Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo

September 2007

Authorship Note

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Table of Contents

Table of Contents ... 3
Introduction ... 5
International and regional law and policy on human rights and HIV ... 8
A. Education and information ... 12
Background considerations and policy guidance ... 12
Analysis ... 14
Model Legislation on HIV/AIDS ... 14
Benin ... 15
Guinea ... 15
Guinea-Bissau ... 15
Mali ... 15
Niger ... 16
Sierra Leone ... 16
Togo ... 17
B. HIV testing issues ... 18
Background considerations and policy guidance ... 18
Analysis ... 19
Model Legislation on HIV/AIDS ... 19
Benin ... 23
Guinea ... 23
Guinea-Bissau ... 25
Mali ... 25
Niger ... 26
Sierra Leone ... 26
Togo ... 26
C. Disclosure obligations and "duty to warn" ... 28
Background considerations and policy guidance ... 28
Analysis ... 29
Model Legislation on HIV/AIDS ... 29
Benin ... 30
Guinea ... 31
Guinea-Bissau ... 31
Mali ... 31
Niger ... 32
Sierra Leone ... 33
Togo ... 34
D. Criminalisation of HIV transmission or exposure ... 36
Background considerations and policy guidance ... 36
Analysis ... 39
Model Legislation on HIV/AIDS ... 39
Benin ... 41
Guinea ... 42
Guinea-Bissau ... 45
Mali ... 45
Niger ... 46
Sierra Leone ... 48
Togo ... 50
E. Women's rights ... 53
Background considerations and policy guidance ... 53
Analysis ... 55
Model Legislation on HIV/AIDS ... 55
Benin ... 56

Guinea ... 57
Guinea-Bissau ... 58
Mali ... 58
Niger ... 58
Sierra Leone ... 58
Togo ... 59
F. Prisons ... 61
Background considerations and policy guidance ... 61
Analysis ... 62
Model Legislation on HIV/AIDS ... 62
Benin ... 64
Guinea ... 64
Guinea-Bissau ... 64
Mali ... 64
Niger ... 64
Sierra Leone ... 64
Togo ... 65
G. Other vulnerable groups ... 66
Background considerations and policy guidance ... 66
Analysis ... 67
Model law ... 67
Benin ... 68
Guinea ... 68
Guinea-Bissau ... 68
Mali ... 68
Niger ... 69
Sierra Leone ... 69
Togo ... 69

Introduction

This paper analyses the recent HIV-specific legislation of seven Central and West African countries from the perspective of human rights. These seven laws (the "laws under consideration") are:

- the "Law on prevention, care and control of HIV/AIDS" (No. 2005-31 of 5 April 2006) in Benin;
- the "Law on prevention, care and control of HIV/AIDS" (No. 2005-25) in Guinea;
- the "Framework law relating to the prevention, treatment and control of HIV/AIDS" in Guinea-Bissau;
- the "Law establishing rules relating to the prevention, care and control of HV/AIDS" (No. 06-28 of 29 June 2006) in Mali;
- the "Law relating to the prevention, care and control of Human Immunodeficiency Virus (HIV)" (No. 2007-08 of 30 April 2007) in Niger;
- "The Prevention and Control of HIV and AIDS Act (2007) in Sierra Leone; and
- the "Law on the protection of people with respect to HIV/AIDS" (No. 2005-012) in Togo.

This paper also considers and provides comments on the model legislation on which these laws were based, the N'Djamena model legislation on HIV/AIDS (2004).

In their entirety, the laws under consideration reflect the commitment of the national governments and civil society organizations to address HIV/AIDS-related issues in Central and West Africa. Given the rapid spread of the HIV epidemic and the vital importance of implementing effective prevention, care, treatment and support activities, a comprehensive and rights-based framework of laws is absolutely essential at this time. N'Djamena, these national governments, and the civil society organizations who participated in these initiatives therefore are to be commended for their actions, although as discussed in throughout this paper, there are fundamental concerns with the laws as enacted that may both limit their effectiveness and result in human rights violations.

It should be noted that the analysis presented in this paper is limited to each country's recent national legislation addressing HIV/AIDS. It does not contemplate any other laws and regulations that may be relevant to the epidemic and how it is spread and experienced, such as laws relating to property rights and inheritance, health care policies, sexual violence, and education, amongst others. Moreover, the paper does not purport to address the many issues arising from the implementation- or lack thereof- of the HIV/AIDS laws.

The observations presented in this paper are informed by international human rights law and policy.[1] In effective responses to the HIV/AIDS epidemic, human rights and health are fundamentally linked. When human rights are not promoted and protected, it is harder to prevent HIV transmission, and the impact of the epidemic on individuals and communities is worsened. National legislation plays a crucial role in shaping a country's response to HIV/AIDS issues, particularly in terms of setting out a comprehensive, human rights-based response. In view of the increasing challenges presented by HIV/AIDS, there is an intensified need for efforts to ensure respect for, and observance of, human rights so as to reduce vulnerability to HIV/AIDS, prevent HIV/AIDS-related discrimination and reduce the impact of the epidemic.

A detailed review of the seven national laws and the N'Djamena model legislation revealed a number of positive features, consistent with UNAIDS/OHCHR's *International Guidelines on HIV/AIDS and Human Rights*. These include:

- Prohibitions on HIV testing without written consent: The *International Guidelines* state that "[p]ublic health, criminal and anti-discrimination legislation should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups."[2]
- Provisions guaranteeing pre- and post- test counselling: The *International Guidelines* provide that "[i]n view of the serious nature of HIV testing and in order to maximise prevention and care, public health legislation should ensure, wherever possible, that pre- an post- test counselling be provided in all cases."[3]
- Provisions guaranteeing health care services for people living with HIV (PLHIV): The *International Guidelines* provide that "[p]ublic health law should fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV and AIDS".[4]
- Provisions guaranteeing the involvement of PLHIV in the provision of certain services, such as outreach: The *International Guidelines* provide that "States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation."[5]

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[1] Much of the spirit and the content of these comments on the N'Djamena model law and the laws in the seven countries in question is derived from applicable international human rights law, as well as the United Nations General Assembly *Declaration of Commitment on HIV/AIDS*, adopted by General Assembly resolution S-26/2 of 27 June 2001 ["the Declaration of Commitment"], UNAIDS/OHCHR *International Guidelines on HIV/AIDS and Human Rights,* 2006 Consolidated version ["International Guidelines"] and UNAIDS/IPU *The Handbook for Legislators on HIV/AIDS, Law and Human Rights,* 1999 ["the Handbook for Legislators"].

[2] *International Guidelines*, para 30(j).

[3] *International Guidelines*, para 20(c).

[4] *International Guidelines*, para 20(a).

[5] *International Guidelines*, para 16.

- Protections of medical confidentiality: The *International Guidelines* provide that "[p]ublic health legislation should ensure that information relative to the HIV status of an individual be protected from unauthorized collection, use or disclosure in the health-care and other settings and that the use of HIV-related information requires informed consent."[6]
- Prohibitions of discrimination on the basis of actual or perceived HIV status, including in the workplace, in educational facilities, health care settings and in relation to credit and insurance coverage: The *International Guidelines* provide that "General anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS.[7]

However, a considerable number of provisions in the laws under consideration raise human rights concerns. These concerns relate to:

- Restrictions on educational and informational campaigns regarding HIV;
- Provisions establishing mandatory HIV testing;
- Overly broad disclosure obligations on people living with HIV ("PLHIV") and overly broad "duty to warn" powers of physicians;
- Overly broad provisions criminalising HIV transmission and/or exposure;
- Limited or non-existent recognition of women's rights;
- Limited HIV programming in prisons; and
- Limited recognition of "vulnerable persons".

An analysis of these concerns is presented in the pages that follow. The human rights concerns that are evident in the laws under consideration are the focus of this paper in the hope that such issues may be addressed when these laws are revised, or avoided if other countries chose to adopt similar legislation.

It should also be noted that in a number of places, the legislation under consideration has not been drafted with adequate care. In some cases, the deficient drafting occurs in the model law and then has been transferred directly into the national laws. Moreover, there are significant differences exist between the French- and English-language versions of the model law which cause inconsistencies.

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[6] *International Guidelin*es, para 20(f).

[7] *International Guidelines*, para 22.

International and regional law and policy on human rights and HIV

International human rights law establishes an obligation on states to respect, protect and fulfil the right to health. One of the first codifications of the right to health can be found in Article 25 of the *Universal Declaration on Human Rights*, which states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...[8]

The most comprehensive expression of this right is found in the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).[9] Article 12 provides that:

> The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: […]
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The ICESCR is a legally binding treaty that imposes both positive and negative obligations on those States Parties that have ratified it. The Covenant acknowledges the constraints placed on countries by limited resources and provides for progressive realisation of the right to health. However, Article 2(1) states:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

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[8] The right to health is also recognised in the *Convention on the Elimination of Racial Discrimination* (CERD) (1963), the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) (1979) and the *Convention on the Rights of the Child* (CRC) (1989). Regional human rights instruments also recognise the right to health, such as *European Social Charter* (1961), the *African Charter on Peoples and Human Rights* (1981) and the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (1988). All seven countries under consideration in this paper have ratified the ICESCR, CERD, CEDAW and CRC as well as the *African Charter on Peoples and Human Rights*. As of March 2007, Benin, Mali and Togo have signed and ratified the *Protocol to the African Charter on Human And People's Rights on the Rights of Women in Africa*, while Guinea, Guinea-Bissau, Niger and Sierra-Leone have signed but not yet ratified this instrument.

[9] *International Covenant on Economic, Social and Cultural Rights* (ICESCR), adopted December 16, 1966, entered into force January 3, 1976, GA Res. 2200 (XXI), 21 UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966). All seven countries under consideration in this paper have ratified the ICESCR.

Progressive realisation means that States Parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of Article 12.[10] The ICESCR contains obligations on States Parties to report their compliance with the provisions of the Covenant.[11]

The Committee on Economic, Social and Cultural Rights also issues General Comments on the rights contained in the ICESCR to serve as authoritative interpretations of the Covenant. The Committee stated that the right to health:

> … is not confined to the right to health care. On the contrary, the drafting history and express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health.[12]

Observance of the right to health requires States Parties to respect, to protect and to fulfil the right. The Committee has specified that:

> [t]he obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[13]

The right to health thus translates into a variety of positive and negative obligations on States "to respect, to protect and to fulfil" the right. Among these obligations is the requirement to adopt legislation and regulations which recognise and provide for realisation of the right. States must also maintain and support the social institutions and practices that deliver or protect these rights in everyday life.

The right to health is obviously central to any treatment of a human rights approach to HIV/AIDS. However, given that massive impact of HIV/AIDS over a wide-range of sectors of society, other rights are equally relevant in the context of the HIV/AIDS epidemic. These would include, but not be limited to:

- Non-discrimination and equality before the law;
- Human rights of women;
- Human rights of children;

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[10] Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: *The right to the highest attainable standard of health*, at para 31.

[11] ICESCR, Articles 16 & 17.

[12] Committee on Economic, Social and Cultural Rights. General Comment 14: The right to the highest attainable standard of health (22nd session, 2000) U.N. Doc. E/C.12/2000/4 (2000).

[13] Ibid., para 33.

- Right to marry and to found a family and protection of the family;
- Right to privacy;
- Right to enjoy the benefits of scientific progress and its applications;
- Right to liberty of movement;
- Right to seek and enjoy asylum;
- Right to liberty and security of the person;
- Right to education;
- Freedom of expression and information;
- Freedom of assembly and association;
- Right to participation in political and cultural life;
- Right to an adequate standard of living and social security services;
- Right to work; and
- Freedom from cruel, inhuman or degrading treatment or punishment.[14]

Member states of the United Nations adopted the *Declaration of Commitment on HIV/AIDS* drafted by the United Nations General Assembly Special Session on HIV/AIDS in June 2001. The *Declaration of Commitment*, while not a legally-binding document, is a statement by governments of what they themselves have pledged to undertake in response to HIV/AIDS. In the *Declaration of Commitment*, UN member states pledged to:

> By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.

The *International Guidelines on HIV/AIDS and Human Rights* were developed at an expert consultation meeting convened in 1996 by the United Nations High Commissioner for Human Rights and UNAIDS. They were originally published in 1998 by OHCHR and UNAIDS. The *International Guidelines* contain 12 specific principles on how human rights should be promoted and protected in the context of the HIV/AIDS epidemic. Guideline 6 – outlining what governments should do, both nationally and internationally, to ensure access to prevention, treatment, care and support - was revised at a special consultation for this purpose in 2002. A consolidated version of the *International Guidelines* was published in 2006.

While the *International Guidelines* themselves are not legally-binding on states, they are based upon previously-existing legal obligations in international human rights law and represent an internationally-recognized standard for governments to live up to. The UN Commission on Human Rights welcomed the *International Guidelines* and requested

[14] This list is taken from the *International Guidelines*, paras. 106-153.

states "to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related human rights as contained in the Guidelines on HIV/AIDS and Human Rights."[15]

The *Handbook for Legislators on HIV/AIDS, Law and Human Rights* was developed by the Inter-Parliamentary Union and UNAIDS in 1999. The Handbook presents concrete measures that legislators and state officials can take to implement the 12 *International Guidelines*. An updated second edition of the Handbook is currently in preparation.

[15] Commission on Human Rights resolution 2003/47, 23 April 2003, para 1.

A. Education and information

Background considerations and policy guidance

Access to information about HIV/AIDS without discrimination is a human right. The *International Covenant on Civil and Political Rights* (ICCPR) guarantees that all people have the right to "seek, receive and impart information of all kinds," including information about their health.[16] The right to education is guaranteed by numerous international legal instruments.[17]

The Committee on Economic, Social and Cultural Rights has interpreted article 12 as requiring "the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS."[18] The Committee notes:

> States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. . . . States should also ensure that third parties do not limit people's access to health-related information and services.[19]

Women's social inequality and lack of access to services contributes to their HIV risk and increases the impact of HIV/AIDS on their lives. Research has shown that even in sub-Saharan African countries with a widespread awareness of HIV/AIDS among members of the general community, such awareness does not translate into knowledge of how to prevent infection—particularly among women and girls.[20] Women may lack access to information about how to prevent and treat HIV, and lack access to materials and supplies for safer sex. In many circumstances, women are not sufficiently aware of their

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[16] *International Covenant on Civil and Political Rights*, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), article 19.

[17] *Universal Declaration of Human Rights*, article 26; *International Covenant on Economic, Cultural and Social Rights*, article 13; *Convention on the Elimination on All Forms of Discrimination against Women*, articles 10 and 14; *Convention on the Elimination on All Forms of Racial Discrimination*, article 5; *Convention on the Rights of the Child*, articles 28 and 29.

[18] Committee on Economic, Social and Cultural Rights (CESCR), *The right to the highest attainable standard of health*, para. 16.

[19] Ibid., paras. 34-35.

[20] Human Rights Watch, *The Less they Know the Better*, 2005, quoting research in UBOS/ORC Macro, *Uganda Demographic and Health Survey 2000-2001*, p. 174.

legal rights and lack resources to vindicate them when they are. Such gender disparities in knowledge of HIV prevention may be explained partly by girls' unequal access to formal education.

The UN Committee on the Elimination of Discrimination against Women recommends that States "intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them."[21] The Committee further recommends that HIV/AIDS programs "give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection."[22]

The *Convention on the Rights of the Child* requires states to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health."[23] The Committee on the Rights of the Child states in its general comment on HIV/AIDS that children have the right to access adequate information related to HIV/AIDS prevention. The Committee has emphasized that:

> Effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (art. 6) States parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.[24]

The *International Guidelines* call on states to take positive steps to "ensure the access of children and adolescents to adequate health information and education, including information related to HIV/AIDS prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively with their sexuality."[25]

Certain HIV/AIDS information and education campaigns should target women and girls specifically. In addition to basic information on HIV prevention, treatment and care, a

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[21] CEDAW Committee, General Recommendation 15, *Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, (Ninth session, 1990), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI\GEN\1\Rev.1 at 81 (1994), (contained in document A/45/38), recommendation (a).

[22] Ibid., recommendation (b).

[23] *Convention on the Rights of the Child*, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), article 24(2)(e).

[24] Committee on the Rights of the Child, *General Comment No. 3 (2003) HIV/AIDS and the rights of the child*, 32nd Sess. (2003), para. 16.

[25] *International Guidelines*, para. 38(g).

number of other issues are important to women and girls in the context of HIV/AIDS, including:

- Information on sexual and reproductive health and rights;
- Training in negotiation and life skills on various ways and means to reduce the risk of HIV transmission;
- Awareness campaigns on issues such as exploitative relationships, e.g., inter-generational sex; and
- Campaigns for women about legal rights including issues of rape, sexual assault, domestic violence, rights related to marriage, inheritance, etc.

With these policy considerations and recommendations in mind, we turn to consider the model legislation and the laws that have been adopted in 4 countries based in part on that model.

Analysis

Model Legislation on HIV/AIDS

Article 2 provides for the establishment of education and information campaigns in schools. One part of this Article provides that "[i]t is forbidden to teach courses such as the one provided for in this Article to minors without prior consultation with parents whose approval is required both for the content and the materials used for such as course."

It is unfortunate that Article 2 places a number of restrictions upon educational activities in schools, as opposed to establishing a positive obligation to provide scientifically accurate and age-appropriate information on HIV and AIDS.

Such an approach is at odds with the reality of the age of first sexual intercourse in many countries. In Mali and Guinea, for example, the median age of first intercourse for girls is 16.[26] Children's access to health education should not be determined by what their parents think is appropriate. Rather, comprehensive education programs that provide complete, factual, and unbiased information about HIV prevention, including information about the correct and consistent use of condoms, are crucial in for adolescents and young adults in such contexts. In school-based programs, it is important to ensure that those teaching the programs are adequately informed about the prevalence of sexual activity among youth and qualified to provide objective, unbiased HIV prevention information and counseling to sexually active pupils and students. In addition to HIV prevention messages, it is important to provide lessons and activities promoting assertiveness, self-esteem, and other life skills.

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[26] M. Bozon, "At what age do women and men have their first sexual intercourse? World comparisons and recent trends" Institut National d'Études Demographiques (France) (drawing on DHS surveys), 2003.

Article 5 establishes an education and information campaign on HIV/AIDS to be undertaken by national AIDS commissions, in collaboration with the Ministry of Health, other government services and civil society organizations. If human rights issues are to be effectively integrated into the national education and information campaign, the responsible authorities should also include the Ministry of Justice, human rights commissions, as well as government bodies responsible for women's affairs, etc. In addition, such efforts must be sure to include human rights organizations, and particularly organizations representing women who are particularly vulnerable to HIV and to human rights abuses (e.g., sex workers), where such organizations exist.

Education and information campaigns about HIV/AIDS should include human rights education for women, and should include education about women's rights in any broader human rights education campaign targeting other audiences or the public at large, as part of promoting a culture of respect for women's rights.

Benin

The Benin law contains no specific language on information and education campaigns.

Guinea

Article 2 of the Guinean law adds a further restriction on HIV/AIDS education by specifically providing that it is forbidden to give HIV/AIDS education to children under 13 years old. For minors aged 14-18, parents must be consulted before youths are provided HIV education.

In Guinea, the average age of first intercourse for girls is 16.[27] See comments on Article 2 of the model legislation (above).

Guinea-Bissau

The law of Guinea-Bissau is substantially the same as the model law. See comments above.

Mali

[27] R. Gorgen, et al., "Sexual Behaviour and Attitudes Among Unmarried Urban Youths in Guinea" *International Family Planning Perspectives*, Vol. 24, No. 2 (Jun., 1998), pp. 65-71; Guinea Demographic and Health Survey 2005, available at http://www.measuredhs.com/pubs/pdf/SR116/SR116.pdf.

Article 2 largely replicates the approach taken in the model legislation. See comments on Article 2 of that law (above).

Niger

Article 7 provides that a section on HIV/AIDS shall be integrated in the curricula of public and private schools, universities and other non-formal educational establishments. It goes on to note that “the Minister of Education, in collaboration with the Minister of Health, will determine the conditions in which education regarding HIV/AIDS will be taught in primary schools, should it occur.”

In comparison with other laws, the article establishing the possibility to provide information and education about HIV/AIDS to school children, including primary school children, is welcome. It is also commendable that the law does not give parents a right to “veto” such information. It is to be hoped that such an approach is maintained in the practical application of the law. The provision could be strengthened further by requiring that comprehensive HIV/AIDS education be provided to school children at all levels of education, removing the discretionary element of the current formulation.

Sierra Leone

The Sierra Leone law contains encouraging language with relation to education and information on HIV/AIDS. Government information programs are destined for (i) schools and educational institutions, (ii) prisons and other places of confinement, (iii) among the “uniformed forces”, and (iv) “at all places of work and in all communities in Sierra Leone”. There is explicit mention of education campaigns in public and private schools, at the primary, secondary and tertiary levels.

There is also vague language in the Sierra Leone law that could be problematic, depending on how it is applied in practice. Article 3(2) of the law provides that the appropriate course content, scope and methodology at each educational level shall be determined “after consultation with the relevant stakeholders”. As with the corresponding provision (article 2) of the model law, it is important that educational programs provide complete, factual, and unbiased information about HIV prevention, including information about the correct and consistent use of condoms. It is to be hoped that such an approach is maintained in the practical application of the law.

Article 3(1) of the law (which provides for HIV/AIDS to be in the curriculum of educational activities) is also of concern, in that it prohibits such educational activities to be “used for the sale or distribution of birth control devices.” For educational activities at a certain age level, the distribution of safer sex materials such as condoms may not be appropriate. However, this blanket ban would make it illegal to distribute condoms during education campaigns designed for those students who *are* sexually active. It

makes little sense in a law aimed at preventing and controlling HIV, to place arbitrary legal barriers on accessing practical means of preventing STDs.

Togo

The Togolese law contains no specific language on information and education campaigns. Article 68 establishes a national council for AIDS and sexually transmitted infections. It is mentioned that the mandate, composition and organisation of the council shall be established by an order of the Council of Ministers. When fixing the mandate and composition of the national council for AIDS and sexually transmitted infections for Togo, it would be desirable that education and information is explicitly covered. It may also be useful to consider the *Ghana AIDS Commission Act* (Act 613 of 2002). This legislation sets up a commission mandated to "formulate HIV/AIDS policy as well as direct and co-ordinate national activities in the fight against HIV/AIDS" (Section 2(1)). Representation of women's issues, as well as number of female members, is provided for in Section 3.

B. HIV testing issues

Background considerations and policy guidance

Some people argue that there are circumstances in which the protection of the public's health justifies either:

- Requiring HIV testing as a condition of obtaining a certain status, service or benefit, such as employment, health services, or marriage certificates (that is, *mandatory testing*); or
- Compelling or forcing a person or group of people to be tested, such that the person cannot choose to refuse testing and cannot legally avoid it (that is, *compulsory testing*).

(Sometimes the terms *mandatory* and *compulsory* are used interchangeably, and the exact meaning of what is being discussed needs to be determined from the context.)

HIV testing without consent is almost never justified. Because of the invasive nature of mandatory and/or compulsory HIV testing, this practice violates an individual's right to privacy and right to bodily integrity.[28] Moreover, by distinguishing between certain population groups and the community in general, provisions of the laws permitting mandatory or compulsory testing may in some cases unjustifiably violate the principle of non-discrimination.

The *International Guidelines* state that "[p]ublic health, criminal and anti-discrimination legislation should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups."[29] The UNAIDS/WHO policy statement on HIV testing clearly states:

> The conditions of the '3 Cs', advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be:
>
> - Confidential;
> - Be accompanied by counseling
> - Only be conducted with informed consent, meaning that it is both informed and voluntary.
>
> UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals.[30]

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[28] See, e.g., art 17 of ICCPR.

[29] *International Guidelines*, para 30(j).

[30] UNAIDS/WHO, *Policy Statement on HIV Testing*, 2004, p 2.

According to WHO, mandatory testing of particular population groups can damage efforts to prevent HIV transmission – and is not therefore in the interest of public health – for the following reasons:

- Because of the stigmatization and discrimination directed at people living with HIV, individuals who believe they might be living with the disease tend to go "underground" to escape mandatory testing. As a result, those at highest risk for HIV infection may not hear or heed education messages about AIDS prevention;
- Testing without informed consent damages the credibility of the health services and may discourage those needing services from obtaining them;
- Mandatory testing can create a false sense of security especially among people who are outside its scope and who use it as an excuse for not following more effective measures for protecting themselves and others from infection;
- Mandatory testing programmes are expensive, and divert resources from effective prevention measures.[31]

In other circumstances, mandatory HIV testing of certain population groups has proven futile and expensive, in addition to causing considerable personal hardship.[32] It is therefore commendable that the laws under consideration include provisions explicitly prohibiting mandatory HIV testing. However, it is recommended that consideration be given to removing the exceptions contained in the laws. The one exception to the prohibition on mandatory testing which is considered justifiable is the case of blood and human tissue/organ donation, where there is an obvious health imperative to perform HIV testing and where the state owes a duty of legal care towards potential recipients.[33]

Analysis

Model Legislation on HIV/AIDS

Mandatory and compulsory HIV testing: Article 18 creates a broad prohibition on mandatory HIV testing, but creates a number of specific exceptions, notably: (i) "when a person is indicted for HIV infection or attempt to infect another person with HIV", (ii) when a person is indicted for rape, (iii) "when determining HIV status is necessary to

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[31] WHO, *Statement from the Consultation on Testing and Counselling for HIV Infection*, 1992, at 3-4.

[32] See *International Guidelines* para 28(h).

[33] *Handbook for Legislators*, p 42.

solve a matrimonial conflict," (iv) organ, cell or blood donations, (v) "when a pregnant woman undergoes a medical checkup." For an unknown reason, the provision establishing compulsory testing of pregnant women in pre-natal care appears in the English version of the model law, but not the French version.

This provision creates an overbroad exception to the principle that HIV testing shall be voluntary and therefore should be removed. More specifically,

Compulsory testing of people indicted on charges of rape and "HIV infection" or attempted infection: As noted above, Article 18 provides for the compulsory HIV testing of accused rapists and those accused of HIV infection or attempted infection. Legislating compulsory HIV testing of people accused of such crimes should be undertaken with extreme caution. Such measures may divert attention away from the health-care needs of victims of sexual violence.[34] The primary reasons for exercising extreme caution with regard to legislation permitting compulsory testing of HIV testing of people accused of such crimes include:

- testing does not provide timely or reliable information about the sexual assault survivor's risks of contracting HIV infection;[35]
- it is a misdirected, potentially negative and unrealistic approach to addressing the needs of a sexual assault survivor;[36]
- it infringes on the rights of an accused to bodily integrity, privacy and human dignity,[37]
- it might not facilitate the survivor's psychological recovery.[38]

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[34] AIDS Law Project (ALP), Centre for Applied Legal Studies, *Submission on the Compulsory HIV Testing of Alleged Sexual Offenders Bill,* 6 February 2003, note 2.

[35] An accused's negative HIV test result does not conclusively prove that the victim was not exposed to HIV as ordinary antibody tests may not show evidence of transmission for up to 6 months – in other words, alleged offenders may be tested during the "window-period" during which enzyme-linked HIV tests will not detect the infection: Legal Assistance Centre (LAC), *A Case Against Mandatory HIV Testing of Rapists*, 1997; AIDS Law Project (ALP), Centre for Applied Legal Studies, *Submission on the Compulsory HIV Testing of Alleged Sexual Offenders Bill,* 6 February 2003. Even where an accused's test is positive, the only way a victim can know whether he/she has been infected is by getting tested him or herself.

[36] Regarding the potential for negative impact, the LAC report noted that if mandatory testing is pursued in order to charge rapists with additional crimes, rape victims could be made vulnerable to questions regarding their sexual history, and their HIV status prior to the assault. Privacy surrounding victims' HIV status post-trial could also become problematic.

[37] Ibid.

[38] The Canadian Interdepartmental Committee on Human Rights and AIDS, *Report of the Working Group on Sexual Assault and HIV Antibody Testing,* 2004, noted that victims "need reliable information about whether they are HIV infected, and support and assistance in coping with uncertainty during the window period, and in living with a positive test result if this occurs." The ALP's report notes that "the vast majority of alleged offenders are not apprehended within a short period." This means that victims will most often not have the benefit of test result information when making decisions regarding the initiation of antiretroviral therapy. Having noted this, the ALP goes on to state "knowledge is an important part of

It is worth noting that any legislation introduced regarding the compulsory testing of accused sexual violence offenders will only affect a small number of victims. The most vulnerable groups of women and other survivors of sexual violence are less likely to "benefit" from this law, including in particular: women who do not report rape and other forms of sexual assault, including women in coercive and abusive relationships who may, for various reasons, not define their experiences as "rape"; victims whose attackers are not arrested; victims who are subject to gang rape, where not all perpetrators are in custody; and the majority of male survivors of sexual violence who are less likely to report their experiences because of shame and stigma.[39]

Having noted the reasons for exercising extreme caution, where states do nonetheless enact legislation with provisions on compulsory testing of accused sexual offenders, the following principles have been identified as appropriate basis for such law reform:

- Compulsory HIV testing of an arrested person should be victim-initiated;[40]
- A specified standard of proof should be required on which to base an order for compulsory HIV testing;[41]
- Victims should never have to attend legal proceedings in which a magistrate determines whether an application should be granted;[42]
- Applications must be considered by a magistrate by means of *in camera* proceedings;[43]
- Pre-test counseling should be provided for the alleged offender, in order to obtain the informed consent of the offender (wherever possible);[44]
- Post-test counseling should be provided for the alleged offender;[45]

"peace of mind" […] with knowledge of a negative result, a survivor can be significantly confident that she or he has not been exposed to HIV infection."

[39] These exceptions are noted by ALP.

[40] This principle is set out in South African Law Commission, *Fourth Interim Report on Aspect of the Law Relating to AIDS: Compulsory HIV Testing of Persons Arresting in Sexual Offence Cases - Project 85,* November 2000.

[41] Both the South African Law Reform Commission and the ALP endorsed the following standard of proof: Prima facie evidence must exist to satisfy the following: i) a sexual offence has been committed against a victim by the arrested person, ii) in the course of such offence the victim may have been exposed to the body fluids of the arrested person, and c) no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

[42] ALP. The SALRC's recommendation on this issue was that the accused need not be present (in order to protect the victim from re-traumatisation in the application proceeding).

[43] ALP.

[44] Ibid.

[45] Ibid.

- Police should be obliged to advise the survivor/victim that she or he should seek counseling regardless of the result of the test;[46]
- Provide for the confidentiality of the arrested person's HIV results (disclose results only to the victim and the accused);[47]
- The test results should not be admissible as evidence in criminal or civil proceedings;[48]
- The state should be responsible for all costs associated with testing;[49]
- Malicious activation of the proposed testing procedure or malicious disclosure of the results should be punishable.[50]

The presumed goal of compulsory testing of accused sexual offenders is to provide an opportunity for victims to receive post-exposure prophylaxis (PEP) where they may have been exposed to HIV. The law should, however, ensure that all victims of sexual offences be given access to PEP and counselling about PEP regardless of whether compulsory testing of sexual offenders is mandated.

In the French version of the model law (but not the English), Article 18 provides that the state will encourage HIV testing for couples about to marry. While this is certainly preferable than mandating HIV testing, assurance is needed that routine offer will not be experienced as forced testing in practice.

Compulsory testing to "resolve a marital dispute": Rarely, if ever, will the resolution of a matrimonial conflict require forced HIV testing. No-fault divorce should eliminate much of the need to mandate HIV testing. Moreover, it is not recommended that HIV status be a ground for voiding a marriage as this would increase stigma against people living with HIV. This provision should be removed.

Compulsory testing of pregnant women: The provision establishing compulsory testing of pregnant women should be removed. Legislation mandating HIV testing for pregnant women would not be the least intrusive and least restrictive means available to accomplish the valid objective of testing pregnant women for HIV. Voluntary counselling and testing programs for pregnant women would be respectful of the autonomy of the women, would maintain the relationship of trust and confidence between a women and her physician, and would not run the risk of driving away some of the most marginal and vulnerable women from HIV testing and prenatal care. A UNAIDS policy statement on HIV testing and counselling states that pregnant women should not be tested without consent:

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[46] Ibid.

[47] SALRC.

[48] SALRC, ALP and LAC all made similar recommendations on this issue.

[49] SALRC.

[50] Ibid.

> Women should be offered information on reproductive and infant feeding options and on the use of antiretroviral treatment to reduce the risk of mother-to-child (vertical) HIV transmission. Regardless of the presence of risk factors or the potential for effective intervention to prevent transmission, women should not be coerced into testing, or tested without consent. Instead, they should be given all relevant information and allowed to make their own decisions about HIV testing, reproduction and infant feeding.[51]

In our view, the routine *offer* of HIV testing to pregnant women (as distinct from routine testing, where testing is done routinely unless the person explicitly refuses – i.e., "opts out"), with counselling and informed consent, is an appropriate response. All pregnant women should be offered HIV testing services with pre-test counseling, information that enables truly informed consent to take place, and confidentiality of test results. Health care providers should be given adequate training to provide HIV testing services and encouraged to offer HIV testing regularly to patients.

Benin

Article 10 provides for the routine offer of HIV testing to all couples before marriage. While the routine *offer* for HIV testing upon pre-marital medical examination is certainly better than mandatory testing, assurance is needed that routine offer will not be experienced as forced testing in practice.

Guinea

Mandatory HIV testing before marriage: Article 28 establishes mandatory HIV testing before a marriage ceremony. Although a policy of mandatory testing of couples before marriage may be motivated by the laudable goal of protecting prospective spouses, it risks undermining effective responses to HIV/AIDS and raises numerous human rights concerns.

There is little evidence that mandatory premarital HIV testing has any effect on reducing rates of HIV. Policies of mandatory testing are often recommended based on intuitive beliefs about their effectiveness, of which there is seldom any monitoring.[52] Effectiveness rests on a number of false assumptions. First, the approach assumes that HIV testing is accurate, when reports of false positives and false negatives indicate otherwise. Second, a negative test does not preclude the possibility of infection. Testing

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[51] UNAIDS, *UNAIDS Policy on HIV Testing and Counselling*. 1997, p 1. The *International Guidelines* emphasize that "States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose." *International Guidelines*, para 38(f).

[52] S. Rennie and B. Mupenda, "Ethics of mandatory premarital testing in Africa: the case of Goma, Democratic Republic of Congo," *Developing World Bioethics* (forthcoming 2007).

may occur during window periods when HIV antibodies cannot be detected, and a partner may become infected *after* the HIV test takes place, and indeed after the marriage takes place. Pre-marital testing may thus create a false sense of security that married people do not need to be concerned about HIV infection. The policy also assumes that the individuals getting married have not already exposed their partners to the virus.

In Illinois [USA], one of the few places where there has been any study of the effects of pre-marital HIV testing, a policy of mandatory pre-marital testing was found to be neither cost-effective nor efficacious in terms of epidemic control compared with voluntary counselling and testing programs.[53] Moreover, the number of marriage licenses issued in Illinois decreased by 22% during the time the policy was in place, and some 40 000 people left Illinois and got married in other states during the time the law was in force.[54] The legislation mandating pre-marital testing was repealed some 18 months after it came into force. Although pre-marital testing policies are more likely to be cost-effective in higher prevalence settings, research has yet to establish the point at which such policies become cost-effective at identifying individual cases of HIV.

In Ghana, national and international human rights groups, as well as the Ghana National Anti-AIDS Commission strongly condemned a decision by Ghanaian churches to make HIV testing a prerequisite for marriage, arguing that it would reinforce discrimination and create fear, undermining AIDS prevention efforts. Consequently, these churches now claim to have changed to voluntary counselling and testing.[55]

Finally, international human rights norms do not support mandatory HIV testing as a precondition to marriage and instead favour voluntary testing with counselling. The *International Guidelines* state, "it is clear that the right of people living with HIV [to marry] is infringed by mandatory pre-marital testing."[56] From a human rights perspective, mandatory pre-marital testing threatens to contribute to the stigma associated with HIV and raises concerns around consent and confidentiality.[57] For example, there is evidence that health workers and leaders of faith-based organizations find it difficult to safeguard the confidentiality of the sero-status of patients.[58] Finally, it is questionable in

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[53] C. Kelly and B. Turnock, Mandatory premarital HIV antibody testing: a twelve month experience, *Int Conf AIDS* 1989 Jun 4-9.

[54] R. Endstad, "AIDS test has 40 000 fleeing the state to wed." Chicago Tribune, California, 4 January 1989.

[55] Luginaah I.N., Yiridoe E.K., Taabazuing M.M., "From mandatory to voluntary testing: Balancing human rights, religious and cultural values, and HIV/AIDS prevention in Ghana," *Social Science and Medicine* 61 (2005) 1689-1700.

[56] At para. 118, citing Article 16 of the *Universal Declaration of Human Rights* which protects the right to marry.

[57] Uneke, C. J., Alo, M. and Ogbu, O. , 'Mandatory pre-marital HIV testing in Nigeria: The public health and social implications', *AIDS Care*, 19:1, 116 – 121 (2007).

[58] Ibid.

ethical terms to require mandatory testing if the policy does not help people to access care, treatment and support.[59] Premarital testing may detract from other goals such as empowering women to negotiate condom use and discussing HIV/AIDS with their partners. Arguably, these other goals are more important for women's protection from HIV infection before, during and after marriage.[60]

Article 28 should be removed from the law.

Guinea-Bissau

Article 17 is substantially the same as the model law. In general, see comments above.

The only difference between the law of Guinea-Bissau and the model law is the provision on mandatory HIV testing for those found guilty on charges of rape, HIV infection and attempted HIV infection (as opposed to those only *indicted* with these crimes in the model law). The presumed goal, however, of compulsory testing of accused sexual offenders is to provide an opportunity for victims to receive post-exposure prophylaxis (PEP) where they may have been exposed to HIV. Hence, this justification cannot apply to those persons that have received a guilty verdict, as post-exposure prophylaxis is not effective if given any later than 72 hours following exposure.[61] Given the absence of the principal justification for such a provision, it is recommended that this provision be removed.

Mali

According to Article 18, the prohibition on mandatory HIV testing is removed when: (i) when a person is indicted for HIV infection or attempt to infect another person with HIV; (ii) when a person is indicted for rape; (iii) when determining HIV status is necessary to solve a matrimonial conflict; (iv) organ, cell or blood donations; and (v) when specifically required by the Ministry of Health.

This Article follows closely Article 18 of the model legislation. Please see relevant comments above.

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[59] Rennie and Mupenda; Human Rights Watch, "AIDS Conference: Drive for HIV Testing Must Respect Rights: WHO, UNAIDS Policies must link testing to consent, counseling and treatment," (2006).

[60] Human Rights Watch.

[61] See WHO/ILO, *Occupational and Non-occupational Post-exposure Prophylaxis for HIV Infection* (HIV-PEP), Joint ILO/WHO Technical Meeting for the Development of Policy and Guidelines: Summary Report (2005).

Niger

Article 12 provides that the state will promote and encourage voluntary testing of high-risk individuals, such as pregnant women and their spouses, future married couples, partners of PLHIV, parents of children infected with HIV, as well as children of parents infected with HIV.

Ensuring that HIV testing is targeted towards such groups is welcome, as is the guarantee that such testing will be carried out on a voluntary basis. It should be ensured that such testing will not be experienced as forced testing in practice.

Sierra Leone

Article 11(2) establishes that no person shall compel another person to undergo an HIV test as a precondition to or for the continued enjoyment of employment, marriage, admission to any educational institution, entry into or travel out of the country, or the provision of healthcare, insurance or any other service. The contravention of this article is an offence. Article 11(4) establishes that "recommending or advising a person to do the HIV test shall not be construed as compelling a person under subsection (2)."

Ensuring that HIV testing will be carried out on a voluntary basis is welcome. Particularly given the language of article 11(4), assurance is needed that such testing will not be experienced as forced testing in practice.

Togo

Article 50 provides for periodic mandatory testing of sex workers for HIV and sexually transmitted diseases.

Mandatory HIV testing of sex workers is contrary to sound public health policy as it drives this often highly marginalized population away from necessary treatment and prevention services. Sex workers who think that attending a health clinic will result in an involuntary HIV test may not attend a clinic at all—thus being deprived of vital HIV prevention services and even primary medical care. Mandatory testing is also highly stigmatizing to sex workers and increases the potential human rights violations they face. Mandatory HIV testing, along with other coercive measures such as the official registration of sex workers, is a violation of medical privacy rights with unclear public health benefits and considerable potential public health costs.

As noted above, the *International Guidelines* oppose mandatory testing of sex workers and recommend a broader prevention approach:

> With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions

> to protect sex workers and their clients, including support for safe sex during work. Criminal law should not impede provision of HIV/AIDS prevention and care services to sex workers and their clients.[62]

Article 50 should be removed from the law.

[62] *International Guidelines*, para 29(c).

C. Disclosure obligations and "duty to warn"

Background considerations and policy guidance

Partner notification is the set of activities by which persons who have had sex or shared drug equipment with an individual with HIV (sometimes called the "index person') are notified and counselled about their possible exposure to HIV and offered services.

For women in particular, confidentiality of medical information (including HIV status) is essential to the protection of their human rights, because women may find themselves abandoned, subject to domestic violence, or ostracized if their domestic partners, families or communities discover that they are HIV-positive. Protection of the right to privacy is also vital to enable women to consent to HIV tests and treatment for themselves and their infants without fear of their long-term sex partners' reactions. Research from Africa indicates that the fear of disclosure of HIV status is one of the main barriers to women's use of voluntary counseling and testing services, and that this fear "reflect[s] the unequal and limited power that many women have to control their risk for infection."[63]

Disclosure of HIV-positive status can be particularly difficult for various reasons, not least the stigma and shame that still too often surround a diagnosis of HIV infection. In some cases – particularly for women – fear of violence may be a reason for not notifying a partner. Some jurisdictions include screening for domestic violence or referral to specialized services for victims of domestic violence as part of the partner notification process.[64] Counselling and support may be needed if violence is a concern, and these considerations need to be addressed as part of making partner notification possible and protecting the health and safety of not only the person notified but also of the index person. Economic dependence and fear of abandonment may also make disclosure difficult.

The *International Guidelines* recommend voluntary partner notification, but with provision for exceptional circumstances. According to the *International Guidelines*:

> Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:
>
> - The HIV-positive person in question has been thoroughly counselled;
> - Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;

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[63] S. Maman et al., "Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counseling and testing," *AIDS Care*, Vol. 13, No. 5, p. 601.

[64] A. Medley, C. Garcia-Moreno, S. McGill, and S. Maman, "Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes." *Bulletin of the World Health Organization*, 2004; 82: 299-307.

- The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
- A real risk of HIV transmission to the partner(s) exists;
- The HIV-positive person is given reasonable advance notice;
- The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice;
- Follow-up is provided to ensure support to those involved, as necessary.[65]

According to the *Legislator's Handbook*, "[i]t is recognized that coercive strategies are inappropriate, ineffective and counter-productive because they deter those at risk of infection from presenting early for counselling, testing, treatment and support."[66]

Analysis

Model Legislation on HIV/AIDS

Broad disclosure obligation: Article 26 requires a person with diagnosed HIV infection to disclose this to his/her "spouse or regular sexual partner" as soon as possible after diagnosis and within 6 weeks at most. (No penalty for non-compliance is specified.) Two comments are warranted.

- First, the Article as worded is overbroad, in that it requires disclosure to a spouse or regular sexual partner, regardless of whether there is any significant risk of HIV transmission, which should be a precondition to requiring disclosure. This provision should be narrowed or eliminated.

- Second, if a provision mandating disclosure to a spouse or sexual partner at some point is maintained, the provision of a "grace period" of this sort is interesting, and not commonly seen in legislation. Whatever the timeframe specified, it will inevitably be arbitrary. However, such a provision recognizes that an HIV diagnosis can be traumatic and raises a host of legal and other challenges for the person. Depending on how it is interpreted with other provisions that impose criminal penalty for HIV transmission, this Article could mitigate the burden of being immediately subject to possible criminal penalty for sex without disclosure. In this regard, it could, for example, be of benefit to an HIV-positive woman who risks or fears retaliation from a husband or sexual partner upon disclosure of her HIV infection but who also exercises limited or no control over the terms of that sexual relationship. She could benefit from a period of time during which she might be able to take the necessary steps to minimize the chance of negative consequences for her (and possibly her children) upon disclosure, to seek

[65] *International Guidelines*, Guideline 3(g).

[66] *Legislator's Handbook*, pg. 45.

assistance with disclosure, etc. It is not clear from the model legislation that it has this effect of relieving against criminal liability. Making this explicit, at least as a factor to be considered where there are particular circumstances impeding disclosure of HIV infection, is advisable if the potential benefit is to be realized.

Benin

Broad disclosure requirement: Article 4 ensures that the health care professional may not disclose a person's HIV status under any circumstances ("en aucun cas"). This broad and principled wording is welcome. Article 4 (paragraph 3) imposes an obligation on a PLHIV to disclose his or her HIV infection to his or her "partners" (which presumably means sexual partners, although this is not explicit) with the support of a counsellor if necessary. This requirement is overly broad. Why is disclosure required by law without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner — regardless of such things as (a) the sexual conduct at issue; (b) whether precautions to prevent transmission are taken; and (c) the PLHIV's ability to disclose safely and concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse.

Breaching confidentiality to warn person at risk: In contradiction of Article 4, Article 6 contains a provision permitting a physician or certain other "professionals" to breach a patient's confidentiality in order to prevent possible HIV transmission to another person. Article 6 allows a health care professional, or anyone else who has information of the HIV status of a patient by reason of their profession, to disclose a patient's HIV status in a certain number of situations, notably: (i) in a case of extreme necessity; (ii) where the HIV-positive person can not consent; (iii) where the behaviour of the HIV-positive person risks placing the health of another person in danger; and (iv) in cases of minors and those without legal capacity.

The existing provision should be narrowed somewhat so as to protect better the privacy interests of the PLHIV. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician should have "reasonable grounds to believe" not only that the PLHIV's behaviour puts another person at risk of harm, but that: (i) the PLHIV has been adequately counselled and refuses to change behaviour; (ii) that the risk to another person is a serious or significant risk in the circumstances; and (iii) the other person is not aware of the PLHIV's infection. This Article would also benefit from including an explicit provision that, before breaching confidentiality, the physician should make reasonable efforts to convince the person perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

The current wording of Article 6 makes it possible that the health care professional (or others) may disclose without previously notifying the HIV-positive person. In those circumstances where the health care professional feels an ethical obligation to disclose the HIV status of their patient to their patient's sexual partners, the Article should

guarantee (at a minimum) that the HIV-positive person is given reasonable advance notice.

Guinea

Breaching confidentiality to warn person at risk: In the Guinean law, this issue appears to be governed by two distinct provisions. Firstly, Article 23 (paragraph 3) requires the partner(s) of a PLHIV to be informed of that person's HIV status. This provision is too broad. The existing provision should be narrowed so as to better protect the privacy interests of the PLHIV. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician should have "reasonable grounds to believe" not only that the PLHIV's behaviour puts another person at risk of harm, but that: (i) the PLHIV has been adequately counselled and refuses to change behaviour; (ii) that the risk to another person is a serious or significant risk in the circumstances; and (iii) the other person is not aware of the PLHIV's infection. This Article would also benefit from including an explicit provision that, before breaching confidentiality, the physician should make reasonable efforts to convince the person perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

Secondly, Article 25 also contains a provision permitting a physician to breach a patient's confidentiality. The overlap between Article 25 and Article 23 (paragraph 4) creates unnecessary confusion. The wording of Article 25 is also too broad, in that it allows the physician to inform (presumably of the person's HIV status) other people (presumably those considered at risk) where: (i) the PLHIV cannot give consent; (ii) the behaviour of the PLHIV risks placing the health of a third part in danger; and (iii) the PLHIV is a minor or otherwise lacks legal capacity. As with Article 23, the current wording of Article 25 makes it possible that the health care professional may disclose without previously notifying the HIV-positive person. In those circumstances where the health care professional feels an ethical obligation to disclose the HIV status of their patient to their patient's sexual partners, the Article should guarantee (at a minimum) that the HIV-positive person is given reasonable advance notice.

Guinea-Bissau

Article 26 is substantially similar to the model law. See discussion above.

Mali

Broad disclosure requirement: Article 27 (part 1) imposes an obligation on a PLHIV to disclose his or her HIV infection to his or her spouse or sexual partner "as soon as possible", and no later than 6 weeks after diagnosis. The requirement under this Article

is overly broad. Why is disclosure required by law without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner — regardless of such things as the sexual conduct is at issue, whether precautions to prevent transmission are taken, and the PLHIV's ability to disclose safely and concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse. The 6-week "grace period" is based on the model legislation. See comment in the section above about this.

Breaching confidentiality to warn person at risk: Article 27 (part 3) contains a provision permitting a physician or other paramedical personnel to breach a patient's confidentiality in order to prevent possible HIV transmission to the person's spouse or sexual partner. The requirement to first inform the PLHIV of the intent to take this step is a positive feature, as is the provision of counseling to support the PLHIV.

The existing provision should be narrowed somewhat so as to protect better the privacy interests of the PLHIV. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician should have "reasonable grounds to believe" not only that the PLHIV's behaviour puts the spouse or sexual partner at risk of harm, but that: (i) the PLHIV has been adequately counselled and refuses to change behaviour; (ii) that the risk to another person is a serious or significant risk in the circumstances; and (iii) the other person is not aware of the PLHIV's infection. This Article would also benefit from including an explicit provision that, before breaching confidentiality, the physician should make reasonable efforts to convince the spouse or sexual partner who is perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

Niger

Broad disclosure requirement: Article 15 imposes an obligation on a PLHIV to disclose his or her HIV infection to his or her spouse or sexual partner "as soon as possible", and no later than 6 weeks after diagnosis. The requirement under this Article is overly broad. Why is disclosure required by law without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner — regardless of such things as the sexual conduct is at issue, whether precautions to prevent transmission are taken, and the PLHIV's ability to disclose safely and concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse. The 6-week "grace period" is based on the model legislation. See comment in the section above about this.

Breaching confidentiality to warn person at risk: Article 17 contains a provision permitting a physician or other "authorised person" to breach a patient's confidentiality in order to prevent possible HIV transmission to the person's spouse or sexual partner. The article requires that the 6-week "grace period" pass, or that someone (presumably the physician) considers that there is risky behaviour that threatens public health ("la

constatation d’un comportement á risque au sein de la communauté”.) The requirement to first inform the PLHIV of the intent to take this step is a positive feature.

The existing provision should be narrowed somewhat so as to protect better the privacy interests of the PLHIV. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician should have “reasonable grounds to believe” not only that the PLHIV’s behaviour puts the spouse or sexual partner at risk of harm, but that: (i) the PLHIV has been adequately counselled and refuses to change behaviour; (ii) that the risk to another person is a serious or significant risk in the circumstances; and (iii) the other person is not aware of the PLHIV’s infection. This Article would also benefit from including an explicit provision that, before breaching confidentiality, the physician should make reasonable efforts to convince the spouse or sexual partner who is perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

Sierra Leone

Broad disclosure requirement: Article 21(1) provides that a PLHIV shall: (a) “take all reasonable measures and precautions to prevent the transmission of HIV to others” and (b) “inform, in advance, any sexual contact or person with whom needles are shared, of that fact.” This requirement to disclose is overly broad. Why is disclosure required by law without regard to the degree of risk of transmission? It is notable that the obligation to disclose is not affected at all by the fact that the PLHIV has taken “all reasonable measures and precautions to prevent the transmission of HIV to others”. Requiring this blanket disclosure to every sexual partner — regardless of such things as the sexual conduct at issue; whether precautions to prevent transmission are taken, and the PLHIV’s ability to disclose safely and concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse.

Breaching confidentiality to warn person at risk: Article 21 is drafted in a way that makes it difficult, if not impossible, for the reader to understand under what circumstances a physician can breach patient confidentiality and warn another person at risk, and potentially undermines the intent behind the legislation.

According to Article 21(7), a physician may inform a patient’s sexual partner of that patient’s HIV-positive status if the patient has not: (i) “taken all reasonable measures and precautions” to prevent the transmission of HIV *and* informed that sexual partner or person with whom needles are shared; or (ii) if that patient is “knowingly or recklessly plac[ing] another person, and in the case of a pregnant women, the foetus, at risk of becoming infected with HIV, unless that other person knew that fact and voluntarily accepted the risk of being infected with HIV”; or (iii) if the PLHIV has not requested the physician to notify that PLHIV’s sexual partner.

This confused construction leaves open the possibility that a physician may inform a sexual partner of a PLHIV of that PLHIV's status even if the PLHIV has taken all reasonable measures and precautions to prevent HIV transmission (but have not, themselves, notified their partner). Strictly interpreted, the current wording also leaves open the possibility that the physician may inform a sexual partner of a PLHIV of that PLHIV's status simply if the PLHIV has not requested the physician to notify the sexual partner. This would have the effect of requiring notification to every sexual partner (i.e., either the patient requests that their physician notify their partner, or the physician has the power to notify).

Article 21 needs to be redrafted. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician should have "reasonable grounds to believe" not only that the PLHIV's behaviour puts another person at risk of harm, but that: (i) the PLHIV has been adequately counselled and refuses to change behaviour; (ii) that the risk to another person is a serious or significant risk in the circumstances; and (iii) the other person is not aware of the PLHIV's infection. This Article would also benefit from an explicit provision that, before breaching confidentiality, the physician should make reasonable efforts to convince the person perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

Togo

Broad disclosure requirement: Article 9 imposes an obligation on a PLHIV to disclose his or her HIV infection to "spouses and any sexual partners as well as to their physicians". This is overly broad. Why is disclosure required by law without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner and physician — regardless of such things as the sexual conduct is at issue, whether precautions (including, in the case of physicians, universal infection precautions) to prevent transmission are taken, and the PLHIV's ability to disclose safely and concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse.

Breaching confidentiality to warn person at risk: Article 10 contains a provision permitting a physician or "other authorized persons" to inform a PLHIV's sexual partner of the PLHIV's HIV infection. The existing provision should be narrowed somewhat so as to protect better the privacy interests of the PLHIV. Specifically, there should be a requirement that, before breaching the confidentiality of the PLHIV by disclosing his or her HIV infection to a third party, the physician or "authorized persons" (which should be more narrowly defined) should have "reasonable grounds to believe" not only that the PLHIV has been adequately counselled and refuses to change behaviour, and that the partner runs a serious risk of contracting HIV, but that the partner is also unaware of the PLHIV's infection. This Article would also benefit from including an explicit provision that, before breaching confidentiality, the physician/authorized person (e.g. public health personnel) should make reasonable efforts to convince the partner to seek information

about HIV and HIV testing, preserving to the extent possible the anonymity of the PLHIV.

D. Criminalisation of HIV transmission or exposure

Background considerations and policy guidance

There is some concern about whether it is helpful or desirable to use criminal law at all to deal with the issue of HIV transmission, even if there may be some limited situations where it is justifiable to do so. Criminal law is generally viewed as "a blunt instrument that can neither adequately capture the complexity of the contexts in which HIV transmission occurs nor deal effectively with matters such as the relative probability of transmission."[67] There is very little evidence of the impact of using the law in this way, but what evidence does exist suggests it is unlikely to have much effect, on a broader population level, as an HIV prevention measure,[68] and is likely to contribute to HIV-related stigma[69] and undermine HIV prevention efforts more broadly.[70]

Law-makers, and those tasked with law enforcement (police and prosecutors) can and should exercise restraint in using criminal prosecutions as a response to HIV transmission or risk behaviour. Indeed, this is a key recommendation from not only a variety of civil society HIV/AIDS organizations but also from UNAIDS, which has urged that public health protection legislation, when it incorporates appropriate procedural and substantive safeguards for human rights (such as due process), offers a more flexible and preferable alternative to criminalization, and that coercive measures — including criminal prosecutions, the most coercive and stigmatizing of measures — should be used as a last resort, only after less intrusive measures have proven ineffective.[71]

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[67] WHO Europe, *WHO technical consultation in collaboration with European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections* (Copenhagen, 16 October 2006), p. 3, online: www.euro.who.int/Document/SHA/crimconsultation_latest.pdf.

[68] Z. Lazzarini, S. Bray & S. Burris, "Evaluating the Impact of Criminal Laws on HIV Risk Behavior", *Journal of Law, Medicine & Ethics* 2002; 30: 239-253; S. Burris et al., "Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial", Legal Studies Research Paper Series, Research Paper No. 2007-03, __ Ariz. State L.J. __ (forthcoming 2007), online: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=977274.

[69] C. Dodds et al., "Outsider Status: stigma and discrimination experienced by Gay men and African people with HIV" (London: Sigma Research, 2004), online: www.sigmaresearch.org.uk/downloads/report04f.pdf; C. Dodds et al., "A telling dilemma: HIV disclosure between male (homo)sexual partners" (London: Sigma Research, 2004), online: www.sigmaresearch.org.uk/downloads/report04e.pdf; R. Klitzman et al., "Naming names: perceptions of name-based reporting, partner notification and criminalisation of non-disclosure among persons living with HIV", *Sexuality Research and Social Policy* 2004; 1(3):38-57.

[70] C.L. Galletly & S.D. Pinkerton, "Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV", *AIDS and Behaviour* 2006; 10: 451-461.

[71] *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* (Geneva: UNAIDS, 2002), pp. 39, online: http://data.unaids.org/Publications/IRC-pub02/JC733-CriminalLaw_en.pdf (English), http://data.unaids.org/Publications/IRC-pub02/jc733-criminallaw_fr.pdf (français).

To the extent that criminal law is used, the *International Guidelines* recommend to States that:

> Criminal and/or public health should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.[72]

In a more detailed examination of this issue, undertaken to guide policy-makers in dealing with this difficult and complex issue, UNAIDS has reiterated the recommendation that, if States decide to resort to criminal law to address HIV transmission, they should not enact HIV-specific legislation, but instead apply general criminal offences.[73] UNAIDS points out that existing offences are likely adequate to deal with such exceptional cases, and that an HIV-specific law is unlikely to have any additional deterrent effect. In addition and perhaps most significantly, UNAIDS cautions that enacting HIV-specific legislation contributes to already widespread HIV-related stigma and invites further discrimination against PLHIV by singling them out as potential criminals. There is serious concern that criminalizing risk activity by PLHIV could provide an additional deterrent to people seeking HIV testing, a concern that cannot be easily dismissed but which has not yet been researched.[74] In addition, contributing to HIV-related stigma undermines HIV prevention education efforts, and criminal prosecutions (or the fear thereof) can impede access to counselling and support services that can assist with disclosing to sexual partners and otherwise changing behaviour to reduce the risk of transmission.[75]

The Inter-Parliamentary Union (IPU) has joined with UNAIDS in recommending that law-makers avoid enacting HIV-specific criminal legislation, and further recommends that "[p]unishment under the criminal or public health law should be reserved for the

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[72] *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version (Geneva: UNAIDS/OHCHR, 2006), Guideline 4, para. 21(a), online: http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (English).

[73] *Criminal Law, Public Health and HIV Transmission*, *supra*, pp. 30-32.

[74] Concerns about criminal prosecutions for HIV transmission/exposure are heightened by the current push from some quarters for making HIV testing even more routine for a much broader swath of the population, with consequently much greater potential for people to end up getting tested for HIV without informed consent, appropriate counselling and confidentiality protections. The number of people thereby exposed to potential criminalization could increase dramatically where such approaches to HIV testing are implemented.

[75] Ibid.

most serious culpable behaviour."[76] In those cases where a new offence is created, they have recommended that "the coverage of the legislation should be limited to deliberate or intentional acts."[77] UNAIDS has also cautioned against extending criminal liability beyond *intentional* conduct, as this "raises a concern about the potential for bias and prejudice to enter into the interpretation and application of the criminal law" — there is the potential for jurors/judges to allow uninformed attitudes and perceptions of HIV, risks of transmission, gender roles, and marginalized groups associated with HIV (e.g., sex workers, men who have sex with men) to influence their assessment of whether conduct is reckless or negligent.[78]

In addition, UNAIDS has recommended that if criminal law is used:

- There should be no criminal liability unless there is clear proof, beyond a reasonable doubt, that the accused person was aware of his or her HIV infection and was aware that the conduct of which he or she is accused posed a significant risk of transmitting HIV;
- There should be no criminal liability in cases where a sexual or other partner was aware of the person's HIV-positive status, and gave a truly voluntary consent, as this would unjustifiably infringe autonomy. (If there is evidence that "consent" was coerced or was not freely given – for example, if the "consent" is given in the context of relationship marked by previous abuse – the law should be crafted so as to take this into account.);
- There should be no criminal liability if the PLHIV has taken precautions to reduce the risk of transmission so that it is not significant (e.g., condom use, avoiding high-risk sexual activities), as this would trivialize the seriousness of criminal sanctions (which are society's harshest response to objectionable conduct) and would penalize those who act responsibly, in accordance with public health advice, by practising safer sex; and
- There should be no criminal liability if the PLHIV does not disclose, or does not take precautions against transmission, because of a reasonable apprehension of violence or other serious adverse consequence. While this may be the reality for many PLHIVs, it is particularly and disproportionately likely to be of concern for women who are living with HIV, given the extent to which women worldwide experience violence, discrimination and other abuse including from their partners.[79]

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[76] *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (Geneva: UNAIDS/IPU, 1999), p. 51, online: http://www.ipu.org/PDF/publications/aids_en.pdf (English), http://www.ipu.org/PDF/publications/aids_fr.pdf (français).

[77] Ibid.

[78] *Criminal Law, Public Health and HIV Transmission*, supra, at p. 36.

[79] *WHO Multi-country Study on Women's Health and Domestic Violence Against Women* (Geneva: WHO, 2004), online: www.who.int/gender/violence/who_multicountry_study/en/index.html; S. Maman & A Medley, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes – A Review Paper* (Geneva: WHO, 2004), online: www.who.int/gender/documents/en/genderdimensions.pdf.

It is generally recommended that HIV/AIDS legislation not include provisions regarding the criminalization of HIV transmission, both because creating HIV-specific criminal law is ill-advised and because of the broader concerns mentioned above that should lead law-makers to avoid using the criminal law to address HIV. In each of these 4 countries, criminalization provisions have been included in their "AIDS law". It is recommended that these be removed.

To the extent that states continue to apply criminal law, whether HIV-specific or generic, to HIV transmission/exposure, there are several additional considerations that must be addressed by law-makers, as recommended by UNAIDS[80] and WHO.[81] These include:

- Measures to prevent the misuse of criminal or public health laws so as to ensure no discrimination based on HIV status, protections for due process, the right to notice and to legal representation, the right to appeal restrictions on liberty, etc;
- Guidelines or rules for police and prosecutors to protect privacy, and to minimize prejudicial, inflammatory, misleading or stigmatizing disclosure of information or media coverage of prosecutions;
- Access to legal services for people infected and affected by HIV/AIDS, and the right to legal representation;
- Educating police, prosecutors, defence lawyers and the judiciary about HIV/AIDS, so as to ensure competent representation of PLWHA in judicial proceedings and to ensure fair conduct of proceedings, free of bias and discrimination in the administration of justice, particularly that which is based on HIV-related stigma or prejudices toward particular groups (e.g., sex workers, men who have sex with men); and
- Legal measures to protect the confidentiality of medical and counselling information from police access and during legal proceedings.

Analysis

Model Legislation on HIV/AIDS

A number of specific provisions in the model legislation, dealing with application of the criminal law to HIV, warrant comment:

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[80] *Criminal Law, Public Health and HIV Transmission*, *supra*, pp. 40-41.

[81] *WHO technical consultation*, *supra*,

<u>"Wilful transmission of HIV":</u> Article 36 is awkwardly drafted and unclear. With no apparent reason, the order of the sub-paragraphs is reversed in the French and English versions.

One portion of Article 36 creates the basic offence of "wilful transmission." If such an HIV-specific offence is created by law (contrary to the general recommendation to avoid such an approach), then it is important that it is only "wilful" transmission that is criminalized, rather than extending the scope of the criminal law further. It is important to make sure that this provision is, in fact, interpreted and implemented correctly in this circumscribed fashion. "Wilful transmission" is defined in Article 1 as transmission of HIV "through any means by a person with full knowledge of his/her HIV/AIDS status to another person". It is appropriate to include actual knowledge of HIV infection as a necessary precondition of criminal liability. However, the phrase "through any means" casts the net too widely, particularly if regard is had to the definition of "HIV transmission" in the definitional section. The effect would be to impose criminal penalties in situations such as: (i) the person who practices safer sex, regardless of whether or not he/she disclosed to a sexual partner and of the actual risk of transmission; (ii) the person who takes steps to disinfect an intravenous needle or other skin-piercing instrument, again regardless of disclosure to the other person using that instrument and of the actual risk of transmission; and (iii) a mother who transmits HIV to a child, including *in utero* or during labour and delivery, regardless of precautions taken to reduce the risk of transmission and of the actual risk thereof. It is problematic to consider all of these situations as "wilful transmission" and to impose criminal penalties in such cases.

Another portion of Article 36 specifically criminalizes health care workers. There is considerable discrepancy between the French and English language versions of the model law. In the English language version, this criminal sanction applies to those health care workers who knowingly transfuse biological products containing HIV or use infected instruments. A criminal sanction for such an act is appropriate. The Article says that the penalty is set out in "the next succeeding article", but (a) this should likely refer to the next paragraph in this same Article (as the next Article is not a penalty clause), and (b) the underlying definition of "wilful transmission" (in Article 1) is worded so as to refer to transmission by a person with full knowledge of his/her HIV status (which would not be the case of a health care worker conducting procedures using contaminated products or instruments).

In the French language version, the paragraph provides that any person (PLHIV or not) or health care worker is an accomplice to an act of "wilful transmission of HIV" who directs, favours, allocates or procures the means to commit the crime referred to in article 35 of the model law. This is clearly a drafting error, as article 35 of the model law is an article providing for criminal sanctions for discriminatory acts under the law, and hence is unrelated to the issue of wilful HIV transmission. It is not clear what this paragraph of the model law intended to criminalise. It is of considerable concern that the model law includes broad provisions outlining potentially serious criminal consequences, but with serious errors in drafting.

Criminal (and other) penalties for HIV transmission in other situations: Article 13 of the model law has a specific provision imposing criminal penalties in the event of HIV transmission in the context of professional services (e.g., health services). There are two concerns with the Article as drafted.

First, the wording deems "clumsiness", "negligence", "carelessness", "recklessness" and "non-compliance to the regulations, as well as protection guidelines" regarding surgical interventions and similar procedures (in Article 12) to constitute "wilfully infecting" another person. However, "wilful" usually connotes some sort of deliberation or intention, which criminal law usually very purposefully treats differently than these other states of mind.

Second, the Article mandates that, in the event the offence is committed in a hospital or private clinic, the institution's licence "shall" be suspended (for up to 12 months). Shutting down an entire health facility, and thereby depriving many people of its services, because of one person's wrongdoing seems a very harsh consequence and one that is counterproductive to health goals more broadly. (A similar concern arises with respect to the last part of Article 28, regarding sanctions for a health facility that breaches confidentiality, and with Article 35, regarding sanctions for discriminatory acts.)

Benin

HIV exposure offence: Article 27 makes it a crime for any person who knows she or he has "the AIDS virus"[82] to engage in "unprotected sexual relations" without disclosing his/her infection to the sexual partner. No actual transmission of HIV is required. As previously noted, it is advisable to have no HIV-specific offence; deleting Article 27 would be the best course of action. Alternatively, if this Article remains, it is overly broad, and a number of changes are suggested:

- One option for consideration would be to limit criminal liability to just those situations where a person who knows she or he has HIV engages in unprotected sex without disclosure and with intent to transmit HIV — this would limit the state's most serious legal tool and penalties to those cases clearly deserving of such treatment;
- It should be clear that "unprotected sex" refers only to vaginal or anal sex without a condom, not other sexual practices that are much lower-risk (e.g., oral sex without a condom);
- It should be a prerequisite of criminal liability that the prosecution prove the PLHIV was aware of the risk of transmission through the sexual acts in question; and

[82] There is no "AIDS virus"; "HIV" should be used instead: *UNAIDS' Terminology Guidelines* (Geneva: UNAIDS, March 2007).

- A person should not be convicted of this offence if s/he lacked the power to determine whether or not to have unprotected sex ability and/or to disclose HIV infection to a sexual partner (e.g., because of the reasonable fear of violence in the circumstances).

Criminal offence of administering contaminated blood: Article 29 makes it an offence to administer HIV-contaminated blood to a person, either "wilfully" (which attracts a higher penalty) or through negligence, carelessness, or failure to observe regulations (which attracts a lower penalty). It does not appear that administration of any other bodily samples attracts this penalty; consideration should be given to expanding this to cover other situations (e.g., use of organs, tissue, ova/semen). (Also, this appears to again be an *exposure* offence, since it does not require actual infection of the person who received the blood, it simply requires the administration of the blood.)

Mandatory minimum sentences: Several articles in the law impose mandatory minimum sentences for various criminal offences.

- Article 27 (unprotected sex without disclosure) carries a minimum penalty of both 5 years' imprisonment and a fine of 1,000,000 francs;
- Article 30 (unprotected sex through coercion) carries a minimum penalty of 5 years' imprisonment and a fine of 3,000,000 francs. If this offence was committed on a particularly vulnerable person, a minor or legally incapable person, or under threat by one or more persons, by a parent or other person abusing a position of authority over the victim, the penalty is life imprisonment. It is not clear if this is meant as a minimum sentence, but this likely the intended meaning and the likely interpretation, given the rest of the Article. and
- Article 29 (administering contaminated blood) carries what appears to be a minimum sentence of life imprisonment in the event of wilful conduct, or a minimum of 1 year's imprisonment in the case of transmission through negligence, carelessness, etc.

Mandatory minimum sentences, for any offence, raise human rights concerns by violating the fundamental sentencing principle of proportionality, which requires that a criminal sentence be not only proportionate to the gravity of the offence but also to the degree of responsibility of the offender, and should therefore take into account the circumstances of the individual case.

Guinea

Crime of "wilful HIV transmission": The basic crime of "wilful HIV transmission" arises out of both Article 35 (which makes transmission through sex or blood an offence) and the underlying definition in Article 1 of the term "wilful HIV transmission" ("transmission volontaire du VIH"). As currently worded, the offence is overly broad. The definition seems to include not only those circumstances in which the virus is

actually transmitted through HIV-contaminated substances, but also any exposure of another to such substances regardless of the consequences ("quelles qu'en aient été les suites"). (Article 36 creates an additional specific offence of sexual exposure with intent to transmit – see below.) In addition, this definition appears to impose criminal liability, for transmission and even for exposure, without regard to: (i) whether the person knew she or he had HIV or was aware of the risk of transmission; (ii) the actual risk of transmission associated with the activity; (iii) whether the PLHIV disclosed to the other person or the other person was aware in some way of the HIV infection; (iv) whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting equipment); and (v) whether in the circumstances the PLHIV had control over the degree of risk (e.g., use by husband or partner of a condom).

The definition of "HIV transmission" in the definitional section specifically includes mother-to-child transmission. The definition of "wilful HIV transmission" leaves open the possibility that mother-to-child transmission, as a form of transmission by way of blood ("par voie sanguine") is a criminal offence. The definition of "wilful HIV transmission" does not contain a mental element of intention. It is unlikely that criminalisation of mother-to-child transmission is the intention of the drafters. To avoid any possible confusion, this issue should be revisited. Wording could read: "Nothing in this Part applies to the transmission of HIV by a woman to her child, either before, during or after the birth of the child."[83]

Limited HIV exposure offences: Articles 36 and 37 clearly create offences of sexual HIV *exposure* rather than *transmission*, although they are appropriately limited in their scope – either to the situation where the exposure is done with the intent of transmitting the virus or through non-consensual sex. However, a few concerns remain:

- Article 36 states that it is a crime for any HIV-positive person to have "unprotected sex with the proven intent to infect" ("rapports sexuels non protégés avec un partenaire dans le but avéré de le contaminer"), and explicitly states that this is an offence regardless of whether HIV is transmitted. However, the defence of consent should exist here, as it should more generally, if the HIV-positive person disclosed the infection to the sexual partner (or the sexual partner was in some other way aware of the infection), and the sexual partner truly voluntarily consented to the sexual encounter. In such cases, there is no justification for criminal prosecution. (If there is evidence that "consent" was coerced or was not freely given – for example, if the "consent" is given in the context of relationship marked by previous abuse – the law should be crafted so as to take this into account.)

- With respect to the issue of coercion, Article 37 states that it is an offence for any HIV-positive person to engage in "unprotected sex with a partner through the use of violence, force/constraint or surprise" (relations sexuelles non protégées "usant de la violence, contrainte ou surprise"). There is no requirement in this clause

[83] This wording is found in *HIV/AIDS Management and Prevention Act*, Papua New Guinea (No. 4 of 2003).

that HIV transmission actually result. This is a particularly good example of where creating an HIV-specific offence is unnecessary and only contributes to HIV-related stigma by reaffirming the image of the "HIV-positive rapist" as a separate sort of offender requiring particular criminalization. Essentially this is an offence of rape/sexual assault, which should already be criminalized as an offence elsewhere in the law (including marital rape). The fact that the accused person is HIV-positive should, if necessary, be treated as an aggravating factor in sentencing if the person is convicted — and it should perhaps only be an aggravating factor if HIV is actually transmitted. (Also, it is not clear on the current wording that the accused person must actually be aware that she or he is HIV-positive as a condition of being convicted. Strictly interpreted, this Article simply says that a person who is infected with HIV who commits this sexual aggression can be convicted. If the person can be subject to a separate criminal conviction just because she or he is HIV-positive, with no requirement that she or he even be aware of his or her infection, this flies in the face of the general requirement that there be some sort of mental culpability with regard to the elements of the offence and would, therefore, amount to discrimination based purely on HIV status.)

<u>Discriminatory provision regarding abandonment:</u> Article 44(a) provides that a husband may not abandon his wife, who he knows to be HIV positive, "without a serious motive." Article 44(b) provides that a wife may not abandon her husband under any circumstances (i.e., the exception providing for "a serious motive" is not available for the female partner). There is no reasonable justification for this distinction. Such a distinction is discriminatory against married women and should be removed.

<u>Mandatory minimum sentences:</u> Several Articles in the law impose mandatory minimum sentences for various criminal offences.

- Article 36 (unprotected sex with intent to infect) carries a minimum penalty of both 5 years' imprisonment and a fine of 1,000,000 francs.
- Article 37 (unprotected sex through coercion) carries a minimum penalty of 5 years' imprisonment and a fine of 3,000,000 francs. If this offence was committed on a particularly vulnerable person, under threat with a gun, by two or more accomplices, by a parent or other person in a position of authority over the victim, the penalty is life imprisonment. It is not clear if this is meant as a minimum sentence, but this is likely the intended meaning and the likely interpretation, given the rest of the Article.
- Article 38 (administering contaminated blood) carries what appears to be a minimum sentence of life imprisonment in the event of wilful conduct, or a minimum of 1 year's imprisonment in the case of transmission through negligence, carelessness, etc.
- Article 39 (various offences related to prostitution) imposes a minimum sentence of 1 year's imprisonment and a fine of 1,000,000 francs. Article 40 raises this to a minimum of 2 years' imprisonment (but oddly, a lower minimum fine) for such

offences in circumstances considered particularly egregious, such as involving a minor, use of coercion or abuse of authority, etc.

See comments above (in relation to Benin's law) on the human rights concerns raised by mandatory minimum sentences.

<u>Sentencing for attempted offences:</u> Article 36 (unprotected sex with intent to transmit HIV) and Article 37 (unprotected sex through coercion) both state that attempting these offences carries the same penalty as the completed offence itself. However, a commonly accepted principle in criminal law is that *attempts* do not generally attract the same full penalty as completed offences. This should be revisited.

Guinea-Bissau

Article 37 of the Guinea-Bissau law repeats the provisions of article 36 of the model law (including that article's drafting errors), albeit with concrete penalties attached (a minimum sentence of 2 years and a maximum sentence of 12 years). See comments on the model law above.

Mali

<u>Crime of "wilful HIV transmission":</u> The basic crime of "wilful HIV transmission" is found in Article 37 (paragraph 1), which makes wilful introduction into the body of HIV-infected substances an act of "wilful HIV transmission". The definition in Article 1 of the term "wilful HIV transmission" ("transmission volontaire du VIH") is overly broad. This definition appears to impose criminal liability for transmission and even for exposure to HIV-infected substances "in any way" ("de quelque manière que ces substances aient été employees our administrées et quelles qu'en aient été les suites"), without regard to: (i) whether the person knew s/he had HIV or was aware of the risk of transmission; (ii) the actual risk of transmission associated with the activity; (iii) whether the PLHIV disclosed to the other person or the other person was aware in some way of the HIV infection; (iv) whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting equipment); or (v) whether in the circumstances the PLHIV had control over the degree of risk (e.g., use by husband or partner of a condom).

The definition of "HIV transmission" in the definitional section specifically includes mother-to-child transmission. The definition of "wilful HIV transmission" leaves open the possibility that mother-to-child transmission, as a form of transmission by way of blood ("par voie sanguine") is a criminal offence. The definition of "wilful HIV transmission" does not contain a mental element of intention. It is unlikely that criminalisation of mother-to-child transmission is the intention of the drafters. To avoid any possible confusion, this issue should be revisited. It could read: "Nothing in this Part

applies to the transmission of HIV by a woman to her child, either before, during or after the birth of the child."[84]

According to Article 37 (paragraph 3), "wilful HIV transmission" is considered attempted murder and punished according to the stipulations of the Penal Code for this offence. But while securing a conviction for attempted murder usually requires proving a high degree of mental culpability; a successful prosecution would require proving that the accused person acted with the intent to kill the other person. In the case of exposure to the risk of HIV transmission through sex, this will be the rare situation. As some commentators have noted, "[h]aving sex is a highly indirect *modus operandi* for the person whose purpose is to kill".[85]

We also note that Article 37 (paragraph 2) seems to contain incorrect wording. It says that a person who contributes in one or more ways to bringing about the offence set out in "Article 36" is a party ("complice") to the offence of willful HIV transmission. But Article 36 refers to a mandatory minimum sentence for various discriminatory acts set out in Chapter VIII of the statute, which is an unrelated matter. This drafting error has been directly incorporated from the model law.

<u>Mandatory minimum sentences:</u> Article 37 (paragraph 4) includes a mandatory minimum sentence of 5 years' imprisonment for the offence of wilful HIV transmission. See comments above regarding the human rights concerns raised by mandatory minimum sentences.

Niger

<u>HIV exposure offence:</u> Article 39 provides that a person who "willingly exposes another person to the risk of infection with the AIDS virus will be punished in conformity with Article 230-1, paragraph 2 of the Penal Code." As noted above, the correct terminology is HIV, not "AIDS virus".

As currently worded, the offence is overly broad. The definition includes not only those circumstances in which the virus is actually transmitted through HIV-contaminated substances, but also any exposure of another to such substances. In addition, this wording appears to impose criminal liability, for transmission and even for exposure, without regard to: (i) whether the person knew s/he had HIV or was aware of the risk of transmission; (ii) the actual risk of transmission associated with the activity; (iii) whether the PLHIV disclosed to the other person or the other person was aware in some way of the HIV infection; (iv) whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting

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[84] This wording is found in *HIV/AIDS Management and Prevention Act*, Papua New Guinea (No. 4 of 2003).

[85] Field, MA and Sullivan KM (1987) 'Aids and the Criminal Law' 15 *Law Medicine and Health Care* 46, at 47.

equipment); and (v) whether in the circumstances the PLHIV had control over the degree of risk (e.g., use by husband or partner of a condom). Further, the defence of consent should exist here, as it should more generally, if the HIV-positive person disclosed the infection to the sexual partner (or the sexual partner was in some other way aware of the infection), and the sexual partner truly voluntarily consented to the sexual encounter. In such circumstances, there is no justification for criminal prosecution.

The article provides that neither mitigating circumstances nor probation will be available to those convicted under this article. This provision raises human rights concerns by violating the fundamental sentencing principle of proportionality, which requires that a criminal sentence be not only proportionate to the gravity of the offence but also to the degree of responsibility of the offender, and should therefore take into account the circumstances of the individual case.

Coerced sex: Article 41 states that it is an offence for any HIV-positive person, using violence or coercion, to engage in sexual relations with another person. There is no requirement in this clause that HIV transmission actually result. This is a good example of where creating an HIV-specific offence is unnecessary and only contributes to HIV-related stigma by reaffirming the image of the "HIV-positive rapist" as a separate sort of offender requiring particular criminalization. Essentially this is an offence of rape/sexual assault, which should already be criminalized as an offence elsewhere in the law (including marital rape). The fact that the accused person is HIV-positive should, if necessary, be treated as an aggravating factor in sentencing if the person is convicted — and it should perhaps only be an aggravating factor if HIV is actually transmitted.

Article 41 states that attempting these offences carries the same penalty as the completed offence itself. However, a commonly accepted principle in criminal law is that *attempts* do not generally attract the same full penalty as completed offences. This should be revisited. It also provides that neither mitigating circumstances nor probation will be available to those convicted under this article. As discussed above, this should also be revisited.

Mandatory minimum sentences: Several Articles in the law of Niger impose mandatory minimum sentences for criminal offences. They are:

- Article 37 (a health care professional who refuses to provide care to a PLHIV) carries a minimum penalty of both 2 months' imprisonment and a fine of 20,000 francs;
- Article 38 (performing an HIV test without consent) carries a minimum penalty of 2 months' imprisonment and a fine of 20,000 francs;
- Article 40 (health care professionals who by "negligence", "recklessness" "clumsiness", "carelessness", and "non-compliance" with the regulations, administers HIV to another) carries a minimum sentence of 2 years' imprisonment and a fine of 200,000 francs;
- Article 41 (coerced sex by a PLHIV) imposes a minimum sentence of 15 year's imprisonment and a fine of 1,000,000 francs;

- Article 42 (counterfeit medical certificates or false HIV test results) carries a minimum sentence of 2 years' imprisonment and a fine of 200,000 francs;
- Article 43 (medical practitioners who break this law) carries a minimum sentence of 2 years' imprisonment and a fine of 200,000 francs;
- Article 44 (spreading erroneous or deceptive information about HIV) carries a minimum penalty of both 2 months' imprisonment and a fine of 20,000 francs. Where this deceptive information relates to medication and other products for care, treatment or prevention the minimum sentence is 1 year and a fine of 100,000 francs (Article 46); and
- Article 45 (responsible for discriminatory acts under this law) carries a minimum penalty of both 2 months' imprisonment and a fine of 50,000 francs. The Article provides that, in the event the offence is committed in a private or religious health care setting, the institution shall be closed for a minimum of 2 months and up to 6 months. Shutting down an entire health facility, and thereby depriving many people of its services, seems a very harsh consequence and one that is counterproductive to health goals more broadly.

Other articles are sentenced under the Criminal Code and may also carry minimum sentences under that law.

See comments above (in relation to Benin's law) on the human rights concerns raised by mandatory minimum sentences.

Sierra Leone

The law in Sierra Leone contains two distinct articles establishing an offence of "HIV transmission" (although in effect both articles establish offences of HIV exposure). Firstly, according to Article 21(1), a person who is infected with HIV (and aware of the fact) must "take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of a pregnant women, the foetus", and also "inform, in advance, any sexual contact or person with whom needles are shared" of their HIV status. Secondly, according to article 21(2) a person who is infected with HIV (and aware of the fact) must not knowingly or recklessly place another person (and in the case of a pregnant woman, the foetus) at risk of becoming infected with HIV, unless that person knew of the fact and voluntarily accepted the risk of being infected. The contravention of either of these provisions is an offence (Article 21(3)).

Under Article 21(1), no actual transmission of HIV is required. A number of observations are warranted:

- The double obligation that someone take: (i) "all reasonable measures and precautions to prevent the transmission of HIV to others; and (ii) disclose to "any sexual contact" is unreasonable. If someone took all reasonable measures and precautions to reduce the risk of HIV transmission, this ought to be enough to negate criminal liability. The fact that they took such actions should negate the

mental element of criminal activity- they have no intent to commit a crime, and cannot be said to be acting recklessly or negligently. Requiring disclosure on the pain of criminal penalties in these circumstances also makes little sense from the perspective of the public health goal of preventing transmission.

- It should be clarified that the obligation to disclose to "any sexual contact" refers only to vaginal or anal sex without a condom, not other sexual practices that are much lower-risk (e.g., oral sex without a condom).
- It should be a prerequisite of criminal liability that the prosecution prove the PLHIV was aware of the risk of transmission through the sexual acts in question.
- A person should not be convicted of this offence if she or he lacked the power to determine whether or not to have unprotected sex ability and/or to disclose HIV infection to a sexual partner (e.g., because of the reasonable fear of violence in the circumstances).

Article 21(1) also places criminal liability on the mother living with HIV (and who knows she is living with HIV) who does not take "all reasonable measures and precautions" to prevent the transmission of HIV to her foetus. First, this provision would violate the right to medical treatment with voluntary informed consent. Informed consent to undergoing antiretroviral therapy to reduce mother-to-child transmission is important because the treatment may affect the health of the pregnant woman.[86] Second, it is not specified what "all reasonable measures and precautions" would include. Indeed, it is not at all clear that such standards are clearly enough articulated and understood by health care professionals and pregnant women, in a way that makes it is appropriate to apply criminal sanctions for a departure from those standards. What would "all reasonable measures and precautions" to prevent mother-to-child-transmission comprise? To cite just one example, would HIV transmission that occurred during breastfeeding attract criminal liability? According to some studies, breastfeeding may be responsible for one-third to one-half of HIV infections in infants and young children in Africa.[87] At the same time, according to current UN recommendations, infants should be exclusively breastfed for the first six months of life to achieve optimal growth and health.[88] Thereafter, "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended."[89] These decisions on infant feeding options involve a complex balancing of risks and benefits, and require the mother to be provided with accurate information on local assessments,

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[86] See Centre for Reproductive Rights, "Pregnant Women Living with HIV/AIDS: Protecting Huma Rights in Programs to Revent Mother-to-Child Transmision of HIV," Briefing Paper, August 2005, at www.reproductiverights.org/pdf/pub_bp_HIV.pdf .

[87] See De Cock, KM, Fowler MG, Mercier E et al. "Prevention of mother-to-child HIV transmission in resource-poor countries- Translating research into policy and practice," *JAMA* 283 (2000): pp. 1175-82.

[88] WHO, New data on the prevention of mother-to-child transmission of HIV and their policy implications. Conclusions and recommendations. WHO technical consultation on behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-agency Task Team on Mother-to-Child Transmission of HIV. Geneva, 11-13 October 2000. Geneva, World Health Organisation 2001, WHO/RHR/01.28.

[89] Ibid.

combined with counselling, care and support. The criminal law has no role to play in this process.

Third, fear that giving birth in a health care facility could expose women to criminal liability risks driving women away from health care facilities and particularly maternity care. Fourth, it is doubtful that criminal punishment of a mother could be in the best interests of her newly-born child.

Article 21(1) is highly problematic and should be removed.

Article 21(2) establishes criminal liability on anyone who "knowingly or recklessly" places another person at risk of HIV infection, unless the other person knew "that fact" (presumably, that person's HIV status) and accepted the risk. Pregnant women are specifically covered by this article. A number of observations are warranted:

- If criminal liability is applicable to these circumstances, it is appropriate that the law specify that: (i) the person must be HIV positive but also aware that they are HIV positive, and (ii) it is clear there is no liability if the other person knew the person's HIV status and voluntarily accepted the risk of HIV infection.
- It should be clarified that "place a person at risk" refers only to high-risk behaviour, such as vaginal or anal sex without a condom, not other sexual practices that are much lower-risk (e.g., oral sex without a condom).
- It should be clarified that using safer sex practices such as condom use, reduce the risk of HIV transmission to such an extent that criminal liability is not appropriate.
- It should be a prerequisite of criminal liability that the prosecution prove the PLHIV was aware of the risk of transmission through the sexual acts in question.
- A person should not be convicted of this offence if she or he lacked the power to determine whether or not to have unprotected sex ability and/or to disclose HIV infection to a sexual partner (e.g., because of the reasonable fear of violence in the circumstances).

Togo

Prohibition on unprotected sex: There are two provisions prohibiting sexual conduct that are unjustifiably overbroad as currently worded.

Firstly, Article 14 is a sweeping provision that imposes an obligation upon *all* persons in Togo to use male or female condoms "in all risky sexual relations." In effect, it makes any vaginal or anal sex without a condom an illegal act, regardless of the circumstances. For example, it mandates the use of condoms for all HIV-negative persons. This is an exceedingly extensive infringement of personal privacy and autonomy, as well as rights to establish a family in Article 10 of the *International Covenant on Economic, Social and Cultural Rights*. It should be deleted.

Secondly, Article 13 specifically targets HIV-positive persons, prohibiting them from any "unprotected sex" — regardless of whether they have disclosed their infection to a sexual partner who is consenting, regardless of the HIV status of their sexual partner, etc. It also ignores other circumstances that may determine the sexual conduct of PLHIV — for example, the woman who lacks control over her sexual relationship, including whether her husband or partner uses a condom, runs afoul of the law. And if she should become pregnant, this fact in itself would constitute proof that she has broken the law by having unprotected sex. By effectively making pregnancy illegal for HIV-positive women, this article infringes women's rights to security of the person, to liberty (if there is a penalty that involves deprivation of liberty), and the right to establish a family under ICESCR Article 10. There is also no definition of "unprotected sex" — does this term refer to vaginal or anal penetration without a condom? There is a risk that it could be interpreted more broadly, which would be an unjustifiable over-extension that disregards different levels of transmission risk. Article 13 also has an additional provision that prohibits any person who knows that she or he has HIV from engaging in "any behaviour likely to transmit the virus". This provision is even vaguer, and the term "likely" invites misinterpretation that extends the law to all sorts of conduct that does not carry a significant risk of transmission.

Criminal offences related to HIV transmission: Article 53 defines two criminal offences related to HIV transmission. The first of these is "dubious HIV/AIDS related medical practices that cause serious disability." This provision is very vague. If a medical practice causes serious disability, but is not "HIV/AIDS related", is there no criminal offence? How is a practice determined to be "dubious"? Greater clarity is needed here in the interests of fairness and predictability in the application of criminal sanctions. Is there existing criminal legislation, not specific to HIV, that would sufficiently address cases of serious medical malpractice that go beyond simple negligence and which amount to gross or serious negligence? If so, should it be the threshold for criminal liability?

The second provision says that it is a criminal offence for a person to have "unprotected sexual relations with the *intention* of transmitting the virus or any other activity to *wilfully* spread the virus". It is recommended elsewhere that there not be HIV-specific offences, so the best course of action would be to remove such a provision from the AIDS law. However, if a provision on criminal transmission remains in the law, it is appropriate that the application of criminal sanctions is limited to conduct that shows this high level of malicious intent, limiting the scope of the state's most serious legal tool and penalties to those cases which are clearly deserving of such treatment. If there is a risk that this provision could be misinterpreted or misapplied to a broader category of situations by police, prosecutors or courts, then it should be clarified that it is limited.

There are a few other concerns about the possible scope of activities that might be covered by this Article as it is presently exists. (1)It should be made clearer that, in the sexual context, the offence only exists if there is unprotected *vaginal or anal* sex (and there is no crime for other sexual acts that are lower risk, such as oral sex without a condom or other, even lower-risk, sexual acts). (2) There should be no criminal offence if

the PLHIV's sexual partner is aware of the person's HIV-positive status. (3) It should be a prerequisite of criminal liability that the prosecution prove the PLHIV was aware of the risk of transmission through the sexual acts in question. (4) A person should not be convicted of this offence if she or he lacked the power to determine whether or not to have unprotected sex ability and/or to disclose HIV infection to a sexual partner. And (5), the phrase "any other activity" is too broad, because it would impose criminal sanctions on an activity even if it carried no significant risk of transmission.

<u>Mandatory minimum sentences:</u> Article 67 raises a number of concerns, namely:

- This Article sets out the penalty for the offence of "unprotected sex with the intention of transmitting the virus", by any person who is aware that "he or she is a carrier of HIV".[90] It imposes a mandatory minimum penalty of at least 5 years' imprisonment. Mandatory minimum sentences, for any offence, raise human rights concerns by violating the fundamental sentencing principle of proportionality, which requires that a criminal sentence be not only proportionate to the gravity of the offence but also to the degree of responsibility of the offender, and should therefore take into account the circumstances of the individual case.

- In the case of a subsequent offence, or the offence of rape (just by an HIV-positive person?), the applicable penalty is life imprisonment. It is not clear if this is a minimum or a maximum penalty, although the wording of the next sentence suggests it is a minimum, because it further fetters the court's discretion by stating that, in the case of rape, "the judge may not grant extenuating circumstances nor give a suspended sentence." This compounds the human rights concern with a mandatory minimum sentence. In addition, it is not clear if the penalty of life imprisonment applies to just the offence of rape committed with the intent to transmit HIV, or to any rape by a person who is aware that she or he has HIV.

Finally, Article 67 (para. 2) also imposes a penalty of life imprisonment on "any individual who wilfully engages in an activity resulting in the transmission of HIV to another person." Again, this is an overly broad provision, as it criminalizes a person without regard to: (a) whether the person was even aware of the presence of HIV or the risk of transmission; (b) the risk associated with whatever activity is the basis of the criminal charge; (c) the degree of control of the accused person over the activity; and (d) other circumstances of the situation that might indicate criminal penalties are unjustified.

[90] It is preferable to avoid the stigmatizing term "HIV carrier" and to instead use a term such as "person living with HIV": *UNAIDS' Terminology Guidelines* (Geneva: UNAIDS, March 2007).

E. Women's rights

Background considerations and policy guidance

Women in sub-Saharan Africa are disproportionately affected by the HIV epidemic – increasingly so.[91] Of the 24 500 000 people living with HIV in Sub-Saharan Africa in 2005, 13 200 000 (57%) were women. This disproportionate impact is particularly evident among young people: the rate of HIV in sub-Saharan Africa is 4.3% among women ages 15-24, compared to 1.5% for men in the same age group. Three quarters of young people infected with HIV/AIDS in sub-Saharan Africa are women.

Benin had an estimated 87 000 people living with HIV in 2005 (56% of whom were women) and adult HIV prevalence estimated at 1.8%. Although Benin's epidemic appears to be stable with HIV prevalence ranging between 1.8% and 2.2% since 2003, prevalence among young women is almost three times as high as among young men.

Among sub-Saharan African countries, **Guinea** has relatively low HIV prevalence. Adult HIV prevalence was an estimated 1.5% in 2005. Of the approximately 85 000 people living with HIV, 53 000 were women. Young women are nearly three times as likely to be infected with HIV as young men, with a prevalence of 1.4% for young women and 0.5% for young men between 15 and 24.

HIV prevalence among adults in **Mali** ages 15-49 is 1.7%, with an estimated 110 000 people, 66 000 of them women, living with HIV. Prevalence among young women is estimated at 1.2%, while among young men it is 0.4%. According to UNAIDS, the HIV epidemic in Mali could be growing after having remained stable for many years, with HIV prevalence among pregnant women rising from 3.3% in 2002 to 4.1% in 2005. UNAIDS also noted that among 15–19 year-old pregnant women, HIV infection levels have risen from 2.5% in 2002 to 3.4% in 2005. They have likewise risen among those older than 35 years from 1.5% in 2002 to 4.5% in 2005. Based on data from Mali's Ministère de la Santé, UNAIDS observed the highest prevalence in the Ségou region, where 5.1% of pregnant women were found to be HIV-infected in 2005, -- "a reminder that serious, localized epidemics are under way in this large country".

Togo has an HIV prevalence of 3.2%. 61 000 of the 95 000 people living with HIV in that country are women. Among young people ages 15-24, there is a prevalence of 2.2% for women and 0.8% for men. UNAIDS has noted that "HIV data for Togo also point to a serious epidemic."

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[91] Prevalence data in this section are drawn from UNAIDS/WHO, *AIDS Epidemic Update: December 2006*, Annex 2: HIV and AIDS estimates and data, 2005 and 2003.

The imperative to address gender dimensions and inequality of women as part of global response to HIV/AIDS is well supported by international law and policy.

The *Convention on the Elimination of all Forms of Discrimination against Women* (CEDAW) calls on States Parties "to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women" (Article 2(f)) and "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (Article 5(a)).[92] CEDAW also calls for "States Parties [to] take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" (Article 12).

At the regional level, the *African Charter on Human and People's Rights* requires that "States shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[93]

Article 14 of the *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, notes:

> 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
>
> a) the right to control their fertility;
> b) the right to decide whether to have children, the number of children and the spacing of children;
> c) the right to choose any method of contraception;
> d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
> e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
> f) the right to have family planning education.

The 2001 UN General Assembly Special Session (UNGASS) *Declaration of Commitment on HIV/AIDS* emphasized the need to integrate the rights of women and girls into the global struggle against HIV/AIDS. It commits states to:

> 59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate

[92] *Convention on the Elimination of all Forms of Discrimination against Women* (CEDAW), G.A. Res. 34/180, U.N. Doc. A/34/46, entered into force September 3, 1981.

[93] Article 18(3).

> the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;
>
> 60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;
>
> 61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls.

The *International Guidelines* highlight the need for legislation addressing discrimination and violence against women. Guideline 8 of the *International Guidelines on HIV/AIDS and Human Rights* ("Women, children and other vulnerable groups") states that:

> Violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated. Positive measures, including formal and informal education programmes, increased work opportunities and support services, should be established… States should support women's organisations to incorporate HIV/AIDS and human rights issues into their programming… States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimise that risk, or to proceed with childbirth, if they do so choose.[94]

Analysis

Model Legislation on HIV/AIDS

The "Justification" to the model law lists, among others, the following principles among the "major aspects" of the proposed law:

- "the government shall vigorously address conditions which increase the transmission of HIV infection including poverty, gender inequality, traditional practices";
- "The government shall recognize the increasing vulnerability of women and children and take actions to address their specific needs."

[94] *International Guidelines*, para 9.

However, the model law does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection and more prone to experience adverse effects as a result of HIV infection.

Benin

Definition of gender and gender-specific approaches to HIV/AIDS: The Benin law is the only one of the laws under consideration that includes a definition of "gender". In this respect, the other laws under consideration should be revisited in light of the positive example of the Benin law and the discussion that follows.

According to one of the definitions found in Article 1, gender is "the recognition of the difference between a man and a woman, without implying a different treatment".

The term "gender" is frequently used without a clear definition. "Gender" has been referred to without a corresponding definition in the final documents of some UN World Conferences, numerous resolutions from the Commission on Human Rights, the Economic and Social Council and the U.N. General Assembly.[95] In this respect, the Benin law is to be commended for attempting to provide legal clarity in the use of the word. However the definition in the Benin law provides a misleading formulation of gender.

According to UNAIDS, "[t]he term 'sex' refers to biologically determined differences, whereas the term 'gender' refers to differences in social roles and relations between men and women."[96] Among UN agencies, the term is defined, although not always consistently, with a general emphasis on three similar points: i) "gender" is socially constructed; ii) the construction of "gender" is influenced by culture, the roles women and men are expected to play, the relationships among those roles, and the value society places on those roles; and iii) the content of "gender" can vary within and among cultures, and over time.[97]

One example of an institutional definition with an emphasis on gender as a social construct is provided by the World Health Organization. According to the WHO, gender

[95] V. Oosterveld, "The Definition of "Gender" in the Rome Statute of the International Criminal Court: A Step Forward or Back for International Criminal Justice," (2005) 18 *Harvard Human Rights Journal,* at 66-67. Oosterveld notes that the term "gender" was included in the 1995 Beijing Declaration and Platform for Action only after states agreed that the President of the Conference would make a statement indicating that the word "gender" as used in the Platform for Action was intended to be interpreted and understood "in [its] ordinary, generally accepted usage" and that "there was no indication that any new meaning or connotation of the term, different from accepted prior usage, was intended in the Platform for Action."

[96] UNAIDS, *UNAIDS' Terminology Guidelines*, 2007, p. 9.

[97] V. Oosterveld, at 66-68.

is "the economic, social and cultural attributes and opportunities associated with being male or female in a particular point in time." The WHO defines sex as "the biological characteristics which define humans as female or male."[98]

The definition of gender in the Benin law should be revisited in light of this definition.

In the Benin law, the word "gender" is found in Article 4 (paragraph 2), which requires that the physician (when notifying his or her patient of the results of an HIV test) use language that respects human dignity and an acceptance of the illness. The Article goes on to ensure that the physician's language must be "sensitive to gender issues, precise and understandable."

The recognition of gender in Article 4 is welcome, as it shows an attempt to recognise the need for gender-specific approaches to HIV/AIDS issues. However, it is unclear why sensitivity towards gender issues should be limited to the physician's language used regarding the notification of HIV test results. Following this welcome recognition of the importance of a gender-specific approach, sensitivity to gender issues should be expanded into other areas of the law. Even a cursory scan of the legislation reveals a number of potential areas where gender-specific approaches could be warranted, namely:

- In the counselling, psychosocial and medical support, etc., guaranteed to all PLHIV (Article2, paragraph 2-3; Article 11);
- Information on HIV/AIDS provided by the health care profession (Article 4, paragraph 5);
- Within the terms of the special HIV fund to combat HIV (Article 8, paragraphs 5-6).
- As part of any consideration of discrimination in the workplace, as women may face discrimination based on combined grounds of gender and real or perceived HIV status.[99]

The definition (Article 1) of vulnerable persons as "women, children and any other incapable persons" ("enfants, femmes, et toutes autres personnes incapables") should be amended so that it does not imply that women are under any legal incapacity.

The law from Benin uses gender-specific language. It would be preferable to revise the law to be gender-neutral.

Guinea

[98] World Health Organization, *Gender and Reproductive Rights Glossary*, 2007, available at http://www.who.int/reproductiv-health/gender/glossary.html

[99] For further analysis of how HIV legislation can reflect women's rights, see the analysis of the HIV bill in Senegal in Professeur Amsatou Sow-Sidibe, Etude Regionale Des Cadres Legaux Relatifs au VIH/sida, Dakar, October 2006, pp 24-25 (unpublished paper on file with author).

Definition of gender and gender-specific approaches to HIV/AIDS: As in the Benin law, Article 23 (paragraph 3) of the Guinean law requires that a physician (when notifying his or her patient of the results of an HIV test) use language that is "sensitive to gender issues, precise and understandable". However, a corresponding definition of gender is not provided in the Guinean law.

The law from Guinea uses gender-specific language. It would be preferable to revise the law to be gender-neutral.

Guinea-Bissau

The law of Guinea-Bissau is substantially the same as the model law. As noted above, this law does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection and more prone to experience adverse effects as a result of HIV infection.

The law from Guinea-Bissau uses gender-specific language. It would be preferable to revise the law to be gender-neutral.

Mali

The law of Mali does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection and more prone to experience adverse effects as a result of HIV infection.

The law from Mali uses gender-specific language. It would be preferable to revise the law to be gender-neutral.

Niger

The law of Niger does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection and more prone to experience adverse effects as a result of HIV infection.

The law from Niger uses gender-specific language. It would be preferable to revise the law to be gender-neutral.

Sierra Leone

The law of Niger does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection and more prone to experience adverse effects as a result of HIV infection.

The law from Sierra Leone uses gender-specific language (e.g. "“person living with HIV and AIDS” means a person whose test indicates that he is infected with HIV, but may not have developed AIDS” from Article 1). It would be preferable to revise the law to be gender-neutral.

Togo

The Protection of Women: The Togolese law is the only law of those under consideration that has a separate section (Chapter VI, Section 1) providing for “the protection of women.” Within this Section, Article 45 provides that “HIV/AIDS prevention, care and treatment programmes shall be established for the benefit of women”. From the perspectives of gender and women's rights, this provision is commendable.

In this respect, the other laws under consideration should be revisited in light of the positive example of the Togo law and the discussion that follows.

Ideally, HIV prevention programmes for women provided for in Article 45 should include information and education about legal and human rights.

Article 46 goes further than Article 45. It provides, “No risky behaviours shall be imposed on women. Women shall have the right to refuse unprotected sex, even in the case of a legally married couple.” The phrase “no risky behaviours shall be imposed on women” is vague (and “risky behaviours” is not defined in the law).

Article 46 has the commendable aim of providing legal protection for women (whether within or outside marriage) against sex without a condom. However, to avoid possible confusion, Article 46 requires amendment. All people have the right to refuse sex, regardless of whether condoms are used or whether the two people are married. Stating that “women shall have the right to refuse unprotected sex” may lead to the mistaken belief that women do not have the right to refuse protected sex. It needs to be emphasised that women (including married women) have the right to refuse sex regardless of whether a condom is used and also that they have the right to control the circumstances under which sex takes place, including by insisting up on condom use.

According to international criminal law, the definition of rape may be formulated as follows:

> A person who intentionally performs a sexual act including penetration, however slight:
> (a) of the vagina or anus of another person by the penis or any other part of the body of the accused or any other object used by the accused; or
> (b) of the mouth of the complainant by the penis of the accused;

where such an act occurs without the consent of the complainant is guilty of rape.[100]

It is relevant to note here that in many legal systems, rape within marriage was often considered lawful. The most commonly-cited reason for exempting marital rape from the crime of rape concerns the nature of marriage. The theory was that upon marriage, a woman gave blanket consent to sexual intercourse with her husband for the duration of the marriage.[101] From a human rights perspective, it is important to distinguish marriage vows from an agreement to engage in sexual intercourse at any time and under any circumstances.[102]

Criminalizing marital rape is consistent with international human rights standards. The UN General Assembly specifically identified marital rape as an act of gender-based violence in its 1993 *Declaration on the Elimination of Violence against Women*.[103] The United Nations Human Rights Committee has issued statements and recommendations to a number of countries urging them to take effective measures to combat marital rape and ensure that violence against women constitutes an offence punishable under criminal law.[104]

With respect to the Togolese law, it is interesting to note that a broad prohibition on sexual violence is found in the section dealing with "protection of children". Article 49 provides that "All sexual violence committed against a child is punishable." This wording is commendable. This Article should be revisited, so that similarly broad language should apply to the prohibition on sexual violence against women and indeed all persons. Togolese law should also specify penalties for marital rape.

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[100] See *Prosecutor v Furundzija* (1998), (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber) at para 179, and *Prosecutor v Kunarac* (2001), (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber) at para 391.

[101] The legacy of this theory at common law has been traced to a pronouncement by Lord Michael Hale, who was Chief Justice in England in the 17th century, that a husband cannot be guilty of rape of his wife "for by their mutual matrimonial consent and contract the wife hath given up herself in this kind unto the husband which she cannot retract." See D. Russel*, Rape in Marriage: Expanded and Revised Edition With a New Introduction*, (Bloomington and Indianapolis: Indiana University Press, 1990), page 17.

[102] D. Hubbard, "Making Rape in Marriage Illegal" Nambia's Legal Assistance Center, 1999.

[103] *Declaration on the Elimination of Violence against Women*. G.A. res. 48/104, 48 U.N. GAOR Supp. (No. 49) at 217, U.N. Doc. A/48/49 (1993). Article 2.

[104] Concluding Observations of the Human Rights Committee: Uzbekistan. 26/04/2001. CCPR/CO/71/UZB. Human Rights Committee, Seventy-first session. Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant. www.unhchr.ch/tbs/doc.nsf/0/537007e299bf539ec1256a2a004b86cb?Opendocument; See also: Concluding Observations of the Human Rights Committee: Greece. 25/04/2005. CCPR/CO/83/GRC. Human Rights Committee, Eighty-third session. Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant; Concluding Observations of the Human Rights Committee: Thailand.19/07/2005. CCPR/CO/84/THA. Human Rights Committee, Eight-fourth session. Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant; Report of the Human Rights Committee, Volume I, General Assembly, Official Records, Fifty-third Session, Supplement No. 40 (A/53/40).

F. Prisons

Background considerations and policy guidance

Except for those limitations that are demonstrably necessitated by the fact of incarceration, prisoners retain the human rights and fundamental freedoms set out in international human rights law.[105] It is a well-established principle that prisoners have the same right to protection of their physical and mental health, and to treatment of disease, of the same quality and standard as is afforded to those who are not imprisoned or detained.[106]

The *International Guidelines* make it clear that HIV programming in prisons should not be limited to merely providing information. They note:

> Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measure, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injecting equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.[107]

Three areas of law and regulation are particularly important to address HIV/AIDS in prison: (1) those that affect the likelihood and duration of time spent in prison, including time spent in pre-trial detention; (2) those that provide a legal foundation for HIV/AIDS care, treatment and support in prison; and (3) those that establish the legal basis of comprehensive HIV prevention services (such as the provision of safer sex materials, harm reduction services for prisoners who inject drugs while in prison, and programs to address sexual violence.)[108] WHO has issued useful and specific guidelines on HIV within prison settings, which should form the basis of any attempts to legislate on these issues.[109]

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[105] UN General Assembly (1990). *Basic principles for the treatment of prisoners*. G.A. Res. 45/111, UN Doc. A/45/49.

[106] UN General Assembly (1982). *Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment*. G.A. Res. 37/194, U.N.GAOR, 111th mtg., Annex, U.N. Doc. A/RES/37/194.

[107] *International Guidelines*, para. 21(e).

[108] These are discussed in greater detail in R. Pearshouse and J. Csete, “Model law to address HIV/AIDS in prison,” *International Journal of Prisoner Health* (2006) 2(3): 193-205.

[109] WHO (1993). *WHO guidelines on HIV infection and AIDS in prisons*.

Given that sexual relationships (both consensual and non-consensual) are common in prisons, the availability of safer sex materials helps prevent the spread of sexually transmitted infections and preserves the right to health of prisoners. As noted above, the *International Guidelines* recommend the availability of condoms as an important component in the prevention of HIV and the preservation of the rights of people living with HIV. Similarly, and consistent with the principle that prisoners should have the same access to health care and treatment as people outside prisons, WHO has recommended that condoms should be made available to prisoners throughout the span of their detention.[110]

Given the association of HIV and Hepatitis C (HCV) transmission with needle sharing, the availability of sterile injecting equipment implicates the right of prisoners to the enjoyment of the highest attainable standard of physical and mental health. Prison sterile syringe programs implemented in a number of countries have been effective in decreasing syringe sharing among prisoners using injection drugs, thereby decreasing the incidence of disease transmission among prisoners.[111] Sterile syringe programs ensure that the right to health of prisoners and prison staff is preserved, and, in jurisdictions where needle exchange programs are available outside of prisons, that prisoners are afforded the same access to health care and treatment as the general population.

Analysis

Model Legislation on HIV/AIDS

Article 8 provides for information on HIV to be provided "in the most appropriate way" in all prison institutions. It gives the Ministries of Justice, Interior and Health the power to implement this article.

Although it is implicit that certain details are to be established by subsidiary legal regulations, this article provides scant direction as to what such regulations should include. Prisons are highly controlled environments that often require explicit legal norms in order for particular services to proceed. It is worth noting that in order to be effective, information about HIV needs to be accompanied by the actual provision of materials to prevent HIV in prison settings, such as condoms and sterile injecting equipment.

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[110] Ibid.

[111] Lines, R., Jürgens, R. Betteridge, G., Stöver, H., Laticevschi, D., & Nelles, J. (2004). *Prison needle exchange: Lessons from a comprehensive review of international evidence and experience.* Canadian HIV/AIDS Legal Network; WHO (2006). *Effectiveness of interventions to manage HIV/AIDS in prison settings — needle and syringe programmes and bleach. Evidence for action technical paper.*

A number of international legal instruments address specifically the issue of the human rights of prisoners. The UN *Standard Minimum Rules for the Treatment of Prisoners* contain provisions directed at respecting the fundamental rights of prisoners and provides a set of guidelines designed to ensure respect for prisoners' rights, including adequate health care, treatment and living conditions.[112] The UN *Basic Principles for the Treatment of Prisoners* states that prisoners shall not be subject to discrimination on a variety of grounds, including health status, and that prisoners shall not have any human rights limited other than those necessarily limited by the fact of incarceration.[113] The *Basic Principles* also provide that prisoners shall have access to the medical and health services available in their country of incarceration without discrimination based on their legal status.[114] One consequence of this principle is the requirement of equivalence of health care, whereby prisoners have the right to receive health care, including preventative measures, equivalent to that available in the general community.[115] This approach to health care and human rights is supported in the World Health Organization's (WHO) *Guidelines on HIV Infection and AIDS in Prisons*, which outline principles relating to (a) prisoners' right to access to health care and (b) implementing HIV prevention strategies in prisons.[116]

According to the *International Guidelines*,

> Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.[117]

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[112] UN, *Standard Minimum Rules for the Treatment of Prisoners,* Adopted by the First United Nations Congress on The Prevention of Crime and the Treatment of Offenders, Geneva, 1955. Articles 22 through 26 set out basic minimum access to health care and treatment for prisoners, including the availability of medical officers and access to hospitals.

[113] UN *Basic Principles for the Treatment of Prisoners,* UN General Assembly. Resolution 45/111 of 14 December 1990, art. 2 and 5.

[114] UN *Basic Principles for the Treatment of Prisoners,* art. 9.

[115] This position has widespread acceptance by United Nations organizations and member states. See, for example, WHO, *WHO guidelines on HIV infection and AIDS in prisons,* 1993, principle 1; Council of Europe, Committee of Ministers, Recommendation No. R (98) 7 Concerning the ethical and organizational aspects of health care in prison, principle 10; UN *Basic Principles for the Treatment of Prisoners*, principle 9; UN General Assembly, *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees from Cruel, Inhuman or Degrading Punishment or Treatment,* Resolution 37/194 of 18 December 1982, Principle 1.

[116] WHO *Guidelines on HIV Infection and AIDS in Prisons*, WHO/GPA/DIR/93.3, 1993.

[117] *International Guidelines*, para 21(e).

Benin

The law ignores the issue of HIV in prisons. This should be revised in light of the commentary above.

Guinea

Article 9 is substantially similar to the model law. See discussion above.

Guinea-Bissau

Article 7 is substantially identical to the model law. See discussion above.

Mali

Article 8 is substantially similar to the model law. See discussion above.

Niger

Article 7 provides that a number of categories of people will receive information about the mode of HIV transmission, the means of prevention, care, the consequences of HIV infection and the rights and obligations of PLHIV. Prisoners are one such category of people.

The limitation of such an approach- providing information on HIV but not the actual means to prevent it- is found in the discussion in the model law section.

Sierra Leone

Article 2(2) provides that a number of categories of people will receive educational and information campaigns on HIV/AIDS. One such category is "in prisons, remand homes and other places of confinement."

The limitation of such an approach- providing information on HIV but not the actual means to prevent it- is found in the discussion in the model law section.

Togo

Section 3 of Chapter V contains a number of provisions relating to HIV within prisons. Article 42 provides that "HIV/AIDS prevention, care and treatment programmes shall be guaranteed to the prison population." This wording is broader than the corresponding provisions on prisons from the other laws under consideration, and explicitly raises the possibility of HIV prevention services in prisons. It is to be hoped that such an approach is maintained in the practical application of the law. Other provisions include: the explicit prohibition of mandatory HIV testing in prisons ("except when ordered by the judge as part of a judicial procedure"); "no discriminatory or segregatory [sic] measures" against PLHIV in prisons; the provision for the possibility of compassionate release (either on parole or by commuting their sentences); and the provision of psychosocial and medical care for people living with HIV/AIDS. These provisions are welcome.

In these respects, the other laws under consideration should be revisited in light of the positive example of the Togo law and the discussion that follows.

G. Other vulnerable groups

Background considerations and policy guidance

According to the *International Guidelines*,

> Depending on the nature of the epidemic and the legal, social and economic conditions in each country, groups that may be disproportionately affected include women, children, those living in poverty, minorities, indigenous people, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users- that is to say groups who already suffer from a lack of human rights protection and from discrimination and/or are marginalized by their legal status.[118]

In some cases, the laws under consideration provide definitions of vulnerable persons. With the main exception being the law from Togo, few of the laws under consideration provide for programmes and interventions directed towards such persons. This issue should be revised in national legislation, in light of the recommendations in the *International Guidelines* and the example of the law from Togo.

More importantly, in each jurisdiction, the legislation under consideration in this paper is only one particular law among the many that address issues related to the HIV epidemic. In order to accurately review the inter-relationship of HIV and the law, a review of law and HIV should not be limited to simply the national HIV law (where such laws exist). The broader legislative framework of each country under consideration is beyond the scope of this paper. It is nevertheless crucial to recognise that other laws, in addition to national HIV laws, should be reviewed in the context of the epidemic.

Such an observation is particularly true with respect to vulnerable persons. The *International Guidelines* provide some points of reference for other laws that should be reviewed in the context of the epidemic.

Among those vulnerable persons identified in the laws under consideration, there is almost no recognition of men who have sex with men. Such an observation is even more relevant given recent research showing elevated rates of HIV infection among men who have sex with men (MSM) in western Africa.[119]

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[118] *International Guidelines*, para 97.

[119] For example, one paper reported an HIV prevalence rate of 21.5% among a cohort of men who have sex with men in Senegal. See A.S. Wade et al., "HIV infection and sexually transmitted infections among men who have sex with men in Senegal," *AIDS* 2005 (19): 2133-2140.

On the issue of laws relating to men who have sex with men (and other persons vulnerable to sexual transmission), the *International Guidelines* note that:

> Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.

On the issue of people who inject drugs, the *International Guidelines* state:

> Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider:
>
> - the authorization or legalisation and promotion of needle and syringe exchange programmes;
> - the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes.

A number of recent national HIV laws from around the world, including from African countries, have including specific reference to harm reduction programmes, including needle and syringe exchange programmes.[120] These are absent from the laws under consideration.

With regard to adult commercial sex work, some of the more problematic provisions targeting sex workers are discussed above in the section on testing and criminal law. More generally, the *International Guidelines* recommend:

> With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.

Analysis

Model law

In Article 1, "HIV risk behaviour" is defined as "frequent participation of a person in activities that increase the risk of transmission or acquisition of HIV".

[120] The framework for sterile syringe programs in Tasmania (Australia) is set out in the *HIV/AIDS Preventative Measures Act* 1993 (Tasmania), No.25 of 1993, part 3. Vietnam's *Law on the Prevention and Control of HIV/AIDS* (2006) calls for the implementation of harm reduction measures (art. 21) which, according to the definition (art. 2.15), include "promotion of the use of … clean needles and syringes". The *HIV and AIDS Preventative Measures Act* 2006 of Mauritius provides for syringe and needle exchanges in Articles 15-17.

According to Article 17 of the French version of the model law, “L’État prendra toutes les dispositions pour encourager le test volontaire aux individus à haut risqué d’infection à VIH” (“The Government shall take all necessary measures to promote voluntary HIV testing of people at high risk of infection”). The English version is considerably different, stating: “The Government shall take all the necessary measures to ensure the provision of VCT services and encourage their use.”

There is no further detail on vulnerable persons, nor programmes to be directed towards them.

Benin

As noted above, the definition of “vulnerable persons” (Article 1) as “women, children and any other incapable persons” (“enfants, femmes, et toutes autres personnes incapables”) should be amended so that it does not imply that women are under any legal incapacity.

Article 13 provides that “The State shall take all necessary arrangements to make compulsory the medical care of people who are at an elevated risk of HIV transmission, who are commercial sex workers, homosexuals, injection drug user, and to encourage voluntary HIV testing.” This provision is ambiguous. If the intent is to prevent health care workers from discriminating against those who are at a greater risk of HIV infection, then it is welcome. However, if the intent is to provide for compulsory medical treatment of such groups, these would be a gross violation of the human rights of individual members of such groups. The implementing legal instrument should clarify this ambiguity.

Guinea

There is no detail on vulnerable persons, nor programmes to be directed towards them.

Guinea-Bissau

The law from Guinea-Bissau is based on the model law. See comments above.

Mali

There is no detail on vulnerable persons, nor programmes to be directed towards them.

Niger

Article 1 provides the definition of "vulnerable persons" as "Persons who are in a socio-economic and cultural disadvantage, increasing the risk of HIV/AIDS infection."

Despite this definition, the law doesn't use the terminology of vulnerable persons. In Article 12, the law provides that "The Government shall promote and encourage voluntary testing, particularly among individuals with risky behaviour, pregnant women and their partners, future married couples, the partners of infected people, the parents of infected children as well as the children of infected parents."

Sierra Leone

There is no detail on vulnerable persons, nor programmes to be directed towards them.

Togo

While the Togolese law does not provide an actual definition of vulnerable persons, chapter VI of the Togo law addresses "The protection of individuals vulnerable to HIV/AIDS". In general, the Togolese law shows the greatest awareness of vulnerable persons from among the laws under consideration. With some important exceptions (noted below), such an approach is welcome.

As mentioned above, there are two articles on "the protection of women, a section addressing women and a section describing "protection of other people at risk." The law provides for HIV/AIDS prevention, care and treatment programmes "for the benefit of women".

The problems with Article 46 are discussed above, under the section on women's rights.

Articles 47-49 provide that HIV/AIDS prevention, care and treatment programmes shall be provided for the benefit of children and that "All sexual violence against children is punishable."

Article 50 provides for periodic mandatory testing of sex workers for HIV and sexually transmitted diseases. The problems with this approach are discussed above, under the section on HIV testing. Article 51 provides that "HIV/AIDS and STI prevention, care and treatment programmes shall be regularly established for the benefit of commercial sex workers."

Article 52 extends “the programmes mentioned in the preceding article” (which, if it is not a drafting error, is the article on programmes for commercial sex workers) to other people at risk (which are listed as including teachers, truck drivers and soldiers.)