

# **ENABLING EFFECTIVE RESPONSES HIV IN PACIFIC ISLAND COUNTRIES**

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Options for Human Rights-Based Legislative Reform

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## EXECUTIVE SUMMARY

UNDP Pacific Centre, the Pacific Regional Rights Resource Team and UNAIDS jointly commissioned a legislative review of HIV, Ethics and Human Rights in 15 Pacific Island Countries — Cook Islands, Fiji, Federated States of Micronesia, Kiribati, Marshall Islands, Niue, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. The review was conducted from 2007-2009 and formed the basis for this report.

This report presents options for human rights-based legislation for the prevention and management of HIV, for protecting those already infected and those particularly affected by or vulnerable to HIV, and ensuring that people living with HIV can continue to live useful and productive lives. It has been designed specifically for the Pacific, taking into account the particular cultural contexts, constraints and opportunities presented in Pacific Island Countries.

### *This report includes —*

- some facts and considerations about HIV, why it is different from other diseases, and its effect on society;
- an explanation of the features and importance of a human rights-based approach to the HIV epidemic;
- a discussion of the traditional public health approach to disease management found in the public health laws of many Pacific countries today;
- a discussion of why a human rights-based approach is preferable to the traditional public health approach for responding to HIV;
- a discussion of various legislative reform strategies, taking into account the variety of existing legislative environments which may be the subject of reforms in the Pacific; and
- examples of implementation and enforcement mechanisms for potential new laws.

The main purpose of this report is to promote an enabling legal environment for the response to HIV. An enabling environment is one which supports effective HIV prevention, treatment, care, and support initiatives, through legislative and policy measures that —

- reduce and prevent HIV-related stigmatisation and discrimination;
- reduce the HIV vulnerability of marginalised groups, such as sex workers and men who have sex with men, by better respecting and protecting human rights;
- appropriately respond to the gendered dimensions of HIV
- decriminalise behaviours, such as sex work and homosexual sex, so as to enable more effective HIV prevention, care, treatment and support;
- establish an HIV testing regime which is voluntary and which ensures informed consent;
- protect individuals' confidentiality regarding their HIV status;
- facilitate access to HIV awareness and prevention information, materials, and services, as well as accessible, affordable and appropriate counselling, support services, care and treatment (including antiretroviral and other medicines);
- avoid using the criminal law or other coercive legal measures in ways that are counter-productive in dealing with conduct that transmits or risks transmitting HIV and uses general criminal law provisions that exist rather than introducing or using HIV specific sanctions.

## EXECUTIVE SUMMARY

The options presented in this report are consistent with international commitments made by the UN General Assembly in the Declaration of Commitment on HIV/AIDS (2001) and the Political Declaration on HIV/AIDS (2006). The options also follow best practice set out in HIV/AIDS and Human Rights: International Guidelines (the International Guidelines) and Handbook for Legislators on HIV/AIDS, Law and Human Rights (the Handbook for Legislators).

The International Guidelines have been prepared by UNAIDS in conjunction with the Office of the UN High Commissioner for Human Rights, and the Handbook in collaboration with the Inter-Parliamentary Union. Both resources are aimed to assist legislators and policy-makers to understand how human rights standards apply in the area of HIV and AIDS. The resources help identify specific, concrete measures that should be undertaken by states, domestically and internationally, to reflect those standards in legislation, policy and practice.

The options presented draw on examples of laws that have content that reflect good practices from the Pacific and other regions. The focus of this paper is on the content of laws and policies, rather than the processes used to develop them, which are beyond the scope of this publication. However, it is recognised that the process used to develop and implement law reform is equally important, and equally requires the observation of all human rights (civil and political, economic, social, and cultural), and the fundamental freedoms of all people, in accordance with international human rights standards.

This report provides Pacific Island countries with a resource which will enable them to think ahead, to learn from the experiences of other countries, and to implement a human rights-based approach in responding to HIV that guarantees safety, security and dignity for all.

### Notes on terminology and spelling:

1. *The terminology associated with HIV has undergone many changes since HIV was first detected over two decades ago, and in all likelihood will continue to do so. For some time, the term HIV/AIDS was used to indicate generally the human immunodeficiency virus, and the acquired immunodeficiency syndrome which it produces. Now that the onset of AIDS can be suppressed or significantly delayed with appropriate medication, and people are living long and productive lives with fewer manifestations of disease, the simple term HIV has gained favour. In this document, HIV is used unless it is not appropriate, or a quotation is used which employs other terminology.*
2. *Standard Anglo-Australian spelling has been used except where direct quotes are taken from documents using other variants.*

## ACKNOWLEDGEMENTS

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### The Suva Declaration on HIV/AIDS by Pacific Parliamentarians (2004)

We the Pacific Parliamentarians will review, reform and enact appropriate legislation that:

- encourages and facilitates legislative actions within our governments and constituencies, including the establishment of appropriate Parliamentary Committees to spearhead the fight against HIV/AIDS;
- promotes economic independence, equal access to resources and opportunities and a life free of stigma, violence and discrimination of the most vulnerable groups in our communities, particularly women and girls, the young and the disadvantaged;
- reinforces universal human rights legislation to protect and ensure the dignity of people living with HIV/AIDS;
- promotes an integrated response to HIV/AIDS that takes into account the interrelation between Sexual Rights and Reproductive Health Rights and prevention of HIV/AIDS and strategies that specifically focus on women and girls;
- protects in the workplace the rights of people living with HIV/AIDS and those at greatest risk of HIV/AIDS, taking into account established international guidelines on HIV/AIDS in the workplace; and further protects the rights of people in the communities and other settings.



## ACRONYMS & ABBREVIATIONS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARV</b>	Antiretroviral (drugs for treatment of HIV)
<b>ART</b>	Antiretroviral Therapy
<b>CBO</b>	Community Based Organisation
<b>ELISA test</b>	Enzyme-linked Immunosorbent Assay
<b>FSM</b>	Federated States of Micronesia
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education and Communication
<b>IJALS</b>	Institute of Justice and Applied Legal Studies, Suva, Fiji Islands
<b>OHCHR</b>	Office of the High Commissioner for Human Rights
<b>PNG</b>	Papua New Guinea
<b>PICT</b>	Provider Initiated Counselling and Testing
<b>RRRT</b>	Regional Rights Resource Team
<b>SPC</b>	Secretariat of the Pacific Community
<b>TRIPS</b>	Trade-Related Aspects of Intellectual Property Rights
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>VCCT</b>	Voluntary and Confidential Counselling and Testing
<b>WHO</b>	World Health Organization



## CHAPTER 1

# INTRODUCTION

### 1.1 About this document

This document has been prepared to assist Pacific countries in making changes to their laws and policies relating to HIV management and prevention, so as to ensure those laws and policies are sound from the perspective of both public health and human rights. It has been specifically designed for the Pacific, taking into account the particular cultural contexts, constraints and opportunities presented in Pacific countries. It is based on and is derived from an extensive review of the current HIV-related laws of 15 Pacific countries.

This document is not a model law. The HIV epidemic is more than just a health issue. It is a development issue, a gender issue, an economic issue, a political issue, a community issue and, indeed, a human rights issue — in short, HIV is a phenomenon which affects all of society. Given the structure of most Pacific legislation, it would be difficult to enact one single comprehensive law to cover all aspects of HIV prevention and management. Rather, various existing laws can be considered individually and adapted to the challenges posed by HIV. The HIV-related laws of Pacific countries vary widely. Some countries have recently reviewed their health legislation; others are still using public health laws which date back to colonial times. Some countries have incorporated HIV into their legislation; others have not. Some countries are trying to manage HIV through their existing legislative framework; others have enacted HIV-specific laws.

Because of these factors, it is difficult to prepare a single model law for all aspects of the management and prevention of HIV. Instead, this document provides examples of various legislative initiatives for the prevention and management of HIV, for protecting those already infected, and for ensuring that people living with HIV can continue to live useful and productive lives. The strategies which are most appropriate for dealing with these issues will depend on a range of factors such as; the characteristics of the legal system, existing legislation and enforcement mechanisms, the state of the epidemic, etc.

### Aims

The aim of this report is to promote an enabling legal environment for appropriate and effective response to HIV. An “enabling environment” is one which supports effective HIV prevention, care, treatment, and support initiatives, through the development and implementation of legislative measures that:

- reduce and prevent HIV-related stigmatisation and discrimination;
- reduce the vulnerability of certain marginalised groups to HIV by better respecting and protecting human rights;
- appropriately respond to the gendered dimensions of HIV
- decriminalise certain behaviours, where necessary, so as to enable more effective HIV prevention, care, treatment and support;
- establish an HIV testing regime which is voluntary, and which ensures informed consent;
- protect individuals’ confidentiality regarding their HIV status;
- facilitate access to HIV awareness and prevention information, materials, and services, as well as accessible, affordable and appropriate counselling, support services, care and treatment (including antiretroviral and other medicines);
- avoid using the criminal law or other coercive legal measures in ways that are counter-productive in dealing with conduct that transmits or risks transmitting HIV.

*This document includes:*

- some facts and considerations about HIV, why it is different from other diseases, and its effect on society;
- an explanation of the importance of a human rights-based approach in HIV epidemic management;

- a discussion of the traditional public health approach to disease management found in the public health laws of many Pacific countries today, why this approach is not effective for responding to HIV, and why a human rights-based approach is preferable;
- a discussion of various legislative reform strategies, and the applicability of different strategies, taking into account the variety of existing legislation that may require reform;
- some examples of implementation and enforcement mechanisms for the new laws.

The options presented in this document are aimed at facilitating effective HIV prevention, care, treatment and support measures. Consequently they do not for the most part recommend tough laws and penalties. Experience has demonstrated that such an approach has little or no effect on complex human behaviours, and can negatively impact on public health and HIV prevention initiatives.<sup>1</sup> However, law can enable behaviour change by working on the social and environmental factors which assist or impede change. This enabling approach is directed towards removing barriers to protective and preventive action.<sup>2</sup>

The options presented draw on examples of laws that have content that reflect best practices from the Pacific and other regions. Although the process used to development and implement law reform is also extremely important, it is beyond the scope of this paper to examine or comment on any of the processes followed in relation to any examples of laws or policies referred to in this paper.

## Format

Each topic starts with a reference to the International Guidelines. This is followed by a list of the human rights most relevant to that topic, some background to the topic, and a discussion of issues to be addressed through legislative reform. Where possible, options for legislative reform and examples of legislative approaches are included.

### 1.2 What is HIV? What is AIDS?

HIV stands for the Human Immunodeficiency Virus. HIV infects cells of the human immune system, and destroys or impairs their function. Infection with this virus results in progressive depletion of the immune system, leading to “immune deficiency”. The immune system is considered deficient when it can no longer

fulfil its role of fighting off infection and diseases. Diseases associated with severe immunodeficiency are known as “opportunistic infections” because they take advantage of a weakened immune system. Unlike other viruses such as cold and flu viruses, HIV remains permanently in the body. Left alone, it slowly destroys the body’s immune system and leads to AIDS. There is no cure for AIDS, but treatments can extend life expectancy for many years. The majority of people infected with HIV, if not treated, develop symptoms of AIDS within 8-10 years.

AIDS stands for Acquired Immunodeficiency Syndrome, and is the most advanced stage of HIV infection, in which the body’s immune system is severely impaired. People with advanced HIV infection have lower numbers of CD4+ T cells, a type of cell involved in the effective functioning of the immune system. Due to the effects of HIV, the immune system of a person with AIDS is unable to fight off certain infectious agents that generally do not affect healthy people, including bacteria, fungi, viruses, parasites, and other microbes. In people with AIDS, these infections are severe, and often fatal if untreated. People with AIDS are also particularly prone to developing various cancers, especially those caused by viruses such as Kaposi’s sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS.

AIDS renders the body defenceless against “opportunistic infections” and diseases, which if left untreated are often fatal. A person with HIV can lead a normal life, by living a healthy lifestyle and by receiving anti-retroviral therapy (ART) and other medicines to prevent or treat opportunistic infections. People living with HIV can continue to live and work as productive members of society. People living with HIV can also provide leadership in HIV responses, including through working with governments and NGOs in creating and implementing more effective prevention, treatment, care and support programmes.

HIV can be difficult to detect. Blood tests for diagnosing HIV generally test for the presence of antibodies, not the virus itself. While more rapid tests have recently been developed, in most Pacific countries only a blood test taken some time after the person has been infected will reveal the presence of antibodies. HIV antibodies usually take between one and two months to appear in your blood. The time between first

1. Norrie (1993).

2. Tawil, O, Verster, A and O’Reilly, K (1995).

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infection and the appearance of antibodies in a blood test is called the ‘window period’. During this time, the person is in the process of “seroconversion”. A test carried out on a person only recently infected, and still in the window period, may show a false negative result. The person can still transmit the virus to others during this period. The level of virus is often heightened during the seroconversion process, meaning HIV can be spread more easily during this early phase of infection.

HIV has a unique way of spreading. Unlike other diseases which can be contracted by touching other people, by sharing eating utensils and towels, or even by breathing the same air, HIV cannot be spread by this sort of casual contact. There is no danger in touching or sharing household items with people living with HIV. HIV can only be spread through:

- unprotected sexual contact;
- contact with infected blood, through such transmission routes as blood transfusions or shared syringes, razors, tattooing instruments, etc.; and
- through mother-to-child transmission during pregnancy, during birth or through breastfeeding.

These very limited modes of transmitting HIV give it another of its unique features: it is preventable in almost all circumstances. Condoms are highly effective in preventing HIV transmission. Treatment of HIV-positive pregnant women with ART can reduce the risk of mother-to-child transmission to approximately 2%.

### 1.3 Why is addressing HIV important?

There are many diseases which cause morbidity and mortality. The question is sometimes asked why so much attention is focused on HIV compared with other diseases. While the prevalence of HIV in Pacific Island countries apart from Papua New Guinea is currently low, there is the potential for a significant increase in HIV infections and AIDS deaths. Pacific Island countries are already experiencing epidemics of STIs, which have the potential to accelerate the spread of HIV. The time to act is now, while we still have the opportunity to maintain low levels of HIV infection, and perhaps even reduce them.

HIV epidemics can remain relatively dormant for years, before entering a growth phase. This has been seen

in countries in Eastern Europe and there have also been recent increases in HIV infections in some western countries with over 20 years experience of responding to the epidemic. The consequences of HIV can significantly impact the health and development of nations. Economic analyses have shown that investment in prevention programmes now can save many times the amount spent through averting future health care costs. Addressing the epidemic now will save lives, protect the workforce and save money that would otherwise be needed for expensive antiretroviral drugs and treatment, care and support services.

### 1.4 The HIV pandemic

A total of 33 million people were living with HIV globally in 2007. This figure includes the estimated 2.7 million people who were newly infected with HIV in 2007.

But if HIV is totally preventable, why has its spread resulted in a global pandemic? Why is it now one of the most formidable development challenge facing the world? There have been other major epidemics throughout human history, but because of its special characteristics, HIV is unique. It cannot be managed in the same way as any other dangerous, life-threatening disease.

*The factors which make HIV different from other diseases and therefore mean that a different response is required are;*

- it is not spread by casual contact;
- it may not be immediately detectable;
- it is not eliminated by disinfection or fumigation, or by isolation of infected persons;
- it is not curable, but it is manageable;
- it is associated with sexual taboos and stereotypes about sexual behaviour, as well as with taboos about other behaviours.

*UNAIDS has pointed to three factors which make this epidemic exceptional:*<sup>3</sup>

1. The epidemic continues to spread. This demonstrates that traditional epidemic control techniques are not appropriate for HIV. The challenge is to find new strategies and methods which will work.

3. Piot, P. (2005).

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2. The social impact of the epidemic is severe and long-lasting. Because it is mainly spread by sexual contact, it primarily kills off young adults who are sexually active. They are both the driving force for economic growth and the progenitors of future generations. Without them, societies are stressed beyond normal expectations. Poverty increases, without their productive labour. Society disintegrates without stable families to help hold it together.

3. Because of HIV's unique transmission characteristics, the epidemic poses special challenges to effective social action. Societies must address the most sensitive issues connected to sexuality, such as:

- gender inequality;
- early and forced marriages;
- harmful traditional practices;
- commercial sex, both male and female;
- men who have sex with men;
- sexual violence within and outside marriage;
- polygamy
- domestic violence
- sexual and reproductive health rights.

All of these issues are already surrounded by deep stigma and discrimination. This must be confronted and dealt with if the HIV epidemic is to be stopped.

### 1.5 HIV in the Pacific

HIV was first reported in the Pacific Island region in 1984. There were estimated to be 54,000 people living with HIV in Papua New Guinea in 2007<sup>4</sup>, which is by far the country with the highest HIV burden in the Pacific region. None of the other Pacific Island Countries and Territories have reported more than 300 HIV cases since testing started. Over 95 per cent of HIV infections have occurred in five Pacific Island Countries and Territories: French Polynesia, Guam, New Caledonia, Fiji Islands and Papua New Guinea. In addition, there are almost certainly many unreported cases throughout the region. Although the number of cases remains low outside Papua New Guinea, there is an upward trend in the region as a whole. Some countries, such as Fiji Islands, have reported steep rises in new HIV diagnoses since 2000.

It is widely recognized that HIV and AIDS have the potential to decimate not only the health status of Pacific populations but also the social and economic fabric underpinning our communities. If the spread of infection goes unchecked, it will place high and unaffordable demands on countries and territories in the region.

*The Pacific Regional Strategy on HIV/AIDS 2004-2008*

*The same HIV risk factors extend throughout the Pacific, including:*

- high rates of other sexually transmitted infections (STIs), which due to biological factors increase the risk of HIV being transmitted;
- low levels of condom use;
- the large number of young people in the region;
- significant movement of people into, through and out of the region;
- taboos that constrain frank discussion of sex and sexuality;
- denial at the national level, because low numbers of reported infections cause society to believe they are safe;
- denial at the individual level, because people believe it may happen to others, but not to them if they lead good lives;
- inadequate health care and testing facilities;
- stigma and discrimination against people living with HIV, sex workers and men who have sex with men;
- gender inequalities and gender-based violence.

Pacific Island countries are becoming aware in general terms of the threat posed by HIV, which can have a devastating effect on island populations. But there is comparatively little information on how to deal with the epidemic at a national and regional level. Health professionals know how to account for HIV transmission, how to conduct HIV tests, how to manage disease, administer drugs and alleviate symptoms. But they do not know how to provide the means by which entire societies can manage and prevent the epidemic. It takes nation-wide initiatives, spearheaded by the leaders of society, to achieve

4. Joint United Nations Programme on HIV/AIDS (2008b).



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effective HIV management and prevention. Some of these initiatives require new ways of thinking, new ways of behaving, and new ways of relating to one another. Some of these require new laws, or changes to old laws.

### 1.6 The importance of human rights

Human rights are universal, indivisible, interdependent and interrelated.<sup>5</sup> Although Pacific countries have different historical, cultural, customary and religious backgrounds, they all have the duty to promote and protect universal human rights and fundamental freedoms.

In response to the increased interest shown by United Nations agencies in incorporating human rights into programmes, in 2003 the UN issued a “common understanding” on human rights-based approaches intended to guide development programmes.<sup>6</sup>

*The elements of a human rights-based approach are that:*

- all programmes should intentionally further human rights;
- all development efforts, or all levels of programming, are guided by human rights principles found in international human rights law; and
- all development efforts must build the capacity of human rights “duty bearers” to meet their obligations, and of “rights holders” to claim and enjoy their human rights.

*Core concepts include:*

- explicit reference to a human rights framework – presenting a normative, legal foundation, that frames demands as legitimate claims on governments and society, through participatory processes, as well as legal/quasi-legal ones;
- emphasis on capacity-building, shifting the approach from one that focuses only on violations of rights to one that also focuses on fulfilment of human rights, good governance and social development.

Abuse of human rights and fundamental freedoms associated with HIV has emerged in all parts of the

world in the wake of the epidemic.<sup>7</sup> The protection of human rights is essential to safeguard human dignity in the context of HIV, and to ensure an effective, rights-based approach to HIV.<sup>8</sup> An effective response requires the implementation of all human rights (civil and political, economic, social, and cultural), and the fundamental freedoms of all people, in accordance with international human rights standards. It also involves establishing governmental institutional responsibilities, implementing law reform, and promoting a supportive environment for people living with HIV, and for groups vulnerable to HIV infection. This approach may require governments to consider controversial measures, particularly regarding the status of women and children, sex workers, men having sex with men, and injecting drug users.

Over two decades of experience in addressing the HIV epidemic have confirmed that the protection and promotion of human rights are necessary both to the protection of the inherent dignity of people living with HIV, and to the achievement of the public health goals of reducing vulnerability to HIV infection, lessening the impact of HIV and AIDS on those affected, and empowering individuals and communities to respond to HIV.

*A lack of human rights protection fuels the epidemic in numerous ways:*

- Discrimination increases the impact of the epidemic on people living with HIV and those presumed to be infected, as well as their families and associates. For example, a person who is terminated from his or her job on the basis of being HIV-positive is faced with many problems. Not only do they face the potential of daily discrimination, they also have no income. They may be faced with the extra economic burdens of additional health care.
- People are more vulnerable to infection when their economic, social or cultural rights are not respected. For example, someone who has been thrown out of their home or banished from the village, may be separated from former sources of support (such as family), and hence more likely to engage in activities which place his or her health at risk (such as unsafe sex).
- Where civil and political rights are not respected — for example, freedom of speech and association is curtailed — it is difficult for civil society to

5. Vienna Declaration and Programme of Action: Report of the World Conference on Human Rights, UN Doc A/CONF.157/23 (1993).

6. The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies Interagency Workshop on Human Rights Based Approach in the Context of UN Reform 3-5 May 2003.

7. International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, at p. 15.

8. Organized jointly by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, Geneva, 23-25 September, 1996.

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respond effectively to the epidemic. In some countries peer education is hampered by laws that refuse official registration to groups with certain memberships (for example, sex workers). In these cases, a meeting of an NGO or community-based organisation with such a membership would be viewed as an illegal activity. Peer education is also hampered where the harassment or intimidation of outreach workers is sanctioned or ignored by the legal system.

*Since the beginning of the HIV epidemic, it has been recognized that:*

- HIV-related stigma and discrimination are major obstacles to scaling up HIV prevention, care and treatment;
- protection of human rights, both of those vulnerable to infection and those already infected, produces positive public health results;
- responses will not work without the full engagement and participation of those affected by HIV, particularly people living with HIV;
- the human rights of women, young people and children must be protected if they are to avoid infection and withstand the epidemic's social impacts;
- the human rights of marginalized groups, including those engaging in activities deemed immoral or illegal, must also be respected for the response to HIV to be effective.

### **Human rights and public health share a common goal**

*Human rights and public health share the common goal of promoting and protecting the well-being of all individuals.*

Public health provides an additional compelling justification for safeguarding human rights: the protection of these rights and freedoms ensures the protection of public health. Human rights and public health share the common objective to promote and 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. An environment in which human rights are respected ensures that:*

- vulnerability to HIV is reduced and efforts to prevent the spread of HIV are more effective;
- those infected with and affected by HIV can live a life of dignity without discrimination; and
- the personal and societal impact of HIV infection is alleviated.

*An approach which does not respect and uphold human rights will increase the spread of HIV.*

Fear of discrimination as a result of simply taking a test, or of a positive diagnosis, prevents people from coming forward for testing and counselling. Therefore, assurances of confidentiality and non-discrimination are critical. Confidentiality is a very important consideration in Pacific Island communities.

States are bound to follow a human rights based approach to HIV, due to their obligations under international law, and in relation to the rights and freedoms guaranteed in national Constitutions. Pacific countries have recognised this in affirming the protection and promotion of human rights as one of the overarching principles of the Pacific Regional Strategy on HIV and other STIs 2009-2013<sup>9</sup> and echoed in the Pacific Plan as a regional priority for implementation.<sup>10</sup>

Human rights approaches to HIV are not abstract, they are practical and cost-effective. Countries which have placed human rights at the centre of their HIV responses have seen epidemics averted or slowed. States which breach human rights and take an

9. Secretariat of the Pacific Community (2008).

10. Pacific Islands Forum Secretariat (2005).



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oppressive approach to HIV management are seeing increases in infections. The international NGO Human Rights Watch lists many such countries, including Russia, Bangladesh, China and Ukraine. Uganda, which once had great success in reducing its HIV prevalence rate through respecting the rights of all to access life-saving preventive measures, is now shifting its approach from scientifically proven community-based and comprehensive prevention programmes to ideologically driven abstinence-only programmes, and statistics of infection rates are rising again. Human rights violations and inadequate health and social welfare policies are undermining progress in the fight against HIV in Zimbabwe.<sup>11</sup>

### Applying public health laws to HIV

The first steps in HIV epidemic management in many countries consisted of applying existing public health laws to HIV. By the early 1990s, some Pacific countries moved to include HIV and AIDS as 'infectious', 'communicable', 'notifiable' or 'venereal' diseases under existing public health legislation. These laws were based on old public health law models that were not rights-based and contained draconian powers of compulsion and punishment. These laws were formulated for managing venereal diseases and infectious or communicable diseases such as measles, typhoid and tuberculosis, which could be controlled and often eliminated through stringent testing, treatment and quarantine methods.

*The management measures in these laws typically included:*

- obligatory reporting and compulsory testing of suspected cases;
- isolation and confinement, in hospital or even special quarantine camps;
- disinfection of houses, clothing, public transport etc. to eliminate the pathogen;
- notification to all those in danger from contact with the infected person;
- criminal penalties for inappropriate activity by those infected e.g. infected persons were banned from food preparation, sharing accommodation, using public transport, landing from inbound ships and so on.

The difficulty with this public health approach is that HIV is not the same as other infectious diseases. Old public health approaches enabled the confinement of infected people in hospitals or quarantine camps, until they were cured. Isolation has sometimes been proposed for "managing" people with HIV: test everyone, and then isolate those who are infected. Such an approach has not been applied in the Pacific, although inclusion of HIV in public health laws has made it theoretically possible. The suggested use of punitive interventions for HIV often relies on mistaken beliefs about the nature of the epidemic. This approach is not appropriate for HIV, because:

- HIV is not spread through casual contact, so there is no need to isolate someone only on the basis of their HIV status;
- there is no cure for HIV, so those isolated would be there permanently, while others will continue to become infected;
- rather than sending the message that everyone needs to take precautions against HIV spread, isolation would demonise those who are isolated and give the public a false sense of security leading to complacency;
- testing will not necessarily reveal accurately who is and is not infected, due to the window period between infection and the production of antibodies to the virus.

*Isolation and quarantine can jeopardise public health and welfare because;*

- people will not come forward to be tested, counselled and treated for fear that they will be denounced, banished, quarantined or attacked;
- behaviour change is more effectively achieved through education and encouraging the voluntary cooperation of people at risk with testing and counselling, rather than through threat and compulsion;
- people at risk of HIV may avoid using HIV prevention measures such as condoms for fear that others will assume they are HIV positive, thereby exposing themselves and others to greater risk of infection;
- stigma is reinforced by applying or threatening to apply punitive measures, both at the individual level, and in the national response to the epidemic.

11. Human Rights Watch (2006b); Treatment Action Campaign (2008).

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Pacific countries are in the process of modernising public health legislation to take into account new models of public health management that incorporate rights-based approaches. Legislation is being developed (such as the HIV/AIDS Management and Prevention Act 2003 (PNG)) that emphasises informed consent, confidentiality, voluntary cooperation of populations in prevention and testing programs, and use of coercive powers only as a last resort and with due process protections in place. These laws are further discussed in Chapter 4 below.

### The role of the law

It is important to place the focus on HIV-related laws in a broader context. Laws have an educative and normative role, and should provide a supportive framework for protecting human rights and creating a supportive environment for effective HIV programmes. However, laws cannot be relied upon as the only means by which to educate, change attitudes, support HIV programmes, or protect people's rights. While a supportive legislative environment is essential, other measures are also necessary.

Laws must not only be enacted, they must be implemented and this requires the development of appropriate policies and administrative structures. Communities need to be educated about rights under the law and how to access the justice system. Courts and legal advice need to be accessible and affordable for populations most at risk of HIV.

Law is one mechanism necessary to foster social change. It is necessary but not, by itself, sufficient. It must be accompanied by political will to give effect to new legislation, a comprehensive national framework for the response to HIV, mobilisation of communities affected by HIV to lead prevention and care efforts, a commitment to community partnerships including with people living with HIV, and the allocation of resources where they will have the greatest impact.

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS.

*United Nations General Assembly Special Session on HIV/AIDS, Declaration of Commitment on HIV/AIDS (para. 58)*

*The role of the law in HIV responses has been recognised by the UN General Assembly in the Political Declaration on HIV/AIDS (2006) which commits states:*

- to enact, strengthen or enforce, legislation to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups;
- to ensure that people living with HIV and members of vulnerable groups have access to education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and
- to developing strategies to combat stigma and social exclusion connected with the epidemic.

### 1.7 Leading texts for a rights-based approach

The rights-based approach to responding to HIV and AIDS is described in the publication *HIV/AIDS and Human Rights: International Guidelines (the International Guidelines)*<sup>12</sup> and elaborated upon in the *Handbook for Legislators on HIV/AIDS, Law and Human Rights (the Handbook for Legislators)*.<sup>13</sup>

#### International Guidelines on HIV/AIDS and Human Rights

The International Guidelines first appeared in 1998, as the outcome of a series of consultations between UNAIDS and the Office of the United Nations High Commissioner for Human Rights. The Consultations brought together experts in the field of 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, representatives of United Nations bodies and agencies, non-governmental organizations and AIDS service organizations. There are 12 Guidelines, the implementation of which through concrete measures will support both human rights and public health in the context of HIV. In 2002, the Guidelines were revised to take account of the legal and human rights issues arising from the development of effective treatments for HIV. This resulted in a new Guideline 6, and the revised Guidelines have now been reissued in a "consolidated version".

12. OHCHR and UNAIDS (2006).

13. UNAIDS and Inter-Parliamentary Union (1999).

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### **Handbook for Legislators**

Following the publication of the International Guidelines, the Inter-Parliamentary Union (IPU) and UNAIDS jointly produced the Handbook for Legislators. Its purpose is to assist legislators to take action and make decisions on HIV-related law and policy reform, by providing information on the critical role of human rights in the overall response to the epidemic. Detailed and practical guidance on HIV-related law and policy reform is provided. The Handbook gives practical examples of implementation of the International Guidelines from around the world.

Both of these documents are available for download from the UNAIDS website. The options presented in this report are based on these two texts. They provide a guide for legislation based on existing international human rights standards and promote a pragmatic approach to public health goals related to HIV and AIDS. Each country must determine how it can best meet its international human rights obligations and protect the public health within its own political, cultural and religious context, in accordance with international human rights norms and standards.

# DEVELOPING NATIONAL HIV STRATEGIES; APPROACHES TO LAW REFORM

## GUIDELINE 1: NATIONAL FRAMEWORK

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

## GUIDELINE 2: SUPPORTING COMMUNITY PARTNERSHIPS

States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS 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.

### 2.1 Introduction

This chapter considers the actions which governments should take to establish an effective national framework for their response to HIV, to ensure the meaningful involvement of people living with and affected by HIV in the national response, and to establish a supportive environment for community organizations working on HIV issues.

### 2.2 National Framework

The HIV epidemic needs a multi-sectoral response. While health ministries will often take the lead, the response cannot be left to health ministries alone. Over 20 years' experience has taught us that HIV has the potential to affect all aspects of national life and government responses should integrate HIV and human rights into a range of sectors, including:

- education;
- law and justice, including police and corrective services;
- employment and public service;
- welfare, social security and housing;
- immigration and foreign affairs;
- health;

- treasury and finance;
- science and research; and
- defence, including armed services.

National governments must ensure, through mechanisms such as high level multi-sectoral forums and co-ordination mechanisms that all relevant government sectors are involved. In addition, civil society must be fully involved, including people living with and affected by HIV and representatives from communities or groups particularly vulnerable to HIV which might be marginalised or subject to infringements of their human rights.

*Effective national policies and procedures should be:*

- across all branches – executive, legislative, judicial;
- developed and implemented at all levels, from national to local;
- multi-sectoral – across departments.

*The reasons for this are:*

- to clarify the respective roles of agencies;
- to ensure a comprehensive and multi-sectoral response rather than a health-based response to the epidemic; and

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- to ensure human rights are adequately considered, costed and budgeted across portfolio responsibilities.

This can be approached through the establishment of inter-sectoral working group, ministerial or parliamentary advisory committees or other interagency planning and policy mechanisms.

Human rights based legislative reform will only be successful with the involvement of civil society. This includes NGOs and community based organisations, people living with HIV, vulnerable groups, faith based organisations, women's groups and youth groups. Community based organisations are better placed than government agencies to reach vulnerable groups. It is critical to ensure that groups at risk and affected by the epidemic are involved. These groups have a unique position of trust, and direct knowledge and experience of how their communities experience and confront the HIV epidemic, and what strategies are most likely to succeed for HIV prevention, care, treatment and support within their communities. The active, free and meaningful participation of vulnerable groups, particularly the most marginalised, is an essential element of a human rights-based approach.

Failure to involve civil society and members of marginalised communities from the outset will result in legislation which may not truly take into consideration the interests and human rights of these groups, or lack sensitivity to issues which are relevant to specific cultures and countries. This may result in resistance to reforms, or a lack of cooperation in implementation at the community level.<sup>14</sup>

Structures need to be created to enable community consultation in all phases of HIV policy and programme design, implementation, and evaluation. This could occur by including community representatives in ministerial, parliamentary and advisory forums, both by formal attendance, and also by inviting written and oral submissions on particular issues under consideration.

The type of agency responsibility adopted depends very much on the resources available to each country. Papua New Guinea established a National AIDS Council as an autonomous statutory body under its own Act. In the Philippines, a National AIDS Council was established by legislation. This multi-sectoral body of 26 members includes several Parliamentarians, representatives from six NGOs, one person living with HIV, two medical organizations, and the heads of the

following government departments or agencies: health; education; employment; social welfare; interior and local government; justice; economic development; tourism; budget management; foreign affairs; and information.

Many Pacific countries may only have the resources to establish a desk within the Ministry of Health, for example. In that case, it is essential to ensure that there are adequate mechanisms and sufficient communication systems in place to enable a truly multi-sectoral approach. UNAIDS recommends a single representative, multisectoral national coordination and advisory body which should include expertise to address legal, ethical and policy issues from a human rights perspective.

An example of a multi-sectoral coordinating body is the Pohnpei HIV Council, established by the Pohnpei HIV Prevention and Control Act of 2007 (Pohnpei Code Title 17, Chapter 6A – 180-182). The Act provides for a Council which will oversee an integrated and comprehensive approach to HIV prevention and care in Pohnpei. Membership of the Council will include the Directors of Departments of Health Services, Education, the General Manager of the Pohnpei Port Authority, representatives of the youth and women's groups of Pohnpei, a person living with HIV, a representative of the International Red Cross, Chief of Primary Health Care Division.

*The Council is responsible for overseeing the development of:*

- state wide information and education campaigns;
- establishment of a comprehensive HIV monitoring system;
- guidelines on medical and other procedures carrying a risk of HIV transmission;
- the provision of accessible and affordable HIV testing and counselling for all those in need;
- the provision of health and support services in hospitals and in communities;
- promotion and protection of the rights of people living with HIV;
- strict observance of medical confidentiality;
- monitoring implementation of rules and regulations of the Act, issue such rules or regulations, or make recommendations to relevant implementing agencies.

14. Handbook for Legislators p.34.



### 2.3 Supporting community partnerships

Governments must actively involve communities at risk and affected by the epidemic in all aspects of the response. Affected communities contribute their unique experience of how and why HIV infection occurs, how to reach vulnerable communities with prevention and care programmes. People living with and affected by HIV have a right to be involved in solving the problems posed by the epidemic. Contributing experience and expertise can also remind people from affected communities just how valuable they are, and can help counter internalized feelings of stigma or low self worth which are the product of external stigma and discrimination. At the societal level, public acknowledgment of the expertise brought by the involvement of people affected by the epidemic helps reduce stigma and discrimination, and reminds us that people living with and affected by the epidemic are an essential part of the response.

At the 1999 Paris AIDS Summit, national governments of 42 countries declared that the principle of the greater involvement of people living with HIV/AIDS (GIPA) is critical to ethical and effective national responses to the epidemic.

*At its most basic, GIPA means two important things:*

- recognizing the important contribution that people living with or affected by HIV can make to responses to the epidemic; and
- creating opportunities within society for their involvement and active participation.

Structural means need to be created to enable community involvement in the design, implementation, and evaluation of HIV/AIDS policies and programmes. This can occur by supporting the inclusion of community representatives on ministerial, parliamentary, and advisory forums. Human rights protection should be a central feature of this involvement. Fear of discrimination, and public disclosure of one's positive HIV status, can be significant impediments to community mobilization and involvement. It must be stressed that GIPA does not necessarily mean disclosing one's HIV status, or membership of an at-risk population. Creating an enabling environment for the involvement of affected communities requires that community representatives have the right to choose whether they will disclose their status, and structures which genuinely promote the involvement of affected communities must also ensure that the right of confidentiality is respected.

In addition to ensuring that human rights are respected, financial and technical support may be required to enable community representatives to actively engage in the response to HIV. Community organizations need adequate funding, and may also need capacity building both within their organizations, and as community representatives participating in external forums.

### 2.4 Legislative Reform Strategies

#### 2.4.1 Factors influencing a National Legislative Reform Strategy

*An appropriate national legislative strategy depends on various factors, including*

- existing laws regarding HIV;
- existing laws on related matters (such as discrimination, privacy and constitutional Bills of Rights);
- existing laws relevant to gender equality, including gender based violence;
- the level of communication and cooperation between various government departments and agencies;
- how easy it is to legislate a package of reforms as opposed to a single comprehensive law.

Various approaches are outlined in this section, with more detailed discussion of how different options have been used by governments in section 2.4.2.

*Some approaches that have been used include:*

- development of one comprehensive HIV-specific statute covering all relevant legislative issues;
- amendments to the relevant sections of existing laws, and the introduction of new laws to fill any gaps in legislative frameworks;
- where HIV has already been included in existing health legislation using a traditional public health approach to disease management: removal of HIV from the public health legislation; or revising the legislation to accommodate a rights-based management strategy; and
- A combination of the above approaches, such as a comprehensive set of HIV-related legislative provisions in one Act, together with amendments to additional relevant acts, which are more appropriately dealt with by separate legislation.

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The aim of legislative reform is to create an enabling environment for a comprehensive rights-based response to HIV. The overriding consideration is to ensure that all substantive issues have been dealt with in a way that promotes a rights-based response to HIV. The substantive issues are considered in detail in chapters 3-6.

A statement of principles included in an Act can serve as a useful reminder of the intention to take a rights-based approach, as well as an aid to interpretation of specific provisions of the Act.

A similar “declaration of policies” is included at the commencement of the Pohnpei HIV Prevention and Control Act of 2007.

Care must be taken with the use of regulations as a tool for legislative change. Only some matters can be appropriately dealt with by regulation, which is subordinate to legislation and cannot override or displace Acts. A prohibition against mandatory testing, for example, should not be dealt with by regulation. As a key element of a rights-based approach, this issue should be clearly spelt out in an Act. For additional clarity, the Act can include a provision that the prohibition against mandatory testing overrides any prior laws or regulations which are inconsistent with it. This approach promotes compliance with human rights principles across the legal system.

A displacement provision, which states that a specified provision of another statute does not apply to HIV-specific matters, is a useful device when it is not the intention to repeal the entire provision of another statute.

### Example

*AIDS is a communicable disease caused by the HIV virus, which is recognized as having no territorial, social, political, and economic boundaries, and there is no known cure. The epidemic has serious impact on social security, stability, and socio-economic development and requires a multi-sectoral response to be undertaken by the State in order to:*

1. *Promote nationwide public awareness, through extensive IEC activities and mass campaigns, about the fact of HIV such as modes of transmission, consequences, means of prevention and control of the spread of the disease;*

2. *Prohibit all kinds of discrimination against those persons suspected or known to be infected or affected by HIV;*
3. *Promote universal precautions on those methodologies and practices which carry the risk of HIV transmission;*
4. *Appropriately address all determinants which drive the HIV epidemic;*
5. *Promote the potential role of people living with HIV for their greater involvement by disclosing of information and sharing their own experiences to the public;*
6. *Make HIV prevention and control programmes a priority in the national development plan.*

*Law on the Prevention and Control of HIV/AIDS 2002  
(Cambodia) Article 2.*

### Example:

*Examples of “displacement provisions” amending existing legislation to ensure they do not infringe HIV-related human rights:*

1. *HIV and AIDS are not infectious/notifiable/venereal diseases for the purposes of the Public Health Act.*
2. *The provisions of Section x of the Quarantine Act do not apply to HIV or AIDS.*

### 2.4.2 Various Pacific approaches<sup>15</sup>

1. **Papua New Guinea** enacted the *HIV/AIDS Management and Prevention Act* 2003 (the HAMP Act) with the National AIDS Council as lead agency. The HAMP Act covers HIV-discrimination, informed consent to testing, counselling, confidentiality and contact-tracing, wilful and reckless transmission, access to means of protection, HIV-related research, displacement of effects of censorship and pornography laws, quarantine laws and venereal disease provisions of the *Public Health Act*, and enforcement mechanisms for all these.

Safety of the blood supply and limitation of liability of those involved in blood transfusions

15. In November 2009, the Interim Government of the Republic of the Fiji Islands began national consultations on a draft HIV Prevention and Treatment Decree. It has not been possible to include details on that draft decree in this publication.

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was achieved by amendments to the *Public Health Act*. Amendments to the rape provisions of the *Criminal Code* were achieved in 2002 as part of a broader exercise to enact laws to make sexual assaults gender-neutral, and to introduce provisions for the protection of children from sexual abuse, including their use for sex work and pornography, as required by the Convention on the Rights of the Child.

Other amendments to the criminal law (such as repeal of laws criminalising sex work, and male-to-male sexual behaviour when it takes place between consenting adults in private) and the *Patents Act* have not yet taken place.

2. **Marshall Islands** enacted the *Communicable Diseases Prevention and Control Act* 1988 to provide for the reporting, identification, prevention and control of communicable diseases, including STIs, HIV and AIDS. This law addresses discrimination and confidentiality, mandates sex education in schools, and requires counselling in appropriate situations. However, it also infringes human rights in several ways, e.g. by requiring mandatory testing of specified groups; mandatory contact-tracing; and HIV screening of immigrants staying longer than 30 days. These provisions could easily be repealed without disturbing the main thrust of the Act.
3. **Cook Islands** included HIV and AIDS in its recent *Public Health Act* 2004. This Act follows the traditional public health approach, which does not acknowledge or follow human rights principles. Amendment of the Act to incorporate a human rights based approach would contribute to an improved enabling environment for the Cook Islands' response to HIV.
4. **Pohnpei** enacted the *HIV Prevention and Care Act* of 2007, introducing a new Chapter into the Pohnpei Code dealing with a range of HIV-related issues including:
  - HIV education in schools, at health services, in the workplace, for Pohnpeians going abroad, and in communities, including a requirement that appropriate information on correct usage accompany all condoms distributed, whether through sale or donation;
  - penalties for misleading information regarding HIV prevention and control, and a requirement

that any promotional marketing of drugs, devices, agents or procedures must receive prior approval through the Department of Health Services;

- infection control for blood, organ, or tissue donation;
- infection control during medical procedures;
- a prohibition against compulsory testing, except where a person is charged with endangering another person with HIV infection;
- a provision for anonymous testing with a guarantee of confidentiality;
- a requirement for pre- and post-test counselling provided by people meeting standards set by the Department of Health;
- a monitoring and surveillance system which respects confidentiality and cannot be used as the basis for employment, school attendance, freedom of abode, or travel;
- prohibition of discrimination in workplaces, schools, public service, and access to credit and insurance services, with penalties for discriminatory acts contrary to law.

To integrate a human rights approach, the Pohnpei HIV Prevention and Care Act 2007 includes a declaration of policy at the outset:

The state shall extend to every person believed to be or known to be infected with HIV full protection of his or her human rights and civil liberties. Towards this end:

- (a) compulsory testing shall be considered unlawful unless otherwise provided by this Chapter;
- (b) the right to privacy of individuals with HIV shall be guaranteed;
- (c) discrimination, in all its forms and subtleties, against individuals with HIV, or persons perceived or believed as having HIV shall be considered inimical to individual and state interest;
- (d) provision of appropriate health and social services for individuals with HIV shall be assured.

*Pohnpei Code, Title 17 Chapter 6A 102(2)*



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### 2.4.3 Examples from other countries

Several countries have chosen the approach of a comprehensive statute covering a wide range of HIV legislative issues, supported by detailed implementing regulations. One of the first examples of this approach is the *Philippines AIDS Prevention and Control Act 1988 (Republic Act No. 8504)* and accompanying implementing regulations (*Rules and Regulations Implementing Republic Act No. 8504*). Examples of this approach can also be found in Cambodia<sup>16</sup> and Vietnam<sup>17</sup>. The *Philippines Act and Regulations* deal with the following topics:

#### Act

- HIV education to be provided: in public and private schools at intermediate, secondary, and tertiary levels; through the provision of health care services; in workplaces; for workers going abroad; for tourists entering the country; in local communities; and in connection with the sale or other distribution of condoms;
- infection control procedures to ensure HIV prevention during blood, organ, and tissue donation, as well as during surgical procedures;
- a requirement that HIV testing be voluntary and subject to written informed consent; compulsory testing is prohibited except in limited circumstances (such as proceedings concerning certain criminal charges) prescribed by the Act; a right to anonymous testing, and to pre-test and post-test counselling by government-accredited counsellors;
- protection of confidentiality including in health care and in epidemiological monitoring (which must use coded identifiers rather than names when reporting HIV and AIDS diagnoses);
- a right of access to basic health care services;
- contract tracing, which may only be performed by the Department of Health, must respect confidentiality; and must not be used for any purposes in connection with qualification for

employment, education, freedom of abode, or travel;

- a prohibition against discrimination in connection with education, freedom of abode, lodging and travel; the right to seek public office; access to credit and insurance services provided that a person's HIV status is not misrepresented upon application for credit or insurance; the provision of burial services;
- the Philippines National AIDS Council is reconstituted under the Act as the central advisory, planning, and policy-making body for a comprehensive and integrated national HIV prevention and control programme.

#### Regulations

*The Regulations which accompany the Act<sup>18</sup> provide guidelines, standards, and procedures to facilitate implementation of the Act, and to achieve the objectives as stated in the Act. Further detail is provided on topics such as:*

- HIV education: the purpose, content, modes of delivery, training of educators, development of "prototype" education curriculum, education in different settings such as schools and workplaces, "misleading" information and the penalties which can be applied to persons involved in disseminating such information.
- safe practices and procedures: guidelines for universal infection control procedures in health care settings including surgical and dental procedures, and blood, organ, and tissue donation; penalties applicable for breaches of required standards.
- testing, screening and counselling: the requirement for written informed consent; prohibitions on compulsory testing and exceptions to the prohibition; procedures to be used where a person requests an anonymous HIV test; procedures and standards for accrediting HIV testing centres; details of requirements for pre-test and post-test counselling.
- health and welfare services: detailed requirements for the provision of hospital-based services (including a Standard Operating Procedures

16. *Law on the Prevention and Control of HIV/AIDS (2002); and Implementing Guidelines of the Law on the Prevention and Control of HIV/AIDS, National AIDS Authority of Cambodia, 2005.*

17. *Law on Prevention and Control of HIV/AIDS (2007) and Government Decree Elaborating Some Articles of the Law on Prevention and Control of HIV/AIDS (2007).*

18. *Rules and Regulations Implementing the Philippines AIDS Prevention And Control Act of 1998 (RA 8504).*

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Manual); community-based services; livelihood programmes and training; control of sexually transmitted diseases; and creation of a Taskforce to study the feasibility of offering a package of insurance services to people living with HIV.

- epidemiological monitoring: establishing a monitoring programme within the Department of Health; requirements for reporting procedures and contact tracing.
- confidentiality: in the context of medical care; releasing HIV test results; penalties for violating confidentiality; the requirement to disclose a positive diagnosis to one's spouse or sexual partner, and the health care services available to support a person through this process;
- discrimination: detailed explanation of the legislative prohibitions against discrimination contained in the Act;
- Philippines National AIDS Council: functions, membership (including method of appointment), subcommittees, secretariat, and reporting requirements;

### **Relevant Department of Health Administrative Orders:**

Those administrative orders which are considered "integral" to the implementing rules and regulations are listed for the purposes of clarity.

### 2.4.4 Legislative reform proposals

The proposals for legislative reform in the following chapters are set out according to the order in which they are addressed by the *International Guidelines*. This order is not necessarily advised for the actual preparation of legislation. Each country's strategy for legislative change should be tailored to reflect country priorities, the state of the HIV epidemic, the existing legislative framework, and the format of relevant legislation in each country.

*The reform topics reviewed are presented as follows:*

- Each chapter begins with the relevant guideline from the *International Guidelines*, together with a list of the human rights principles relevant to the guideline.
- This is followed by a short discussion of how implementing the guideline will contribute to an enabling environment for responding to the HIV epidemic.
- The chapter then considers the various legislative and policy measures which should be taken to implement the guideline. While the guideline provides a broad statement of principle, a number of measures are generally needed to implement each guideline. This section includes discussion of why a human rights based approach is important for each of the necessary measures identified, using relevant text from the *International Guidelines* and the *Handbook for Legislators*. Examples are provided of relevant legislation and policies from various jurisdictions, with a focus on examples from Pacific Island countries where possible.

## CHAPTER 3:

# ENSURING PUBLIC HEALTH LAWS ARE HUMAN RIGHTS COMPLIANT

## GUIDELINE 3: Public Health Legislation

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

### 3.1 Relevant human rights

- right to life
- right to liberty
- right to privacy
- right to security of the person and bodily integrity
- right to equality and freedom from discrimination
- right to education and information
- right to freedom of association
- sexual and reproductive health rights

### 3.2 Background

Inclusion of HIV and AIDS in existing public health laws was the initial measure taken by many countries, including in the Pacific. The objective of public health laws should be to prevent the spread of disease through education and preventive measures, while ensuring that the human rights of those infected and affected are protected. Traditional public health measures such as mandatory testing, disinfection of dwellings, confinement in quarantine areas, and isolation in hospital, are not effective for HIV management. Applying traditional public health measures to HIV can also compound stigma and undermine efforts to reach populations most at risk.

The recommendations included under Guideline 3 of the *International Guidelines* are not necessarily confined to public health legislation in all cases. Some of the topics in the category of 'public health law' may fall under other legislation, depending on the country's existing legislative framework.

### 3.3 Checklist – public health law

Does the legislation empower public health authorities to provide the following comprehensive prevention and treatment services?

- information and education;
- voluntary testing and counselling;
- STD, sexual and reproductive health services;
- access to means of prevention e.g. condoms and clean injecting equipment;
- access to HIV medication, including ART, treatment for opportunistic infections, and medication for pain prophylaxis?

### Information and education

HIV education should aim to provide timely, accurate, specific, and relevant HIV education and information that will empower people to think and act in ways that protect them from HIV infection, that minimize the risk of HIV transmission, and that mitigate the personal and social consequences of HIV infection. While promoting awareness is essential, it is also necessary to empower people so that they have the skills and confidence to act on the information and to change behaviours. Sustained behaviour change also requires influencing community norms and beliefs through education challenging stigma and addressing issues such as gender inequalities and homophobia.

The *Philippines AIDS Prevention and Control Act 1998* contains detailed provisions regarding the content of HIV education and information interventions. Article 1 provides that HIV education shall be provided in public and private schools at intermediate, secondary, and tertiary levels; through the provision of health care services; in workplaces; for workers going abroad; for tourists entering the country; in local communities; and in connection with the sale or other distribution of condoms. The regulations accompanying the *Act* make detailed provisions for HIV information and education in a variety of settings including schools, workplaces, health care facilities, and for Filipinos going abroad. The regulations also establish standard minimum content for HIV/AIDS education, which can be augmented depending on the audience:

### Section 7. Content

The standardized basic information on HIV/AIDS shall be the minimum content of an HIV/AIDS education and information offering. Additional content shall vary with the target audience.

Selection of content or topic shall be guided by the following criteria:

- accurate - biomedical and technical information is consistent with empirical evidence of the World Health Organization, the Department of Health, or other recognized scientific bodies. Published research may be cited to establish the accuracy of the information presented.
- clear - the target audience readily understands the content and message.
- concise - the content is short and simple.
- appropriate - content is suitable or acceptable to the target audience.
- gender-sensitive - content portrays a positive image or message of the male and female sex; it is neither anti-women nor anti-homosexual.
- culture-sensitive - content recognizes differences in folk beliefs and practices, respects these differences and integrates, as much as possible, folkways and traditions that are conducive to health.
- affirmative - alarmist, fear-arousing and coercive messages are avoided as these do not contribute to an atmosphere conducive to a thorough discussion of HIV/AIDS.

- non-moralistic and non-condemnatory - education and information materials or activities do not impose a particular moral code on the target audience and do not condemn the attitudes or behaviours of any individual or population group.

### Voluntary testing and counselling

Laws should support access to testing and counselling services, and require specific informed consent before testing to ensure that a person's rights to security of the person and privacy are protected. Breaches of human rights in health care settings, or the fear that such breaches may take place, are likely to discourage people from accessing health services, and thus undermine the effectiveness of responses to the epidemic. A feature of effective responses to HIV has been the active participation of people living with and affected by HIV in community responses to the disease. Traditional models of public health suggest a different approach, whereby health care workers decide what to do about the disease and make decisions on behalf of people living with HIV. A human rights-based approach is one in which people living with HIV are supported in leading responses to the epidemic and in making informed decisions about their own health, including testing.

### Sexual health services

Sexually transmitted infections (STIs) can facilitate HIV transmission, both by making people with HIV more infectious, and by making people with STIs more susceptible to HIV infection. STIs can cause severe discomfort, pain, and illness, particularly in women, who can suffer reduced fertility from untreated STIs. Laws should require States to take measures that will promote the prevention and control of STIs, including through education and information, and the provision of accessible and affordable sexual health services delivered in a manner which is sensitive to the target client population. Respecting the human rights and dignity of clients in this context is important for the same reason that it is important in the context of HIV testing: it will encourage clients to use services, improve sexual health at the population level, and contribute to more effective responses to the STI and HIV epidemics.

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**Access to means of HIV prevention e.g. condoms and clean injecting equipment**

Access to HIV prevention equipment is fundamental to preventing HIV transmission. Legal restrictions on the availability of preventive measures, such as male and female condoms, lubricant, bleach and sterile injecting equipment should be repealed. States should consider the provision of prevention equipment through vending machines in appropriate locations, in the light of the increased accessibility and anonymity afforded to clients by this method of distribution.

HIV awareness materials, discussion of safe sex techniques and condoms are sensitive matters. For cultural and religious reasons, many people do not want to address these issues. Objections are raised in many ways (e.g. arguments that sex education for teenagers will promote promiscuity, giving condoms to prisoners will encourage sodomy in prisons). It is worth noting that research clearly shows that talk or provision of condoms promotes responsibility and safety, not promiscuity.

While personal sensitivities and the right to hold a certain opinion or belief should be respected, they should not be imposed on or allowed to interfere with the rights of others. Hindering people who are seeking to access a means of prevention or infection interferes with their rights to life and health. Hence hindering access to prevention equipment should be prohibited by law.

*An example of the use of this provision is as follows:*

A rural church-run clinic refuses to stock or distribute condoms or any materials on the use of condoms. It also refuses to tell people where to get condoms. The clinic may be within its rights to refuse to distribute condoms. But it should not prevent people from accessing materials about condom use, or withhold information about alternative sources of condoms.

**Example: Access to means of protection**

*(1) It is unlawful to deny a person access, without reasonable excuse, to a means of protection from infection of himself or another by HIV.*

*(2) Proof of a reasonable excuse in Subsection*

*(1) is on the person alleged to be denying the access.*

*(3) In particular, and without limiting the generality of Subsection (1), "means of protection" includes—*

*(a) HIV/AIDS awareness materials; and*

*(b) condoms, condom lubricant and any other means of prevention of HIV transmission; and*

*(c) exclusive personal use of skin penetrative instruments, including razors, needles and syringes; and*

*(d) means of disinfecting skin penetrative instruments; and*

*(e) pre- and post-exposure prophylaxis drugs.*

*(based on) PNG HIV/AIDS Management and Prevention Act*

The provision may be included in public health law, a specific HIV law, or an anti-discrimination law.

Access to HIV medication, including ART, treatment for opportunistic infections, and medication for pain prophylaxis

Public health law should fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV/AIDS, including ART, treatment for opportunistic infections, and medication for pain prophylaxis. A rights-based approach to the provision of medication for HIV-related conditions promotes respect for the right to life, the right to the highest attainable standard of health, and the right to enjoy the benefits of scientific progress. Access to appropriate treatments helps mitigate the impact of the epidemic on individuals, their families, and carers, and assists people to live longer and more productive lives.



Specific measures to be taken by States to improve access to HIV treatments are discussed in more detail under Guideline 6: Access to Prevention, Treatment, Care and Support.

### Check list

Does the legislation:

- require specific informed consent, with pre- and post-test counselling to be obtained from individuals before they are tested for HIV in circumstances where they will be given the results of the test (i.e. not unlinked, sentinel surveillance)?
- provide that if there are any exceptions to individual testing with informed consent, such testing can only be performed with judicial authorization?

### Specific informed consent with pre- and post-test counselling

Testing for HIV is carried out by a blood test. But an HIV test will not indicate the presence of HIV in the blood immediately after infection. Antibodies to the virus will only show up several weeks after first infection. The time between first infection and the appearance of antibodies in a blood test is called the 'window period'. A test carried out on a person only recently infected, and still in the window period, may show a false negative result. But the person can still transmit the virus to others. The fact that an HIV test result may show a false negative result has consequences for the way in which testing procedures should be implemented, as well as for the use of HIV testing as an infection control measure.

The average window period using the test generally used in the Pacific (ELISA test) is 22 days. Screening tests such as the ELISA are also designed to be very sensitive, so as to catch any possible element in the blood that might indicate HIV infection, but are not very specific to HIV, meaning that they may yield a positive result even if the person is not actually infected with HIV, because the test is detecting something else. This is called a "false positive" result. Therefore an HIV diagnosis is not considered to be confirmed

until a person who has tested positive using the ELISA test, also tests positive using a second confirmatory test, usually the Western Blot test (which works differently, but is more expensive to perform). Such confirmatory testing facilities are scarce in the Pacific. In recent years, a variety of "rapid tests" to screen for HIV antibodies have been developed. The World Health Organization recommends that a combination of two or three different rapid tests, which work in different ways, could be used to provide a confirmed diagnosis of HIV infection.

### Mandatory testing

Mandatory testing refers to the requirement that a certain person, or group of people, such as employees, hospital patients and police must be tested for HIV, as a pre-condition to obtaining a benefit (such as employment) or a service (such as health care), or to exercising a right (such as freedom of movement). The person may have the option to refuse HIV testing, but forgoes access to the benefit or service, or exercise of the right, as a result. Sometimes, mandatory testing is carried out without the knowledge of the person tested, for example as part of a "general" health test required for employment, immigration, etc. Mandatory testing almost always involves a breach of confidentiality, as the test result is generally given to the person requiring the test as well as, or instead of, to the person who has been tested. Mandatory testing is justified in very few cases where necessary to protect public health, such as testing of all blood or other human tissue that has been donated for medical purposes.

### Compulsory testing

Compulsory testing is HIV testing where the person tested has no option to refuse the test. In some countries compulsory HIV testing is performed on an ad hoc basis, in certain locations, or amongst certain populations (such as prisoners, drug users, or sex workers), in order to provide a "snapshot" of the epidemic at a particular time. The disadvantages of this approach is that it is expensive, it is rarely carried out in a way which permits identification of trends in HIV incidence and prevalence over time, it is difficult to do in a way which is representative of the population being tested, and it fuels HIV-related stigma and discrimination through the manner in which it is usually done (authoritarian, and disrespectful of human rights, particularly the right to privacy, and the right to security of the person and bodily integrity).

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### Routine testing

Routine testing is HIV testing which is carried out on a regular basis, either alone or as part of a general medical check-up. Where it is carried out as part of a general medical check-up, it may be carried out without the knowledge of the people tested. Routine testing is generally performed without the voluntary informed consent of the person tested either because it is compulsory, or mandatory, or done without the person's knowledge.

By contrast, voluntary, confidential counselling testing (VCCT) relies on HIV testing being offered to people who have given full and informed consent, who may then choose freely whether to be tested, after receiving relevant information about the testing procedure, about HIV and the consequences of a positive or negative test, and about their rights and responsibilities. Only when people have this information are they able to give informed consent. An environment which is supportive of human rights is supportive of people who choose voluntarily to be tested, it enables them to understand the consequences of a positive or negative test result, to learn about prevention, and about the availability of treatment, care and support for people living with HIV.

Compulsory or mandatory testing of any person or group violates human rights. Public health interests are not served by mandatory or compulsory testing, which contribute to HIV-related stigma and discrimination and impede the effectiveness of HIV programmes.

*There are strong grounds for not using compulsory or mandatory testing*

- compulsory and mandatory testing breach the right to privacy, the right to security of the person, the right to equality, the right to freedom from discrimination and the right to information;
- compulsory and mandatory testing may be carried out in circumstances where people are not informed of their test results, and are thus denied vital information about their own health, and the need to protect the health of others such as sexual partners;
- compulsory or mandatory testing stigmatizes HIV, and encourages people to deny the behaviour that may have put them at risk of HIV infection, such as sex work or transactional sex, having multiple sex partners and injecting. This makes implementation of specially designed HIV programmes including peer education and support more difficult;
- testing cannot be enforced equally in hierarchical societies. In Pacific Island societies social systems are strongly hierarchical with the chiefly structure being an important feature. The stigma and discrimination faced by particular groups, the hierarchies that remain in many Pacific island countries, the various taboos that operate, and widespread gender inequalities, would all greatly affect the ability to ensure that compulsory testing could be carried out in a non-discriminatory manner;
- when compulsory or mandatory testing or screening is used to justify refusal of employment, segregation of HIV-positive prisoners, or denial of migration applicants, it ignores the long asymptomatic period during which people living with HIV are well and productive work can be performed;
- compulsory and mandatory testing undermine individual responsibility to avoid infection, as people tend to rely on the assumption that others are HIV-negative unless identified as HIV-positive;
- compulsory and mandatory testing weaken compliance with universal infection precautions by falsely reassuring people that they have accurate prior knowledge of the HIV status of others, thereby leading to less careful practices;
- these approaches can send the wrong message to the community that HIV is a problem of 'risk groups', thereby promoting an 'us and them' mentality and creating further fear, denial and stigma;
- the 'window period', the time between incurring infection and the infection showing up in a test, means that no HIV test is conclusive as to freedom from infection. Infection may have occurred shortly before the test sample is taken, or shortly afterwards before test results are known. A negative test is not a guarantee of freedom from infection, and tests must be repeated at a later stage;
- initial testing must be confirmed by a further process known as confirmatory testing. Many Pacific Island countries do not have these facilities and the samples must be sent overseas. Hence "one-off" testing regimes provide a less accurate diagnosis of a person's HIV status;

- wide-scale HIV testing is generally not justified in resource poor, low HIV prevalence countries as it diverts scarce resources from cost effective HIV and STI prevention and care programmes, which are of more benefit to the community;
- where there are already insufficient resources to enforce current laws there are unlikely to be sufficient resources to enforce new laws for compulsory or mandatory testing, with the result that the only function such laws serve is to reinforce HIV-related stigma and discrimination;
- HIV prevention measures such as condom use can be implemented without any need for testing.

### Prisoners

*Sometimes it is erroneously claimed that compulsory testing of prisoners is of benefit. The reasons that are sometimes given are because —*

- both consensual and non-consensual sex often occurs in prisons;
- “sharps” are often shared for the purposes of drug use, tattooing or scarification.

However, there is no rational connection between compulsory testing and a presumed reduction in rape, or the sharing of sharps in prisons, or of consensual sexual activity, that will also translate into a reduction in the transmission of HIV. A better means of ensuring protection from transmission in prisons is to provide HIV awareness materials, condoms and disinfectants (to reduce the risk of HIV transmission through shared skin-piercing devices) to prisoners.

### Antenatal testing

Voluntary informed consent should be obtained before an HIV test is performed on a pregnant woman. In low prevalence settings, it should not be assumed that all pregnant women should be tested. A decision to take an HIV test should only be made after a thorough assessment is made of factors which may have placed the woman at risk of HIV infection, and such assessment explained to the woman. Consent to HIV testing should not be assumed because the woman has consented to a medical examination. In resource poor low prevalence settings, the expense of “routine” testing of all pregnant women may outweigh the benefits obtained from such an approach.

### Testing of women in labour

When a woman is in labour, she is extremely vulnerable. The process of giving birth, in an environment which suggests urgency, is physically, mentally and emotionally stressful. There is little privacy, and women are often at the mercy of the care-givers attending her. Testing is often done at this time, on the grounds that it is necessary for the protection of her baby, or on other grounds of expediency and urgency. Testing performed under these circumstances does not meet the requirements of voluntary informed consent, and violates human rights. Testing should not be offered to women while they are in labour, when they are burdened with the need to decide during a time of stress. This is likely to prevent them from giving truly informed consent and, if positive, from effectively dealing with the implications.<sup>19</sup> Where possible, the issue of HIV testing should be considered by women and their health care providers prior to the onset of labour.

### Emergency situations

The use of unscreened blood should only be considered in emergency situations, where a transfusion is essential to save life, it is a matter of urgency and there is no screened blood available.

### Onus of proof

The onus of proving that an HIV test has been performed with voluntary informed consent, which should include pre-test and post-test counselling for both positive and negative results, should be placed on the person performing or causing the test to be performed. Ensure that consent to a general medical test does not constitute consent to an HIV test.

### Requirements of consent

Consent to an HIV test should be voluntary and informed, meaning that it should be given without any force, fraud, or threat, and with knowledge and understanding of the possible medical and social consequences of a negative or positive test result.<sup>20</sup> See also “General medical tests” below.

### Consent on behalf of another

Consent may be given by someone other than the person to be tested only where that person is incapable of giving consent e.g. is under a disability which prevents them from understanding the meaning and

19. International Community of Women Living with HIV/AIDS (2006).

20. See HIV/AIDS Preventive Measures Act 1993 (Tasmania), section 3.



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consequences of an HIV test, or is a child too young to understand the meaning and consequences of a test. Children under the age of 18 may be capable of this understanding. Legislation should therefore go beyond the simple exception of 'a minor' i.e. someone under the age of 18, and provide a cut-out age somewhere around the age of puberty, above which consent must be obtained from the child himself or herself. It must be remembered that children enjoy all the same human rights as adults, including the right to privacy, and must therefore be permitted to enjoy those rights as soon as they are capable of understanding their implications. Guideline 5.30(g) provides that laws should 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, and should protect children against mandatory testing. Virtually all Pacific countries have ratified the Convention for the Rights of the Child and are bound by its principles.

### Example: Testing of Child

*A test may be performed ...where the person to be tested is aged 12 years or less and is, in the opinion of the person providing the pre-test information, not capable of understanding the meaning and consequences of an HIV test—with the voluntary informed consent of a parent or guardian of the person.*

*HIV/AIDS Management and Prevention Act s.14(2) (PNG)*

### **130(1) Subject to section 132, no child may be tested for HIV except when-**

- a) *it is in the best interests of the child and consent has been given in terms of subsection (2); or*
- b) *the test is necessary in order to establish whether-*
  - i) *a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or*

- ii) *any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court.*

### **2) Consent for a HIV-test on a child may be given by-**

- a) *the child, if the child is-*
  - i) *12 years of age or older; or*
  - ii) *under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;*
- b) *the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;*
- c) *the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;*
- d) *a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;*
- e) *the superintendent or person in charge of a hospital, if-*
  - i) *the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and*
  - ii) *the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or*

- f) *a children's court, if-*
- i) *consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld; or*
  - ii) *the child or the parent or care-giver of the child is incapable of giving consent.*

**132 (1) A child may be tested for HIV only after proper counselling, by an appropriately trained person, of -**

- a) *the child, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test; and*
- b) *the child's parent or care-giver, if the parent or care-giver has knowledge of the test.*

**(2) Post-test counselling must be provided by an appropriately trained person to -**

- a) *the child, if the child is of sufficient maturity to understand the implications of the result; and*
- b) *the child's parent or care-giver, if the parent or care-giver has knowledge of the test.*

**Confidentiality of information on HIV status of children**

**133(1) No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except-**

- a) *within the scope of that person's powers and duties in terms of this Act or any other law;*
- b) *when necessary for the purpose of carrying out the provisions of this Act;*
- c) *for the purpose of legal proceedings; or*
- d) *in terms of an order of a court.*

**2) Consent to disclose the fact that a child is HIV-positive may be given by -**

- a) *the child, if the child is-*
  - i) *12 years of age or older; or*
  - ii) *under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;*
- b) *the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;*
- c) *a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;*
- d) *the superintendent or person in charge of a hospital, if-*
  - i) *the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and*
  - ii) *the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or*
- e) *a children's court, if -*
  - i) *consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld and disclosure is in the best interests of the child; or*
  - ii) *the child or the parent or care-giver of the child is incapable of giving consent.*

*Children's Act 2005 (South Africa)*

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### General medical tests

Sometimes HIV tests are conducted, particularly in employment situations, under the guise of a general medical examination, without telling the person tested. It is important to ensure that HIV tests cannot be performed as part of a general medical test, without explicit, specific informed voluntary consent. If an HIV test is included as part of a medical examination required by an employer, it will probably not satisfy the criteria of explicit, informed, voluntary consent.

#### Example of appropriate legislation:

*A consent, written or otherwise,... to the provision of a medical service or to the performance of a general medical review does not constitute consent to an HIV test.*

*HIV/AIDS Management and Prevention Act s.9(2) (PNG)*

### Counselling

Pre- and post-test counselling should be required by law. Pre-test counselling is a necessary step in obtaining informed consent to an HIV test. Post-test counselling can fulfil a valuable role in ensuring that people tested receive appropriate information on protecting themselves (and others, if they test positive) from the risk of HIV infection. Counselling is a vital means of reducing HIV incidence, as well as an opportunity to provide information on HIV prevention, treatment, care, and support services.

Counselling need not be elaborate. It is an easy matter to train counsellors to an adequate level to assist in HIV counselling. All health care workers should receive basic training in counselling along with general training.

#### Pre-test counselling

Pre-test counselling refers to the counselling given, preferably by the person about to administer the test, to the person about to be tested. *It should include information about:*

- the nature of HIV and AIDS;
- the nature and purpose of an HIV test;
- the testing process and the probable time-frame for obtaining results;

- the means of securing confidentiality of test results;
- the legal and social consequences of having a test;
- the legal and social consequences of being infected, including the possibility of notifying sexual partners;
- the ways to prevent infection by and transmission of HIV.

A distinction should be made between voluntary confidential testing and counselling (VCCT) and provider initiated counselling and testing (PICT). The World Health Organization and UNAIDS have issued Guidance on provider initiated testing and counselling.<sup>21</sup> The Guidance recommends an “opt-out” approach to provider-initiated HIV testing and counselling in health facilities, including simplified pre-test information. The guidance prescribes the information to be given prior to testing. The basic conditions of confidentiality, consent and counselling apply but the more extensive pre-test counselling used in VCCT services is adapted to simply ensure informed consent, without a full education and counselling session.

*Provider initiated testing and counselling is recommended by the Guidance:*

- (i) for all patients whose clinical presentation might result from underlying HIV infection;
- (ii) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and
- (iii) more selectively in concentrated and low-level epidemics at sexually transmitted infection services, health services for populations at most risk, and antenatal, childbirth and postpartum services. Patients are given information about HIV, how the test will be carried out, and are tested unless they specifically decline.

*The WHO/UNAIDS Guidance states that the minimum amount of information that patients require in order to be able to provide informed consent as part of a PICT approach is the following:*

- The reasons why HIV testing and counselling is being recommended;
- The clinical and prevention benefits of testing and the potential risks, such as discrimination, abandonment or violence;

21. World Health Organization (2007).

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- The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available;
- The fact that the test result will be treated confidentially and will not be shared with anyone other than health care providers directly involved in providing services to the patient;
- The fact that the patient has the right to decline the test and that testing will be performed unless the patient exercises that right;
- The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status;
- In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV;
- An opportunity to ask the health care provider questions;
- Patients should also be made aware of relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/or drug injecting partners.

Some patient groups, such as populations most at risk of HIV transmission and women, may be more susceptible to coercion to be tested and to adverse outcomes. In such cases, additional measures to ensure informed consent may be appropriate beyond the minimum requirements defined above. The health care provider may need to particularly emphasize the voluntary nature of the test and the patient's right to decline it. Additional discussion of the risks and benefits of HIV testing and disclosure of HIV status, and providing further information about the social support that is available to the patient, may also be appropriate.

*In addition to the information above, pre-test information for women who are or may become pregnant should include:*

- The risks of transmitting HIV to the infant;
- Measures that can be taken to reduce mother-to-child transmission, including antiretroviral prophylaxis and infant feeding counselling;
- The benefits to infants of early diagnosis of HIV.

### Post-test counselling

*Post-test counselling refers to the further counselling given to a person tested, when informing of the results*

*of the test. Where the result is negative, the counselling should include information about —*

- the nature of HIV and AIDS;
- the effects of the window period (the time between first infection and the infection showing up in a test) and the desirability of repeating the test after the window period has elapsed;
- the ways to prevent infection by HIV and transmission of HIV.

*Post-test counselling where the result is positive should include information about:*

- the nature of HIV and AIDS;
- the ways to prevent transmission of HIV;
- the treatment available (if any) to mitigate the effects of infection;
- the care available and where possible, referral to an appropriate care service;
- the legal and social issues associated with HIV and AIDS;
- the rights of people living with HIV including the statutory guarantees of confidentiality and other legal rights such as non-discrimination;
- the desirability of informing sexual partners, the possible problems associated with informing sexual partners, alternative possibilities such as authorising someone else to do the informing.

### Examples

- (1) *“voluntary informed consent”, in relation to an HIV test, means consent specifically related to the performance of an HIV test, freely given, without threat, coercion, duress, fraudulent means or undue influence, after provision of pre-test information and with the reasonable expectation of post-test support;*
- (2) *Pre-test information, in relation to an HIV test, includes information about –*
  - (a) *the nature of HIV and of AIDS; and*
  - (b) *the nature and purpose of an HIV test; and*

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- (c) *the testing process and the probable time frame for obtaining test results; and*
  - (d) *the legal and social consequences, including the possibility of notifying sexual partners, of –*
    - (i) *having an HIV test; and*
    - (ii) *being infected with HIV; and*
  - (e) *the ways to prevent transmission of HIV.*
- (3) *Post-test support, in relation to an HIV test, includes –*
- (a) *where the HIV test result is negative – information about –*
    - (i) *the nature of HIV and of AIDS; and*
    - (ii) *the effects of the window period and the desirability of repeating the test after a specified time; and*
    - (iii) *the ways to prevent infection by HIV; and*
  - (b) *where the HIV test result is positive – information about –*
    - (i) *the nature of HIV and of AIDS; and*
    - (ii) *the legal and social issues associated with HIV and AIDS; and*
    - (iii) *the ways to prevent transmission of HIV; and*
    - (iv) *the treatment available (if any) to mitigate the effects of infection; and*
    - (v) *the care available, together with any necessary referral to an appropriate care service; and*
    - (vi) *the desirability of informing the tested person's sexual partner or partners, and the action that may be taken (under the Act) in the event of failure or refusal by the tested person to inform the sexual partner or partner; and*
    - (vii) *any other matter relevant to the personal circumstances of the tested person.*

*HIV/AIDS Management and Prevention Act 2003 (PNG),  
section 12*

### Example

*Pre-test and post-test counselling. All testing centres, clinics, or laboratories which perform any HIV test shall be required to provide and conduct free pre-test counselling and post-test counselling for persons who avail of their HIV/AIDS testing services. However, such counselling services must be provided only by persons who meet the standards set by the Department of Health.*

*Philippines AIDS Prevention and Control Act 1998,  
section 20*

### Example: Pre-Test and Post-Test Counselling

*All individuals, centres, clinics, blood banks or laboratories offering HIV testing shall provide, free of charge, pre-test and post-test counselling for persons who avail of their HIV testing services.*

*Pre-test counselling shall include the following:*

- a. *Purpose of HIV testing;*
- b. *Other diseases that should be tested, if applicable;*
- c. *Window period;*
- d. *HIV test procedure;*
- e. *Meaning of a negative and a positive test result;*
- f. *Guarantees of confidentiality and risk-free disclosure;*
- g. *When the result is available and who can receive the result;*
- h. *Basic information on HIV/AIDS infection: nature, modes of transmission, risk behaviors and risk reduction methods; and*
- i. *Informed consent and prohibition of compulsory testing under most circumstances.*

*Post-test counselling after a negative test result shall include the following:*

- a. *Release of the test result to the test person or legal guardian of minor;*



- b. Review of the meaning of negative test result;
- c. Discussion of the test person's immediate concerns;
- d. Review of the basic information on HIV/AIDS infection; and
- e. Provision of HIV/AIDS information literature and arrangement for a community referral, if necessary.

*Post-test counselling after a positive test result shall include the following:*

- a. Release of the test result to the test person or legal guardian of minor;
- b. Assistance and emotional support to the person in coping with the positive (+) test result;
- c. Discussion of the person's immediate concerns;
- d. Review of the meaning of a positive test result;
- e. Review of HIV/AIDS infection transmission and risk reduction;
- f. Explanation of the importance of seeking health care and supervision;
- g. Arrangements for referral to health care and other community services and to any organization of people living with HIV/AIDS; and
- h. Assistance with the disclosure of HIV status and health condition to the spouse or sexual partner, as soon as possible

*Pre-test and post-test counselling shall be done in a private place away from possible interruptions. It may be done at the bedside of an ill person, in a counselling room or in a person's home, and preferably in a pleasant atmosphere.*

*When tests are undertaken of workers prior to their employment overseas, group pre-test and post-test counselling may be done. However, individual counselling shall be provided for a worker with an HIV positive result. Only health workers who had undergone HIV/AIDS counselling training shall provide pre-test and post-test counselling. The DOH shall produce*

*a training kit and a trainer's training kit for HIV/AIDS counselling... The trainers shall conduct HIV/AIDS counselling training for counsellors at the provincial and institutional levels.*

*Philippines AIDS Prevention and Control Regulations, section 31*

### Screening

*No person should be required*

- to take an HIV test;
- to produce certification of freedom from HIV infection;
- to answer questions which might tend to show that the person questioned is a member of or associated with a marginalised group or a group believed to be associated with HIV infection.

*International Guidelines 3 and 5*

*Screening should always be prohibited, including for such things as:*

- employment, promotion, acceptance into a partnership;
- education or training;
- provision of goods, services or public facilities;
- membership of clubs, associations, industrial and professional organisations;
- accommodation;
- couples intending to marry;
- prisoners;
- entry into the country, or residence or citizenship.

Screening refers to various forms of requirement that people must disclose or prove that they are not HIV-positive, that they have had an HIV test, or whether they have associations with some form of suspected 'high-risk' activity or group such as sex workers or men who have sex with men (which might be interpreted to indicate they are, or are likely to be, HIV positive).

Screening is usually carried out in such contexts as employment, promotion, training, benefits,

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immigration. But because HIV is not casually transmitted, being HIV-positive does not affect any of these situations. A person with HIV can remain asymptomatic for a long time, and is capable of performing the same duties as a person who does not have HIV.

*The screening requirement offends many human rights-*

- by denying the right to equality, the right to work and freedom from discrimination when people are excluded from training, employment, freedom of abode, freedom of movement, denial of entry visas, etc. if they are positive;
- as with all mandatory requirements regarding HIV, screening fuels stigma and discrimination, because confidentiality is breached and positive people are identified to those requiring the screening, and to anyone else who may come into possession of the information;
- poverty is increased where people are dismissed from employment, refused training, education or promotion, or the chance to work.

### The “domino” effect of HIV screening

HIV screening is a prime example of how the violation of one right leads to the violation of others, each with disastrous consequences. When screening is used, it becomes a factor in relation to whether a person will get a job or a promotion, or access to education or training. If they refuse to provide proof, or test positive, the likely result is that they will not be hired, will be fired, or will not get the promotion, or will not get the admission to the education or training (and all of these are additional violations of human rights). Each of these results would also have harsh economic consequences, thereby underscoring the links between poverty, development and HIV-related stigma and discrimination.

### Immigration

In most Pacific countries (although not all) the screening requirement is usually reserved for foreigners seeking long-term entry. Short-term stays and nationals are not screened, but just as both the short-term tourist and long-term stay may transmit HIV, so too may nationals travelling abroad and who may become infected there. The only justification for screening immigrants is to avoid the financial burden on the country's health system, however even

countries with immigration laws to this effect generally provide for the admission of people with HIV on compassionate grounds, such as marital or other family ties.

Screening requirements for immigrants in other jurisdictions may affect Pacific Islanders trying to go overseas. Many countries require intending, long-term foreign residents or immigrants to submit to a medical examination, or produce proof that they are HIV negative. The rationale is that this will keep HIV out of the country. It will not work because:

- there can be no guarantee that HIV is not already in the country. Screening of intending long term residents and migrants (like isolation of those known to be HIV positive), creates a false sense of security that a country can protect its citizens from HIV, by for example, refusing entry to HIV positive people.
- screening of intending long-term residents and immigrants amounts to mandatory testing. It is a violation of human rights, and contributes to HIV-related stigma and discrimination.
- screening cannot be relied on to identify all people infected with HIV, because if a person is tested during the “window period” between the time they are infected and the time when their body starts producing antibodies to HIV, the test will produce a false negative result.

### Examples

*Below are examples of human rights-compliant legislative provisions regarding HIV screening*

#### Unlawful screening

- (1) *...it is unlawful to require or coerce —*
- (a) *a person seeking, being considered for or applying for*
    - (i) *employment or contract work; or*
    - (ii) *acceptance in a partnership; or*
    - (iii) *membership of an industrial or professional organization, club, sporting association or other association; or*

- (iv) admission to an education institution; or
  - (v) accommodation, including rental, hotel and guesthouse accommodation; or
  - (vi) the provision of or access to goods, services or public facilities; or
  - (vii) adoption or marriage; or
  - (viii) entry into, residence in or citizenship of the country; or
- (b) a —
- (i) contract worker or employee; or
  - (ii) partner; or
  - (iii) member of an industrial or professional organization, club, sporting association or other association; or
  - (iv) student in an education institution; or
  - (v) person in accommodation; or
  - (vi) person being provided with goods, services or public facilities; or
- (c) a detainee or person in custody, to undergo an HIV test, produce proof that he is not infected with HIV or answer any questions the answer to which may tend to show that he is a person of a kind referred to in Section 6(1), except in accordance with this Act.

(2) A consent, written or otherwise, by a person of a kind referred to in Subsection (1) to the provision of a medical service or to the performance of a general medical review does not constitute consent to an HIV test.

*HIV/AIDS Management and Prevention Act 2003 (PNG) S.9*

#### *Prohibitions on compulsory HIV testing*

*6A-131 Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the state, the right to travel, the provision of medical service or any other kind of service, or the continued enjoyment of said undertakings shall be deemed unlawful. Intentional violation of this section is punishable*

*with a penalty of imprisonment for not less than six months or more than two years, a fine of not more than \$1000, or both such fine and imprisonment.*

*Pohnpei National Code, Title 17, Chapter 6A-131*

#### **Exceptions to informed consent with judicial authorisation**

Exceptions to the rule that HIV testing should only be performed with informed consent should be subject to a legal requirement of judicial consideration and ruling, except in medical emergencies where the person is unconscious or otherwise unable to give consent and the medical practitioner believes that the test is clinically necessary or desirable. In this way, a person or institution wishing to perform an HIV test without a person's consent can be required to show that the seriousness of the situation warrants overriding the human rights of the person sought to be tested, and the possible negative public health outcomes which can result. This will usually involve circumstances where a person is charged with a serious crime and the result of an HIV test is relevant to the criminal proceedings, or where a person is suspected of placing others at risk of HIV infection, and all other interventions such as counselling and warning have failed to result in the required behaviour change.

#### **Example:**

##### ***Compulsory testing in certain cases***

- (1) *The Secretary may require a person charged with a crime of a sexual nature under Chapter XIV or Chapter XX of the Criminal Code to undergo an HIV test.*
- (2) *The Secretary may require a person to undergo an HIV test where it is necessary to determine the medical treatment of another person who may be at risk of becoming infected with HIV and whose condition, or suspected condition, in the opinion of a medical practitioner, is directly or indirectly caused by the person required to undergo the HIV test.*
- (3) *The Secretary must require a person to undergo an HIV test if the Secretary has*



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*reasonable grounds to believe that the person –*

- (a) is infected with HIV; and*
- (b) behaves in such a way as to place other persons at risk of becoming infected with HIV; and*
- (c) is likely to continue to behave in such a way.*

*HIV/AIDS Preventive Measures Act 1993 (Tasmania), S.10*

### **Compulsory orders**

*(1) If a person who is required to undergo an HIV test under section 10 refuses to do so, the Secretary may apply to a magistrate for an order requiring that person to undergo the HIV test.*

*(2) A hearing under this section is to be in a closed session.*

*(3) When determining whether to make an order under this section, a magistrate shall consider the following matters:*

- (a) whether other persons are or have been exposed to the possibility of transmission of HIV;*
- (b) the right to information of a person at risk of infection;*
- (c) the availability of a proven treatment in relation to HIV.*

*(4) A magistrate is not to make an order under this section unless satisfied on the balance of probabilities that it is in the interests of public health to make the order.*

*HIV/AIDS Preventive Measures Act 1993 (Tasmania) S. 11*

### **Testing facilities**

A major issue in the Pacific is the lack of facilities for testing. Where there are no testing facilities, or facilities are inadequate, this leads to problems when official figures of case numbers, which are likely to be artificially low, are published. Low numbers may lull people into a false sense of security, because they think that they have nothing to fear, as they believe that the epidemic is not wide-spread.

### Check list

1. Does the legislation only authorise the restriction of liberty/detention of persons living with HIV on grounds relating to their behaviour of exposing others to a real risk of transmission (i.e. not casual modes, such as using public transport), as opposed to their mere HIV status?
2. Does the legislation provide in such cases the following due process protections:
  - reasonable notice of case to the individual;
  - rights of review/appeal against adverse decisions;
  - fixed periods of duration of restrictive orders (i.e. not indefinite);
  - right of legal representation?

### Restriction of liberty on grounds of real risk

There is no public health justification for imposing civil detention solely on the basis of HIV status, rather than behaviour. The liberty of people living with HIV should be restricted only in exceptional cases of illegal behaviour, and due process protections should be guaranteed.

*Handbook for Legislators, p.45.*

Graded interventions are recommended. For example, in the first instance, a written warning should be issued from health authorities outlining reasons why the person should cease behaving irresponsibly, and warning that if they do not do so, formal proceedings will be instituted. The criteria for the exercise of coercive powers should be structured as objectively as possible – that the person:

- has in the past willingly or knowingly behaved in such ways as to expose others to a significant risk of infection;
- is likely to continue such behaviour in the future;

- has been counselled without success in achieving appropriate and responsible behaviour change; and
- presents a danger to others.

Due process protections which are important include:

- adequate notice of proceedings;
- urgent rights of review/appeal to a higher tribunal or court;
- right to legal representation;
- notification of rights, explaining the nature of relevant orders and obligations and rights of review/appeal.

Proceedings under public health legislation should ordinarily be held in camera (in private as opposed to in public), because of the great stigma associated with HIV/AIDS, and the social and economic consequences which may flow from unauthorised publication of a person's HIV status.

*Handbook for Legislators, p.46.*

### Examples

(1) *Where the Director believes, on reasonable grounds, that a person –*

- (a) *is and is aware of being infected with HIV; and*
- (b) *has behaved in such a way as to expose others to a significant risk of infection; and*
- (c) *is likely to continue that behaviour in future; and*
- (d) *has been counselled without success in achieving appropriate behaviour change; and*
- (e) *presents a real danger of infection to others, the Director may issue a written notice to the person.*

(2) *A notice under Subsection (1) shall state –*

- (a) *the grounds upon which the Director believes that it should be issued; and*
- (b) *the reasons why the person should not continue the behaviour referred to in Paragraph (a); and*

- (c) *a direction that the person should not continue the behaviour, or should commence to behave in a specific manner; and*
- (d) *any other matters or directions that the Director considers are necessary or convenient to ensure an appropriate change of behaviour; and*
- (e) *that breach of a direction in the notice is an unlawful act, and may be dealt with according to this Act.*

*HIV/AIDS Management and Prevention Act 2003 (PNG)*

(1) *The Secretary may apply to a magistrate for an order where the Secretary reasonably believes that a person infected with HIV ....*

- (b) *knowingly or recklessly places another person at risk of becoming infected with HIV; or*
- (c) *is likely to continue the behaviour referred to in paragraph (b).*

(2) *For the purpose of subsection (1), a magistrate may make any or all of the following orders:*

- (a) *an order that the person infected with HIV undergoes such medical and psychological assessment as the Secretary determines;*
- (b) *an order imposing restrictions on the behaviour or movements of that person for a period not exceeding 28 days;*
- (c) *an order requiring that the person be isolated and detained by a person, at a place and in the manner specified in the order for a period not exceeding 28 days.*

(3) *In making an order in respect of a person under subsection (2), a magistrate is to take into account the following matters:*

- (a) *whether, and by what method, the person transmitted HIV;*
- (b) *the seriousness of the risk of the person infecting other persons;*
- (c) *the past behaviour and likely future behaviour of the person;*

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(d) any other matter the magistrate considers relevant.

(4) The Secretary may apply to a magistrate to renew an order made under subsection (2)(b) or (2)(c) for a further period or periods not exceeding 28 days.

(5) In renewing an order, a magistrate may vary the terms of the order.

(6) A person must not fail, without reasonable cause, to comply with an order made under subsection (2) or renewed under subsection (5).

*Penalty: Fine not exceeding 50 penalty units or imprisonment for a term not exceeding 2 years.*

(7) Proceedings under this section are to be heard in a closed session.

(8) A person must not publish or cause to be published a report of, or any information relating to, the whole or any part of the proceedings under this section.

*HIV/AIDS Preventive Measures Act 1993 S.21 (Tasmania)*

The PNG Act provides a useful model because it requires that a person has first been counselled without success in achieving appropriate behaviour change before an order is made. The Tasmanian Act is a useful model because it protects the privacy of the person living with HIV and there are fixed rather than indefinite periods of court ordered detention (up to 28 days).

### Check List

1. Does the legislation authorise health-care professionals to notify sexual partners of their patients' HIV status in accordance with the following criteria?

- counselling of the HIV-positive patient has failed to achieve appropriate behaviour change;
- the HIV-positive patient has refused to notify or consent to notification of the partner;

- a real risk of HIV transmission to the partner exists;
- the identity of the HIV-positive partner is concealed from the partner where this is possible;
- necessary follow-up support is provided to those involved?

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.

*International Guideline 3(g)*

Partner-notification, or contact-tracing, is the process of identifying the sexual partners of a person who tests positive that someone they have had sexual contact with has tested positive. It can be of assistance in tracing HIV infection, which is not visible or apparent except through a blood test. Partner notification can assist in reaching those who are not yet aware of their HIV status, so as to provide counselling and offer them the choice of testing. The premise is that testing is done so that if positive, they will have access to prevention information, ART, care and treatment.

However, partner notification can also have very negative impacts. For example, particularly in small communities such as those in many parts of the Pacific, it is often a fiction that partner notification can be done in a way that protects the privacy of the HIV-positive partner (or ex partner). There may be no question about the identity of the HIV-positive partner or ex-partner.

There is very real potential for danger in the process of partner notification for HIV, particularly for women. Because of the widespread use of surveillance testing in ante-natal clinics, and the propensity for women to be more likely to be concerned about their health and request tests, it is more often wives and female partners whose infection is detected first. A woman who has tested with HIV may be reluctant, with good reason, to notify her husband or partner, even though it may have been he who infected her in the first place. Angry male partners can resort to violence and other

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drastic action. Even health care workers who have the job of notifying partners or ex-partners can also be at risk of violence. All these factors mean that partner or contact tracing should only be undertaken according to strict protocols as described in the Checklist above.

A decision to use partner notification or contact tracing processes should never be mandatory, but only optional, when:

- the HIV-positive person in question has been thoroughly counselled; and
- counselling of the HIV-positive person has failed to achieve appropriate behavioural changes; and
- the HIV-positive person has refused to notify, or consent to the notification of his/her partner(s), and this refusal is not based on a legitimate fear of reprisal (including violence) or loss of social support; and
- a real risk of HIV transmission to the partner(s) exists; and
- the HIV-positive person is given reasonable advance notice, sufficient for the person to warn or indicate refusal to warn the person(s) the health care professional intends to notify; and
- the identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
- follow-up is provided to ensure support to those involved, as necessary; and
- there is no real danger of violence as a result of notification

#### Example:

*(1) a person providing a treatment, care or counselling service to a person infected with HIV may notify a sexual partner of the person that the person is infected with HIV where—*

- (a) the notifying person is requested by the infected person to do so; or*
- (b) in the opinion of the notifying person—*
  - (i) counselling of the infected person has failed to achieve appropriate behavioural change; and*

*(ii) the infected person has refused to notify, or consent to the notification of, the sexual partner; and*

*(iii) there is a real risk of transmission of HIV by the infected person to the sexual partner; or*

*(c) the infected person is—*

*(i) dead, unconscious or otherwise unable to give consent; and*

*(ii) unlikely to regain consciousness or the ability to give consent; and*

*(iii) in the opinion of the notifying person, there is or was a real risk of transmission of HIV by the infected person to the sexual partner.*

*(2) A notification under Subsection (1) shall be made in such a manner as to conceal, so far as is possible, the identity of the infected person from the sexual partner.*

*(3) Where a person has been notified under Subsection (1), the notifying person shall offer appropriate counselling.*

*HIV/AIDS Management and Prevention Act S.20 (PNG)*

#### Check List

Does the legislation provide for protection of the blood, tissue, and organ supply against HIV contamination (i.e. requiring HIV testing of all components)?

Legislation should ensure that the blood/tissue/organ supply should be free of HIV and other blood-borne diseases. Transfusion with

contaminated blood or blood products is the most efficient route of HIV transmission. In some parts of the developing world it has proved difficult to ensure blood safety. Three essential elements for safe blood supplies are

- a national non-profit blood transfusion service which is accountable to the government



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- voluntary unpaid donors, to reduce the risk of taking blood from donors from the poorest levels of society, who sell their blood to generate income, and may have a higher risk of HIV infection
- screening of donated blood for HIV and other diseases.

It is essential that those acting in good faith and without negligence in accordance with appropriate blood safety legislation are protected from liability in cases of accidental infection incurred from a blood transfusion. Failure to do this will discourage blood supply services from effective operation, and may even cause them to cease operations altogether.

### Testing

Testing of blood for transfusion can be done in three ways

- By testing the donor before blood is donated (and refusing the donation if infection is detected) this option is a form of mandatory testing, and has the potential to discourage blood donations. It is not a recommended approach.
- By testing the blood after it is donated (and discarding the blood or treating it to remove or destroy infection). This should only be done with the donor's informed voluntary consent. The donor should be informed if they test positive for HIV or other blood-borne pathogens, and should be provided with appropriate counselling. Systems should be established to ensure that donor confidentiality is protected. This approach is not recommended in resource-constrained settings where notification and counselling cannot be provided.
- By testing an entire batch of blood after all identifiers have been removed (and discarding the batch or treating it to remove or destroy the infection) this option has the advantage of total anonymity, and ensures the security of the blood supply. It has the disadvantage of being unable to inform a donor of a positive HIV test result, however information regarding the availability of VCCT services can be provided to donors at very little cost. It is the recommended approach for resource-constrained settings.

### Organ and tissue donations

If tissue or organs (e.g. eye corneas) are imported for transplant, they should be included in the legislative provisions governing infection control. The provisions below regarding reciprocal agreements for infection control cover tissue and organ transplant as well as donated blood.

### Sale of blood

Where blood donors are paid, people living in poverty, people who are most marginalised and at risk of contracting HIV, often resort to selling blood (possibly on a regular basis) to meet their basic needs to survive. Allowing payment for the sale of tissue and organs raises the same problems. Where payment and sale of blood, organs and/or tissue is allowed, the possibility of an infected blood, tissue and organ supply must be acknowledged. It is both exploitative and dangerous. Therefore, it should be an offence to sell or buy blood, tissue, or organs, or to enter into any contract for the sale or purchase of blood, tissue, or organs.

### Reciprocity for imports

Where blood products, tissue or organs are imported for transfusion or transplant, a reciprocity provision can be inserted in the legislation to permit imports only from countries with adequate screening facilities and appropriate legislation. This will both safeguard the blood, tissue and organ supply, and will protect the personnel involved from liability in respect of possible infection.

### Protection from liability

Where proper legislative procedures such as those outlined above have been followed in good faith, all those concerned should be absolved of any liability if infection occurs following the transfusion or transplant. Compensation should only be available where there is evidence of negligence, willful misconduct or false declarations (which are more likely if someone is poor and desperate to get payment for blood, tissue or organ 'donations'). This provision will protect the blood supplier and the medical personnel (usually government personnel) who perform the testing and transfusion.

## Infection control in health care settings

### Introduction

The issue of screening patients for HIV was discussed briefly in section 3.1, and identified as an inappropriate and ineffective approach to infection control in health care settings. Screening patients for HIV and other approaches to infection control which are both more effective and respectful of human rights are examined in more detail in this section.

### Human Rights Principle

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.

*International Guidelines, paragraph 28 (i)*

### Relevant rights:

- right to life
- right to health
- right to privacy
- security of the person

### Background

It is not uncommon for health care workers to assert the “right to know” the HIV status of their patients. As noted in section 3.2(d), it is appropriate for health care workers to be informed of a patient’s HIV-positive status where this is necessary for the health care worker to be able to provide appropriate health care to the patient. However health care workers must still observe strict rules of confidentiality regarding HIV-related information, and not disclose it except to another health care worker also responsible for providing care to the patient, or in other limited circumstances such as complying with a court order to produce such information. Epidemiological notification of patients’ HIV and AIDS diagnoses should be made only after all identifying information has been removed.

Patients need to be able to rely on the confidentiality of their medical records, and to trust health services to

respect their privacy, or they will be unwilling to use health services. In the absence of such trust, the effectiveness of HIV prevention, treatment, care, and support will be compromised, to the detriment of individual patients, and to the effectiveness of a country’s response to the epidemic.

Testing or requiring proof of a patient’s HIV status is ineffective as an infection control measure, due to the possibility of false negative HIV tests during the window period. Production of proof of a recent negative test result by a patient, even if accurate, cannot provide information about risk behaviour or infection subsequent to the time of the HIV test. Mandatory testing of patients is ineffective as a means of infection control, and as a breach of human rights, brings with it the negative consequences for individuals and for public health already discussed. It can also lead to a false sense of security on the part of health care workers, based on the belief that they are able to identify all patients who are HIV-positive, and may also lead to less strict adherence to universal infection control precautions.

### Should there be compulsory testing of a “source person” following exposure to that person’s blood or other bodily fluids?

This question arises where a health care worker has been exposed to the possibility of HIV transmission, for example through accidental penetration with a used needle. In most cases, the person on whom the needle has been used (the “source person”) will agree to be tested for HIV, where their HIV status is not known. For the small minority of people who refuse to be tested, should they be forced to undergo an HIV test? Although compulsory testing may appear justified in these circumstances, it constitutes a serious breach of the human rights to bodily integrity (by inserting a needle and extracting the person’s blood without their consent) and to privacy (by analysing their blood and distributing the results without their consent). The situation is not analogous to the taking of blood in cases of suspected drink-driving, or the taking of a DNA sample in the case where a serious crime is suspected to have been committed. It is not a crime if, while a person is receiving health care, the health care worker is accidentally exposed to their body fluids.

Professional associations in many countries acknowledge that forced HIV testing in cases of occupational exposure is unethical and unjustified.<sup>22</sup> It is unethical because it breaches health care workers’

22. E.g. Canadian Medical Association, the Canadian Association of Nurses in AIDS Care, Canadian Public Health Association.



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ethical rules of obtaining a person's informed consent for any medical procedure. It is unjustified because the average risk of HIV transmission from occupational exposure to body fluids is very low. On average, the risk of contracting HIV after exposure to HIV-infected blood through a needle stick or cut is estimated to be 0.3 percent, or 1 in 300. In other circumstances, the risk of infection is estimated to be even lower.

Rather than focusing on the forced testing of "source persons" in cases of accidental exposure, a person exposed should encourage bleeding at the site of the injury (if the exposure was through a needle stick injury), flush areas with large amounts of water (if exposure is through splash of fluid on to mucous membrane such as eye, nose or mouth), wash the area well with soap and water (if the exposure was through splash of fluid to the skin), and undergo medical assessment to determine whether post-exposure prophylaxis treatment with ART is warranted.<sup>23</sup>

Universal infection control precautions are a more reliable method of preventing the spread of HIV and other blood-borne pathogens in health care and other settings involving exposure to blood and other body fluids. Universal infection control requires health care workers to treat all patients as potentially infectious, and to implement infection control procedures in all situations involving exposure or potential exposure to blood or other body fluids. Universal precautions minimise the risk of health care consumers and providers acquiring a health care associated or occupational infection. They should apply to all categories of health care services, including medical practitioners, nurses, dentists, dental technicians, physiotherapists, and podiatrists.

**Example:****Standard Precautions**

*Standard precautions apply to:*

- *blood*
- *all body substances, secretions and excretions, excepting sweat, regardless of whether or not they contain visible blood*
- *non-intact skin*
- *mucous membranes*

*Standard Precautions are designed to reduce the risk of transmission of micro-organisms from both recognised and unrecognised sources of*

*infection in health care settings. Standard Precautions involve the use of safe work practices and barriers including:*

- *Hand washing: after touching blood, body substances, and contaminated items, whether or not gloves are worn*
- *Gloving: wear gloves (clean, non-sterile gloves are adequate) when touching blood, body substances, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Remove gloves promptly after use, before touching non-contaminated items and environmental services, and before going to another patient, and wash hands immediately to avoid transfer of micro-organisms to other patients or environments.*
- *Masking: wear a mask or face protection and eye shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient care activities that are likely to produce splashes of blood, body fluids, secretions, and excretions.*
- *Gowning: wear a fluid-resistant gown or apron made of impervious material to protect skin and prevent soiling of clothes during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions or cause soiling of clothing.*
- *Appropriate device handling: Handle used patient care equipment soiled with blood and body substances in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of micro-organisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed; and that single use items are properly discarded after use.*
- *Appropriate handling of laundry: Handle, transport and process linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures; contamination of clothing; and transfer of micro-organisms to other patients and environments.*

*Adapted from: Infection Control Policy, Department of Health, New South Wales, 2005.*

23. For more detailed information see: Canadian HIV Legal Network (2002)

**Disinfection**

Disinfection and fumigation of houses, vehicles etc. has been used for infectious and contagious diseases which are spread through casual contact or through coughing, sneezing etc. But such measures are unnecessary for HIV, which is only spread through unprotected sex, through sharing skin penetrative instruments, from mother to child, or from infected blood, organ, or tissue donations. Disinfection is only an important HIV prevention measure in certain limited situations. Disinfection is of benefit in situations of

sharing skin-penetrative instruments or 'sharps', such as injecting equipment, tattooing instruments, razors, and equipment used in medical procedures where there is a risk of blood-to-blood contact.

Disinfection of houses, eating utensils, clothing and bedding, offices, workplaces, vehicles etc. is not necessary because HIV is not transmissible through this means. Proposals for these kinds of measures rest on misinformation about HIV and on fear, and perpetuate stigma and discrimination against people living with HIV or thought to be infected.

## CHAPTER 4:

## CRIMINAL LAWS AND CORRECTION SYSTEMS

**GUIDELINE 4: Criminal Laws and Correctional Systems**

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

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.

*International Guideline 4 para 29(a)*

**4.1 Relevant human rights**

- right to life
- right to liberty
- right to dignity
- right to privacy
- right to freedom from torture and inhuman treatment
- right to security of the person and bodily integrity
- sexual and reproductive health rights
- freedom from sexual assault and exploitation

**4.2 Background**

It is understandable that people want protection from real or perceived threats to their lives and safety. Many people think that the creation of a new offence for transmitting HIV will help to protect against the risk of HIV infection. However coercion is a crude tool in educating for behaviour change, particularly in areas of intimate private activity like sex. Criminal laws that are already in place will generally be adequate for dealing with cases of HIV transmission that warrant criminal prosecution. Criminalising behaviours that risk the transmission of HIV contributes to stigma and discrimination and impedes the effectiveness of HIV programmes.

*The main means of HIV transmission in the Pacific is unprotected sex. Criminalisation of sexual activities thought most likely to transmit HIV, such as sex between men and sex work, are not effective HIV prevention measures because —*

- They contribute to the stigma and discrimination associated with HIV and some of the behaviours which transmit the virus.
- Criminalizing such behaviours does not prevent them. Rather, criminalization impedes HIV prevention programmes by encouraging those who may be at risk of HIV to avoid taking precautionary measure (such as having or using condoms). Hiding or denying risk behaviours makes people harder to reach with HIV prevention information and equipment. It may also lead to the harassment or prosecution of people working in HIV programmes trying to reach marginalised and vulnerable population.
- Criminalising stigmatised behaviours such as male-to-male sex and sex work, overlooks the spread of the epidemic through other forms of sexual behaviour, such as unprotected non-commercial heterosexual sex, which is extremely prevalent in the Pacific. Increasingly, in countries with advanced HIV epidemics, new HIV cases are highest amongst women who identify as housewives.

UNAIDS has developed guiding principles regarding the use of criminal law in HIV prevention. UNAIDS recommends that, in developing law and policy regarding the use of criminal sanctions or coercive measures, government officials and the judiciary should be cognizant of the following guiding principles:<sup>24</sup>

- the best available scientific evidence regarding modes of HIV transmission and levels of risk must be the basis for rationally determining if, and when, conduct should attract criminal liability;
- preventing the transmission of HIV should be the primary objective and this, rather than any other objective, should guide policy-makers in this area;
- any legal or policy responses to HIV, particularly the coercive use of state power, should not only be pragmatic in the overall pursuit of public health but should also conform to international human rights norms, particularly the principles of non-discrimination and of due process;
- state action that infringes on human rights must be adequately justified, such that policy-makers should always undertake an assessment of the impact of law or policy on human rights, and should prefer the 'least intrusive' measures possible to achieve the demonstrably justified objective of preventing disease transmission

### 4.3 Checklist – criminal law

- 1 Does the law provide for the legal operation of needle and syringe exchange? Are intermediaries (e.g. clients who distribute to third parties) covered by such protection, and is the evidentiary use of needles and syringes with trace elements of illegal drugs restricted (e.g. immunity for contents of approved disposal containers).

Does the law allow the following sexual acts between consenting adults in private:

- homosexual acts e.g. sodomy;
- fornication or adultery;
- street sex work;

- brothel or escort sex work?

- 2 If sex work is prohibited, or there are prostitution-related offences, is there any exception for HIV prevention and care services (e.g. evidentiary immunity for carrying condoms)?
- 3 Does the legislation regulate occupational health and safety in the sex industry to require safer sex practices to be:
  - practised by clients;
  - practised by workers; and
  - promoted by owners/managers (including prohibiting the requirement of unsafe sex)?
- 4 Does the legislation protect sex workers, including children, from coercion and trafficking? Is the object of such protection the removal and support of such workers, rather than criminalizing their behaviour as opposed to those responsible (i.e. owners or intermediaries)?
- 5 Does the law provide for general, rather than specific, offences for the deliberate or intentional transmission of HIV?

### Needle and syringe exchange and other prevention and care services

Injecting drug use is not yet a major issue in the Pacific. In many Asian countries, injecting drug use is widespread, and the sharing of injecting equipment is a major factor in the spread of HIV. People who use drugs are entitled to the same protection of their human rights as everyone else, notwithstanding the illegal status of drug possession, use and supply. The enjoyment of human rights is undermined by stigma and discrimination against people who use drugs and people living with HIV.

In the Pacific, narcotics laws are mainly directed against drug trafficking and marijuana use. The presence of injectable drugs in a country is often linked to drug trafficking. An additional issue throughout the region is the potential for HIV transmission through the sharing of needles and blades for tattooing and scarifying.

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### *Injecting drug use involves issues of*

- criminal law (as applied to personal use and possession of injecting equipment, and related to alternative sentencing);
- stigma and discrimination;
- provision of facilities for sterilisation of equipment and drug consumption, including provision in prisons; dependency treatment; and medical prescription.

### **Personal use and alternative sentencing**

Alternative means of dealing with drug users by the criminal justice system can have positive health outcomes. For example, many jurisdictions distinguish between drug-related crimes involving personal use or small scale user/dealer offences, from those involving large scale trafficking of illicit drugs. The former may be dealt with through diversionary programmes which place offenders in rehabilitation programmes rather than in prisons. Such measures increase the likelihood that the offender will cease using illicit drugs, and avoid the harms (including HIV infection) associated with illicit drug use.

### **Drug rehabilitation services**

In many countries, the demand for access to drug rehabilitation services far exceeds the availability of such services. Governments must take all possible measures to ensure that those people wishing to cease illicit drug use have access to services which will support them to do so.

### **Harm reduction services**

Where drug use is illegal, the effectiveness of harm reduction services is frequently hampered by law enforcement activities, however a pragmatic approach can be adopted which permits HIV prevention programmes to operate notwithstanding the illegality of drug use. Collaboration between government ministries responsible for law enforcement, and those responsible for public health, should be promoted on issues of drug-related harm reduction. Jurisdictions in which drug use is illegal have nevertheless established needle and syringe exchange programmes, to reduce the rate of sharing injecting equipment, and thus the risk of transmission of HIV and other blood-borne pathogens such as hepatitis C.

The effectiveness of needle and syringe programmes has been thoroughly documented<sup>25</sup>, with one study demonstrating that they prevented thousands of cases of HIV infections, and saved billions of dollars in health care costs.<sup>26</sup> While the impact of such programmes will depend on the extent of injecting drug use in a society, their efficacy is undeniable. Furthermore, there is no evidence to support assertions that such programmes increase the rate of illicit drug use, or of injecting. In many cases, needle and syringe programmes provide an entry point for drug users seeking access to drug detoxification and rehabilitation services. Harm reduction services do not condone or promote drug use, but they do acknowledge the reality that at a given time some people use illicit drugs, and can be helped to avoid some of the severe harms that can accompany such use.

### **Sexual acts between consenting adults in private**

#### *Homosexual acts*<sup>27</sup>

Sex between men occurs in every culture and society, though its extent and public acknowledgement vary from place to place. It occurs in diverse circumstances and among men whose experiences, lifestyles, behaviours and associated risks for HIV vary greatly. It encompasses a range of sexual and gender identities among people in various socio-cultural contexts. It may involve men who identify as homosexual, gay, bisexual, transgendered, or heterosexual. Men who have sex with men are often married, particularly where discriminatory laws or social stigma of male sexual relations exist. Men who have sex with men often also have female partners. A survey in PNG found that 12% of young men said they had had sex with men, three quarters of whom said they had also had sex with women.<sup>28</sup>

Many governments fail to acknowledge that sex between men happens, and that unprotected anal sex contributes to the transmission of HIV. Even if they recognize that it happens, there may often be insufficient political will, funding, and programming, to address the issue. Experience shows that recognition of the rights of people with different sexual identities, both in law and practice, combined with sufficient scaled-up HIV programming to address HIV and health needs are necessary and complementary components for a successful response to HIV.

25. World Health Organization (2005) p.15.

26. Health Outcomes International, et al. (2002)

27. This section is based on the UNAIDS policy brief "HIV and sex between men" (Aug 2006).

28. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008b) p.2.



A number of UN human rights mechanisms have noted that sexual identity or orientation is a prohibited ground for discrimination, and that laws which criminalize homosexual acts between consenting adults violate the right to privacy. In *Toonen v Australia*,<sup>29</sup> the UN Human Rights Committee found that the right to privacy, guaranteed by Article 17 of the *International Covenant on Civil and Political Rights* was breached by laws which criminalize private homosexual acts between consenting adults. The UN Human Rights Committee has also found that discrimination against persons on the ground of sexuality is a breach of Article 26 of the *International Covenant on Civil and Political Rights* (right to equality and non-discrimination).<sup>30</sup> Fulfilling the human rights of men who have sex with men is not only intrinsically valuable, it will also improve health outcomes for them and the broader community. In countries where sex between men is not criminalized and where stigma and discrimination have been reduced, men who have sex with men are more likely to take up HIV prevention, care, support, and treatment services.

The 2001 UNGASS Declaration of Commitment on HIV/AIDS, which was adopted by all UN member states, emphasized the importance of “addressing the needs of those at the greatest risk of, and most vulnerable to, new infection as indicated by such factors as ... sexual practices.” In 2005, 22 governments from different regions, along with representatives of nongovernmental organizations and people living with HIV, called for the development of programmes targeted at key affected groups and populations, including men who have sex with men, describing this as “one of the essential policy actions for HIV prevention.”<sup>31</sup>

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*In 2008, the Vatican stated to the United Nations General Assembly the Catholic Church’s position that “every sign of unjust discrimination towards homosexual persons should be avoided and (the Church) urges States to do away with criminal penalties against them”*<sup>32</sup>

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### Fornication or adultery

Fornication or adultery are still illegal or grounds for divorce and compensation in many Pacific Island countries. Women are often placed at a disadvantage due to these laws. Women may be reluctant to seek divorce from a violent partner if they are required to give evidence about a husband’s infidelity, as this may expose them to further violence. Criminal laws prohibiting specific sexual activity between consenting adults in private, such as adultery, sodomy, fornication or acts against the “order of nature” or social order or morality, can impede the provision of HIV prevention and care programmes. Many jurisdictions have repealed these laws because they are ineffective and out of date, are out of step with modern community values of social inclusion and on public health grounds. Protection of the human rights of privacy and equality also requires repealing such legislation.

### Sex work

Laws criminalizing sex work impede the provision of HIV prevention, treatment, care and support services, by driving people engaged in the sex industry underground, and out of reach of HIV services. Laws should be reviewed with the aim to decriminalize sex work, and to regulate occupational health and safety to protect sex workers and their clients.<sup>33</sup> Criminal law should ensure that children and adult sex workers who have been trafficked or otherwise coerced into sex work are protected from non-consensual participation in the sex industry and are not prosecuted for such participation but rather are provided with medical and psycho-social support services.

Sex workers are often blamed for spreading HIV, but outreach work and peer education with sex workers to promote condom use can reduce the incidence of HIV and STI infections among sex workers to below that of the general population. The demonisation of sex workers for spreading HIV also overlooks the role of the male clients of sex workers in onward transmission of HIV to their wives, which can then lead to mother-to-child transmission of HIV. The 100 Percent Condom Use Programme in Thailand promoted condom use and sexual health clinical services for male clients as well as for sex workers.<sup>34</sup> Notwithstanding these dynamics of HIV transmission, it is more common for the selling of sexual services to be criminalised than it is for the purchasing of those services and it is more common for sex workers to be prosecuted for criminal

29. *Toonen v. Australia*, HRC Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994).

30. See e.g. *Young v Australia* HRC Communication No. 941/2000, U.N. Doc CCPR/C/78/D/941/2000 (2003).

31. *Joint United Nations Programme on HIV/AIDS* (2005).

32. *Vatican Information Service* (2008).

33. *Handbook for Legislators*, at p.56.

34. *POLICY Project* (2003).

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offences than it is for their clients.

Criminalisation of sex work drives sex workers underground, making them harder to reach with programmes for HIV and STI prevention and sexual health promotion. In addition, it can lead to a culture of impunity regarding crimes such as rape and sexual assault against sex workers, who are seen as undeserving of the protection the criminal law affords other citizens. Denial of the right to equality before the law can have a direct causal link to sex workers' vulnerability to HIV transmission.

Health and safety standards, which are an accepted part of the regulation of most forms of work, are not applied to sex work where it is an illegal activity. Laws requiring the use of condoms during commercial sex, as well as the maintenance of other safety standards regarding lighting, sanitation, and the personal security of sex workers, all contribute to a reduction in HIV transmission. Experience from many countries has demonstrated the effectiveness of such measures in preventing the spread of HIV and STIs, however health and safety standards are generally absent where sex work is illegal.

Banning sex work does not prevent people from buying sex, but when it hinders prevention programmes and access to prevention measures it assists the spread of HIV. No law has ever succeeded in stamping out commercial sex, even in affluent societies.

In the Pacific, many women, girls and men and boys turn to commercial sex for economic survival, whether they are paid in money or in kind. But the consequences of criminalisation go further than prosecution and fines or imprisonment. Those who sell sex may be further victimised by the attitudes and actions of society generally and of state agencies such as the police. Hence laws criminalising sex work can further victimise the already under-privileged. In Australia and New Zealand, decriminalising sex work has allowed regulation of the industry and safeguards to be provided for those who are forced into this sector. Laws and policies can be put in place to support income-generation schemes for sex workers, and which focus on providing sex workers with education, support, and services for HIV prevention and sexual health promotion.

### Options – sex work law reform

#### *Legalisation*

Legalisation involves the abolition of the offence of prostitution, and putting in its place a regulatory regime which may require sex workers and brothels to be registered, require or encourage sex workers to have regular sexual health checks, and impose occupational health and safety standards. This approach has been adopted in many developed countries, where regulation focuses on safety standards in brothels and during sexual acts. This approach is effective in circumstances of good governance, and where there are well-resourced monitoring mechanisms.

This approach faces challenges in poorer countries with weak infrastructure. Legislation requiring the registration of sex workers can result in a dual system, whereby some sex workers remain unregistered and therefore illegal. There are risks associated with requirements such as mandatory health checks, which may be implemented in a way that is disrespectful of sex workers, reinforcing their low status, and perpetuating the stigma associated with sex work. Where the rule of law is weak, those responsible for monitoring compliance with sex industry regulation may use their positions of power for corrupt practices. These can include demanding cash bribes, or free sexual services from sex workers.

#### *Decriminalisation*

This refers to the removal of references to prostitution and related offences from the criminal law. This approach helps to reduce the stigma associated with sex work. It can create a more enabling environment for programmes designed to reduce HIV transmission through commercial sex, empowering sex workers to take control of their own sexual health, as well as addressing other health and safety issues for sex workers and their clients. The Sonagachi Project in Calcutta, India, is an example of successful management by sex workers of their own health, and health and safety standards in the sex industry in which they work.<sup>35</sup>

Decriminalisation should include decriminalisation of associated activities such as brothel-keeping, pimping (living on the earnings of prostitution) and so on. The half-way approach of decriminalising sex work but not

<sup>35</sup> See e.g. D Gangopadhyay (2005).

associated activities such as brothel keeping or living on the earnings of prostitution, may substantially undermine the public health benefits of decriminalising commercial sex. For example, the offence of 'living on the earnings of prostitution' could be interpreted to mean that a sex worker engaging in a legal activity (sex work), nevertheless commits a crime if she contributes to the material support of another person (such as a child or other relative) using the money earned from sex work. Decriminalising sex work but not associated offences may do little to promote the environment necessary to implement prevention programmes for sex workers and their clients. This approach to decriminalization of sex work and associated activities is reflected in *Translating CEDAW Into Law: CEDAW Legislative Compliance in Nine Pacific Island Countries*.<sup>36</sup>

In PNG, the National Court has interpreted the offence of 'living on the earnings of prostitution' to apply to the 'prostitute' herself, thereby continuing the criminalisation of sex work.<sup>37</sup> The 'living on the earnings of prostitution' and vagrancy offences should be reviewed to ensure that they are not inappropriately applied to sex workers themselves.

### No legislative reform

Many countries have not decriminalised sex work. To mitigate the damaging effects of criminalisation, efforts should be made to reduce persecution of sex workers through collaboration between Ministries responsible for law enforcement and Ministries responsible for public health. Laws prohibiting discrimination on the grounds of occupation can be used to reduce stigma and discrimination against sex workers. Criminal laws should not impede public health programmes that save lives.

### Exceptions in prostitution-related offences for HIV prevention and care services

In countries where decriminalization of sex work is not a realistic political option in the short term, other pragmatic options can be considered. Legislation in some jurisdictions prohibits use of the possession of condoms or of HIV education and prevention materials as evidence of the commission of any prostitution-related offence. Without such protection, sex workers may fear carrying condoms on the person or keeping supplies where they work, in case of police searches or raids. The implications for HIV prevention in such circumstances are clear. Sex workers will be

discouraged from carrying and using condoms, and there is a strong risk that HIV and STI prevention programmes targeting sex workers and their clients will be undermined.

### Occupational health and safety in the sex industry

#### Example

*A culture of safer sex can be promoted in the industry and responsible behaviour by clients, workers, and management can be encouraged. In New Zealand, the Prostitution Reform Act 2003 aims to safeguard the human rights of sex workers, to protect them from exploitation, to promote the welfare and occupational health and safety of sex workers, to be conducive to public health, and to prohibit the use in prostitution of persons under 18 years of age.*

*Shortly after the law changed, occupational safety and health guidelines were developed by the Department of Labour in consultation with sex workers. The guidelines contain specific references to supporting sex workers in maintaining conditions that are conducive to their well being. The guidelines not only promote best practice in the provision of*

*commercial sexual services, but also include information about HIV education. The ability to negotiate with clients to promote sexual services that are safe is enhanced in this decriminalized environment. Sex workers' anonymity is protected. There is no mandatory HIV testing, and clients are dissuaded from asking about the HIV status of sex workers, because brothel owners would be in breach of the law if they revealed this information.*

*The New Zealand Prostitutes Collective notes that while there are many strong legal features supporting the human rights of sex workers, implementation of the law requires commitment from government agencies, and others. The changes brought about by the law are substantial, and require a reorientation of responses to the sex industry from prosecution to protection of health and safety.*<sup>38</sup>

36. Vedna Jivan and Christine Forster, *Translating CEDAW into Law: CEDAW Legislative Compliance in Nine Pacific Island Countries* (UNDP Pacific Centre & UNIFEM) 2007.

37. Anna Wemay & Ors. v Kepas Tumdual [1978] PNGLR 173

38. HIV and the decriminalization of sex work in New Zealand (2006)

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**Operators of businesses of prostitution must adopt and promote safer sex practices**

8(1) Every operator of a business of prostitution must—

- (a) take all reasonable steps to ensure that no commercial sexual services are provided by a sex worker unless a prophylactic sheath or other appropriate barrier is used if those services involve vaginal, anal, or oral penetration or another activity with a similar or greater risk of acquiring or transmitting sexually transmissible infections; and
  - (b) take all reasonable steps to give health information (whether oral or written) to sex workers and clients; and
  - (c) if the person operates a brothel, display health information prominently in that brothel; and
  - (d) not state or imply that a medical examination of a sex worker means the sex worker is not infected, or likely to be infected, with a sexually transmissible infection; and
  - (e) take all other reasonable steps to minimise the risk of sex workers or clients acquiring or transmitting sexually transmissible infections.
- (2) Every person who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine not exceeding \$10,000.
- (3) The obligations in this section apply only in relation to commercial sexual services provided for the business and to sex workers and clients in connection with those services.
- (4) In this section, health information means information on safer sex practices and on services for the prevention and treatment of sexually transmissible infections.

**Sex workers and clients must adopt safer sex practices**

9(1) A person must not provide or receive commercial sexual services unless he or she has taken all reasonable steps to

ensure a prophylactic sheath or other appropriate barrier is used if those services involve vaginal, anal, or oral penetration or another activity with a similar or greater risk of acquiring or transmitting sexually transmissible infections.

- (2) A person must not, for the purpose of providing or receiving commercial sexual services, state or imply that a medical examination of that person means that he or she is not infected, or likely to be infected, with a sexually transmissible infection.
- (3) A person who provides or receives commercial sexual services must take all other reasonable steps to minimise the risk of acquiring or transmitting sexually transmissible infections.
- (4) Every person who contravenes subsection (1), subsection (2), or subsection (3) commits an offence and is liable on summary conviction to a fine not exceeding \$2,000.

10(1) A sex worker is at work for the purposes of the Health and Safety in Employment Act 1992 while providing commercial sexual services.

*Prostitution Reform Act 2003 (New Zealand)*

**Protection from coercion and trafficking**

Criminal penalties should apply to the use of children as sex workers, and the trafficking or use of coercion against sex workers. People who are trafficked or coerced should not be prosecuted for their participation in the sex industry, but provided with medical and psychosocial support services, including those related to HIV. It is important not to conflate sex work with trafficking, as many people enter and remain in sex work voluntarily. Trafficking involves threats or use of force or other forms of coercion, abduction, fraud, deception, or abuse of power for the purpose of exploitation.



## General rather than specific offence for the deliberate or intentional transmission of HIV

### Principle

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.

*International Guideline 4, para 29*

Many countries have specific criminal offences for the intentional exposure or transmission of HIV. The existence of these offences has little impact on the spread of the virus, given that the vast majority of cases of HIV transmission occur at a time when the infected person is unaware of his or her own infection. The use of criminal prosecutions can also add to the stigma and discrimination associated with HIV infection. People with HIV may be perceived as criminals, and programmes designed to reach affected communities with prevention, treatment, care and support programmes will face even greater challenges.

UNAIDS cautions against a “rush to legislate”, in favour of careful consideration of the issues.<sup>38</sup> There is no evidence that criminal laws are effective for preventing HIV transmission.

### Public health laws as an alternative

Policy-makers need to consider how interventions under public health laws, in comparison to criminal law approaches, can better achieve public health goals.

In an area of already considerable stigma and discrimination, great care must be taken to avoid letting the desire for punishment and retribution in individual cases determine public policy, particularly if there are other important, competing policy considerations.

There is greater scope for flexibility in interventions under public health legislation. Rather than responding simply with prosecution and punishment, public health powers can be used to support individuals in avoiding conduct that may result in HIV transmission and addressing possible underlying circumstances such as addiction or domestic violence.

In extreme cases, public health legislation offers coercive interventions that are preferable to criminal prosecution in achieving the goal of incapacitation. Public health powers can be used to detain an individual who persists in conduct that places others at risk, if less intrusive measures fail, and in the placement of the individual in a setting with less high-risk activity than a prison (and thus, where appropriate health care services are available, better serving the goal of rehabilitation).

Finally, public health interventions may not only be better tailored to the individual’s circumstances than the blunt tool of a criminal prosecution; they may also become increasingly coercive, if necessary, while still allowing for a more careful balancing of individual liberty and public health protection.

Where it is proposed to create a new offence, the *Handbook for Legislators* provides a detailed assessment of the issues which need to be considered, and how they should be resolved in a manner which helps confine the use of the criminal law to those cases which represent the most serious culpable behaviour.<sup>39</sup> UNAIDS urges governments to limit criminalization to cases of intentional transmission where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.

*In particular, criminal law should not be applied to cases where there is no significant risk of transmission or where the person:*

- did not know that s/he was HIV positive;
- did not understand how HIV is transmitted;
- disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or
- previously agreed on a level of mutually acceptable risk with the other person.

38. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2002).

39. See *Handbook for Legislators* at pp.51-52 and Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008c).



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UNAIDS recommends that States should also:

- issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining “intentional” transmission, by stipulating that an accused person’s responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution); and
- ensure any application of general criminal laws to HIV transmission is consistent with their international human rights obligations.<sup>40</sup>

### New offences

This approach is not recommended. However, some jurisdictions have preferred to creating a new offence.

#### Example

*Any person knowingly infected with AIDS or HIV, who purposefully or through gross negligence transmits such disease to another person, shall be guilty of a criminal offence.*

*Communicable Diseases Prevention and Control Act 1988  
§1511 (Marshall Islands)*

If a new offence is created, it should be generic rather than HIV specific, and apply to other communicable diseases.

#### Example

*Every one is liable to imprisonment for a term not exceeding fourteen years who wilfully and without lawful justification or excuse, causes or produces in any other person any disease or sickness.*

*Crimes Act Section 223 (Cook Islands)*

### Use of existing offences

Relevant existing charges for intentional HIV transmission include attempted murder, assault and causing bodily harm. The offence selected should accord with the criminal practice of the country e.g. a conviction for grievous bodily harm in PNG requires evidence of visible wounding, which would not occur in a situation of HIV transmission, so the lesser offence of assault occasioning bodily harm is used there.

#### Example

*The intentional transmission or attempted transmission of HIV to another person is—*

- (a) *an assault or attempted assault, as the case may be, occasioning bodily harm within the meaning of Section 340; and*
- (b) *where death has occurred—an act of unlawful killing within the meaning of Section 298, of the Criminal Code.*

*HIV/AIDS Management and Prevention Act S.23(1) (PNG)*

### Defences

There are significant privacy and autonomy interests of individuals being able to choose to engage in sexual activities without state intervention. Draconian measures that prohibit HIV-positive people from having sex, even with informed consent, are impossible to enforce and undermine public health campaigns designed to encourage people to present themselves early for counselling, testing, treatment and support. Informed consent, and use of preventive measures, should be defences against charges of intentional HIV transmission. Women’s fear of violence should also be able to be raised in defence.

#### Examples

##### *Defence if condom used*

*It is a defence to a charge of an offence relating to the intentional or attempted transmission of HIV to another person that—*

- (a) *the other person was aware of the risk of infection by HIV and voluntarily accepted that risk; or*

40. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008c).

- (b) *the other person was already infected with HIV; or*
- (c) *where the transmission or attempted transmission is alleged to have occurred by sexual intercourse—*
- (i) *a condom or other effective means of prevention of HIV transmission was used during penetration; or*
- (ii) *the accused person was not aware of being infected with HIV.*

*HIV/AIDS Management and Prevention Act S.23(3) (PNG)*

#### **Exception if women fear violence**

*Every person who is HIV-positive, is aware of such status and, has been counselled in accordance with this Act or is aware of the nature of HIV and how it is transmitted, shall take all reasonable measures and precautions to prevent the transmission of HIV to others which may include adopting strategies for the reduction of risk or informing in advance any sexual contact or person with whom needles are shared of that fact.*

*Exception: There shall be no duty to prevent transmission, particularly in the case of women, where there is a reasonable apprehension that the measures and precautions may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health and safety of the HIV-positive person, their children or someone who is close to them.*

*HIV/AIDS Bill (India) S.14<sup>a</sup>*

a. Bill prepared on request of MPs and the National AIDS Control Organisation by Lawyers Collective HIV/AIDS Unit, Mumbai: <http://www.lawyerscollective.org/hiv-aids/draft-law>.

#### **Mother to child transmission**

A pregnant woman who knows she is HIV-positive is entitled, and often encouraged, to give birth. Some countries have proposed that a criminal charge of intentionally transmitting HIV be available against the mother if her child is HIV positive, which could be the result of transmission from the mother during pregnancy, during labour, or through breast-feeding.

*This is inappropriate because:*

- everyone has the right to have children, including

women living with HIV;

- when pregnant women are counselled about the benefits of antiretroviral therapy, almost all agree to being tested and receiving treatment;
- in the rare cases where pregnant women may be reluctant to undergo HIV testing or treatment, it is usually because they fear that their HIV-positive status will become known and they will face violence, discrimination or abandonment;
- forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for mother-to-child transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent; and
- often, HIV-positive mothers have no safer options than to breastfeed, because they lack breast milk substitutes or clean water to prepare formula substitutes.<sup>41</sup>

Transmission offences should therefore exclude application of the offence to mother-to-child transmission, or provide a defence to HIV transmission in these circumstances. Public health measures, including counselling and social support, are more appropriate to deal with the rare cases of pregnant women or mothers with HIV who refuse treatment. Governments should ensure both parents have information and access to measures to reduce mother-to-child transmission, including access to HIV testing and treatment. Women also need effective measures to protect them and their infants from violence and discrimination related to their HIV status.

#### **The year-and-a-day rule**

This refers to a principle of criminal law inherited from British law (and which has already been abolished by some) that for charges of murder or manslaughter the death must occur within a year and a day of the incident alleged to have caused the death. Due to the long period of latency of the HIV virus before it proceeds to AIDS and death in many cases, this would eliminate any possibility of a charge of unlawful killing where this rule still exists. Where this rule does not still exist, a criminal prosecution for murder based on transmission of HIV would still be technically possible.

41. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008c).

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### Other diseases

A generic offence of causing transmission of a disease may be applied to other communicable diseases, however there would need to be discretion in the application of punishment, based on the seriousness of the disease. Legislators and policy makers would also need to consider whether any useful purpose would be served by the use of the criminal law in cases concerning, for example, the transmission of STIs. The guiding principles defined by UNAIDS suggest that a public health rather than a criminal law intervention would better serve the interests of the community and the welfare of the individual.

#### Example:

*Infecting with disease - Every one is liable to imprisonment for a term not exceeding fourteen years who wilfully and*

*without lawful justification or excuse, causes or produces in any other person any disease or sickness.*

*Cook Islands Crimes Act 1969 S.223*

### Reckless behaviour

It is important to distinguish deliberate acts done with the intention to transmit infection from mere reckless behaviour which may result in transmission. Reckless transmission, which can take place when risky behaviour is continued without regard for the possible consequences, should not be treated as a crime. The law considers that a criminal offender is someone who is capable of taking full responsibility for his or her actions, but this is often not the case in the Pacific setting. For example, in the Pacific context, women may encounter extreme difficulty in negotiating safe sex practices and condom use with long-term partners and spouses, yet it is often the woman who is the first to come forward for testing, or who is tested anyway at the ante-natal clinic. Informing her partner (who may well have infected her in the first place) may lead to her being blamed for infecting him, with sometimes disastrous consequences.

Many women prefer not to disclose their HIV status, because the remote risk of being charged with an offence and taken to court (if this risk is understood) is insignificant compared to the immediate risk of rejection, desertion or violence.

Another issue particularly relevant in the Pacific context is that many people may not fully appreciate the consequences of HIV infection, despite counselling. Counselling may be inadequate, or come in written form only, which is hard to read and understand. Indicators may show that, for example, a person should have known that practising unsafe sex could result in the infection of a sexual partner, but took no notice of any warning.

### To prosecute or not to prosecute?

The issues discussed above illustrate the complexity surrounding decisions as to whether it is appropriate to prosecute a person for transmitting HIV. It may appear difficult to argue that the intentional infliction of harm upon another person through infecting them with HIV should be exempt from criminal prosecution, when other forms of inflicting harm are regularly subject to prosecution. However, the circumstances in which a person with HIV fails to take precautions against infecting another can vary greatly: they can involve an imbalance of power between the two parties (for example a woman who is diagnosed with HIV, and her undiagnosed husband); the quality of information a person with HIV receives about the nature of HIV infection, and their capacity to understand that information; the quality and accessibility of support services available to people with HIV; and access to preventive equipment such as condoms, to name just some examples. The issue is further complicated by the potential for negative public health outcomes through the further stigmatization of people living with HIV as criminals or potential criminals.

Many of the accepted rationales for criminal prosecutions, such as denunciation, deterrence, prevention, and rehabilitation, do not apply to prosecutions for deliberate transmission in the way they do for other acts considered criminal.

For these reasons, a decision to prosecute should not be left to police or other prosecuting authorities alone, but should only be made in consultation with public health officials. A written protocol governing the principles and procedures to be followed should be developed jointly by ministries responsible for police and for public health, to provide guidance for decision making where a criminal prosecution is being considered. In this way can the interests of criminal justice and public health can be reconciled.

#### 4.4 Checklist: Prisons/Correctional Laws

1. Does the legislation provide for access equal to the outside community to the following HIV-related prevention and care services in prisons or correctional facilities:
  - information and education;
  - voluntary counselling and testing;
  - means of prevention e.g. condoms, bleach, and clean injecting equipment;
  - treatment – ART and treatment for opportunistic infections;
  - choice to participate in clinical trials (if available)?
2. Does the legislation provide for the protection of prisoners from involuntary acts that may transmit the virus e.g. rape, sexual violence or coercion?
3. Does the legislation provide for the confidentiality of prisoners' medical and/or personal information, including HIV status?
4. Does the legislation not require segregation of prisoners, merely on the basis of their HIV status, as opposed to behaviour?
5. Does the legislation (e.g. sentencing) provide for medical conditions, such as AIDS, as grounds for compassionate early release or diversion to alternatives other than incarceration?
6. Does the legislation provide for non-discriminatory access to facilities and privileges for HIV-positive prisoners?

#### Principle

Prison authorities should take all necessary 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 injecting 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.

*International Guidelines, para.29(e)*

Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.

*Statement by UNAIDS to the UN Commission on Human Rights, 1996.*

HIV prevalence in prisons is often much higher than that in the general community. Behaviours such as drug use and sex work are illegal in many countries, and these behaviours, as well as their criminalization, increase people's risk of acquiring HIV infection. Moreover there is risk of HIV transmission in prisons because of unsafe male-to-male sex (whether consensual or coerced), tattooing, and the sharing of injecting equipment for drug use. Although such activity is illegal in prisons, and despite attempts to repress it, such behaviour is a reality. Prisoners are condemned to prison for their crimes, but they are not condemned to HIV infection, and prison authorities have a duty of care to ensure that HIV transmission in prison does not occur. Loss of liberty does not entail the loss of other human rights, including the right to health.

#### Access to information and education

Prisoners should have access to education and information services equivalent to those available to the general public.

#### Access to means of prevention

Consultation with prisoners, prison staff, and their unions, is essential to the success of any programme if it is to be acceptable to all parties. One strategy used by legislators in attempting to change the controversial prison environment has been to firstly trial projects to secure support from potential opponents, such as staff. Where condoms are made



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available in prisons, this usually involves the use of automatic distribution machines. The evaluation of such programmes indicated that inmates use the machines. Studies have revealed low levels of harassment of users of the machines by other inmates and few incidents of improper condom disposal. The reported level of safer sex was high among those who had sex and there was no evidence of any unintended consequences as a result of condoms being available.<sup>42</sup>

## Example

- *In New South Wales, Australia, condoms have been made available in prisons since 1996, after a prisoner sued the Government after being infected with HIV in prison.*
- *Establishing needle and syringe programmes in prisons. The first such programme started in 1992 in Switzerland. As of March 2004, over 50 such programmes were operating in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus. All evaluations of programmes have been favourable. Reported drug use decreased or remained stable over time, and reported sharing of injecting equipment reduced dramatically. The evaluations found no reports of serious unintended negative events, such as the initiation of injection, or the use of needles as weapons. Overall, evaluations indicated that prison syringe exchange programmes are feasible, and do provide benefit in the reduction of risk behaviour and the transmission of blood borne infection without any negative effects.<sup>b</sup>*
- *Fiji's Prisons and Corrections Act 2006 requires those implementing the legislation to apply "the accepted practices and standards identified in the context of HIV/AIDS, and in particular the International Minimum Standards on HIV/AIDS and Human Rights" and to ensure that "prisoners who are infected with HIV/AIDS ...are treated in a manner which takes into account their basic rights and special needs". Fiji's legislation also specifies that "there shall*

b. World Health Organization (2005a) p.48.

*be no programme or policy of compulsory testing of prisoners to determine their HIV/AIDS status" and "no separation shall be ordered only on the basis of a prisoners HIV/AIDS status".*

*Condoms are not specifically mentioned, although there is a requirement to provide health education to prisoners.*

- *Solomon Islands Correctional Services Act 2007 provides an example of protective legislation for prisoners' health. It states that health care facilities and primary care services shall be provided for prisoners to a community standard while also taking into account the special circumstances and health care needs of prisoners.*

## Voluntary counselling and testing

Mandatory HIV testing is not a solution to the challenges of protecting the health of prisoners. It violates their rights, and contributes to stigma and a lack of confidentiality for HIV-positive prisoners, without providing any protection for prisoners who are not infected.

## Access to ART, other HIV-related treatments, and clinical trials

The World Health Organization has noted that "health care for injecting drug users and their families, both primary health care and support and treatment for HIV-related illness, can be carried out anywhere."<sup>43</sup> Health care for prisoners with HIV may be non-existent or minimal, compared to what is available outside of prison. One means which has shown to be successful in improving the standard of health care available to prisoners is to put prison health under the responsibility of health authorities, rather than prison authorities. As well as resulting in better health care for prisoners, this arrangement has the advantage of strengthening the link between health services (including health education and counselling) in prisons and health services in the community. In some cases, conditions in prisons have improved significantly since the new policy was introduced.<sup>44</sup>

Prisoners' human rights should be respected, including the right to health care. Denial of treatment,

42. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2004)

43. *Ibid* p.70.

44. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2004).



care and voluntary participation in clinical research trials can be viewed as a form of inhuman or degrading punishment.

### **Protection from involuntary acts such as rape, sexual violence, or coercion**

Measures that are respectful of human rights include providing sufficient staffing resources to enable effective surveillance and appropriate disciplinary measures to protect prisoners from rape, sexual violence and coercion.

### **Confidentiality of prisoners' personal and/or medical information**

Protection of the confidentiality of personal and medical information is as important in the prison environment as it is in the general community. Stigma and discrimination, which can result from the disclosure of a prisoner's HIV-positive status, are likely to be worse than outside of prisons, because of the often overcrowded, violent, and unsafe conditions in many prisons.

### **Segregation not merely on the basis of HIV status**

Segregation per se reveals a prisoner's HIV status to other prisoners and to prison staff, providing an excuse for abuse and threats, which can enhance stigma and isolation, even after a prisoner is released back into the community. Segregation is stigmatizing and implies that casual contact with people living with HIV is unsafe. It can also result in the denial of privileges such as work release or workshop access in prison. Sometimes it results in the mixing of maximum and minimum security prisoners in the same unit, because of the restricted availability of space.

### **Medical conditions as grounds for compassionate early release**

In sentencing prisoners courts have sometimes viewed HIV as a mitigating factor. Reduced sentences or compassionate early release of prisoners with AIDS has become the practice in some countries, on the basis that it should be treated like other life-threatening illnesses.

### **Non-discriminatory access to facilities and privileges for prisoners**

Prisoners with HIV should be granted access to work and recreational opportunities on the same basis as other prisoners. There are no grounds for the arbitrary separation of HIV-positive prisoners from other prisoners solely on the basis of their HIV status. The right to freedom from discrimination in relation to work, recreation and other privileges underlines the importance of protecting confidentiality. Unauthorized disclosure of a prisoner's HIV status could result in discriminatory treatment either by other prisoners or by prison staff, which could prevent non-discriminatory access to facilities and privileges.

#### **Example**

*An act of unlawful discrimination may take place... in relation to detainees and persons in custody, in—*

- *the application of detention, restriction or segregation procedures or conditions; or*
- *the provision of and access to health facilities and care; or*
- *the subjecting of a detainee to any other detriment in relation to detention or custody*

*HIV/AIDS Management and Prevention Act S.7(e) (PNG)*

## CHAPTER 5:

## ANTI-DISCRIMINATION AND PROTECTIVE LAWS

## GUIDELINE 5

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS 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.

## Introduction

Pacific countries all have some measure of human rights enshrined in legislation, including (in the case of independent nations) guarantees of rights and freedoms in national Constitutions.

*Typically, these provisions include a right of equality before the law, and freedom from discrimination on specified grounds. These rights and freedoms can only be qualified or limited in very specific circumstances, such as —*

- where the enjoyment of the right or freedom might interfere with the rights of others
- where the enjoyment of the right is prohibited by law (such as in international human rights treaties where the temporary suspension of some specific civil and political rights may be justified during times of particular strife such as war, civil unrest)
- in cases of public emergency.

The circumstances under which a State Party may limit enjoyment of the rights guaranteed under the International Covenant on Civil and Political Rights are known as the “Siracusa Principles”. These state that a state party may take measures derogating from its obligations under the International Covenant on Civil and Political Rights only when faced with a situation of exceptional and actual or imminent danger which threatens the life of the nation. A threat to the life of the nation is one that:

- (a) affects the whole of the population and either the whole or part of the territory of the State; and;

- (b) threatens the physical integrity of the population, the political independence or the territorial integrity of the State or the existence or basic functioning of institutions indispensable to ensure and protect the rights recognized in the Covenant.<sup>45</sup>

Some members of society are more vulnerable than others, are more likely to be targets for stigma, discrimination and ill-treatment at the hands of their immediate community, society in general, and the state and its agents. Women, children and criminalised groups such as sex workers and men who have sex with men are all disadvantaged generally in many societies and may also experience additional disadvantage by reason of actual or assumed HIV status.

*The International Guidelines* are designed to achieve a pragmatic approach to public health goals. Within the framework of the *Guidelines*, countries can establish how they can best meet their international human rights obligations and protect the public health within their political, cultural and religious contexts. 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, norms and standards, and in the light of the understanding that repression and criminalisation of marginalised groups does not prevent HIV, but rather assists its spread.

45. United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities (1984).

## 5.1 Discrimination and stigma

### Human Rights Principles:

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 due to the discrimination they face. Disability discrimination laws should also be enacted or revised to include HIV in the definition of disability.

*International Guideline 5 para.30(a)*

### 5.1.1 Relevant human rights

- right to life, liberty and dignity
- right to privacy
- freedom of movement and residence
- freedom from torture and inhuman treatment
- right to equality and freedom from discrimination
- right to work
- right to health care
- right to freedom from all forms of discrimination against women and girls

### 5.1.2 Background

The U.N. Commission on Human Rights has resolved that

“... discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”<sup>46</sup>

Discrimination creates and sustains vulnerability to HIV. People who are frightened of stigmatisation and discriminatory treatment, if they are or think they may be HIV-positive, may be afraid to come forward and seek testing or treatment. This makes it harder for health workers and civil society to reach them and keep them informed. HIV-related discrimination should

be made unlawful by specific legislation, which should provide for effective enforcement mechanisms.

In some cases it may be possible to litigate for the protection of human rights based solely on the rights guaranteed under the Constitution. However this may not be an easily accessible form of legal remedy, as it may require complex Court proceedings at significant cost to the litigant. Another possible disadvantage in relying on the Constitution is that the human rights guarantees it contains may be expressed in general rather than specific terms. In the absence of clear legal precedent, it may be difficult to judge the likely success of such litigation.

### 5.1.3 Checklist - Anti-discrimination legislation

- 1 Does the legislation provide for protection against discrimination on the ground of disability, widely defined to include HIV/AIDS?
- 2 Does the legislation provide for protection against discrimination on the ground of membership of a group made more vulnerable to HIV/AIDS e.g. gender, homosexuality?
- 3 Does the legislation contain the following substantive features:
  - coverage of direct and indirect discrimination;
  - coverage of those presumed to be infected, as well as carers, partners, family, or associates;
  - coverage of vilification;
  - the ground complained of only needs to be one of several reasons for the discriminatory act;
  - narrow exemptions and exceptions (e.g. superannuation and life insurance on the basis of reasonable actuarial data);
  - wide jurisdiction in the public and private sectors (e.g. health care, employment, education, and accommodation)?
- 4 Does the legislation provide for the following administrative features:

46. United Nations Commission on Human Rights Resolutions 1995/44; 1996/43, 1999/49; 2001/51 and Sub-Commission Resolution 1995/21

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- independence of a complaint body;
- representative complaints (e.g. public interest organizations on behalf of individuals);
- speedy redress e.g. guaranteed processing of cases within a reasonable period, or fast-tracking of cases where the complainant is terminally ill;
- access to free legal assistance;
- investigatory powers to address systemic discrimination;
- confidentiality protections e.g. use of pseudonyms in reporting of cases?

5 Does the legislation provide for the institution administering the legislation (e.g. humanrightscommissionorombudsperson) to have the following functions:

- education and promotion of human rights;
- advising government on human rights issues;
- monitoring compliance with domestic legislation and international treaties and norms;
- investigating, conciliating, resolving or arbitrating individual complaints;
- keeping data/statistics of cases and reporting on its activities?

The form and placement in legislation of a prohibition against HIV-related discrimination will depend on each country's existing legislative environment. Anti-discrimination provisions can be included in a country's Constitution. Several Pacific countries are currently undergoing constitutional reviews, which provide an opportunity to revise the freedom from discrimination provision to include health status, HIV status or disability generally in the prohibited grounds of discrimination, along with other grounds such as gender and sexuality.

The *UN Convention on the Rights of Persons with Disabilities* (the 'Disability Convention') came into operation in 2008. States ratifying this Convention are bound to ensure that their domestic legislation complies with and enacts the requirements of the Convention.

States should enact legislation that clearly prohibits discrimination including HIV-related discrimination, provides for accessible forums in which to take legal action and enables enforcement of decisions. Some jurisdictions have already enacted general disability discrimination laws, and defined disability to include HIV and AIDS. Other countries are considering doing so. However, a warning should be sounded. Some disability discrimination proposals involve the identification and registration of disabled people. This is not appropriate in the context of HIV as it could breach confidentiality in respect of people living with HIV.

### Disability discrimination widely defined to include HIV/AIDS

#### Example

##### *Disability means:*

- (b) *the presence in a person's body of organisms causing or capable of causing disease or illness.*

*Anti-Discrimination Act 1977 NSW (Australia) S.4.*

This approach fulfils the criterion of defining disability widely to include HIV (or other types of) infection

### Protection for vulnerable groups, associates, and those presumed to be infected

It is important to ensure that legislation covers persons such as family members, relatives, and other associates of people living with HIV in the prohibitions against discrimination.

*Guideline 5* recommends the protection of those with HIV, those suspected or presumed to be infected, such as family members and relatives, members of vulnerable populations, and their associates or family. Groups made more vulnerable to HIV due to the discrimination they face, such as sex workers, men who have sex with men and transgender populations should also be protected.

#### Example

*"person infected or affected by HIV/AIDS" means a person who—*

- (a) *is, or is presumed to be, infected*

*by HIV or has, or is presumed to have, AIDS; or*

- (b) *has had, is having, is seeking to have or has refused to have an HIV test; or*
- (c) *is related to or is associated with a person who is, or is presumed to be, infected by HIV or has, or is presumed to have, AIDS; or*
- (d) *is, or is presumed to be, a member of or associated with a group, activity or occupation, or living in an environment, which is commonly associated with, or presumed to be associated with, infection by, or transmission of, HIV*

*HIV/AIDS Management and Prevention Act S.2 (PNG)*

As well as promoting respect for human rights in the context of HIV, this broad definition should assist in implementing HIV programs for marginalized populations. It can also help address cultures of impunity in which crimes against populations such as sex workers, men who have sex with men and transgender populations are ignored, tolerated, or even encouraged by law enforcement agencies.

### **Anti-discrimination provisions in public health legislation**

Anti-discrimination provisions can also be included in health legislation. This is appropriate where specific HIV-related legislation is enacted, such as the *HIV/AIDS Management and Prevention Act 2003* (PNG). However for the sake of clarity and accessibility, it is not advisable to include anti-discrimination provisions in general public health legislation dealing with a range of issues such as protection of water supplies, pest control, immunisation, and other issues commonly dealt with in such legislation.

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*Many people die of loneliness  
before they die of AIDS.*

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### **Prohibition of direct and indirect discrimination**

#### *Definition of discrimination*

Discrimination can be “direct” or “indirect”. Both forms of discrimination should be covered by anti-discrimination legislation.

#### *Direct discrimination*

Direct discrimination occurs if a person treats someone with a particular attribute less favourably than they treat someone without that attribute, in the same or similar circumstances. Where HIV is the relevant “attribute”, an example of direct discrimination would be the refusal to allow someone with HIV to use a public swimming pool, where that person’s HIV status does not prevent them using the swimming pool in the same way as other members of the general public in the same or similar circumstances. Direct discrimination would occur whether the attribute is real or merely assumed by the discriminator.

#### *Indirect discrimination*

Indirect discrimination occurs if a person imposes a requirement or condition which:

- someone with an attribute does not or cannot comply with; and
- a higher proportion of people without the attribute can or do comply with; and
- the requirement or condition is not reasonable.

In the case of HIV, an example of indirect discrimination would be the imposition that all members of a golf club regularly donate blood to the local blood bank. A person with HIV will be unable to comply with this requirement, a higher proportion of people without HIV will be able to comply with the requirement, and the requirement is not a reasonable condition for membership of a golf club.

HIV-related discrimination should be defined broadly, to include people affected or assumed to be affected by HIV, as well as people who are or are assumed to be HIV positive. The reason why discrimination should be defined broadly is that it affects people assumed to be vulnerable to or otherwise affected by HIV, as well as people known or assumed to be HIV positive, such as sex workers, men who have sex with men, or the families or associates of people living with HIV. Discrimination should be classed as HIV discrimination even when HIV is only one of several reasons for a discriminatory act.



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6(2) *No person shall discriminate against any worker or prospective worker on the grounds of ethnicity, colour, gender, religion, political opinion, national extraction, sexual orientation, age, social origin, marital status, pregnancy, family responsibilities, state of health including real or perceived HIV status, trade union membership or activity, or disability in respect of recruitment, training, promotion, terms and conditions of employment, termination of employment or other matters arising out of the employment relationship.*

75. *For the purposes of this Part, the prohibited grounds for discrimination whether direct or indirect are actual or supposed personal characteristics or circumstances, including: ... disability, HIV/AIDS status...*

*“indirect discrimination” means any apparently neutral situation, regulation or practice which in fact results in unequal treatment of persons with certain characteristics that occurs when the same condition, treatment or criterion is applied to everyone, but results in a disproportionately harsh impact on some persons on the grounds set out in sections 6(2) and 75 and is not closely related to any inherent requirement of the job.*

*Employment Relations Promulgation 2007 (Fiji)*

*It is unfair discrimination for a person, while involved in any of the areas set out in subsection (3), directly or indirectly to differentiate adversely against or harass any other person by reason of a prohibited ground of discrimination.*

*Human Rights Commission Act S.17 (Fiji)*

#### **Definition of disability discrimination -**

*“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental*

*freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.*

*Convention on the Rights of Persons with Disabilities Article 2*

### **Prohibition of vilification/stigmatisation**

It is not just discriminatory actions which cause hurt and damage. Stigmatisation and hatred are equally damaging and rooted in the shame and fear associated with HIV. Therefore stigmatisation or vilification of those infected or affected by HIV should also be prohibited in law.

#### **Example**

*“stigmatise” means to vilify, or to incite hatred, ridicule or contempt against a person or group on the grounds of an attribute of the person or of members of the group, by—*

- (a) the publication, distribution or dissemination to the public of any matter; or*
- (b) the making of any communication to the public, including any action or gesture, that is threatening, abusive, insulting, degrading, demeaning, defamatory, disrespectful, embarrassing, critical, provocative or offensive;*

*HIV/AIDS Management and Prevention Act S.2 (PNG)*

In some laws, the term “vilification” is used rather than “stigmatisation”, although the meaning is similar.<sup>47</sup>

Exceptions may be made for stigmatizing actions or vilification which forms part of religious discussion or instruction. However it should be borne in mind that the impact of such actions can be as harmful as, or more harmful than, similar actions by others who do not occupy positions of respect and social leadership as are held by religious leaders. For these reasons, such exceptions should either not apply or be phrased and interpreted narrowly. Efforts should be made to engage religious leaders in authorities responsible for advising on responses to HIV.

47. See e.g. Anti-Discrimination Act 1977 (NSW) sections 49ZT and 49ZXB.

**Example**

- (1) Subject to Subsection (2), it is unlawful to stigmatise a person on the ground that the person is infected or affected by HIV/AIDS.
- (2) Subsection (1) does not apply to—
- (a) a fair report of an act of stigmatisation referred to in Subsection (1); or
  - (b) the communication, dissemination, distribution or publication of any matter that is subject to a defence of absolute privilege in proceedings under the Defamation Act (Chapter 293); or
  - (c) a public act, done reasonably, in good faith and not actuated by ill-will to the person stigmatised, for academic, artistic, scientific, research or religious discussion or instruction purposes or for other purposes in the public interest, including discussion or debate about and expositions of any act or matter.

*HIV/AIDS Management and Prevention Act S.10 (PNG)*

**HIV need be only one of several reasons for discrimination**

Often where HIV-related discrimination is alleged to have occurred, the person or institution will respond that other factors were the reason for less favourable treatment, or that HIV-related reasons were only one of the factors leading to less favourable treatment. In order to effectively address HIV-related discrimination, it is important that anti-discrimination legislation covers situations where HIV is only one contributing factor to the less favourable treatment.

**Example**

*Prohibition where HIV is only one of several reasons for a discriminatory act -*

*It is unlawful to discriminate against a person to the detriment of that person on the grounds that the person is infected or affected by HIV/AIDS.*

**Where—**

- (a) an act of discrimination is done for two or more reasons; and
  - (b) one of the reasons is a ground set out in Subsection (1), whether or not it is the dominant or substantial reason for doing the act,
- the act is presumed to have been done for that reason.*

*HIV/AIDS Management and Prevention Act S.6 (PNG)*

**Narrow exemptions and exceptions****Insurance**

The circumstances in which HIV-related discrimination is prohibited should be framed as widely as possible, while allowing clearly defined defences for differential treatment that is reasonable. One of the areas where discrimination may be reasonable is in the area of insurance, where decisions regarding the sale of insurance policies are based on assessment of various risk factors. However, even in this context, there should be an onus on the insurer to prove that a decision to treat a person living with HIV less favourably than someone who does not have HIV is based on sound data, and not merely on prejudice. HIV should be treated no differently to analogous pre-existing medical conditions when determining the extent and price of insurance cover.

There are several ways in which insurance schemes may deal with pre-existing conditions. One approach is to exclude the pre-existing condition from the policy, while providing insurance cover in respect of other conditions. Other approaches can include charging a higher premium for coverage in respect of a pre-existing condition, or imposing a waiting period during which claims cannot be made based on the pre-existing condition. Superannuation and insurance companies are entitled to determine the conditions of a policy based on an assessment of risk, which includes taking into account any pre-existing conditions which might predispose the insured person to make a claim on their policy. The key consideration is that people living with HIV are not treated less favourably than people with comparable medical conditions

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*Nothing in Section 7(h) renders unlawful any discrimination in relation to any class of insurance or superannuation business, membership of a superannuation or provident fund or scheme, or similar matter involving the assessment of risk, where the discrimination—*

*(a) is effected by reference to actuarial or statistical data on which it was reasonable to rely; and*

*(b) is reasonable having regard to the content of the data and any other relevant factors,*

*or, where no actuarial or statistical data is available and cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors.*

*HIV/AIDS Management and Prevention Act S.8 (PNG)*

*Credit and loan services, and health, accident and life insurance shall not be denied to a person on the basis of his/her actual, perceived or believed HIV status, provided the person with HIV has not concealed or misrepresented the fact to the credit, loan or insurance company upon application. Extension and continuation or credit and loan services and insurance shall likewise not be denied solely on the basis of said health condition.*

*Pohnpei Code Chapter 6A, 174*

HIV is not a valid ground for refusal to insure against conditions unrelated to HIV, such as accident insurance, or unemployment insurance where the cause of unemployment is unrelated to HIV.

It may be possible in some circumstances for people living with HIV to obtain death and disability insurance through what are known as “industry schemes”. These are large group schemes, usually negotiated between trade unions and insurance companies, under which an insurance company will agree to provide death and disability insurance for all workers in a certain sector, such as the construction industry, without screening for pre-existing conditions. The large volume of customers joining such schemes, and the level of benefits payable in the event of a claim, enable insurers to absorb any additional risks they may take

on as a result of forgoing health screening as a condition of joining the scheme. Whether insurance benefits are available to people living with HIV will depend on them being employed in a sector where “group cover”, rather than an individually assessed policy, is available.

### Wide jurisdiction in the public and private sectors

#### *Areas where discrimination is prohibited*

The areas covered by prohibitions against discrimination should be as broad as possible, including health care, social security, welfare benefits, employment, education, sport, accommodation, clubs, trade unions, qualifying bodies, access to transport, insurance and other services. It may be advisable to use a phrase such as ‘including but not limited to...’, or ‘in particular, and without limiting the generality of...’, in order to cover discrimination in a form not envisaged at the time of drafting legislation.

#### *Health care workers*

Discrimination in the health care sector is common in many countries. 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 practice, 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.<sup>48</sup>

### Family matters

In some places, the HIV status of an adult has been used as a factor in denying child custody, access, fostering, or adoption, despite the fact that people living with HIV can live long healthy lives with proper care and support. HIV status does not affect whether someone can or should be a parent. The HIV status of a parent or child should not be treated any differently from any other analogous medical condition in making decisions regarding child custody, access, fostering or adoption.

### The media

The media plays a significant role in shaping public opinion concerning people living with and vulnerable to HIV, and the role of the state in responding to the epidemic. States should encourage the media and

<sup>48</sup> *International Guidelines para 28(j).*

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 could include the production of resources, such as handbooks containing preferred terminology, so as to eliminate use of stigmatizing language, and a professional code of behaviour in order to ensure respect for confidentiality and privacy.<sup>49</sup>

## Administrative features of legislation

### Independent complaints body

Principles for establishing Human Rights Commissions have been developed by the UN Commission on Human Rights. In the Pacific, only Fiji has a Human Rights Commission, although other countries are considering establishing one.

Some Pacific countries have an Ombudsman Commission or an Ombudsman. The Ombudsman is often no more than a single officer, perhaps only operating part-time in the role. Further, the establishing legislation usually spells out the role of the Ombudsman as that of investigating public bodies or administrative action only. In some countries however, the Ombudsman has wider powers, or the establishing provisions allow for the grant of wider powers.

### Examples

*The Fiji Human Rights Commission has powers to:*

*Inquire generally into any matter, including any enactment or law, or any procedure or practice whether government or non-governmental, if it appears to the Commission that human rights are, or may be, infringed thereby;*

*Investigate allegations of violations of human rights and allegations of unfair discrimination, on its own motion or on complaint by individuals, groups or institutions on their own behalf or on behalf of others;*

*Resolve complaints by conciliation and refer unresolved complaints to the courts for decision.*

*Human Rights Commission Act 1999 S.7 (Fiji)*

*The functions of the Ombudsman Commission are—*

- *to investigate the conduct on the part of a governmental service or an officer or member of it*
- *to investigate any defects in any law or administrative practice*
- *to investigate, either on its own initiative or on complaint by a person affected, any case of an alleged or suspected discriminatory practice within the meaning of a law prohibiting such practices*

*Conduct is wrong if it is—*

- *contrary to law*
- *unreasonable, unjust, oppressive or improperly discriminatory, whether or not it is in accordance with law or practice*
- *based wholly or partly on improper motives, irrelevant grounds or irrelevant considerations*
- *based wholly or partly on a mistake of law or of fact*
- *conduct for which reasons should be given but were not.*

*Constitution S.219 (PNG)*

*The functions of the Ombudsman shall be to:-*

- (a) enquire into the conduct of any person to whom this section applies in the exercise of his office or authority, or abuse thereof;*
- (b) assist in the improvement of the practices and procedures of public bodies; and*
- (c) ensure the elimination of arbitrary and unfair decisions.*

*Parliament may confer additional functions on the Ombudsman.*

*Constitution S.97 (Solomon Islands)*

### Representative complaints

Anti-discrimination legislation should permit representative complaints, in which one person or a group of people take action against HIV-related discrimination on behalf of all people affected by a

<sup>49</sup> *International Guidelines para 40(d).*



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particular form of discrimination. In this way, complaints bodies can deal more efficiently with an issue which affects a class of people. Representative complaints can also reduce the number of people who must become personally involved in the process of litigation, which can be time-consuming, as well as physically and emotionally taxing. Representative complaint procedures can also be used to ensure that a complaint does not lapse if a complainant dies, and also to enable community groups and other representatives such as trade unions to lodge complaints on behalf of their constituents. Remedies should also be available for systemic discrimination by respondent agencies or individuals, rather than simply for individual cases.

### Speedy redress

Complaints bodies should provide quick avenues for redress, with special procedures for fast-tracking cases where the complainant is terminally ill. Otherwise, respondents may seek to delay proceedings until a complaint dies.

### Access to free legal assistance

Legal assistance should be made available to those complainants who cannot afford to pay for assistance themselves. This measure is necessary in order to ensure that access to justice does not depend on the financial means of the person subject to discrimination.

### Investigatory powers to address systemic discrimination

In order to address systemic discrimination, broader investigative powers by the agency administering the anti-discrimination legislation are necessary.

### Confidentiality protections

As well as taking time and energy from complainants, proceedings can result in publicity and victimization, so legislation should make it possible for complaints to use pseudonyms to protect their identity.

### Educative and advisory functions

The focus of anti-discrimination legislation is primarily educative rather than punitive. Remedies from tribunals or boards which hold formal hearings should be available as a last resort when conciliation has not resolved complaints. In order to fulfil educative and complaints resolution functions, agencies

administering the legislation should be empowered to fulfil the following functions:

- education about and promotion of respect for human rights;
- providing advice to governments on human rights issues;
- monitoring compliance with domestic anti-discrimination laws, and international treaties;
- investigating, conciliating, resolving, or arbitrating individual complaints;
- keeping data and statistics of cases, and reporting publicly on its activities.

### Other measures

Other forums provide opportunities for promoting HIV-related human rights. States should encourage educational institutions, trade unions, and workplaces to include HIV and human rights in curricula addressing issues such as human relationships, citizenship, social studies, legal studies, health care, law enforcement, family life, sex education and welfare counselling. States should support HIV-related human rights and ethics training for government officials, the police, prison staff, politicians, as well as village, community and religious leaders and professionals.

## 5.2 Discriminatory impact of laws affecting vulnerable populations

### 5.2.1 Checklist - equality of legal status of vulnerable populations

1. Does the law ensure the equal legal status of men and women in the following areas:
  - ownership of property and inheritance;
  - marital relations e.g. divorce and custody;
  - capacity to enter into contracts, mortgages, credit and finance;
  - access to reproductive and STI health information and services;
  - protection from sexual and other violence, including rape in marriage;



- recognition of de facto relationships;
  - prohibition of harmful traditional practices e.g. female genital mutilation?
2. Does the legislation prohibit the mandatory testing of targeted or vulnerable groups, such as orphans, the poor, sex workers, minorities, indigenous populations, migrants, refugees, internally displaced persons, people with disabilities, men who have sex with men, and injecting drug users?
  3. Does the law require children to be provided with age-appropriate information, education and means of prevention?
  4. Does the law enable children and adolescents to be involved in decision-making in line with their evolving capacities in regard to:
    - consent to voluntary testing with pre- and post-test counseling;
    - access to confidential sexual and reproductive health services?
  5. Does the law provide protection for children against sexual abuse and exploitation? Is the object of such legislation the rehabilitation and support of survivors, rather than further victimizing them by subjecting them to penalties?
  6. Does the law provide an equal age of consent for heterosexual and homosexual acts? Does the law recognize same-sex marriages or domestic relationships?

### Background

The disproportionate impact of HIV on particular populations makes the improvement of their legal status and realization of their human rights critical if an effective response to the epidemic is to be achieved. Vulnerable populations include women, children and young people, people with disabilities, sex workers, men who have sex with men and transgender persons. Without full respect for human rights, vulnerable

populations are not in a position to avoid infection because they either do not receive prevention education and information, or cannot act on it, and when infected are disempowered to cope with the impact.

Recommendations in this section directed specifically at the protection of vulnerable groups may be sensitive and controversial in some national, cultural or religious contexts. Individuals, societies and governments may feel uncomfortable confronting these issues. Culture can be an excellent vehicle for promoting HIV prevention, but it can also be a barrier to effective action.<sup>50</sup>

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, norms and standards, and in the light of the understanding that repression and criminalisation of marginalised groups does not prevent HIV, it assists its spread.

Decriminalisation of sex work and male-male sex raise emotionally charged issues for those who want to provide a better environment for HIV prevention and care in the Pacific. The immediate reaction may be to accuse and to prohibit. But these issues must be considered more carefully.

### 5.2.2 Women

#### Human rights principle

Anti-discrimination and protective laws should be enacted to reduce human rights violations against women in the context of HIV/AIDS, so as to reduce vulnerability of women to infection by HIV and to the impact of HIV/AIDS.

*International Guideline 5, para 22(f)*

#### Relevant human rights

- right to equality and freedom from discrimination
- freedom from torture and inhuman treatment
- right to security of the person and bodily integrity
- right to privacy
- sexual and reproductive health rights

<sup>50</sup> UNAIDS (2005).

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- right to decide the number and spacing of children
- freedom from assault and exploitation

**Background**

Gender inequality is a significant cause of HIV and STI vulnerability of women. Women face discrimination in the legal, social, political and economic spheres in all Pacific Island countries. A thorough examination of the full range of legislative measures required to achieve compliance with CEDAW have been developed and applied to the existing legal frameworks in ten Pacific Island Countries and should also inform HIV related law reform.<sup>51</sup> Women generally have less social status than men and less economic and political power. Due to women's relative lack of power in society generally and in their personal relationships, they are often less able to insist on fidelity from their partners and less able to effectively negotiate condom use.

Physical and sexual violence accentuates the vulnerability of women and girls. Studies from Rwanda, Tanzania and South Africa show up to three fold increases in risk of HIV among women who have experienced violence compared to those who have not.<sup>52</sup> Studies in Pacific Island countries confirm high rates of gender based violence. In PNG, 66% of wives reported having been hit by their husbands; in Samoa, 46% of women reported some form of partner abuse; and in Fiji 80% of women surveyed had at sometime in their life witnessed violence within the home.<sup>53</sup>

In PNG, HIV prevalence among women aged 15–29 years have been found to be twice as high as those found among men of the same age, and the key factor in the spread of HIV in married women is believed to be the extramarital relationships of husbands.<sup>54</sup>

Women are often blamed for spreading infection. A greater proportion of women than men may be tested for HIV, because of the provision of HIV testing at antenatal clinics. This can mean that a wife is often the first one in a family to learn of her HIV status, and is therefore blamed for having acquired it from outside. This can lead to violence or other acts of retribution directed at women.

**Constitutional protection of gender equality**

Most Pacific Island countries have Constitutional guarantees of equality and non-discrimination. However, these Constitutional protections are to some extent subject to pre-existing customary laws.

Traditional attitudes towards women and the roles imposed on them by customs and cultural practices can lead to the perpetuation of discrimination against women. International law requires States to take all appropriate measures to eliminate prejudices and any customary practices that are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.<sup>55</sup> States are required to take all appropriate measures including legislation, to modify or abolish customs and practices which constitute discrimination against women.<sup>56</sup>

There are many positive and empowering aspects of customary laws that focus on community welfare. However, human rights and customary law can conflict. Customary law in the Pacific is generally based on concepts of community values, rather than individual rights, and often assumes male dominance rather than equality between men and women. Courts in the Pacific are often called on to strike a just balance between formal law and customary practices.

An unambiguous constitutional guarantee can ensure discriminatory customary practices do not prevail over principles of equality and non-discrimination. There are a number of ways of reconciling this conflict while preserving the operation of non-discriminatory aspects of customary law. Fiji and South Africa have taken a similar approach, although Fiji continues to recognise discriminatory customary laws in relation to land and chiefly title.

51. Vedna Jivan and Christine Forster, *Translating CEDAW into Law; CEDAW Legislative Compliance in Nine Pacific Island Countries (UNDP Pacific Centre & UNIFEM) 2007*.  
Vedna Jivan and Christine Forster, *Translating CEDAW into Law; CEDAW Legislative Compliance in the Cook Islands (UNDP Pacific Centre & UNIFEM) 2008*.  
52. Maman, Mbawambo J K, Hogan N M et al. (2002); A van der Straten, King R, Grinstead O et al. (1998) K Dunkle, Jewkes R K, Brown H C et al. (2004).  
53. U Singh (2004)  
54. Joint United Nations Programme on HIV/AIDS (UNAIDS)(2008a)

55. Convention on Elimination of Discrimination Against Women Article 5.  
56. Convention on Elimination of Discrimination Against Women Article 2.

*Fiji is making progress in promoting gender equality:*

- gender is included in the objectives and key performance indicators of Development Plans;
- a Bill of Rights within the *Constitution* established an equal employment opportunity policy;
- the *Family Law Act 2003* introduced more equitable property and custody laws;
- the Human Rights Commission employs an officer specializing in gender equity cases; and
- the Law Reform Commission is reviewing legislation relating to sexual and family violence, based on a broad national consultative process.

## Examples

### Fiji

#### Section 38 Equality

- (1) *Every person has the right to equality before the law*
- (2) *A person must not be unfairly discriminated*

*against, directly or indirectly, on the ground of his or her:*

- (a) *actual or supposed personal characteristics of circumstances, including race, ethnic origin, colour, place of origin, gender, sexual orientation, birth, primary language, economic status, age or disability; ...*

#### Section 43 Interpretation

- (1) *The specification in this Chapter of rights and freedoms is not to be construed as denying or limiting other rights and freedoms recognised or conferred by common law, customary law or legislation to the extent that they are not inconsistent with this Chapter.*
- (2) *In interpreting the provisions of this Chapter, the courts must promote the values that underlie a democratic society based on freedom and equality and must, if relevant, have regard to public international law applicable to the protection of the rights set*

*out in this Chapter.*

*[Note: the Fiji Constitution also includes provisions which preserve customary law in respect of inheritance of land and chiefly title (S.38(8)). Fijian customary inheritance laws relating to land are legal even though they discriminate against women. It is not recommended that such exclusions be included in Constitutions or equality legislation]*

*Fiji Islands Constitution 1997*

### South Africa

#### Section 9 Equality

- (1) *Everyone is equal before the law and has the right to equal protection and benefit of the law.*
- 2) *Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.*
- (3) *The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.*

#### Section 39 Interpretation of Bill of Rights

- (1) *When interpreting the Bill of Rights, a court, tribunal or forum –*
  - (a) *must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;*
  - (b) *must consider international law; and*
  - (c) *may consider foreign law.*
- (2) *When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.*
- (3) *The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.*

*Republic of South Africa Constitution 1996*

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**Property and inheritance**

Knowledge of customary laws of succession in the Pacific is incomplete, as these laws are sometimes fluid and may vary from island to island.<sup>57</sup> It is generally the case however that customary laws favour men, and these laws are generally applied or taken into account by many courts in the Pacific.

A review of nine Pacific island countries (Marshall Islands, FSM, Fiji, PNG, Solomon Islands, Samoa, Vanuatu, Kiribati and Tuvalu) found that two have no inheritance legislation and two contain discriminatory provisions. The study found that all nine Pacific countries reviewed give constitutional status to customary law in relation to land, which may result in discriminatory outcomes for women in inheritance and property ownership.<sup>58</sup>

In Fiji, few women own businesses, because the customary inheritance laws practiced by both major ethnic groups in the Fiji Islands usually exclude women from inheriting land or other fixed assets. Fijian women in most parts of the country are excluded from inheritance rights in customary land, and have no rights in land other than those permitted them by their fathers or husbands.<sup>59</sup> Fiji's *Succession, Probate and Administration Act* [Cap 60] 1970 provides for equal inheritance rights for men and women, however Fijian custom in relation to land has constitutional status and may lawfully discriminate against women.

In PNG, under customary law, only men inherit property, not women. Even in PNG's matrilineal societies, the land passes through the women's line, but goes to men in that line. In most PNG societies, when a man dies, his sons or nephews inherit his land. When a man dies, his wife does not expect to inherit anything - even the children, who stay with their father's line.<sup>60</sup> Although the PNG *Constitution* provides that all citizens the same rights irrespective of sex, customary inheritance and property laws continue to be upheld by the Courts even where custom disadvantages women.

Inheritance in Marshall Islands and FSM is determined according to custom. Inheritance in these countries is historically matrilineal, which means that land and property are passed through females. However men still control many aspects of the use of land and property.

In Tuvalu and Kiribati eldest sons are advantaged over daughters in relation to both land and important resource rights such as fishponds.<sup>61</sup>

In some circumstances, Constitutional provisions can be used to overrule customary laws. In *Noel v Toto*, the Vanuatu Supreme Court disallowed evidence of customary succession on the ground that a custom rule that favoured males was unconstitutional.<sup>62</sup>

In *Tanavulu & Tanavulu v Tanavulu and SINPF* the *Solomon Islands Court of Appeal* considered customary inheritance for the purpose of the *Solomon Islands National Provident Fund Act*. That *Act* provides that, if a member of the fund dies without nominating a beneficiary for their accumulated funds, distribution is to be in accordance with the custom of the member, 'to the children, spouse and other persons' entitled in custom. The Court of Appeal found that the trial judge was correct in holding that the *Act* was not unconstitutional because it discriminated against the widow. This decision confirmed that discrimination founded on customary law is lawful.<sup>63</sup>

Legislation regarding rights of inheritance can help to ensure women are left with a substantial share of the estate should their husband or de facto partner die first. This can be important in the context of an HIV epidemic where women bear significant financial burdens in caring for and supporting their families should their husband pre-decease them. A woman's own HIV vulnerability, and capacity to care for HIV affected family members, may significantly increase if she is left financially destitute after her husband's death.

Two approaches for ensuring that a widow has access to an adequate share of her husband's estate are:

- (i) family provisions legislation, which can ensure the widow is provided for in the distribution of the estate despite the fact that the husband's will has left the whole or bulk of the estate to others; and
- (ii) statutory legacies, which can ensure a widow is left a substantial share of her husband's estate when there is no will.

57. G Woodman (1987).  
58. V Jivan, C Forster (2007).  
59. Asian Development Bank (2006) pp.xii, 25.  
60. V Griffen (1976).

61. V Jivan, C Forster (2007) p.15.  
62. K Brown (2000) citing : Noel v Toto Vanuatu Supreme Court Civil Case 18 of 1994; USP Law School Internet Reports No. 6.  
63. Ibid.



## Support to widow through 'family provisions' legislation<sup>64</sup>

Family provisions legislation specifies categories of persons who are entitled to apply for provision out of the estate of a deceased person where the deceased person's will has not left adequate provision. The legislation can also be used to apply for additional provision if there was no will left by the deceased and the way the estate has been divided has not provided adequately or fairly for family members. Family provisions legislation is often important to ensure that women are adequately provided for, taking into account future needs, including for her health care and care of children. The example of legislation below allows customary law to be taken into account as one factor (e.g. in relation to other claims on the estate) as well as the woman's needs and her contributions to improvement of her husband's estate and care of his children.

### Example

#### *Family Provisions Act*<sup>c</sup>

6(1) *The following members of the family of a deceased person may apply to the Court for a family provision order in respect of the estate of the deceased person:*

- (a) *the wife or husband of the deceased person at the time of the deceased person's death,*
- (b) *a person who was, at the time of the deceased person's death, the de facto partner of the deceased person,*
- (c) *a non-adult child of the deceased person.*

10(2) (2) *The Court may make such order for provision out of the estate of the deceased person as the Court thinks ought to be made for the maintenance, education or advancement in life of the person in whose favour the order is made, having regard to the facts known to the Court at the time the order is made.*

#### *Matters to be considered by the court;*

(2) *The following matters may be considered by the Court:*

c. Queensland Law Reform Commission (2004).

- (a) *any family or other relationship between the person in whose favour the order is sought to be made (the proposed beneficiary) and the deceased person, including the nature and duration of the relationship,*
- (b) *the nature and extent of any obligations or responsibilities owed by the deceased person to the proposed beneficiary, to any other person in respect of whom an application has been made for a family provision order or to any beneficiary of the deceased person's estate,*
- (c) *the nature and extent of the deceased person's estate (including any property that is, or could be, designated as notional estate of the deceased person) and of any liabilities or charges to which the estate is subject, as in existence when the application is being considered,*
- (d) *the financial resources (including earning capacity) and financial needs, both present and future, of the proposed beneficiary, of any other person in respect of whom an application has been made for a family provision order or of any beneficiary of the deceased person's estate,*
- (e) *any physical, intellectual or mental disability of the proposed beneficiary, any other person in respect of whom an application has been made for a family provision order or any beneficiary of the deceased person's estate that is in existence when the application is being considered or that may reasonably be anticipated,*
- (f) *the age of the proposed beneficiary when the application is being considered,*
- (g) *any contribution, whether made before or after the deceased person's death, for which adequate consideration (not including any pension or other benefit) was not received, by the proposed beneficiary to the acquisition, conservation and improvement of the estate of the deceased person or to the welfare of the deceased person or the deceased person's family,*
- (h) *any provision made for the proposed*

64 Some Pacific Island countries have forms of family provision laws drawn from colonial laws e.g. see Part VI Wills Probate and Administration Act (Cap 291) (PNG); Part IV Administration Act (Samoa); Part VII Wills Probate and Administration Act Cap 33 (Solomon Islands); Inheritance (Family Provision) Act 1938 (UK) (may apply in Kiribati and Tuvalu); Inheritance (Provision for Family and Dependents) Act 1975 (UK) may apply in Vanuatu (s.3 High Court of New Hebrides Regulation 1976 (UK))



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beneficiary by the deceased person, either during the deceased person's lifetime or any provision made from the deceased person's estate,

- (i) the date of the will (if any) of the deceased person and the circumstances in which the will was made,
- (j) whether the proposed beneficiary was being maintained, either wholly or partly, by the deceased person before the deceased person's death and, if the Court considers it relevant, the extent to which and the basis on which the deceased person did so,
- (k) whether any other person is liable to support the proposed beneficiary,
- (l) the character and conduct of the proposed beneficiary or any other person before and after the death of the deceased person,
- (m) any relevant (Aboriginal or Torres Strait Islander) customary law or other customary law,
- (n) any other matter the Court considers relevant, including matters in existence at the time of the deceased person's death or at the time the application is being considered.

*Draft Uniform Succession Law (Australia)*

By way of comparison, PNG legislation, which does not apply to customary land, provides only that the Court shall have regard, among other things, to:

- (a) the net value only of the estate of the testator, as ascertained by deducting from the gross value all debts, testamentary and funeral expenses and all other liabilities and charges to which the estate is subject; and
- (b) whether the spouse or children or any of them are entitled to independent means, whether secured by any covenant, settlement, transfer, gift or other provision made by the testator during his or her life or derived from any other source.

*Wills Probate and Administration Act (Cap 291) (PNG) Section 128(2)*

### Support to widow when husband dies without a will

Legislation can prescribe that a wife (or husband) is entitled to a specific sum should the husband (or wife) die first without leaving a will (intestate). The purpose of the legacy is to enable the spouse to remain in the matrimonial home and to assist in his or her day to day maintenance. An option popular in common law countries is for legislation to prescribe how the estate is to be shared between the spouse and the children, while according a generous preferential share to the surviving spouse. The prescribed amount of the statutory legacy is either included in legislation or fixed by regulation. For example, in the Canadian province of Manitoba, where there are children who are not children of the surviving spouse, legislation entitles the surviving spouse to a statutory legacy of \$50,000 or half the estate, whichever is greater, and then gives the surviving spouse a further half share of the residue of the estate.

#### Example

##### *Entitlement of surviving spouse*

##### *12 Spouse's entitlement where there are no descendants*

*If an intestate leaves a spouse but no descendants, the spouse is entitled to the whole of the intestate estate.*

##### *13 Spouse's entitlement where descendants are also descendants of the spouse*

*If an intestate leaves a spouse and descendants and the descendants are all also descendants of the spouse, the spouse is entitled to the whole of the intestate estate.*

##### *14 Spouse's entitlement where at least one descendant is not a descendant of the spouse*

*If an intestate leaves a spouse and at least one descendant who is not a descendant of the spouse, the spouse is entitled to—*

- (a) the intestate's personal effects; and
- (b) a statutory legacy; and
- (c) one-half of the remainder (if any) of the intestate estate.

*Draft Uniform Succession Law (Australia)<sup>d</sup>*

d. For a description of approaches in common law countries to statutory legacies and the recommended uniform law for Australia, see: NSW Law Reform Commission (2007) Chapter 4.

**Example**

2(3) *If an intestate dies leaving a surviving spouse or common-law partner and issue (a child or children), and one or more of the issue are not also issue of the surviving spouse or common-law partner, the share of the surviving spouse or common-law partner is:*

- (a) *\$50,000, or one-half of the intestate estate, whichever is greater; and*
- (b) *one-half of any remainder of the intestate estate after allocation of the share provided by clause (a).*

*Intestate Succession Act CCSM c 185 S.2(3) Manitoba  
Canada*

**Property division after divorce**

Loss of financial security of women after marital breakdown can contribute to HIV and STI vulnerability. Women may turn to sex work to supplement income or they may exchange sex for goods and services. It can also cause great hardship if the wife has the added burden of caring for children or aged relatives, particularly if the wife and/or her children are living with HIV and have significant health care needs.

Women are disadvantaged in property disputes if legal title to property is in the husband's name and the law fails to recognise women's non-financial contributions to a marriage or financial contributions that were made by her but not formally attributed to her. Division of marital property after divorce should include recognition of non-financial contributions during a marriage such as raising children, caring for elderly and household duties.

Family law regarding property division after separation in many Pacific Island states does not recognise non-financial contributions to the marriage. In the Marshall Islands and the FSM, property division upon divorce is determined on the basis of 'justice' and 'the best interests of all'. In Kiribati there is no legislative provision for the division of property after separation and divorce. Consequently, any determination is left to custom, which may discriminate against women.<sup>65</sup> By way of contrast, Fijian legislation explicitly recognises non-financial contributions to the marriage, with more equitable outcomes for women (below). In

Solomon Islands, the courts have been prepared to take into account non-financial contributions to a marriage,<sup>66</sup> despite the lack of legislation.

**Example**

162.(1) *In considering what order (if any) should be made under section 161 in proceedings with respect to any property of the parties to a marriage or either of them, the court must take into account-*

- (a) *the financial contribution made directly or indirectly by or on behalf of a party to the marriage or a child of the marriage to the acquisition, conservation or improvement of any of the property of the parties to the marriage or either of them, or otherwise*

*in relation to any of the last-mentioned property, whether or not the last-mentioned property has, since the making of the contribution, ceased to be the property of the parties to the marriage or either of them;*

- (b) *the contribution (other than a financial contribution) made directly or indirectly by or on behalf of a party to the improvement of any of the property of the parties to the marriage or either of them, or otherwise in relation to any of that last-mentioned property, whether or not that last-mentioned property has, since the making of the contribution, ceased to be the property of the parties to the marriage or either of them;*

- (c) *the contribution made by a party to the marriage to the welfare of the family constituted by the parties to the marriage and any children of the marriage, including any contribution made in the capacity of homemaker or parent. ...*

*(2) For the purposes of subsection (1) the contribution of the parties to a marriage is presumed to be equal, but the presumption may be rebutted if a court considers a finding of equal contribution is on the facts of the case repugnant to justice, (for example as a marriage of short duration.)*

*Family Law Act 2003 (Fiji)*

65. V Jivan, C Forster (2007).

66 Goodhew v Goodhew [2007] SBHC 140

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**Gender based violence**

Violence against women in all its forms increases risk of HIV infection. Forms of violence include sexual assaults, rape (marital and other) and other forms of coerced sex, non-sexual physical violence and psychological violence. Violence reduces women's self-esteem, their physical well-being, their economic security, their ability to negotiate safe sex or compel fidelity in their partners, and their ability to work.

*Sexual assault offences should incorporate the following features:*<sup>67</sup>

- Range of offences covering different ways women are violated e.g. not limited to penile penetration
- Penalties that reflect the seriousness of the offence
- Consent should not be available as a defence for assaults on girls under 18
- Consent should be comprehensively defined to include absence of threat, coercion etc
- There should be no defence of honest and reasonable belief that the victim is of legal age
- No exemption for marital rape
- Removal of incest as an offence for girls and women
- Mandatory prosecutions and specification of minimum sentences
- Prohibition on requiring corroborative evidence of the assault
- Prior sexual conduct of the victim should not be taken into account
- Domestic violence legislation should include restraining orders and specific offences

There should be no defences of "passion" or preservation of a man's or family's "honour".

*PNG has progressive sexual assault legislation that aims to protect the rights of women. The main features of PNG's sexual assault laws, which were revised in 2002, are:*<sup>68</sup>

- Creation of clearly defined sexual offences against children, including sexual touching and sexual exploitation, with increased penalties for those in a position of trust, such as parents,

teachers and the police.

- Definition of incest expanded to cover more categories of relationships, in line with custom.
- Improved court procedures to protect survivors' safety and dignity.
- Definition of rape expanded to cover penetration of the mouth or anus and use of objects; requirement for medical corroboration removed; victim's previous sexual conduct not admissible as evidence.
- Rape in marriage became illegal by the removal of the final three words from the existing definition of rape in the Criminal Code: 'unlawful sexual intercourse with a woman, not his wife'.

The rape offence in some Pacific countries still does not apply to rape within marriage, either by defining rape as sexual assault by a person/man against a woman or girl who is not his wife, by providing a defence to a charge of rape that the woman or girl was his wife at the time, or requiring the spouses to be either legally separated or living apart at the time of the rape for prosecution to ensue. Law reform attempts are sometimes met with objection from male leaders. Men often advance arguments to the effect that wives are considered to be the property of their husbands, and forcing sex on them is a natural male right. The arguments include appeals to traditional practices.

Rape in marriage is contrary to human rights, including the right to security of the person and bodily integrity, and sexual and reproductive health rights. As far as the law protects women from forced sex, the protection should be extended to all women regardless of their marital status. In this respect, women in de facto relationships have more legal protection than those legally married, because they can seek the protection of rape laws.

It is a matter of including marital rape as a crime. It may be done as part of making the offence gender-neutral. Or it may be done by excision of the 'wife' exception from existing wording.

67. V Jivan, C Forster (2007).

68 AusAID (2008) p.109.

**Example**

*A person who sexually penetrates a person without his consent is guilty of a crime of rape.*

*For the purposes of this Part, “consent” means free and voluntary agreement.*

*Criminal Code Ss.347 and 347A (2002 Amendments) (PNG)*

**‘Sexual penetration’ is defined as —**

- (a) *the introduction, to any extent, by a person of his penis into the vagina, anus or mouth of another person; or*
- (b) *the introduction, to any extent, by a person of an object or a part of his or her body (other than the penis) into the vagina or anus of another person, other than in the course of a procedure carried out in good faith for medical or hygienic purposes.*

*Criminal Code S.6 (2002 Amendments) (PNG)*

*Sexual assault is intentionally subjecting another person to sexual penetration, or forcing another person to make a sexual penetration on himself or another or on an animal, against the other person’s will, or under conditions in which the offender knows or should know that the other person is mentally or physically incapable of resisting or understanding the nature of his conduct.*

*Sexual penetration is sexual intercourse, cunnilingus, fellatio, anal or oral intercourse, or the causing of penetration of the genital, anal, or oral opening of another to any extent and with any object whether or not there is an emission.*

*Kosrae State Code Title 13. Section 13.311. Sexual assault. (FSM)*

**Example**

*A person who has carnal knowledge of a woman or girl, not being his wife—*

- a) *without her consent; or*
- (b) *with her consent, if the consent is obtained—*
  - (i) *by force; or*
  - (ii) *by means of threats or intimidation; or*
  - (iii) *by fear of bodily harm; or*
  - (iv) *by means of false and fraudulent representations as to the nature of the act; or*
- (c) *in the case of a married woman, by personating her husband, is guilty of the crime of rape.*

While this option successfully makes marital rape a punishable offence, it is gender-specific and excludes rape of men or boys.

**Domestic violence protection orders**

In Fiji, the *Family Law Act 2005* allows magistrates to make injunctive orders in cases of violence. These can be made on urgent application in the absence of the defendant, and extended for up to one year once heard in court. Breach is automatically a criminal offence. However these orders are only available to married couples.

New Zealand’s *Domestic Violence Act 1995* provides a useful precedent because of its rehabilitative focus, attempting to address the violent behaviour itself as well as delivering sanctions for breach. The NZ Act’s objects are to provide programs for victims of domestic violence, and to require perpetrators to attend programs for preventing domestic violence. On the making of a protection order, the court must direct the defendant to attend a perpetrator program unless the court considers that there is a good reason for not making that direction. The programs available may be general violence prevention sessions, or may be specifically tailored so as to meet cultural or other needs. Free educational programs are also available to the victims and their children. An evaluation of the New Zealand legislation found that the rehabilitative focus of the Act is seen by those who used it as being particularly valuable.<sup>69</sup>

69. NSW Law Reform Commission (2002) Chapter 6.



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**Example****3 Meaning of domestic violence**

(1) *In this Act, domestic violence, in relation to any person, means violence against that person by any other person with whom that person is, or has been, in a domestic relationship.*

(2) *In this section, violence means—*

(a) *Physical abuse:*

(b) *Sexual abuse:*

(c) *Psychological abuse, including, but not limited to,—*

(i) *Intimidation:*

(ii) *Harassment:*

(iii) *Damage to property:*

(iv) *Threats of physical abuse, sexual abuse, or psychological abuse:*

(v) *In relation to a child, abuse of the kind set out in subsection (3) of this section*

**7 Application for protection order**

(1) *A person who is or has been in a domestic relationship with another person may apply to the Court for a protection order in respect of that other person.*

**14 Power to make protection order**

(1) *The Court may make a protection order if it is satisfied that—*

(a) *The respondent is using, or has used, domestic violence against the applicant, or a child of the applicant's family, or both and*

(b) *The making of an order is necessary for the protection of the applicant, or a child of the applicant's family, or both.*

**19 Standard conditions of protection order**

(1) *It is a condition of every protection order that the respondent must not—*

(a) *Physically or sexually abuse the protected person or*

(b) *Threaten to physically or sexually abuse the protected person or*

(c) *Damage, or threaten to damage, property of the protected person or*

(d) *Engage, or threaten to engage, in other behaviour, including intimidation or harassment, which amounts to psychological abuse of the protected person or*

(e) *Encourage any person to engage in behaviour against a protected person, where the behaviour, if engaged in by the respondent, would be prohibited by the order.*

(2) *... it is a condition of every protection order that at any time other than when the protected person and the respondent are, with the express consent of the protected person, living in the same dwelling house, the respondent must not,—*

(a) *Watch, loiter near, or prevent or hinder access to or from, the protected person's place of residence, business, employment, educational institution, or any other place that the protected person visits often or*

(b) *Follow the protected person about or stop or accost the protected person in any place or*

(c) *Without the protected person's express consent, enter or remain on any land or building occupied by the protected person or*

(d) *Where the protected person is present on any land or building, enter or remain on that land or building in circumstances that constitute a trespass or*

(e) *Make any other contact with the protected person (whether by telephone, correspondence, or otherwise), except such contact—*

(i) *As is reasonably necessary in any emergency or*

(ii) *As is permitted under any order or written agreement relating to the role of providing day-to-day care for, or contact with, or custody of any minor or*



(iii) *As is permitted under any special condition of the protection order or*

(iv) *As is necessary for the purposes of attending a family group conference*

### **29 Programmes for protected persons**

(1) *Subject to subsection (4) of this section, where the Court makes a protection order, the applicant may request a Registrar to authorise the provision of a programme to all or any of the following persons:*

(a) *The applicant;*

(b) *A child of the applicant's family;*

### **32 Power to direct respondent or associated respondent to attend programme**

(1) *On making a protection order, the Court must direct the respondent to attend a specified programme, unless the Court considers that there is good reason for not making such a direction.*

*Domestic Violence Act 1995 (New Zealand)*

## **Duties to provide medical and legal assistance and protect privacy of sexual assault survivors**

Several countries have developed internal policies requiring police to prosecute domestic assaults and making domestic assault by police a disciplinary offence.

Fiji's 'No-Drop Policy', introduced in 1995,<sup>70</sup> protects women from being pressured by husbands and families to drop charges by requiring police to see every case through to court. The No-Drop Policy protects victims from pressure and retribution by other family or community members. The policy transfers the responsibility for resolution from the police to trained magistrates in the courts.

The Philippines has comprehensive legislation requiring female police officers and prosecutors to investigate complaints of assaults on women, referral to medical services and privacy rights to be respected.

## **Example**

### **4. Duty of the Police Officer.**

*Upon receipt by the police of the complaint for rape, it shall be the duty of the police officer to:*

- (a) *Immediately refer the case to the prosecutor for inquest/investigation if the accused is detained; otherwise, the rules of court shall apply;*
- (b) *Arrange for counselling and medical services for the offended party; and*
- (c) *Immediately make a report on the action taken.*

*It shall be the duty of the police officer or the examining physician, who must be of the same gender as the offended party, to ensure that only persons expressly authorized by the offended party shall be allowed inside the room where the investigation or medical or physical examination is being conducted.*

*For this purpose, a women's desk must be established in every police precinct throughout the country to provide a police woman to conduct investigation of complaints of women rape victims. In the same manner, the preliminary investigation proper or inquest of women rape victims must be assigned to female prosecutor or prosecutors after the police shall have endorsed all the pertinent papers thereof to the same office.*

### **5. Protective measures.**

*At any stage of the investigation, prosecution and trial of a complaint for rape, the police officer, the prosecutor, the court and its officers, as well as the parties to the complaint shall recognize the right to privacy of the offended party and the accused. Towards this end, the police officer, prosecutor, or the court to whom the complaint has been referred may, whenever necessary to ensure fair and impartial proceedings, and after considering all circumstances for the best interest of the parties, order a closed-door investigation, prosecution or trial and that*

<sup>70</sup> AusAID Office of Development Effectiveness (2008) p.156.

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*the name and personal circumstances of the offended party and/or the accused, or any other information tending to establish their identities, and such circumstances or information on the complaint shall not be disclosed to the public.*

*Rape Victim Assistance and Protection Act of 1998  
(Philippines)*

In South Africa, Guidelines impose various duties on the police, health care workers and others who are tasked with providing services to survivors of sexual assault.<sup>71</sup> The guidelines require co-operation between the health, justice, social development and safety and security (police) sectors. The Guidelines give survivors of sexual assault the right to counselling, referrals, STI prophylaxis, HIV prophylaxis (PEP), emergency contraception, care of injuries, medico-legal advice and documentation of their evidence.

In South Africa, legislation allows for alleged perpetrators of sexual assault to be compulsorily tested for HIV. The compulsory testing can assist the survivor of the assault to decide whether to take ARVs as post-exposure prophylaxis (PEP) to prevent HIV transmission. PEP consists of the administration of two or three ARVs for 28 days. The number and combination of medications required depends upon the type of exposure and what is known about the source person's HIV viral status and treatment history. PEP appears to be most effective when commenced as soon as possible after exposure to HIV but can be started up to 72 hours after an exposure.

As discussed above, compulsory testing is generally not recommended as a public health measure because it violates the human rights of the person tested and may deter people from accessing HIV services. In the case of testing of perpetrators of sexual assault, legislators need to carefully consider the human rights of both the survivor and the perpetrator, and the public health ramifications of introducing a compulsory testing approach. If a law enabling compulsory testing of perpetrators is introduced, it is important that it is viewed as a highly exceptional measure that is required to protect the rights of the survivor.

### Example

*Services for victims relating to Post Exposure Prophylaxis and compulsory HIV testing of alleged sex offenders 28. (1) If a victim has been exposed to the risk of being infected with HIV as the result of a sexual offence having been committed against him or her, he or she may—*

- (a) subject to subsection (2)—*
  - (i) receive PEP for HIV infection, at a public health establishment designated from time to time by the cabinet member responsible for health by notice in the Gazette for that purpose under section 29, at State expense and in accordance with the State's prevailing treatment norms and protocols;*
  - (ii) be given free medical advice surrounding the administering of PEP prior to the administering thereof; and*
  - (iii) be supplied with a prescribed list, containing the names, addresses and contact particulars of accessible public health establishments contemplated in section 29(1)(a); and*
- (b) subject to section 30, apply to a magistrate for an order that the alleged offender be tested for HIV, at State expense.*

*(2) Only a victim who—*

- (a) lays a charge with the South African Police Service in respect of an alleged sexual offence; or*
- (b) reports an incident in respect of an alleged sexual offence in the prescribed manner at a designated health establishment contemplated in subsection (1)(a)(i), within 72 hours after the alleged sexual offence took place, may receive the services contemplated in subsection (1)(a).*

71. Department of Health Government of South Africa (2002).

(3) A victim contemplated in subsection (1) or an interested person must—

(a) when or immediately after laying a charge with the South African Police Service or making a report in respect of the alleged sexual offence, in the prescribed manner, be informed by the police official to whom the charge is made or by a medical practitioner or a nurse to whom the incident is reported, as the case may be, of the—

(i) importance of obtaining PEP for HIV infection within 72 hours after the alleged sexual offence took place;

(ii) need to obtain medical advice and assistance regarding the possibility of other sexually transmitted infections; and

(iii) services referred to in subsection (1); and

(b) in the case of an application contemplated in section 30, be handed a notice containing the prescribed information regarding the compulsory HIV testing of the alleged offender and have the contents thereof explained to him or her.

*Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007 (South Africa)*

- right to freedom from torture and inhuman treatment
- right to privacy
- right to liberty and security

Children are particularly vulnerable to stigma and discrimination, and because of their relative powerlessness, face difficulties in dealing with these issues. If their parents have HIV, they may also be assumed to have the virus even if they are negative. If they are positive, they face a shortened lifespan, while they are less able to deal with medical and social consequences of HIV, and less able to enforce their rights. Even if they are HIV negative, their parent's HIV status may result in discrimination against the child. This can include expulsion from child care, schools and loss of housing. Children orphaned by AIDS are likely to be excluded from educational opportunities and may be homeless.

Circumcision is being encouraged as an HIV prevention intervention. Studies in Kenya, South Africa and Uganda have confirmed that circumcision can reduce the likelihood that a man will acquire HIV and some STIs. Circumcision should only occur under medically supervised conditions. In the case of minors, and the boy's consent should be obtained if a boy is old enough to understand the nature and consequences of the procedure. This issue has been addressed in South African legislation (below).

*Laws should be reviewed to ensure adequate protection of children in the following areas:*

- the right to access condoms at an appropriate age;
- harmful social, cultural and religious practices;
- not to be circumcised, except under medical supervision;
- freedom from trafficking, prostitution, sexual exploitation and abuse;
- the right to receive information and education targeted at children on avoidance of HIV and STI infection and how to cope, both inside and outside school, if infected;
- access to voluntary counselling and testing with the consent of the parent or guardian or child, in accordance with the child's evolving capacities;
- special protection and assistance if deprived of family environment, including alternative care, protection and adoption; and

### 5.2.3 Children

#### Human rights principle

Anti-discrimination and protective laws should be enacted to reduce human rights violations against children in the context of AIDS, so as to reduce the vulnerability of children to infection by HIV and to the impact of HIV/AIDS.

*International Guideline 5, para 22(g)*

#### Relevant human rights

- right to highest attainable standard of health
- right to equality and freedom from discrimination

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- involving children in the design and implementation of programmes for them.

**Example***Right to access condoms*

134. (1) No person may refuse:

- (a) to sell condoms to a child over the age of 12 years; or
  - (b) provide a child over the age of 12 years with condoms on request where condoms are provided or distributed free of charge. ...
- (3) A child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect.

*Children's Act 2005 South Africa*

**Example**

*Child's right not to be subjected to harmful social, cultural and religious practices;*

*Child's right not to be circumcised unless able to consent or in exceptional circumstances*

12. (1) Every child has the right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being.

(2) A child - (a) below the minimum age set by law for a valid marriage may not be given out in marriage or engagement; and

(b) above that minimum age may not be given out in marriage or engagement without his or her consent.

(3) Genital mutilation or the circumcision of female children is prohibited.

(4) Virginity testing of children under the age of 16 is prohibited.

(5) Virginity testing of children older than 16 may only be performed

(a) if the child has given consent to the testing in the prescribed manner;

(b) after proper counselling of the child; and

(c) in the manner prescribed.

(6) The results of a virginity test may not be disclosed without the consent of the child.

(7) The body of a child who has undergone virginity testing may not be marked.

(8) Circumcision of male children under the age of 16 is prohibited, except when

(a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or

(b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.

(9) Circumcision of male children older than 16 may only be performed

(a) if the child has given consent to the circumcision in the prescribed manner;

(b) after proper counselling of the child; and

(c) in the manner prescribed.

(10) Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision.

*Children's Act 2005 South Africa*

**5.2.4 Men who have sex with men****Relevant human rights**

- right to equality and freedom from discrimination
- right to freedom from torture and inhuman treatment
- right to privacy
- right to liberty and security
- freedom of movement
- freedom of expression



- freedom of association
- freedom from arbitrary detention.

### Human Rights Principles

Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men. 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.

*International Guideline 5, para.22(h)*

*The World Council of Churches discussed the issue of male-male sex in its Guidelines on Partnership Between Churches and People Living with HIV/AIDS Organizations and concluded that “it is wrong to violate the human rights of anybody for any reason – including sexual orientation.”<sup>72</sup>*

### Background

Over time, it has become acknowledged that discrimination on the basis of sexual orientation violates human rights. Fiji explicitly prohibits discrimination on the basis of sexual orientation in its national *Constitution of 1997*. In other Pacific countries, this recognition is also developing, albeit more slowly.

In the Pacific, as many other places in the world, in part because of discrimination and stigma that causes

men who have sex with men to keep private their sexual practices, it is not uncommon for men who have sex with men to also be having sex with women. This means that women are also put at risk because of the discrimination and stigma associated with men who have sex with men.

In every context, various forms of same-sex sexual activity and sex work still exist. As in all societies, there are diverse sexualities in the Pacific, including transgender persons and men who have sex with men. Some men who have sex with men present as masculine and are married or partnered to women. Diverse same-sex practices and traditions are known to have existed historically in many parts of the Pacific e.g. effeminate men known as ‘geegle’ or ‘goggle’ in Marshall Islands. More recently some men who have sex with other men are identifying as gay men, particular where they have been exposed to gay communities in countries such as Australia, New Zealand and the USA.

Groups of people in Pacific societies who, while of the male sex, regard themselves and are regarded by society as being of the feminine gender include the fa’afafine of Samoa, the fakaleiti of Tonga, the pinapinaaine of Tuvalu and Kiribati, and the vakasalewalewa of Fiji.<sup>73</sup> These groups of men may dress in female clothes and are often males who have been reared as females and see themselves as females. Biologically such transgendered persons are men, but psychologically they may be women, perceiving themselves as women and carrying out women’s work. Some, but not all, may engage in sex with men. Some may be married to women and have children.

As elsewhere in the world, colonisation brought the introduction of laws that criminalised same-sex behaviour, particularly male-male sex and in some countries cross-dressing. Although these laws have been repealed in common law countries such as the UK, South Africa, Australia and New Zealand, colonial indecency and sodomy laws remain in penal codes in most Pacific countries. An example of these offences is:

***Indecency between males - (1) Every one is liable to imprisonment for a term not exceeding five years who, being a male***

***(a) Does any indecent act with or upon any other male; or***

72. World Council of Churches (2005).

73. S Farran, A Su’a (2005).



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(b) *Induces or permits any other male to do any indecent act with or upon him.*

*It is not defence to a charge under this section that the other party consented.*

**Sodomy - (1) Every one who commits sodomy is liable—**

(a) *Where the act of sodomy is committed on a female, to imprisonment for a term not exceeding fourteen years;*

(b) *Where the act of sodomy is committed on a male, and at the time of the act that male is under the age of fifteen years and the offender is of over the age of twenty-one years, to imprisonment for a term not exceeding fourteen years;*

(c) *In any other case, to imprisonment for a term not exceeding seven years.*

(2) *It is no defence to a charge under this section that the other party consented.*

Sex between consenting adults in private should be no concern of the law. Criminalization of consensual acts between adults in private violates the right to privacy. Privacy rights cannot be applied only when it is convenient to do so. In many Pacific countries, there has been a noticeable contradiction in the way privacy issues have been treated. For example, many laws concern themselves greatly with consensual male-male sex conducted in private, and make it illegal. However, the law is too often reluctant to interfere in 'family' or 'domestic' incidents which involve force and physical or sexual assaults against women and children. The criminal law should be used to protect against violence, not to punish adults for consensual sexual activities that do not involve violence.

The Fijian cases of *Nadan v The State*<sup>74</sup> and *McCoskar v The State*<sup>75</sup> required the High Court to review the prosecution of two men engaged in consensual, intimate, private conduct. The High Court found that the Penal Code was invalid due to being inconsistent with the Constitution of Fiji to the extent that it purported to criminalize acts constituting the private consensual

sexual conduct "against the course of nature" between adults. It found that a state that embraces difference, dignity and equality does not encourage citizens without a sense of good or evil, but rather creates a strong society built on tolerant relationships with a healthy regard for the rule of law. Such a country allows citizens to define their own good moral sensibilities.

The international human rights system has evolved to the point that it now includes significant body of law on discrimination on the basis of sexual orientation. Most of the human rights treaty bodies have interpreted their respective treaties as including prohibitions against discrimination on the basis of sexual orientation. In 2008, 66 nations supported a joint statement urging all nations to "promote and protect human rights of all persons, regardless of sexual orientation and gender identity".<sup>76</sup>

The UN Human Rights Committee has called on States not only to repeal laws criminalizing homosexuality but to also include the prohibition of discrimination based on sexual orientation in law. The cases of *Toonen v Australia*, heard by the UN Human Rights Committee, established that laws against consenting sex between adult males in private is a breach of the right to privacy under the *International Covenant on Civil and Political Rights*.<sup>77</sup> The UN Human Rights Committee has also found that discrimination against persons on the ground of sexuality is a breach of the right to equality and non-discrimination *International Covenant on Civil and Political Rights*.<sup>78</sup> Similarly, a growing number of UN human rights special mechanisms, such as special rapporteurs, have included issues of discrimination on the basis of sexual orientation in their work. Fulfilling the human rights of men who have sex with men is not only intrinsically valuable, it will also improve health outcomes for them and the broader community. In countries where sex between men is not criminalized and where stigma and discrimination have been reduced, men who have sex with men are more likely to take up HIV prevention, care, support, and treatment services.

There are often several laws that can be applied to lay charges against sex between men. Because the sodomy offence carries a far higher penalty than that of indecency, it is often the chosen charge.<sup>79</sup> Sexual activity between fully consenting adults should not be

74. [2005] FJHC 1.  
75. [2005] FJHC 500.

76. UN: 66 States Condemn Violations Based on Sexual Orientation and Gender Identity <http://www.ilga.org/news> 19 December 2008).

77. *Toonen v. Australia*, HRC Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994).

78. See e.g. *Young v Australia* HRC Communication No. 941/2000, U.N. Doc CCPR/C/78/D/941/2000 (2003).

79. See for example, *The State v Merriam* [1994] PNGLR 104

equated with rape or sexual assault. However, fear, ignorance, discrimination and stigma have often resulted in these two distinct issues being treated as the same thing by the law. As a consequence, the true nature of the offence can become misunderstood, and is often confused with rape, even by judges.

In 1991 in PNG, Jalina J. said of a prison rape that it was ‘the behaviour of animals’ and awarded a deterrent sentence.<sup>80</sup> Four years later Pipit J., in a case of sex between two adult men in the privacy of a hotel room, echoed these words and thereby revealed that the distinction between consensual and non-consensual sex had become completely blurred.<sup>81</sup> In Fiji, a court echoed the views of an English judge a hundred years beforehand in considering homosexuality as a kind of physical abnormality.<sup>82</sup> This case pre-dates the *Nadan and McKoskar Cases*, which represent breakthrough in the acknowledgement of the human rights principles of privacy and equality.

By contrast, the Solomon Islands, when called upon to declare the sodomy offence unconstitutional as infringing the right to equality on the grounds of sex, refused to do so. The offence was framed so as to apply to men only, and the court’s solution, adopted by Parliament, was to amend the provision so as to apply equally to males and females. It was considered that the right to privacy was overridden by the interests of public health and public morality.<sup>83</sup> The HIV pandemic makes it clear that continued criminalisation of same sex relations will in fact endanger public health. This was recognised by the UN Human Rights Committee in the *Toonen v Australia case*.

Legislators should focus on the question of consensual versus non-consensual sex, and regard consensual sex between adults in private as a matter of personal morality, rather than a legal issue. The older gender-biased and inconsistent laws should be replaced with a system which makes all sexual assault, whether of forced sex with an adult or sex with a child, gender-neutral (this is discussed in the next section).

In addition to laws prohibiting sodomy, public order laws and municipal regulations may have the effect of discriminating against men who have sex with men and transgender persons, including regulations regarding indecency, vagrancy or obscenity.

Laws against consensual sex between men in private should be repealed as contrary to human rights, and because they are counterproductive to effective public health responses to HIV. Policies should be implemented to ensure that policing does not impede HIV and STI prevention programs such as outreach and condom distribution to men, or harassment or assault of men who have sex with men which will drive them underground. Ministries responsible for law enforcement and public health should collaborate and adopt a pragmatic approach.

### Assaults against men who have sex with men

Men who have sex with men are often subject to violence fuelled by prejudice and bigotry. Pacific countries should introduce hate crimes legislation to provide protection to men who have sex with men from violent attacks, as well as people living with HIV. Hate crimes (also known as bias motivated crimes) occur when a perpetrator targets a victim because of his or her membership in a certain social group, which may be defined by racial or ethnic group, religion, sexual orientation, gender identity or disability. There are several categories of hate crimes legislation: (1) laws defining specific bias-motivated acts as distinct crimes; (2) criminal penalty-enhancement laws; (3) laws creating a distinct civil cause of action for hate crimes; and (4) laws requiring administrative agencies to collect hate crime statistics.

The link between HIV/AIDS and marginalized, “different,” or socially “deviant” populations in the collective consciousness has been strong from the beginning. Hence the public health and human rights question:

Would further repression or isolation of these populations be effective in containing the spread of HIV, or would working with them in a rights-respecting way be more effective?

—Joanne Csete, 2005

The following is an example of legislation that has the object of protecting people with disabilities (including people living with HIV) and men who have sex with men from hate crimes:

<sup>80</sup> *State v. Pos* [1991] PNGLR 208

<sup>81</sup> *State v Johnny Mala CR 96 of 1997, Tabubil 25-26th February 1997*

<sup>82</sup> *State v Mutch* [1999] FJHC 116

<sup>83</sup> *DPP v Noel Bowie* [1988-1989] SILR 113

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**Example**

*Increase in sentence for assault related to disability or sexual orientation*

- (1) *This section applies where the court is considering the seriousness of an offence committed in any of the circumstances mentioned in subsection (2).*
- (2) *Those circumstances are—*
  - (a) *that, at the time of committing the offence, or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on—*
    - (i) *the sexual orientation (or presumed sexual orientation) of the victim, or*
    - (ii) *a disability (or presumed disability) of the victim, or*
  - (b) *that the offence is motivated (wholly or partly)—*
    - (i) *by hostility towards persons who are of a particular sexual orientation, or*
    - (ii) *by hostility towards persons who have a disability or a particular disability.*
- (3) *The court—*
  - (a) *must treat the fact that the offence was committed in any of those circumstances as an aggravating factor, and*
  - (b) *must state in open court that the offence was committed in such circumstances.*
- (4) *It is immaterial for the purposes of paragraph (a) or (b) of subsection (2) whether or not the offender's hostility is also based, to any extent, on any other factor not mentioned in that paragraph.*
- (5) *In this section "disability" means any physical or mental impairment.*

*Criminal Justice Act 2003 (England and Wales) s.146*

It is a feature of many Pacific criminal laws, which are derived from English common law, that heavy penalties are placed on anal sex between consenting adults in private. The offence of rape is often limited to the sexual assault of women and girls. Sexual assault laws that do not cover the rape or sexual assault of men contravene human rights principles. The result is that men do not have the same legal protection afforded women and girls. Of particular concern are rape in prisons, which leaves men with very little legal protection and redress, and sexual assault of boys by older boys or men.

The HIV epidemic raises new concerns regarding male rape. Unprotected anal sex carries high risks of HIV transmission, as the lining of the rectum is thin and can easily tear. It is important to recognise that a man who has been raped is even less likely than a woman to report the matter and try to seek justice through shame or for fear that he may be blamed.

Many of the Pacific countries' criminal and penal codes carry old common law definitions of rape. These need to be reformed in the light of high incidence of rape committed on men and boys. Some jurisdictions have recognised the injustices inherent in a gendered crime of rape, and so have followed the non-discriminatory path of making all sexual assault gender-neutral. All references to women, girls, boys and male persons are removed, and the law's attention is focussed on the action and the issues of consent, force and age. This reform should be accompanied by reforms that strengthen laws to deal with sexual abuse of children.

**Example**

*A person commits the offence of sexual assault in the first degree if:*

- (a) *the person knowingly subjects another person to an act of sexual penetration by strong compulsion;*
- (b) *the person knowingly engages in sexual penetration with another person who is younger than sixteen (16) years of age.*

*Criminal Code Title 31 §152 (Marshall Islands)*

### 5.3 Sexual and Reproductive Health Rights

#### Human rights principles

Laws should be enacted to ensure women's sexual and reproductive health rights, including the right of independent access to reproductive and STI 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.

*International Guideline 5 para. 30(f)*

#### Relevant human rights

- right to life
- right to liberty and security
- freedom from torture and inhuman treatment
- right to equality and freedom from gender discrimination
- rights of women and girls to informed choices
- right to health, reproductive health and family planning
- right to privacy
- right to freedom of conscience and religion
- right to information
- right to marry and found a family
- right to decide the number and spacing of children
- right to education
- freedom from sexual assault and exploitation
- right to modify customs which discriminate against women

- right to enjoy the benefits of scientific progress
- right to consent to experimentation

Sexual and reproductive health issues “are among the most sensitive and controversial in international human rights law, but they are also among the most important”

*Paul Hunt - UN Special Rapporteur on the right to health*

#### Background

The full range of sexual and reproductive health rights are intimately linked with HIV prevention, treatment, care and support. In 1994, at the International Conference on Population and Development, countries agreed that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights instruments and other consensus documents and everyone has the right ‘to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents...’ Reproductive health ‘therefore implies that people are able to have a safe and satisfying sex life, that they have the capability to reproduce and the freedom to decide if, when and how often to do so.’

Sexuality and sexual health are related to but distinct from reproductive health. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.<sup>84</sup> Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

Abortion is but one aspect of a wide range of sexual and reproductive health rights relevant to HIV. Women decide to have abortions for many reasons, including:

- they chose not to have (more) children
- they are too young
- they have too few economic resources to raise a child

84. Fourth UN World Conference on Women (1995) para 96.



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- they wish to complete education
- their relationship has ended or is unstable
- childbearing would adversely affect their health
- the pregnancy is the result of rape or incest
- they are HIV positive and have no access to services to prevent mother-to-child transmission.

State obligations to respect, protect and fulfil sexual and reproductive health rights lie at the heart of an effective and rights-based approach to HIV. Abortion remains an emotionally charged issue for many people, and law reform efforts in this area are often controversial. Abortion can be limited both by law and by access to services.

The right to comprehensive reproductive health services, including abortion, is rooted in international human rights standards guaranteeing the rights to life, health, privacy, and non-discrimination. These rights are violated if abortion services are inaccessible. Under international law, governments can be held accountable for restrictive abortion laws and for failure to ensure access to abortion when it is legal.<sup>85</sup>

In contrast to global trends, abortion remains illegal in most Pacific Island countries. Marshall Islands, and the FSM states of Kosrae, Pohnpei and Yap have no legislation that criminalises abortion. Other countries do criminalise abortion with an exception only to save the mother's life (except PNG). However, in all countries access to safe abortion facilities is limited. The failure to provide safe accessible facilities for women who require abortions endangers their life, health and that of any child subsequently born after a failed abortion.

The Pacific roll-out of ARVs to minimise the occurrence of mother-to-child transmission of HIV has been well-received. Little or no attention has been paid to the factors involved, particularly for HIV-positive women, in the decision to have a child. An HIV positive woman has the right to decide on whether or not to have a child, the number of children she will have, and spacing of children, regardless of her HIV status, just like all other women. It is important also to consider the particular factors that may influence the decision of HIV-positive women to not have children or carry a pregnancy to term. Poverty, lack of care, support and sustainable access to medications may be relevant factors. Some may choose not to bear a child which she may not live to see grow up, a child which may be orphaned and probably condemned to a life of

poverty, even if the child is not HIV-positive. This is all the more significant for women and girls who have no access to ART.

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*It is women from the poorest and lowest levels of society who are placed in the greatest predicament regarding their unwanted pregnancies, and their voices and stories are rarely heard. This is not to say that an HIV-positive woman or girl must have an abortion, simply that she should have the right of access to safe, legal abortion, and the right to choose that option.*

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This is a reform likely to meet with resistance around the Pacific. Paradoxically, abortion and infanticide were common methods of securing community health and well-being in many countries before the advent of Christianity, and sometimes well afterwards. Criminalisation of abortion at home does not stop women trying to deal with the matter. Today, many Pacific women seeking abortions travel to other countries if they have the financial resources to do so, or if they lack the necessary financial resources they must resort to unsafe illegal abortions.

It is unlikely that an HIV positive woman or girl who is already living in circumstances of poverty, with her health already compromised, will be able to travel overseas for an abortion. She may not have the support and assistance of a caring partner or family. She is more likely to seek a traditional or 'backyard' abortion at home, sometimes with disastrous results to her health.

One woman dies every minute as a result of pregnancy and childbirth. Every day, there are approximately 1,400 maternal deaths worldwide. Unsafe abortion accounts for at least 13% of all maternal deaths<sup>86</sup>. Every year, 20 million women undergo an abortion in illegal and mostly unsafe circumstances, which is approximately one in ten pregnancies worldwide. Unsafe abortion results in tens of thousands of deaths annually, the vast majority of which are preventable. Millions more suffer injuries, illness or disability resulting from unsafe abortion. Worldwide, every

85. See eg *K.L. v. Peru*, UN Human Rights Committee Comm. No. 1153/2003, 24 October 2005, U.N. Doc. CCPR/C/85/D/1153/2003.

86. World Health Organisation. *Unsafe abortion: Global and regional estimates of incidence of unsafe abortion and associated mortality in 2000 - 4th Ed.*



minute, 100 women have an abortion, 40 of which are unsafe; at least one-quarter of the women are girls aged 15-19<sup>87</sup>.

Abortion should not be confused with infanticide. Many Pacific criminal laws contain a definition of human being or person as one already born.

### Example

*A child becomes a human being within the meaning of this Act when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not.*

*Cook Islands Crimes Act S.179*

There is no intention to repeal the offence of infanticide. But it is worth considering that the incidence of infanticide might be reduced if safe and legal abortion is available.

AIDS has not raised any new issues for the church to deal with. What it has done is to highlight all the issues which the church has in the past chosen to ignore.

*Sister Maura O-Donohue, CAFOD*

## 5.4 Privacy and confidentiality

### Introduction

The principle of the right to privacy and security of the person includes the right of a person not to disclose information about medical status, or have it disclosed by others. Patient confidentiality is a central part of the doctor-patient relationship under the law, and is the basis upon which sensitive information relevant to health status is voluntarily given. Attention should be paid to preserving confidentiality about HIV and STIs in particular situations such as within the extended family; within the village; in the workplace; in schools and training institutions. To breach confidentiality in these situations is to invite the possibility of discrimination and stigmatisation, and to undermine trust in health services, further impeding the effectiveness of HIV and STI programmes.

### Human Rights Principles:

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 the unauthorized use and/or publication of HIV-related information on individuals should be prohibited.

*International Guidelines 3 and 5*

### Relevant human rights

- right to privacy
- security of the person
- freedom from discrimination

### 5.4.1 Checklist

1. Does the legislation provide for general privacy or confidentiality protection for medical and/or personal information, widely defined to include HIV-related data?
2. Does the legislation prohibit unauthorised use and disclosure of such data?
3. Does the legislation provide for the subject of the information to have access to his or her own records and the right to require that the data are:
  - Accurate;
  - Relevant;
  - Complete;
  - Up-to-date?
4. Does the legislation provide for the independent agency administering the legislation (e.g. privacy or data protection commissioner) to have the following functions:
  - education and promotion of privacy;
  - advising government on privacy issues;
  - monitoring compliance with domestic legislation and international treaties and norms;

87. *ibid*

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- investigating, conciliating, resolving or arbitrating individual complaints;
  - Keeping data/statistics of cases and reporting on activities?
5. Does other general or public health legislation provide for the right of HIV-positive people to have their privacy and/or identity protected in legal proceedings (e.g. closed hearings and/or use of pseudonyms)?
  6. Does public health legislation provide for reporting of HIV/AIDS cases to public health authorities for epidemiological purposes with adequate privacy protections (e.g. coded rather than nominal data)?

### Background

As long as stigma and discrimination attach to HIV status, confidentiality is vital to preserve safety and security. However, there can be considerable resistance to the protection of personal HIV information. Leaders and managers may insist on knowing 'for planning purposes' or 'to ensure the safety of the community'. Generally these alleged concerns for safety or planning are not rationally connected to knowing someone's HIV status. Where there is a risk, either perceived or actual, of confidentiality being breached by health care workers, people will be discouraged from accessing health care services. Effective service provision depends on consumers trusting health service facilities and the people who staff them to respect the confidentiality of their personal information. It is not achieved through identifying individuals affected by HIV to people responsible for health service planning and delivery.

The general public, and health care workers in particular, may consider they have the right to know who has HIV 'in order to protect themselves'. The general right to information may be used to demand disclosure 'in the public interest'. However, as already noted, HIV is not casually transmitted, and the public identification of people who are HIV positive is not an effective prevention strategy. It leads to a false sense of security that HIV prevention measures are not necessary because people with HIV can be identified and avoided. It is impractical to try to identify all people with HIV because of the expense of mass screening,

the possibility that a person will be HIV infected but in the "window period" at the time they are tested, and the fact that even an accurate diagnosis that a person is HIV negative is only valid at the time the test is performed. It gives no guarantee that the person will not subsequently become infected with HIV.

For health care workers, the same uncertainty regarding the result of a patient's HIV test applies because of the window period. Where a patient's HIV status is known, it should only be disclosed where it is relevant to the patient's medical treatment, and only to those health care workers directly involved in providing health care to the patient. Relying on knowledge of a patient's HIV status is not an effective infection control strategy. Instead, public health legislation 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.<sup>88</sup> HIV is only one of a range of blood-borne pathogens to which persons working in such settings may be exposed, and the risk of exposure to HIV is only one reason why universal infection control precautions should be used. This issue is discussed in more detail below.

There is a very real danger that disclosure of personal HIV information can lead to termination of employment, eviction, banishment, persecution and violence. The right to information generally extends only to information held by the state or government authorities, although it may be extended to non-government bodies that are in receipt of or otherwise involved in the management of public funds. The right to information is not absolute, and must always be balanced against other rights, including the right to privacy. If a person's right to privacy has to be breached to ensure another person's right to information, and that breach leads to detriments such as discrimination, stigmatisation and exposure to violence then the right to information cannot be upheld. The potential conflict between the right to information and the right to privacy need not arise in the context of epidemiological monitoring, where information about HIV and AIDS diagnoses can be recorded without the use of personally identifying markers.

### Obligation of confidentiality

There are practical challenges to ensuring the confidentiality of HIV-related information throughout

<sup>88</sup> *International Guidelines para27(h)*.

an entire society, particularly in the Pacific context where it is very difficult to keep information secret. Legislation can play a significant role in helping to shape social norms and behaviours, and for this reason the duty of confidentiality should apply widely. However it may be appropriate to provide for penalties only in cases of those who come by the information in a professional capacity, such as:

- those providing, or being associated in the course of duties whether paid or unpaid with the provision of, an HIV testing, treatment, care, counselling, or associated health care service, including the maintenance of medical records and death certificates;
- those working in or responsible for pharmacies and drug supplies;
- those acting or assisting in the administration of the relevant legislation;
- those present in any room or place where a matter involving HIV status is being investigated, inquired into or heard;
- representatives of the media;
- those acting in a professional capacity as a clergyman of a church or other religious leader of any religious denomination;
- those conducting surveillance or research.

A statement of principle regarding the right to privacy is one means of establishing the importance of this right as a social norm.

### Example

*The right to privacy of individuals with HIV shall be guaranteed.*

*Philippines AIDS Prevention and Control Act 1998 S.2(a)*

Other specific provisions dealing with the circumstances listed above can be included separately in the relevant legislation.

### Rights of children

It is important to remember that children too have the right to privacy. The rights and freedoms guaranteed in Constitutions and at international law apply to children as much as they apply to adults. Every Pacific Island country has ratified the CRC, and Article 16 states that 'No child shall be subjected to arbitrary or unlawful interference with his or her privacy...'

Children who are old enough to understand the implications of HIV status have the right to confidentiality, just like everyone else. This means that they have the right to choose whether or not their parents and guardians should be informed of test results, whether or not they have had a test, their HIV status, and so on. Many parents may not agree with this, and point to the caring role of parents in the family. But this does not mean that children and teenagers who are capable of understanding the consequences of having an HIV test, and have this right to decide if and when they will tell their parents or guardians about their status, will always choose to keep this information private.

In an ideal situation, there would be no danger of negative repercussions if parents are told that their child is HIV-positive. However not all children's lives or family situations are ideal. The rights enjoyed by children and adolescents are an acknowledgement that sometimes they are particularly vulnerable and special care must be taken to ensure their rights are protected.

### Epidemiological reports

HIV and AIDS cases reported to public health authorities for epidemiological purposes, such as the compilation of statistics, should be subject to strict rules of data protection and confidentiality<sup>89</sup>. All information which could be used to establish the identity of the person who is the subject of the diagnostic data collected should be removed.

<sup>89</sup> International Guidelines para28(e).

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**Example**

*A medical practitioner must not state the name or address on communication made for the purpose of arranging a test to find out whether the patient suffers from HIV.*

*Pathology laboratories must notify the Director General of Health of a confirmed HIV antibody positive test result. The notification must be made on an approved form and must not disclose the name or address of the patient.*

*A medical practitioner who finds a patient to have an AIDS-defining diagnosis is required to notify the Director General of Health using an approved form. The medical practitioner must not state the name or address of the patient on the notification form unless a health care worker has reasonable grounds to believe that the patient is behaving in such a way that the health of the public is at risk.*

*A fine of up to \$5,000 can be imposed for not providing the required information. A fine of up to \$5,000 can be imposed for unauthorised disclosure of information, unless a court is satisfied there is a lawful excuse for disclosure.*

*Public Health Act 1991 (NSW), sections 14, 17, and 75.*

**Medical records and information**

HIV-related information concerning an individual should be protected from unauthorized collection, use or disclosure in the health-care and other settings. The use of HIV-related information should require informed and voluntary consent.<sup>90</sup> Medical records may already be considered to be protected by the right to privacy. If not, their confidentiality should be ensured. An exception to the rule against disclosure is appropriate where the information is necessary for a person involved in providing care to, or treatment or counselling of a person who has been tested for or who is infected with HIV, if the information is required in connection with the provision of such care, treatment, or counselling. A person should have the right to see his or her own records and to request amendments to ensure that such information is accurate, relevant, complete and up to date. Although it is preferable for these matters to be dealt with by law, in some cases they are the subject of departmental policy.<sup>91</sup>

**Court proceedings**

In many countries, it is recognised that there are certain circumstances in which the identity of someone involved in a court proceeding must be protected. Usually this is done out of a recognition that the person is particularly vulnerable to negative consequences if her/his identity is made public (e.g. in cases of child sexual abuse, the name of the victim is often repressed because of the attached stigma). Some of the same concerns justify ensuring that the privacy and identity of people living with HIV involved in certain court proceedings are protected.

People living with HIV should be able to request that their identity and privacy be protected in legal proceedings in which information on these matters will be raised, even in proceedings involving a charge of intentional transmission, where such charges exist. Court closure should be enabled, either on request by the person to whom the HIV information relates, or on the court's own volition, after considering the social, psychological or economic consequences to the person to whom the information relates. This confidentiality should extend to suppression of publication of details in reports of the proceedings.

**Example****Section 129. Closure of court or tribunal**

*(1) If, in a matter before a court or tribunal, evidence is proposed to be given of any matter relating to HIV, the court or tribunal, in addition to any other powers the court or tribunal may have, if it is of the opinion that it is necessary to do so because of the social or economic consequences to a person if the information is disclosed, may-*

- (a) order that the whole or any part of the proceedings be heard in closed session; or*
- (b) order that only persons specified by it may be present during the whole or any part of the proceedings; or*
- (c) make an order prohibiting the publication of a report of the whole or any part of the proceedings or of any information derived from the proceedings.*

<sup>90</sup> International Guidelines para 28(f).

<sup>91</sup> For an example of a departmental policy dealing with the duty of health care workers to maintain the privacy of HIV-related information, see NSW Health (2006).



(2) *If an order has been made under this section, the court or tribunal must cause a copy of it to be posted on a door of, or in another conspicuous place at, the place at which the court or tribunal is being held.*

(3) *A person must not contravene an order made and posted under this section.*

*Health Act 1958 (Victoria)*

### Confidentiality to extend beyond death

The requirement to maintain confidentiality about a person's HIV status should extend beyond the person's death. This is to preserve the rights of the person's family and associates, whether or not they too are HIV-positive. HIV discrimination and stigmatisation can affect these people. Children may be refused entry to child care or schools. Widows can be evicted from houses. Spouses and children can be refused health care. People may lose their jobs, or be subject to social isolation and ostracism. Businesses may fail as former customers avoid a family which is known to have been affected by HIV.

## 5.5 Employment law<sup>92</sup>

### Human rights principles

Laws, regulations, and collective agreements should be enacted or reached so as to guarantee the following workplace rights:

- a national policy on HIV and the workplace agreed upon by a tripartite body representing labour, employers and government;
- freedom from HIV screening for employment, promotion, training, or benefits;
- confidentiality regarding all medical information, including HIV status;
- employment security for workers living with HIV until they are no longer able to work, including reasonable alternative working arrangements;
- defined safe practices for first aid and adequately equipped first aid kits;
- protection for social security and other benefits for workers living with HIV including life insurance, health insurance, pension, termination and death benefits;

- adequate health care accessible in or near the workplace;
- adequate supplies of condoms available free to workers at the workplace;
- workers' participation in decision-making on workplace issues related to HIV;
- access to information and education programmes on HIV, as well as to relevant counselling and appropriate referral;
- protection from stigmatization and discrimination by colleagues, unions, employers and clients;
- appropriate inclusion in workers compensation legislation of the occupational transmission of HIV (e.g. due to needle stick injuries), addressing such matters as the long latency period of infection, testing, counselling and confidentiality.

### Relevant human rights

- right to non-discrimination, equal protection and equality before the law
- right to work
- right to an adequate standard of living
- right to social security, assistance and welfare

#### 5.5.1 Checklist: Employment law<sup>e</sup>

1. Does the legislation prohibit HIV screening for general employment purposes, i.e. appointment, promotion, training, and benefits?
2. Does the legislation prohibit mandatory testing of specific employment groups, e.g. military, transport workers, hospitality/tourist industry workers, and sex workers?
3. Does the legislation require implementation of universal infection control measures, including training and provision of equipment in all settings involving exposure to blood/body fluids, e.g. first aid, and health care work?
4. Does the legislation require provision of access to information and education about HIV for occupational health and safety

e. Handbook for Legislators p.78.

92 See also: International Labor Organization (2001) and the collection of legislation at : [www.ilo.org/public/english/protection/trav/aids/laws/collection.htm](http://www.ilo.org/public/english/protection/trav/aids/laws/collection.htm)



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reasons, e.g. workers travelling to areas of high incidence?

5. Does the law provide for employment security while HIV-positive workers are able to work (e.g. unfair dismissal rules), and social security and other benefits where workers are no longer able to work?
6. Does the law provide for confidentiality of employees' medical and personal information, including HIV status?
7. Does workers' compensation legislation recognize occupational transmission of HIV?

### Background

Areas of concern in employment law are that workers with HIV are not subjected to unfair discrimination, that prevention measures are available for occupational health and safety reasons, and that adequate compensation is available for workers who are occupationally infected with HIV. Attempts to exclude people living with HIV from the workforce are unfair and a breach of human rights. They are also potentially uneconomic, as they can arbitrarily exclude the most qualified person from a position and create an unnecessary burden on the social security system.

There should be no legal obligation on employees to disclose HIV status to their employers, although exceptional cases involving irresponsible behaviour that risks the safety of others can be dealt with under

provisions in public health legislation. The performance of invasive procedures by HIV-infected health care workers is adequately regulated by their treating clinician, specially formed expert panels, or professional registration boards on an individual case-by-case basis. When HIV-positive employees are unable to work, then policies applicable to analogous diseases should apply (e.g. in relation to the taking of sick leave).

Fiji's Ministry of Labour, Industrial Relations, Tourism and Environment issued a National Code of Practice for HIV/AIDS in the Workplace in 2007. The Code of Practice is based on the International Labor Organization Code of Practice on HIV/AIDS and the World of Work. The Fijian Code addresses:

- rights and responsibilities of Government, employees and employers;
- discrimination and equality rights;
- risk management including universal precautions and post exposure prophylaxis;
- education and training;
- prohibition of compulsory testing;
- care and supported for people living with or affected by HIV.

The Code is not legally binding although can be used as evidence in proceedings under relevant legislation (eg. in relation to duty of care). Under Fiji's *Health and Safety at Work Act 1996* and the *Employment Relations Promulgations 2007* the Minister for Labour, Industrial Relations, Tourism and Environment has the authority to approve the Code of Practice for the purpose of providing practical guidance on matters relating to those Acts.

## Examples

*38(2) It is prohibited and constitutes an offence where a contract of service specifies that a medical examination is required in the course of a worker's employment, for the medical examination to comprise HIV/AIDS screening, or screening for sexually transmitted diseases or pregnancy.*

*Employment Relations Promulgation 2007 (Fiji)*

*It is unlawful to require or coerce a person seeking or applying for employment or contract work,... or a person who is a contract worker or employee, ...to undergo an HIV test, produce proof that he is not infected with HIV or answer any questions the answer to which may tend to show that he is a person (infected with HIV or affected by HIV), except in accordance with this Act.*

*HIV/AIDS Management and Prevention Act 2003 S.9 (PNG)*

*Compulsory HIV testing as a precondition to employment, ...or the continued enjoyment of said undertakings shall be deemed unlawful. Intentional violation of this section is punishable with a penalty of imprisonment for not less than six months and no more than two years, a fine of not more than \$1000, or both such fine and imprisonment.*

*Pohnpei National Code, Title 17, Chapter 6A-131*

*No employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his employment, his HIV status . . . No person shall, except with the written consent of the employee to whom the information relates, disclose any information relating to the HIV status of any employee acquired by that person in the course of his duties unless the information is required to be disclosed in terms of any other law.*

*Labour Relations (HIV/AIDS) Regulations of 1998 (Zimbabwe)*

*In Namibia the Labour Ministry and Ministry of Health and Social Services formulated the National Code on HIV/AIDS and Employment. The Code, which was adopted under the Labour Act, 1992, provides guidelines and instructions applying the relevant provisions of the Labour Act in respect of HIV/AIDS in employment. It outlaws discrimination in employment on the basis of HIV/AIDS; prohibits direct or indirect HIV testing of workers or job applicants; guarantees confidentiality regarding HIV/AIDS and the workplace; and encourages the implementation of workplace HIV prevention and education programmes. The tripartite Labour Advisory Council and the Ministry of Labour are entrusted with the implementation, monitoring and review of the Code.*

*National Code on HIV/AIDS in Employment 1998 (Namibia)*

## CHAPTER 6:

# ACCESS TO PREVENTION, TREATMENT, CARE AND SUPPORT

### **GUIDELINE 6: Access to Prevention, Treatment, Care and Support**

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

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

### Introduction

Based on human rights principles, universal access requires that the goods, services and information necessary for HIV prevention, treatment and care are not only available, acceptable and of good quality, but are also within physical reach and affordable for all who require them.

The provision of information involves considerations of school curricula, censorship laws, criminal laws, taxation measures, intellectual property laws, and anti-discrimination laws. Some of the recommended actions involve legislation, some may require only the proper implementation of existing provisions, and others may involve changes of policy. In all of the recommended measures, though, the guiding principle is the fundamental rights of all to life and to enjoy the highest attainable standard of health.

### 6.1 Checklist

1. Does the law enable consumers to gain access to affordable HIV/AIDS medications (for example through the mechanisms of parallel importing or compulsory licensing)?
2. Does the law give consumers the right to access affordable HIV/AIDS health care (for example, a subsidized or free universal health scheme)?

3. Does the law regulate the sale, distribution and marketing (including protection for consumers against fraudulent claims) of pharmaceuticals and vaccines to ensure that they are safe and efficacious?
4. Does the law regulate the quality, accuracy, and availability of HIV tests (including rapid or home testing, if approved) and the sale and quality of condoms (e.g. monitoring compliance with the International Condom Standard)?
5. Does the law provide for the following legal protection for subjects in ethical human research (before, during and after participation): requiring informed consent; confidentiality of personal information obtained in the course of research; and counselling, health, and support services?

### Human Rights Principles

Universal access to HIV/AIDS 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. 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... Restrictions on the availability of preventive measures, such as condoms, bleach, clean needles and syringes, should be repealed.

*International Guidelines: Revised Guideline 6*

### Relevant human rights

- right to life
- right to liberty and security
- freedom from discrimination
- right to protection of the law
- right to health, reproductive health and family planning
- right to information and education
- right to privacy
- right to marry and found a family
- right to decide the number and spacing of children
- freedom from sexual assault and exploitation
- right to enjoy scientific progress
- right to consent to experimentation

### Background

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 physical and mental health. Widespread provision of preventive measures through various means, including condom and lubricant 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. HIV information should not be inappropriately subject to censorship or other broadcasting standards, particularly as this will have the effect of impeding access to information vital to life, health and human dignity.

While everyone should have access to all available means of protection and care, some measure of government oversight is necessary. Legislation, regulations and policies should be strengthened to prevent fraudulent claims regarding the safety and efficacy of drugs, vaccines and medical devices, including those relating to HIV or AIDS. Most countries address efficacy and safety issues through their medicines regulatory authorities. Regulation of medicines may involve use of a range of legal and policy mechanisms including relying on approvals from other countries or the World Health Organization.

It is important to remember that all people are entitled to human rights, not just adults. This means that parents and teachers should not restrict children's access to condoms and sex education. This is particularly important for adolescents. Prevention measures should be made available to children according to their ability to understand their implications.

### Censorship of information

Censorship, pornography and indecency laws should include a provision stating that such things as HIV awareness materials, school curricula, instructions and demonstrations of condom use for example are not indecent or obscene objects, performances, publications or materials for the purposes of those laws. Alternatively, the relevant laws themselves can be amended. Or a displacement provision can be included in a general HIV law describing HIV awareness materials and stating that these are not indecent, obscene or otherwise objectionable under the law.

Some countries such as Tonga already have laws excluding educational materials from censorship requirements. In this case, HIV awareness materials can be explicitly added to the law.

For the purpose of exclusion from censorship, it is necessary to define what may constitute HIV awareness materials, and include a provision for a declaration in cases of doubt.

The question is whether we love our youth enough to put aside our own prejudices

*Ratu Joni Madraiwiwi*

## CHAPTER 6

## Examples

*“HIV/AIDS awareness material” includes—*

- (a) *written, drawn, constructed, fabricated, photographic, film, video, theatrical, or audio material, however presented, performed, published or displayed, which raises awareness of HIV/AIDS, its management and prevention; and*
- (b) *instructions for use of condoms and condom lubricant, and other means of prevention of HIV transmission;*

*The Minister may, on the advice of the Council, by notice in the National Gazette, declare any material to be, or not to be, HIV/AIDS awareness material where he is of the opinion that, but for the declaration, doubt would exist whether or not the material is HIV/AIDS awareness material.*

*HIV/AIDS Management and Prevention Act S.2 (PNG)*

**Evidence in criminal charges**

Criminal and evidence laws should also be amended to remove any possibility that possession of condoms, injecting equipment, awareness resources or other HIV prevention materials will be used as evidence for other alleged crimes, for example brothel-keeping, vagrancy, prostitution, etc.

## Examples

- (1) *The fact that a place is being used for the purposes of prostitution may be inferred from evidence of the condition of the place, material found at the place and other relevant factors and circumstances.*
- (2) *However, evidence of condoms and other material for safe sex practices is not admissible against a defendant.*

*Criminal Code S.229N (Queensland, Australia)*

**Safe sex education**

While accurate information about HIV prevention should be available to all, the education of young people is particularly important in the Pacific context which has an above-average youthful population (37.6% under 15, and 57.1% under 25, overall based on the SPC's 2004 data).

The Marshall Islands has legislated specifically to require health education within the school curriculum.

## Examples

*The Ministry of Education, in consultation with the Ministry of Health Services, public and private schools, and parents of school age children, shall develop health education curriculum for primary and secondary schools in the Marshall Islands. Such curriculum shall include education about the transmission and prevention of communicable diseases; knowledge and prevention of prevalent non-communicable disease; the use and abuse of tobacco, alcohol and other drugs; preparation for adult life; knowledge about basic bodily functions; nutrition; preparation for raising families; sanitation; and health occupations. In the development of the health education curriculum, the Ministry of Education shall give due consideration to community values and the age of the students.*

*Communicable Diseases Prevention and Control Act 1988  
§1510 (Marshall Islands)*

A further step was taken in regulations accompanying the *Philippines AIDS Prevention and Control Act*, to ensure minimum standards for HIV education. These minimum standards are consistent with a rights-based approach to HIV, and should be incorporated into laws or regulations dealing with HIV education. Section 7 of the regulations states:

**Section 7. Content of education and information**

The standardized basic information on HIV/AIDS shall be the minimum content of an HIV/AIDS education and information offering. Additional content shall vary with the target audience.

Selection of content or topic shall be guided by the following criteria:

5.5 Accurate - Biomedical and technical information is consistent with empirical evidence of the World Health Organization, the DOH, or other recognized scientific bodies. Published research may be cited to establish the accuracy of the information presented.



5.6 Clear - The target audience readily understands the content and message.

5.7 Concise - The content is short and simple.

5.8 Appropriate- Content is suitable or acceptable to the target audience.

5.9 Gender-sensitive - Content portrays a positive image or message of the male and female sex; it is neither anti-women nor anti-homosexual.

5.10 Culture-sensitive - Content recognizes differences in folk beliefs and practices, respects these differences and integrates, as much as possible, folkways and traditions that are conducive to health.

5.11 Affirmative - Alarmist, fear-arousing and coercive messages are avoided as these do not contribute to an atmosphere conducive to a thorough discussion of HIV/AIDS.

5.12 Non-moralistic and non condemnatory - Education and information materials or activities do not impose a particular moral code on the target audience and do not condemn the attitudes or behaviors of any individual or population group.

5.13 Non-pornographic - Content or activity informs and educates and do not titillate or arouse sexual desire.

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*Talking about sex and condoms does not promote promiscuity. It promotes knowledge.*

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Pohnpei State of FSM has legislated to require a national HIV education campaign, including inclusion in school curricula:

### Example

#### **6A-102 Declaration of policies**

*(1) The State shall promote public awareness about the causes, modes of transmission, consequences and means of prevention of HIV through a comprehensive, state wide education and information campaign organized and conducted by the state. Such campaign shall promote value formation and employ scientifically proven approaches, focus on family, as a basic social unit, support the development of appropriate skills, and be carried out in all schools, training centres, workplaces, and communities. The program shall involve affected communities and groups including people living with HIV.*

*(4) The State shall recognize the potential role of affected individuals in propagating vital information and educational messages about HIV and shall utilize their experience to inform the public about HIV, promote HIV testing and encourage the modification of behaviour that may be associated with HIV acquisition.*

#### **6A-110 HIV education in schools**

*(1) The Department of Education, utilizing official information provided by the Department of Health Services, shall integrate instruction on the modes of transmission and ways of preventing HIV and other sexually transmitted infections in subjects taught in public and private schools at intermediate grade, secondary and tertiary levels, including non-formal and indigenous learning systems, PROVIDED that if the integration of HIV education is not appropriate or feasible, the Department of Education shall design special modules in HIV prevention and care.*

*(2) Flexibility in the formulation and adoption of appropriate course content, scope, and methodology in each educational level of group shall be allowed after consultation with parent-teacher associations, private school associations, school officials, and other interested groups. As such, no instruction shall*

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*be offered to minors without adequate prior consultation with parents.*

*(3) All teachers and instructors of HIV education shall be required to undergo training on HIV prevention and care supervised by the Department of Education, in coordination with the Department of Health Services, and demonstrate proficiency in skills relating to education on the prevention of HIV and other STIs, before they are allowed to teach on the subject.*

*Pohnpei Code, Title 17 Chapter 6A (Pohnpei HIV Prevention and Care Act 2007)*

### 6.3 Access to treatment

As the number of people diagnosed with HIV in the Pacific region increases, sustained access to affordable HIV treatments is emerging as a key issue. ARVs are being made available in the Pacific through support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which is currently the primary source of funds for procuring HIV medicines. Supportive legislative frameworks are important to ensure ongoing and sustainable supplies of affordable and quality assured ARVs, and drugs for treatment of opportunistic infections and STIs. Legislation should ensure that:

- the human right to the highest attainable standard of health is recognised in law (see examples below)
- taxes and tariffs do not make essential drugs unaffordable (6.3.1)
- patent and drug registration laws do not restrict access (6.3.2, 6.3.3, 6.3.4)
- advertising of false cures is illegal. (6.3.5)

In the Pacific, pooled procurement arrangements are being implemented for drugs and diagnostics for HIV and STIs. This enables small countries to purchase items they could not otherwise access, or could not access at reasonable prices. Pacific Island countries that receive support from the Global Fund Multi-Country Grant for Western Pacific are able to access ARVs through bulk procurement arrangements (Cook Islands, Palau, Federated States of Micronesia,

Samoa, Kiribati, Solomon Islands, Marshall Islands, Tonga, Nauru, Tuvalu, Niue, Vanuatu). Pooled procurement has proven to be cost-effective in the Caribbean where the nine Organisation of Eastern Caribbean States achieved cost savings of approximately 44% in 2002 through joint procurement, compared to the sums individual countries would have paid.

Legislation requiring drug registration is not yet in place in all Pacific Island countries and countries rely on certification of drugs by WHO and registration of drugs by other countries (e.g. New Zealand, Australia or USA). Fiji maintains an Essential Drugs List and drugs listed are available free from government health centres and hospitals. In PNG the *Medicines and Cosmetics Act* requires all pharmaceutical products to be registered with the National Department of Health. Harmonization of drug regulatory approaches will assist Pacific Island countries to collaborate in pooled procurement and other cooperative arrangements.

#### Examples

##### *Constitutional guarantee of right to health*

*27(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security. . . .*

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

*(3) No one may be refused emergency medical treatment*

*28(1) Every child has a right . . . (b) to family care or parental care, or to appropriate alternative care when removed from the family environment; (c) to basic nutrition, shelter, basic health care services and social services. . . .*

*Constitution, Republic of South Africa*

*South Africa's Constitutional Court has held that the right to health in South Africa's Constitution requires ARVs to be supplied by the Government to prevent mother to child transmission of HIV.<sup>1</sup>*

<sup>1</sup> *Minister of Health v. Treatment Action Committee, Constitutional Court of South Africa, 2002 (10) BCLR 1033.*

*Palau includes health entitlements in its Constitution, which states:*

*The national government shall provide free preventive health care for every citizen.*

*Similarly, the Constitution of Federated States of Micronesia and the Constitution of the Republic of the Marshall Islands recognize the right of the people to health care and education and “the obligation to take every step reasonable and necessary to provide these services”.*

*The Constitution of the Autonomous Region of Bougainville 2004 (Section 34) includes a constitutional commitment to tackling HIV in the following terms:*

*The Autonomous Bougainville Government shall make the fight against HIV/AIDS and its threat to the clans and to the future of Bougainville a major priority.*

*The Bougainville Constitution also provides that the Government will:*

*take all practical measures –*

- (a) to promote primary health care; and*
- (b) to pursue universal health care of the highest standard; and*
- (c) to ensure the provision of basic medical services to the population...*

*(Section 33)*

*In Nauru, the Constitutional Review Commission recommended in 2007 that a right to health services be introduced into the Constitution in the following terms:<sup>93</sup>*

*13C(1) Everyone has the right to access basic health services, including maternity and related care for every woman.*

*(2) The government must take reasonable legislative and other measures, within its*

*h. Nauru Constitutional Review Commission (2007) “Naoero Ituga” Report, Yaren Nauru.*

*available resources, to achieve the progressive realisation of this right, and to progressively improve the standard of health services.*

*17. Right to Health. – (1) Every person has the right to enjoy the highest attainable standard of physical and mental health.*

*(2) The State shall respect, protect and fulfil the right to the highest attainable standard of physical and mental health of all persons.*

*(3) Without prejudice to the generality of subsections (1) and (2), the State shall, based on principles of availability, accessibility and acceptability, provide: ...*

*(b) free of cost treatment for HIV/AIDS for all persons.*

*Explanation:– For the purposes of this Chapter ‘treatment’ includes health facilities, goods, measures, services and information for the curative and palliative care of HIV/AIDS and related opportunistic infections and conditions including:*

- (i) counselling;*
- (ii) the effective and monitored use of medicines for opportunistic infections;*
- (iii) post exposure prophylaxis;*
- (iv) anti-retroviral therapy;*
- (v) nutritional supplements;*
- (vi) measures for the prevention of mother-to-child transmission;*
- (vii) infant milk substitutes; and*
- (ix) other safe and effective medicines, diagnostics and related technologies.*

*(4) To fulfil its obligations under this Chapter, the State shall, inter alia, ensure that continuous and sustainable access to HIV-related prevention and treatment is not hampered or impeded by procedural or other requirements and shall ensure that the process whereby its obligations are fulfilled is transparent and accountable and is evaluated on a regular basis.*

*(5) The Government shall within 180 days of the coming into force of this Act ensure the availability of medical infrastructure, including diagnostic*

In India, a Bill has been drafted for the National AIDS Control Organization that includes a model provision guaranteeing the right to health of people living with HIV as follows<sup>93</sup>:

93 Bill prepared on MPs request by Lawyers Collective HIV/AIDS Unit, Mumbai: <http://www.lawyerscollective.org/hiv-aids/draft-law>

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technologies, required for the prevention and treatment of HIV/AIDS within its jurisdiction.

**18. Protocols for HIV-related treatment.** – The National HIV/AIDS Authority shall, within 180 days of its constitution and establishment, notify protocols for HIV/AIDS-related testing and HIV-related treatment that shall be applicable to all persons through a consultative process and ensure the wide dissemination of the same.

**19. Measures to be taken by State.** – The Government shall take effective legislative, administrative and fiscal measures including:

(a) ensuring the use of all options to promote access to healthcare including provision of travel subsidies for HIV-positive persons to facilitate access to treatment;

(b) the training and capacity building of healthcare providers and public health authorities, in consultation with HIV-positive persons and other protected persons, for the provision, prescription and monitoring of HIV-related treatment and prevention;

(c) ensuring that all other laws are in consonance with the provisions of this Chapter and in particular that the right to health is not in any manner restricted or compromised on account of the protection of intellectual property rights;

(d) introducing tax incentives and exemptions on HIV-related treatment in order to promote its affordability, accessibility and availability;

(e) ensuring that the pricing of medication, diagnostics and related technologies pursuant to any statute, regulation or order is fixed in a manner that is transparent, accountable and open to public scrutiny and that promotes its affordability, accessibility and availability;

(f) ensuring that incentives to encourage investment in research and development are provided to entities, particularly those run by the State to develop, manufacture, market and distribute affordable and accessible preventive, curative and palliative care and treatment.

## 6.3.1 Taxes and duties on drugs

**Human Rights Principles**

States have an immediate obligation to take steps, and to move as quickly and effectively as possible, towards realizing access for all to HIV/AIDS prevention, treatment, care and support. They should therefore review and, where necessary, amend or adopt laws, policies, programs and plans to realize universal and equal access to medicines, diagnostics and related technologies. Duties, customs, laws and value-added taxes may hinder access to medicines, diagnostics and related technologies at affordable prices.

*International Guideline 6, Recommendation c.*

**Relevant human rights**

- right to life
- right to equality
- right to health
- right to enjoy scientific progress

**Background**

While developing countries face a growing need for internally generated revenue, this should not displace the right of all for access to medicines. Few Pacific countries have tax benefits schemes for cheap drugs, but many have across-the-board impositions of goods and services tax (VAT or GST). Essential medicines should be an exception to the application of tax regimes and customs duties.

Each country has its own revenue-raising regime. Where they exist, taxes and duties on treatments for HIV and for associated medical conditions should be removed, as should taxes on diagnostic and related technologies. In some cases, exceptions and exemptions for essential medicines are already in place.



**Example*****National Drug Policy: Drug Financing Policy Statement***

- *Government shall continue to finance the procurement and management of adequate quantities of good quality essential drugs in the public sector.*
- *Government shall exempt selected essential drugs from Value Added Tax (VAT) and other forms of taxation. Such exempted drugs shall be reviewed periodically, but not beyond two years.*
- *Raw materials used for local manufacturing shall be subject to VAT exemption on conditions to be determined by parliament.*
- *Government shall ensure that essential drugs are affordable and a national pricing policy put in place.*

*Ghana National Drug Policy 2004*

and protect all human rights and, where those agreements impede access to prevention, treatment, care and support, should amend them as necessary.

*International Guideline 6 Recommendation z. & Guideline 5*

**Relevant human rights**

- right to life
- right to equality
- right to information and education
- right to health
- right to enjoy the benefits of scientific progress

**Background**

Recognition of patent rights is likely to become an issue of increasing importance for Pacific Island countries as they integrate into the global economy.

Patent laws can restrict access by developing countries to medicines because when new drugs are patented the company with the patent enjoys a monopoly, which means that the price of the medicine may be high. Patent laws prevent competitors from manufacturing and selling low cost generic versions of the same drugs. Patent activity is current low in the Pacific. However patent applications for medicines are expected to increase rapidly as more Pacific Island countries join the World Trade Organization (WTO) and/or enter free trade agreements requiring them to have patent protections for pharmaceutical products.

Patent owners can prevent others from making, using, selling or importing patented medicines for a prescribed period of time, usually 20 years. Whether a generic ARV can be locally manufactured or imported legally depends on the intellectual property law in the country. If an ARV is still under patent, a generic version can only be manufactured or imported legally if there is an exception that can be invoked under national law, enabling compulsory licensing of the product, or if the patent holder has voluntarily entered into a licensing agreement or has agreed not to enforce the patent.<sup>94</sup>

The patent laws that a country introduces are influenced by the country's trade and investment agreements with other countries (e.g. free trade agreements) and whether the country is a member of

**6.3.2 Patents and compulsory licensing****Human Rights Principles**

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.

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 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

94. See: L Gable et al (2007) p189ff.



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the WTO. Countries that are members of the WTO are required to comply with the Agreement on Trade-Related Aspects of Intellectual Property Rights 1994 (“TRIPS”). The TRIPS Agreement stipulates the minimum standards of patent protection that member states are required to have in place. The TRIPS Agreement makes it obligatory for member countries to apply standards for patent protection for new medicines.

While recognizing its international obligations, each country should shape its patent law according to its economic and public health needs and objectives. The TRIPS Agreement allows countries to design their patent laws to address public health concerns.

*Countries that have a patent law can make it more health oriented by legislation that provides for:*<sup>95</sup>

- no patents on medicines – countries that are not WTO Members are not required to have patent legislation in place that applies to medicines;
- no patents on essential medicines;
- patents on medicines that are only available for a short period (however WTO members are required by TRIPS to provide 20 year patent terms).

Currently, of the Pacific countries, only Fiji, Tonga, PNG and the Solomon Islands are members of WTO and therefore subject to TRIPS requirements. Samoa and Vanuatu have engaged in consultations on membership, while most other Pacific countries are not seeking membership.

WTO members that are Least Developed Countries (LDCs) do not have to grant or enforce patents until 1 January 2016, with a possibility of further extension. Fiji and PNG were required to provide patent protection for pharmaceutical products from 1 January 2005, however, because it is an LDC, the Solomon Islands does not have to comply until 2016. The Solomon Islands also has until 2013 to implement other elements of TRIPS Agreement. Under its WTO accession package, Tonga had until 1 June 2008 to implement TRIPS obligations.

The supply of generic equivalents of patented medicines is likely to be affected as countries move towards full implementation of the TRIPS Agreement and enter trade agreements containing requirements similar or additional to those contained in the TRIPS Agreement.

Regional trade agreements may require all countries, not just WTO members, to implement TRIPS standards. In addition to the minimum standards for patent laws that TRIPS prescribes, countries may be required to introduce further patent safeguards by reason of bilateral or regional trade and investment agreements e.g. the proposed Economic Partnership Agreement (EPA) between Pacific Island countries and the European Union. Additional patent protection requirements could apply to all Pacific Island countries that sign up to the EPA, regardless of their WTO member status.

*Examples of some of the public health implications arising from concluding bilateral or regional trade agreements include:*

- Limitations on the circumstances under which compulsory licenses may be issued;
- Extending the minimum period of patent protection beyond the 20 years required by TRIPS;
- Requiring Drug Regulatory Authorities (DRAs), most of whom have limited expertise of patents, to consider the patent status of drugs before granting marketing authorization to generic manufacturers;
- Restricting the use of data submitted to DRAs. DRAs traditionally rely on this data to establish the efficacy and safety of generic products which has the effect of hastening the registration process; and
- Restricting parallel imports to certain geographic areas, which may prevent developing countries from sourcing generics from the cheapest global supplier.

The TRIPS Agreement needs to be interpreted in the context of the *Declaration on the TRIPS Agreement and Public Health*, known as the *Doha Declaration*, adopted by the WTO in 2001.

The Doha Declaration acknowledges the right of WTO members to take necessary measures to protect public health. The flexibilities allowed by the TRIPS Agreement include, in particular:

- compulsory licenses;
- public non-commercial use;
- exceptions to exclusive rights, for instance, for parallel importing and for early working.

<sup>95</sup> Sanya Reid Smith (2007)

## Compulsory licensing

Particularly since the advent of HIV, compulsory licensing has emerged as an important tool for the regulation of patents for public health purposes in developing countries. The Doha Declaration acknowledges that WTO member states can take measures to address public health crises, including those relating to HIV, which represent a national emergency or other circumstance of extreme urgency. Where a country has made the appropriate amendments to its patent laws, it is possible for it to grant licenses for importing, or the local manufacture of, generic versions of ARV medicines without paying large royalties to the patent-holder. This practice is known as compulsory licensing.

Compulsory licensing enables a government to license a company, government agency or other party the right to use a patent without the title holder's consent. The person granted the license must generally compensate the title-holder, by way of royalties.

The TRIPS Agreement specifically allows Member States to grant compulsory licenses on grounds to be determined by each Member country (Article 31). The TRIPS Agreement specifies some grounds for the granting of compulsory licenses, although this is not an exhaustive list. The Agreement requires conditions to be met should a compulsory license be granted.

*These conditions include the requirement, in certain cases, that a license be voluntarily requested before being granted on compulsory terms, non-exclusivity, and adequate remuneration to the patent holder. Patent laws should specifically provide for grounds for compulsory licenses, notably:*

- emergency: such as when urgent public health needs exist as a result of epidemics;
- anti-competitive practices: for instance, to correct excessive prices;
- public interest: broadly defined to cover situations where the public interest is involved;
- government use: such as to provide health care to the poor.

Some patent regimes provide for public non-commercial use of patents by governments. In such cases, a determination by a government agency or Minister is generally required to attest that the government use is justified and is within the terms of

the national law. Government use orders are usually framed in broad terms and may be subject to less procedural requirements than are compulsory licences.<sup>96</sup> Alternatively, legislation can include government use as a ground for issuing a compulsory license (see examples below), but with different requirements than other forms of license. There are important differences that make public and non-commercial use of patents procedurally simpler. A notable difference is the waiver of the requirement for the government or its authorized party to first seek a voluntary licence (Article 31(b) of the TRIPS Agreement). This waiver provides flexibility and allows for the use of patents to be 'fast-tracked', which is of importance when lifesaving medicines are required. There may only be an obligation to inform the patent holder of the proposed use of the patent, or promptly after such use.<sup>97</sup>

Provisions relating to government rights to use patents in the laws of Commonwealth countries were generally modelled after the Patents, Designs & Trademarks Act 1883 (UK), which provided for broad powers to the government to "make, use, exercise and vend the patented invention for any purpose for which appears to the government necessary or expedient". The law of the United States provides a useful illustration of how public use of patents may be broadly framed. Under section 28 USC 1498 the United States Government may use patents, or authorize a third party to use patents, for virtually any public use, and the government does not have to seek a licence or negotiate for the use of a patent or copyright.

In Pacific Island countries that have patent legislation but do not have capacity to manufacture drugs, compulsory licenses may be important to facilitate legal importation of generic versions of ARVs. Importation may be the only viable alternative where the size of the local market does not justify local manufacturing, or where there is a need to promptly address an emergency situation or anti-competitive practices.

The WTO agreed a system in 2005 for export of medicines under patent to countries that do not have capacity to manufacture drugs. The system requires the issue of a compulsory license in the exporting country. It also imposes notification requirements on the importing country, and the issue of a compulsory license in the importing country (assuming that country already has a patent law and the product's patent is recognised in that country). If an importing country has patents legislation in place, to take advantage of

<sup>96</sup> S Musungu S, C Oh (2006)

<sup>97</sup> Ibid.

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the system there needs to be provision in that legislation for compulsory licenses under which imports can be made to address public health needs. Various exporting countries (including Canada, China, the EU, India, the Netherlands, and Norway) have implemented this system in their legislation. However, the WTO-approved exporting system has only been used once, to export ARVs from Canada to Rwanda.

Potential negative impacts of compulsory licensing include the possibility of discouraging foreign investment and diplomatic pressure. Therefore even when the law allows compulsory licensing, governments may be reluctant to make use of the law. Nonetheless, in countries that have patent legislation it is very important that a legislative framework exists for compulsory licensing so that the option is available. The threat of compulsory licenses has been effectively used as a tool to negotiate and to reduce ARV prices, for instance in Brazil.

Ensuring simple procedures for applying for a compulsory license is important. Procedures that are burdensome may discourage use of the system. The most significant barrier to the use of compulsory licensing is the absence of straightforward legislative and administrative procedures, which establish clear decision-making processes and responsibilities. A multi-agency committee may need to be set up to enable agencies to discuss and take joint decisions. The setting of adequate remuneration or compensation (as required by Article 31(h) of TRIPS), such as the adoption of royalty guidelines, should also be predictable and easy to administer, to reduce uncertainty and to facilitate speedy decisions. Determination of the remuneration to be paid to the patent holder is also a key issue, depending on the market volume, turnover of the product and other factors. The table below provides examples of the royalties paid where compulsory licenses have issued.

Examples of compulsory licenses in developing countries<sup>i</sup>

Date	Country	Type	Product	Duration	Royalty
April 2003	Zimbabwe	CL	all HIV medicines	not indicated	not indicated
Oct. 2003	Malaysia	GU	HIV medicines: didanosine, zidovudine - didanosine+zidovudine	2 years	not indicated
Sept. 2004	Zambia	CL	HIV lamivudine+ stavudine+nevirapine	until notification of expiry of the compulsory license	2.5%
Oct. 2004	Indonesia	GU	HIV: Lamivudine - nevirapine	7-8 years (remaining patent term)	0.5%
Nov. 2005	Taiwan, China	--	Oseltamivir	until December 2007	--
Nov. 2006	Thailand	GU	HIV: Efavirenz	until 31 December 2011	0.5%
Jan. 2007	Thailand	GU	HIV: lopinavir/ritonavir	until 31 January 2012	0.5%
Jan. 2007	Thailand	GU	Clopidogrel	patent expiry or no longer needed	0.5%
Mar. 2007	Indonesia	GU	HIV: Efavirenz	until 07 August 2013	0.5%
May 2007	Brazil	GU	HIV : Efavirenz	5 years	1.5%
Sept. 2007	Canada export to Rwanda	CL	HIV: lamivudine+ zidovudine+nevirapine	2 years	0.45%
Jan. 2008	Thailand	GU	cancer drugs	patent expiry or no longer needed	3-5%

**CL = compulsory license; GU = government use (CL for public non-commercial use)**

<sup>i</sup> World Health Organization (2008)

## Pacific Island Patent Laws

Patent laws in the Pacific vary widely across the region, and therefore the approach to law reform to promote access to medicines will be diverse. Countries can be classified under three categories:

- (i) **Registration countries:** countries that re-register United Kingdom, EU or other overseas patents and do not have the capacity to examine and register in their own country e.g. Kiribati, Nauru, Solomon Islands, Tuvalu and Vanuatu . (TRIPS does not require re-registration, so even WTO Members are not required to do it). In Marshall Islands and FSM, it is probable that the patent law of USA applies as there is no domestic patent legislation. In Kiribati the *Registration of UK Patents Act Cap 87* refers to the *Patents Act 1977* (UK), while the *Patents Act 1949* (UK) applies in the Solomon Islands. The *Patent Act 1953* (NZ) applies in Niue, Tokelau and Cook Islands.
- (ii) **WTO-based reform countries:** these states have joined WTO, or are in the process of doing so, and have revised their patent laws to comply with TRIPS e.g. PNG, Tonga and Vanuatu (*Vanuatu's Patents Act 2003*, which was introduced to comply with TRIPS, has not yet commenced operation as law; Vanuatu has legislated to re-register EU patents: *Registration of United Kingdom Patents (Amendment) Act 2008*). In some cases the legislation goes beyond the minimum standard required by the WTO TRIPS Agreement. The World Intellectual Property Organization is providing technical assistance to these countries to draft laws. As a consequence, there are many similarities in the legislation of these countries;
- (iii) **Transitional countries:** in the process of reviewing and amending their patent laws to ensure TRIPS compliance (eg Fiji, Samoa). These reviews are undertaken in the context of either the country being a WTO member or seeking to accede to the WTO. This is particularly the case for compulsory licensing where some countries do not take full advantage of the TRIPS flexibilities.

*Refs: S Farran, D Paterson (2004) South Pacific Property Law Cavendish, London.*

*S Meads (2008) Trade, Medicines & Human Rights: Protecting Access to Medicines in Fiji & the Pacific (Thesis)*

*Victoria University of Wellington*

## Examples

### **Model compulsory license provision (incorporating government use)<sup>i</sup>**

**1(a) Non-exclusive compulsory licenses shall be granted in any of the following cases:**

- (i) *when the patentee has refused to grant a voluntary license under reasonable commercial terms and conditions, and the working or efficient working of any other patented invention which makes a substantial technical contribution is prevented, or the establishment or development of commercial or industrial activities are unfairly prejudiced;*

*j. C Correa (2000)*

- (ii) *in cases of declared national emergency;*
- (iii) *when required for reasons of public health, such as to ensure the availability to the population of essential drugs, or when required in the public interest, including for security reasons;*
- (iv) *to remedy anti-competitive practices;*
- (v) *when required by the government or a public entity to provide to the population goods and services for health care or other public purposes, on a non-profit basis;*
- (vi) *when the patent fails to be worked or is insufficiently worked in the country, and working is necessary for health*



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care or to promote a sector of vital interest for socio-economic development;

- (vii) to use a patent which cannot be exploited without infringing another patent, provided that the former patent covers an invention that involves an important technical advance of considerable economic significance, and the owner of the latter patent is entitled to a cross license on reasonable terms.
- (b) A compulsory license can be conferred to import or to locally produce the patented product or a product directly made with a patented process.
- (c) The license shall be granted for the remaining lifetime of the patent, unless a shorter term is justified in the public interest.
- (d) Except in the cases mentioned in (a)(ii), (a)(v) and (a)(vi), a compulsory license shall be granted if the requesting party has made efforts to obtain authorization from the patent holder on reasonable commercial terms and conditions, and such efforts have not been successful within 150 days from the request. In situations of national emergency or other circumstances of extreme emergency, the right holder shall, nevertheless, be notified as soon as reasonably practicable. In the case of public non-commercial use, where the government or contractor, without making a patent search, knows or has demonstrable grounds to know that a valid patent is or will be used by or for the government, the right holder shall be informed promptly.
- (e) A compulsory license shall be non-assignable, except with that part of the enterprise or goodwill which enjoys such use.
- (f) The use of a compulsory license shall be predominantly for the supply of the domestic market, except in cases of paragraph (a)(v) above.
- (g) The remuneration for a compulsory license shall be determined as a percentage of net sales, taking into

account the value of the license in the relevant domestic market and the average royalty rates usually paid in the sector or branch to which the invention belongs. The remuneration can be reduced or excluded when the license is granted to remedy anticompetitive practices.

- (h) The patent office shall have the authority to review, upon request, the continued existence of the circumstances that led to the granting of a license, and may admit or refuse a request to terminate the license.

The eventual termination shall be subject to the adequate protection of the legitimate interests of the persons authorized to use the invention, particularly when the licensee has made serious preparations or commenced to execute the invention.

- (i) The patentee shall have the right to request from a competent higher authority the review of any decision relating to the legal validity of a compulsory license or to the remuneration determined by the national authority. An application for review shall not suspend the effects of a granted license.

*PNG compulsory license law*

#### **Exploitation by Government or Person Authorized by Government.**

32(1) Where –

- (a) the public interest, in particular, national security, nutrition, health or the development of other sectors of the national economy so requires; or
- (b) the Minister has determined that the manner of exploitation of a patented invention by the owner or his licensee is anti-competitive, and he is satisfied that the exploitation of a patented invention in accordance with this Division would remedy such practice, the Minister may at the request of a Government agency or other person authorized, by notice in the National Gazette, the exploitation of the patented invention by the requesting agency or person predominantly for the supply of the market in Papua New



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Guinea, even without the agreement of the owner of the patent.

- (2) The Minister may impose such terms and conditions on an authorization under Subsection (1) as he thinks fit.
- (3) Subject to Subsection (5), prior to granting an authorization under Subsection (1), the Minister must be satisfied that the owner of the patent has received from the Government agency or person requesting the authorization, a request for a contractual licence, but that that Government agency or person has been unable to obtain such a licence on reasonable commercial terms and conditions and within a reasonable time.
- (4) Subject to Subsection (5), the Minister shall not authorize the exploitation of the patented invention under Subsection (1) until he has given the owner of the patent and any other person known to the Minister to be an interested person, an opportunity to be heard, and where they wish to be heard, has heard them.
- (5) Subsections (3) and (4) do not apply in cases of national emergency under Part X of the Constitution or in other circumstances of extreme emergency, but in such cases the owner of the patent shall be notified of the decision of the Minister as soon as is reasonably practicable.
- (6) The exploitation of a patented invention which is authorized by the Minister under Subsection (1) shall –
  - (a) be limited to the purpose for which the Minister authorized its use; and
  - (b) be subject to payment to the owner of the patent of adequate remuneration as determined by the Minister; and
  - (c) shall not exclude –
    - (i) the conclusion of licensing contracts by the owner of the patent; and
    - (ii) the continued exercise, by the owner of the patent, of his rights under Section 29(1).
- (7) In determining the amount of compensation referred to in Subsection (6)(b), the Minister shall take into account –

- (a) the economic value of his decision under Subsection (1); and
- (b) where the decision has been taken under Subsection (1)(b), the need to remedy the anti-competitive practices.

*Patents and Industrial Designs Act 2000 (PNG)*

#### **Tonga compulsory license law**

- (a) Where the public interest, in particular, national security, nutrition, health or the development of other vital sector of the national economy so require, the Minister may decide that, even without the permission of the patentee, a government agency or a third person designated by the Minister may exploit the invention, subject to the payment of an equitable remuneration to the patentee.
- (b) The decision of the Minister with regard to remuneration may be the subject of an appeal before the Court.

*Industrial Property Act 1994 S.13 (Tonga)*

#### **Brazil**

Brazilian Decree 3201/99 established that in cases of national emergency or public interest, declared by the Federal Executive Authorities, a temporary *ex officio nonexclusive compulsory license* can be granted. Public interest is defined to include public health protection, satisfying nutritional requirements, protection of the environment and other areas of fundamental importance to the technological or social and economic development of Brazil.

#### **Zimbabwe Declaration of HIV Emergency**

1. This notice may be cited as the Declaration of Period of Emergency (HIV/AIDS) Notice, 2002.
2. In view of the rapid spread of HIV/AIDS among the population of Zimbabwe, the Minister hereby declares an emergency for a period of six months, with effect from the date of promulgation of this notice, for the purpose of enabling the State or a person authorised by the Minister under section 34 of the Act

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(a) *to make or use any patented drug, including any antiretroviral drug, used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions;*

(b) *to import any generic drug used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS-related conditions.*

*Declaration of Period of Emergency (HIV/AIDS) Notice 2002  
(Zimbabwe)*

### **Case study: Compulsory licensing for government use**

#### **Malaysia<sup>96</sup>**

*In 2003, the Malaysian government authorized a local company to import three generic versions of ARV medicines from India to supply public hospitals. Section 84 of the Malaysian Patents Act allows the Minister to authorize a government agency or third person to exploit a patented invention in the case of a national emergency or where the public interest requires.*

*The authorization contained specific conditions with regard to price, differentiation in shape and colour from the patented product, and labelling of the medicines. The medicines were labelled with the words "Ministry of Health Malaysia".*

*The Ministry of Health reported a significant reduction in monthly costs of treatment as a consequence of the introduction of the generic ARVs. The Ministry offered the patent holders 4% royalties. The patent holders however were not interested in accepting or negotiating the proposed remuneration. Following the government use authorization, patent holders reduced their prices by 50-80%. However, treatment costs were still lower when using generics, and the number of patients treated with generic ARVs in the public sector more than doubled.*

### 6.3.3 Exceptions to exclusive patent rights

The TRIPS Agreement recognises that there may be exceptions to the exclusive rights of a patent which can operate without the need of a specific authorization by a court or administrator. Under Article 30 of TRIPS, patent legislation of WTO members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties. Examples of such exceptions are:

- Parallel imports;
- Use of an invention for the purpose of obtaining approval of a generic product before the patent expiration date (early working);
- Research and experimental use;
- Medicines prepared for an individual by a pharmacy or doctor in accordance with a medical prescription.

The exceptions relating to parallel imports and early working are discussed in more detail below as they have implications for access to affordable HIV and STI medicines in Pacific Island countries.

#### **Parallel imports**

Pooled procurement is likely to be the preferred approach of Pacific Island countries to procuring ARVs and other pharmaceutical products for diagnosing and treating HIV and STIs at reduced prices. However, if this is not available for particular products or a country is not participating in a regional pooled procurement initiative, another option may be to source cheaper products through parallel importing.

Patent legislation may be drafted to allow countries to import medicines that have been put on the market in other countries at a cheaper price than is available locally. The pharmaceutical industry generally sets prices differently throughout the world for the same medicines. Importation of a patented medicine from a country where it is sold at a lower price will enable more patients in the importing country to gain access to the product.

The rationale for allowing parallel imports is that, since the inventor has been rewarded through the first sale and distribution of the product in the exporting country,

the inventor thereafter has no right to control the use or resale of goods. Whether parallel importing is legal depends on how the question of patent “exhaustion” is dealt with under the importing country’s law. “Exhaustion” refers to the loss of the right to enforce a patent on the resale of the protected product after the first sale. An important clarification of the Doha Declaration was that WTO Members are free under the TRIPS Agreement to adopt laws regarding patent exhaustion regime that best fits their needs.

Kenya provides an example of an international exhaustion regime that allows parallel imports of patented and generic medicines, provided that they have legitimately already been placed on the market elsewhere. This applies a very broad interpretation of the principle of the international exhaustion of rights, allowing even for the importation of legitimately marketed generic medicines.

To limit the provision so that it would generally only allow for importing of original brand name patented medicines rather than generic versions of medicines, the legislation would need to be reworded so that it applies to articles put on the market “by the owner of the patent or with his express consent” (see e.g. South Africa Medicines Act below).

Restrictive formulations on parallel imports should be avoided, such as those that require “express consent” of the patent holder before a patented product is imported. If the consent of the patent holder is required for the import of a patented product, the ability to parallel import will be restricted to those cases where the patent holder has given consent, which is an unlikely prospect. For instance, although the patent owner may for a fee grant voluntary licences for others to manufacture a medicine in a foreign country, the patent holder is unlikely to permit licensees to export the medicine.<sup>98</sup>

The Kenyan model is recommended if countries wish to provide optimum flexibility to ensure that generic medicines can be imported if required.

### Examples

*The rights under the patent shall not extend to acts in respect of articles which have been put on the market in Kenya or in any other country or imported into Kenya. The limitation on the rights under a patent in section 58(2) of the Act extends to acts in respect of articles that are imported from a country where the articles were legitimately put on the market.*

*Industrial Property Act 2001 Section 58(2); cl.37 Industrial Property Regulations (Kenya)*

In South Africa, the Medicines Act authorizes the Minister to prescribe “conditions for the supply of more affordable medicines in certain circumstances so as to protect the health of the public”. The Minister, “in particular may ... determine that the rights with regard to any medicine under a patent granted in the Republic shall not extend to acts in respect of such medicine which has been put onto the market by the owner of the medicine, or with his or her consent” (Article 15C).

This wording does not support importing of generic medicines. The parallel import exception in South Africa is limited to medicines, and it is subject to the prior decision of the Ministry of Health. South Africa has issued regulations and guidelines prescribing procedures under which a parallel importer must obtain a permit. This ensures that parallel import medicines are approved and registered by the Department of Health.

*The Andean Group Common Regime on Industrial Property states that the patent owner cannot exercise exclusive rights in the case of “importation of the patented product that has been marketed in any country with the consent of the owner, a licensee or any other authorized person” (article 34).*

98. S Musungu, C Oh (2006).

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**Drafting options - Parallel imports**<sup>99</sup>

Options for a legislative provision relating to parallel imports include:

**Option 1.** *A patent shall have no effect in relation to a product which has been put on the market in any country by the patent holder or with his consent.*

**Option 2.** *A patent shall have no effect in relation to a product which has been put on the market in any country by the patent holder, with his consent or in another legitimate manner.*

**Option 3.** *A patent shall have no effect in relation to a product which has been put on the market in any country by the patent holder or by an authorized party.*

**Option 1** provides for an exception relating to parallel imports originating in any country, subject to the condition that the product was marketed in such country by the patent owner or with his consent.

**Option 2** broadens the exception, as it would also allow parallel imports in cases where the product was marketed in a foreign country in a legitimate manner, even without the authorization of the patent owner, such as where the product was not protected in the exporting country, or where it was sold under a compulsory license. This could enable importation of generic versions of a product that is still under patent.

A compromise between these two Options would be to limit the cases in which parallel imports without the consent of the patent owner are permitted, by requiring that the sale in the exporting country be made by an authorized party (**Option 3**). The authorization may be given by the patent owner or by a State authority under a compulsory license.

**Early working (Bolar provisions)**

It often takes at least a year between the time a patent expires and the time a generic alternative is available on the market. During this period, the previous patent holder still enjoys an effective monopoly. Delay is largely due to the drug registration process. Delay can be minimised by completing the drug registration process during the life of the patent, so that generic alternatives are already registered and can therefore be sold immediately when the patent expires.

However, beginning the registration process during the life of the patent may be a violation of the patent, because the law normally prevents anyone from using a patented product without the express authorisation of the patent holder. This problem can be overcome by including an early use exception in patent legislation. This is referred to as a Bolar provision.

An early use provision allows generic manufacturers to register a generic version of a medicine during the life of the patent of the original version. Even where they are not likely to be producers of medicines, developing countries should incorporate a Bolar provision within their domestic law, to enable generic medicines to gain regulatory approval to be imported and marketed soon after the expiry of the patent.<sup>100</sup> This permits the foreign manufacturers of generic medicines to use the technology of a patented pharmaceutical to perform work that would assist in the marketing or regulatory approval of the generic version of the product, while the patent is in force. Bolar provisions have been upheld as conforming to the TRIPS agreement.

**Example**

*It shall not be an act of infringement of a patent to make, use, exercise, offer to dispose of, dispose of or import the patented invention on a non-commercial scale and solely for the purposes reasonably related to the obtaining, development and submission of information required under any law that regulates the manufacture, production, distribution, use or sale of any product.*

*Patents Act S.69A South Africa*

**6.3.4 Data exclusivity**<sup>101</sup>

In order to be allowed on the market, a medicine usually has to be registered by the country's national drug regulatory authority. This process is important to ensure safety and efficacy of drugs that are marketed, but can result in delays in generic medicines becoming available unless appropriate legislation is in place.

Data exclusivity refers to the granting of exclusive rights over the test data required for registration of medicines (clinical and preclinical trial data). Granting exclusive rights to data to the patent holders can

99. C Correa (2000).

100 S Musungu, C Oh (2006)

101 See: World Health Organization (2006); K Timmermans (2007)



jeopardize access to medicines by delaying entry to the market of generic versions of drugs, and by preventing compulsory licensing from operating. Although a compulsory license may enable the legal manufacture of the generic version of a patented medicine, the generic manufacturer may still not be able to register the generic medicine if the generic manufacturer is not able to rely on the test data submitted for marketing approval of the patented product.

Data exclusivity diminishes the likelihood of speedy marketing of generics, and delays competition and price reductions because generic producers would have to delay the launch of their product until the end of the exclusivity period.

Developing countries should allow drug regulatory authorities to approve equivalent generic substitutes on the basis of reliance on the data generated by the company that first developed and tested the product (the originator). Countries should implement data protection legislation that is consistent with public health objectives, that is, to facilitate the entry of generic competitors.

Article 39.3 of the TRIPS Agreement requires WTO Members to provide protection for undisclosed test or other data submitted for the purposes of obtaining marketing approval against “unfair commercial use”. In response to this requirement, some countries have legislated to guarantee data exclusivity periods e.g. of five or ten years. Drug regulatory authorities are then not permitted to rely on an originator’s test data to approve other registration applications during this period of exclusivity. However, the TRIPS Agreement does not require data exclusivity; the obligation is to protect against unfair commercial use.

Regulatory authorities in resource poor countries often rely on data that is already published and in the public domain, and that therefore does not strictly fall within the scope of Article 39.3 of the TRIPS Agreement (which only imposes protection for undisclosed data). If a drug regulatory authority approves marketing authorization for medicines on the basis of prior approval in another country such as Australia or New Zealand and on already published data, such data would not qualify for protection under the terms of Article 39.3. In these circumstances countries are not in breach of the TRIPS Agreement if they allow drug regulatory authorities to approve equivalent generic substitutes on the basis of reliance on the originator data.

Some trade agreements require patent holders to be

granted data exclusivity. WTO accession may also require commitments to grant data exclusivity periods. If a country, as a result of entering a trade agreement, does grant data exclusivity, it is important to limit its potential negative implications on access to medicines. This can be done by limiting its duration and/or scope and by providing that reliance on the originator’s safety and efficacy data is allowed in case of compulsory licensing.

### 6.3.5 False cures

#### Human Rights Principles

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 relating to HIV/AIDS.

*International Guidelines: Guideline 6 k.*

#### Relevant human rights

- right to life
- right to health
- right to information and education

#### Background

As awareness of HIV grows in the Pacific, so too do rumours, theories and half-truths. Amongst these is the practice of promoting false cures or ineffective prevention techniques. This raises false hopes and people affected by HIV, who may already be in financial difficulties, may lose even more money in the hope of purchasing a ‘cure’.

Countries usually have legislation controlling the advertising and sale of medicines or consumer protection legislation that prohibits deceptive conduct. These laws can be used to control the sale of false cures. Where there is no such legislation, provisions can be included in public health legislation. Some public health Acts already have provisions banning the advertising of false cures for STIs.

An alternative possibility would be to employ existing controlled or dangerous drugs legislation. Quite often, the list of drugs prohibited by this kind of legislation can be amended by simple notice, rather than requiring an amending bill or regulations.



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It is important that prohibitions against false cures do not prevent the use of traditional medicinal remedies and methods for the alleviation of suffering. An approval process for traditional medicinal remedies and methods in drug or pharmaceutical law is a way to avoid this.

Pacific Island Countries face unauthorised use of their traditional knowledge. Conventional patent laws do not protect traditional knowledge. A model law on Traditional Biological Knowledge, Innovation and Practices is being developed by the Pacific Islands Forum Secretariat.<sup>102</sup>

### Example

Commercial advertisements of misinformation on the treatment and means of prevention of HIV/AIDS that is contrary to the measures set by the National AIDS Authority, and medical and scientific basis, shall be strictly prohibited.

*Law on the Prevention and Control of HIV/AIDS 2002  
(Cambodia) Article 12*

### 6.4 Quality of HIV tests and condoms

#### Checklist

1. Does the legislation regulate the quality, accuracy and availability of HIV tests (including rapid or home testing, if approved)?
2. Does the legislation provide for approval to only be given for sale, distribution and marketing of pharmaceuticals, vaccines and medical devices if they are safe and efficacious?
3. Does the legislation regulate the quality of condoms? Does such regulation include monitoring compliance with the International Condom Standard?

#### Condoms

In relation to condoms, legislation should enforce the International Condoms Standard ISO 4074: 2002. This Standard may need to be supplemented by regulation where additional safety issues arise e.g. inclusion of

spermicides in condoms.

#### Examples

*The matters specified in International Standard “ISO 4074:2002(E) Natural Latex Rubber Condoms - Requirements and Test Methods, including Technical Corrigendum 1” shall constitute the standard for rubber condoms.*

*Therapeutic Goods Order No. 61A (Australia)*

*In addition to ISO 4074: 2002 the following applies in relation to condom labelling claims:*

#### 1. All condoms

*The following claims may be included on either the outside consumer package or a leaflet contained within the consumer package:*

- i. condoms can help reduce the risk of pregnancy;*
- ii. condom use may help reduce the risk of transmission of HIV/AIDS and other sexually transmitted infections (STIs)*

#### 2. Condoms containing nonoxynol 9

*In relation to the labelling of, and package inserts for, condoms containing nonoxynol 9:*

*Any claim for “added protection” shall specify that this claim is limited only to added protection against pregnancy.*

*Claims implying that the addition of nonoxynol 9 helps reduce or prevent HIV/AIDS or sexually transmitted infections (STIs) shall not be included.*

*The label or package insert shall bear the following information:*

*“The presence of nonoxynol 9 has not been shown to reduce the risk of transmission of HIV/AIDS or other sexually transmitted infections (STIs).”*

*Therapeutic Goods Act 1989: Medical Device Standards Order (Standards for Natural Latex Rubber Condoms) 2008  
(Australia)*

#### Rapid HIV tests<sup>103</sup>

It is highly desirable for HIV test kits and protocols for the use of tests to be subject to regulation so as to ensure accuracy of diagnoses.

102. Meads (2007) p.133.

103. See Department of Health and Ageing, Australia (2006) HIV Testing Policy Canberra.

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Rapid testing is of benefit in situations where there are difficulties with access to testing and delays in returning results. Rapid testing is also useful for community-based testing interventions for high risk or hard to reach populations. Rapid HIV tests are manually performed and read subjectively (a person views the results and makes a decision concerning the interpretation of the results). Rapid tests are relatively easy to use, but are subject to error if protocols are not followed exactly. Interpretation of results may lead to errors in results because they are subjectively read. Testing should be conducted by suitably trained personnel.

Rapid tests are often unable to detect low levels of antibody. Confirmatory testing, to distinguish false from true positive results, must be performed on each reactive sample. In low prevalence populations, a greater proportion of reactive results detected in screening by rapid tests will be false positives. Therefore, confirmatory testing must always be performed to distinguish false from true positive results.

### Example

*(1) The Minister may, upon the recommendation of the Council, by notice in the National Gazette, approve a type or class of HIV test kit for use in the country.*

*(2) An approval under Subsection (1) may include conditions as to use.*

*(3) A person who manufactures, imports, sells, distributes, supplies, uses or authorises the use of or otherwise deals with an HIV test kit –*

- (a) that is not an approved HIV test kit; or*
- (b) contrary to any condition of approval for its use, is guilty of an offence.*

*Penalty: A fine not exceeding K10,000.00.*

*(4) Any HIV test kit in respect of which a person is convicted of an offence under Subsection (3) is forfeited to the State and shall be disposed of as the Director directs.*

*HIV/AIDS Management and Prevention Act 2003 (PNG) S.31*

*A quality assurance process (will) be implemented to evaluate, and monitor test kit performance and to ensure that suitably trained personnel use approved kits. Trained personnel should be monitored to ensure that the test kits are used correctly.*

*Only tests approved and validated by the National Institute of Virology (NIV)... will be recommended for use or for consideration for tender purposes.*

*Evaluations of rapid tests must be carried out by the NIV or by other specified institutions at the cost of the applicant and by arrangement of the applicant with the appropriate institution.*

*Use of specific rapid tests in the public sector must be decided in consultation with NIV or another specified laboratory.*

*The Directorate of Medicines Administration will develop specific regulations and specifications for Rapid HIV test tendering (and) will make recommendations to the Pharmaceutical Association concerning the marketing of rapid tests to the public.*

*It is recommended that until further notice, home test kits or 'over the counter HIV test kits' not be made available to the public unless prescribed by a doctor or mental health professional and accompanied with pre and post-test counselling.*

*South Africa Department of Health Policy on Rapid Tests  
2000*

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## 6.4 Ethical research

## Checklist

1. Does the law provide for legal protection for human subjects in HIV/AIDS research? Does the legislation require the establishment of ethical review committees to ensure independent, ongoing evaluation of research? Do the criteria used in such evaluation include the scientific validity and ethical conduct of research?
2. Does the legislation require subjects to be provided before, during and after participation with:
  - counselling;
  - protection from discrimination;
  - health and support services?
3. Does the legislation provide for informed consent to be obtained from the subjects?
4. Does the legislation provide for confidentiality of personal information obtained in the process of research?
5. Does the legislation provide for subjects to be guaranteed equitable access to the information and benefits of research?
6. Does the legislation provide for non-discriminatory selection of subjects?

## Example

- 1) *The Council may from time to time issue Guidelines for the conduct of research relating to HIV/AIDS.*
- 2) *No person shall conduct research relating to HIV/AIDS, whether or not that is the primary purpose of the research, without the approval of the Council or a Committee of the Council appointed for the purpose under the National AIDS Council Act 1997.*
- 3) *It is unlawful to conduct research except in accordance with –*
  - (a) *this Act; and*
  - (b) *any Guidelines issued under Subsection (1); and*
  - (c) *approval under Subsection (2).*

*HIV/AIDS Management and Prevention Act 2003 (PNG)*

## CHAPTER 7:

## ENFORCEMENT

**GUIDELINE 7: Legal Support Services**

States should implement and support legal support services that will educate people affected by HIV/AIDS 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 10: Development of Public and Private Sector Standards and Mechanisms for Implementing These Standards**

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

**GUIDELINE 11: State Monitoring and Enforcement of Human Rights**

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

**Guideline 7****Background**

Law reform alone cannot achieve the realisation of human rights. Helping individuals to enforce their rights in practice is essential. There are many successful legal services in the HIV/AIDS area, in developed and developing countries, and funded by both government and the private sector. Some examples are:

- the Lawyers Collective India – largely self-funded, and operating since 1981;
- a wide range of public and private sector-funded legal services in the United States;
- the HIV/AIDS Legal Centre – a government funded legal centre in Sydney, Australia;
- the HIV/AIDS Legal Clinic – funded under the US President's Emergency Plan For AIDS Relief in Ho Chi Minh City, Vietnam.

To increase the number of people who can be assisted, many of these services have developed materials such as printed information resources, do-it-yourself legal documents (such as wills), legal services

directories, training manuals for volunteer lawyers, printed resources for judicial officers, and general legal texts.

**Relevant human rights:**

- right to liberty and security
- freedom from torture and inhuman treatment
- right to equality and freedom from discrimination
- right to information
- right to equal protection before the law

**Guideline 10****Background**

"...(L)aw in any form is an important expression of social and cultural values and can therefore be used to change these values. Where laws uphold certain customs or behaviours that give rise to HIV transmission risks, such as traditional marriage patterns in some cultures, the abolition of these laws can provoke a questioning of the customs and values that underpin them. The active prohibition of certain conduct which may hitherto have been considered acceptable but which places individuals at risk of HIV can also be a

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powerful force for change. There is, therefore, a need to harness the symbolism of the law in all its manifestations ... and to use it to promote rather than impede the changes necessary to reduce the spread of HIV.”<sup>104</sup>

Certainly, the law has its educative role, and this needs no enforcement. But there will be situations which require some measure of coercive intervention. It is not enough to establish a regulatory framework if there are no appropriate enforcement mechanisms. It is vital that people are helped to enforce their rights. The way in which this is done can be educative in itself. For example, a well publicised test case can have widespread impact.

There are various mechanisms used to enforce laws. They may be classed generally as follows:

- criminal sanctions: offences are usually penalised by imposing a fine, a prison sentence, a good behaviour bond or community service work.
- orders from civil courts declaring rights and obligations, or requiring:
  - payment of compensation,
  - actions to re-establish the previous order of things,
  - injunctions that require a person to do or refrain from doing some act.
- recommendations or orders of a body or tribunal concerned with addressing systemic problems, in addition to individual grievances.

An “enabling environment” is one which supports effective HIV prevention, treatment, care, and support initiatives, through the development and implementation of legislative measures which:

- prevent HIV-related stigmatisation and discrimination;
- decriminalise certain behaviours which can transmit HIV, and reduce threats to vulnerable and marginalised groups;
- establish an HIV-testing regime which is voluntary, is undertaken with informed consent and is accompanied by appropriate counselling;
- promote confidentiality regarding HIV status;
- facilitate access to HIV awareness materials, counselling, care, treatment, drugs etc; and

- ensure that cases of deliberate and wilful transmission of HIV are dealt with under general criminal law provisions, rather than HIV-specific provisions.

Each of these aims requires a different approach to enforcement. Some may require a choice of approaches, depending on the particular circumstances in each case. Generally, the focus of anti-discrimination laws will be on education to reduce the incidence of discriminatory behaviour, and remedying unsatisfactory situations, such as discrimination against an individual person, or the existence of discriminatory policies or practices affecting a class of persons. Anti-discrimination laws provide a means by which to sensitize public opinion, expose stereotypes, and change attitudes and behaviour. Conciliation between disputing parties is usually the first means by which resolution of the dispute is sought, and informal mediation may be sought so as to avoid the cost of lengthy court proceedings. More formal court or tribunal hearings, and the making of legally binding rulings, with enforceable remedies, are generally employed only when other less coercive attempts to settle a dispute have failed.

Other HIV-related matters subject to legal regulation, such as the advertising and sale of false treatments and cures for HIV infection, or a blood bank’s persistent failure to implement blood safety requirements, may be more appropriately dealt with through criminal prosecution and the imposition of penalties.

### Guideline 11

#### Human Rights Principles:

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/AIDS ombudspersons to existing or independent human rights agencies, national legal bodies and law reform commissions.

*International Guideline 11 para.44(d)*

104. Hamblin J. *The role of the law in HIV and AIDS policy. UNDP HIV and Development Programme, 1991.*



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

*International Guideline 10 para.42*

## 7.1 Criminal penalties

The purposes of the criminal law are commonly understood to be:

- **retributive** — the offender is punished for blameworthy behaviour
- **deterrent** — the offenders (and others) are deterred from engaging in the blameworthy behaviour
- **preventive** — imprisoning the offender prevents further harm to other people
- **rehabilitative** — the offender is taught not to engage in the prohibited conduct once released from prison
- **denunciation** — publicly denouncing the offending behaviour (and in the Pacific context, shaming the offender by the denunciation process).<sup>105</sup>

All of these purposes focus on the offender rather than the person offended against. But HIV laws are intended primarily to help combat the spread of the epidemic, by changing or enabling change in behaviours and attitudes. In many instances the type of behaviour targeted and its hoped-for change is something new — the preservation of confidentiality, for example, in small communities where everyone assumes that there is a natural right to information about everyone else.

The penalties which can be applied on conviction for a criminal offence include entering into a bond to be of good behaviour, an order to perform community service, payment of a fine, a term of imprisonment, payment of restitution to the victim of the crime, or a combination of these. While some of these options may be consistent with positive public health outcomes in responding to the epidemic (for example an enforceable undertaking not to repeat the offending behaviour, or the performance of appropriate

community service), and may reinforce messages regarding the importance of respecting HIV-related human rights, other outcomes may produce the opposite effect. A person who receives a prison sentence may fall into bad company in prison, or a gang member may actively seek imprisonment to achieve status, as is reported to be the case in PNG.

Fines are not necessarily effective either, especially in cases where the offender lives in a subsistence economy situation and has very little if any cash with which to pay the fine. There is the additional consideration that frequent or prominent prosecutions involving HIV issues can tend to associate HIV with criminality in the public's perception, and thereby contribute to stigma and discrimination.

Taking all these factors into account, the creation of a criminal offence for breach of an HIV-related legal provision should only be considered when there is a clear justification for criminalisation, and the imperative for invoking the criminal law outweighs possible adverse consequences for public health.

## 7.2 Constitutional law

Most HIV-related issues sought to be regulated by law involve infringements of fundamental human rights. All countries have some process for adjudicating rights. Sometimes this is through litigation relying on the interpretation or application of human rights provisions of the Constitution. Although there can be procedural and economic impediments to the assertion of rights through litigation based on Constitutional provisions (see section 4.1 above), the availability of remedies will vary from country to country. In some cases, an application for relief based on the Constitution will be the best, or perhaps the only option. Some Pacific Island countries' Constitutions make specific provision for litigating complaints of human rights breaches.

Some countries make specific reference to the place of international law in the deliberations of their domestic courts.

<sup>105</sup> D Peavoy (2006)

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**Examples**

*(1) Subject to the provisions of subsection (5) of this section, if any person alleges that any of the provisions of sections 3 to 16 (inclusive) of this Constitution has been, is being or is likely to be contravened in relation to him (or in the case of a person who is detained, if any other person alleges such a contravention in relation to the detained person) then, without prejudice to any other action with respect to the same matter which is lawfully available, that person (or that other person) may apply to the High Court for redress.*

*Constitution S.17 (Kiribati)*

*(1) A right or freedom referred to in this Division shall be protected by, and is enforceable in, the Supreme Court or the National Court or any other court prescribed for the purpose by an Act of the Parliament, either on its own initiative or on application by any person who has an interest in its protection and enforcement, or in the case of a person who is, in the opinion of the court, unable fully and freely to exercise his rights under this section by a person acting on his behalf, whether or not by his authority.*

*(5) Relief under this section is not limited to cases of actual or imminent infringement of the guaranteed rights and freedoms, but may, if the court thinks it proper to do so, be given in cases in which there is a reasonable probability of infringement, or in which an action that a person reasonably desires to take is inhibited by the likelihood of, or a reasonable fear of, an infringement.*

*Constitution S.57 (PNG)*

*Anyone who considers that any of the rights guaranteed to him by the Constitution has been, is being or is likely to be infringed may, independently of any other possible legal remedy, apply to the Supreme Court to enforce that right.*

*Constitution S.6 (Vanuatu)*

**Example**

*In interpreting the provisions of this Chapter, the courts must promote the values that underlie a democratic society based on freedom and equality and must, if relevant, have regard to public international law applicable to the protection of the rights set out in this Chapter.*

*Constitution S.43(2) (Fiji)*

*In determining whether a law or act is reasonably justifiable in a democratic society that has a proper respect for human rights and dignity, a court may have regard to-*

- (a) traditional standards, values and practices, as well as previous laws and judicial decisions, of Tuvalu; and*
- (b) law, practices and judicial decisions of other countries that the court reasonably regards as democratic; and*
- (c) international conventions, declarations, recommendations and judicial decisions concerning human rights; and*
- (d) any other matters that the court thinks relevant.*

*Constitution S.15(2) (Tuvalu)*

**7.3 Other non-criminal remedies**

While constitutional law is one area of law that is non-criminal in nature and may provide remedies for human rights infringements in some situations, there are also other bodies of non-criminal law which may provide remedies. Many of these have been discussed in these guidelines. They include anti-discrimination laws, various protections against discrimination and other human rights infringements in labour or employment laws, as well as laws governing the provision of certain services, and the standards required of certain professions.

**Human Rights Commissions**

The principles for establishing Human Rights Commissions were developed by the UN Commission on Human Rights. In the Pacific, only Fiji has a Human Rights Commission, although other countries are considering establishing one. The Fijian Commission

is established under Fiji's new Constitution, by the Constitution Amendment Act 1997. Some general powers and functions are set out there, but more specific functions are to be found in the Human Rights Commission Act 1999.

### Ombudsman Commissions

Some Pacific countries have an Ombudsman Commission or at least an Ombudsman. However, the Ombudsman is often no more than a single officer, perhaps only operating part-time in the role. Further, the establishing legislation usually spells out the role of the Ombudsman as that of investigating public bodies or administrative action only. In some countries however, the Ombudsman has wider powers, or the establishing provisions allow for the grant of wider powers.

#### Example

*The functions of the Ombudsman Commission are—*

- *to investigate the conduct on the part of a governmental service or an officer or member of it*
- *to investigate any defects in any law or administrative practice*
- *to investigate, either on its own initiative or on complaint by a person affected, any case of an alleged or suspected discriminatory practice within the meaning of a law prohibiting such practices.*

*Conduct is wrong if it is—*

- *contrary to law*
- *unreasonable, unjust, oppressive or improperly discriminatory, whether or not it is in accordance with law or practice*
- *based wholly or partly on improper motives, irrelevant grounds or irrelevant considerations*
- *based wholly or partly on a mistake of law or of fact*
- *conduct for which reasons should be given but were not.*

*Constitution S.219 (PNG)*

*(1) The functions of the Ombudsman shall be to:-*

- (a) enquire into the conduct of any person to whom this section applies in the exercise of his office or authority, or abuse thereof;*
- (b) assist in the improvement of the practices and procedures of public bodies; and*
- (c) ensure the elimination of arbitrary and unfair decisions.*

*(2) Parliament may confer additional functions on the Ombudsman.*

*Constitution S.97 (Solomon Islands)*

### Professional bodies

Many of the requirements of HIV legislation relate to obligations of professionals, not only health care workers, but also lawyers, state servants such as public servants and police, etc. Where there is provision in the legal regime for disciplinary proceedings against professionals, this process can often be employed to good effect. For example, police and public service legislation usually contains processes for disciplining police and public servants. Health and legal professionals may have their own professional bodies, with the power to adjudicate allegations of misconduct.

Codes of conduct for health care workers such as physicians in various jurisdictions prohibit discriminatory conduct against patients.<sup>106</sup> Professional codes of conduct for the various professions should be reviewed so as to include principles based on human rights as elaborated in these guidelines. In the case of health care workers (broadly defined to include doctors, nurses, dentists and dental technicians, traditional healers etc), legislation should provide for complaints to be made about breaches of professional standards by a finding of professional misconduct in relation to matters such as confidentiality, informed consent, and the duty to treat.

106. See, for example, Australian Medical Association (1999) paragraph 1.1(j).

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## 7.4 Using enforcement mechanisms

**Human Rights Principles**

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.

*International Guidelines  
Commentary on Guidelines 3 – 7 para.34*

## 7.4.1 Choice of forum

Most Pacific countries have inadequate resources to support a fully-functioning tribunal which can investigate and arbitrate human rights and discrimination issues. In some countries, the courts have the capacity to deal with such matters. In others, the courts are already overburdened and the strengthening of existing institutions or the establishment of new ones may be more effective. For this reason, and to achieve optimal outcomes, the best option is to draft enforcement legislation so as to enable a choice of forum.

**Example**

*An unlawful act under this Act—*

- (a) is a discriminatory practice within the meaning of Section 219(1)(c) of the Constitution and the Organic Law on the Ombudsman Commission; and*
- (b) is professional misconduct under the Medical Registration Act (Chapter 398) and the Lawyers Act 1986; and*
- (c) is a disciplinary offence under the Public Services (Management) Act 1995, the Police Act 1988, the Correctional Service Act 1995 and the Defence Act (Chapter 74); and*
- (d) may be the subject of an action under Section 28; and*
- (e) is an offence...*

*HIV/AIDS Management and Prevention Act S.27 (PNG)*

## 7.4.2 Right to commence proceedings

There are many reasons why people whose rights have been breached may be unable to take action on their own behalf to enforce those rights and include:

- the formal legal system, and bodies such as Human Rights Commissions and Ombudsmen, are often remote from the people they are intended to serve;
- people whose rights have been infringed may be unaware that this is the case, or that there are avenues of redress available to them;
- the person in need of redress may be ill, in hospital or prison; or
- the enforcement may be needed to be taken on behalf of a group of people rather than a single person.

Enforcement provisions should therefore enable representation by another person or body in the appropriate forum. Representatives may be drawn from civil society, may be a relative or kinsman, from the same village or area, may be a traditionally sanctioned representative such as a chief or noble, or may be a church or social worker.

Court actions should not be restricted by strict standing rules (*locus standii*), which limit the classes and kinds of people who are able to take a case to court. This is particularly significant in the case of HIV-related actions, where the claimant may be too ill or destitute to undertake proceedings, or an action is contemplated by a person with a strong interest in the outcome of the case but who has no formal connection. Representation should also be enabled whether or not the person or group represented has given permission, and whether or not the person or all members of the group are still alive.

**Examples**

*Subject to the provisions of subsection (5) of this section, if any person alleges that any of the provisions of sections 3 to 16 (inclusive) of this Constitution has been, is being or is likely to be contravened in relation to him (or in the case of a person who is detained, if any other person alleges such a contravention in relation to the detained person) then, without prejudice to any other action with respect to the same matter which is lawfully available, that person*



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*(or that other person) may apply to the High Court for redress.*

*Constitution S.17 (Kiribati)*

*Action in respect of an unlawful act may be taken in accordance with any paragraph of Subsection (1) by any person who has an interest in the unlawful act complained of, or in the case of a person who is, in the opinion of the court, unable fully and freely to exercise his right under this section, by a person acting on his behalf, whether or not by his authority.*

*Action in respect of an unlawful act may be taken in accordance with any paragraph of Subsection (1) notwithstanding either or both of the following:—*

*(a) that the person the object of the unlawful act has died, whether the death occurred before or after the occurrence of the act;*

*HIV/AIDS Management and Prevention Act S.27 (PNG)*

### 7.4.3 Timing of action

Actions should not have to wait until the action to be complained of has actually happened.

#### Example

*Relief under this section is not limited to cases of actual or imminent unlawful acts but may, if the Court thinks it proper to do so, be given in cases in which—*

*(a) there is a reasonable probability that the act will be performed; or*

*(b) something that a person reasonably desires to do is inhibited by the likelihood that, or a reasonable fear that, the act will be performed.*

*HIV/AIDS Management and Prevention Act 2003 S.28*

### 7.4.4 Outcomes

The outcomes of enforcement action should be drawn as widely as possible, so as to suit the circumstances of each particular case. They need not necessarily place any imposition on the offender.

This may be achieved by drawing up a wide outcome clause;

#### Example

*[the court] may make such orders, issue such writs and give such directions as it may consider appropriate for the purpose of enforcing or securing the enforcement of any of the provisions...*

*Constitution S.17(2) (Kiribati)*

Or it may be preferable to give some guidance to the court or tribunal:

#### Example

*Relief under Subsection (1) may include any order or declaration the Court considers necessary or appropriate in the circumstances of the case, including but not limited to, the following:—*

*(a) a declaration that the act complained of is unlawful;*

*(b) an order that the act is not to be repeated or continued;*

*(c) a declaration that an act similar to the act complained of is not to be performed in future;*

*(d) an order for apology or retraction;*

*(e) an order for damages by way of compensation for any loss, damage or injury to feelings suffered by reason of the act complained of;*

*(f) an order for payment of punitive or exemplary damages;*

*(g) an order for provision or restoration of access, admission, readmission or reinstatement to the place, facility, situation, workplace or institution from which the person the object of the act complained of has been excluded, ejected or dismissed;*

*(h) an order for employment, re-employment, promotion or restoration of benefits;*



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- (i) *an order for provision of or restoration of access to a means of protection from infection by HIV;*
- (j) *an order for the performance of any reasonable act or course of conduct to redress any loss or damage suffered by reason of the unlawful act;*
- (k) *an order declaring void in whole or in part, either ab initio or from such date as may be specified in the order, any contract or agreement made in contravention of this Act;*
- (l) *a declaration that the termination of a contract or agreement should be varied to redress any loss or damage suffered by reason of the termination;*
- (m) *a declaration that it would be inappropriate for any further action to be taken in the matter.*

*HIV/AIDS Management and Prevention Act S.27 (PNG)*

## TOWARDS AN ENABLING ENVIRONMENT

HIV requires us to address many challenging topics. The use of punitive laws to regulate behaviour, such as laws criminalizing sex work and sex between men, can impede the effectiveness of HIV prevention. The stigma associated criminalized behaviours adds to and reinforces the stigma associated with HIV infection.

In countries with low recorded numbers of HIV infections, it may seem that measures such as decriminalizing sex work and homosexuality are unnecessary and undermining of traditional values. However, a few recorded cases do not necessarily reflect the reality of an epidemic. Effective monitoring systems require adequate resources and technical capacity, in order to develop an accurate picture of a country's epidemic. In many places, monitoring systems are not yet capable of giving us an accurate assessment of the epidemic. In any case, prevention that starts early is much less expensive, and more effective at saving lives, than prevention efforts which begin only after an epidemic is established.

Some may argue that there are more important health problems requiring attention, and that HIV is the subject of unwarranted attention in comparison with other health issues. However, once HIV gains a foothold in a community it can spread rapidly. Unless

HIV is kept under control, AIDS can quickly develop into a major health problem with high treatment costs. The way to prevent this from happening is to prevent HIV transmission now.

In addition to the human costs, HIV epidemics can lead to problems of public order and national security, especially if HIV is increasingly found among military and police staff. Where HIV spreads rapidly, the number of people seeking attention from health care services for conditions related to HIV can require the diversion of scarce resources away from other health issues into HIV treatment and care. Ministries of Health, as well as those responsible for finance and budgeting, need to consider the impact which a rapidly expanding epidemic could have. A large AIDS epidemic can overwhelm the health sector and erode national economies as it impacts people in their most productive years, with the cumulative toll of illness and death affecting productivity.

Examples of effective, rights-based approaches to HIV can be seen in Pacific countries, as this report has illustrated. While each country is culturally unique, HIV is a global epidemic that knows no boundaries. We must take the opportunity to learn from the experience of countries in creating the enabling environment required for effective responses to HIV.

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