Section One: Introduction
Prior to the HIV/AIDS epidemic, the link between health policies and human rights was rarely drawn. Indeed, public health, which traditionally has employed measures that can be coercive, compulsory, and restrictive, has often been considered as one of the legitimate grounds for restricting human rights (Gruskin et al 1996; Mann et al 1992). The HIV/AIDS epidemic heightened the need to explore the nexus between health policies and human rights, because the common initial response to the epidemic – very much in the tradition of public health in tackling a communicable disease – imposed coercive measures, such as identifying infected individuals who were then labelled as carriers and subjected to isolation and quarantine.

The disease also quickly became associated with certain population groups, such as homosexuals, commercial sex workers, refugees, or migrant workers, who in most cases already are marginalised within society. Blame and fear spurred many of the initial HIV policies and interventions. Groups that often lacked a voice in the political and policymaking realm became easy targets for coercive and restrictive measures. This phenomenon precipitated the mobilisation of human rights groups and activists who questioned the effectiveness of such measures and sought to find alternative means of containing the spread of HIV. The early stage of the epidemic was characterised by confrontation between the public health and human rights communities.

The relationship between human rights and HIV/AIDS, however, has evolved in the last two decades. By the late 1980s, the World Health Organisation (WHO) began to adopt a policy that respects and promotes human rights as an integral component of HIV prevention. It began to espouse a view that discriminating against people living with HIV/AIDS (PLWHA) and blaming certain population groups as ‘vectors’ of the virus are counterproductive to prevention and mitigation efforts by driving the epidemic underground. Stigmatisation and discrimination discourage those who are most affected and vulnerable from seeking assistance from health and social services.
Coercive measures, such as mandatory testing, breaches of confidentiality, and forcible segregation, will further reinforce the resistance to acquiring help and impede outreach and education efforts.

Discrimination is counterproductive to HIV prevention
The following are examples of how discrimination impedes efforts to curb the spread of HIV, as it drives the epidemic underground.

**Illinois, USA:** when Illinois introduced mandatory reporting and contact tracing of HIV/AIDS cases, the percentage of those not appearing for appointments to be tested at Chicago’s two city test centres rose from 34 per cent in April to 41 per cent in May to 46 per cent in June (Chicago Tribune, August 5, 1987, cited in Cohen and Wiseberg 1991).

**Germany:** when the state government of Bavaria required mandatory testing of prostitutes and drug users, many of them moved out of the state to avoid the test, whereas others dropped out of research projects, causing the projects to close (World AIDS, May 1989, cited in Cohen and Wiseberg 1990).

**Australia:** legislation proposed in 1985 by the minister of health, which mandated reporting of HIV-positive test results and criminalised sexual relations with people infected with HIV (unless the partner was notified prior to the relation), led to an immediate drop in requests for HIV tests by 40 per cent from August to September (University of New South Wales, cited in Cohen and Wiseberg 1990).

Section Two: Human rights in the context of HIV/AIDS

2.1 International law
The Universal Declaration of Human Rights, drafted by the United Nations in 1945, inspired numerous international, regional, and subject-specific conventions, which serve as a foundation for modern international human rights law (Cook 1995). The International Covenant on Civil and Political Rights; the International Covenant on Economic, Social, and Cultural Rights; the African Charter on Human and People’s Rights; and the Convention on the Elimination of All Forms of Discrimination Against Women are a few of the legal instruments that provide a set of human rights principles that now have come to be considered as international customary law (Cook 1995). The modern legal order requires governments to respect international customary law in their international and domestic affairs as a condition of their legitimacy as governments (Cook 1995).

The community of nations has committed itself to the notion that sovereignty does not give governments or national leaders the authority to mistreat their citizens. There are a number of limits on the authority of the state, and there are rights that are so fundamental that they cannot be given or
taken away by any government or individual. They exist not as a consequence of our citizenship, but of our humanity (Whelen 1993).

In the area of human rights, the law has identified certain principles, or peremptory norms of conduct, from which no divergence is permitted. A nation may, therefore, be held to be in breach of inviolable standards of customary international law, if it practises, encourages, or condones:

- genocide
- slavery or slave trade
- the murder or causing the disappearance of individuals
- torture or other cruel, inhuman, or degrading treatment or punishment
- prolonged arbitrary detention
- systematic racial discrimination


Various other acts breach customary law if perpetrated regularly and in accordance with state policy. A country also, therefore, violates international law if it practices, encourages, or condones:

- a consistent pattern of gross violations of internationally recognised human rights (this refers to violations of those rights that are universally accepted and that no government would admit to violating as state policy). An abuse not defined gross will be deemed as such if it is carried out as part of a consistent pattern, i.e., systematic harassment, invasions of the privacy of the home, denial of the right to return to one’s country, mass uprooting of a country’s population, denial of freedom of conscience and religion, and invidious racial or religious discrimination (Ragland 1994).

It is important to note that the international human rights covenants, although legally binding, are not self-executing. This means that each state must enact domestic enabling laws in order to actualise the human rights principles. The key conventions, such as the Political Covenant, entail the establishment of committees responsible for monitoring compliance by states that have ratified these conventions. Some committees require governments to provide periodic reports, whereas others receive and investigate human rights violations alleged by individuals against the state (Cook 1995). The principal concern of human rights law is this relationship between the individual and the state.

Existing legal treaties and customary law therefore ensure the protection of the human rights of PLWHA and others tackling the HIV/AIDS epidemic and provide a strong foundation for these rights that is secured by, among others, the principles of nondiscrimination, right to privacy, right to liberty and security, right to marry and found a family, and freedom of movement.

It is important to recognise that public health is one of the legitimate grounds for infringement of the rights of individuals (others include national security and public order and morality). However, public health may only serve as a justification when the impediments placed on human rights:
are conducted in accordance with the law
serve the interest of a legitimate objective of general interest
are carried out in the absence of an appropriate alternative (a less intrusive means) to reach the same goal
are not imposed arbitrarily or discriminatorily (Gruskin et al 1996; UNHCR 1994).

2.2 HIV/AIDS and human rights organisations

Human rights violations often are reported to intergovernmental agencies by individuals and national or international nongovernmental organisations (NGOs) (Gruskin et al 1996). Major international human rights organisations have only recently begun to address HIV/AIDS-related human rights abuses. One reason is that the organisational mandate of such groups as Human Rights Watch and Amnesty International requires that they work within the framework of political and civil rights and concentrate primarily on negative rights – i.e., calling upon states to cease violations and enforce domestic laws that prevent or prohibit violations committed by citizens.

Health traditionally is omitted from their mandate, as it falls primarily within the domain of economic, social, and cultural rights, and is considered a positive right. Since the early 1990s, however, human rights organisations have begun to explore means of incorporating HIV/AIDS into their work. For example, Amnesty International studied AIDS service organisations to determine under what circumstances HIV/AIDS issues can fall within its mandate. Human Rights Watch’s documentation on trafficking of Burmese and Nepali girls and women into the brothels of Thailand and India, respectively, has successfully placed HIV/AIDS-related violations within the context of political and civil rights (Human Rights Watch 1992, 1994).

**Trafficking of Burmese women and girls into brothels in Thailand**

HIV testing is frequently imposed on Burmese girls and women in the sex industry on a mandatory basis without informed consent. Testing occurs in brothels and in detention (‘immigration jails’), and is reported by the Burmese military junta after the women are deported. Mandatory testing without informed consent is explicitly prohibited by both WHO Guidelines and the Thai National AIDS Plan. This intervention violates the individual’s basic right to privacy. The right to privacy can be justifiably disregarded by governments for the greater good of protecting public health, provided the stringent conditions are met. But mandatory testing of Burmese girls and women does not meet these conditions, notably:

1. Thai law does not allow mandatory testing of commercial sex workers.
There appears to be a consensus among public health experts—e.g., at the WHO—that mandatory testing is not an effective means for slowing the spread of infection, especially for women whose knowledge of their status has no remedial value, as they are subjected to slave-like conditions.

Other alternative measures, such as prosecuting trafficking agents and brothel owners and promoting targeted education in the Burmese language, have not been employed.


Section Three: Analysis of the findings of the AIDS in the World human rights survey

The objective of this section is to discuss the findings from a survey of national AIDS programmes conducted for the second volume of AIDS in the World. The survey inquired about the laws and practices that protect and violate human rights related to HIV/AIDS in countries worldwide. The questionnaire was sent to 187 countries, of which 118 responded. The focus being low- and middle-income countries, the analysis included only 93 respondents. It addressed the following areas of concern:

- monitoring mechanisms
- restrictions based on HIV status (law and practice)
- reports on allegations of human rights violations related to HIV/AIDS
- obligatory testing
- restrictions on entry to the country.

This section examines HIV/AIDS-related human rights laws and practices that were in existence at the time of the survey from December 1993 to June 1994.
3.1 Monitoring mechanisms

Two survey questions address the issue of monitoring human rights violations. One seeks to determine the existence of a mechanism within the national AIDS programme, and the other explores the existence of organisations outside the governmental structure that act as monitors. Eighty-six countries (92.5 per cent) responded to the first question, 34 per cent of which had established a mechanism within the governmental structure to receive and pursue allegations of human rights abuses (the specifics were not included, such as the capability to investigate, to work with other agencies – i.e., law enforcement). About half of the countries (49 per cent) reported having an organisation or group outside the government that documents and monitors HIV/AIDS-related human rights abuses.

3.2 Restrictions based on HIV status

Marriage

‘The right of men and women of marriageable age to marry and to found a family shall be recognised’. (International Covenant on Civil and Political Rights, Article 23, in UN 1988)

Mandatory premarital HIV testing, coupled with the denial of a marriage licence to those infected with HIV and prohibiting the marriage of individuals known or suspected to be HIV-infected, interferes with the right to marry and found a family (UNCHR 1994). A public health rationale does not provide sufficient justification for violating this right, because such a restriction does not serve as an effective means of preventing either sexual or perinatal transmission of HIV. Extramarital and premarital sexual activity are common.

Only three respondents (4 per cent) reported that in practice PLWHA were prohibited from marrying, whereas five reported the existence of a law dictating this practice. For example, in Colombia, Moldova, and St. Lucia, the law prohibiting marriage of PLWHA was not enforced. In Oman, this type of restriction took place without the existence of a law. Panama and Peru prohibited those who are infected with HIV from marrying, both in law and in practice.

Sex work

About the same number of countries in practice and in law (12 per cent of those which responded to the question) imposed restrictions on commercial sex workers who are infected with the AIDS virus. Colombia and St. Lucia did not enforce a law that restricts prostitutes based on their HIV status. On the other hand, Belize, Mexico, Peru, and Brunei did prohibit PLWHA from commercial sex work without the existence of law supporting this practice. Ecuador, Panama, Jamaica, Moldova, Jordan, and Malaysia had enacted legislation that is also actively pursued. The nature of the restriction – license revocation or confinement – was not addressed by the survey. It is also unclear how these restrictions are actually enforced.
Freedom of movement (segregation)

‘Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law’. (International Covenant on Civil and Political Rights, Article 9, in UN 1988)

Public health has provided a legitimate ground for depriving an individual of liberty, for example, through measures of compulsory quarantine or internment, commonly employed in cases of communicable diseases. However, such measures need to satisfy conditions to ensure that they are not arbitrarily imposed, but are taken on reasonable grounds and in accordance with a procedure established by law (UNCHR 1994). The government would have to establish a case that the individual who has been detained indeed has the infection and that the detention is essential for preventing the spread of the virus. In the case of HIV/AIDS, the WHO recommends ‘that persons suspected or known to be HIV-infected should remain integrated within society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others’ (UNCHR 1994).

In eight countries (9 per cent), PLWHA were admitted into special centres, whereas 11 countries had laws that prescribe compulsory confinement or quarantine of infected people. Where laws existed restricting freedom of movement of PLWHA, some countries, such as Azerbaijan, Algeria, the Kyrgyz Republic, Turkmenistan, and Malaysia, did enforce them. Others, such as Costa Rica, Senegal, Russia, Jordan, and Syria, did not. In Venezuela and Mali, confinement and restrictions were practised without the presence of supporting legislation. The survey did not ask for the duration or nature of the confinement.

Examples of quarantine and isolation policies

**Romania:** a law was passed in 1987 that called for mandatory hospitalisation of anyone having AIDS or suspected of having AIDS.

**South Korea:** the minister of health was given authority to isolate people with HIV in ‘protected establishments’.

**Pakistan:** in 1988 a housemaid was sentenced to a three-month detention in an isolation ward in a maximum security prison hospital. The condition of her release was that she would be quarantined in a public hospital.

**India:** the 1987 Goa Public Health Act mandated detention of HIV-positive people. Four people were arrested and kept in the TB sanatorium for two years. They were released after the mandatory provisions of the law were changed.

3.3 HIV/AIDS human rights violations

The survey examined six different types of human rights violations:

- mandatory testing
- breach of confidentiality
- discrimination at workplace and school
- discrimination in housing
- discrimination by health services.

The human rights abuses discussed in this section predominantly involve violations of the right to privacy and of the principle of nondiscrimination.

Mandatory testing and breach of confidentiality

‘No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.’ (International Covenant on Civil and Political Rights, Article 17, and Universal Declaration of Human Rights, Article 12, in UN 1988)

Public health can be employed as a justification for interfering with the right to privacy only if stringent conditions, mentioned above, are met. In this case, the United Nations Commission on Human Rights and the WHO uphold the view that not only do coercive measures, such as mandatory testing, not meet the conditions, but they may actually hinder HIV prevention and mitigation efforts.

The Case of Cuba

In 1987 Cuba launched a systematic HIV screening of its entire population and established 13 sanatoriums for those who are found HIV-positive. Once tested positive, the person must move to one of the sanatoriums.

Cuba received much attention from the international community not only because it was placing people in isolation and under surveillance, but also because it provided them with the medical services and lifestyle that are generally better than that of the general public. The residents of the sanatorium are paid 100 per cent of their salaries, guaranteed a high-protein diet, and transferred to a hospital when they have progressed to AIDS and receive treatment there.

They are permitted to leave the sanatorium grounds one day a week within a specified time. After six months, if they are deemed responsible, they are allowed to leave for the weekend without company. Sexual activity is permitted and condoms are made available.

Cuba is a unique case. Its policies provoked heated discussions and tensions within the public health and human rights communities. While some
human rights groups decried the initiative, others noted that the Cuban government is not violating human rights law, because it is fulfilling the responsibility of respecting the dignity of PLWHA by providing humane living conditions and health care.

Discrimination

‘Everyone is entitled to all the rights and freedoms set forth in the Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status’. (Universal Declaration of Human Rights, Article 2, in UN 1988)

Although HIV/AIDS status is not explicitly included in the universally recognised nondiscrimination principle, the Sub-Commission on Prevention of Discrimination and Protection of Minorities claimed that

‘discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards and the term “or other status” in non-discrimination provisions of international human rights texts should be interpreted to cover health status, including HIV/AIDS’. (UNCHR 1994, 7)

Although only 12 countries answered the question on ‘Other’, it is worthwhile to mention a few of the other problems faced by PLWHA. The Brazilian national AIDS programme received reports that HIV-positive persons were being denied religious services, and the Mexican programme received reports of refusals to bury people who had or were suspected to have died of AIDS. (The Syrian Arab Republic answered this question in the survey as ‘rights never violated; protected by law’.)

3.4 Mandatory/compulsory testing of population groups

Obligatory testing can either be mandatory or compulsory. Under compulsory testing, an individual or groups may not refuse the procedure, which is upheld by law or national policy. Consent is not obtained nor required by compulsory testing (Panos 1990). This method is often employed to test ‘captive populations’, such as refugees, prisoners, and soldiers (Whelen 1993). Mandatory testing, on the other hand, serves as a means for determining whether an individual should be allowed access to benefits, such as scholarship, employment, and travel. A positive test result, as well as the refusal to be tested, generally leads to denial of the benefits sought by the individual (Panos 1990). Whelen (1993) cited the following reasons for the Global Programme on AIDS’ opposition to mandatory testing and its contention that it is deleterious to public health.
1 People who believe they may be infected by HIV will go ‘underground’ to avoid mandatory testing, because of the discrimination and stigmatisation that is associated with HIV/AIDS. They will not use the health care system and other services that can provide them with information and education about HIV.

2 Testing without informed consent and breach of confidentiality destroy the credibility of health care workers.

3 Not all HIV-positive people can be identified because of the window period and problems associated with false positive and negative results.

4 Mandatory testing will give people a false sense of security.

5 The high cost of mandatory testing programmes will divert resources from much needed and more effective prevention measures.

The survey identified 11 groups that often are subjected to compulsory/mandatory HIV testing:

- sex workers
- gay men
- pregnant women
- prisoners
- health care workers
- TB patients
- military recruits
- applicants for certain jobs
- citizens applying for school fellowships
- blood donors
- people getting married.

Again, it distinguishes between practice and law in carrying out these obligatory testing procedures. The finding indicates that, across all groups, the proportion of countries conducting obligatory testing is higher in practice than in law. For example, 39 per cent of the countries (respondents) imposed obligatory testing on all military recruits, but only 14 per cent of the countries had legislation that mandated this intervention.

3.5 Obligatory testing of migrants and travellers

‘Everyone has the right to freedom of movement and residence within the borders of each State. Everyone has the right to leave any country, including his own and to return to his country’. (Universal Declaration of Human Rights, Article 13, in UN 1998)

Mahal (1995) indicates that a public health rationale is the most commonly cited justification for barring travellers with contagious conditions, including HIV/AIDS, from entry into other countries (other rationales include public safety/order and economic burden). In international law, the right to enter a country is confined to the nationals of the country. States do not have an obligation to approve entry for foreigners (migrants or travellers).
But for nationals, the right to enter is absolute and is not subject to any restriction, and so states cannot legitimately subject national returnees to HIV testing as a condition of reentering the country (UNCHR 1994).

Testing of foreigners for HIV infection can be imposed only in cases where the state can establish an argument that this testing would help protect the health of the public. The WHO has stated that excluding foreigners and travellers will not prevent the introduction and spread of HIV, as the virus is already present in every country in the world (UNCHR 1994).

The survey selected seven groups of migrants and travellers:
- national returnees
- immigrants
- tourists
- permanent residence applicants
- foreign labourers
- foreign students
- asylum applicants.

National returnees
Azerbaijan, Moldova, and Syria required testing of their citizens returning from abroad. The Kyrgyz Republic, Turkmenistan, and Ukraine carried out obligatory testing without legislation. Russia, on the other hand, had a law that prescribed obligatory testing but indicated that this was not enforced.

Immigrants
Seven countries (Argentina, Bulgaria, Jordan, the Kyrgyz Republic, Panama, Russia, and Turkmenistan) indicated a positive response to obligatory testing of all immigrants, both in law and practice. El Salvador and Ethiopia employed this practice despite the absence of a law.

Tourists
China and the Kyrgyz Republic carried out testing of tourists with legislative support. Moldova indicated that testing occurred but did not indicate the legal foundation.

Permanent residence applicants
Argentina, Benin, Bulgaria, the Kyrgyz Republic, Lithuania, Panama, Russia, and Turkmenistan required all applicants for permanent residence to undergo a test for HIV, which was endorsed by legislation. El Salvador did so without any law.

Foreign labourers
Eleven countries (Bulgaria, China, Jordan, the Kyrgyz Republic, Kuwait, Malaysia, Oman, Panama, Russia, Turkmenistan, and Ukraine) practised obligatory testing of foreign labourers with legislative support, whereas
Brunei, Lebanon, and St. Lucia carried out tests without legal foundation. A law existed in Israel but was not enforced. Azerbaijan, Belize, Mauritius, and Moldova conducted testing of foreign labourers, but did not refer to any legal foundation for the practice.

Foreign students
Obligatory testing of foreign students was carried out and supported by legislation in eight countries (Bulgaria, China, Jordan, the Kyrgyz Republic, Kuwait, Russia, Turkmenistan, and Ukraine). Although Croatia had a law that mandated testing of this particular population group, it did not respond to the question about enforcement of this law. Azerbaijan, Belarus, Moldova, and Syria conducted testing.

Asylum applicants
Only three countries (Bulgaria, Russia, and Turkmenistan) practiced obligatory testing of asylum applicants with a legal foundation. Belize and Moldova indicated a practice of this form of testing, but not a law.

3.6 Restriction of entry into the country based on HIV status
The survey selected four different groups of HIV-positive migrants and travellers:
- short term
- long term
- asylum seekers
- refugees.

Once again, the question distinguished between law and practice.

Short term
Eight countries (9 per cent) imposed restrictions on short-term HIV-positive travellers in practice, whereas six countries did so only in law. The Kyrgyz Republic, Kuwait, Malaysia, Oman, and Turkmenistan restricted entry both in practice and in law. Brunei prohibited this group from entering the country without legislative support, whereas Micronesia had a law that was not enforced. Moldova and Syria did not indicate an answer for the legal question but acknowledged carrying out this form of restriction in practice.

Long term
Fourteen countries gave a positive response to the question about prohibiting entry of HIV-infected long-term travellers, while 10 countries have the legal foundation to do so. Jordan, the Kyrgyz Republic, Kuwait, Malaysia, Micronesia, Oman, Panama, Russia, and Turkmenistan bar entry to this group of travellers, and this policy is supported by a law. Bulgaria, Moldova, and Syria disregarded the legal question but provided a positive response to the practice of barring. Israel, on the other hand, does not enforce its law.
Asylum seekers

Eight countries (9 per cent) stated that they prevent HIV-positive asylum seekers from entering the country in practice, but only three had legislation requiring this restriction. Countries that both in practice and in law prohibited this group of PLWHA included the Kyrgyz Republic, Malaysia, and Turkmenistan. Brunei did not have a legal foundation for such a restriction, but it was imposed. Bulgaria, Guatemala, Moldova, and Syria gave no response to the legal question, but stated that in practice they barred entry.

Refugees

Eight per cent of the countries that responded to the question banned entry of HIV-positive refugees into the country, whereas 5 per cent indicated that they had laws that mandate this form of restriction. Estonia, the Kyrgyz Republic, Malaysia, and Turkmenistan enforced laws that restrict entry of refugees who are infected with HIV. Although they disregarded the legal question, Bulgaria, Moldova, and Syria gave a positive response to the question of imposing barriers to entry. Brunei restricted HIV-positive refugees from entering without legislative support.

Section Four: Conclusion – continuing needs in human rights and AIDS

Human rights remain a contentious issue in many parts of the world. They have often been framed as an ‘East-West’ debate, where issues of sovereignty and cultural relativism come into play. However, there is a great need not only to monitor human rights abuses against people living with HIV/AIDS, but also to continue the process of documenting if and/or how infringements on human rights may increase vulnerability to HIV infection.

It would also be a contribution to the area of human rights and HIV to compile lessons learned and the best practices of those governments that have managed to curb the spread of HIV within their countries and at the same time respected the rights of infected individuals.

References


