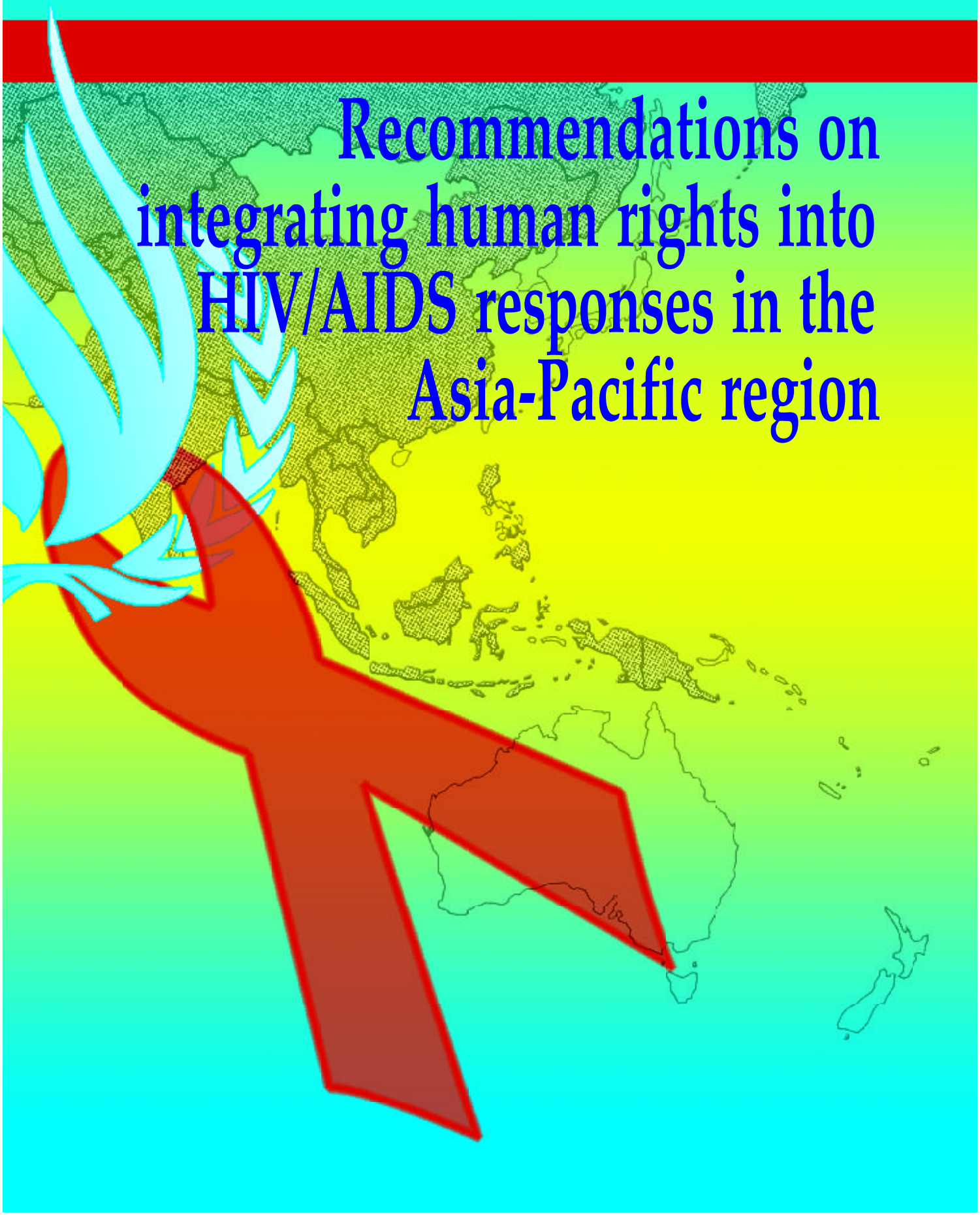
Recommendations on integrating human rights into HIV/AIDS responses in the Asia-Pacific region



Acknowledgements

These Recommendations were developed through a consultative process drawing on expertise across the region. Input to the Recommendations was provided by:

- an Expert Meeting on HIV/AIDS and Human Rights in Asia-Pacific that took place in Bangkok on 23-24 March 2004; and
- country consultations conducted in the Asia-Pacific region in 2004.

More information on the process that informed the drafting of these Recommendations can be obtained at www.un.or.th/ohchr/issues/hivaids/hivaidsmain.html

The assistance of the numerous individuals from across the Asia-Pacific who commented on drafts of these Recommendations is gratefully acknowledged.

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June 2004 edition

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Recommendations on integrating human rights into HIV/AIDS responses in the Asia-Pacific region

Contents

Executive Summary: Key recommendations

Principles

HIV/AIDS responses should be guided by the following principles:

- Health and human rights are interdependent
- Community mobilization is essential for an effective, participatory, human rights based response
- Responsibility for ensuring equity in access to treatment, prevention, care and support services and for promoting the human rights of people living with HIV/AIDS and vulnerable populations rests primarily with governments.

Priority actions for governments

Cross cutting issues

Addressing vulnerability

- Ensure national HIV/AIDS responses include measures that address the social, economic and cultural factors that drive the epidemic, with particular emphasis on gender
- Remove legal and social impediments to addressing the sexual health and HIV prevention, treatment and care needs of people living with HIV/AIDS and vulnerable populations, particularly highly stigmatised populations such as drug users, sex workers and men who have sex with men.

Discrimination and stigma

- Educate communities, employers and professional groups to combat stigma and discrimination
- Enact laws to protect people living with HIV/AIDS and vulnerable populations from stigma and discrimination and provide access to justice for people who experience discrimination
- Support people living with HIV/AIDS groups to document human rights violations, to conduct peer led advocacy to address discrimination, and to engage in community education to combat stigma and to change discriminatory attitudes and practices.

Privacy and confidentiality

- Enact privacy laws and develop workplace and service standards to protect the confidentiality of people living with HIV/AIDS
- Prohibit compulsory testing and ensure that health care services have rigorous confidentiality protections in place relating to HIV test results and other HIV/AIDS related patient records
- Develop standards for service providers to ensure that information relating to drug use, sexuality, gender orientation and sexual practices is kept confidential.

Specific issues affecting people living with HIV/AIDS

Support for the principle of Greater Involvement of People Living with HIV/AIDS

- Support the participation of people living with HIV/AIDS and vulnerable populations in policy making, program design, delivery of peer education programmes, evaluation and monitoring
- Build the capacity of people living with HIV/AIDS and vulnerable populations to engage in planning and delivering effective responses.

Freedom of movement

- Remove visa or entry permit restrictions that prevent people living with HIV/AIDS from travelling
- Ensure that migration laws provide for a discretion to be exercised to enable people living with HIV/AIDS to gain residency status in appropriate cases

Criminalization and the right to privacy in personal relationships

- Support the right of people living with HIV/AIDS to sexual and reproductive health
- Do not enact HIV specific criminal laws

Specific issues affecting vulnerable populations

Injecting drug users

- Promote health based approaches to managing drug dependency rather than applying criminal laws
- Laws should be reviewed with a view to removing criminal penalties for drug use
- Adopt harm reduction methods, including needle and syringe exchanges and voluntary drug substitution treatment programmes
- Involve drug user groups in developing and implementing policies and programmes
- Educate communities and service providers to reduce the stigma associated with drug use

Sex workers

- Decriminalise adult sex work
- Promote self-regulatory approaches to health promotion in the sex industry that support sex workers to organise collectively so that they can determine their own occupational health and safety strategies
- Ensure that police practices support HIV/AIDS prevention and care efforts and that sex workers are not harassed by police or other authorities

Women

- Promote gender equity in all HIV/AIDS related health and social service policies and programmes including access to sexual and reproductive health services for all women and adolescent girls
- Develop programmes to reduce the social and economic burden on women as the primary care providers in HIV affected communities

- Equalise the social, legal, economic and political status of women including in domestic and marital relationships, work, inheritance, property, finances and contractual capacity

Youth and children

- Ensure that children's best interests are a primary consideration in HIV/AIDS policies and programmes, and that the views of children are heard and respected in HIV/AIDS policy making, program delivery and decision making processes affecting their rights.
- Ensure that adolescents have access to HIV prevention tools and information
- Support children's rights to primary education, HIV prevention and treatment services, basic health services, nutrition and access to safe water and sanitation
- Provide children without carers with placement in family environments, and protect children against abuse and neglect
- Ensure the right of children to birth registration and protect the inheritance rights of orphans

Men who have sex with men and transgendered people

- Conduct education and develop service standards to address discrimination by health services against men who have sex with men and transgendered people
- Ensure that policing and prosecution practices do not hinder health promotion outreach work with men who have sex with men and transgendered people, and that these populations are not harassed by police or other authorities
- Support peer education and community based prevention and advocacy services
- Decriminalise sex between consenting adults and review laws relating to relationships, inheritance and property to ensure that they do not discriminate on the grounds of sexuality, gender orientation or transgender status.

Prisoners

- Provide prisoners with access to HIV prevention information, condoms, clean needles and syringes or sterilising agents such as bleach
- Ensure that prisoners are not tested for HIV without consent and that prisoners living with HIV/AIDS are not required to be segregated from other prisoners
- Provide prisoners living with HIV/AIDS with access to adequate standards of treatment and care including antiretroviral therapies and treatment for tuberculosis and other opportunistic infections.

Mobile populations

- Provide culturally appropriate HIV/AIDS education, care and support programmes for migrant populations including populations moving between and within countries, seafarers and military, and undocumented workers
- Ensure that migrant workers are not subject to mandatory testing and deportation on the grounds of HIV status
- Protect trafficked women and girls from sexual violence and ensure that they have access to confidential health services including voluntary testing and counselling
- Provide legal remedies for people who have been coerced into trafficking, and implement programmes that address the social and economic security of women and children who are vulnerable to being trafficked.

· Ensure the right to information about HIV/AIDS for spouses and sex partners in source communities

Sectoral priorities

Health

· Eliminate stigma and discrimination in the health sector as a barrier to equitable access to health services for people living with HIV/AIDS and vulnerable populations
· Ensure that a national HIV/AIDS policy framework is in place that integrates treatment, care, and prevention as part of a comprehensive package
· Develop national procurement and delivery plans that ensure equitable access to treatments
· Expand access to voluntary counselling and testing, and prevention services for all who need them
· Strengthen health sector capacity to deliver integrated treatment and prevention services, by investing in health infrastructure, expanding primary care services and training staff
· Promote voluntary, non-punitive approaches to public health measures, through requiring informed consent to testing and prohibiting use of compulsory measures
· Support organizations of people living with HIV/AIDS to provide community based treatment education and treatment advocacy programmes
· Enact blood safety laws that ensure screening and donor declarations, and promote universal infection precautions in health services.

Employment

· Support public and private sector workplace education programmes to combat stigma and discrimination and to educate employees about HIV/AIDS
· Prohibit workplace discrimination including HIV testing as a requirement for employment
· Encourage employer and employee groups to cooperate in providing HIV prevention education and access to care and support services for employees living with HIV/AIDS and their families
· Work with business coalitions to provide workplace HIV/AIDS prevention, treatment and care programmes.

Education

· Ensure the right to primary education for all young people
· Provide sex education and HIV prevention information in schools and non formal settings
· Prohibit HIV/AIDS related discrimination against students and teachers by educational services
· Promote the involvement of people living with HIV/AIDS in providing HIV/AIDS education
· Review school curricula to ensure that the content of educational programmes does not add to the stigma experienced by people living with HIV/AIDS and vulnerable populations.

Faith based initiatives

- Engage faith based organizations in care, support and prevention programmes, and work with religious leaders to challenge discrimination and reduce stigma
- Work with faith based organizations to encourage community solidarity with people living with HIV/AIDS and vulnerable populations, and to promote non-judgmental messages relating to sexuality and drug use
- Ensure that the work of faith based organizations does not impede people's rights to sexual and reproductive health, including access to condoms for HIV prevention.

Trade policy

- Ensure that the provisions of trade and investment agreements relating to intellectual property rights, data exclusivity, pharmaceutical pricing and privatization of health services support the rights of people living with HIV/AIDS to access essential medicines
- Enact patent legislation that enables full advantage to be taken of the flexibilities provided by the Doha Declaration on TRIPS and Public Health in relation to compulsory licensing and importing of medicines
- Ensure that trade frameworks enable governments to pursue strategies to reduce the price of essential medicines, such as promotion of generic competition and removal of import tariffs.

Research

- Support social research on the lived experiences of stigma, discrimination and other human rights violations
- Ensure that research addresses the needs of all vulnerable populations
- Develop ethical standards to guide research that take into account local cultural contexts, protect vulnerable populations from exploitation in research, and ensure that populations such as drug users and women are not unreasonably excluded from participation in clinical trials
- Require epidemiological research to be conducted that can be broken down into categories such as age and gender that indicate risk and vulnerability so that data can be used to inform policy and planning, without breaching confidentiality

Implementing these recommendations

Governments can develop HIV/AIDS and human rights action plans, including national audits of policies and laws to assess compliance with human rights standards including the *International Guidelines on HIV/AIDS and Human Rights,* and to monitor progress in implementing these recommendations. Audits can measure the impact of policies and laws on equity of access to treatment, prevention, care and support services for people living with HIV/AIDS and vulnerable populations.

Measures to promote the human rights of people living with HIV/AIDS and vulnerable populations can be integrated into:

- National HIV/AIDS Strategies, National Treatment and Prevention Plans, national development policies such as Poverty Reduction Strategies, and the work of national human rights institutions
- Regional initiatives on health and development, and the work of regional and sub-regional inter-governmental summits, fora and associations
- International initiatives including trade agreements, the operation of multilateral trade and finance institutions, development assistance programmes, and cooperation with UN agencies and treaty monitoring processes.

Priority policy issues for regional and sub-regional cooperation to support human rights based HIV/AIDS responses include:

- Regional and sub-regional approaches to procurement of medicines, diagnostics and preventive technologies
- Promotion of harm reduction measures in regional and sub-regional drug control strategies
- Initiatives in relation to the human rights of mobile populations.

1.0 Introduction

These recommendations build on the substantial work that has already been done within the UN system to promote human rights based responses to HIV/AIDS. In particular, they draw on the *International Guidelines on HIV/AIDS and Human Rights* that were first developed in 1996 (see Appendix).[1] These recommendations are intended to apply the *International Guidelines* to the challenges currently facing the Asia-Pacific. They aim to support integration of a human rights approach into the design, implementation, monitoring and evaluation of national policies, laws and programmes on HIV/AIDS. The recommendations can help countries to improve the effectiveness of their response to the epidemic by helping countries to integrate human rights into responses.

These recommendations are intended as a resource to help governments to meet the commitments made in the UN's *Declaration of Commitment on HIV/AIDS*.[2] The *Declaration of Commitment* commits States to take action on HIV/AIDS and human rights. The *Declaration* states that:

- Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS
- Respect for the rights of people living with HIV/AIDS drives an effective response.

The recommendations will also assist countries in the Asia-Pacific region to comply with human rights obligations that arise under the Universal Declaration of Human Rights and human rights treaties, including the International Covenant on Civil and Political Rights, the International Covenant on Economic Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Racial Discrimination and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[3] Human rights obligations are not only a framework of principles, but are also legally binding on States that have ratified relevant treaties or that are members of international organizations. The

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[1] The International Guidelines and revised Guideline 6 have been published with comprehensive commentary: *International Guidelines on HIV/AIDS and Human Rights* UNAIDS & OHCHR Geneva 1998, *HIV/AIDS and Human Rights Revised Guideline 6* UNAIDS & OHCHR Geneva 2002; see also: *Legislators Guide to HIV/AIDS, Human Rights and the Law,* UNAIDS and Inter-Parliamentary Union 1999.

[2] UN General Assembly Special Session on HIV/AIDS, *Declaration of Commitment*, UN Doc. A/Res/S-26/2, 27 June 2001.

[3] The Universal Declaration of Human Rights, General Assembly Resolution 217A (III) UN GAOR Res. 71, UN Doc. A/810, 10 December 1948; the International Covenant on Civil and Political Rights General Assembly Resolution 2200A (XXI) UN GAOR 21st Session, Supp. No. 16 at 49 Res. 71, UN Doc. A/6316, 16 December 1966, 999 UNTS 17; the International Covenant on Economic, Social and Cultural Rights General Assembly Resolution 2200A (XXI) UN GAOR 21st Session, Supp. No. 16 at 49 Res. 71, UN Doc. A/6316, 16 December 1966, 993 UNTS 3; the Convention on the Elimination of All Forms of Racial Discrimination (CERD) General Assembly Resolution 2106A(XX), 21 December 1965, 660 UNTS 195; Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) General Assembly Resolution 34/180, UNGAOR, 34th session, Supp. No. 46 at 193, UN Doc. A/34/46, 18 December 1979, 1249 UBTS 13; the Convention on the Rights of the Child (CRC) General Assembly Resolution 44/25, UNGAOR, 44th Session, Supp. No. 49 at 166, UN Doc. A/44/25, 20 November 1989; and the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) General Assembly Resolution 39/45, UNGAOR, 39th Session, Supp. No. 51 at 197, UN Doc. A/39/51, 10 December 1984.

recommendations also recognise the key role of civil society, including non-governmental and community-based organisations, employers, businesses and faith based organisations.

Human rights recognised by international law that are particularly relevant to HIV/AIDS responses include the human rights to:

- life
- the highest attainable standard of health
- non-discrimination and equality
- work
- adequate standard of living and social security
- privacy
- education and information
- marry and found a family
- liberty and freedom of movement
- freedom of association and to participate in public life
- enjoy the benefits of scientific progress
- be free from cruel, inhuman or degrading treatment or punishment.

For every human right, governments have responsibilities at three levels:

1. they must *respect* the right ie, governments cannot violate human rights directly
2. they must *protect* the right ie, governments have to prevent violations of rights by employers, religious bodies, corporations and other non-state actors, and offer people a way to seek redress if a violation occurs
3. they must *fulfil* the right, by taking deliberate steps to move towards the progressive realization of rights, such as law reform, commitment of financial resources, and building sustainable infrastructure to support enjoyment of rights.

Human rights determine the relationship between individuals and groups with valid claims (rights-holders) and State and non-state actors with correlative obligations (duty-bearers). A rights based approach strengthens the capacities of rights-holders to make their claims, and of duty-bearers to meet their obligations.

The focus of these recommendations is on the role of governments in discharging their obligations as primary duty-bearers that are directly bound by human rights responsibilities under international treaties. Bodies such as faith based organizations, corporations, and multilateral institutions are also duty-bearers, and these recommendations consider the ways that government bodies can assist some of the other important duty-bearers to discharge their obligations relating to HIV/AIDS. Governments have the responsibility to provide an enabling legislative and policy environment that supports the promotion and enjoyment of human rights by all actors in society. Governments are multi-faceted, and action can be taken by a variety of government actors to implement a human rights based approach, including central, state/ provincial and local governments, officials working in ministries and departments, parliamentarians, the judiciary, public sector media, and security and law enforcement agencies.

The Asia-Pacific region is highly diverse. Differing social, economic and cultural contexts mean that different approaches will be required across the region to implement human rights obligations. Resource-poor countries are responsible for striving toward human rights goals to the maximum extent possible given their resource constraints. Wealthier countries are responsible for ensuring domestic compliance with human rights obligations and also that development assistance and cooperation programmes support less wealthy countries in the region to achieve human rights objectives.

2.0 Principles underpinning the recommendations

2.1 Health and human rights are interdependent

Measures to protect individual rights should not be viewed as contradicting collective interests. Rights based responses that ensure that individual human rights are respected, protected and fulfilled are necessary so that improved public health outcomes can be achieved that benefit society as a whole.

The success of HIV/AIDS responses is dependent on the realisation of a broad range of civil, political, social, economic and cultural rights. HIV/AIDS requires an approach whereby health and human rights are viewed as mutually reinforcing. Cultural factors, such as traditional gender roles, and socio-economic factors, such as poverty and literacy levels, directly influence health outcomes.

Addressing the social determinants of HIV vulnerability is essential to the success of prevention, care and treatment strategies. Vulnerability to HIV/AIDS is exacerbated where rights to housing, social security, and education are not fully enjoyed. By focusing on the variety of factors that contribute to an individual's vulnerability to HIV/AIDS, a human rights approach directs the attention of policy makers to the underlying structural determinants of the HIV/AIDS epidemic.

Traditional public health approaches to communicable diseases have often involved curtailing human rights to achieve public health goals, for example through measures such as mandatory testing and isolation. Public health laws designed to control highly communicable diseases are not appropriate for HIV/AIDS because HIV is not casually transmitted and is easily preventable. HIV prevention requires sustained changes in intimate sexual and drug use behaviours, which are most effectively achieved through voluntary health promotion interventions rather than legal compulsion.

Experience in a range of settings has demonstrated that recognising human rights in the design, implementation, and evaluation of health and development policies and programmes helps to improve the effectiveness of HIV/AIDS responses. Prevention and treatment responses need to be based on the active cooperation of people living with HIV/AIDS and those populations most at risk. Behaviour change can most effectively be achieved by working with communities through a combination of voluntary responses that address knowledge, attitudes, beliefs, norms and practices, as well as action to address the social and legal context in which behaviour takes place. Human rights violations undermine the effectiveness of HIV prevention, treatment and care strategies because violations erode the trust and confidence of vulnerable populations in services. If people do not have assurances that their rights will be respected, they may actively avoid testing and contact with prevention, care and treatment services.

Human rights violations also have devastating impacts on the quality of life of people living with HIV/AIDS, and their carers, friends, partners and families. Freedom from discrimination makes people living with HIV/AIDS and affected populations less fearful of disclosing their status, and

enables them to organise peer-led groups that can contribute to prevention, treatment, care and impact mitigation responses. Policy and law reforms, such as decriminalization of practices and introduction of legal protections from discrimination, can provide an enabling environment for educational and community development interventions.

2.2 Community mobilization is essential to support effective, rights based responses

A rights based response requires government actions to be participatory, transparent and accountable. Partnerships between people living with HIV/AIDS, communities, and government are essential to support participatory, human rights based responses to the epidemic. Multi-sectoral responses are required, involving governments at all levels working with all aspects of civil society, including people living with HIV/AIDS and affected communities, non-government organizations (NGOs) and community-based organizations (CBOs), faith communities, businesses and professions.

Governments need to allocate resources for community development and mobilization efforts that support rights based responses to HIV/AIDS. Civil society organizations have an essential role in promoting human rights. NGOs and CBOs require support from governments to conduct human rights education and advocacy. Governments should support the development of organizations representing people living with HIV/AIDS and vulnerable populations. Such organizations can participate in policy development processes, share information on successful interventions, monitor human rights violations, and advocate on human rights issues to governments. People living with HIV/AIDS should be supported to participate in policy development processes through which decisions are made affecting their rights. Legal guarantees of freedom of expression and freedom of association provide a supportive context for the work of NGOs and CBOs as human rights duty-bearers.

Many highly stigmatized populations that are living with or vulnerable to HIV/AIDS (such as sex workers, drug users, and men who have sex with men) do not identify as members of identifiable communities. To support their participation in and creation of new responses that they themselves can shape and lead, governments should support community development programmes that work with these specific populations and that aim to empower people to gain control over their lives by organizing collectively. This is more likely to lead to improved health outcomes than imposed solutions.

The broader community also needs to take ownership of the human rights based approach to HIV/AIDS. An ongoing community dialogue aimed at engaging the general public and community leaders in constructive discussions and decision making on how best to adapt human rights principles to local cultural contexts should be fostered.

2.3 Responsibility for ensuring equity in access to services and promoting human rights rests primarily with governments.

Under international law, responsibilities to implement human rights obligations rest primarily with governments. To support current efforts to rapidly scale up treatment, prevention, care and support programmes in the region, governments have the responsibility to ensure equity in access to services for people living with HIV/AIDS and vulnerable populations. Governments can adopt measures to promote equity and non-discrimination in both publicly and privately provided services. Governments should provide a legal framework that requires equity and non-discrimination in service delivery and that supports the provision of services that are available, accessible, acceptable and of good quality.[4] Governments should provide support to community based groups that can help assure equity by working with marginalised communities and service providers to remove barriers in access to services.

Governments should ensure that accountability mechanisms are in place and that the policy making process is transparent. Community involvement in the policy making process and programme implementation can help governments to discharge their obligations in relation to equity and human rights.

[4] P Hunt *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur* UN Doc E/CN.4/2004/49 16 February 2004 para 41.

3.0 Cross cutting issues

3.1 Addressing vulnerability

Strategies to address vulnerability need to address the intersecting factors that contribute to a person's life situation, rather than dealing with issues in isolation. People's lives are complex and cross cutting vulnerabilities are often experienced.

Poor people (particularly women and girls) confront a range of factors that contribute to their vulnerability to HIV/AIDS. Many male and female sex workers sell sex because of poverty. Poverty is associated with low levels of literacy. Factors such as lack of access to education and homelessness compound vulnerability to HIV/AIDS. Further, social factors that cause HIV vulnerability are not limited to poor people, and issues such as youth vulnerability, racism, gender inequalities and women's vulnerability to gender based violence affect a broad spectrum of society.

Human rights abuses against vulnerable populations can be based upon their non-conformity with social, moral, sexual or gender roles. Social marginalization means that these populations usually have lower access to information, education and basic health and social services, and are more vulnerable to violence and rape. These populations may also be treated unequally by the law. Existing laws against harassment, exploitation, and violence should be enforced to protect vulnerable populations. Vulnerable populations can be adversely targeted by law enforcement agencies with vague and arbitrary powers, such as under vagrancy laws.[5] Sexual assault can fail to be investigated in the case of sex workers, men who have sex with men, and women raped by their husbands. Social marginalization makes vulnerable populations more likely to be the subject of police scrutiny and intervention than other populations, and hence more likely to experience incarceration. This combination of factors reduces the capacity of these populations to protect themselves from risks including HIV.

Vulnerability to HIV/AIDS is generally increased in emergency situations such as conflict and natural disasters. War and civil unrest intensifies vulnerability to infection, due to factors such as movement of populations, increased numbers of armed forces and refugees, deepening poverty, rape of women and weakening of governance.

The identification of vulnerable populations can in itself increase stigma, if these populations are inappropriately labelled as 'victims' or vectors of disease. Care needs to be taken to ensure that programming does not inadvertently increase stigma by drawing negative attention to particular groups in society that already experience stigma and discrimination. However, it is also important that the rights of diverse vulnerable populations are appropriately highlighted so that their needs are not ignored. Equitable access to education, information, treatment, care and support programmes should be guaranteed for all people living with HIV/AIDS and for all vulnerable populations, including:

[5] Human Rights Watch, *Ravaging the Vulnerable: Abuses Against Persons of High Risk of HIV Infection in Bangladesh* 2003.

- female and male sex workers
- people who use illicit drugs
- men who have sex with men
- transgendered persons
- women
- children and youth
- minority ethnic, racial, religious or caste groups
- indigenous populations
- mobile populations, including stateless people and undocumented migrants
- rural and remote populations
- homeless people and street children
- people with disabilities
- prisoners and people in detention outside the adult prison system eg, people in migration detention, people in compulsory psychiatric care, and children in institutions.

3.2 Stigma and discrimination

The stigma associated with HIV/AIDS acts as a powerful disincentive to people coming forward for testing, counselling and treatment. Stigma also sets the social context for discrimination that can be devastating to the lives of people living HIV/AIDS, their carers, families, partners and friends. Aspects of life in which discrimination is reported by people living with HIV/AIDS include:

- health care (refusal of treatment or requirements for HIV testing)
- education (exclusion from schools, colleges and universities)
- employment (pre-employment screening, workplace harassment and dismissal)
- accommodation (refusal to provide, or eviction from, housing)
- financial services (refusal of insurance).

Stigma and discrimination against people living with HIV/AIDS is pervasive across the region.[6] Numerous studies have documented both negative attitudes and active discrimination. Stigma and discrimination not only hamper specific prevention and care interventions, but also threaten the social solidarity and community mobilization essential to an inclusive and sustainable response.

Causes of HIV related stigma include ignorance about transmissibility of HIV/AIDS, fears of death and disease, sexual norms, and the association of HIV/AIDS with socially marginalised populations such as sex workers, drug users and men who have sex with men.[7] These populations already experience stigma, which is compounded by the association of their status with HIV/AIDS. A range of interventions is required to address the complex causes of stigma relating to both HIV status and the status of vulnerable populations.

[6] See eg. APN+ (Asia Pacific Network of People Living with HIV/AIDS) *AIDS discrimination in Asia*, 2004 http://www.gnpplus.net/regions/files/AIDS-asia.pdf

[7] International Centre for Research on Women, *Disentangling HIV and AIDS Stigma* 2003.

Research is needed to understand stigma and identify its causes in local communities. The lived experiences of people living with HIV/AIDS need to be better understood. Documenting human rights violations and conducting social research into the lives of people living with HIV/AIDS is important to inform policy responses to human rights problems, such as discrimination in health care, employment and accommodation.[8] Research is also needed to assess how testing and treatment programmes can assist to reduce stigma by breaking the association between AIDS, illness and death.

Anti-discrimination laws should be enacted to ensure that people living with HIV/AIDS and populations that are vulnerable to HIV/AIDS such as drug users, men who have sex with men, transgendered people and sex workers are protected against discrimination. The discrimination experienced by drug users, sex workers, men who have sex with men and transgendered people can be a significant disincentive to accessing health services, resulting in avoidance of testing and treatment for fear of identification and hostile reactions from service providers.

It is preferable that anti-discrimination laws address HIV/AIDS within broader grounds that should also be protected from discrimination, such as discrimination on the ground of medical conditions or disabilities. Anti-discrimination laws should also protect people from discrimination on other relevant grounds such as gender, race, and sexuality. Some countries in the region (eg Papua New Guinea,[9] Cambodia, Philippines, Australia, New Zealand) have enacted laws prohibiting discrimination against people living with HIV/AIDS in employment, housing, education, access to medical care and other services.[10] Although such laws do not guarantee enforcement or access to representation, creating the right legal climate is an important indication of political commitment.

The UN *Declaration of Commitment on HIV/AIDS* commits governments to enact, strengthen and enforce legislation to eliminate all forms of discrimination against people living with HIV/AIDS and vulnerable populations, and to develop strategies to combat stigma and social exclusion connected with the epidemic. The deadline for compliance with this commitment was 2003. Governments need to recommit to legislative action to address discrimination and stigma without further delay.

Agencies that administer and enforce anti-discrimination laws should adopt approaches to resolving complaints that educate discriminators about the harmful impact of discrimination. Agencies such as Ombudsman offices or human rights offices should have the power to investigate and conciliate complaints. Enforceable remedies should be available as a last resort. Independent and accessible human rights commissions need to be established in the region.[11] Alternatives to formal court procedures should be considered for handling discrimination

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[8] See eg: J Grierson, et al *HIV Futures 3: Positive Australians on Services, Health and Well Being.* Monograph Series No. 37 Australian Research Centre in Sex, Health and Society 2002.

[9] The PNG *HIV/AIDS Management and Prevention Act* 2003 was passed in 2003 but is yet to commence operation.

[10] Examples of HIV/AIDS anti-discrimination laws in the Philippines, Cambodia and other countries are available at: http://www.ilo.org/public/English/protection/trav/aids/laws/

[11] Governments should comply with the *Principles Relating to the Status of National Institutions* ('Paris Principles'), UN General Assembly Resolution 48/134 of 20 December 1993.

complaints, to promote access to justice by people from socio-economically disadvantaged groups. Human rights institutions should integrate HIV/AIDS issues into their investigation, monitoring and enforcement mandates.[12]

Governments should systematically review practices to identify and eliminate discrimination. For example, UNAIDS has developed a Protocol to guide reviews of discriminatory laws and practices in the areas of health care, employment, legal systems, prisons, migration, social welfare, housing, education, family life, insurance, public accommodations and services.[13] Pilots of the Protocol have been conducted in the Philippines, Thailand, Indonesia, China, Viet Nam and India.[14]

Education campaigns can help to reduce stigma and discrimination. HIV/AIDS education campaigns can seek to dispel harmful myths and misinformation and support assertion of the rights of people living with HIV/AIDS. Education should address misconceptions about HIV transmission and sensitise the media and public to HIV/AIDS and human rights issues. Education campaigns should avoid depicting people as victims and give a voice and visible human face to people living with HIV/AIDS so that prejudices and stereotypes can be challenged. Care should be taken when involving people living with HIV/AIDS in education campaigns to ensure that informed consent to disclosure of their identity is given and appropriate protections against discrimination are in place.

A recurring theme in studies of stigma is that information alone is generally not sufficient to alter discriminatory behaviour. Efforts to encourage people living with HIV/AIDS to organise in peer led groups that can advocate their rights are also required. Such groups can address stigma and discrimination by conducting education in local communities to challenge prevailing community attitudes and beliefs. Groups can also develop advocacy services that can resolve cases as they arise, and that can take up issues with governments where a change in law or policy will address systemic or institutionalised discrimination. Training opportunities should be provided for people to become peer counsellors, advocates and educators. People living with HIV/AIDS should be supported in developing the skills necessary to develop autonomous community-based organizations, to advocate for their needs to government, and to train their peers.

Promotion of compassion, understanding and solidarity can be achieved through influential leaders such as parliamentarians, media personalities, sporting figures, and faith leaders openly engaging with people living with HIV/AIDS and members of marginalised populations in decision-making forums and championing their rights.[15] Community leaders can shape and change values and opinion on HIV/AIDS issues because of the trust, authority and respect they already hold in society. Lack of openness is an impediment to the community mobilization that is necessary

[12] A regional meeting was convened with this aim by the Asia Pacific Forum of National Human Rights Institutions in Melbourne in 2001: The Asia Pacific Forum of National Human Rights Institutions, *HIV/AIDS and Human Rights: The Role of National Human Rights Institutions in the Asia Pacific,* held in conjunction with the Sixth ICAAP 2001.

[13] UNAIDS, *Protocol for the Identification of Discrimination Against People Living with HIV* 2000.

[14] D Reidpath, K Yee Chan, *A Situational Analysis of HIV/AIDS Related Stigma and Discrimination in the Asia Pacific: Progress Report*, February 2002.

[15] UNICEF, *What Religious Leaders Can Do About HIV/AIDS: Action for Children and Young People* 2003.

to address individual behavioural and social change. By adopting direct and open approaches to discussing HIV/AIDS, leaders can confront social prejudices and help to reduce stigma.

3.3 Privacy and confidentiality

Laws that require HIV-related information to be kept confidential are important to safeguard the human right to privacy and to prevent further human rights violations, such as discrimination, harassment and violence that can follow disclosure of HIV status. People are more likely to come forward for testing and treatment when confidentiality protections are in place. All testing and treatment should be with fully informed consent (see 6.1 below).

The exact content of the duty of confidentiality should be clarified by governments through legislation or enforceable guidelines that apply to service providers, employers and other agencies that keep records about health status.

As a general principle, disclosure of HIV status should only be made with the consent of the person concerned, or, in the case of children too young to consent, with the consent of a parent or guardian. Exceptions to disclosure with consent should be limited to clearly defined, highly exceptional circumstances, fully considering the impact on the human rights of all parties concerned. If disclosure without consent occurs, there may be negative public health consequences if people at risk are deterred from presenting for testing or treatment. Courts have granted confidentiality orders in some cases to protect the identity of HIV-positive litigants so that lack of privacy is not a barrier to accessing justice.[16]

Measures to protect the privacy of vulnerable populations are also important to support uptake of services, and service providers should ensure that information relating to drug use, sexuality, gender orientation and sexual practices is kept confidential.

[16] For example in the Indian Supreme Court - *Mr X v Hospital Z*, [1998] 8 SCC 296.

4.0 Specific issues affecting people living with HIV/AIDS

4.1 Support for the GIPA principle (Greater Involvement of People Living with HIV/AIDS)[17]

Governments should support the participation of people living with HIV/AIDS and vulnerable populations in policy making, programme design, delivery of peer education programmes, and evaluation and monitoring of programmes. Organizations of people living with HIV/AIDS are playing a central role in strengthening the policy responses to the epidemic in a growing number of countries across the region. Where organizations have been able to operate successfully at the national level, they have played a critical role in challenging stigma, contributing to education, treatment, care and support programmes, and advocating for policy and law reform. At a regional level, the Asia Pacific Network of People Living with HIV/AIDS (APN+) has contributed to important initiatives on treatment access and research on discrimination. Governments should give formal recognition to the pivotal role that people living with HIV/AIDS can play in national and regional responses.

Participation of people living with HIV/AIDS in policy development and law reform processes should be meaningful rather than tokenistic. Organizations of people living with HIV/AIDS require resources so that people wishing to participate in policy processes can be trained in skills relevant to policy development and can receive organizational support.

People living with HIV/AIDS can play a vital role in promoting treatment scale-up. People living with HIV/AIDS can develop treatment literacy strategies that disseminate treatment information in accessible language and formats to their peers, with the goal of promoting treatment uptake and creating community-based support for voluntary testing, treatment and care efforts.[18]

4.2 Freedom of movement

Most countries in the region apply travel restrictions to people living with HIV/AIDS. There is no public health rationale for restricting liberty in movement or choice of residence on the ground of HIV status.[19] Travel restrictions that prevent people living with HIV/AIDS from gaining entry visas should be removed. Such restrictions are discriminatory, contribute to stigma and engender a false sense of security in the general population.

A policy of requiring applicants for visas to declare if they have HIV is flawed. If countries adopt the policy of not allowing entry to people living with HIV/AIDS, then people will be deterred from ever testing or disclosing their status for fear they will be unable to travel. The policy of refusing entry to people living with HIV/AIDS incorrectly assumes that people who

[17] The 1994 Paris AIDS Summit recognised the importance of initiatives to strengthen the capacity of networks of people living with HIV/AIDS and of community-based organizations to support the 'greater involvement of people living with AIDS' (GIPA) in the response to the epidemic. This has become known as the GIPA Principle.

[18] See eg, AIDS Treatment Project of Australia http://www.napwa.org.au/atpa

[19] *International Guidelines on HIV/AIDS and Human Rights* UNAIDS & OHCHR Geneva 1998, para 105.

have been diagnosed with HIV are a likely threat to others in the community. Such a policy demonises people who have tested positive to HIV and risks creating a false sense of security within the population, reinforcing the myth that HIV is a 'foreign' problem that can be solved by border controls. An unfortunate consequence of that belief is that risky behaviour might in fact be encouraged in the domestic population, causing the spread of HIV to increase.

The public health goal should be to encourage voluntary counselling and testing. Travel bans applying to people living with HIV/AIDS undermine the achievement of this goal. There is no epidemiological evidence to suggest that travel bans have any beneficial impact in terms of the pattern of the epidemic. Attempts to halt the spread of HIV by controlling the movement of infected or potentially infected persons have proven futile and expensive, as well as the cause of considerable personal hardship.

Migrant workers who test positive for HIV should not be forcibly repatriated (see 5.7 below).

In the case of applicants for permanent residence, HIV status should not be an absolute bar to residence. Migration laws should provide for discretion to allow people living with HIV/AIDS to obtain permanent residency status in appropriate cases. This is particularly important in the case of people seeking to gain residence status so that they can reside with family members.

4.3 Criminalization, restrictions on liberty and the right to privacy in personal relationships

Governments should acknowledge that people living with HIV/AIDS retain the right to privacy including the right to have fulfilling personal and family relationships. People living with HIV/AIDS have a right to sexual and reproductive health. The stigma associated with HIV and sexuality often means that authorities are reluctant to acknowledge that people living with HIV/AIDS continue to have sex lives, and related sexual and reproductive health needs.

Sometimes authorities seek to criminalize the sexual activities of people living with HIV/AIDS. Such laws lend themselves to arbitrary or selective enforcement, undermine health promotion efforts and are likely to be counter-productive. Authorities should seek the voluntary cooperation of people living with HIV/AIDS in health promotion strategies to prevent HIV, rather than seeking to influence behaviour by criminal sanctions. Inappropriate use of criminal laws to target people living with HIV/AIDS can have detrimental public health effects, such as reinforcing stigma, deterring people from testing and counselling, and creating a false sense of security in the community.

The application of the criminal law to people living with HIV/AIDS who may be placing others at risk of infection should be restricted to highly exceptional cases of deliberate transmission. Specific offences for the deliberate and intentional transmission of HIV are not effective in public health terms.[20] It is preferable to bring prosecutions under general criminal assault laws that may be applicable to exceptional cases of deliberate transmission. Where prosecutions

[20] UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* 2002.

under criminal laws occur human rights principles must be respected, through providing due process protections and rights of representation and appeal.

People living with HIV/AIDS have at times been subject to mandatory isolation and detention under public health laws. There is no justification for detention or isolation solely on the basis of HIV status. Powers of detention under public health laws have been used by health authorities when concerns have arisen that a person is behaving in such a way as to endanger the health of the public. Application of these laws should be limited to highly exceptional circumstances where there is evidence of ongoing deliberate attempts to infect other people. Due process protections such as rights of notice, appeal and legal representation must be guaranteed.

When government authorities exercise public health or security powers that limit the enjoyment of freedom of movement of people living with HIV/AIDS, international human rights law requires that this action must be taken only as a last resort, and should meet the following criteria:

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.
4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, ie, in an unreasonable or otherwise discriminatory manner.[21]

People should only be subject to detention orders after extensive efforts have been made to achieve behaviour change through measures that are less restrictive on individual liberty such as voluntary counselling, and after measures have been taken to address any mental health or welfare needs that may be contributing to risk taking behaviour.[22] Arbitrary measures taken by public health authorities against people living with HIV/AIDS that fail to consider other less restrictive alternatives are abusive of human rights principles and contrary to public health best practice.

[21] United Nations Economic and Social Council (ECOSOC) 1985 *The Siracusa Principles on the limitations and derogation provisions in the international covenant on civil and political rights*. UN Doc. E/CN.4/1985/4, Annex.

[22] See eg *Management of people with HIV infection who risk infecting others*, Health Department of New South Wales Circular 2001/104.

5.0 Issues affecting vulnerable populations

5.1 Injecting drug users

The illegality of drug use and the characterization of drug users as 'evil' has led some authorities in the region to express the view that human rights do not apply to drug users unless they stop using drugs. This is contrary to international human rights law, which requires governments to respect, protect and fulfil the human rights of drug users. Drug dependence is recognised by the World Health Organization as a form of disability. Drug users' human right to health should be protected through the provision by public health authorities of a comprehensive range of services for treating drug dependence, and for the prevention and treatment of HIV/AIDS and other blood borne viruses in drug using populations.

Human rights violations against drug users in the region have included extra-judicial violence and detention. Governments must ensure that drug users, as a highly vulnerable population, are protected from breaches of their fundamental rights to life and liberty.

Public health sectors need to work more closely with public security sectors to promote health based, harm reduction approaches to drug use policies. Health Ministries responsible for HIV prevention should be encouraged to coordinate strategies with Ministries responsible for drug control, as there are often contradictory approaches pursued by different branches of government.

Standards of health care need to be assured in the full range of service settings, from open voluntary community settings to compulsory facilities operating within a public security framework. Mandatory drug treatment programmes violate human rights, and are less effective than voluntary treatment programmes that are more responsive to the individual needs and rights of drug users.

Implementation of HIV/AIDS prevention measures for people who inject drugs has been slow in many countries in the region.[23] Governments should adopt harm reduction approaches to ensure access to:

- public health programmes of information, peer education and voluntary counselling
- sterile needle and syringe distribution and disposal
- voluntary treatment options including substitution drug therapies in community and custodial settings (provision of drug substitutes such as methadone for treatment purposes is not prohibited by international drug control Conventions when offered as part of a wider effort to reduce demand for drugs).[24]

Countries in the region that have established needle and syringe exchange programmes have

[23] G Reid and G Costigan, R*evisiting 'The Hidden Epidemic' A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS*, The Centre for Harm Reduction, The Burnet Institute, Australia 2002.
[24] International Narcotics Control Board, *Annual Report*, March 2004

found them to be a highly cost effective, successful prevention measure.[25] Governments should ensure that a legal framework exists for the operation of needle and syringe exchange programmes. It should not be an offence to possess or distribute needles and syringes, or to self-administer drugs. Outreach workers and peer educators working with drug users can be threatened by law enforcement agencies with arrest for aiding and abetting illegal behaviours such as drug use and sex work. Laws should provide defences or exemptions from criminal liability for health promotion workers. Policing practices and prosecution guidelines should ensure that outreach workers and educators are able to operate without fear of arrest or prosecution.

Governments should support piloting and evaluation of innovative harm reduction measures, such as medically supervised safer injection rooms.[26]

The voice of injecting drug users needs to be recognised and supported by governments. Community based drug user groups have been effectively mobilised in some countries in the region, such as Thailand and Australia, to develop peer based responses to HIV/AIDS education, treatment and care. Drug users who are HIV positive experience stigma associated with both their drug use and HIV status, and are often unwilling or unable to access treatment and care services because of concerns about stigma and fear of being treated in a discriminatory manner by health services. Community based drug user organizations can help to confront stigma and break down these barriers to access. HIV positive drug users should be encouraged to participate in advocacy within a safe environment that does not expose them to undue risk of arrest, detention or exposure to violence.

To minimise stigma, criminal laws and prosecution practices should distinguish between penalties imposed on drug users, dealers, and large scale drug trafficking. UN Conventions on illicit drugs do not require penalties for minor drug possession or personal consumption to be heavy, and authorise non-custodial options such as fines or simple censures.[27] For both public health and human rights reasons, laws should be reviewed with a view to remove criminal penalties for drug use. As a medical, social and behavioural condition, drug dependence should not be criminalised. The existence of criminal sanctions for drug use invites arbitrary policing that drives drug users away from services. Criminal penalties act as a disincentive to people who use drugs from accessing services such as needle exchanges or support services for fear of arrest or police harassment.

Governments should endorse the frameworks for effectively addressing injecting drug use and HIV/AIDS that have been set out in the Warsaw Declaration on Effective Action on HIV/AIDS

[25] Australia's needle and syringe exchange program is estimated to have saved at least AUD$2.4 billion in health sector costs through preventing HIV and HCV infections: Commonwealth Department of Health and Ageing. *Return on investment in needle and syringe programmes in Australia*. Canberra: Department of Health and Ageing, 2002. Available at: www.health.gov.au/pubhlth/publicat/hac.htm

[26] Supervised injection centres that have been trialled have demonstrated successful outcomes in a number of countries including Australia, Germany, Netherlands, Switzerland and Spain. See eg Medically Supervised Injecting Centre Evaluation Committee. *Final report on the evaluation report of the Sydney medically supervised centre.* Sydney: MSIC Evaluation Committee, 2003.

[27] UNAIDS and UNODCP, *Drug Use and HIV Vulnerability: Policy Research Study in Asia,* Task Force on Drug Use and HIV Vulnerability 2000.

and Injecting Drug Use,[28] and the Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia.[29]

5.2 Sex workers

Laws relating to sex work should treat adult sex work as a legitimate occupation. Governments should move towards decriminalising sex work.[30]

Regardless of whether sex work is technically legal or illegal, policies should recognise that male and female sex workers are entitled to human rights protections. Labour and industrial laws should be applied to address health and safety issues in sex work, rather than criminal laws. Decriminalization enables sexual health promotion to be addressed among sex workers in an open, rather than underground, working environment.

Condom use in the sex industry needs to be promoted collaboratively by sex workers as an occupational health and safety issue, and through programmes that empower sex workers to protect their own and others' health. It is important that the responsibility for safer sex practices is not placed solely on the worker, but is also borne by clients and management. Policies should support and enforce the refusal of unsafe sex.

Barriers to distributing or carrying condoms should be removed. The law should not allow possession of condoms to be used as evidence of prostitution-related offences.

Condom promotion alone is inadequate to address vulnerability to HIV/AIDS amongst sex workers. Additionally, community development approaches need to be adopted to mobilise sex workers to work collectively and assert their dignity and human rights to health and safety. Governments should provide a supportive context for sex workers to organise collectively and to pursue peer based approaches to health promotion.

Street based sex workers are highly vulnerable to violence and health harms. Special measures should be taken to ensure that street based sex workers are able to access education and support services such as outreach workers, and are not subject to selective policing or harassment from authorities.

The capacity of sex workers to design, plan and implement HIV/AIDS prevention interventions should be strengthened through participatory processes. Self organization and self determination for sex workers are key strategies for HIV/AIDS prevention. Support for sex workers to organise collectively provides a context in which sex workers can negotiate to improve their working conditions. The Sonagachi Project in Kolkata, India, provides a well documented example of success of self regulation by the sex industry to reduce HIV vulnerability.[31]

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[28] *The Warsaw Declaration: A Framework for Effective Action on HIV/AIDS and Injecting Drug Use*, Second International Policy Dialogue on HIV/AIDS, November 2003.

[29] *Dublin Declaration on HIV/AIDS in Prison in Europe and Central Asia: Prison Health is Public Health*, February 2004.

[30] Australia and New Zealand have decriminalized the adult sex industry and introduced regulation of brothels.

[31] S Singh, S Chowdury *A Dream, a Pledge, a Fulfilment: Five Years Stint at Sonagachi 1992-1997*, All India Institute for Hygiene and Public Health Calcutta

One hundred per cent Condom Use Programmes can be a successful approach to promoting sexual health among sex workers.[32] However, the sustainability of these successes is undermined where such programmes are developed without consultation with sex workers, and where they are enforced through mandatory measures rather than through voluntary, peer led, educative processes. It can be counter-productive to make it compulsory for brothels to register every sex worker they employ or to require mandatory checks for sexually transmitted infections. Enforcement of such policies by police can involve violence and corrupt practices, and have the effect of driving brothel based sex workers underground away from health services. Instead, self-regulatory approaches should be encouraged.[33]

Criminal laws should protect sex workers from sexual assault and other forms of violence. For example, the Supreme Court of Nepal has ruled that rape of sex workers should be punished equally to rape of women who are not sex workers.[34]

It is important that trafficking issues be addressed separately from issues relating to consensual adult sex work. A clear distinction should be drawn between people who have freely chosen sex work for economic reasons and who travel to seek employment opportunities, and those that have been coerced. By merging discussions of trafficking and prostitution, the individual agency of adult sex workers is overlooked and their human rights to employment and an adequate standard of living may be violated.[35]

5.3 Women [36]

Women, particularly young women, are vulnerable to HIV/AIDS for physiological reasons. This vulnerability is compounded by social, economic and cultural factors such as traditional gender roles, gender based violence and experiences of systemic discrimination. Research that has documented the experiences of women living with HIV/AIDS has identified human rights violations in the forms of coerced HIV testing, sterilizations and forced terminations performed on pregnant women living with HIV/AIDS.[37] These practices should be outlawed. Women living with HIV/AIDS are significantly more likely to face discrimination than men, and are often wrongly blamed for spreading HIV. [38]

The human right to health encompasses women's rights to sexual and reproductive health.[39] Women often have no capacity to exercise their sexual and reproductive health rights. Women

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[32] O'Reilly et al , Review of the 100 per cent condom use programme in Cambodia, Phnom Penh: WHO & UNAIDS 2003.

[33] D Lowe *Perceptions of the Cambodian 100% condom use programme: documenting the experience of sex workers*, Phnom Penh: POLICY Project, 2003

[34] R Limbu, *Marital rape outlawed by Nepal's Supreme Court* Panos London Online 01/10/2002

[35] K Butcher, Confusion between prostitution and sex trafficking *The Lancet* Vol 361, p1983, 7 June 2003.

[36] See S Paxton et al *'Oh this one is infected!': Women, HIV and human rights in the Asia Pacific Background Paper to expert meeting on HIV/AIDS and Human Rights* March 2004.

[37] Centre for Advocacy and Research, *Positive Speaking: Voices of Women Living with HIV/AIDS,* UNIFEM South Asia Regional Office 2003.

[38] Supra note 6.

[39] *General Comment 14: the Right to the Highest Attainable Standard of Health* UN Comm on Econ Soc & Cultural Rts, 20th Sess, UN Doc E/C.12/2000/4.

have limited access to health services and commodities. Female controlled HIV prevention methods are urgently needed, and subsidised distribution and promotion of female condoms is required to make them more affordable and accessible.

Cultural norms and traditional gender roles that impede women making and acting upon decisions about sexuality and use of HIV prevention measures (including male and female condoms) should be challenged. This requires recognition of the adverse health impacts of attitudes that value ignorance about female sexuality and women's passivity. In some contexts, women may risk violence if they insist on condom use. In terms of male roles, the promotion of risk-taking masculine identities can also have adverse health impacts. Stronger legal protections for women, and educational programs that address gender roles and the need for gender equality should be designed to address these issues.

Antenatal HIV testing policies should require that testing be conducted with informed consent, and should recognise the dire social consequences for women of an HIV positive diagnosis. Women who test positive may be subject to violence from their spouse or eviction from the family home. Legal protections from domestic violence such as restraining orders should be available to women with HIV/AIDS on a confidential basis.

Women living with HIV/AIDS should be entitled to antiretroviral treatment in their own right. ARV treatment delivery programmes should not just focus on mother to child transmission but should extend to ongoing, holistic treatment of the mother, rather than only prevention of transmission from mother to baby.

Women generally face a greater physical and psychosocial burden than men in caring for partners, children and other family members. Decentralized social protection schemes that specifically assist women, such as village banks that provide credit and savings products, can help support women to obtain financial independence.

There is a need to equalize the social, economic and political status of women. Equality of legal rights should be guaranteed in all areas of life, including family law, domestic and marital relationships, work, inheritance, maintenance, property, finances and contractual capacity. The age of free consent to sex and marriage should be equal for males and females. Sexual assault laws should be applied without discrimination and marital rape should be a crime. In several countries, such as Papua New Guinea and Nepal, laws have been reformed to protect women by criminalizing rape in marriage.

Legal impediments that restrict the human rights of people living with HIV/AIDS to marry and found a family should be removed. Women living with HIV/AIDS should have the right to have children when they want to, and should be supported to do so without judgment. They should also have the right to choose to terminate a pregnancy on learning of their HIV status, and should be supported to do so without judgment.

Women living with HIV/AIDS should be supported in participating in community based education and advocacy groups. Women who are prepared to disclose their HIV status, including women in leadership roles, can make a significant contribution to fighting stigma and changing

community attitudes.[40] Women who speak out should belong to an established network of HIV positive people who can provide support to them. Governments should assess the need for organizations representing women living with HIV/AIDS to receive support so that they can contribute to shaping policies and programmes, and thereby help to ensure greater gender equity in HIV/AIDS responses.

Rights relevant to HIV/AIDS recognised by UN Conference processes such as the International Conference on Population and Development and the Beijing Declaration and Platform for Action have not been fully implemented. Efforts to achieve the objectives of these UN initiatives need to be revitalised.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) requires targeted implementation to address issues relevant to HIV/AIDS.[41] CEDAW addresses the key gendered aspects of the HIV/AIDS pandemic by identifying the discrimination and inequality that contribute to women's vulnerability, and by providing guidance for action. For example, CEDAW requires the elimination of discrimination against women and girls to ensure equality of access to health care, including family planning services.[42] The CEDAW Committee's General Recommendation on Health highlights the need for HIV/AIDS programmes to give special attention to factors relating to women's reproductive role and subordinate social status.[43]

CEDAW also addresses the need to lessen the burden on women as primary care givers, for example by requiring special support for rural women[44] and the elimination of discrimination in inheritance laws.[45] Countries should ratify the Optional Protocol of the CEDAW Convention, which provides the mechanism through which the rights contained in CEDAW can be interpreted and applied.

5.4 Children and young people[46]

The Convention on the Rights of the Child (CRC) and other human rights instruments recognize children as rights-holders, not merely as beneficiaries of protective measures. Governments need to increase their implementation of the CRC as outlined by General Comment 3 on HIV/AIDS and the Rights of the Child.[47] CRC affirms that governments are required to provide assistance to parents and legal guardians to enhance their capacity to perform their childrearing responsibilities, and to provide special protection for children deprived of a family environment. CRC is based on the following four central principles that have direct application to HIV/AIDS:

[40] S Paxton The paradox of public HIV disclosure *AIDS Care* 2002; 14: 559-567.
[41] UNIFEM, *Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic* 2001.
[42] Article 12 CEDAW.
[43] Committee on the Elimination of Discrimination against Women *General Recommendation No. 24 Women and Health (Article 12)* Twentieth session, 1999.
[44] Article 14 CEDAW.
[45] *General Recommendation on Equality in Marriage and Family Relations CEDAW General Recommendation 21*, UN GAOR, 1994, Doc. No. A/47/38.
[46] For the purpose of this document 'children' refers to people aged up to 18 years of age.
[47] *General Comment No 3: HIV/AIDS and the Rights of the Child,* Committee on the Rights of the Child, 32nd Sess., UN Doc CRC/GC/2003/1 2003.

(i) Best interests of the child: In decisions affecting children with HIV/AIDS, orphans and other children made vulnerable by HIV/AIDS, the children's best interests are a primary consideration.

(ii) Right to non-discrimination: Children living with HIV/AIDS, orphans and other children affected by HIV/AIDS are at great risk of discrimination, abandonment or denial of care. Special measures are required for especially vulnerable children such as those who are homeless, subjected to abuse, or in detention to ensure that they have access to services and information.

(iii) Right to survival, well-being and development: CRC recognises every child's inherent right to survival and development including in spiritual, moral, psychological and social aspects of life.

(iv) Right to have views respected: Children are entitled to express their views in matters affecting them, and their views should be given due weight in accordance with the child's age and maturity. Children can enrich decision-making and participate in HIV/AIDS policy making and program delivery. The views of orphans regarding their future care should be heard when decisions about their lives are being made.

Consultation about effective HIV educational messages can increase young people's ownership and engagement in prevention campaigns. Interventions have been found to benefit children most when they are actively involved in shaping and delivering programmes, such as through peer education. Governments should support children to carry out their own initiatives, and to participate in program design, implementation, monitoring and review.

CRC requires governments to ensure that children have sustained and equal access to comprehensive HIV/AIDS treatment and care including antiretroviral therapies.[48] Children should be able to access essential HIV/AIDS services. Voluntary HIV counselling and testing services provide key entry points for identifying HIV positive and other vulnerable children in need of health care and support services. Short-term programmes for prevention of mother-to-child transmission need to be expanded to provide ongoing treatment and care for whole families. Ongoing provision of antiretrovirals to parents with HIV will reduce the number of children born with HIV, save lives and reduce the burden on children and communities of loss of parents.

The evolving capacity of young people should be recognised. This includes the rights of children who are old enough to understand the nature and consequences of an HIV test to provide informed consent to HIV testing and to disclosure of test results. Young people have the right to access accurate information and confidential sexual health care. Governments should protect the confidentiality of test results consistent with the obligation to protect the right to privacy of children contained in CRC. The law should allow young people to access condoms, and clean needles and syringes should they need them for protection from HIV. Prevention programmes need to recognise the realities of the sexual lives of adolescents. Governments should support adolescent sexual and reproductive health programmes that educate about the means of pre-

[48] Ibid.

vention, including condom use, and which address the particular needs of female adolescents, street children and institutionalised children.

Priority issues for children living with and affected by HIV/AIDS include increasing school enrolment and attendance, ensuring birth registration, access to basic health and nutrition services, and ensuring foster or community care for children without family care. The rights of orphans and other children made vulnerable by HIV/AIDS should be protected by laws that:

- Prohibit discrimination against children living with or affected by HIV/AIDS in health care, schools, employment and social services.
- Provide for placement and guardianship of children who lack adequate adult care
- Protect the inheritance rights of orphans and widows
- Protect children against abuse, neglect and sexual contact with adults
- Eliminate barriers that keep the poorest children from accessing health care and education
- Protect street children.

Governments should develop policies that support care placements for children without adequate family care eg, standards and screening criteria for residential placements to ensure that children are placed in institutional care only when no better placement options are possible, and only until a family or community placement can be made. Limits should be placed on the length of time children spend in institutions, and programmes should support children to reintegrate into their communities. Segregation of children living with HIV from other children in institutions should be avoided as it compounds stigma and can result in less favourable treatment. Assistance should be provided so that, to the maximum extent possible, children remain within existing family structures. It may be necessary to strengthen traditional community mechanisms of care for children, for example by providing economic support to extended families rather than simply institutional care.[49] Expansion of home based care and support for HIV positive children and AIDS affected families is critical to the welfare and self-esteem of children and their families. Adoption and foster care services are needed to help children living with and affected by HIV who require special placement. Measures to ensure rapid placement of abandoned infants are required. Developing, financing, implementing and monitoring community systems of care based on the principles of providing children with a family environment are a high priority.

Children should be guaranteed a right to have their birth registered. Some countries require father's to be present at the registration of a birth. Lack of birth registration papers can lead to difficulties for children living with or affected by HIV/AIDS in accessing services. Female children may be subject to harmful traditional practices such as early or forced marriage, which may increase their vulnerability to infection from their husbands. Early marriage may interrupt access to education and place girls in a weak position to take measures to protect their sexual and reproductive health within their marriage. Governments should ensure that a legal framework exists to protect children from abuse, exploitation and loss of inheritance. States should consider ratification and incorporation into domestic law of the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography.[50]

[49] WHO and UNICEF, *Action for Children Affected by AIDS: Programme Profiles and Lessons Learned* 1994.
[50] UN Doc. A/RES/54/263, UN General Assembly Resolution of 25 May 2000.

5.5 Men who have sex with men and transgendered people

Transgendered people and men who have sex with men are highly stigmatised and their sexual behaviour is criminalized in some countries. Support is required for CBOs and NGOs that conduct HIV/AIDS educational and awareness work with these populations. The development of organizations that empower men who have sex with men and transgendered people is urgently needed so that their health and safety needs can be better understood and addressed. Sexual health and HIV prevention and care services should be available on a non-discriminatory basis.[51]

The human rights of men who have sex with men and transgendered people are often ignored by policy makers and programme implementers. Governments, donors, NGOs and research bodies often have limited or no understanding of these populations and issues affecting their vulnerability. Agencies show a degree of discomfort in providing sexual health and care and support programmes to these populations because of the stigma associated with perceived gender and sexual preference. The needs and rights of people with differing sexualities and gender orientations are generally not well included within social, behavioural or epidemiological research agendas.

Reform of criminal laws should be informed by the general principle that sex between consenting adults should be legal. The full range of criminal offences including indecency and public nuisance offences need to be reviewed, as well as policing and prosecution practices. Decriminalization of private, consensual adult sexual acts (including between men) is required to establish equality of legal rights and to address social exclusion of sexual minorities. Governments should review laws that create inequality of legal status such as laws that provide for differing ages of consent to heterosexual and homosexual acts, and exclusion of same sex partners from legal definitions of 'dependent' for purposes such as inheritance, property, and insurance.

Hate crime models should be considered so that the criminal law can be used to protect rather than punish men who have sex with men and transgendered people. Options include increasing the severity of penalties available for assaults where an element of hatred directed at these populations is involved, or creation of new offences such as offences for vilifying people on the ground of their sexuality or transgender status. As yet, very few countries in the region have anti-discrimination laws relating to sexual orientation and transgender status. Useful legislative precedents exist in Australia and New Zealand. Anti-discrimination laws are required that cover grounds such as sexuality, transgender status and gender orientation. Attention needs to be given to religious and customary laws to ensure that such laws do not contribute to the marginalization of men who have sex with men and transgendered people, and thereby worsen the impact of the epidemic through increasing vulnerability to HIV and contributing to stigma and discrimination.

It is important that education occurs first to lay the groundwork for law reform. Protective laws are important, but they only work where legal systems are accessible and functioning. Action

[51] P Hunt, *Report of the Special Rapporteur on Health* February 2004 UN Doc E/CN/para 39.

aimed at changing attitudes is required at the family and community level via schools and the media, as well as at the political and government level. Educational work with government should include a broad range of institutions, including in particular parliamentarians, the police and the judiciary. Law reform needs to be supported by ongoing educational work to inform policy development and to broaden community understanding about gender choices and alternative sexualities.

Policy development and law reform needs to be informed by an understanding of gendered roles in society (including gender choices) and the impact of concepts of masculinity and femininity on HIV vulnerability. Behaviours, identities and roles that need to be considered include:

- Transgendered men and women
- Feminine males, and their diverse social roles in different cultural contexts (eg Kothis in India and Fa'afafine in Samoa)
- Masculine men who play a penetrative role in sex with feminine males
- Female partners / wives of men who have sex with other men
- People who identify as gay or lesbian
- Same sex behaviours in institutions such as prisons and the military
- Bisexual behaviours
- Culturally specific same sex behaviours such as sexual initiations.

5.6 Prisoners

International law recognises that prisoners retain their human rights, and must be treated with dignity and respect.[52] The WHO *Guidelines on HIV Infection and AIDS in Prisons* recognise that prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community.[53] These Guidelines contain general principles on preventing HIV and mitigating its impact in prison and other detention settings, especially where many detainees are drug users.

Diverting drug users from the criminal justice system can reduce the risk of transmission of HIV, hepatitis and tuberculosis in custodial settings. Education, information, care and support are required for adult and juvenile detainees, including access to the means of prevention of HIV and other blood borne viruses, including condoms, clean needles and syringes, or, in their absence, bleach. Peer education can be an effective strategy for HIV prevention in prison environments, and prisoners should be supported in designing and implementing education programmes. The reality that consensual male to male sex occurs in many prison environments should be recognised by prison health services.

There should be no mandatory HIV testing, segregation of HIV-positive prisoners, or denial of access to prison facilities and release programmes. Prison authorities have a duty of care towards prisoners and must protect them from rape, sexual assault and other violence.

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[52] Human Rights Committee, General Comment 21, Article 10 (Forty-fourth session, 1992), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI\GEN\1\Rev.1 at 33, 1994.

[53] WHO, *Guidelines on HIV Infection and AIDS in Prisons* 1993.

Prisoners often face overcrowding and poor nutrition, and may face systematic denial of access to HIV/AIDS treatments. Internationally agreed standards state that sick prisoners have the right to be transferred to prison hospitals or civil hospitals, and that prison hospitals must have pharmaceutical supplies that are proper for the treatment of prisoners.[54] To protect their rights to life and health, prisoners living with HIV/AIDS should have access to antiretroviral therapies and treatment for tuberculosis and other opportunistic infections.

Sentencing laws should enable the HIV status of offenders to be taken into account as a mitigating factor. Consideration should be given to non-custodial sentencing options if the health status of an offender is likely to be aggravated by incarceration. Where prisoners with HIV/AIDS are at the terminal phase of illness, the law should provide for prisoners to have the right to apply for early release on compassionate grounds.

5.7 Mobile populations

Under international law, governments have human rights obligations towards all people within their territory, not only citizens.[55] Non-citizens should not be denied rights of redress for human rights violations and should have access to essential health services. Programmes for mobile populations should include undocumented and irregular migrants and refugees.[56]

Governments should also identify and remove any discriminatory national laws that restrict women or other segments of society from regular forms of migration. These laws may cause people to choose irregular modes of migration, thereby placing them at greater health and safety risk. Such laws could expose people, particularly women and girls, to exploitative conditions under which they are more vulnerable to HIV/AIDS.

There is a need for culturally and linguistically appropriate education, information, care and support programmes for mobile populations moving between countries at various stages, including pre-departure, post-arrival and during re-integration. Regional policies should be developed that address work conditions and health protections for migrant workers including undocumented workers. Policy and program responses are required that are consistent in terms of the human rights approach adopted for 'sending' communities, 'transit' communities and 'receiving' communities.[57]

Programmes should target vulnerable mobile populations, including seafarers, security personnel sent overseas on tour of duty, migrant sex workers and their clients, and transport workers who spend nights away from home. Programmes should also consider the needs of populations that move between urban centres and rural or remote areas within countries. Programmes should work to build community resilience to HIV/AIDS, particularly along remote regional transport

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[54] *Standard Minimum Rule for the Treatment of Prisoners,* art 22(2) ESC Res 663C (XXIV) UN ESCOR 24th Sess, Supp No.1 Un Doc E/3048 1957.

[55] U.N. Human Rights Committee, General Comment 15, *The position of aliens under the Covenant* (Twenty-seventh session, 1986), U.N. Document HRI/GEN/1/Rev.1 1994.

[56] WHO, *International Migration, Health and Human Rights* 2003.

[57] J du Guerny, Lee-Nah Hsu *Towards Borderless Strategies Against HIV/AIDS*, UNDP South East Asia HIV and Development Programme May 2002.

corridors or within and near large infrastructure projects. Finally, programmes should ensure that non-mobile populations who are affected by mobility can protect themselves from the epidemic. A multi-sectoral approach is required in addressing mobile populations and HIV/AIDS.

Migrant labourers are vulnerable to HIV/AIDS due to lack of access to prevention education and poor standards of basic health care, food and housing. They often face barriers to accessing health services including cost, negative staff attitudes, and concerns about breach of confidentiality and the impact on employment status. Women migrant workers may also experience gender based violence and domestic workers are subject to particularly poor conditions and the risk of sexual assault.

Governments should ensure that voluntary and confidential counselling and testing services are offered to migrant workers. Human rights obligations are breached by practices such as mandatory testing of migrant labourers when they renew their work permits, and deportation by receiving countries of workers diagnosed with HIV. Testing of migrant workers is rarely fully informed, and confidentiality of test results is seldom guaranteed. Migrant workers have the right to be informed of test results. The practice of deporting workers without providing test results breaches human rights and places the health of the worker and their partner at risk.

Governments should monitor and regulate recruitment agencies for migrant workers, such as female domestic workers, to prevent and redress human rights violations. Government should comply with obligations under specific treaties, such as the Convention Relating to the Status of Refugees, and the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

Trafficking in people needs to be addressed through prevention, reporting of cases, and prosecution of traffickers. Trafficking control policies need to be consistent with HIV/AIDS policies in their recognition of human rights principles. Documentation of human rights violations, such as coerced HIV testing, can serve as powerful advocacy tools for NGOs to pressure for government interventions.[58] Trafficking policies should make a clear distinction between consensual and non-consensual movement of people. Adult sex workers who travel voluntarily for work opportunities should not be subject to criminal sanctions or suffer other disadvantages by being inappropriately targeted by anti-trafficking measures.

Governments should provide opportunities for longer-term social and economic security for women and children in order to divert them from being trafficked, as well as intervention and rehabilitation measures.

Governments should consider legislation to allow nationals to be prosecuted overseas through cooperation between justice systems. Several countries in the region, such as Japan, have enacted laws that operate extra-territorially to prohibit sexual exploitation of children.[59]

[58] See eg Human Rights Watch Reports *A Modern Form of Slavery*; Human Rights Watch, *HIV/AIDS and the Trafficking of Burmese Women and Girls into Thai Brothels 1994.*

[59] Following the First and Second World Congress Against the Sexual Commercial Exploitation of Children in Stockholm 1996 and Yokohama 2001.

Governments can promote human rights approaches through cross border Memoranda of Understanding (MOU) on mobile populations. Countries should ratify and implement the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children attached to the UN Convention Against Transnational Organized Crime.[60]

[60] UN Doc. A/RES/55/25, UN General Assembly Resolution of 15 November 2000.

6.0 Sectoral issues

6.1 Health

Health sector strategies should comply with the WHO's Global Health Sector Strategy on HIV/AIDS[61] and encompass access to treatments, information, voluntary and confidential counselling and testing, male and female condoms, clean needles and syringes, and safe blood supply. Governments can establish National HIV/AIDS Treatment, Care and Prevention Plans that set out concrete steps, targets and timeframes for rapidly expanding access. Treatment, care and prevention should be supported as part of an integrated package, rather than as competing strategies.

Access to medicines

Under international law, governments are responsible for the progressive realization of the right to the highest attainable standard of physical and mental health. This includes responsibilities to provide equitable access to antiretroviral medicines, treatments for opportunistic infections such as tuberculosis, and treatments for sexually transmitted infections.[62] Antiretroviral medicines are also important for preventive purposes, such as use in preventing mother to child transmission and for post exposure prophylaxis after sexual exposure to HIV or for medical personnel exposed to HIV in the workplace.

Access to treatments must be equitable. International law requires that essential medicines must be provided on a non-discriminatory basis, without distinction of any kind based on race, ethnic group, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[63] All people living with HIV/AIDS should enjoy equitable access to treatments. Governments should assess whether special measures are required to ensure equity for socially marginalised populations that are highly vulnerable to HIV/AIDS such as sex workers and drug users. Equitable access to essential HIV/AIDS medicines should be a budgetary priority and should be supported through public sector procurement and distribution policies, and laws relating to competition, pricing, patents, tariffs and licensing.

Treatments should be made available at affordable prices. In countries where price is a significant barrier to access, governments should consider promoting generic competition as a way to ensure that prices are reduced. Governments in low and middle-income countries should seek to procure sustainable supplies of fixed dose combination antiretrovirals. Generic fixed dose combinations should be sought where they are priced at lower levels than brand name equivalents. Promoting access to fixed dose combination antiretrovirals is an important strategy

[61] *Global Health Sector Strategy on HIV/AIDS* Geneva: WHO 2003

[62] *General Comment 14: the Right to the Highest Attainable Standard of Health* supra note 38; *Access to Medication in the Context of Pandemics such as HIV/AIDS* UN ESCOR Res 2002/32 UN Doc E/Cn/4/2002/200 2002

[63] General Comment 14, supra note 38, para 11-12

because of the benefits that this form of treatment provides in promoting adherence to complex treatment regimens. Governments should consider use of compulsory licenses to assure access to generic medicines in circumstances where producers set prices at a level that presents a substantial barrier to access (see discussion of the WTO TRIPS Agreement at 6.5 below).

Governments should adopt a national pharmaceutical policy that includes domestic price control measures that support equitable access to essential medicines. Equity pricing can be encouraged, whereby prices of essential medicines in poor markets are set as close as possible to the marginal costs of production. To support such approaches, regulatory measures should be taken to prevent differentially priced medicines from being re-exported to wealthy markets.[64]

Governments should promote community mobilization in support of expanded treatment access. The existence of a vibrant treatment access movement led by civil society is an important component of a national response to HIV/AIDS treatment needs. Governments should provide a supportive context for community based advocacy including by providing resources for treatment access groups. Community based treatment advocacy groups can be effective in promoting uptake of testing and treatment by conducting peer education, and can help to promote gender equity in health care provision. Health authorities should work with community based groups to ensure that treatment services are accessible and acceptable to diverse populations. Advocacy groups should be supported in pursuing legal challenges that seek to clarify and enforce rights of access to essential medicines. For example, in 2002 a Thai NGO, AIDS Access Foundation, and two people living with HIV/AIDS successfully challenged pharmaceutical patents that affected the affordability of HIV medicines through test case litigation.[65]

Strengthening the health infrastructure is important for supporting access to treatments and prevention services. Priorities include the development of primary care services that integrate treatment and prevention, building laboratory capacities, and training staff in prescribing HIV/AIDS medicines and patient monitoring. However, governments should not delay making antiretroviral treatments available once a basic level of clinical infrastructure and staffing is in place. Studies have shown that antiretrovirals can be effectively administered in resource poor settings, and it may be unreasonable to wait until all aspects of infrastructure are in place.[66] The impact on HIV/AIDS of access to nutritional food, safe water, shelter and transport should also be recognised.

Governments must not impose preconditions on access to medicines based on labelling of groups as innocent (and therefore deserving of treatment) or guilty (and undeserving of treatment) based on moral judgments about means of transmission of HIV. A rights based approach requires governments to avoid assigning blame for acquisition of HIV when making decisions about access to medicines. Adolescents who engage in drug use, or women who participate

[64] See eg European Council Regulation (EC) No 953/2003 of 26 May 2003

[65] N Ford, D Wilson, O Bunjumnong, T von Schoen Angerer The role of civil society in protecting public health over commercial interests: lessons from Thailand *The Lancet* Vol 363, February 14, 2004, 560-563.

[66] See *Minister of Health v. Treatment Action Campaign* (Constitutional Court of South Africa, July 2002) at para 50; see also. Joseph S Pharmaceutical Corporations and Access to Drugs: The Fourth Wave of Corporate Human Rights Security 25 *Hum Rts Q* 425, 2003 at 444.

voluntarily in the sex industry, require access to treatments on a non-discriminatory basis. They should not be punished by denial of services or blamed for their own vulnerability.[67]

Where health care is largely provided through the private sector or where public service provision is on a fee for service basis, exclusion of the poor can be a major barrier to expanding access. Health systems need to contain an appropriate mix of public and private services to ensure that the right to health is implemented equitably, and that poor people have access to primary health care. Affordability of medicines to consumers can be supported through making use of regulatory price control mechanisms, social health insurance and other social security schemes. For example, rural community health insurance schemes are being piloted in the Lao PDR, the Philippines and Viet Nam, with WHO support. Governments should aim to progressively increase public sector financing of essential medicines so that HIV/AIDS treatments can be made available for free to the poorest through the publicly funded health sector.

Governments should ensure that a regulatory framework exists to ensure quality and efficacy of medicines. Consumer protections against untested medicines and penalties for misrepresenting the effectiveness of treatments in advertising or labelling should be provided.

Access to voluntary counselling and testing

Voluntary counselling and testing supports prevention, treatment and care interventions.[68] Voluntary testing services should be easily accessible for vulnerable populations. In order to minimise possibilities of discrimination or avoidance of testing due to stigma, it may be necessary for testing services to be made discreetly available within health care centres.

Care needs to be taken to ensure that rights to informed consent to testing and treatment are not compromised by over-zealous efforts to meet targets for expansion of coverage of HIV/AIDS treatment services. Pressure to identify those eligible for antiretroviral treatments threatens to skew counselling and testing towards screening those with symptoms. There is a risk that such an approach could result in populations such as prisoners, drug users, and sex workers being coerced into testing.[69] This would be counterproductive to broader efforts to break down stigma and to work with vulnerable populations through voluntary responses. Legislation should prohibit HIV testing without informed consent. Exceptions to the requirement of informed consent should be very narrowly defined, and may include

- where the person is a child who is not old enough to be capable of understanding the meaning and consequences of an HIV test, in which case the law should require that the voluntary informed consent be provided by a parent or guardian;
- where the person has a disability that renders the person incapable of giving consent, in which case the law should require that voluntary informed consent be obtained from

[67] See: A Yamin Not just a tragedy: Access to medications as a right under international law. *Boston University International Law Journal*, Vol 21:101, 2003, at 122
[68] UNAIDS, *The Impact of Voluntary Counselling and Testing: A Global Review of the Benefits and Challenges* 2001.
[69] W Holmes, 3 by 5, but at what cost? *Lancet*, Vol 363, No. 9414, 1072-3, 27 March 2004

either a guardian of the person, or a relative (eg, a spouse or partner, parent, or an adult son or daughter of the person)

- where a person is required to undergo an HIV test in court proceedings on reasonable grounds.

Blood safety and infection control

Blood safety measures and infection control precautions have not been implemented fully in the region.[70] Governments should require the universal screening of blood units for HIV, donor declarations, policies on voluntary replacement and a licensing scheme for blood banks.

Detailed guidelines need to be developed and resources allocated to implement universal precaution systems against risk of infection. When health systems do not provide health care workers with basic infection control equipment, such as rubber gloves, needles and syringes and sharps disposal containers, this violates the right to health of patients and denies workers a safe working environment.

6.2 Employment

Unions, workers, employers and governments should work together to formulate and implement appropriate workplace policies that support the right to work of people living with HIV/AIDS and that are consistent with the ILO *Code of Practice on HIV/AIDS and the World of Work*.[71] Implementation can occur through collective or industry-wide agreements and development of local workplace policies. Policies should address availability of:

- basic information about HIV/AIDS prevention and care
- infection control equipment, such as sharps disposal containers in heath care settings
- condoms
- voluntary counselling and testing
- STI diagnosis and treatment
- HIV treatment.

Involvement of people living with HIV/AIDS in the planning and delivery of workplace education programmes is important to enhance effectiveness.

Labour laws should be reviewed to ensure consistency with the ILO *Code of Practice*. Laws should prohibit HIV testing for employment purposes and other discriminatory measures such as dismissal or restricted work conditions. Attention should be given to specific employment sectors where workers may be more susceptible to the risk of infection, such as the armed forces, mining and other situations where workers may be separated from their families. Pre-employment health tests should only be required to assess a person's current ability to perform

[70] Human Rights Watch, *Locked Doors: The Human Rights of People Living with HIV/AIDS in China* 2003 and UN Theme Group on HIV/AIDS in China, *HIV/AIDS: China's Titanic Peril* 2002.

[71] See also *ILO Education and Training Manual: Implementing the ILO Code of Practice on HIV/AIDS and the World of Work*

the essential requirements of their job. HIV testing should not be included in pre-employment tests. It is not recommended that employers require evidence of the HIV status of health care workers. It should be the goal of all employers and health care facilities to achieve voluntary compliance and self-disclosure, where appropriate, by the establishment and maintenance of an environment in which health care workers know their confidentiality will be protected and they will not suffer unlawful discrimination. Maintenance of confidentiality will encourage workers to seek testing, counselling and treatment and to voluntarily disclose their HIV status to their employers in appropriate cases.

Ignorance about the real occupational risks of HIV transmission continues to be a major factor causing HIV stigma and discrimination in the workplace. Workplace education should attempt to overcome, rather than reinforce, existing behavioural norms, and may need to challenge traditional gender roles if such roles impede women's enjoyment of workplace equality. There is a particular need to increase women's access to economic resources in informal workplaces.

Public health and employment legislation may need to be reviewed to remove discriminatory and ineffective provisions that inappropriately classify HIV/AIDS as an 'infectious' disease, such as quarantine laws and prohibitions on working in certain industries.

Legal recognition of the rights of workers to organise in both the formal and informal sectors is important to ensure that workers have a voice in workplace HIV/AIDS responses.

Governments should support private sector initiatives that promote the human rights of people living with HIV/AIDS in the workplace. Access to care and support for workers and families affected by HIV/AIDS can be provided in work settings. Some employers have included antiretroviral therapy in their employee health programmes. Sick leave provisions need to be flexible to take into account workers' variable ability to work depending on fluctuating health, and responsibilities to care for partners and families. The Asian Business Coalition on AIDS is an international alliance with coalition partners that facilitate workplace programmes on HIV/AIDS by providing training and consultation on HIV/AIDS workplace policy development. For example, the Thai partner of the Coalition, the Thai Business Coalition on AIDS, is working in partnership with the Thai Government and community organizations on projects to reduce workplace discrimination and to improve access to health care.

6.3 Education

The right to education is central to HIV/AIDS prevention and care. Inequality of access to education and information causes vulnerability through lack of knowledge of the means of prevention or the availability of care and appropriate use of treatments. This is a factor especially for women whose literacy levels are often lower than men. Studies have shown a strong correlation between the level of education and wealth, and knowledge about HIV/AIDS protective measures and use of the means of prevention, such as condoms.[72]

[72] Studies in Vietnam and Cambodia cited in UNDP, *Human Development Report: HIV/AIDS and Development in South Asia* 2003, p25.

The UN *Declaration of Commitment on HIV/AIDS* sets a target that by 2005 governments must ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. To meet this target, Governments should guarantee young people's right to learn about HIV/AIDS and the means to protect themselves.

Human rights obligations require governments to ensure that education services are available, accessible, acceptable and adaptable. These concepts encompass obligations to:[73]

- ensure compulsory and free education for children up to at least the minimum age of employment regardless of HIV status
- ensure that children living with or affected by HIV/AIDS have access to education without discrimination
- set minimum standards for the content, methods and medium of teaching relevant to HIV prevention, such as sex and relationships elements of life-skills education
- design education for children precluded from formal schooling (eg, internally displaced children) and to adapt education to the needs of children living with or affected by HIV/AIDS.

Age appropriate HIV/AIDS and sexual health education should be provided by schools, educational institutions and communities. Learner-centred methods should be used to impart knowledge, values, skills and protective behaviours. Learner-centred approaches are generally participatory in nature and ensure that the learning experience is tailored to individual need and not simply imposed by the teacher or by the dictates of a rigid syllabus. Sex education needs to be more than just biological, it needs to include social aspects of sexuality and should be integrated into broader life skills education. Sex education that addresses HIV should be a part of the core school curriculum, rather than being optional. Educational methods should also be responsive to the needs of children who are not in formal settings. Education should aim to promote gender equality and should actively challenge norms and values that reduce or restrict the status of women in society.

HIV/AIDS-sensitive curricula need to be developed for schools and colleges that are non-stigmatising and that promote acceptance and solidarity with children living with and affected by HIV/AIDS. Guidance on curricula and approaches to effective HIV education should be provided that can be adopted by private schools and religious schools. Close involvement of religious and traditional groups in devising HIV education strategies may be essential in some countries to ensure community support for programmes that address taboo sexuality and drug use issues. Effective HIV/AIDS prevention requires governments to refrain from censoring, withholding or misrepresenting health related information, including sex education and sexual health information.

People living with HIV/AIDS, particularly women and young people, should be supported in participating in delivery of school HIV education programmes. Education departments should

[73] J Wijngaarden, S Shaeffer, *Human Rights and the Education Sector in the Context of HIV/AIDS in Asia* UNESCO Asia Pacific Regional Office for Education 2004.

implement workplace HIV/AIDS policies that support teachers living with HIV/AIDS to remain in the workplace for as long as possible. Such policies should support teachers who have HIV/AIDS to access antiretroviral medicines. Laws should prohibit HIV testing as a pre-condition for entry to educational programmes. Discrimination laws should protect staff and students who have HIV from being excluded from educational institutions on the grounds of HIV status.

In communities heavily affected by HIV/AIDS, children (especially girls) from affected families face difficulty staying in school and the number of teachers lost to AIDS limits access to education. Every child has the right to a primary education and it is vital for children's futures that they attend school. Beyond academic learning, education is also important for psychosocial development. Education can also reduce children's risk of HIV infection by increasing knowledge, awareness, skills and opportunities. Educational authorities and communities must identify the barriers to education and define locally appropriate strategies for keeping children in school. Fees and other hidden costs of schooling can be the greatest barriers. The abolition of school fees can be critical to ensuring that orphans and other children made vulnerable by HIV/AIDS enter and stay in school.

The media plays a significant role in educating children and the general population about HIV/AIDS. Media should avoid perpetuating myths and stereotypes relating to HIV/AIDS, sexuality and drug use. The media has a responsibility to provide objective information about HIV/AIDS and to respect privacy in reporting on HIV/AIDS stories. Governments should support media bodies in preparing Codes of Ethics for media professionals in responsible coverage of HIV/AIDS issues. Licensed broadcast media that engage in vilification of people living with HIV/AIDS should be subject to licensing penalties.

Open discussion of HIV/AIDS issues is critical to formulating and implementing effective responses. Censorship and obscenity laws should include educational exemptions to enable the effective operation of HIV/AIDS, safer drug use and sexual health education.

6.4 Faith based initiatives

Faith based Organizations (FBOs) and religious leaders can play a crucial role in supporting human rights based responses to HIV/AIDS. Government HIV/AIDS policies should facilitate faith based initiatives that promote the rights of people living with HIV/AIDS and vulnerable populations.

A UNICEF review of South Asian government HIV/AIDS responses has found that national HIV/AIDS policies exist in eight South Asian countries, but there have been few systematic, concerted efforts by governments to engage FBOs for prevention, care and support.[74] Many FBOs have initiated their own programmes primarily from a tradition of welfare and charitable services to the poor. The exceptions are countries where state-sanctioned religions give faith based organizations a natural place in their national response to HIV/AIDS.

[74] *Faith-motivated actions on HIV/AIDS prevention and care for children and young people in South Asia: a regional overview* United Nations Children's Fund Regional Office for South Asia, 2003

For example, the Islamic Foundation of Bangladesh, a body of the Ministry of Religious Affairs, has introduced HIV/AIDS in its training curriculum for Imams, and in Bhutan, HIV/AIDS training and advocacy is now a part of the government's national Religion and Health Program, and religious groups are trained as primary communicators of HIV/AIDS prevention messages. In the Mekong region, the Buddhist Leadership Initiative has worked with police, health workers, teachers, and other community leaders on care, prevention, and to break down stigma. Buddhist initiatives in the Mekong region have involved partnerships with lay workers so that explicit sexual matters can be discussed by the lay workers that monks cannot discuss, and Buddhist monasteries have been powerful advocates for human rights through their community work with people living with HIV/AIDS and their families.

A major challenge for faith based initiatives is to ensure that prevention messages are effective and non judgmental. Governments should work with religious bodies to address the harmful impact on HIV prevention and care of judgmental messages regarding sexuality and drug use. Education that is based on moral judgments that assert blame can aggravate the incidence of stigma and discrimination. HIV/AIDS is often linked by religious authorities to moral decline and sexual corruption. Strict religious tenets regarding sexual behaviour, promiscuity and relationships can prevent people from being open about HIV status and can generate shame and fear.

Morality based prevention programmes can be counterproductive if they lead to people being denied access to the means of prevention. Religious objections regarding the use of condoms for contraceptive purposes can be harmful if they are used to prevent access to condoms to prevent HIV. Governments should work with faith based organizations to ensure that people at risk of HIV are able to access condoms and safe sex information to enable them to protect themselves and their partners from infection. Governments should prevent religious authorities from unreasonable interference with public health efforts to promote condom use as a valid HIV prevention strategy. Abstinence and fidelity based prevention programmes can be potentially harmful to women if they do not recognise the vulnerability of women who are monogamous but are not in a position to control their partner's fidelity. Religious interpretations that blame married women not only for their own infections, but also for their husbands' infections, do not reflect the reality of women's lack of power to negotiate safety in sexual relationships.

Religious practices that disadvantage women such as stoning of adulterous women or requiring early marriages for girls should also be reviewed, as they breach human rights and increase women's vulnerability to HIV/AIDS.

6.5 Trade policy

Under international law, trade and investment policy should comply with human rights principles. For example, international rules on intellectual property protection should abide by international human rights law. Domestic intellectual property regimes should not make it more difficult for a State to comply with its obligations in relation to the right to health.[75]

[75] *General Statement on Human Rights and Intellectual Property* ESCR Committee 2001

Governments should ensure that provisions of bilateral and multilateral trade and investment agreements support equitable access to essential medicines. Provisions of trade agreements relating to intellectual property and privatisation of health services should be carefully scrutinised to ensure that they promote equity and expansion of access to essential medicines.

Government obligations to fulfil the right to health should not be subordinated to commercial interests. The flexibilities provided for countries in the *Doha Declaration on TRIPS and Public Health*[76] need to be acted upon. The Doha Declaration states that governments should interpret the TRIPS agreement "in a manner supportive of WTO members' right to protect the public health and, in particular, to provide access to medicines for all". The TRIPS agreement permits local production or importing of generic medicines for public non-commercial use in specified circumstances. Governments need to ensure that their patent legislation enables them to make use of compulsory licensing and government use provisions as allowed by TRIPS.

The Doha Declaration provides that Least Developed Countries that are members of the WTO are not required to implement or enforce pharmaceutical product patent protection until 2016. Least Developed Countries should ensure that their patents legislation exempts pharmaceutical products until 2016, and that trade agreements do not reduce this period of exemption.[77]

Governments have the responsibility to ensure that trade agreements do not include 'TRIPS-plus' requirements if such requirements have the effect of reducing access to essential medicines. 'TRIPS-plus' provisions include provisions that grant extended periods of data exclusivity for pharmaceutical manufacturers thereby delaying the introduction of generic competition even in the absence of patent barriers, and patent standards that are more rigorous than those required of the country by TRIPS.

Countries that have the capacity to export generic medicines should ensure that legislation is in place to facilitate exports to countries that have little or no domestic capacity to manufacture generics, in compliance with WTO requirements.[78]

Governments should ensure that anti-competition remedies are available that support access to affordable medicines. For example, remedies should be provided where brand name drug producers price their products at prices that are excessive, as compared to generic equivalents.[79]

Import taxes and tariffs on essential HIV/AIDS medicines should be eliminated. Tariffs can drive up the prices charged to consumers for medicines even where they have been heavily discounted by suppliers.

[76] World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)
[77] See for example the Cambodian *Law on Patents, Utility Model Certificates and Industrial Design 2003*
[78] Legislation in Canada facilitates exports to developing countries of generic drugs, following the WTO decision of 30 August 2003 see: http://www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm
[79] L Yamin, supra note 64 at 130.

6.6 Research

Governments in countries with research capacity should ensure that national research programmes exist that are able to address basic scientific, clinical, epidemiological, social and behavioural research needs relating to HIV/AIDS. Social research programmes should include research into experiences of stigma and discrimination in health care provision, employment, accommodation and other areas, gender vulnerability, and the impact of human rights violations on the effectiveness of public health responses to HIV/AIDS.

Research priorities should take into account the need for new products and approaches that address the social inequalities that drive the epidemic. For example, research into female controlled methods of protection such as microbicides should be supported where products provide the potential to empower women to protect themselves from HIV. Research programmes should also include specific studies that contribute to prevention, care, treatment and impact reduction for children. Systems should be established to ensure that community research priorities are addressed. For example, community representation can be invited onto research councils, funding bodies and research centre advisory groups.

Governments should ensure that ethical standards are developed to guide local ethical review of biomedical and social research protocols. Ethical review should be consistent with international ethical standards, such as the Declaration of Helsinki and the International Ethical Guidelines for Biomedical Research Involving Human Subjects.[80]Community input into ethical review processes should be encouraged and supported, through ensuring community representation on ethical review bodies and establishing community advisory boards or similar bodies. Guidelines should be developed on ethical issues that arise in conducting research with vulnerable communities such as sex workers and drug users. Such guidelines should be developed in conjunction with members of vulnerable populations and address issues such as confidentiality of information, duty of care, and the ethical and legal implications of disclosure of illegal conduct to researchers. Participants in research need clear information in understandable, accessible and culturally appropriate language and formats so that they can provide voluntary and informed consent. In line with the child's evolving capacities, consent of a child to participation in research should be sought or consent from parents or guardians if necessary, but in all cases consent must be based on full disclosure or risks and benefits.

Discriminatory grounds should not be used to exclude vulnerable populations such as drug users or women from clinical trials. Specific attention should be given to clarifying the rights of participants in prevention trials to HIV/AIDS treatment and care in the event that participants become infected with HIV during the trial.

Public health surveillance and epidemiological monitoring should collect non-identifiable data for use in tracking trends in the epidemic and to inform public health planning. Epidemiological monitoring and behavioural data are essential to maximise the effectiveness of responses. Governments need to ensure that confidential data is regularly collected to inform the development

[80] World Medical Association *Declaration Of Helsinki: Ethical Principles for Medical Research Involving Human Subjects* 1964-2002 see: http://www.wma.net/e/policy/b3.htm; CIOMS (Council for International Organsations of Medical Sciences) *Guidelines*, Geneva 2002, see: www.cioms.ch/frame_guidelines_nov_2002.htm

of policies and programmes. Epidemiological data should be non-identifying, but should be capable of being broken down by categories that indicate risk or vulnerability such as gender and age. Social research should encompass all vulnerable populations.

7.0 Implementing these recommendations

7.1 National policy and law reform

A range of strategies can be adopted by governments to support dissemination and implementation of these recommendations. All relevant stakeholders should be involved in the process of developing strategies for implementing these recommendations, including government bodies, people living with HIV/AIDS, affected communities, NGOs and CBOs, businesses and professions. Implementation can be achieved by:

- Integrating HIV/AIDS human rights priorities into National HIV/AIDS Strategies, National Treatment and Prevention Plans, or National Development Plans and Poverty Reduction Strategies.[81]
- Including responsibility for HIV/AIDS related human rights issues in the mandate of Multisectoral National AIDS bodies.
- Incorporating HIV/AIDS issues in the mandate of existing human rights bodies such as Human Rights Commissions and conducting training to build their capacity to address HIV/AIDS issues.
- Developing specific national action plans on HIV/AIDS and human rights.

Action plans could define a national law reform agenda and policy review process that systematically addresses the impact of laws and policies on the human rights of people living with HIV/AIDS and vulnerable populations. The *International Guidelines on HIV/AIDS and Human Rights* (see Appendix) are recommended as an important tool for use in conducting reviews. Audits and human rights evaluations can be developed to review and monitor the extent that law and policy implements human rights obligations. For example, human rights audits of HIV/AIDS laws have been conducted in Nepal, Cambodia and Australia. Audits can assess the extent to which laws, policies and programmes have an impact positively and negatively on human rights and the steps required to progress toward the optimal synergy between the promotion and protection of health and human rights. Benchmarks can be used to measure progressive realisation of economic, social and cultural rights, including the rights to health, education and work.

National action plans on HIV/AIDS and human rights can support development of Codes of Conduct that integrate human rights approaches into workplace policy and disciplinary procedures. This can allow discrimination and breaches of confidentiality to be raised in complaints proceedings relating to employment conditions or service provision in sectors such as health care, education and law enforcement. Human rights training of public officials working in health care, drug treatment, prisons and police could be included in national action plans.

UN Theme Groups on HIV/AIDS at country level should use the recommendations as a framework to help plan national responses.

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[81] Practical tools should be used to analyze the impact of major development projects on the epidemic, such as UNDP's and UNPF's HIV Impact Assessment Tool, and Checklist for Mainstreaming HIV/AIDS in Poverty Reduction Strategies. See: Regional Bureau for Asia and the Pacific HIV and Development Programme, *HIV Impact Assessment Tool: The Concept and Its Application* 2000. UNFPA, *The Impact of HIV/AIDS: A Population and Development Perspective* 2003.

7.2 Regional initiatives

Priority issues for regional cooperation include:

- Regional approaches that support national scale-up of testing, treatment and prevention programmes, such as achieving price reductions through pooled procurement of antiretroviral medicines, diagnostics and preventive technologies[82]
- Promotion of harm reduction in regional drug control policies
- Initiatives in relation to the human rights of mobile populations, such as addressing rights of non-discrimination and access to health and social services of migrant and trafficked populations.

The human rights content of regional political commitments on HIV/AIDS, health and development need to be supported and strengthened.[83] Regional cooperation groups such as the Association of South East Asian Nations (ASEAN)[84], South Asian Association for Regional Cooperation (SAARC)[85] and the Pacific Islands Forum should address HIV/AIDS related human rights issues within their agendas. Human rights should be incorporated into the HIV/AIDS work of forums such as the Asia Pacific Leadership Forum on HIV/AIDS and the United Nations Economic and Social Commission for Asia and the Pacific.[86]

Governments should support regional efforts to mainstream HIV/AIDS into national human rights institutions or their equivalents. Governments should support the Asia-Pacific Forum of National Human Rights Institutions in conducting training and capacity building work on HIV/AIDS issues.

Governments should cooperate in exploring opportunities for establishing new regional or sub-regional human rights systems that bridge the varying perspectives of governments and communities.[87]

7.3 International initiatives

Governments should provide detailed monitoring and reporting of their progress in achieving objectives and targets set by the UN *Declaration of Commitment on HIV/AIDS*, with particular attention to benchmarks relating to human rights and vulnerable populations. Monitoring and reporting should be integrated into national planning cycles to inform policy priorities, rather than being performed in a minimal or tokenistic way.

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[82] Millennium Project, *Interim Report of Task 5 Working Group on Access to Essential Medicines*, Commissioned by the UN Secretary General and supported by the UN Development Group 2004.

[83] See eg the 2001 ASEAN Summit Declaration and the 2001 Melbourne Ministerial Statement on HIV/AIDS.

[84] eg, the ASEAN and China Cooperative Operations in Response to Dangerous Drugs

[85] SAARC Parliamentarians made a Declaration on the Prevention and Control of HIV/AIDS in 1998 in Katmandu.

[86] The Economic and Social Commission for Asia and the Pacific published a series of publications in a package *To Care and To Dare: Fight HIV/AIDS Saves Lives* 2003.

[87] See *Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms* UN Doc. A/RES/53/144, UN General Assembly Resolution 53/144 of 8 March 1999.

As there is no regional or sub-regional human rights system for Asia or the Pacific, human rights monitoring is limited to national, local and international levels. Governments need to review the extent of their general human rights commitment in terms of ratification and domestic implementation of international treaties, and engagement with UN treaty monitoring bodies. Governments that are signatories to human rights treaties are required to submit periodic reports on their progress in implementing human rights obligations, and to engage in dialogue with UN treaty monitoring bodies. Governments may need to allocate resources to ensure comprehensive reporting of compliance with treaty obligations in relation to HIV/AIDS issues.

Civil society can engage in treaty monitoring processes by submitting non-official shadow reports to the UN committees. National and regional HIV/AIDS groups, such as the Asia Pacific Network of People Living With HIV/AIDS (APN+) and the Asia Pacific Council of AIDS Service Organizations (APCASO), should be supported in networking and sharing experiences so that they can engage in the treaty monitoring process.

International agencies need to collaborate with governments and civil society to share knowledge and experience concerning HIV/AIDS-related human rights issues. Human rights monitoring mechanisms are required to report on human rights abuses in the HIV/AIDS area so that they can be publicised and to create pressure for changes to policies and practices to prevent future violations.

Donor countries in the region should include human rights objectives within international development assistance and cooperation policies. Human rights indicators should be integrated into evaluation of development assistance programmes. For example, indicators could measure the impact of aid programmes on equity of access to treatment, prevention, care and support services for people living with HIV/AIDS and members of vulnerable populations. International human rights obligations may be breached if donor governments impose restrictive conditions on development assistance, such as prohibitions on using funds for abortion services, which prevent recipients of aid from using funds to provide integrated sexual and reproductive health services.[88]

As members of inter-governmental and multilateral institutions that provide development financing and set trade and investment policies (such as the World Trade Organization, World Bank, International Monetary Fund, and the Asian Development Bank), governments should ensure that these institutions' policies promote a human rights approach to HIV/AIDS. Governments should account to their domestic constituencies on the support that these institutions provide to countries to develop equitable national health systems and to finance the scaling up of HIV/AIDS responses.

[88] E Reid Health, human rights and Australia's Foreign Policy *Medical Journal of Australia* 2004 Vol 180(4):163-165.

APPENDIX

The International Guidelines on HIV/AIDS and Human Rights[89] (OHCHR & UNAIDS, 1996)

Guideline 1: 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: 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 field of ethics, law and human rights, effectively.

Guideline 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/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.

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

Guideline 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/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.

Guideline 6: 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/AIDS 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/AIDS and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

Guideline 7: States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights,

[89] Supra note 1.

develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

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

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

Guideline 10: States should ensure that government and private sectors 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: 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 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

This publication was made possible thanks to the support of: