African Unity, the European Commission on Human Rights, the European Commission, the Council

of Europe, the Association of South-East Asian Nations, etc.) should receive the Guidelines and make them available to the largest possible number of members and relevant divisions with a view to assessing how their activities might be made consistent with the Guidelines and promote their implementation.

90. Specialized agencies and other concerned bodies (such as the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees, the United Nations Research Institute for Social Development and the World Trade Organization) should receive the Guidelines and transmit them widely among members and throughout their programmes with a view to assessing how their activities can be made consistent with the Guidelines and promote their implementation.

C. Non-governmental organizations³⁴

91. NGOs should implement the Guidelines within a broad framework of communication in terms of HIV and human rights, including the establishment of ongoing communication between the HIV community and the human rights community by:
 - (a) Establishing contacts at the international, regional and local levels between networks of ASOs, human rights NGOs, and people living with HIV.

³⁴ Including AIDS service organizations, community-based organizations, regional and national networks on ethics, law, human rights and HIV and networks of people living with HIV. These networks comprise not only non-governmental and AIDS service organizations but also professionals (e.g. lawyers, health-care workers, social workers), people living with HIV, academics, research institutions and other concerned citizens. The networks are important voices for mobilizing change and protecting human rights.

- (b) Developing mechanism(s) for ongoing communication and dissemination and implementation of the Guidelines, such as a bulletin board and/or home page on the Internet allowing for input and exchange of information on human rights and HIV and database linkages between groups working on human rights and HIV;
 - (c) Networking with human rights NGOs at meetings of United Nations human rights bodies;
 - (d) Promoting discussion of the Guidelines in their newsletters and other publications, as well as through other media;
 - (e) Developing an action-oriented and accessible version(s) of the Guidelines;
 - (f) Developing a strategy and process for the dissemination of the Guidelines and seeking funding and technical cooperation in that regard.
92. Non-governmental organizations at the regional level should:
- (a) Establish or use existing focal points to disseminate the Guidelines, with popularization and/or training;
 - (b) Establish a regional “technical group” to introduce the Guidelines to the region;
 - (c) Use the Guidelines as a tool for advocacy, interpretation, monitoring abuse and establishing best practices;
 - (d) Prepare regular reports on the implementation of the Guidelines to human rights bodies (human rights treaty bodies and United Nations extra-conventional fact-finding mechanisms, such as special rapporteurs and

representatives, as well as regional commissions) and other relevant international agencies;

- (e) Bring cases of HIV-related discrimination and other violations of human rights in the context of HIV to regional human rights judicial and quasi-judicial mechanisms.

93. In order to advocate the Guidelines, NGOs at the national level should obtain consensus on their acceptance and establish a joint strategy with governmental and non-governmental partners as a baseline for monitoring the Guidelines, through the following actions:

- (a) hold national NGO strategy meetings on the Guidelines that include human rights NGOs (including women's organizations and prisoners' rights organization), ASOs, community-based organizations, networks on ethics, law, human rights and HIV and networks of people living with HIV;
- (b) Hold meetings with national governmental human rights bodies;
- (c) Hold meetings with national Government (relevant ministries), legislative and the judiciary;
- (d) Establish or use existing national focal points to gather information and develop systems of information exchange on HIV and human rights, including the Guidelines.

III. International human rights obligations and HIV

Introduction: HIV, human rights and public health

94. Several years of experience in addressing the HIV epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV and AIDS. The protection and promotion of human rights are necessary both to the protection of the inherent dignity of persons affected by HIV and to the achievement of the public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV and AIDS on those affected and empowering individuals and communities to respond to HIV.

95. In general, human rights and public health share the common objective to promote and to protect the rights and well-being of all individuals. From the human rights perspective, this can best be accomplished by promoting and protecting the rights and dignity of everyone, with special emphasis on those who are discriminated against or whose rights are otherwise interfered with. Similarly, public health objectives can best be accomplished by promoting health for all, with special emphasis on those who are vulnerable to threats to their physical, mental or social well-being. Thus, health and human rights complement and mutually reinforce each other in any context. They also complement and mutually reinforce each other in the context of HIV.

96. One aspect of the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection.³⁵ In particular, people will not seek HIV-related counselling, testing, treatment and support if this would mean facing discrimination, lack of confidentiality and other negative consequences. Therefore, it is evident that coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support.
97. Another aspect of the linkage between the protection of human rights and effective HIV programmes is apparent in the fact that the incidence or spread of HIV is disproportionately high among some populations. Depending on the nature of the epidemic and the legal, social and economic conditions in each country, groups that may be disproportionately affected include women, children, those living in poverty, minorities, indigenous people, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users—that is to say groups who already suffer from a lack of human rights protection and from discrimination and/or are marginalized by their legal status. Lack of human rights protection disempowers these groups to avoid infection and to cope with HIV, if affected by it.³⁶
98. Furthermore, there is growing international consensus that a broadly based, inclusive response, involving people living

³⁵ J. Dwyer, "Legislating AIDS Away: The Limited Role of Legal Persuasion in Minimizing the Spread of HIV", in 9 *Journal of Contemporary Health Law and Policy* 167 (1993).

³⁶ For the purposes of these Guidelines, these groups will be referred to as "vulnerable" groups although it is recognized that the degree and source of vulnerability of these groups vary widely within countries and across regions.

with HIV in all its aspects, is a main feature of successful HIV programmes. Another essential component of comprehensive response is the facilitation and creation of a supportive legal and ethical environment which is protective of human rights. This requires measures to ensure that Governments, communities and individuals respect human rights and human dignity and act in a spirit of tolerance, compassion and solidarity.

99. One essential lesson learned from the HIV epidemic is that universally recognized human rights standards should guide policymakers in formulating the direction and content of HIV-related policy and form an integral part of all aspects of national and local responses to HIV.

A. Human rights standards and the nature of State obligations

100. The Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights in June 1993,³⁷ affirmed that all human rights are universal, indivisible, interdependent and interrelated. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, States have the duty, regardless of their political, economic and cultural systems, to promote and protect universal human rights standards and fundamental freedoms.
101. A human rights approach to HIV is, therefore, based on these State obligations with regard to human rights protection. HIV demonstrates the indivisibility of human rights since the realization of economic, social and cultural rights, as well as

³⁷ A/CONF.157/24 (Part I), chap. III.

civil and political rights, is essential to an effective response. Furthermore, a rights-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions.

102. The key human rights principles which are essential to effective State responses to HIV are to be found in existing international instruments, such as the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child. Regional instruments, namely the American Convention on Human Rights, the European Convention for the Protection of Human Rights and Fundamental Freedoms and the African Charter on Human and Peoples' Rights also enshrine State obligations applicable to HIV. In addition, a number of conventions and recommendations of the International Labour Organization are particularly relevant to the problem of HIV, such as ILO instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. Among the human rights principles relevant to HIV/AIDS are, *inter alia*:
- The right to non-discrimination, equal protection and equality before the law;
 - The right to life;
 - The right to the highest attainable standard of physical and mental health;

- The right to liberty and security of person;
 - The right to freedom of movement;
 - The right to seek and enjoy asylum;
 - The right to privacy;
 - The right to freedom of opinion and expression and the right to freely receive and impart information;
 - The right to freedom of association;
 - The right to work;
 - The right to marry and to found a family;
 - The right to equal access to education;
 - The right to an adequate standard of living;
 - The right to social security, assistance and welfare;
 - The right to share in scientific advancement and its benefits;
 - The right to participate in public and cultural life;
 - The right to be free from torture and cruel, inhuman or degrading treatment or punishment.
103. Particular attention should be paid to human rights of children and women.

B. Restrictions and limitations

104. Under international human rights law, States may impose restrictions on some rights, in narrowly defined circumstances, if such restrictions are necessary to achieve overriding goals, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security. Some rights are non-derogable and cannot be restricted under any circumstances.³⁸ In order for restrictions

³⁸ These include the right to life, freedom from torture, freedom from enslavement or servitude, protection from imprisonment for debt, freedom from retroactive penal laws, the right to recognition as a person before the law and the right to freedom of thought, conscience and religion.

on human rights to be legitimate, the State must establish that the restriction is:

- (a) Provided for and carried out in accordance with the law, i.e. according to specific legislation which is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly;
- (b) Based on a legitimate interest, as defined in the provisions guaranteeing the rights;
- (c) Proportional to that interest and constituting the least intrusive and least restrictive measure available and actually achieving that interest in a democratic society, i.e. established in a decision-making process consistent with the rule of law.³⁹

105. 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. The right to privacy is known to have been restricted through mandatory testing and the publication of HIV status and the right to liberty of person is violated when HIV is used to justify deprivation of liberty or segregation. Although such measures may be effective in the case of diseases which are contagious by casual contact and susceptible to cure, they are ineffective with regard to HIV since HIV is not casually transmitted. In addition, such coercive measures are not the least restrictive measures possible and

³⁹ P. Sieghart, *AIDS and Human Rights: A UK Perspective*, British Medical Association Foundation for AIDS, London, 1989, pp. 12-25.

are often imposed discriminatorily against already vulnerable groups. Finally, and as stated above, these coercive measures drive people away from prevention and care programmes, thereby limiting the effectiveness of public health outreach. A public health exception is, therefore, seldom a legitimate basis for restrictions on human rights in the context of HIV.

C. The application of specific human rights in the context of the HIV epidemic

106. Examples of the application of specific human rights to HIV are illustrated below. These rights should not be considered in isolation but as interdependent rights supporting the Guidelines elaborated in this document. In the application of these rights, the significance of national and regional particularities and various historical, cultural and religious backgrounds must be taken into consideration. It remains the duty of States, however, to promote and protect all human rights within their cultural contexts.

1. NON-DISCRIMINATION AND EQUALITY BEFORE THE LAW

107. International human rights law guarantees the right to equal protection before the law and freedom from discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Discrimination on any of these grounds is not only wrong in itself but also creates and sustains conditions leading to societal vulnerability to infection by HIV, including lack of access to an enabling environment that will promote behavioural change and enable people to cope with HIV. Groups suffering from discrimination, which also disables

them in the context of HIV, are women, children, those living in poverty, minorities, indigenous people, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users. Responses by States to the epidemic should include the implementation of laws and policies to eliminate systemic discrimination, including where it occurs against these groups.

108. The Commission on Human Rights has confirmed that “other status” in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS.⁴⁰ This means that States should not discriminate against people living with HIV or members of groups perceived to be at risk of infection on the basis of their actual or presumed HIV status.⁴¹
109. The Human Rights Committee has confirmed that the right to equal protection of the law prohibits discrimination in law or in practice in any fields regulated and protected by public authorities and that a difference in treatment is not necessarily discriminatory if it is based on reasonable and objective criteria. The prohibition against discrimination thus requires States to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV-related criteria.⁴²

⁴⁰ See, *inter alia*, Commission on Human Rights resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996.

⁴¹ Other groups singled out for discriminatory measures in the context of HIV, such as mandatory screening, are the military, the police, peacekeeping forces, pregnant women, hospital patients, tourists, performers, people with haemophilia, tuberculosis or sexually transmitted diseases (STDs), truck drivers and scholarship-holders. Their partners, families, friends and care providers may also be subject to discrimination based on presumed HIV status.

⁴² Human Rights Committee, General Comment No. 18 (37). *Official Records of the General Assembly, Forty-fifth Session, Supplement No. 40 (A/45/40)*, vol. I, annex VI A.

2. HUMAN RIGHTS OF WOMEN

110. Discrimination against women, de facto and de jure, renders them disproportionately vulnerable to HIV and AIDS. Women's subordination in the family and in public life is one of the root causes of the rapidly increasing rate of infection among women. Systematic discrimination based on gender also impairs women's ability to deal with the consequences of their own infection and/or infection in the family, in social, economic and personal terms.⁴³
111. With regard to prevention of infection, the rights of women and girls to the highest attainable standard of physical and mental health, to education, to freedom of expression, to freely receive and impart information, should be applied to include equal access to HIV-related information, education, means of prevention and health services. However, even when such information and services are available, women and girls are often unable to negotiate safer sex or to avoid HIV-related consequences of the sexual practices of their husbands or partners as a result of social and sexual subordination, economic dependence on a relationship and cultural attitudes. The protection of the sexual and reproductive rights of women and girls is, therefore, critical. This includes the rights of women to have control over and to decide freely and responsibly, free of coercion, discrimination and violence, on matters related to their sexuality, including sexual and reproductive health.⁴⁴ Measures for the elimination of sexual

⁴³ See report of the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery for the Advancement of Women, convened by the Division for the Advancement of Women, Vienna, 24-28 September 1990 (EGM/AIDS/1990/1).

⁴⁴ Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, 4/5 September 1995 (A/CONF.177/20).

violence and coercion against women in the family and in public life not only protect women from human rights violations but also from HIV infection that may result from such violations.

112. Violence against women in all its forms during peacetime and in conflict situations increases their vulnerability to HIV infection. Such violence includes, *inter alia*, sexual violence, rape (marital and other) and other forms of coerced sex, as well as traditional practices affecting the health of women and children. States have an obligation to protect women from sexual violence in both public and private life.
113. Furthermore, in order to empower women to leave relationships or employment which threaten them with HIV infection and to cope if they or their family members are infected with HIV, States should ensure women's rights to, *inter alia*, legal capacity and equality within the family, in matters such as divorce, inheritance, child custody, property and employment rights, in particular, equal remuneration of men and women for work of equal value, equal access to responsible positions, measures to reduce conflicts between professional and family responsibilities and protection against sexual harassment at the workplace. Women should also be enabled to enjoy equal access to economic resources, including credit, an adequate standard of living, participation in public and political life and to benefits of scientific and technological progress so as to minimize risk of HIV infection.
114. HIV prevention and care for women are often undermined by pervasive misconceptions about HIV transmission and epidemiology. There is a tendency to stigmatize women as "vectors of disease", irrespective of the source of infection. As

a consequence, women who are or are perceived to be HIV-positive face violence and discrimination in both public and in private life. Sex workers often face mandatory testing with no support for prevention activities to encourage or require their clients to wear condoms and with little or no access to health-care services. Many HIV programmes targeting women are focused on pregnant women but these programmes often emphasize coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre- and post-natal testing followed by coerced abortion or sterilization. Such programmes seldom empower women to prevent perinatal transmission by prenatal prevention education and an available choice of health services and overlook the care needs of women.

115. The Convention on the Elimination of All Forms of Discrimination against Women obliges States parties to address all aspects of gender-based discrimination in law, policy and practice. States are also required to take appropriate measures to modify social and cultural patterns which are based on ideas of superiority/inferiority and stereotyped roles for men and women. The Committee on the Elimination of Discrimination against Women (CEDAW), which monitors the Convention has underscored the link between women's reproductive role, their subordinate social position and their increased vulnerability to HIV infection.⁴⁵

⁴⁵ CEDAW, general recommendation No. 15 (ninth session, 1990). *Official Records of the General Assembly, Forty-fifth Session, Supplement No. 38 (A/45/38)*, chap. IV.

3. HUMAN RIGHTS OF CHILDREN

116. The rights of children are protected by all international human rights instruments and, in particular, under the Convention on the Rights of the Child, which establishes an international definition of the child as “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier” (art. 1). The Convention reaffirms that children are entitled to many of the rights that protect adults (e.g. the rights to life, non-discrimination, integrity of the person, liberty and security, privacy, asylum, expression, association and assembly, education and health), in addition to particular rights for children established by the Convention.
117. Many of these rights are relevant to HIV prevention, care and support for children, such as freedom from trafficking, prostitution, sexual exploitation and sexual abuse since sexual violence against children, among other things, increases their vulnerability to HIV. The freedom to seek, receive and impart information and ideas of all kinds and the right to education provide children with the right to give and receive all HIV-related information needed to avoid infection and to cope with their status, if infected. The right to special protection and assistance if deprived of his or her family environment, including alternative care and protection in adoption, in particular protects children if they are orphaned by HIV. The right of disabled children to a full and decent life and to special care and the rights to abolition of traditional practices which are prejudicial to the health of children, such as early marriage, female genital mutilation, denial of equal sustenance and inheritance for girls are also highly relevant in the context of HIV. Under the Convention, the right to non-discrimination and privacy for children living with HIV and finally the rights

of children to be actors in their own development and to express opinions and have them taken into account in making decisions about their lives should empower children to be involved in the design and implementation of HIV-related programmes for children.

4. RIGHT TO MARRY AND TO FOUND A FAMILY AND PROTECTION OF THE FAMILY

118. The right to marry and to found a family encompasses the right of “men and women of full age, without any limitation due to race, nationality or religion, ... to marry and to found a family”, to be “entitled to equal rights as to marriage, during marriage and at its dissolution” and to protection by society and the State of the family as “the natural and fundamental group unit of society”.⁴⁶ Therefore, it is clear that the right of people living with HIV is infringed by mandatory pre-marital testing and/or the requirement of “AIDS-free certificates” as a precondition for the grant of marriage licences under State laws.⁴⁷ Secondly, forced abortions or sterilization of HIV-infected women violates the human right to found a family, as well as the right to liberty and integrity of the person. Women should be provided with accurate information about the risk of perinatal transmission to support them in making voluntary, informed choices about reproduction.⁴⁸ Thirdly, measures to ensure the equal rights of women within the family are

⁴⁶ Article 16 of the Universal Declaration of Human Rights.

⁴⁷ People living with HIV should be able to marry and engage in sexual relations whose nature does not impose a risk of infection on their partners. People living with HIV, like all people who know or suspect that they are HIV-positive, have a responsibility to practise abstinence or safer sex in order not to expose others to infection.

⁴⁸ The chances of an HIV-infected woman giving birth to an HIV-positive baby is approximately 1 in 3. This rate may be significantly reduced if the woman is able to undergo pre-and post-natal treatment with antiretrovirals. Since extremely difficult and complex ethical and personal decisions are involved, the choice to have a child should be left to the woman, with input from her partner, if possible.

necessary to enable women to negotiate safe sex with their husbands/ partners or be able to leave the relationship if they cannot assert their rights (see also “Human rights of women” above). Finally, recognition of the family as the fundamental unit of society is undermined by policies which have the effect of denying family unity. In the case of migrants, many States do not allow migrants to be accompanied by family members, and the resulting isolation can increase vulnerability to HIV infection. In the case of refugees, mandatory testing as a precondition of asylum can result in HIV-positive family members being denied asylum while the rest of the family is granted asylum.

5. RIGHT TO PRIVACY

119. Article 17 of the International Covenant on Civil and Political Rights provides that “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks”. The right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status.
120. 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.

121. The duty of States to protect the right to privacy, therefore, includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent, that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual. In this context, States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and that individuals are protected from arbitrary interference with their privacy in the context of media investigation and reporting.
122. In societies and cultures where traditions place greater emphasis on the community, patients may more readily authorize the sharing of confidential information with their family or community. In such circumstances, disclosure to the family or community may be for the benefit of the person concerned and such shared confidentiality may not breach the duty to maintain confidentiality.
123. The Human Rights Committee has found that the right to privacy under article 17 of the International Covenant on Civil and Political Rights is violated by laws which criminalize private homosexual acts between consenting adults. The

Committee noted that “... the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS...by driving underground many of the people at risk of infection...

[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention”.⁴⁹

124. The Committee also noted that the term “sex” in article 26 of the Covenant which prohibits discrimination on various grounds includes “sexual orientation”. In many countries, there exist laws which render criminal particular sexual relationships or acts between consenting adults, such as adultery, fornication, oral sex and sodomy. Such criminalization not only interferes with the right to privacy but it also impedes HIV/AIDS education and prevention work.

6. RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS AND ITS APPLICATIONS

125. The right to enjoy the benefits of scientific progress and its applications is important in the context of HIV in view of the rapid and continuing advances regarding testing, treatment therapies and the development of a vaccine. More basic scientific advances which are relevant to HIV concern the safety of the blood supply from HIV infection and the use of universal precautions which prevent the transmission of HIV in various settings, including that of health care. In this connection, however, developing countries experience severe resource constraints which limit not only the availability of

⁴⁹ Human Rights Committee, Communication No. 488/1991, *Nicholas Toonan v. Australia* (views adopted on 31 March 1994, fiftieth session). *Official Records of the General Assembly, Forty-ninth Session, Supplement No. 40 (A/49/40)*, vol. II, annex IX EE, para. 8.5.

such scientific benefits but also the availability of basic pain prophylaxis and antibiotics for the treatment of HIV-related conditions. Furthermore, disadvantaged and/or marginalized groups within societies may have no or limited access to available HIV-related treatments or to participation in clinical and vaccine development trials. Of deep concern is the need to share equitably among States and among all groups within States basic drugs and treatment, as well as the more expensive and complicated treatment therapies, where possible.

7. RIGHT TO LIBERTY OF MOVEMENT

126. The right to liberty of movement encompasses the rights of everyone lawfully within a territory of a State to liberty of movement within that State and the freedom to choose his/her residence, as well as the rights of nationals to enter and leave their own country. Similarly, an alien lawfully within a State can only be expelled by a legal decision with due process protection.

127. There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever.⁵⁰ Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns.

128. Where States prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable

⁵⁰ WHO International Health Regulations (1969).

conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.

8. RIGHT TO SEEK AND ENJOY ASYLUM

129. Everyone has the right to seek and enjoy asylum from persecution in other countries. Under the 1951 Convention relating to the Status of Refugees and under customary international law, States cannot, in accordance with the principle of non-refoulement, return a refugee to a country where she or he faces persecution. Thus, States may not return a refugee to persecution on the basis of his or her HIV status. Furthermore, where the treatment of people living with HIV can be said to amount to persecution, it can provide a basis for qualifying for refugee status.
130. The United Nations High Commissioner for Refugees issued policy guidelines in March 1988 which state that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening being used to exclude HIV-positive individuals from being granted asylum.⁵¹
131. The Human Rights Committee has confirmed that the right to equal protection of the law prohibits discrimination in law or in practice in any fields regulated and protected by public authorities.⁵² These would include travel regulations, entry requirements, immigration and asylum procedures. Therefore,

⁵¹ UNHCR Health Policy on AIDS, 15 February 1988 (UNHCR/IDM).

⁵² Human Rights Committee, general comment No. 18 (37), op. cit.

although there is no right of aliens to enter a foreign country or to be granted asylum in any particular country, discrimination on the grounds of HIV status in the context of travel regulations, entry requirements, immigration and asylum procedures would violate the right to equality before the law.

9. RIGHT TO LIBERTY AND SECURITY OF PERSON

132. Article 9 of the International Covenant on Civil and Political Rights provides that “Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law”.
133. The right to liberty and security of person should, therefore, never be arbitrarily interfered with, based merely on HIV status by using measures such as quarantine, detention in special colonies, or isolation. There is no public health justification for such deprivation of liberty. Indeed, it has been shown that public health interests are served by integrating people living with HIV within communities and benefiting from their participation in economic and public life.
134. In exceptional cases involving objective judgments concerning deliberate and dangerous behaviour, restrictions on liberty may be imposed. Such exceptional cases should be handled under ordinary provisions of public health, or criminal laws, with appropriate due process protection.
135. Compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of person. This coercive measure is often utilized with regard to groups least

able to protect themselves because they are within the ambit of Government institutions or the criminal law, e.g. soldiers, prisoners, sex workers, injecting drug users and men who have sex with men. There is no public health justification for such compulsory HIV testing. Respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent

10. RIGHT TO EDUCATION

136. Article 26 of the Universal Declaration of Human Rights states in part that “Everyone has the right to education. ... Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship...”. This right includes three broad components which apply in the context of HIV/AIDS. Firstly, both children and adults have the right to receive HIV-related education, particularly regarding prevention and care. Access to education concerning HIV is an essential life-saving component of effective prevention and care programmes. It is the State’s obligation to ensure, in every cultural and religious tradition, that appropriate means are found so that effective HIV information is included in educational programmes inside and outside schools. The provision of education and information to children should not be considered as promoting early sexual experimentation; rather, as studies indicate, it delays sexual activity.⁵³
137. Secondly, States should ensure that both children and adults living with HIV are not discriminatorily denied access to

⁵³ M. Alexander, “Information and Education Laws”, in Dr. Jayasuriya (ed.) *HIV, Law, Ethics and Human Rights*, UNDP, New Delhi, 1995, p. 54. Impact of HIV and sexual health education on the sexual behaviour of young people: a review update, UNAIDS, 1997.

education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status. There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings. Thirdly, States should, through education, promote understanding, respect, tolerance and non-discrimination in relation to persons living with HIV.

11. FREEDOM OF EXPRESSION AND INFORMATION

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

12. FREEDOM OF ASSEMBLY AND ASSOCIATION

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

13. RIGHT TO PARTICIPATION IN POLITICAL AND CULTURAL LIFE

141. Realization of the right to take part in the conduct of public affairs,⁵⁴ as well as in cultural life,⁵⁵ is essential to guaranteeing participation by those most affected by HIV in the development and implementation of HIV-related policies and programmes. These human rights are reinforced by the principles of participatory democracy; this assumes the involvement of people living with HIV and their families, women, children and groups vulnerable to HIV in designing and implementing programmes that will be most effective by being tailored to the specific needs of these groups. It is essential that people living with HIV remain fully integrated in the political, economic, social and cultural aspects of community life.
142. People living with HIV have the right to their cultural identity and to various forms of creativity, both as a means of artistic expression and as a therapeutic activity. Increasing recognition has been given to the expression of creativity as a popular medium for imparting HIV information, combating intolerance, and as a therapeutic form of solidarity.

14. RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH

143. The right to the highest attainable standard of physical and mental health comprises, *inter alia*, “the prevention, treatment and control of epidemic...diseases” and “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”.⁵⁶

⁵⁴ Article 25 of the International Covenant on Civil and Political Rights.

⁵⁵ Article 15 of the International Covenant on Economic, Social and Cultural Rights.

⁵⁶ Article 12 of the International Covenant on Economic, Social and Cultural Rights.

144. In order to meet these obligations in the context of HIV, States should ensure the provision of appropriate HIV-related information, education and support, including access to services for sexually transmitted diseases, to the means of prevention (such as condoms and clean injection equipment) and to voluntary and confidential testing with pre-and post-test counselling, in order to enable individuals to protect themselves and others from infection. States should also ensure a safe blood supply and implementation of “universal precautions” to prevent transmission in settings such as hospitals, doctors’ offices, dental practices and acupuncture clinics, as well as informal settings, such as during home births.
145. States should also ensure access to adequate treatment and drugs, within the overall context of their public health policies, so that people living with HIV can live as long and as successfully as possible. People living with HIV should also have access to clinical trials and should be free to choose amongst all available drugs and therapies, including alternative therapies. International support is essential from both the public and private sectors, for developing countries for increased access to health care and treatment, drugs and equipment. In this context, States should ensure that neither expired drugs nor other invalid materials are supplied.
146. States may have to take special measures to ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services. The human rights obligations of States to prevent discrimination and to assure medical service and medical attention for everyone in the event of sickness require States to ensure that no one is discriminated against in the health-care setting on the basis of their HIV status.

15. RIGHT TO AN ADEQUATE STANDARD OF LIVING AND SOCIAL SECURITY SERVICES

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

16. RIGHT TO WORK

149. “Everyone has the right to work...[and] to just and favourable conditions of work”.⁵⁷ The right to work entails the right of every person to access to employment without any

⁵⁷ Article 23, of the Universal Declaration of Human Rights.

precondition except the necessary occupational qualifications. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits on the grounds of a positive result. States should ensure that persons with living with HIV are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers' compensation, pension benefits and health insurance schemes. States' obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV, should extend to the private sector.

150. As part of favourable conditions of work, all employees have the right to safe and healthy working conditions. "In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker."⁵⁸ However, where a possibility of transmission does exist in the workplace, such as in health-care settings, States should take measures to minimize the risk of transmission. In particular, workers in the health sector must be properly trained in universal precautions for the avoidance of transmission of infection and be supplied with the means to implement such procedures.

⁵⁸ Consultation on AIDS and the Workplace (World Health Organization, in association with the International Labour Organization), Geneva, 1988, sect. II, "Introduction".

17. FREEDOM FROM CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

151. The right to freedom from cruel, inhuman or degrading treatment or punishment can arise in a variety of ways in the context of HIV, for example in the treatment of prisoners.
152. Imprisonment is punishment by deprivation of liberty but should not result in the loss of human rights or dignity. In particular, the State, through prison authorities, owes a duty of care to prisoners, including the duty to protect the rights to life and to health of all persons in custody. Denial to prisoners of access to HIV-related information, education and means of prevention (bleach, condoms, clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or punishment. The duty of care also comprises a duty to combat prison rape and other forms of sexual victimization that may result, *inter alia*, in HIV transmission.
153. Thus, all prisoners engaging in dangerous behaviour, including rape and sexual coercion, should be subject to discipline based on their behaviour, without reference to their HIV status. There is no public health or security justification for mandatory HIV testing of prisoners, nor for denying inmates living with HIV access to all activities available to the rest of the prison population. Furthermore, the only justification for segregation of people living with HIV from the prison population would be for the health of themselves. Prisoners with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside prison.

ANNEX I

History of the recognition of the importance of human rights in the context of HIV

1. The World Health Organization (WHO) held an International Consultation on Health Legislation and Ethics in the Fields of HIV/AIDS in April 1988 at Oslo. It advocated bringing down barriers between people who were infected and those who were not infected and placing actual barriers (e.g. condoms) between individuals and the virus. On 13 May 1988, the World Health Assembly passed resolution WHA41.24 entitled “Avoidance of discrimination in relation to HIV-infected people and people with AIDS”, which underlined how vital respect for human rights was for the success of national AIDS prevention and control programmes and urged member States to avoid discriminatory action in the provision of services, employment and travel. In July 1989, the first international consultation on AIDS and human rights was organized by the then United Nations Centre for Human Rights, in cooperation with the World Health Organization/GPA. The report of the consultation highlighted the human rights issues raised in the context of HIV/AIDS and proposed the elaboration of guidelines. Resolution WHA45.35 of 14 May 1992 recognized that there is no public health rationale for measures which arbitrarily limit individual rights, such as mandatory screening. In 1990, the World Health Organization conducted regional workshops on the legal and ethical aspects of HIV/AIDS at Seoul, Brazzaville and New Delhi. The first of these workshops developed guidelines to evaluate current and elaborate

future legal measures for the control of HIV to be used as a check-list by countries considering legal policy issues.⁵⁹ In November 1991, the WHO Regional Office for Europe and the International Association of Rights and Humanity held a Pan-European Consultation on HIV/AIDS in the Context of Public Health and Human Rights in Prague, which considered the Rights and Humanity Declaration and Charter and developed a consensus statement (the Prague Statement). Three further consultations on HIV, law and law reform were convened during 1995 by the WHO Regional Office for Europe, for countries in Eastern Europe and Central Asia.

2. The United Nations Development Programme held Inter-Country Consultations on Ethics, Law and HIV in Cebu (Philippines) in May 1993 and in Dakar, in June 1994.⁶⁰ Both of these consultations produced consensus documents reaffirming a commitment to voluntarism, ethics and the human rights of those affected (the Cebu Statement of Belief and the Dakar Declaration). UNDP also held Regional Training Workshops on HIV Law and Law Reform in Asia and the Pacific at Colombo, Beijing and Nadi (Fiji) in 1995.
3. Law reform programmes focusing on human rights have been ongoing in countries such as Australia, Canada, the United States, South Africa and in the Latin American region, together with networks of legal advocates, practitioners and activists at governmental and community levels. One concrete achievement of such groups has been the successful lobbying for general anti-discrimination legislation at national and local levels which defines disability broadly and sensitively enough to

⁵⁹ See WHO document RS/90/GE/11(KOR).

⁶⁰ R. Glick (ed.), *Inter-Country Consultation on Ethics, Law and HIV* (Cebu), New Delhi, India, 1995; UNDP, *Inter-Country Consultation on Ethics, Law and HIV*, Dakar, Senegal, 1995.

explicitly include HIV/AIDS. Such civil legislation exists in the United States, the United Kingdom, Australia, New Zealand and Hong Kong. In France, such a definition is contained in the Penal Code. Some countries have constitutional guarantees of human rights with practical enforcement mechanisms, such as the Canadian Charter of Rights.

4. The United Nations General Assembly, in its resolutions 45/187 of 21 December 1990 and 46/203 of 20 December 1991, emphasized the need to counter discrimination and to respect human rights and recognized that discriminatory measures drove HIV/AIDS underground, making it more difficult to combat, rather than stopping its spread. The Special Rapporteur of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities on discrimination against HIV-infected people and people living with AIDS presented a series of reports to the Sub-Commission between 1990 and 1993.⁶¹ The Special Rapporteur's reports highlighted the need for education programmes to create a genuine climate of respect for human rights in order to eradicate discriminatory practices which are contrary to international law. The right to health can only be implemented by advising people of the means of prevention and the Special Rapporteur made specific reference to the vulnerable situation of women and children in the spread of HIV. Since 1989, the Sub-Commission, at its annual sessions, has adopted resolutions on discrimination against people living with HIV.⁶²

⁶¹ E/CN.4/Sub.2/1990/9, E/CN.4/Sub.2/1991/10, E/CN.4/Sub.2/1992/10 and E/CN.4/Sub.2/1993/9.

⁶² Sub-Commission resolutions and decisions 1989/17, 1990/118, 1991/109, 1992/108, 1993/31, 1994/29, 1995/21, 1996/33, 1997/40.

5. The United Nations Commission on Human Rights, at its annual sessions since 1990, has also adopted numerous resolutions on human rights and HIV which, *inter alia*, confirm that discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing international human rights standards and clarify that the term “or other status” used in the non-discrimination clauses of such texts “should be interpreted to include health status, such as HIV/AIDS”.⁶³
6. There have also been prestigious academic international studies of HIV and human rights: these include the work of the late Paul Sieghart for the British Medical Association Foundation for AIDS;⁶⁴ the François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health;⁶⁵ the International Federation of Red Cross and Red Crescent Societies; the National Advisory Committee on AIDS in Canada;⁶⁶ the Pan-American Health Organization (PAHO);⁶⁷ the Swiss Institute of Comparative Law;⁶⁸ by the Danish Centre on Human Rights⁶⁹ and by the Georgetown/Johns Hopkins University Program in Law and Public Health.⁷⁰

⁶³ Commission on Human Rights resolutions 1990/65, 1992/56, 1993/53, 1994/49, 1995/44 and 1996/43. Relevant reports of the Secretary-General submitted to the Commission on Human Rights are E/CN.4/1995/45 and E/CN.4/1996/44 and E/CN.4/1997/37.

⁶⁴ P. Sieghart, *op. cit.*

⁶⁵ International Federation of the Red Cross and Red Crescent Societies, *AIDS, Health and Human Rights: An Explanatory Manual*, Geneva, 1995. See, in particular, p. 43 on the Four-Step Impact Assessment of Public Health and Human Rights.

⁶⁶ HIV and Human Rights in Canada, submitted to the Minister of National Health and Welfare, January 1992.

⁶⁷ PAHO, *Ethics and Law in the Study of AIDS*, Scientific Publication No. 530, Washington, D.C., 1992.

⁶⁸ Swiss Institute of Comparative Law (Lausanne), *Comparative Study on Discrimination of Persons Infected with HIV or Suffering from AIDS*, Council of Europe, Steering Committee for Human Rights, CDDH (92) 14 Rev. Bil., Strasbourg, September 1992.

⁶⁹ Danish Centre on Human Rights, *AIDS and Human Rights*, Akademisk Forlag, Copenhagen, 1988.

⁷⁰ L. Gostin and Z. Lazzarini, *Public Health and Human Rights in the HIV Pandemic*, Oxford University Press, 1997.

7. Numerous charters and declarations which specifically or generally recognize the human rights of people living with HIV have been adopted at national and international conferences and meetings, including the following:
 - London Declaration on AIDS Prevention, World Summit of Ministers of Health, 28 January 1988;
 - Paris Declaration on Women, Children and AIDS, 30 March 1989;
 - Recommendation on the Ethical Issues of HIV Infection in the Health Care and Social Settings, Committee of Ministers of the Council of Europe, Strasbourg, October 1989 (Rec. 89/14);
 - Council of Europe, Committee of Ministers, Recommendation R(87) 25 to member States concerning a common European public health policy to fight AIDS, Strasbourg, 1987;
 - European Union, European Parliament and Council Decisions on “Europe Against AIDS” programme (including dec. 91/317/EEC and dec. 1279/95/EC);
 - Declaration of Basic Rights of Persons with HIV/AIDS, Organizing Committee of the Latin American Network of Community-Based Non-Governmental Organizations Fighting AIDS, November 1989;
 - Declaration of the Rights of the People with HIV and AIDS, United Kingdom, 1991;
 - Australian Declaration of the Rights of People with HIV/AIDS, National Association of People Living with HIV/AIDS, 1991;
 - Prague Statement, Pan-European Consultation on HIV/AIDS in the Context of Public Health and Human Rights, November 1991;

- Rights and Humanity Declaration and Charter on HIV and AIDS, United Nations Commission on Human Rights, 1992;⁷¹ South African AIDS Consortium Charter of Rights on AIDS and HIV, 1 December 1992;
- Cebu Statement of Belief, UNDP Inter-Country Consultations on Ethics, Law and HIV, the Philippines, May 1993;
- Dakar Declaration, UNDP Inter-Country Consultations on Ethics, Law and HIV, Senegal, July 1994;
- Phnom Penh Declaration on Women and Human Rights and the Challenge of HIV/AIDS, Cambodia, November 1994;
- Paris Declaration, World AIDS Summit, Paris, 1 December 1994;
- Malaysian AIDS Charter: Shared Rights, Shared Responsibilities, 1995;
- Chiang Mai Proposal on Human Rights and Policy for People with HIV/AIDS, submitted to the Royal Thai Government, September 1995;
- Asia-Pacific Council of AIDS Service Organization's Compact on Human Rights, September 1995;
- Montréal Manifesto of the Universal Rights and Needs of People Living with HIV Disease;
- Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development, March 1995;
- New Delhi Declaration and Action Plan on HIV/AIDS, Interdisciplinary International Conference: AIDS, Law and Humanity, December 1995.

⁷¹ E/CN.4/1992/82, annex.

8. The formulation of the present Guidelines is a culmination of these international, regional and national activities and an attempt to draw on the best features of the documents described above, whilst also focusing on strategic action plans to implement them. It has been noted that, although some positive measures at the national level to promote and protect human rights in the context of HIV/AIDS are in place, a dramatic gap exists between professed policy and implementation on the ground.⁷² It is hoped that these Guidelines, as a practical tool for States in designing, coordinating and implementing their national HIV policies and strategies, will assist in closing the gap between principles and practice and be instrumental in creating a rights-based and effective response to HIV.

⁷² See E/CN.4/1995/45 and E/CN.4/1996/44.

ANNEX II

List of participants of the Second International Consultation on HIV/AIDS and Human Rights

Geneva, 23–25 September 1996

Chair

Michael Kirby

Judge of the High Court of Australia, Canberra

Participants

Aisha Bhatti [Rights and Humanity, London] ■ **Edgar Carrasco** [Acción Ciudadana contra el SIDA (ACCSI), Caracas] ■ **David Chipanta** [Network of African People living with HIV/AIDS (NAP+), Lusaka] ■ **Isabelle Defeu** [International Community of Women Living with HIV/AIDS (ICW+), London] ■ **Lawrence Gostin** [Georgetown University, Law Center, Washington] ■ **Anand Grover** [Lawyers Collective, Bombay] ■ **Meskerem Grunitzki-Bekele** [National AIDS Programme, Lomé] ■ **Julia Hausermann** [Rights and Humanity, London] ■ **Mark Heywood** [AIDS Law Project, Centre for Applied Legal Studies, University of Witwatersrand, Witwatersrand] ■ **Babes Igancio** [ALTERLAW, Manila] ■ **Ralph Jurgens** [Canadian HIV/AIDS Legal Network, Montréal] ■ **Yuri Kobyshcha** [National Anti-AIDS Committee, Kiev] ■ **Joanne Mariner** [Human Rights Watch, New York] ■ **Shaun Mellors** [Global Network of People Living with HIV/AIDS (GNP+), Amsterdam] ■ **Ken Morrison** [International Council of AIDS Service Organisations (ICASO), Vancouver] ■ **Galina Musat** [Asociatia Romana Anti-SIDA (ARAS), Bucharest] ■ **Sylvia Panebianco** [Consejo Nacional de Prevención y Control del

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Observers

Jane Connors [Division for the Advancement of Women, United Nations Headquarters] ■ **Sev Fluss** [World Health Organization, Geneva] ■ **Angela Krehbiel** [NGO Liaison Office, United Nations Office at Geneva] ■ **Lesley Miller** [United Nations Children's Fund (UNICEF), Geneva] ■ **David Patterson** [United Nations Development Programme (UNDP), New York] ■ **Mari Sasaki** [United Nations Population Fund (UNFPA), Geneva] ■ **Frank Steketee** [Council of Europe, Strasbourg] ■ **Janusz Symonides** [United Nations Scientific, Cultural and Educational Organization (UNESCO), Paris] ■ **Benjamin Weil** [United Nations Development Programme (UNDP), Dakar]

Others

Geneviève Jourdan [Women's International League for Peace and Freedom, Geneva] ■ **James Sloan** [International Service for Human Rights, Geneva] ■ **Jacek Tyszko** [Permanent Mission of Poland to the United Nations Office at Geneva]

ANNEX III

List of participants of the Third International Consultation on HIV/AIDS and Human Rights

Geneva, 25–26 July 2002

Chair

Michael Kirby

Judge of the High Court of Australia, Canberra

Participants

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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