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The HIV/AIDS Pandemic and Human Rights: A Continuum Approach

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*Ellen M. Walker**

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I. INTRODUCTION

The pandemic of the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) has generated a global human rights crisis.[1] Despite evidence showing that protecting human rights helps prevent the transmission of HIV and reduce the impact of HIV/AIDS, fundamental rights continue to be violated.[2] There is a two-way causal relationship between HIV/AIDS and states' related human rights violations, complicated by the need for international cooperation. While many would agree that HIV/AIDS adversely impacts rights, there lacks a common understanding of how states must apply existing international human rights protections vis-à-vis HIV/AIDS. The international community is insufficiently aware of the many rights currently being violated, the cumulative effect of these violations, and how, together, they truly constitute a global human rights crisis that will likely exist for some time.

This Article tries to draw attention to some of these major issues and challenges and suggests ways that international human rights law can be used to help. In Part II, the author provides an introduction to the HIV/AIDS crisis. To understand the human rights crisis, one must first understand some basic concepts of the pandemic. It is submitted that, in order adequately to protect human rights, human rights lawyers and policymakers should adopt a broader, interdisciplinary approach to understanding vulnerability and access to relevant resources. In Part III, the author sketches some key international developments providing

1. *See* UNAIDS & OHCHR, *International Guidelines on HIV/AIDS and Human Rights (2006 consolidated version),* U.N. DOC. HR/PUB/06/09 (2006) [hereinafter *Guidelines*], http://www.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf., at 15, ¶ 8: "HIV continues to spread throughout the world at an alarming rate. The widespread abuse of human rights and fundamental freedoms associated with HIV has emerged in all parts of the world in the wake of the epidemic." *See also* David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy,* 17 HARV. HUM. RTS. J. 99, 134 (2004). For an introduction to HIV/AIDS and impacted human rights, see also UNWorks, Lesson Plan on HIV/AIDS, *available at* http://www.un.org/works/goingon/lessonplan_hivaids.html (last visited Dec. 12, 2007).

2. Fidler, *supra* note 1, at 134 n.197.

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necessary context for understanding HIV/AIDS and human rights today. These developments all recognize the need to protect human rights in light of HIV/AIDS. In addition, in Part III, it is submitted that states' existing human rights obligations, concerning a range of rights, constitute proper grounds for compulsory licensing of pharmaceutical patents. In Part IV, the author suggests a conceptual approach to the human rights crisis. Unfortunately, this crisis will likely exist for many years to come; thus, the model proposed here is meant to offer human rights lawyers a point of departure for grasping the crisis, their role in it, and the need for a greater immediate response to document violations and to protect human rights. In addition, this approach indicates a wider range of possible human rights responses than those undertaken to date. In Part V, the author applies this framework to examine the international protection of a few impacted human rights vis-à-vis HIV/AIDS under the major human rights treaties.

II. THE HIV/AIDS PANDEMIC

As demonstrated by the most recent statistics compiled by the Joint U.N. Programme on HIV/AIDS,[3] HIV/AIDS represents a massive threat to human life.[4] Since the first AIDS diagnosis in 1981, an estimated twenty-five million people have died of AIDS, worldwide, and about 65 million people have been infected.[5] Sub-Saharan Africa is shockingly disproportionately affected. Despite the fact that sub-Saharan Africa is home to only about 10% of the world's population,[6] it is home to about two-thirds of the estimated 38.6 million people currently infected with HIV worldwide (24.5 million people).[7] Of the new infections that occurred in 2005, about two-thirds (2.7 million out of the global 4.1 million total) occurred in sub-Saharan Africa.[8] In addition, about 71% of the global 2.8 million deaths that occurred in 2005 occurred in sub-Saharan Africa; that is to say, 2.0 million people died of AIDS there in 2005.[9] Thus about 5,480

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3. The Joint U.N. Programme on HIV/AIDS (UNAIDS) comprises ten U.N. system organizations: the Office of the U.N. High Commissioner for Refugees, the U.N. Children's Fund, the World Food Programme, the U.N. Development Programme, the U.N. Population Fund, the U.N. Office on Drugs and Crime, the International Labour Organization, the U.N. Educational, Scientific and Cultural Organization, the World Health Organization (WHO), and the World Bank.

4. *See* UNAIDS, *2006 Report on the Global AIDS Epidemic* (June 2006) [hereinafter UNAIDS, *2006 Report*], http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

5. *Id.* at 4.

6. *Id.* at 15.

7. *Id.* at 8 & 15.

8. *Id.*

9. UNAIDS, *2006 Report*, *supra* note 4, at 8 & 15.

people are dying in this region, each day of AIDS. By comparison, in all of North America, "only" 1.3 million people are currently infected and eighteen thousand people died of AIDS in 2005.[10]

The UNAIDS 2006 Report on the Global AIDS Epidemic illustrates problems of significant magnitude in other regions as well. In Asia, an estimated 8.3 million people are living with HIV, and 930,000 people were newly infected in 2005.[11] The 2006 Report notes, "[t]he epidemics in eastern Europe and central Asia continue to expand."[12] It estimates the number of people living with HIV there to be 1.5 million in 2005—"a twenty-fold increase in less than 10 years."[13] In addition, almost twice as many people died in 2005 as did in 2003, that is to say, about 53,000 people; and, there were an estimated 220,000 new infections in 2005.[14]

Clearly, "[i]t is difficult to grasp the implications of the collective global experience of AIDS. Attempts to quantify the losses cannot reflect the true human struggles and tragedies reflected by each individual."[15] However, international human rights law, which traditionally aims to improve collective and individual well-being, offers a framework for trying to understand the global and individual implications of the pandemic.

A. *Understanding the HIV/AIDS Pandemic*

HIV/AIDS is at once a global problem and one quite specific to local conditions. Within regions, the epidemic can vary by country, province, state or district.[16] Low prevalence percentages can thus be misleading, since (1) even countries with a lower prevalence percentage can have areas, or groups, in crisis; (2) some places that report low prevalence percentages may have a high amount of stigma and discrimination, and inadequate testing; (3) lower prevalence can result from higher numbers of deaths; and (4) countries with extremely large populations, as in Asia, can a have lower prevalence percentage but still a huge number of infections.

It is submitted that, before human rights lawyers and policymakers can ascertain states' obligations under international human rights law, they

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10. *Id.* Annex II, HIV and AIDS Estimates and Data, 2005 and 2003, at 529 & 532.

11. *Id.* at 13.

12. *Id.* at 33.

13. *Id.* at 33-34.

14. UNAIDS, *2006 Report*, *supra* note 4, at 13 & 34.

15. Mark E. Wojcik, *Global Aspects of AIDS*, *in* AIDS AND THE LAW 443, 448 (David W. Webber ed., 3d ed. 1997).

16. *See, e.g.*, UNAIDS, *2006 Report*, *supra* note 4, at 15 (noting variation of HIV prevalence "between and within subregions and countries").

must attempt to understand two key points concerning the HIV/AIDS pandemic and its local characteristics. First, as just noted, statistics can be misleading. Second, and perhaps even more important, it is crucial to understand that, globally, many factors affect any given individual's risk of infection and his or her chances for access to relevant resources. Such factors include, e.g., international developments, national responses, local customs, family structures, and interpersonal relationships. Human rights lawyers must ask: to what extent are states responsible for controlling such factors affecting individuals' and groups' risk of contracting HIV and access to needed resources?

B. *Vulnerable Groups*

An epidemic can vary not only between areas marked by political boundaries, but also between groups otherwise defined. Pre-existing social, legal and economic inequalities contribute significantly to the impact of HIV/AIDS on certain groups. Those most at risk of HIV infection and its adverse effects are often "those people who before the arrival of HIV/AIDS were marginalized, stigmatized and discriminated against[.]"[17] In 1998, UNAIDS and the U.N. Office of the High Commissioner for Human Rights (OHCHR) published the International Guidelines on HIV/AIDS and Human Rights (Guidelines),[18] which includes a section on international human rights obligations and HIV/AIDS (§ III). Section III gives examples of disproportionately affected, marginalized groups, who often have disproportionately high prevalence within national populations:

> [G]roups that may be disproportionately affected include women, children, those living in poverty, minorities, indigenous peoples, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users—that is to say groups who already suffer from a lack of human rights protection and from discrimination and/or are marginalized by their legal status. Lack of human rights protection disempowers these groups to avoid infection and to cope with HIV/AIDS, if affected by it.[19]

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17. David Patterson & Leslie London, WHO, *International Law, Human Rights and HIV/AIDS*, 80 BULL. WHO 964, 964 (2002).

18. *Guidelines*, *supra* note 1.

19. *Id.* § III, International Human Rights Obligations and HIV/AIDS, ¶ 97. *See also* Wojcik, *supra* note 15, at 445-46. Wojcik explains:

Some marginalized populations may be unaware that, based on municipal or international laws, their states owe them human rights protections. More generally, the status of international human rights law is also a problem in many jurisdictions.

African Americans are disproportionately affected in the United States: although this group constitutes approximately 12% of the U.S. population, in 2005, African Americans accounted for "50% of new HIV diagnoses in the 35 areas with long-term, confidential name-based HIV reporting."[20] In Canada, indigenous peoples comprised 3.3% of the population in 2001; yet, in 2002, they comprised about 14% of people living with AIDS among those whose ethnicity was known.[21] Since then, Canada's Centre for Infectious Disease Prevention and Control has continued to find Aboriginal peoples to be over-represented in the epidemic.[22] Over half (51.7%) of AIDS cases in this group were estimated to be in injecting drug users in 2003.[23] The epidemic affects Aboriginal women more than other women: females comprised 45% of reported HIV results among Aboriginal peoples, compared to 20.0% among others.[24] Aboriginal peoples are also infected at a younger age.[25]

Individuals with disabilities are also vulnerable to HIV/AIDS, as indicated by a joint study of 57 nations done by Yale University and the World Bank.[26] Disabled people, who "are among the poorest, most

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> In analyzing the global data, it emerges that this infection has spread alarmingly among the dispossessed, however one chooses to define them. AIDS is disproportionately a disease of those at greatest risk of discrimination: women, homosexuals, drug users, the poor, the homeless, refugees, immigrants, sex workers, people of color, the young, and generally people living in developing nations. Wherever there are difficulties in determining one's destiny, it can be argued that possible exposure to HIV is increased.

Id.

20. UNAIDS, *2006 Report*, *supra* note 4, at 46.

21. *Guidelines*, *supra* note 1, at 32.

22. CTR. FOR INFECTIOUS DISEASE PREVENTION AND CONTROL, PUB. HEALTH AGENCY OF CAN., HIV/AIDS EPI UPDATE 32 (2003), *at* http://www.phac-aspc.gc.ca/publicat/epiu-aepi/hiv-vih/pdf/epiact_0403_e.pdf [hereinafter *2005 Epi Update*], *cited in* Joanne Csete, *HIV/AIDS and Human Rights: We've Only Just Begun*, 10 HIV/AIDS POL'Y & LAW REV. 1, 8 (2005), http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1139.

23. *Id.* at 53-54.

24. *Id.* at 57.

25. *Id.* at 58-59.

26. The World Bank, Disability & HIV/AIDS [hereinafter *Disability & HIV/AIDS*], http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONAND POPULATION/EXTPHAAG/0,,contentMDK:20655822~menuPK:1314766~pagePK:64229817 ~piPK:64229743~theSitePK:672263,00.html (last visited Aug. 18, 2007).

stigmatized and most marginalized of all the world's citizens[,]"[27] are an equal or greater risk of HIV infection as are those who are not disabled.[28] According to the same study, all individuals with disabilities are at risk of HIV infection, but subgroups within the disabled population face a greater risk, including women, members of ethnic and minority communities, adolescents, and those who live in institutions.[29] In this way, one can see the adverse impact of belonging to more than one vulnerable group. "Poverty and social sanctions against marrying a disabled person mean that disabled women, in particular, are likely to become involved in a series of unstable relationships. They are often targeted by abusers who assume they are non-sexual and therefore safe."[30] Such assumptions about presumed safety actually increase risk for these and other groups.[31] Disabled women who do choose to confront HIV have difficulty accessing services, with distant testing centers and wheelchair-inaccessible buses.[32]

Thus, there are increased challenges in the effort to prevent HIV and provide health care services for disabled people.[33] However, the Supreme

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27. *Id.*

28.

> Too often, individuals with disability have not been included in HIV prevention and AIDS outreach efforts because it is assumed that they are not sexually active and at little or no risk for HIV infection .... Individuals with disability have equal or greater exposure to all known risk factors for HIV infection. For example, adolescents and adults with disability are as likely as their non-disabled peers to be sexually active. Homosexuality and bisexuality appear to occur at the same rate among individuals with disability as among the non-disabled. Individuals with disability are as likely as non-disabled people to use drugs and alcohol .... Men and women with disabilities are even more likely to be victims of violence or rape, although they are less likely to be able to obtain police intervention, legal protection or prophylactic care ....

Id.

29. Tafi Murinzi, *Zimbabwe: Disabled at Greater Risk of HIV Infection*, INTER PRESS SERV., May 24, 2005, http://www.aegis.com/ news/ips/2005/IP050508.html.

30. *Id.*

31. *See* COMM. ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, *Concluding Observations of the Comm. on the Elimination Against Women: United Republic of Tanzania*, ¶ 206, ¶ 213, U.N. DOC. A/53/38/Rev.1 *July 10, 1998) [hereinafter COMM. ON ELIMINATION OF DISCRIMINATION: *Tanzania*].

32. Murinzi, *supra* note 29.

33.

> Even when AIDS messages do reach disabled populations, low literacy rates and limited education levels complicate comprehension of these messages. The global literacy rate for adults with disability is as low as 3%, and 1% for women with disability[.]. . . But even literacy may not overcome all obstacles; HIV messages and communication are often inaccessible to people who are blind or deaf, and

Court of Canada, for one, has addressed the issue of disabled people's right to equal access to health services.[34] In *Eldridge v. British Columbia (Attorney General)*, the Court found that the right to equality, enshrined in Article 15(1) of Canada's Charter of Rights and Freedoms, requires that deaf persons have access to publicly-funded sign language interpretation in order to access medical services; because hospitals exercise a specific governmental objective, they must conform with the Charter.[35] Such an approach indicates how equality, and, one could say, the indivisible right to health, can be interpreted vis-à-vis people vulnerable to, or impacted by HIV/AIDS.

Members of the military can be a vulnerable group.[36] There, recent UNAIDS research indicates that the increased risk results from the high numbers of the age group at greatest risk (15-24 years), a military ethos encouraging risk-taking, and the purchase of sex.[37] Thus, one must consider that vulnerable groups interact, increasing risk for both groups.

Women especially are disproportionately affected.[38] The WHO reports a host of contributing factors, e.g.: women's lack of control over their own sexuality and sexual relationships; poor reproductive and sexual health; neglect of health needs, nutrition, and medical care; lack of clinical studies based on women; all forms of coerced sex; harmful cultural practices; more stigma and discrimination regarding HIV as compared to men; less

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> health service facilities are often not accessible to people with physical disabilities. There are few rehabilitation services, especially in rural areas. It is estimated that only 3% of all disabled individuals get the rehabilitation services they need. . . . Finally, disabled individuals in many countries report being turned away when they are able to reach HIV testing centers or AIDS clinics. Frequently, disabled people report that they are told to go home by clinical staff, who assure them that disabled people "cannot get AIDS". Where AIDS medications are scarce and where services and support for individuals with HIV or AIDS are limited, individuals with pre-existing disabilities report being placed last on the list of those entitled to care.

Disability and HIV/AIDS, *supra* note 26.

34. Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624, *available at* http://www.escr-net.org/usr_doc/ EldridgeDecision.doc.

35. *Id.* ¶¶ 50-52, 79-80.

36. *Botswana: Anti-Aids Drugs for Armed Forces*, U.N. INTEGRATED REGIONAL INFORMATION NETWORKS, Mar. 10, 2005 [hereinafter IRIN], http://www.aegis.com/news/IRIN/2005/IR050342.html. IRIN news reports cited throughout this article can be accessed at IRIN Humanitarian News and Analysis, http://www.irinnews.org.

37. *Id.*

38. *See A Dose of Reality: Women's Rights in the Fight Against HIV/AIDS*, HUM. RTS. WATCH, Mar. 21, 2005, http://hrw.org/english/docs/2005/03/21/africa10357.htm (describing various abuses of the rights to dignity, equality, security of person, property, and health in Uganda, Kenya, Zambia, and South Africa).

access to education for prevention; sexual abuse; increased problems related to disclosure of serostatus, partner notification, and confidentiality, and lack of access to care and support.[39]

Continuing with an overview of some vulnerable groups, sex workers are a vulnerable group. Like the poor in general, male and female sex workers tend to be stigmatized. The Canadian HIV/AIDS Legal Network describes the demonization and abuse impacting sex workers' human rights: criminalization; violence; police brutality and exploitation; children's decreased access to education; decreased access to health care; and a view of women as "carriers," "vectors," and "core transmitters."[40] The latter results in moral and judgmental attitudes, i.e., that AIDS is an impure disease affecting immoral persons.[41] Such judgments can skew policy interventions to unfairly target and penalize sex workers.[42]

Vulnerable groups can comprise a large percentage of a country's population, as in Nigeria, Swaziland, and Zimbabwe. In Nigeria, the vulnerability of youth, with 60% of the population under twenty-four, creates an enormous challenge.[43] In Swaziland, 47.7% of women, forming a quarter of the total population, are of childbearing age—a highly vulnerable group there, especially younger women.[44] In Zimbabwe, drought, international isolation, drastic land reform, and HIV/AIDS are increasing the numbers and size of vulnerable groups.[45]

C. *Factors Affecting Vulnerability*

To understand factors affecting vulnerability requires interdisciplinary approaches. From a public health perspective, a risk factor can be defined

39. *Human Rights, Women and HIV/AIDS*, WHO Fact Sheet No. 247, June 2000, http://library.unesco-iicba.org/English/HIV_AIDS/ cdrom%20materials/human%20rights.htm. *See also* Gillian McNaughton, *Womens Human Rights Related to Health-Care Services in the Context of HIV/AIDS* (WHO, Health and Human Rights Working Paper Series No. 5, 2004), http://www.who.int/hhr/information/en/Series_5_womenshealthcarerts_MacNaughtonFINAL.pdf.

40. Meena Saraswathi Sexhu & Joanne Csete, *Still Underground: Searching for Progress in Realizing the Human Rights of Women in Prostitution*, 9 HIV/AIDS POL'Y & LAW REV., 1, 8-10 (2004), http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=201.

41. *Id.* at 10.

42. *See* LAWRENCE O. GOSTIN, THE AIDS PANDEMIC: COMPLACENCY, INJUSTICE, AND UNFULFILLED EXPECTATIONS 72-77 (2004).

43. UNAIDS, Nigeria: Country Situation Analysis (2004), http://www.unaids.org/en/Regions_Countries/Countries/nigeria.asp (last visited Aug. 12, 2007); Nigeria, SIECUS PEPFAR COUNTRY PROFILES: FOCUSING IN ON PREVENTION AND YOUTH, 99, http://www.siecus.org/inter/pepfar/Nigeria.pdf.

44. UNAIDS, *UNAIDS at Country Level—Progress Report*, at 90, U.N. Doc. UNAIDS/04.35E (Sept. 2004) [hereinafter UNAIDS, *Country Level*], http://data.unaids.org/Publications/IRC-pub06/JC1048-CountryLevel_en.pdf.

45. *Id.* at 98.

as:

> an aspect of someone's behaviour or lifestyle, a characteristic that a person was born with, or an event that he or she has been exposed to that is known to be associated with a health-related condition. A *behavioural* risk factor describes a specific behaviour that carries a proven risk of a particular outcome.[46]

Specifically, some public health scholars examine the pandemic, and factors affecting risk, from a "social epidemiology" perspective, i.e., they examine how human behavior affects risk and interacts with the spread of disease. This means that, whereas the group at greatest risk in one community could be girls from ages fifteen to nineteen, in another community, it could be men over the age of fifty.[47] This approach involves trying to understand patterns of human behavior, which can be specific to place. For example, cultures that keep women subservient while proscribing open discussion of issues related to sex,[48] and the frequency of multi-partner sexual relations without condoms,[49] affect risk. Even in cultures in which condoms are available and commonly used, and sex is more openly discussed, generation gaps and social norms can put older women and men (married, divorced or widowed) and their partners at increased risk.[50]

Other factors contributing to disease emergence and spread are, according to a 1992 study by the U.S. Institute of Medicine: human demographics and behavior; technology and industry; economic development and land use; international travel and commerce; microbial adaptation and change; and breakdown of public health measures.[51] The same institute subsequently identified seven other factors: human susceptibility to infection; climate and weather; changing ecosystems; poverty and social inequality; war and famine; lack of political will; and

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46. *2005 Epi Update*, *supra* note 22, at 118.

47. Interview with Dr. Shingai A. Feresu, MPH, Ph.D., Assistant Professor Epidemiology, Ann Arbor, MI, Nov. 10, 2001. The author thanks Dr. Feresu for this explanation, and notes that the fault for any error lies with the author.

48. *Namibia: New Hope for Caprivi with Launch of AIDS Treatment*, IRIN, Oct. 15, 2004 [hereinafter *Namibia*], http:// www.aegis.com/news/irin/2004/IR041068.html.

49. UNAIDS, *Country Level*, *supra* note 44, at 110.

50. Fidler, *supra* note 1, at 102-03 (citing COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH, INSTITUTE OF MEDICINE, EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE U.S. (Joshua Lederberg et al. eds., 1992)).

51. *Id.* at 103 (citing COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH, INSTITUTE OF MEDICINE, EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE U.S. (Joshua Lederberg et al. eds., 1992)).

intent to harm.[52] Some of these factors can also be called "social determinants of health[.]"[53]

It is submitted here that human rights lawyers and policymakers need to understand more broadly the concepts of risk factors and factors affecting access to resources, to determine state responsibility for HIV/AIDS-related human rights violations. In addition to the factors commonly studied by public health, or "health and human rights" scholars, many other factors affect individuals' and groups' risk of infection and access to resources. Such factors need to be understood to improve states' protection of human rights vis-à-vis HIV/AIDS. State action or inaction with regard to risk factors and access to relevant resources can affect and constitute human rights violations.

Geographic and environmental factors affect transmission. Human rights lawyers should increase cooperation with environmental scholars attempting to understand the interplay between land, communities, and health. Examples of geographic and environmental factors are: dense human populations; roads; the location of cash crops, the timing of their harvests, and use of trade routes; seasonal changes in the weather and corresponding migrant agriculture and fishing, and even a popular conception that a particular area has a low prevalence.[54] When the latter is combined with economic disadvantage (as is often the case for remote areas), certain groups, including children, can be at increased risk of human trafficking and sex work, and at increased risk of infection.[55] Thus, human behavior and geography can combine to increase risk.

Assumptions about safety, which serve to increase risk, can thus be based on a person's membership in one or more groups, including being disabled, age, sex, or geographic location, or other factors. For example, young girls can be victims of violence because of their presumed serostatus: "Young girls were particularly vulnerable to sexual abuse, as men believed there was less risk of contracting HIV/AIDS from them,

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52. *Id.* (citing COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH IN THE 21ST CENTURY, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, MICROBIAL THREATS TO HEALTH: EMERGENCE, DETECTION, AND RESPONSE 23-51 (Mark S. Smolinksi et al. eds., 2003) [hereinafter INSTITUTE OF MEDICINE 2003]).

53. *Id.* at 104-05 (citing INSTITUTE OF MEDICINE 2003, *supra* note 52, at 54).

54. COMM. ON ELIMINATION OF DISCRIMINATION: *Tanzania*, *supra* note 31.

55. *See, e.g.*, UNAIDS, Migrant Populations and HIV/AIDS. The Development and Implementation of Programmes: Theory, Methodology and Practice (June 2000), *available at* http://data.unaids.org/Publications/IRC-pub01/JC397-MigrantPop_en.pdf.

among other reasons."[56] Presumed safety thus complicates the determination of a person's actual risk; however, states must ascertain and counter such presumptions to protect human rights in the context of HIV/AIDS.

Other factors that affect vulnerability include economic factors. Economic factors include, most importantly: poverty, education, and health infrastructure and human resources.[57] Their roles in affecting risk and access cannot be overstated. International bargaining power, the cost of supplies and medicines, and an increased cost of goods resulting from lack of infrastructure, are other economic factors. As economists can better explain, a certain percentage of the price of all goods comes from transportation costs, which can be exponentially higher in developing countries, for instance for lack of paved roads. Socioeconomic situations increase risk for young girls and women.[58]

Conflict, and internal and external migration are also factors. However, significant recent UNHCR research challenges assumptions about the specific ways in which refugees or internally displaced persons affect the spread of HIV, as compared to local populations.[59] A variety of factors contribute to the vulnerability of displaced persons whose needs should be addressed through an integrated approach that also takes into account the needs of the local population. Post-conflict challenges, e.g., demobilization of troops, poverty, and drought, affect risk and access.[60] Unfortunately, many such risk factors are often present at once.[61]

History, too, plays a role. Physical markers of colonial legacies, for example, the location of some roads, hospitals, schools, government buildings, and centers of administration, and less tangible remnants, such as forms of government, legal systems, and citizens' relationship to the

56. Concluding Observations of the Comm. on the Elimination of Discrimination Against Women, United Republic of Tanzania, U.N. GAOR, 53d Sess., Supp. No. 38, ¶¶ 206-42, 213, U.N. Doc. A/53/38/Rev.1 (1998).

57. *See* UNAIDS, *2006 Report*, *supra* note 4, at 64-65, 73, 75 & 84.

58. *Id.* at 15, 19.

59. *See* Paul B. Spiegel et al., *Prevalence of HIV Infection in Conflict-Affected and Displaced People in Seven Sub-Saharan African Countries: A Systemic Review*, 369 LANCET 2187-95 (2007).

60. UNAIDS, *Country Level*, *supra* note 44, at 72.

61. In Namibia, "poverty, instability and a transport corridor used by long-distance truckers, as well as a culture that keeps women subservient, and the open discussion of issues related to sex, taboo[,]" all combine to worsen the problem. *Namibia*, *supra* note 48. In Chad, "[i]nfection rates are likely to increase rapidly because of the frequency of multiple sex partners and lack of condom use; socioeconomic conditions rendering young girls and women vulnerable; conflict and post-conflict situations; domestic and crossborder migration; illiteracy, poverty, socio-cultural taboos and limited access to health care and prevention services." UNAIDS, *Country Level*, *supra* note 44, at 110.

same, affect inhabitants' risk and access to resources and some states' responses.

D. *Barriers to Understanding the Pandemic*

Understanding the many factors affecting individuals' and groups' risk and access to resources thus requires the interdisciplinary efforts of medical and public health professionals, social workers, historians, lawyers, economists, and more. Scholars in different disciplines must examine their fields' relevance to addressing the global crisis, and seek to inform each other.

Yet, it is suggested, there are barriers to understanding the pandemic and the human rights crisis. A few possible barriers are put forth, here. First, one's "cultural understanding of disease," which I am defining as a perspective which results from one's witnessing an epidemic as it affects vulnerable groups locally, can prevent one from understanding (or, unfortunately, perhaps even from wanting to understand) the global pandemic. This is to suggest that the same factors that create vulnerable groups, who are more susceptible to HIV, also act to limit the rest of society's willingness to address HIV locally and globally. In other words, the failure to address the global pandemic is in part caused by the same prejudices, failures, and omissions that cause local epidemics which especially threaten certain individuals or groups. Put yet another way, local discrimination translates into global apathy. Local conditions, and early detected trends, affect: one's perception of HIV/AIDS as it exists at home and abroad; the way "AIDS and the law" is studied (as it may relate only to one vulnerable group); and, therefore, how works on HIV/AIDS and law are collected in law libraries. Arguably, around the globe, the study of HIV/AIDS and the law has experienced marginalization by association with vulnerable groups. In other words, scholars have not embraced the study of HIV/AIDS and the law the way they would have if it were not vulnerable groups in societies throughout the world who were the most obviously affected. Globally, increasingly, it is young people and heterosexual women who are at risk.[62] In the United States today, African American women represent about 72% of new HIV diagnoses in all women.[63] The position of these groups in societies, it is suggested, has resulted in a dearth of scholarship and advocacy to address the pandemic

62. UNAIDS, *2006 Report*, *supra* note 4, at 15. For example, in Kenya, "[t]he majority of new infections occur among youth, especially among young women aged 15-24 and young men under the age of 30." UNAIDS, *Country Level*, *supra* note 44, at 76.

63. *North America, Western and Central Europe*, *in* UNAIDS & WHO, AIDS Epidemic Update 2004, http://data.unaids.org/Publications/Fact-Sheets04/fs_high-income_en.pdf.

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in legal and political circles. It is difficult to comprehend how millions of people are still contracting, and dying from, a preventable disease. One can only conclude from the enormous scale of the pandemic that it must not matter. This lack of a truly internationalized response, which can be inferred from numbers of people newly infected, not receiving treatment, and dying each year, also makes for more limited responses at the local level. For example, in the United States, many achievements have been made on antidiscrimination and privacy; however, international human rights lawyers could buttress this work with approaches using the full array of internationally protected rights.

What is more, it is suggested, people from high-income states can also be "victims of their own success" in terms of understanding the pandemic: the relative "success" of their home governments vis-à-vis the pandemic can engender complacency. One's cultural understanding of HIV/AIDS is also influenced by one's country's response to HIV/AIDS. Ignoring for the moment the facts that certain groups can be in crisis in any given high-income country, or that large percentages of infected people are unaware of their status,[64] a high-income country may, nevertheless, have relatively widespread public education, access to prevention and medicines, and remedies for some rights violations. Such "successes," and the failure to self-educate act as a blinder and create complacency for HIV/AIDS as it exists at home and abroad. Thus, many people from such high-income countries are unaware not only of groups in crisis or large numbers of undiagnosed people at home, but also of the people in the world lacking any and all government responses to HIV/AIDS, including the most basic HIV/AIDS education and prevention programs, or the necessary measures to ensure the safety of blood supplies—responses implemented roughly two decades ago in some places. But which states are responsible for this disparity in states' preparedness, responses, and resources?[65]

64. Consider Canada and the United States. In Canada, an estimated 30% of people living with HIV at the end of 2002 were unaware of their positive status. *2005 Epi Update*, *supra* note 22, at 8. In the United States, at the end of 2003, an estimated 24-27% of people were undiagnosed and unaware of their HIV infection. Centers For Disease Control and Prevention, U.S. Dep't of Health and Human Servs., Basic Statistics, http://www.cdc.gov/hiv/topics/surveillance/basic.htm (last visited Mar. 13, 2007).

65. Scholars focusing merely on the "self-interest" of States may wish to consider, in addition, the effect of the lack of international cooperation on HIV/AIDS on the international community's capacity to adapt to new health challenges.

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III. KEY INTERNATIONAL DEVELOPMENTS

A. *The International Guidelines on HIV/AIDS and Human Rights*[66]

In 1998, UNAIDS and the OHCHR jointly published the Guidelines. Based on existing international human rights laws, principles and standards, the Guidelines provide a brief description of some relevant human rights principles, and they outline action-oriented measures for states to take to protect human rights and public health goals with regard to HIV/AIDS. The Guidelines consist of twelve short guidelines, concerning: the creation of national responses to HIV/AIDS;[67] community consultation for policy formation; the review and reform of public health laws; the review and reform of criminal laws and correctional systems; the enactment or strengthening of anti-discrimination and other protective laws that protect vulnerable groups; the enactment of legislation providing for the regulation of an access to HIV-related goods, services, and information; legal support services; a supporting and enabling environment for vulnerable groups; education and training; codes of conduct and accompanying enforcement mechanisms; monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights; and cooperation especially concerning human rights protection at the international level.

B. *The Millennium Development Goals*

At the 2000 Millennium Assembly of the United Nations, the participants adopted the Millennium Development Goals, aiming to reduce global inequalities by 2015.[68] One of the goals was to combat HIV/AIDS, malaria and other diseases.[69] The U.N. members set a target to halt and reverse the spread of HIV/AIDS by 2015.[70] Yet Stephen Lewis, then the

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66. *Guidelines*, *supra* note 1. After this Article's completion, the U.N. Convention on the Rights of Persons with Disabilities and its Optional Protocol were adopted (Dec. 6, 2006).

67. *See also* Population Division, Dep't of Economic and Social Affairs, *National Responses to HIV/AIDS: A Review of Progress*, U.N. Doc. UN/POP/MORT/2003/13 (Aug. 13, 2003), http://www.un.org/esa/population/publications/adultmort/POPDIVNs_Paper13.pdf (discussing the creation of national policy responses). *See also* John Stover & Alan Johnston, *The Art of Policy Formulation: Experiences from Africa in Developing National HIV/AIDS Policies*, THE POLICY PROJECT, Aug. 1999, *at* http://www.policyproject.com/pubs/occasional/op-03.pdf.

68. G.A. Res. 55/2, U.N. DOC. A/RES/55/2 (Sept. 8, 2000) [hereinafter *Millennium Declaration*].

69. *Id.*

70. *Id.*

U.N. Secretary-General's Special Envoy on AIDS in Africa, has noted the unlikelihood of success.[71]

C. *The U.N. General Assembly Declaration of Commitment on HIV/AIDS (2001),*[72] *and Follow-Up*

In its 2001 Declaration of Commitment, the General Assembly "note[d] that 'the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic.'"[73] The Declaration set "concrete, time-bound targets for the introduction of national legislation and other measures to ensure the respect of rights in regard to education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection[.]"[74] It enjoined states to ensure that, by 2003, their legislation address all forms of discrimination against people impacted by HIV/AIDS, and that, by 2005, laws and policies contribute to the protection of women and girls from HIV by ensuring equality under the law, addressing all forms of sexual violence, banning harmful traditional practices, and otherwise contributing to their empowerment to enable them to have more control over their sexual lives.[75]

A UNAIDS follow-up report[76] on the progress made toward the goals set in the Declaration of Commitment noted that "(1) 38% of countries

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71. STEPHEN LEWIS, RACE AGAINST TIME 3-4 (2000).

> [E]very learned commentator, from the World Bank to the [U.N.] Development Programme (UNDP) asserts that not a one of the high-prevalence HIV countries will make the goals. In fact, sub-Saharan Africa is so poor, so besieged by a range of communicable diseases, so lacking in human capacity, so barren of infrastructure, that it is entirely likely that not a single country in the region will make the goals. Nor has that situation been radically altered by the G8 Summit in July 2005.

Id.

72. G.A. Res. 5-26/2, at 1, U.N. DOC. A/Res/S-26/2 (June 27, 2001) [hereinafter *Declaration of Commitment*]. *See also* ICASO, *Advocacy Guide to the Declaration of Commitment on HIV/AIDS* (2001), http://www.icaso.org/ungass/advocacyeng.pdf.

73. Patterson & London, *supra* note 17, at 966 (quoting *Declaration of Commitment, supra* note 72, ¶ 16).

74. *Id.* (citing *Declaration of Commitment, supra* note 72, ¶ 58).

75. *Declaration of Commitment, supra* note 72, ¶¶ 58-61.

76. UNAIDS, *Follow-Up to the 2001 U.N. General Assembly Special Session on HIV/AIDS: Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003*, U.N. DOC. UNAIDS/03.37E (Sept. 2003) [hereinafter UNAIDS, *2001 Follow-Up*], http://whqlibdoc.who.int/unaids/2003/9291732885.pdf.

ha[d] yet to adopt legislation prohibiting discrimination against people living with HIV/AIDS, (2) 64% of countries ha[d] not adopted legislation to prohibit discrimination against populations that are vulnerable to HIV/AIDS, and (3) the disproportionate impact of HIV/AIDS on women and girls continue[d] to grow."[77] In 2005, UNAIDS published guidelines for further follow-up of the declaration.[78] A subsequent General Assembly Resolution arranged for a high-level meeting and a review of the progress achieved vis-à-vis the Declaration of Commitment, to take place from May 31-June 2, 2006.[79] There, the Secretary-General would present another follow-up report.[80]

D. *HIV/AIDS, Human Rights, and the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)*

Trade laws have significant effect on states' protection of human rights in relation to HIV/AIDS.[81] WTO agreements regulating trade between WTO Members "greatly influence national income and the distribution of income within and between countries, and hence influence the resources available to governments for effective prevention, treatment and care."[82]

1. The WTO TRIPS Agreement[83]

The TRIPS Agreement forms part of the WTO framework that significantly affects human rights protections vis-à-vis the pandemic, especially as concerns pharmaceutical patent protection.[84] The TRIPS Agreement requires WTO Member States to provide a common minimum

77. McNaughton, *supra* note 39, at 14 (citing UNAIDS, *2001 Follow-Up, supra* note 76, at 10-11).

78. UNAIDS, *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators*, U.N. Doc. UNAIDS/05.17E (July 2005), http://www.hivpolicy.org/Library/HPP000617.pdf.

79. G.A. Res. 60/224, at 107, U.N. DOC. A/60/49 (Dec. 23, 2005).

80. The Secretary General, *Follow-Up to the Outcome of the Twenty-Sixth Special Session: Implementation of the Declaration of Commitment on HIV/AIDS, Declaration of Commitment on HIV/AIDS: Five Years Later*, delivered to the General Assembly, ¶¶ 35-37, U.N. DOC. A/60/736 (Mar. 24, 2006) (discussing human rights). The high-level meeting resulted in the *Political Declaration on HIV/AIDS*, G.A. Res. 60/262, U.N. DOC. A/RES/60/262 (June 2, 2006).

81. Patterson & London, *supra* note 17, at 965.

82. *Id.*

83. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, Legal Instruments—Results of the Uruguay Round vol. 31, 33 I.L.M. 81 (1994) [hereinafter TRIPS Agreement].

84. *Id.*

level of intellectual property rights protection, and to protect adequately such rights within their territories.[85] However, it also includes the possibility for exceptions, or "flexibilities," that can be invoked for the protection of public health.[86] This was originally provided for in the "old—but still in force"[87] Article XX, General Exceptions, of the General Agreement on Tariffs and Trade (1947), indicating that states could unilaterally set aside market access obligations for non-trade considerations, including measures "necessary to protect human . . . life or health[.]"[88] Notably, the GATT (1947) anticipated exceptions, not just to protect public health, but to protect individual life and health as well.[89] These are inseparable from public health. This is consistent with the view—which would be articulated in the human rights texts soon to follow that instrument[90]—that all rights are indivisible. In any case, today, these, and subsequent relevant instruments concerning such flexibilities should be interpreted to be in harmony with states' human rights obligations.

The objectives and principles of the TRIPS Agreement include the protection of human rights, and the protection of public health.[91] Article 7 somewhat obliquely refers to existing human rights obligations. It provides,

> The protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations.[92]

Intellectual property rights, and corresponding promotion of innovation are put in opposition to, and must be balanced with the rights to technology and development,[93] to the mutual advantage of producers and users. The

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85. *Id.*

86. *Id.*

87. *See infra* note 161 and accompanying text.

88. General Agreement on Tariffs and Trade art. XX(b), Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194 [hereinafter GATT] (states can unilaterally set aside market access obligations for measures essential to acquisition or distribution of products in general or local short supply).

89. *Id.*

90. *See infra* Part V. Impacted Human Rights (discussing these human rights texts and some obligations therein).

91. TRIPS Agreement, *supra* note 83, arts. 7-8.

92. *Id.* art. 7.

93. Universal Declaration of Human Rights, art. 27, G.A. Res. 217A, at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. DOC. A/810 (Dec. 12, 1948) [hereinafter UDHR]; International

"manner conducive to social and economic welfare" seemingly indicates that among the objectives of the TRIPS Agreement is to be "conducive" to socioeconomic rights, including the right to health. However, so-called second-generation, or cultural, social, and economic rights, and third-generation rights such as the rights to technology and development, are all inseparable from first-generation, or civil and political rights, which include the rights to life, equality, and many others impacted by HIV/AIDS.[94]

Article 8 provides, "Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition . . . ."[95] However, international and municipal laws include the *obligation* for states to take necessary measures to protect health.[96]

TRIPS Article 27 covers patentable subject matter, and, in 27(2), the possibility for exclusion from patentability: "Members may exclude from patentability inventions, the prevention within their territory of the commercial exploitation of which is necessary to protect *ordre public* or morality, including to protect human, animal or plant life or health . . . ."[97]

Covenant on Economic, Social and Cultural Rights, art. 51(1)(b), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, art. 14, Nov. 17, 1988, O.A.S.T.S. No. 69, 1144 U.N.T.S. 123 [hereinafter the Protocol of San Salvador]; African Charter on Human and Peoples' Rights, June 27, 1981, 1520 U.N.T.S. 217 [hereinafter ACHPR].

94. *See, e.g.*, UDHR, *supra* note 93, art. 28; ICESCR, *supra* note 93, pmbl.; International Covenant on Civil and Political Rights pmbl., Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; Vienna Declaration, World Conference on Human Rights, Vienna, U.N. Doc. A/CONF. 157/24 (June 14-25, 1993) [hereinafter Vienna Declaration].

> All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.

Vienna Declaration, *supra*, ¶ 5.

95. TRIPS Agreement, *supra* note 83, art. 8.

96. *See, e.g.*, ICESCR, *supra* note 93, art. 12(2) ("necessary" "steps"); Convention on the Elimination of All Forms of Discrimination Against Women, art. 12(1), Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW] ("all appropriate measures"); Convention on the Rights of the Child, art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC] ("appropriate measures"]; ACHPR, *supra* note 93, art. 16(2) ("necessary measures"). *See generally* WHO's International Digest of Health Legislation, *at* http://www3.who.int/idhl-rils/frame.cfm?language=english who.int (a searchable online database containing a selection of international and national health legislation).

97. TRIPS Agreement, *supra* note 83, art. 27(2).

Article 27(3)(a) also allows Member States to exclude from patentability "diagnostic, therapeutic and surgical methods for the treatment of humans or animals."[98] Article 30 stipulates that members may provide limited exceptions to the rights conferred by a patent.

Article 31 sets forth conditions that apply when, in accordance with national law, members (or authorized third parties) decide to use compulsory licensing; it permits such use when the proposed user has already tried unsuccessfully to obtain authorization, but waives this requirement "in the situations of national emergency or other circumstances of extreme urgency," or "in the case of public non-commercial use."[99] The authorization granted under compulsory licensing must be nonexclusive,[100] and the use must be predominantly for supplying the domestic market of the authorizing state.[101] In addition, the right holder must be "paid adequate remuneration in the circumstances of each case, taking into account the economic value of the authorization."[102] Part VI of the TRIPS Agreement provides for transitional arrangements, including extension periods for developing countries or for those changing from centrally-planned to market economies,[103] and for least-developed countries.[104]

The TRIPS Agreement, as it relates to pharmaceuticals, has since been clarified and ultimately altered by a series of Ministerial Declarations, decisions of the Council for TRIPS, and decisions of the General Council.[105] Most significantly, a change to TRIPS Article 31(f) has been made permanent and is expected to come into force before December 1, 2007.

2. The WTO Ministerial Declaration of November 14, 2001[106]

The Doha Declaration underscored the need to implement and interpret TRIPS to "support" public health, by promoting access to existing medicines and the creation of new ones.[107] The same day, the Ministers

98. *Id.* art. 27(3)(a).
99. *Id.* art. 31(b).
100. *Id.* art. 31(d).
101. *Id.* art. 31(f).
102. TRIPS Agreement, *supra* note 83, art. 31(h).
103. *Id.* art. 65.
104. *Id.* art. 66.
105. World Trade Organization (WTO) documents are available on the WTO Web Site, http://www.wto.org.
106. WTO Ministerial Declaration of 14 Nov. 2001, WT/MIN(01)/DEC/1 41 I.L.M. 746 (2002) [hereinafter Doha Declaration].
107. *Id.* ¶ 17.

adopted a separate declaration[108] on TRIPS and public health. At the time of the Doha declarations, Brazil, for example, had already decided to allow local generic manufacture of patented medications, unless the manufacturers drastically reduced the cost of the drugs or started making them in Brazil.[109]

3. The Doha TRIPS and Public Health Declaration

This declaration recognized the effect of public health problems such as HIV/AIDS on developing and least-developed countries.[110] Paragraph 4 affirmed the "right" of members to interpret and implement TRIPS provisions, including those concerning compulsory licensing and parallel importing, "to protect public health" and "to promote access to medicines for all."[111] However, this "right" could equally be termed an "obligation," in light of existing human rights obligations. Specifically, paragraph 4 provides that the TRIPS Agreement "should not prevent members from taking measures to protect public health"—which members must in fact do to protect human rights, including but not limited to the right to health.[112] It affirms that the agreement "can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."[113]

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108. WTO, Ministerial Declaration on the TRIPS Agreement and Public Health (Nov. 14, 2001), Doc. WT/MIN(01)/DEC/2 (Nov. 20, 2001) [hereinafter Doha TRIPS & Public Health Declaration].

109. *See* Tina Rosenberg, *How to Solve the World's AIDS Crisis: Look at Brazil*, N.Y. TIMES MAG., Jan. 28, 2001. *See also* Patterson & London, *supra* note 17, at 966 nn.37-39. *But see* Theo Smart, *Brazil's HIV/AIDS Programme is a Model for the Rest of the World, But the Cost of Second-Line Therapies and the Spread of HIV-1C Could Spell Danger for the Future*, 53 HIV & AIDS TREATMENT IN PRACTICE No. 53 (UK), Aug. 18, 2005, *available at* http://hivinsite.ucsf.edu/InSite?page=pa-hatip-53 (reporting about 60% prevalence among injecting drug users in the port cities of Santos and Itajai, Santos having the highest general HIV prevalence in the country).

110. Doha TRIPS & Public Health Declaration, *supra* note 108, ¶ 1.

111. Paragraph 4 provides,

> 4. We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

Doha TRIPS & Public Health Declaration, *supra* note 108, ¶ 4.

112. *Id.*

113. *Id.*

Thus, members should interpret and apply TRIPS provisions to be consistent with states' obligations to protect individual and public health (and to take the correlating necessary measures) that exist under international and municipal laws. For example, states' ensuring of access to medicines for all is required as a facet of the right to health and of the rights to dignity, equality and life as enshrined in international and municipal laws.[114]

Paragraph 5 provided important clarifications relevant to the protection of human rights vis-à-vis HIV/AIDS.[115] Paragraph 5(a) underscores that the TRIPS Agreement must be interpreted in light of its objectives and principles, as for instance articulated by TRIPS Agreement Articles 7 and 8. As discussed previously, Article 7 refers to the protection of the indivisible rights of different generations, whereas Article 8 states that Member States "may" take measures to protect public health and nutrition (although numerous human rights obligations already require states to take such measures). Paragraph 5(b) of the declaration clarified that, with respect to compulsory licensing, each member is free to determine the grounds upon which the licenses are granted, thereby providing "a usefulcorrective to the view sometimes expressed that some form of emergency is a pre condition for compulsory licensing."[116]

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114. *See infra* Part V.

115. Paragraph 5 provides:

> 5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:
> a. In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.
> b. Each member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.
> c. Each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.
> d. The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

Doha TRIPS & Public Health Declaration, *supra* note 108, ¶ 5.

116. *See* WTO, *TRIPS: TRIPS and Public Health, The Separate Doha Declaration Explained*, www.wto.org/English/tratop_e/trips_e/healthdeclexpln_e.htm (last visited Mar. 13, 2007).

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The declaration also emphasized, in paragraph 5(c), that each member has "the right to determine what constitutes a national emergency or other circumstances of extreme urgency," and that public health crises, including HIV/AIDS, tuberculosis, malaria, and other epidemics, can qualify as such.[117] The "right" to make such a determination can be juxtaposed with the obligation to assess and control epidemic, as exists for example in ICESCR Article 12(2)(c).

Paragraph 7 includes a further extension of pharmaceutical patent protection exemptions for least-developed countries until 2016. This followed a similar extension from a 2002 decision[118] of the Council for TRIPS, which had postponed until January 1, 2006 the end of the transition period for patents for pharmaceutical products, for least-developed countries.

The declaration also required, in paragraph 6, the Council for TRIPS to resolve problems with Article 31(f) of the TRIPS Agreement, concerning the domestic market limitation on compulsory licensing. The problem remained: how countries with little or no manufacturing capacity could import pharmaceuticals using compulsory licenses, when countries with manufacturing capacity were restricted on the amounts they could export by the requirement that compulsory licensing be done predominantly to supply the domestic market. Thus, paragraph 6 of the Doha TRIPS and Public Health Declaration required the Council for TRIPS to resolve this by December 31, 2002, but this did not happen by that date.

4. The General Council Decision of August 30, 2003[119]

This General Council decision recognized that, in some cases, waivers of Article 31 (f-h) would be justified; furthermore, this waiver would stay in force until Article 31 had been amended. The waiver, subject to certain conditions, was meant to make it easier for manufacturing members to export generics under compulsory licenses to members in need. In his recent article, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*,[120] Professor Frederick M. Abbott examines this decision in depth, the negotiations leading up to it, and the

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117. *Id.*

118. Decision of WTO Council for TRIPS, Extension of the Transition Period under Article 66.1 of the TRIPS Agreement for Least-Developed Country Members for Certain Obligations with Respect to Pharmaceutical Products, (June 27, 2002), Doc. IP/C/25 (July 1, 2002).

119. Decision of WTO General Council (Aug. 30, 2003), WT/L/540 and Corr.1 (Sept. 1, 2003).

120. Frederick M. Abbott, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*, 99 AM. J. INT'L L. 317 (2005).

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threat posed to the use of TRIPS flexibilities by Free Trade Agreements (FTAs) between the United States and trading partners.[121] He emphasizes that the negotiations did not focus on whether compulsory licenses could be issued; rather, they concerned how to make supplies available to countries with limited manufacturing capacity.[122]

5. The General Council Decision of December 6, 2005[123]

This decision transformed the August 2003 waiver into a permanent amendment of TRIPS Article 31(f), to enter into force in accordance with WTO Agreement Article X(3) by December 1, 2007.[124] The waiver and amendment allow any Member State to use compulsory licenses to export pharmaceuticals to eligible importing members.[125]

6. The Hong Kong Ministerial Declaration[126]

A Ministerial Declaration adopted at the Hong Kong Ministerial Conference put the Ministers' stamp of approval on the interpretation of, and changes to TRIPS for the protection of public health. Paragraph 40, "TRIPS and Public Health," recognizes the importance of the decisions of August 30, 2003 and December 6, 2005.[127]

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121. *See discussion infra* text accompanying notes 156-63.

122. Abbott, *supra* note 120, at 326.

> Compulsory licensing of patents has been a feature of the international patent system virtually since its inception . . . . [T]he subject matter of the negotiations on the Decision was not whether governments may issue compulsory licenses with respect to pharmaceutical products. Under Article 31 of the TRIPS Agreement, any country, whether developed or developing, can issue such licenses. These negotiations were limited to one aspect of compulsory licensing, the extent to which supplies could be made available to countries without manufacturing capacity.

Id.

123. Decision of WTO General Council (Dec. 6, 2005), Doc. WT/L/641 (Dec. 8, 2005).

124. *Id.*

125. *Id.*

126. WTO, Ministerial Declaration on the Doha Work Programme (Dec. 18, 2005), Doc. WT/MIN(05)/DEC (Dec. 22, 2005).

127.

> We reaffirm the importance we attach to the General Council Decision of 30 August 2003 on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health, and to an amendment to the TRIPS Agreement replacing its provisions. In this regard, we welcome the work that has taken place in the Council for TRIPS and the Decision of the General Council of 6 December 2005 on an Amendment of the TRIPS Agreement.

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7. States' Implementing Legislation

Several countries with manufacturing capacity have created implementing legislation to facilitate exports using compulsory licensing.[128] In May 2004, Canada amended its Patent Act and its Food and Drugs Act to allow compulsory licenses to be issued to Canadian manufacturers of generics for export to poor countries.[129] The products listed in the legislation are drawn from the WHO's list of essential medicines and include ARVs.[130] Implementation of the legislation, the Jean Chrétien Pledge to Africa Act (the "Canadian Medicines Export Act"),[131] was delayed by a political battle over accompanying regulations,[132] which came into force June 1, 2005.[133]

8. States' HIV/AIDS-Related Human Rights Crises: Grounds for Using TRIPS Flexibilities

The TRIPS flexibilities have not yet been used to import or export pharmaceuticals for HIV/AIDS. However, states' obligations to protect human rights, including the right to health, as well as the full panoply of human rights impacted by HIV/AIDS,[134] should serve as sufficient justification for invoking TRIPS flexibilities. The current impact of HIV/AIDS on human rights needs to be better understood, in order for states to take the necessary actions to help protect (and required by) impacted rights.

Id. ¶ 40.

128. *See* Abbott, *supra* note 120, at 332-34, 337, & 341-43.

129. WHO, *Human Rights, Health, and Poverty Reduction Strategies*, at 36, U.N. DOC. WHO/ETH/HDP/05.1 (Draft) (Apr. 2005).

130. *Id.*

131. The Jean Chrétien Pledge to Africa Act was passed by Canada's House of Commons on May 4, 2004, passed in Senate without amendment on May 13, received royal Assent on May 14, 2004, and was proclaimed into force on May 14, 2005. *See* Press Release, Richard Elliott, Canadian HIV/AIDS Legal Network, News Release: Human Rights Advocacy Group Welcomes Law on Generic Medicine Exports Coming into Force, Calls for Follow-Through (May 13, 2005), *available at* lists.essential.org/pipermail/ip-health/ 2005-May/007909.html.

132. *See* Abbott, *supra* note 120, at 318 n.8.

133. Elliott, *supra* note 131 (reporting that the regulations accompanying the Jean Chrétien Pledge to Africa Act came into force upon their publication on June 1, 2005: Use of Patented Products for International Humanitarian Purposes Regulations, Under the Patent Act; Regulations Amending the Food and Drug Regulations (1402—Drugs for developing countries), SOR/2005-141, under the Food and Drugs Act; and Regulations Amending the Medical Devices Regulations (Developing Countries), SOR/2005-142, under the Food and Drugs Act).

134. *See infra* Part V (discussing such rights).

9. TRIPS Article 8 and "Measures to Protect Public Health"

TRIPS Article 8 states that states "may" take measures to protect health. However, protection of the right to health includes the obligation to take the "necessary measures" to protect health.[135] The right to health includes, for example, states' duties to assess and control epidemic. This right may also require states with limited resources to use such resources in order to maximize protection of the right to health. For some, the use of compulsory licences and the import or export of cheap generic drugs could constitute necessary measures to protect the right to health.

10. Impacted Human Rights as Grounds for Compulsory Licensing

HIV/AIDS-impacted human rights could provide the necessary policy justification for using TRIPS flexibilities in the following ways, or in a combination thereof: (1) As envisioned in TRIPS Article 31(b), because of a situation of national emergency, circumstances of extreme urgency, or cases of public noncommercial use; (2) States could create other grounds for compulsory licensing as described by national law, as referred to by paragraph 5(b) of the Doha TRIPS and Public Health Declaration; and (3) States can rely on other sources of international law or guidance providing similar policy bases.

11. TRIPS Article 31(b)

Under TRIPS Article 31(b), the need to protect human rights vis-à-vis HIV/AIDS could constitute a base for a national emergency, circumstances of extreme urgency, or public noncommercial use. Compulsory licensing for export, based on such a situation in another state, is consistent with the object and purpose of TRIPS and subsequent instruments.[136] One state's national emergency, circumstances of extreme urgency or case of public noncommercial use could also create such a situation for another state. Equally, one state's determination of such a situation could be grounds for another state's finding.[137]

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135. *See supra* note 93.

136. *See* Abbott, *supra* note 120, at 342 n.173 (giving Canada's debate on whether fast-track procedure to export to another country could be based on another country's emergency or whether it had to be a domestic emergency, ultimately resolved by recognizing that the object and purpose of the Aug. 30, 2003 decision includes recognizing and ameliorating public health emergencies in other states).

137. *See id.* at 341.

> [T]he TRIPS Agreement does not prevent a member from recognizing and giving effect to a compulsory license granted by another member under the Decision.

As referred to in paragraph 5(c) of the Doha TRIPS and Public Health Declaration, each member has "the right to determine what constitutes a national emergency or other circumstances of extreme urgency."[138] In addition to the explicit statement in 5(c) that public health crises like HIV/AIDS can qualify as such, states are also presumably free to determine, in accordance with 5(c), that a national emergency, or other circumstances of extreme urgency exists in the context of HIV/AIDS: (1) on the basis of a generalized, national human rights crisis; (2) with respect to a group in crisis; or, (3) with respect to the protection of a single impacted right, such as the right to equality, health, or life. Paragraph 5(c) does not seem to distinguish between importing and exporting states being able to make such a determination.

This raises some questions, for example: whether states would be likely to make such a determination about their own emergencies or urgent circumstances (possibly a question of political will, public relations, and international finance); the effect of this on findings of violations at international and municipal levels; unwanted side effects of such declarations; or, whether a notification that a state is using compulsory licensing in accordance with TRIPS Article 31 could qualify as such a declaration under international[139] or municipal laws. Concerning unwanted side effects, the draft TRIPS implementing legislation of the European Union[140] has raised concerns about the requirement and desirability of such a declaration, including potential derogation from human rights.[141] (The European Union is a TRIPS signatory.) There is a potential disjuncture between invoking a human rights crisis as a policy justification for using TRIPS flexibilities, on one hand, and declaring a situation of emergency,

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> Article 31(a) provides that a license shall be considered on its individual merits but does not mean that a government cannot base its determination of the merits of granting a license on another member's decision.

Id.

138. Doha TRIPS and Public Health Declaration, *supra* note 108, ¶ 5(c).

139. Convention for the Protection of Human Rights and Fundamental Freedoms, art. 15, Nov. 4, 1950, Europ. T.S. No. 5, 213 U.N.T.S. 221, *as amended by* Protocol 11, May 11, 1994, Europ. T.S. No. 155, 2061 U.N.T.S. 12 [hereinafter ECHR].

140. *Commission Proposal for a Regulation of the European Parliament and of the Council on Compulsory Licensing of Patents Relating to the Manufacture of Pharmaceutical Products for Export to Countries with Public Health Problems*, COM(2004) 737 final, *available at* http://trade.ec.europea.eu/doclib/docs/2006/january/tradoc_126996.pdf.

141. *See* Abbott, *supra* note 120, at 343 ("[N]ational law in the importing country may set conditions on formal declarations of emergency that make that option procedurally difficult, or national law may allow the government to take steps in declared emergency situations (such as suspending constitutional rights) that make such a declaration undesirable from a policy standpoint.").

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which could allow derogation from some rights, on the other. But this concern is seemingly obviated by the inclusion of nonemergency options for using the flexibilities. And in some places, HIV/AIDS constitutes a grave national emergency, as witnessed by the revived debate on mandatory testing at the expense of certain individual rights.[142]

12. Paragraph 5(b) of the Doha TRIPS and Public Health Declaration

States, as referred to in paragraph 5(b) of the Doha TRIPS and Public Health Declaration, have "the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted."[143] Thus states can create or invoke national laws allowing for compulsory licensing where the protection of human rights so requires, including nonemergency situations. Such grounds could include the protection of the right to health and life, and the protection of the full range of rights impacted by HIV/AIDS or similar health problems.

13. Other Human Rights Grounds for Patent Exceptions

In addition to the WTO TRIPS provisions and related instruments, grounds for a "public health," "national emergency," or "extreme urgency" exception to some patent protections can arguably be seen elsewhere. The Guidelines, the Millennium Development Goals, General Comment 14 of the Committee on Economic, Social and Cultural Rights,[144] resolutions of the Commission on Human Rights (especially on the right to the highest attainable standard of health and access to medication),[145] General

142. Andrew T. Price-Smith & John L. Daly, *Downward Spiral: HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe*, at 37 (U.S. Inst. of Peace, Peaceworks No. 53, 2004), http://www.usip.org/pubs/peaceworks/pwks53.pdf (recommending mandatory testing of Zimbabwean military and peacekeeping forces, and the placement of those who test HIV-positive in assignments where they are less likely to contribute to the spread of HIV).

143. Doha TRIPS and Public Health Declaration, *supra* note 108, ¶ 5(b).

144. Comm. on Economic, Social and Cultural Rights (CESR), *General Comment 14: The Right to the Highest Attainable Standard of Health: Substantive Issues Arising in the Implementation of the International Covenant on Economic Social and Cultural Rights*, U.N. DOC. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, *General Comment 14*].

145. The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Comm'n on Hum. Rts. (C.H.R.) Res. 2002/31, U.N. DOC. E/CN.4/Res/2002/31 (Apr. 22, 2002); Access to Medication in the Context of Pandemics such as HIV/AIDS, C.H.R. Res. 2002/32, U.N. DOC. E/CN.4/RES/2002/32 (Apr. 22, 2002) [hereinafter C.H.R., Access to Medication]; The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), C.H.R. Res. 2005/84, U.N. DOC. E/CN.4/RES/2005/84 (Apr. 21, 2005); The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), C.H.R. Res. 2003/47, U.N. DOC. E/CN.4/RES/2003/47 (Apr. 23, 2003).

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Comment 3 of the Committee on the Rights of the Child,[146] the work of the Special Rapporteur on the Right to Health, Professor Paul Hunt,[147] and more, all help to support individuals', groups', and peoples' rights to access drugs as part of their rights to the best attainable state of health. Of course, the many rights inseparable from the right to health are widely protected elsewhere. Increased interpretation of these protections vis-à-vis HIV/AIDS, and increased documentation of violations could help improve the protection of rights, and prevent further violations, via trade. Arguably, Article 24 (Distress), and Article 25 (Necessity) of the International Law Commission's Draft Articles on Responsibility of States for Internationally Wrongful Acts indicate the preclusion of wrongfulness of what could otherwise be an internationally wrongful act, that is, potential patent violations.[148]

In addition, in international human rights law, states can invoke the protection of public health and morals to justify limiting individual rights; great weight has thus been given to public health in the realm of civil and political rights, at least in name. Three implications of this are, first, states should be expected to protect the health and life of people within their jurisdiction: the invocation of trade exceptions to meet human rights obligations should come as no surprise. Second, in interpreting the right to health, enforcement bodies should consider the great weight traditionally attached to the protection of public health and morals. Third, the right to health cannot be separated from public health. Whereas it has thus far been mainly interpreted as a broad limiter of individual rights, the content of this individual right, and how it is connected with many other individual rights, which impact public health, has been increasingly elaborated.

14. Nonmember States

A question that remains is how impoverished states that are not WTO Members can use compulsory licensing, to fulfil their obligations to

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146. Comm. on the Rights of the Child, *General Comment No. 3, HIV and the Rights of the Child*, U.N. DOC. CRC/GC/2003/3 (Mar. 17, 2003).

147. Paul Hunt was appointed to his position in 2002 by the C.H.R. *See* The Special Rapporteur, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, E/CN.4/2006/48; *see also* The Secretary-General, *Note by the Secretary-General Transmitting the Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, A/60/348 (Sept. 12, 2005, *available at* http://daccessdds.un.org/doc/UNDOC/GEN/N05/486/77/PDF/N0548677.pdf?OpenElement.

148. *See* Draft Articles on Responsibility of States for Internationally Wrongful Acts, International Law Comm'n, *adopted in* G.A. Res. 56/83, U.N. DOC. A/RES/56/83 (Jan. 28, 2002).

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protect individuals' and the public's health, including taking the correlating necessary measures, and to protect all the rights impacting, and impacted by HIV/AIDS. Conversely, the question remains how WTO Members can use compulsory licensing to export to nonmembers.[149] WTO Members could export to nonmembers on the basis of TRIPS Article 30 exceptions.[150] Paragraph 9 of the August 30, 2003 Decision does not affect members' rights to use Article 30 exceptions for example with respect to nonmembers;[151] continuing in this vein, the amendment of December 6, 2005[152] emphasizes that the TRIPS amendment is without prejudice to other TRIPS "rights, obligations and flexibilities,"[153] which would include Article 30. In addition to serving as the justification for exports to nonmembers, such rights, like those in Article 30 "[m]ore generally, . . . may . . . constitute an alternative to use of the system established by the Decision . . . ."[154]

Presumably, states that are not WTO Members are also free to define grounds for compulsory licensing via national legislation. The obligation to protect individuals' and public health, to take correlating necessary measures, and to protect all impacted rights, could serve as such grounds. The use of such grounds would not be part of the TRIPS system, but acts done by WTO Members in conjunction with such legislation of states that are not WTO Members could be consistent with the object and purpose of TRIPS and subsequent texts. Article 7, including the exhortation to interpret intellectual property rights to be conducive to human "welfare" (i.e., rights), does not contain any limiting language concerning Member States or nonmembers.[155]

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149. *See* Abbott, *supra* note 120, at 337-38 nn.139-42.

150. *See id.*

151. *See id.* at 340.

152. *See* Doc. WT/L/641 (Dec. 8, 2005) art. 31 ¶ 5.

> This Article and the Annex to this Agreement are without prejudice to the rights, obligations and flexibilities that members have under the provisions of this Agreement other than paragraphs (f) and (h) of Article 31, including those reaffirmed by the Declaration on the TRIPS Agreement and Public Health (WT/MIN(01)/DEC/2), and to their interpretation. They are also without prejudice to the extent to which pharmaceutical products produced under a compulsory licence can be exported under the provisions of Article 31(f).

Id.

153. *Id.*

154. Abbott, *supra* note 120, at 340.

155. TRIPS Agreement, *supra* note 83, art. 7.

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15. Threats to the TRIPS Flexibilities

Bilateral Free Trade Agreements (FTAs) entered into by the United States and trading partners may pose a threat to the use of TRIPS flexibilities,[156] since, for example, some agreements "limit the grounds on which compulsory licenses may be granted."[157] Abbott suggested that the creation of the amendment to Article 31 (which had not yet taken place as of the completion of his article) could present the opportunity to clarify norms;[158] thus, the amendment could

> require WTO members to recognize the priority of TRIPS flexibilities with respect to pharmaceutical products. A hierarchy of norms would be established. "Rights" established under the TRIPS Agreement, the Doha Declaration, and the Decision would not be subject to derogation in another agreement. A breach of this obligation in the application of an FTA might give rise to a WTO-based cause of action on the part of any affected member . . . . In the Doha Declaration, WTO ministers expressly recognized the right of WTO members to protect the health of their citizens . . . . This right should be given effect by the members, and by the Dispute Settlement Body . . . . For example, WTO members might consider whether FTA provisions regulating access to medicines may impede the right to protect public health, at least in specific contexts. This possibility has already been raised by UN human rights organs . . . . The WTO Committee on Regional Trade Agreements might be charged with evaluating this question . . . . Ultimately, the WTO Dispute Settlement Body might consider whether a member's right to protect public health, as acknowledged in the Doha Declaration, has been impaired by a term in an FTA or by its implementation.[159]

Arguably, the problem of derogation from WTO "rights" can be avoided by putting proper emphasis on existing human rights obligations as a basis for the same actions that would be taken on the basis of TRIPS "rights." Leaving aside the question whether the amendment did establish such a hierarchy of norms, Abbott discusses two kinds of obligations: he terms the prioritization of the "rights" created in the WTO agreements an "obligation"; and, he alludes to members' "right" (really, their obligation)

156. *Id.* at 349-54.
157. *Id.* at 350 n.239.
158. *Id.* at 356-57.
159. *Id.* (footnotes omitted).

to protect health.[160] However, the view that use of TRIPS flexibilities, rather than just being "rights," are a function of the protection of existing human rights obligations, or indeed can form part of the content of impacted rights such as the right to health (insofar as they are necessary or appropriate measures to protect health, life, and related impacted rights), can strengthen policy bases for using the flexibilities.

Human rights require states to take necessary actions to protect rights, as seen in treaty language protecting, for example, the right to health, or in the broader notion of "positive obligations" for instance elaborated under the ECHR. Such necessary actions should pass the necessity test needed to use trade flexibilities now part of TRIPS. The need to comply with existing human rights obligations, including the right to health, forms part of any hierarchy of norms including WTO agreements and FTAs. The WTO's Director-General, Pascal Lamy, recently underscored the WTO's recognition of "non-WTO norms" that WTO law envisions as grounds for exceptions, and emphasized that the specialized body of WTO law lies within the general body of public international law, and as such, is at least not above other specialized areas of law.[161] But when does a recognized

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160. TRIPS Agreement, *supra* note 83, at 356-57.

161. *See* Pascal Lamy, Director-General, World Trade Organization, Address at the European Society of International Law in Sorbonne, Paris: The Place and Role of the WTO (WTO Law) in the International Legal Order (May 19, 2006), http://www.wto.org/english/news_e/sppl_e/sppl26_e.htm. With respect to his second topic of discussion, "The link between the legal system of the WTO and the legal systems of other international organizations[,]" the Director-General expressed accord with the view that the WTO operates within the compound of the international legal order, as evident from the Appellate Body's use of general principles of public international law in interpreting the WTO. The Director-General noted,

> The WTO does, therefore, take into account other norms of international law. Absent protectionism, a WTO restriction based on non-WTO norms, will trump WTO norms on market access. In so doing, it expands coherence between systems of norms or legal order. Moreover, I believe that in leaving Members with the necessary policy space to favour non-WTO concerns, the WTO also recognizes the specialization, expertise and importance of other international organizations.

Id. The Director-General subsequently noted the challenge of fragmentation of international law, in that a WTO judge could "determine the balance, the 'line of equilibrium' between trade norms and norms of other legal orders[,]" in determining whether a trade restriction was a justified exception. "In assessing the invocation of such WTO exception justification, the WTO judge may in fact be deciding on the relative hierarchical value between two sets of norms." He proposed, "The solution to the potential imbalance I alluded to lies, I believe, in strengthening the enforcement (the effectiveness) of other legal orders so as to rebalance the relative power of the WTO in the international legal order." Thus, this solution (for imbalance, but not for fragmentation) could imply the need for increased enforcement of HIV/AIDS-impacted rights, and a greater capacity for human rights enforcement mechanisms to challenge bilateral trade agreements that

exception (to protect human health and life) become a WTO norm?

Abbott also discusses the negative effect of uncertainty caused by FTAs and the problems that "ambiguous pharmaceutical-related rules" present: they discourage the use of TRIPS flexibilities.[162] However, giving human rights obligations their proper due should lessen this uncertainty and ambiguity. Doing so also calls into question the validity of such parts of the FTA agreements that compromise the parties' ability to fulfil existing human rights obligations flowing, for example, from anterior treaties. States' actions taken in concluding such FTAs could certainly contravene the exhortation for states "[t]o refrain from taking measures which would deny or limit equal access for all persons to preventive, curative or palliative pharmaceuticals or medical technologies used to treat pandemics such as HIV/AIDS or the most common opportunistic infections that accompany them . . . ."[163]

E. Minister of Health v. Treatment Action Campaign *(July 5, 2002)*

A short step back in time from recent TRIPS developments (considered together for clarity), the 2002 decision of the South African Constitutional Court, *Minister of Health v. Treatment Action Campaign* (July 5, 2002)[164] represents another key international development. In that case, the Court considered the constitutional right of everyone to access public health care services[165] and the right of children to special protection (Art. 28).[166] The policy at issue was the government's program to alleviate mother-to-child transmission (MTCT), which made Nevirapine available only limitedly per province, impeding other public sector doctors' prescriptions.[167] The respondents contended the state had failed its constitutional duty under Articles 7(2) and 8(1) to enforce Articles 27 and 28.[168] They also argued that, per the ICESCR, the government was obligated to plan and implement an effective, comprehensive, and progressive program to prevent MTCT.[169]

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impact rights. *Id.*

162. Abbott, *supra* note 120, at 353.

163. C.H.R., Access to Medication, *supra* note 145, ¶ 3(a); *see also* CESR, *General Comment 14*, *supra* note 144.

164. Min. of Health v. Treatment Action Campaign (Case CCT 8/02) 2002 (5) SA 721 (CC) ¶ 2 (S. Afr.).

165. *Id.* ¶ 4; *see also* S. AFR. CONST. 1996, art. 27.

166. *Min. of Health* (5) SA 721 ¶ 4; *see also* S. AFR. CONST. 1996, art. 28.

167. *Min. of Health* (5) SA 721 ¶ 58.

168. *Id.* ¶¶ 22-23, 25.

169. *Id.* ¶¶ 5, 44.

Responding to the appellants' contention questioning the efficacy of the drug to prevent MTCT absent a comprehensive support package, the Court considered much scientific evidence, and international and foreign law.[170] While the Court recognized that the state did not have to go beyond its resources to provide the right of access to health care, and that this socioeconomic right could be implemented on a progressive basis, it found that the state was required to give effect to those rights, which, per relevant Constitution provisions, imposed positive obligations.[171] In the Court's view, the government's measures fell short of constitutional obligations: positive obligations required a change in health policy.[172]

Recent budgetary actions indicated that, in the instant case, a slow progressive approach was not required;[173] moreover, having increased immediate availability in the public health sector was preferable to having the perfect policy later. Conducting research did not justify delaying a comprehensive program. The Court declared unconstitutional the policy and ordered the government: to remove restrictions on Nevirapine; to permit and facilitate the drug's use where medically indicated; to make provision for the training of counsellors, and, to take reasonable measures to extend testing and counselling facilities.[174] The Court's decision was facilitated by South Africa's international law-friendly constitution, requiring all state courts, tribunals and *fora* to consider international legal obligations when interpreting the Constitution's Bill of Rights.[175]

Implementation of the decision has been difficult, but the decision was a key development because it helped galvanize international efforts to increase access to drugs. It also shows how enforcement bodies can apply existing human rights law to protect HIV/AIDS-impacted people. Effect must be given to first- and second-generation rights in the context of

170. *Id.* ¶¶ 90, 107-11, 113.

171. *Id.* ¶¶ 23, 29, 39 135(2)(c).

172. *Min. of Health* (5) SA 721 ¶¶ 80, 95, 96, 128.

173. *Id.* ¶¶ 131-33, 135(3).

174. *Id.* ¶ 135(3).

175. S. AFR. CONST. 1996 art. 39. Interpretation of Bill of Rights.

> 1. When interpreting the bill of Rights, a court, tribunal or forum—
> a. must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
> b. must consider international law; and
> c. may consider foreign law.
> 2. When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport, and objects of the bill of Rights. [. . .].

Id.

HIV/AIDS. An approach considering justiciable second-generation rights can directly increase the protection of all rights, and can improve the overall human rights environment for people impacted by HIV/AIDS. For some people, this approach means getting access to life-saving medicines.

F. *The WHO's "3 by 5" Campaign*

Other international efforts, such as the "3 by 5" campaign launched by UNAIDS and WHO in 2003, followed, aiming to reduce the global disparity in drug availability.[176] The "3 by 5" campaign set a target of providing 3 million people living with HIV/AIDS in low- and middle-income countries with ARV therapy (ART) by the end of 2005.[177] (Consider that 40 million people were then estimated to be infected, worldwide.[178]) Although progress was made, the world failed to meet this goal of making universal access to HIV/AIDS prevention and treatment available as a human right. Millions of people were newly infected in 2005; drugs are widely unavailable, and where they are limitedly available nationally, for many individuals with no access to health care, global developments remain irrelevant. In parts of sub-Saharan Africa with extremely high prevalence, ART drugs and drugs to treat opportunistic infections are still completely unavailable.[179] A June 2005 update on 3 by

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176. *See, e.g.*, WHO, "About 3 by 5," *available at* http://www.who.int/3by5/about/en/ (last visited Dec. 12, 2007).

177. *Id.*

178. UNAIDS, Global Estimates of HIV/AIDS Pandemic as of End 2001, July 2002, *cited in* The Henry J. Kaiser Family Foundation, HIV/AIDS Policy Fact Sheet: The Global HIV/AIDS Epidemic, July 2002, http://www.kff.org/hivaids/upload/The-Global-HIV-AIDS-Epidemic-Fact-Sheet-Fact-Sheet.pdf.

179. UNAIDS, Sub-Saharan Africa: United the World Against AIDS, *at* http://www.unaids.org/en/Regions_Countries/Regions/SubSaharanAfrica.asp (last visited Mar. 14, 2007).

> Progress in expanding treatment and care provision in sub-Saharan Africa in the past year has been uneven. At least one third of people in need of antiretroviral therapy are receiving it in such countries as Botswana and Uganda, while in Cameroon, Côte d'Ivoire, Kenya, Malawi and Zambia between 10% and 20% of people requiring antiretroviral drugs were receiving them in mid-2005. However, there is extensive unmet need in most of the region. At least 85% (almost 900 000) of South Africans who needed antiretroviral drugs were not yet receiving them by mid-2005; the same applied to 90% or more of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.

Id.

5 highlighted many of the bottlenecks impeding universal access.[180] ART roll-out requires many other factors to be in place, for example, adequate transportation, medical equipment to monitor seroprevalence, the personnel and training to operate this equipment, and more.[181] Where there is not widespread access to ART, the introduction of ART at select hospitals can strain those hospitals and communities.[182] Today, people in some of the poorest countries of the world are trying to scrape together enough money to order drugs from neighbouring countries, or to go there, often without success.[183] HIV/AIDS strains relationships, families, and communities. Yet global efforts have made a difference at least for a fraction of the people in need.

G. *Revised Guideline 6 (Now Incorporated Into the Consolidated Guidelines)*

Another such development was the revision of Guideline 6 of the Guidelines.[184] It now recommends extensive government actions to ensure availability of, and equal access to, HIV prevention, treatment and care and support.[185] The text introducing Revised Guideline 6 notes:

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180. UNAIDS & WHO, *Progress on Global Access to HIV Antiretroviral Therapy: An update on "3 by 5"* (June 2005) [hereinafter UNAIDS & WHO (June 2005)]; *see also* UNAIDS & WHO, *Progress on Global Access to HIV Antiretroviral Therapy: A report on "3 by 5" and Beyond* (Mar. 2006).

181. UNAIDS & WHO (June 2005), *supra* note 180, at 22, 27.

182. *Id.* at 24.

183. *Id.* at 18, 22, 23, 28.

184. Revised Guideline 6 was initially published as a separate document (UNAIDS and Office of the U.N. High Comm'r for Human Rights (OHCHR), HIV/AIDS and Human Rights: International Guidelines, Revised Guideline 6, Access to Prevention, Treatment, Care and Support, U.N. DOC. UNAIDS/02.49E (Aug. 2002)); however, this document is no longer available separately as the text and commentary of Revised Guideline 6 have been incorporated into the Consolidated Guidelines. *See Guidelines*, *supra* note 1, at 11-12 (explaining the background of the revision of Guideline 6).

185. Guideline 6 (as revised) reads,

> 23. States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.
> 24. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions.

"Significant developments have taken place with regard to the right to health and access to HIV/AIDS-related prevention, treatment, care and support, including advances in the availability of diagnostic tests and HIV/AIDS-related treatments, including antiretroviral therapies."[186] The Commentary to Guideline 6 (as revised) emphasizes that prevention, treatment care and support are a continuum, and that "[b]ased on human rights principles, universal access requires that these good services and information not only be available, acceptable and of good quality, but also within physical reach and affordable for all."[187] In the "Recommendations for Implementation of Guideline 6," the Guidelines indicate: "[i]n their conduct in international forums and negotiations, States should take due account of international norms, principles and standards relating to human rights. In particular, they should take account of their obligations to respect, protect and fulfil rights related to health, as well as of their commitments to provide international assistance and cooperation."[188]

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

Id. at 37-38.

186. *Guidelines, supra* note 1, at 11.

187. *Id.* Commentary on Guideline 6, ¶ 26, at 38.

188. *Id.* Recommendations on Implementation of Guideline 6, ¶ 51, at 47. It continues,

> States should also avoid taking measures that would undermine access to HIV prevention, treatment, case and support, including access to antiretroviral and other medicines, diagnostics and related technologies, either domestically or in other countries, and should ensure that medicine is never used as a tool for political pressure. Particular attention must be paid by all States to the needs and situations of developing countries.

Id.

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

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There is also, in the same section, an exhortation to make use of TRIPS flexibilities, in order to meet human rights obligations:

> States should ensure that, in interpreting and implementing international agreements, domestic legislation incorporates to the fullest extent any safeguards and flexibilities therein that may be used to promote and ensure access to HIV prevention, treatment, care and support for all, including access to medicines, diagnostics and related technologies. States should make use of these safeguards to the extent necessary to satisfy their domestic and international obligations in relation to human rights. States should review their international agreements (including on trade and investment) to ensure that these are consistent with treaties, legislation and policies designed to promote and protect all human rights and, where those agreements impede access to prevention, treatment, care and support, should amend them as necessary.[189]

H. *New Institutions and Mechanisms: The New African Court, the U.N. Human Rights Council, and a Possible Optional Protocol to the ICESCR*

Current developments, including the new African Court of Human and Peoples' Rights, the new U.N. Human Rights Council, and the possibility of individual complaint under the ICESCR have potentially far-reaching implications for the international protection of HIV/AIDS-impacted rights.[190]

The Organization of African Unity (OAU) was created by the Organization of African Unity Charter.[191] In 1981, the OAU concluded the African Charter on Human and Peoples' Rights (1981)[192] (ACHPR) in Banjul, Gambia. The ACHPR, which includes collective rights and individual duties, entered into force on October 21, 1986.[193]

Id.

189. *Id.* ¶ 53.

190. Another recent development within the African Union is the establishment of the African Centre for Infectious, Endemic Diseases and HIV/AIDS in Cairo. *See* African Union, Executive Council 7th Ordinary Sess. (June 28-July 2, 2005, Sirte, Libya), Decision on Egypt's Proposal to Establish the African Centre for Infectious, Endemic Diseases and HIV/AIDS in Cairo, Doc. EX.CL/Dec.214 (VII), *in* Doc. EX.CL/Dec. 192-235 (VII); for Egypt's proposal, see Doc. EX.CL/205 (VII)/Add.2. African Union documents are available at <http://www.africa-union.org>.

191. Organization of African Unity Charter (1963) [hereinafter OAU Charter].

192. *See* ACHPR, *supra* note 93.

193. African Union, OAU/AU Treaties, Conventions, Protocols, Charters, at http://www.africa-union.org/root/AU/Documents/Treaties/treaties.htm (last visited Dec. 12, 2007).

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The ACHPR provided for an African Commission on Human and Peoples' Rights, a quasi-judicial body with mainly promotional functions and no binding powers.[194] ACHPR Article 45 defined the functions of the commission to include, inter alia, formulating rules on rights and freedoms to be modeled by African States' legislation;[195] cooperating with other African and international institutions concerned with the promotion and protection of human and peoples' rights;[196] ensuring the protection of human and peoples' rights according to the Charter;[197] and interpreting the Charter at the request of a State Party, the OAU or an African Organization recognized by the OAU.[198]

In June 1998, the OAU's Assembly of Heads of State and Government adopted the Protocol Establishing the African Court on Human and Peoples' Rights.[199] The Protocol envisioned an adjudicatory and advisory capacity for the Court, so that it would complement, not replace the commission.[200] Article 3 of the Protocol accorded the African Court of Human and Peoples' Rights the power to decide cases on violations of ACHPR rights (including those of different "generations") or of any other relevant human rights instruments that a respondent state had ratified. The Protocol required fifteen ratifications to enter into force.[201]

Meanwhile, the African Union was established on July 11, 2000,[202] and effectively replaced the OAU. The African Union Assembly is charged with determining African Union policies, monitoring their implementation and ensuring Member State compliance. Today, all African countries—except Morocco—are African Union Members and have ratified the ACHPR.[203]

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194. *See id.* art. 30; *see also* Udeme Essien, *The African Commission on Human and Peoples' Rights: Eleven Years After*, 6 BUFF. HUM. RTS. L. REV. 93 (2000); INST. FOR HUMAN RIGHTS AND DEVELOPMENT (Banjul, Gambia), COMPILATION OF DECISIONS ON COMMUNICATIONS OF THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS: EXTRACTED FROM THE COMMISSION'S ACTIVITY REPORTS, 1994-2001 (2001).

195. ACHPR, *supra* note 93, art.45(1)(b).

196. *Id.* art. 45(1)(c).

197. *Id.* art. 45(2).

198. *Id.* art. 45(3).

199. Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights, June 9, 1998, Doc. OAU/LEG/MIN/AFCHPR/PROT (III) [hereinafter Protocol].

200. *See id.*

201. ACHPR, *supra* note 93, art. 34.

202. Org. of African Unity [OAU], Constitutive Act of the African Union, July 11, 2000, OAU Doc. CAB/LEG/23.15.

203. List of Countries Which Have Signed, Ratified/Acceded to the African Charter on Human and Peoples' Rights [previously Doc. No. CAB/LEG/67.1 (Aug. 19, 2003)], updated version of

The Protocol came into effect on January 25, 2004, six years after its adoption.[204] While the African Court of Human and Peoples' Rights was coming into existence, events in Africa made it clear that the protection of human rights required urgent action and attracted criticism for the slow process,[205] as well as consideration of the Court's role, the role of NGOs, and the need for the right of individual complaint.[206]

In July 2004, the African Union Assembly decided to combine the African Court of Human and Peoples' Rights with the African Court of Justice.[207] The Commission of the African Union hosted expert meetings resulting in recommendations and a draft legal instrument to be considered at the July 2005 ordinary session of the Executive Council; among their recommendations were that: "(1) the operationalisation of the African Court should continue, (2) the ratification of the protocol establishing the Court of Justice of the AI should continue until it comes into force, and (3) that only then should the process to integrate the two courts resume."[208] At

May 26, 2007, *available at* http://www.africa-union.org/root/au/Documents/Treaties/List/African%20Charter%20on%20Human%20and%20Peoples%20Rights.pdf.

204. On Dec. 26, 2003, the Union of Comoros was the fifteenth state to deposit a ratification of the Protocol; thus, the Protocol entered into force on Jan. 25, 2004. The other states to have ratified the Protocol are: Algeria; Burkina Faso; Burundi; Côte d'Ivoire; Gabon; Gambia; Ghana; Kenya; Lesotho; Libya; Mali; Mauritania; Mauritius; Mozambique; Niger; Nigeria; Rwanda; Senegal; South Africa; Togo; Tunisia; Uganda; and the United Republic of Tanzania. AFRICAN UNION, List of Countries which Have Signed, Ratified/Acceded to the African Union Convention on Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (as of Oct. 15, 2007).

205. *See* AMNESTY INT'L, *African Union: Assembly Should Establish an Effective African Court on Human and Peoples' Rights* (A.I. Index IOR 30/018/2004) (July 6, 2004); *Public Statement, Item 8: The Establishment of the African Court on Human and Peoples' Rights* (AI Index IOR 30/0011/2005) (May 6, 2005).

206. *See, e.g.*, Abdelsalam A. Mohamed, *Individual and NGO Participation in Human Rights Litigation Before the African Court of Human and Peoples' Rights: Lessons from the European and Inter-American Courts of Human Rights*, 8 MICH. ST. U.-DCL J. INT'L L. 377 (1999); Vincent O. Orlu Nmhielle, *Towards an African Court of Human Rights: Structuring and the Court*, 6 ANN. SURV. INT'L & COMP. L. 27 (2000); Nsongurua J. Udombana, *An African Human Rights Court and an African Union Court: A Needful Duality or a Needless Duplication?*, 28 BROOK. J. INT'L L. 811 (2003); ASSN. FOR THE PREVENTION OF TORTURE [Geneva], *Occasional Paper, The African Court on Human and Peoples' Rights, Presentation, Analysis and Commentary: The Protocol to the African Charter on Human and Peoples' Rights, Establishing the Court* (Jan. 2000), *available at* http://www.apt.ch/Africa/African%20Court.pdf. *See generally* PROJECT ON INT'L COURTS AND TRIBUNALS, *African Commission and Court of Human and Peoples' Rights—Selected Bibliography* (last updated Apr. 18, 2004), http://www.pict-pcti.org.

207. Decision on the Seats of the African Union, Addis Abiba, Ethiopia, July 6-8, 2004, Doc. Assembly/AU/Dec.45 (III), ¶ 4, *in* Doc. Assembly/AU/Dec.33-54 (III).

208. *See* Coalition for an Effective African Court on Human and Peoples Rights Web Site, http://www.africancourtcoalition. org/editorial.asp?page_id=16 (last visited Dec. 12, 2007). *See also A Human Rights Court for Africa*, 15 FOCUS FOR INTERIGHTS BULL. (London) (2005).

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the July 2005 African Union Summit, the African Union Assembly decided that a draft instrument on the merged courts would be considered at the next meeting of the Executive Assembly,[209] and decided to operationalize the African Court of Human and Peoples' Rights—to elect judges, determine the budget, and operationalize the registry[210]—although the Protocol to the Court of Justice of the African Union[211] was not yet in effect.[212] The first judges of the new Court were elected on January 22, 2006.[213] Issues to be resolved for the merged Court are the relationship between the Court and the commission, individuals' right of access and the role of NGOs.[214]

HIV/AIDS-related claims have the potential to strain the African Court on Human and Peoples' Rights; however, rather than being an argument against a right of individual access, this could equally weigh in favor of it if it could establish precedents according to which States could then set up mechanisms to address widespread violations, at the domestic level. The strength of those mechanisms could later be tested in admissibility decisions of the Court. Litigation relating to alleged violations of: the right to "the best attainable state of physical and mental health" contained in

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209. Decision on the Merger of the African Court on Human and Peoples' Rights and the Court of Justice of the African Union, adopted in Sirte, Libya, July 4-5, 2005, Doc. Assembly/AU/DEC.83 (V), ¶ 2, *in* Doc. Assembly/AU/Dec.73-90 (V). For an analysis of this decision, see Gena Bekker, *The African Court on Human and Peoples' Rights: Safeguarding the Interests of African States*, 51 J. AFR. L. 151-72 (2007).

210. *Id.* ¶ 3. *See also African Court On Human Rights to Merge With AU Justice Court*, ETHIOPIAN HERALD, July 7, 2005.

211. Protocol to the Court of Justice of the African Union, adopted in Maputo, Mozambique, July 11, 2003.

212. The Protocol establishing the African Union's Court of Justice has not entered into force, having received thus far thirteen of the fifteen necessary ratifications. *See* List of Countries Which Have Signed, Ratified/Acceded to the Protocol of the Court of Justice of the African Union, *available at* http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20 the%20Court%20of%20Justice.pdf (last visited Nov. 12, 2007). The countries that have ratified the Protocol to date are: Comoros; Egypt; Gabon; Lesotho; Libya; Mali; Mozambique; Mauritius; Niger; Rwanda; South Africa; Sudan; and the United Republic of Tanzania.

213. African Union Executive Council, Decision on the Election of Judges of the African Court on Human and Peoples' Rights, 8th Ordinary Sess., Khartoum, Sudan, Jan. 16-21, 2006, Doc. EX.CL/Dec.261 (VIII), *in* Doc. EX.CL/Dec.236-277 (VIII) (electing the judges); *see also* African Union Assembly, Decision on the Election of Judges of the African Court on Human and Peoples' Rights, Khartoum, Sudan, Jan. 23-24, 2006, Doc. Assembly/AU/Dec.100 (VI), *in* Doc. Assembly/AU/Dec.91-110 (appointing the judges).

214. *Compare* Protocol to the ACHPR on the Establishment of an African Court on Human and Peoples' Rights arts. 5(3), 34(6), *with* Protocol of the Court of Justice of the African Union, http://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20to%20the%20Africa n%20Court%20of%20Justice%20-%20Maputo.pdf.

ACHPR Article 16;[215] health-related and independent alleged violations of other ACHPR rights; and, alleged violations prohibited by other international legal instruments,[216] could stress the new Court. Yet, such developments could act as a regional catalyst for change, draw needed international attention to ongoing violations, compel states to take necessary steps to protect the rights at issue, and increase dialogue about the responsibilities of the rest of the world. Like other institutions, the African Court will almost certainly be faced with the challenge of apportioning responsibility between heavily impacted and other states, and balancing some states' limited resources with the fact that states are bound by existing obligations, not all of which may be progressively realized.

The new U.N. Human Rights Council recently established by General Assembly resolution[217] should play a significant role in the protection of HIV/AIDS-impacted rights. The resolution creating the council explicitly recognizes the importance of socioeconomic rights and their indivisibility from other rights, and gives the council the mandate to: promote human rights education and provide advisory and technical assistance;[218] serve as a forum for dialogue on thematic issues on all human rights;[219] make recommendations to the General Assembly to further the development of international human rights law;[220] promote the implementation of existing obligations, goals, and commitments;[221] undertake a universal periodic review of states' implementation of human rights;[222] and contribute, through dialogue and cooperation, towards the prevention of human rights violations and respond promptly to human rights emergencies.[223] In fulfilling all of these functions, the council should take a leading role in addressing the global crisis of HIV/AIDS-impacted rights. It is hoped that the council will examine HIV/AIDS as a "thematic issue" in accordance with paragraph 5(b). In so doing, it should examine how, in fulfilling all of its functions, it can improve the protection of HIV/AIDS-impacted rights. In addition, it should require, in the Universal Periodic Review

215. ACHPR, *supra* note 93, art. 16(1).

216. *See* Protocol to the ACHPR on the Establishment of an African Court on Human and Peoples' Rights, art. 3(1) (allowing complaints under other international legal instruments, including other international human rights treaties that have been ratified by the States concerned).

217. Human Rights Council, G.A. Res. 60/251, U.N. Doc. A/RES/60/251 (Apr. 3, 2006).

218. *Id.* ¶ 5(a).

219. *Id.* ¶ 5(b).

220. *Id.* ¶ 5(c).

221. *Id.* ¶ 5(d).

222. Human Rights Council, *supra* note 217, ¶ 5(e). *See also* Human Rights Council, Report of the Fifth Session (11-18 June 2007), U.N. Doc. A/HRC/5/21 (Aug. 7, 2007), at 4-10 (establishing the particulars of the Universal Periodic Review mechanism).

223. *Id.* ¶ 5(f).

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mechanism to begin soon, that States report on how they are meeting their many human rights obligations with respect to people with HIV/AIDS.

Reform of treaty bodies such as the CESCR could also improve the protection of impacted rights. Such reform will now doubtless continue with an eye to developments concerning the Human Rights Council. The possibility of an individual or group complaint mechanism under the ICESCR, formulated in an optional protocol similar to the mechanism under the ICCPR,[224] has been explored by a working group of the soon-to-be defunct U.N. Commission on Human Rights.[225] A strong complaint mechanism under the ICESCR could be a useful tool for redressing HIV/AIDS-related human rights violations.

IV. THE "CONTINUUM" OF HIV/AIDS: A MODEL FOR UNDERSTANDING THE ROLE OF HUMAN RIGHTS IN THE HIV/AIDS PANDEMIC

A. *Health and Human Rights*[226]

Scholars in the interdisciplinary field of "health and human rights" have identified important relationships between the fields of public health and human rights. Current approaches to HIV/AIDS and human rights rely on this groundbreaking work.[227] However, the crossover areas so far identified capture only a portion of the full impact of HIV/AIDS on human rights and vice-versa. Thus, for human rights lawyers to understand the

224. *See* Optional Protocol to the International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 302 [hereinafter Opt. Protocol to ICCPR].

225. *See* C.H.R., Res. 2002/24, U.N. DOC. E/CN.4/RES/2002/24 (Apr. 22, 2002); C.H.R., *Report of the Open-Ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the ICESCR on Its First Session*, U.N. DOC. E/CN.4/2004/44 (Mar. 15, 2004). Since the completion of this Article, the mandate of the Working Group was extended for another two years, in Human Rights Council Res. 2006/3, ¶ 2; in the same paragraph, the Council charged the Working Group with drafting an Optional Protocol to the ICESCR. In July 2007, the Working Group presented the First Draft Optional Protocol on their web site. Open-Ended Working Group on an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, *available at* http://www2.ohchr.org/english/issues/escr/intro.htm. The First Draft Optional Protocol provides for the right of individual and group communications (art. 2) and for NGO communications (art. 3).

226. *See generally* HEALTH AND HUMAN RIGHTS: A READER (Jonathan M. Mann et al. eds., 1999); AIDS IN THE WORLD II (Jonathan Mann & Daniel Tarantola eds., 1996); AIDS IN THE WORLD: A GLOBAL REPORT (Jonathan Mann et al. eds., 1992).

227. WHO, Health and Human Rights, http://www.who.int/hhr/ en/ (last visited Mar. 14, 2007). *Cf.* Introduction to HIV/AIDS and Human Rights, http://www.ohchr.org/english/issues/hiv/introhiv.htm (describing the relationships between health and human rights).

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full impact of HIV/AIDS, this interdisciplinary work can provide a helpful starting point, but it cannot be the whole picture. Much more can be done from the human rights side, and it is human rights—not public health—experts and institutions who should speed up the pace to ensure significant and immediate human rights responses.

One of the pioneering health and human rights scholars, Professor Lawrence O. Gostin,[228] recently authored *The AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations*.[229] In it, he notes that before the work of the late Jonathan Mann (who founded UNAIDS' predecessor organization, the WHO's Global Programme on AIDS), "health and human rights rarely had been linked in an explicit manner."[230]

As envisioned in the classic article Jonathan Mann wrote with Professor Gostin, Sofia Ruskin, and others in the first issue of the *Journal of Health and Human Rights*,[231] the three main relationships between health and human rights are: (1) the impact of health policies on human rights; (2) the impact of human rights violations on health; and (3) the inextricable link between health and human rights.[232] The authors proposed a framework of understanding for health and human rights professionals, including interdisciplinary education and health and human rights collaboration.

In looking at the first relationship, they examined the "burdens" that health policies could put on human rights (i.e., human rights violations that could result from health policies, as a human rights practitioner might say): for example, coercive policies that violate rights to personal integrity and privacy; or, discriminatory assessment that inadequately measures the impact of a health problem on certain groups. They proposed that health professionals "respect human rights in developing policies, programs and practices . . . [and] contribute actively from their position as health workers to improving societal realization of rights."[233] Elsewhere, these

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228. Professor of Law and Assoc. Dean (Research and Academic Programs), Georgetown Univ.; Professor of Public Health, Johns Hopkins Univ.; and, Director of the Georgetown/Johns Hopkins Program on Law and Public Health.

229. *See* GOSTIN, *supra* note 42. *See also* Lawrence O. Gostin et al., *The Domains of Health Responsiveness—A Human Rights Analysis* (WHO, Health and Human Rights Working Paper Series No. 2, 2003), http://www.who.int/hhr/information/en/Series_2%20Domains%20of%20health%20responsiveness.pdf.

230. GOSTIN, *supra* note 42, at 64.

231. Jonathan M. Mann et al., *Health and Human Rights*, 1, No. 1 HEALTH & HUM. RTS. (1994), http://www.hsph.harvard.edu/fxbcenter/V1N1mannetal.htm.

232. *Id.*

233. *Id.*

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scholars have also called for human rights impact assessments for proposed policies.[234]

The authors posited, concerning the second relationship, that the health impacts of human rights abuses are under-appreciated, and that health can be impacted by many, if not all, human rights violations; for example, "governmental withholding of valid scientific health information about contraception or measures (e.g., condoms) to prevent infection with a fatal virus (HIV)."[235] (This implicitly notes the inter-relatedness of generations of rights.) The authors pointed out the adverse effects of occupation-related illness on the right to work, and the recognized need to increase women's education to improve health status in developing countries.

With respect to the third relationship, the authors explored the "inextricable linkage" between health and human rights, which focuses on the underlying conditions affecting both health and human rights. Noting that both fields serve to advance general human well-being, and that both recognize that underlying conditions "establish the foundation for realizing physical, mental and social well-being," the authors questioned why little priority had been given to understand such conditions within health research.[236] Since then, human rights approaches have increasingly incorporated an "underlying condition" or "environment" approach; for example, the Guidelines emphasize such an approach in states' protection of human rights vis-à-vis the pandemic.[237]

But one important difference between the approaches of the fields of public health and human rights is that, whereas public health scholars are

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234. *See* Lawrence O. Gostin & Jonathan M. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1, No.1 HEALTH & HUM. RTS. (1994) (recommending steps to: clarify the public health purpose, evaluate its likely effectiveness; determine whether it is well targeted; examine it for possible human rights burdens; determine whether it is the least restrictive alternative; if a coercive public health measure is the most effective, least restrictive alternative, base it on the "significant risk" standard; and, if a coercive measure is truly necessary to avert a significant risk, guarantee fair procedures to persons affected). *See also* GOSTIN, *supra* note 42, at 68-78. Similarly, Abbott has suggested that "agreements affecting intellectual property rights be subject to objective prior impact assessment. Such evaluations would assist all stakeholders in weighing the trade-offs involved in these agreements." Abbott, *supra* note 120, at 356 n.277 (citing Frederick M. Abbott, *Toward a New Era of Objective Assessment in the Field of TRIPS* and *Variable Geometry for the Preservation of Multilateralism*, 8 J. INT'L ECON. L. 77 (2005)).

235. Mann et al., *supra* note 231.

236. *Id.*

237. *See, e.g.*, Guideline 8: "States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups." *Guidelines*, *supra* note 1, ¶ 60.

forced to do grisly calculations to determine where interventions can be most cost-effective, in theory, the protection of human rights is not subject to such calculations. States cannot choose between their human rights obligations. All individuals and groups protected by rights are owed all existing obligations all the time. But what about the proposition that states must allocate resources efficiently in order to protect rights, including health? It seems that a human rights approach challenges the traditional "greatest good for the greatest number" efficiency approach to public health, because *all* individuals are owed rights, even the most marginalized, socially, geographically, or historically.[238] A human rights approach can test notions of efficiency that result in marginalization and violations. The discretion in public health policies that leaves some people to the side, and contributes to or perpetrates violations, in the name of efficiency, must be re-examined, as HIV/AIDS shows. Conversely, in choosing among possible public health interventions, policymakers should consider the impact on human rights, and that a decision that an obligation is to be short-changed could also constitute a human rights violation. Where relevant rights are justiciable, there may be increased human rights-based interventions with state allocation of resources. These interventions must balance the need for efficiency and protection of the individual—notions that seem intrinsically at odds. But whereas efficiency seems pitted against the individual, increased protection of individuals can improve public health.

The aim of this Article is to increase understanding of what must be understood as a global HIV/AIDS human rights crisis. Thus the last Part of this Article examines select impacted rights. However, it is worth noting that not all impacts on human rights occur via health policies (as in the first crossover area identified by Mann and his colleagues). The impact of HIV/AIDS on human rights must be considered by looking at the totality of factors affecting risk and access, in addition to those created by health policies, or the ill effects on health caused by human rights violations, or rights- and health-degrading underlying conditions. Whereas many human rights impacts can be classed as belonging to one of these three "health and human rights" crossover areas, here, the author suggests another way for understanding the human rights crisis, at least as a point of departure. Part V, which examines select impacted rights, applies this approach to show how the international protection of key rights currently leaves gaps.

238. *See* UDHR, *supra* note 93; Vienna Declaration, *supra* note 94, ¶ 5.

B. *The Continuum of HIV/AIDS: A Model for Understanding*

Medical and public health experts can best describe the "continuum" of HIV and AIDS from the perspective of understanding, respectively, the progress of a disease in an individual, or disease and epidemic control in a population. However, it is submitted that human rights practitioners and policymakers should conceptualize HIV/AIDS in its entirety as a continuum, along which the rights of individuals, groups, and peoples are "primarily" and "secondarily" impacted. This continuum includes all of the stages of an HIV/AIDS epidemic, ranging from pre-infection, to infection, to post-infection, to post-mortem. It is helpful to visualize this continuum along an "x-axis," along which people are drawn in.

Within the field of human rights, a limited idea of a continuum has been adopted with respect to the right to health. For example, Guideline 6 (as revised) recommends actions to ensure availability of, and equal access to, HIV prevention, treatment and care and support; this recommendation is based, inter alia, on the premise that prevention, treatment, care and support are a continuum.[239] In addition, the Committee on Economic, Social and Cultural Rights (the CESCR), charged with monitoring parties' implementation of the ICESCR, has underscored the need to protect the right to health both preventatively and once people are ill, in its General Comment No. 14 on ICESCR Article 12, the right to health.[240] For instance, the committee clarified that the right to health in ICESCR Article 12, specifically, the right to prevention, treatment and control of diseases in Article 12(2)(c), requires states to protect the right to health in all the different stages that occur in an epidemic: prevention, education, prevalence assessment, treatment, and more.[241] The CESCR has further emphasized such an approach, e.g., in underscoring the need to protect women's right to health throughout their "life span."[242]

Thus it should now be widely understood that the right to health must be protected along a continuum. But what is generally lacking is the understanding of how all human rights are impacted along the "continuum" of HIV/AIDS. This continuum can be illustrated as follows:

- pre-infection: prevention; education; and testing
- post-infection: testing and counseling; care, treatment, and support for HIV-positive persons; and care, treatment, and support for persons living with AIDS

239. *See supra* text accompanying notes 179-88.
240. *See* CESCR, *General Comment 14*, *supra* note 144.
241. *See id.* ¶ 16.
242. *Id.* ¶ 21.

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- post mortem.

Human rights are impacted at every stage of this continuum. One can conceptualize this sequential continuum of pre-infection/infection/post-infection/death, or wellness/disease/epidemic as having a spectrum of state human rights obligations attached to it. In other words these obligations run to people along the continuum. That spectrum of state obligations touches different people and groups, e.g.: people at high risk of HIV infection (based on numerous factors), PLHA, their families, caretakers, and sexual partners. State human rights obligations also exist as a "live" background that can positively or negatively affect people along the HIV/AIDS continuum (as described in the "environment" approach mentioned *infra*).

Thus, the HIV/AIDS human rights crisis is complicated in that, along the HIV/AIDS continuum, people are "primarily" or "secondarily" impacted. This means, for example, that a child's rights can be impacted, either primarily, by a state's failure to prevent MTCT or by a failure to educate children about how HIV is transmitted, which could each result in the child's infection; or, secondarily, by a family member's illness or death that results, for example, in the child's loss of education, adequate standard of living, food and water, ability to participate in cultural life, or later infection.[243] People can also be both primarily and secondarily impacted. People can experience such impacts at any point along the continuum. It is worth mentioning that to say that someone is secondarily impacted does not mean that the impact is any less significant than primary impact, or that the state is any less responsible for these rights violations.

Currently, mechanisms to protect impacted rights often only look at a right at one particular point along the continuum, making for uneven, spotty enforcement in terms of responding to the pandemic. Yet certain rights—the right to equality, for instance—are implicated at every stage of the HIV/AIDS continuum. Others may be more important at specific points: for instance, the right to privacy is crucial during testing, care treatment and support for people with HIV/AIDS. Regardless, examining the impact of HIV/AIDS on a certain right should include examining how it is impacted at all points. And, insofar as states have positive obligations vis-à-vis a particular right, such positive obligations must be considered at the various points along the continuum. Another example of a right that must be protected at all points is the right to education. Currently, one

243. *See, e.g.*, GOSTIN, *supra* note 42, at 65 ("Human rights violations also occur against those affected but not infected by HIV, such as the millions of children whose parents have died of AIDS. Some governments fail to protect children who are orphaned by AIDS and at higher risk of human rights abuse." (citations omitted.)).

might look at, for example, women's right to education once they are already infected with HIV (post-infection). To look at the totality of the protection of women's right to education vis-à-vis HIV/AIDS requires examining this right all along the HIV/AIDS continuum, ranging from pre-infection, to access to education once living with HIV or AIDS, and how education is impacted by the deaths of others.

As noted previously, individuals who are already disadvantaged in any given society can be more vulnerable to HIV/AIDS-related human rights violations.[244] Improving human rights protections as a whole, and creating a climate in which human rights are enforced, can therefore help to prevent states' human rights violations with regard to HIV/AIDS. In addition, protecting rights at earlier stages of the continuum can also affect the protection of rights at later stages.

As just listed, the various stages in the HIV/AIDS continuum are somewhat self-explanatory. Following is a brief sketch of how this continuum is inseparable from a spectrum of state obligations that arise along the continuum.

C. *Pre-Infection: Prevention and Education*

States are responsible for helping to prevent new infections—particularly in people validly and nonjudgmentally deemed to be especially vulnerable. Education is needed throughout but merits special attention, pre-infection. States are responsible for educating the public about how HIV can be transmitted and how transmission can be prevented, again, expending extra resources for populations validly deemed to be especially at risk. Education on the rights of PLHA can help to prevent further violations.

D. *Testing*

States, to control the spread of epidemic, must devise health policies that will effectively test the general public but that do not violate other existing rights (e.g., privacy and physical integrity) as protected in municipal and international laws. Accurately assessing the epidemic, for instance in a baseline study,[245] is necessary to control its spread and thereby to protect human rights. In addition, such accurate assessments can provide states with needed leverage in order to make necessary policy decisions, such as those relating to the provision of essential drugs and

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244. *See supra* notes 17-19 and accompanying text.

245. International resources and cooperation are available to help governments to conduct in-depth baseline surveys (e.g., UNAIDS, WHO, OHCHR, and African Medical and Research Foundation (AMREF)).

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supplies. Of course, these supplies are needed to conduct the testing. Yet, adequate regard for rights at this stage of the continuum affects the protection of rights at a later stage.

Laws establishing mandatory testing have been recognized as counterproductive; their coercive nature may impede prevention efforts by alienating those at risk, rather than encouraging conduct that would reduce the spread of HIV.[246] Yet mandatory testing is now being re-examined because of the extent of the crisis in some countries. Ironically, this means that prior failures of states' human rights protection, and of international cooperation, may now result in further "burdens" on individual rights. In contrast, in Botswana, the government recently withdrew regulations that would have imposed a fine for noncompliance with an HIV/AIDS impact survey.[247] A Botswana NGO, Ditshwanelo, had expressed concerns that the imposition of fines for noncompliance would have led to involuntary participation in the survey, and that the information sought was overly intrusive.[248]

E. *Counseling*

Devising a policy to provide for comprehensive testing, without devising a companion policy to include counseling, can result in a failure to prevent the further spread of HIV.[249] Counseling engages further state obligations, for example, privacy considerations in couples' testing, and measures to ensure women's safety where this is at risk. Counseling provides an opportunity to help prevent further transmission and, it is suggested, an opportunity to provide, in a constructive way, HIV-positive and -negative people with information on human rights and HIV/AIDS.

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246. Mark Wojcik, *Global Aspects of AIDS*, *in* AIDS AND THE LAW 265, 286 (David W. Webber ed., 3 ed. Supp. 2006) [hereinafter *Global Aspects of AIDS*, 2006 Supp.]; GOSTIN, *supra* note 42, at 65. *See also* MICHAELA FIGUEIRA & WILLEM ODENDAAL, AIDS LAW UNIT, LEGAL ASSISTANCE CENTRE, TESTING THE AWARENESS OF THE NAMIBIAN PUBLIC AND PRIVATE SECTORS ON THE GUIDELINES FOR THE IMPLEMENTATION OF A NATIONAL CODE ON HIV/AIDS IN EMPLOYMENT, *at* http://www.lac.org.na/alu/Pdf/testawar. pdf (visited Mar. 14, 2007) ("HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at ris[k] of infection (see J. Dwyer, "Legislating AIDS Away: The Limited Role of Legal Persuasion in Minimising the Spread of HIV", in *Contemporary Health Law and Policy, 1993: 197*).").

247. Ditshwanelo—Botswana Centre for Human Rights, Press Statement on the HIV/AIDS Household Survey (Mar. 10, 2004), *at* http://www.ditshwanelo.org.bw/index/Current_Issues/HIV_AIDS/HIV%20AIDS%20Household%20Survey%20-%2010%20March%202004.htm (discussing government withdrawal of Statutory Instrument No. 10 of 2004).

248. *Id.*

249. *See Guidelines*, *supra* note 1, Guideline 3: Public Health Legislation, ¶ 20(c).

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F. *Care, Treatment, and Support for HIV-Positive Persons*

States owe extensive obligations to people who test HIV-positive, whose rights should be identified with those of the population as a whole. Global attempts to posit the interests of the infected and uninfected populations as being diametrically opposed, used by states to justify extreme reactionary measures, have been proved misguided and futile.[250] In many societies, people who test positive for HIV are subject to extreme stigma and discrimination, and in many places the situation is dramatically worse for women.[251] States need to prevent public and private discrimination, for example, in the workplace, against people who are HIV positive. Health facilities (public or private) should not be used in cooperation with government or businesses requiring employees' mandatory HIV testing, some at timed intervals in violation of international human rights and standards. Where there are limited economic opportunities, this practice is especially egregious because employers can take advantage of a surplus of workers. On the "front lines" in many ways (being at the point of service delivery), health workers require training, in conjunction with national programs, on how to avoid acts or omissions that constitute human rights violations. In addition, states should ensure universal access to necessary drugs in order to protect, inter alia, the rights to, equality, health, and life.

G. *Care, Treatment, and Support for Persons Living with AIDS*

Along the same lines, states must effectively implement extensive protections for people living with AIDS, who are often subject to abject poverty, stigma, and discrimination. The rights to dignity, equality, health, and life include the right to health care, and drugs for opportunistic infections or antiretroviral treatment, and access thereto. The rights to food, safe water, and housing must be ensured. Secondary violations must be prevented or mitigated, for example, for children.

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250. *See* Wojcik, *supra* note 15, at 454 (discussing this false dichotomy). *See also* GOSTIN, *supra* note 42, at 65.

> More often than not . . . respect for the rights of the individual will actually promote healthy outcomes. If individuals feel secure in their autonomy and dignity, they are more likely to engage in health-promoting activities, cooperate with public health and medical professionals, and disclose their health status to their sex and needle-sharing partners.

Id.; *see also Screening and Exclusion of Travelers and Immigrants*, *in* GOSTIN, *supra* note 42, at 279-88.

251. *See supra* notes 38-39 and accompanying text.

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H. *Post-Mortality*

Post-mortality issues largely concern the rights of those "adversely affected" (to put it callously) by other people dying of AIDS: individuals, families, communities and peoples. Pre-existing inequalities adversely affect the protection of rights of widows and orphans, such as the rights to an adequate standard of living, property, and housing. Deaths can also threaten the existence of culturally distinct peoples who may already be small in number. Ironically, for some indigenous peoples, the same geographic barriers, that is, mountains, forests or islands, that have facilitated the survival of these distinct cultures also create challenges for states to protect rights like the rights to education and health—which lack now may threaten the existence of such peoples. Similarly, "[c]ountries with small populations, like Namibia, Lesotho and Swaziland, are particularly vulnerable to the impact of HIV/AIDS."[252] The decrease of farmer populations in mountainous areas exacerbates ongoing food crises.[253] Deaths in the education and health sectors worsen already difficult situations, and the protection of these rights. As does sickness, AIDS deaths drastically impact states' populations, agriculture, businesses, and economies.[254]

Improving the overall "environment" of human rights—that is, creating an environment of improved protections for vulnerable groups, and an environment in which human rights are enforced—will affect the protection of rights at all points of the continuum. Thus the Guidelines focus on this environment approach, by addressing protection of vulnerable groups.[255] For States Parties to CEDAW,[256] a similar obligation exists in Article 5(a).[257]

252. *Namibia: Orphan Crisis a Disaster Greater than Floods/Drought*, IRIN, May 4, 2004.

253. *See Swaziland: Humanitarian Crisis Worsening, Warn Relief Agencies*, IRIN, Feb. 28, 2005.

254. *See, e.g.*, UNAIDS, *2006 Report*, *supra* note 4, at 100 fig.4.8, Projected Reduction in African Agricultural Labour Force Due to HIV and AIDS by 2020; *id.* at 79 ch. 4, The Impact of AIDS on People and Societies.

255. *See Guidelines*, *supra* note 1, Guideline 8.

256. *See supra* text accompanying note 96.

257. CEDAW, *supra* note 96, art. 5(a). Article 5(a) requires States Parties to take all appropriate measures

> [t]o 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[.]

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In sum, one must view HIV/AIDS as a continuum, along which rights must be protected. States must uphold their obligations—including their positive obligations—at all points along the continuum. HIV/AIDS is a continuum of wellness, disease and epidemic; HIV/AIDS progresses sequentially from pre-infection to post-mortem. Along this path many rights are implicated—for people primarily and secondarily impacted. Protecting human rights at an earlier phase of the continuum will necessarily reduce both the total number of people primarily and secondarily impacted, and, the number of people impacted at later stages of the continuum. While this preventative approach may seem like a basic principle to public health experts concerned with disease control, human rights lawyers can borrow a page from the public health's book to improve the protection of human rights vis-à-vis HIV/AIDS, while keeping in mind that one cannot choose between binding human rights obligations. In addition, it was posited previously that an interdisciplinary approach was needed to understand states' duties to control factors affecting risk and access to resources. States' actions and omissions with regard to such factors must also be considered at all points along the HIV/AIDS continuum. Thus far, the world has already decided to abandon the majority of people at the later stages of the continuum. For many people suffering from this preventable disease, infections and diarrhea can be the fatal sickness—hardly the world of dignity and rights envisioned by the drafters of human rights treaties.

V. IMPACTED HUMAN RIGHTS

This part examines the implementation of fundamental protections of dignity, equality, nondiscrimination, and life, vis-à-vis HIV/AIDS. It demonstrates the approaches taken to date under the major human rights treaties and how those fit in with the HIV/AIDS continuum. With a few exceptions, the focus is on findings of international, rather than municipal, human rights enforcement bodies.[258] While a panoply of other rights are obviously impacted, especially the right to health (a discrete right, widely protected in international human rights instruments), they could not all be discussed here.

Id.

258. For a comparative law study of litigation concerning discrimination, access to medicines, and prevention and care in prisons, see *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV*, UNAIDS Best Practice Collection, jointly published by the Canadian HIV/AIDS Legal Network and UNAIDS, U.N. Doc. UNAIDS/06.01E (Mar. 2006).

A. *Dignity: International Protections and Their Interpretation Vis-à-Vis HIV/AIDS*

HIV/AIDS threatens the right to dignity that underpins modern human rights. Section III of the Guidelines elaborates on "[i]nternational human rights obligations and HIV/AIDS."[259] It notes at the outset:

> The protection and promotion of human rights are necessary both to the protection of the inherent dignity of persons affected by HIV/AIDS and to the achievement of the public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV and AIDS on those affected and empowering individuals and communities to respond to HIV.[260]

In considering "Human rights standards and the nature of State obligations," the Guidelines emphasize the universality of human rights, and assert that "a rights-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions."[261]

The UDHR describes dignity as an underlying basis for the UDHR in the first line of the Preamble,[262] in Article 1,[263] and in Article 4. Jonathan Mann and his colleagues, in looking at the health effects of human rights violations (the second health and human rights crossover area), considered the great reach of violations of dignity as elaborated in the UDHR: they identified a "complex problem involv[ing] the potential health impact associated with violating individual and collective dignity."[264] They continued:

> The [UDHR] considers dignity, along with rights, to be inherent, inalienable and universal. While important dignity-related health impacts may include such problems as the poor health status of

259. *See Guidelines, supra* note 1, ¶¶ 94-153.

260. *Id.* ¶ 94.

261. *See id.* ¶ 101.

262. UDHR, *supra* note 93, pmbl. The Preamble begins with recognition of "the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world," and stresses how, in the Charter, peoples "reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and . . . determined to promote social progress and better standards of life in larger freedom." *Id.*

263. *Id.* art.1. Article 1 provides, "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." *Id.*

264. Mann et al., *supra* note 231.

> many indigenous peoples, a coherent vocabulary and framework to characterize dignity and different forms of dignity violations are lacking. A taxonomy and an epidemiology of violations of dignity may uncover an enormous field of previously suspected, yet [thus far] unnamed and therefore undocumented damage to physical, mental and social well-being.[265]

This vocabulary is still lacking.

The common preambular language of the ICCPR and the ICESCR stresses the dignity of all people, and dignity as a foundation for all rights.[266] ICCPR Article 8 also protects this right. In its Preamble, the American Convention on Human Rights[267] recognizes the universal basis for human rights and incorporates such principles as enshrined in the American Declaration of the Rights and Duties of Man,[268] the UDHR, and elsewhere, which include dignity.[269]

The ACHPR similarly emphasizes dignity in its Preamble.[270] In addition, ACHPR Article 5 stresses the universal nature of human dignity: "Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status."[271] The African Commission on Human and Peoples' Rights has considered the application of Article 5 to prisoners receiving inadequate medical care, finding that "[t]he conditions of overcrowding and acts of beating and torture that took place in prisons in Malawi" and "excessive solitary confinement, shackling within a cell, extremely poor quality food and denial of access to adequate

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265. *Id.*

266. ICCPR, *supra* note 94, pmbl.; ICESCR, *supra* note 93, pmbl. They provide, "Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." ICCPR, *supra* note 94, pmbl.; ICESCR, *supra* note 93, pmbl.

267. American Convention on Human Rights, Nov. 22, 1969, O.A.S. T.S. No. 36; 1144 U.N.T.S. 123 [hereinafter ACHR].

268. Res. XXX, adopted by the Ninth International Conference of American States (1948), *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, OAS/Ser.L/V/I.4 Rev. 9 (2003).

269. ACHR, *supra* note 267, pmbl.

270. ACHPR, *supra* note 93, pmbl. It invokes "the Charter of the Organi[z]ation of African Unity, which stipulates that 'freedom, equality, justice and dignity are essential objectives for the achievement of the legitimate aspirations of the African peoples.'" *Id.*

271. *Id.* art. 5.

medical care" violated Article 5.[272] By implication, inadequate medical care as concerns HIV/AIDS in prisons would violate ACHPR Article 5.

At the national level, the right to dignity has been the subject of HIV/AIDS litigation, in conjunction with other rights. For example, in a recent case before the Colombian Constitutional Court, reported in the *HIV/AIDS Policy and Law Review*,[273] the plaintiff alleged that her rights to life, equality and dignity were violated upon the nonrenewal—allegedly based on her HIV status—of her fixed-length employment contract.[274] Noting that the employee had complied with the contract and that the conditions that give rise to the contract were still in force, the Court found that she had a right to contract renewal, based on the constitutional principles of stability of employment and solidarity (previously recognized in Colombian law) and the obligation to progressively improve the quality of life for marginalized groups.[275] In the Court's view, "[a]s a matter of humanitarianism and solidarity . . . there [was] a general constitutional obligation to assist those who need help."[276] Elsewhere, a Ukraine District Court recently held that the complainant's constitutional rights to dignity[277] and work[278] had been violated when the employer harassed and terminated the plaintiff based on an HIV-positive status.[279] Article 3 of Ukraine's Constitution gives the highest priority to human rights: it provides, in part,

272. *See* Communication 64/92, 68/92, 78/92, Achutan (on behalf of Banda) and Amnesty Int'l (on behalf of Orton and Vera Chirwa) v. Malawi, African Comm'n on Hum. and Peoples' Rights, ¶ 7 (1995).

273. Germán Humbero Rincón Perfetti, *Columbia: Constitutional Court Grants Interim Order Reinstating HIV-Positive Woman in Her Job*, 10 HIV/AIDS POL'Y & L. REV., Apr. 2005, at 57. *See also* Tetyana Bordunis, *Ukraine: Dismissal on the Basis of HIV Status Ruled Unconstitutional*, 10 HIV/AIDS POL'Y & L. REV 60 (2005) (discussing case in which Ukrainian District Court held that complainant's constitutional rights to dignity and work had been violated when employer harassed and terminated plaintiff based on HIV-positive status).

274. *Id.* at 57.

275. *Id.* at 58.

276. *Id.*

277. UKR. CONST. 1996, art. 3, *in* COUNCIL OF EUROPE, CONSTITUTIONS OF EUROPE: TEXTS COLLECTED BY THE COUNCIL OF EUROPE VENICE COMMISSION, Vol. 2, 1943 (2004). The Constitution protects the right to dignity, throughout: "The human being, his or her life and health, honour and dignity, inviolability and security are recognised in Ukraine as the highest social value" (Art. 3); "All people are free and equal in their dignity and rights" (Art. 21); "Everyone has the right to respect of his or her dignity" (Art. 28); "Everyone is obliged to strictly abide by the Constitution of Ukraine and the laws of Ukraine, and not to encroach upon the rights and freedoms, honour and dignity of other persons" (Art. 68). *Id.*

278. UKR. CONST. 1996, art. 43. Article 43 provides, in part, "Everyone has the right to labour, including the possibility to earn one's living by labour that he or she freely chooses or to which he or she freely agrees," and, "Citizens are guaranteed protection from unlawful dismissal." *Id.*

279. *See* Tetyana Bordunis, *Ukraine: Dismissal on the Basis of HIV Status Ruled Unconstitutional*, 10 HIV/AIDS POL'Y & L. REV., Apr. 2005, at 60.

"Human rights and freedoms and their guarantees determine the essence and orientation of the activity of the State. The State is answerable to the individual for its activity. To affirm and ensure human rights and freedoms is the main duty of the State."[280] In that case, the complainant also relied on Article 17 of the Law of Ukraine on AIDS Prevention and Social Protection of Population, which makes it clear that PLHA enjoy all rights in the Ukrainian Constitution.[281]

In general, the right to dignity is jeopardized by preventable ill health, by widespread discrimination, and by the many indignities forced upon the ill and dying, many of whom are impoverished and inadequately cared for. Widespread stigma and discrimination also presumably injure the right to dignity of a person who feels obligated to obfuscate the cause of his or her impending death, as occurs from place to place. Presumably, this infringement of dignity does not have good health effects. For people primarily and secondarily impacted, dignity is threatened, for example, by reduced access to education, work, and participation in cultural life. As HIV/AIDS-related human rights violations increasingly appear in courts around the world, the right to dignity, widely protected on paper in international law and in many constitutions, should be increasingly at issue. Dignity must be protected all along the continuum for people primarily and secondarily impacted. In addition, ensuring dignity as a "live" background, or environment, will improve the lives of people impacted along the continuum, and society as a whole.

B. *Equality: International Protections and Their Interpretation Vis-à-Vis HIV/AIDS*

The Guidelines emphasize equality all throughout the different guidelines and accompanying commentary and recommendations.[282] The UDHR provides for the right to equality in Articles 1[283] and 7.[284] UDHR Article 7 requires equal protection of the law for all people.[285]

The preambular language contained in both the ICCPR and the ICESCR stresses States Parties' recognition of equality, along with

280. UKR. CONST. 1996, art. 3.

281. Bordunis, *supra* note 279, at 60.

282. *See, e.g.*, *Guidelines*, *supra* note 1, § III, International Human Rights Obligations and HIV/AIDS, ¶¶ 107-09.

283. *See supra* note 263.

284. *See infra* note 285.

285. UDHR, *supra* note 93, art. 7. Article 7 provides, "All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination." *Id.*

dignity.[286] The ICCPR and the ICESCR also take similar approaches in common Article 3 of each text, requiring State Parties to extend equally to men and women the rights protected in the treaties.[287] The ICCPR also provides for equality before the law and equal protection of the law for people in the category "or other status."[288] The Human Rights Committee (the Committee), responsible for overseeing implementation of the ICCPR, has considered these provisions, if not in light of HIV/AIDS directly, with respect to problems that exacerbate, and are exacerbated by HIV/AIDS.[289]

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286. *See supra* note 266.

287. ICCPR, *supra* note 94, art. 3; ICESCR *supra* note 93,art. 3. ICCPR Article 3 provides, "The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant." Similarly, ICESCR Article 3 provides, "The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant." ICCPR, *supra* note 94, art. 3; ICESCR, *supra* note 93, art. 3.

288. ICCPR, *supra* note 94, art. 26.

> All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Id.

289. HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights Comm.: Uganda*, ¶ 9, U.N. DOC. CCPR/CO/80/UGA (May 4, 2004) [hereinafter HUMAN RIGHTS COMM., *Uganda*].

> The Committee notes with concern the continued existence of customs and traditions in the State party that affect the principle of equality of men and women and that may impede the full implementation of many provisions of the Covenant. In particular, the Committee deplores the fact that polygamy is still recognized by law in Uganda; in this context, it refers to its general comment No. 28, which states that polygamy is incompatible with equality of treatment with regard to the right to marry . . . . (arts. 3 and 26).

Id.; *see also* HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights Comm.: Namibia*, ¶ 9 U.N. DOC. CCPR/CO/81/NAM (July 30, 2004)[hereinafter HUMAN RIGHTS COMM., *Namibia*].

> The Committee welcomes the Married Persons Equality Act, which eliminates discrimination between spouses. It nevertheless remains concerned by the high number of customary marriages which continue to be unregistered. It is also concerned about the deprivation of rights that women and children experience as a consequence, in particular with regard to inheritance and land ownership (arts. 3, 23 and 26).

HUMAN RIGHTS COMM., *Namibia*, *supra*.

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The ACHR provides for a person's right to equal protection of the law.[290] The ACHPR includes equality in its Preamble[291] and in Article 3, which provides for equality before the law[292] and the equal protection of the law.[293] In addition, the ACHPR provides for equal access to public property and services in Article 13(3), which, in the context of HIV/AIDS, could include information, education, health services, medicines, etc.: "Every individual shall have the right of access to public property and services in strict equality of all persons before the law."[294]

The right to equality is currently especially threatened for vulnerable individuals, groups and peoples all along the HIV/AIDS continuum, that is, from pre-infection to post-mortem. People primarily and secondarily impacted by HIV/AIDS are owed the equal protection of all rights and equal protection of the law at every stage of an epidemic.

C. *Nondiscrimination: International Protections and Their Interpretation Vis-à-Vis HIV/AIDS*

Freedom from discrimination is crucial for people at risk and for PLHA. For the latter, one's serostatus is often the basis for discrimination, in violation of international and municipal human rights obligations. Like the basic rights of dignity and equality, prohibitions against discrimination can protect those affected by HIV/AIDS and can help buttress their other rights. The Guidelines emphasize nondiscrimination as one of the most vital protections for persons living with HIV/AIDS; recommendations to eliminate discrimination are found throughout all of the Guidelines.[295] Guideline 6 (as revised) emphasizes this approach: "States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations."[296] But the Guidelines emphasize that changing the law is insufficient to change problems

290. ACHR, *supra* note 267, art. 24. Article 24, Right to Equal Protection, provides: "All persons are equal before the law. Consequently, they are entitled, without discrimination, to equal protection of the law." *Id.*

291. *See supra* note 270.

292. ACHPR, *supra* note 93, art. 3(1).

293. *Id.* art. 3(2).

294. *Id.* art. 13(3).

295. *See, e.g.*, *Guidelines*, *supra* note 1, Guideline 5, Anti-Discrimination and Protective Laws, ¶ 22 (a-j); *id.* Guideline 8, Women, Children and Other Vulnerable Groups, ¶ 60 (a-j); *id.* Commentary on Guideline 8, ¶ 61; *id.* Guideline 9, Changing discriminatory attitudes through education, training and the media, ¶ 62 (a-f); *id.* Commentary on Guideline 9, ¶ 63. *See also Guidelines*, *supra* note 1, Guideline 6 (as revised), Recommendations for Implementation, ¶¶ 30-31.

296. *Guidelines*, *supra* note 1, Guideline 6 (as revised), ¶ 25.

relating to stigma and discrimination.[297] Difficult societal and behavioral changes must occur.[298] In many countries, even where there is estimated to be widespread awareness nationally, behavior is slow to change.[299] To what extent are states responsible for life-threatening behavior? One must also ask if vulnerable groups are getting prevention messages, or have access to inexpensive protective measures or health education.

Discrimination on a variety of grounds is prohibited in many international human rights instruments. Many contain a catch-all prohibited ground for discrimination, that based on "other status," in addition to specifically named grounds like race and sex. Responding to ongoing discrimination violations, "[t]he Commission on Human Rights has confirmed that 'other status' in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS."[300] In addition, "[o]n several occasions, the [Commission on Human Rights] has . . . urged states to review their legislation in line with the Guidelines and especially to create mechanisms to enforce measures related to discrimination based on HIV status."[301]

"Health status" and "other status," applying the concept that rights must be protected at all points of the HIV/AIDS continuum, also protect healthy individuals. Discrimination can be, and often is, on the basis of serostatus: in other words, it can occur post-infection. But "health status" and "other status" should be understood to be prohibited grounds for discrimination for people who have an actual or perceived low or high risk of contracting HIV, potentially because of membership in one or more

297. See, for example, the discussion of Namibia's policy response, subsequent continued widespread discrimination, and eventual adoption of a HIV/AIDS Charter of Rights in 2000, in *Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 362-69.

298. *See, e.g.*, *Botswana: Raising Youth AIDS Awareness like 'Trying to Fight a Dead Animal,'* IRIN, Jan. 26, 2005.

299. Charles Ayiku, *HIV AIDS and Sports in Ghana*, ModernGhana.Com, Jan. 1, 2007, http://www.modernghana.com/GhanaHome/lifestyle/lifestyle_details.asp?id=VFhwTlBRPT0=&menu_id=16. "While awareness in Ghana of the epidemic is thought to be over 95%, this awareness has yet to translate into widespread behavioural change." *Id.* "While HIV/AIDS awareness among the population is high (above 80%), behaviour change is very slow with new infections being contracted." UNAIDS, *Country Level*, *supra* note 44, at 92.

300. *See Guidelines*, *supra* note 1, § III, Int'l Human Rights Obligations and HIV/AIDS, ¶ 108, n.40 (citing, inter alia, The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), C.H.R., Res. 1995/44, U.N. DOC. E/CN.4/RES/1995/44 (Mar. 3, 1995); The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), U.N. DOC. E/CN.4/RES/1996/43 (Apr. 19, 1996).

301. Csete, *supra* note 22, at 10 (citing the Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), C.H.R. Res. 2003/47); *see supra* note 145.

groups.[302] Discrimination, and risk and access can form a cycle. Thus, states must prevent discrimination against people perceived to be—or actually at risk of—infection, on the basis of their presumed or actual HIV status, in addition to discrimination post-infection.[303] This necessarily wider approach to discrimination can be used in conjunction with a variety of rights in existing human rights treaty mechanisms that protect particular vulnerable groups.

Turning to international human rights instruments, UDHR Article 2 proscribes discrimination in the extension of the rights of the UDHR, including that based on "other status."[304] Similarly, the ECHR prohibits discrimination in the extension of ECHR-protected rights via Article 14, which includes "other status."[305] In *Nitecki v. Poland*[306] (discussed later, under the right to life) the European Court of Human Rights briefly considered the application of Article 14 to a state's nonprovision to a pensioner of the full cost of a life-saving drug, in accordance with the

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302. For example, it could be widely believed that a certain rural community is unaffected by HIV/AIDS; as a result, a state takes no steps whatsoever to protect the health of that community with respect to HIV/AIDS—no prevention measures, no health education, no health care, no protection for those secondarily impacted by others' deaths. Arguably, inaction based on perceived safety or geographic location could amount to discrimination based on "other status" (this could be in addition to membership in an indigenous people, as another prohibited ground, for some).

303. *See Guidelines*, *supra* note 1, § III, Int'l Human Rights Obligations and HIV/AIDS, ¶ 108.

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

Id. n.41. *See also* UNAIDS, *Report of the UNAIDS Expert Panel on HIV Testing in U.N. Peacekeeping Operations* (Nov. 28-30, 2001, Bangkok, Thailand), *available at* http://www.unaids.org. *Compare* Price-Smith & Daly, *supra* note 142.

304. UDHR, *supra* note 93, art. 2. Article 2 provides, "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status*." *Id.* (emphasis added).

305. ECHR, *supra* note 139. Article 14, Prohibition of discrimination, provides, "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth *or other status*." *Id.* (emphasis added).

306. Nitecki v Poland [2002] App. No. 65653/01, Eur. Ct. H.R., decision of Mar. 21, 2002 (inadmissible). Case law under the ECHR can be found at the Court's Web Site at http://www.echr.coe.int/echr/.

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state's insurance scheme. In this decision,[307] the Court considered that the respondent state's socioeconomic difficulty in allocating "scarce financial resources" sufficiently justified the treatment received by the applicant, and deemed manifestly ill-founded the relevant part of the application.[308]

The European Social Charter,[309] said to be the social rights counterpart to the ECHR, also prohibits discrimination. The Charter's Preamble indicates, "the enjoyment of social rights should be secured without discrimination on grounds of race, colour, sex, religion, political opinion, national extraction or social origin."[310] While the original text does not include "disability" or "other status," this was improved in the 1996 revised version[311] which "prohibits discrimination in the enjoyment of Charter rights on grounds of race, sex, language, religion, political or other opinion, national extraction or social origin, *health*, association with a national minority, birth *or other status*."[312] The categories, "health" and "or other status," are thus significant improvements vis-à-vis HIV/AIDS.

ICCPR Article 2(1) also contains a prohibition of discrimination based on "other status."[313] The Committee has observed that Article 2 requires states' antidiscrimination legislation adequately to protect PLHA.[314] The

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307. *Id.* The Law, ¶ 3.

308. *Id.*

309. European Social Charter, Oct. 18, 1961, Europ. T.S. No. 35 [hereinafter EUR. SOC. CHARTER]. Three Protocols were added to the Charter in 1988, 1991, and 1995. The revised Social Charter was opened for signature in 1996 and entered into force on July 1, 1999. It will progressively replace the first Charter. The European Committee of Social Rights is the body responsible for monitoring compliance in States Party to the Charter. Eur. Soc. Charter (revised), May 3, 1996, Europ. T.S. No. 163.

310. EUR. SOC. CHARTER, *supra* note 309, pmbl.

311. *Id.* pt. V, art. E.

312. *See* DONNA GOMIEN ET AL., LAW AND PRACTICE OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND THE EUROPEAN SOCIAL CHARTER 407 (Council of Eur. Publ'g 1996) (emphasis added).

313. ICCPR, *supra* note 94, art. 2(1). Article 2(1) reads,

> Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status.*

Id. (emphasis added).

314. HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights Comm.: Trinidad and Tobago*, ¶ 11, U.N. DOC. CCPR/CO/70/TTO (Nov. 10, 2000), *compare Comments by Gov't of Trinidad and Tobago on Concluding Observations of the Human Rights Comm.*, ¶¶ 32-33, U.N. DOC. CCPR/CO/70/TTO/Add.1 (Jan. 15, 2001). Concerning Trinidad and Tobago, the Committee observed, "The State party should, thereafter, introduce amending legislation to extend the

Committee has also considered Article 2 with respect to discrimination violations that exacerbate, and are exacerbated by HIV/AIDS.[315] The ICESCR contains a similar protection in Article 2(2).[316]

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)[317] contains additional prohibitions against discrimination relevant to HIV/AIDS.[318] Article 2 requires that States Parties prevent and eliminate discrimination "by all appropriate means and without delay," and imposes positive obligations.[319] The ICERD also makes it clear, in Article 5, that Articles 2 and 5 should be applied together to eliminate racial discrimination: Article 5 provides for equality before the law, including in the enjoyment of economic, social and cultural rights, and in particular, of "[t]he right to public health, medical care, social security and social services."[320] While Article 14 permits individual complaints to States Parties that have made the necessary declaration, this mechanism has rarely been used, let alone in the context of HIV/AIDS.

The Committee on the Elimination of Racial Discrimination has mentioned HIV/AIDS in several concluding observations on states' reports submitted in accordance with ICERD Article 9. As evident from the examples cited below, immediately following this paragraph, the committee's focus has varied. It has noted: concerns about infection and prevalence in some vulnerable groups; the potential discriminatory

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provisions of the Act to those suffering discrimination on grounds of age, sexual orientation, pregnancy or infection with HIV/AIDS." HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights Comm.: Trinidad and Tobago*, ¶ 11, U.N. DOC. CCPR/CO/70/TTO (Nov. 10, 2000).

315. *See, e.g.*, HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights. Comm.: Kenya*, ¶¶ 9-10, U.N. Doc. CCPR/CO/83/KEN (Apr. 29, 2005) [hereinafter HUMAN RIGHTS COMM., *Kenya*] (noting with concern limited access to domestic courts and enforcement of court orders and judgments and systematic discrimination against women on a host of matters.

316. ICESCR, *supra* note 93, art. 2(2). Article 2(2) reads, "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status*." *Id.* (emphasis added).

317. International Convention on the Elimination of All Forms of Racial Discrimination, Dec. 21, 1965; 660 U.N.T.S. 195 [hereinafter ICERD].

318. *Id.* art. 1(1). Article 1(1) defines "racial discrimination" as

> any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

Id.

319. *See id.* art. 2(1), 2(1)(b-d).

320. *Id.* art. 5(e)(iv).

protection of the right to health; strategies for responding to an epidemic sweeping a country, especially impacting certain groups; giving due consideration to the specific situation of women; and, the inhibiting effect of HIV/AIDS on the protection of all ICERD rights.

In 1995, concerning Article 2, the committee requested more information on Italy's ethnic minorities (e.g., the Roma, foreign nationals, and migrant workers) and on "social indicators," including diseases such as AIDS, for these groups.[321] In 1997, with regard to Norway, the committee expressed "concern that the State party's health services allege that immigrants of African descent disproportionately test positive for HIV, and that Africans have been obliged to undergo tests for HIV simply because they are Africans."[322]

The committee praised Germany in 2001 for its delegation's willingness to answer "questions concerning, *inter alia*, the State party's response to the concerns of developing countries with respect to the high prices of medicines for persons living with HIV/AIDS."[323] In 2002, with respect to Botswana, the committee concluded, "The Committee is concerned that HIV/AIDS affects all population groups in Botswana. It requests more information on the impact on the various ethnic groups of the national strategies developed in this regard, and that due consideration be given to the specific situation of women."[324] That year, the committee also expressed concern about Lithuania's new restrictive law on citizenship, specifically "about the denial of citizenship under article 13 of the Law on Citizenship to persons affected by HIV/AIDS, who may belong to groups vulnerable to racism and racial discrimination."[325] Concerning Mali, the committee requested additional information on "the impact of AIDS and other endemic diseases and the measures envisaged to control and prevent them."[326]

In 2003, the committee recognized HIV/AIDS as one of the factors and difficulties impeding implementation of ICERD in both Malawi and

321. Comm. on the Elimination of Racial Discrimination (CERD), *Report of the CERD*, ¶ 81, ¶ 108, U.N. DOC. A/50/18 (Sept. 22, 1995).

322. CERD, *Conclusions and Recommendations of CERD, Norway*, ¶ 16, U.N. Doc. CERD/C/304/Add.40 (Sept. 18, 1997). *See* ICERD, *supra* note 317, arts. 2, 5(e)(iv) (guaranteeing the right to equality before the law in the enjoyment of the right to health).

323. CERD, *Concluding Observations of the CERD: Germany*, ¶ 9, U.N. Doc. CERD/C/304/Add.115 (Apr. 27, 2001).

324. CERD, *Concluding Observations of the CERD: Botswana*, ¶ 306, U.N. Doc. A/57/18 (Jan. 11, 2002).

325. CERD, *Concluding Observations of the CERD: Lithuania*, ¶ 12, U.N. Doc. CERD/C/60/CO/8 (May 21, 2002).

326. CERD, *Concluding Observations of the CERD: Mali*, ¶ 405, U.N. Doc. A/57/18 (Jan. 11, 2002).

Uganda. Of Malawi, it noted, "The Committee is aware that the State party is currently facing a very difficult situation, owing in part to serious food shortages and a very high incidence of AIDS among the population."[327] Regarding Uganda, in addition to recognizing HIV/AIDS as one of the factors and difficulties impeding the implementation of the Convention,[328] the committee expressed concern "about the rapid spread of this disease which affects the population throughout the country, particularly marginalized ethnic groups,"[329] and recommended "that the State party continue to develop strategies in this regard and that, in this context, due consideration be given to the specific situation of women."[330]

A final example of the interpretation of nondiscrimination under ICERD vis-à-vis HIV/AIDS occurs in the Committee's observations on Suriname's 2004 report, expressing concern about "information about the spread of sexually transmitted diseases such as HIV/AIDS amongst indigenous and tribal people, in connection with the expansion of mining and forestry operations in the interior of the country," and recommending "that the State party introduce a plan of action to combat AIDS in the interior."[331]

The ACHR prohibits discrimination in the extension of ACHR rights by means of Article 1, which includes the catch-all prohibited ground, "or any other social condition."[332] The ACHR's Protocol of San Salvador takes the same approach, concerning rights enshrined therein.[333]

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327. CERD, *Concluding Observations of the CERD: Malawi*, ¶ 4, U.N. Doc. CERD/C/63/CO/12 (Dec. 10, 2003).

328. CERD, *Concluding Observations of the CERD: Uganda*, ¶ 7, U.N. Doc. CERD/C/62/CO/11, ¶ 7 (Mar. 21, 2003).

329. *Id.* ¶ 18.

330. *Id.*

331. CERD, *Concluding Observations of the CERD: Suriname*, ¶ 17, U.N. Doc. CERD/C/64/CO/9 (Apr. 28, 2004).

332. ACHR, *supra* note 267, art. 1. Article 1, Obligation to Respect Rights, provides:

> The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, *or any other social condition.*"

Id. (emphasis added).

333. Protocol of San Salvador, art. 3, Nov. 17, 1988, O.A.S.T.S. No. 69. Article 3, Obligation of Non-Discrimination, provides: "The State Parties to this Protocol undertake to guarantee the exercise of the rights set forth herein without discrimination of any kind for reasons related to race, color, sex, language, religion, political or other opinions, national or social origin, economic status, birth *or any other social condition.*" *Id.* (emphasis added).

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Likewise, ACHPR Article 2 prohibits discrimination based on "fortune" and on "other status."[334] The African Commission on Human and Peoples' Rights has considered the application of Article 2 in several communications concerning discrimination on the basis of national origin and mass expulsion of aliens,[335] but has yet to interpret "other status" in the context of HIV/AIDS. However, in Commission Nationale des Droits de l'Homme et des Libertés v. Chad, the Commission interpreted Article 1 of the ACHPR to mean that States Parties must *ensure* the rights guaranteed in the Charter, "even if the State or its agents are not the immediate cause of the violation,"[336] meaning that States Parties can be held responsible under the ACHPR for far-reaching discrimination vis-à-vis HIV/AIDS and Charter rights (all along the continuum); in that decision, the Commission also emphasized the non-derogable nature of all the rights in the Charter,[337] thus, even if HIV/AIDS constitutes a national emergency, this does not preclude the wrongfulness of acts or omissions contravening the Charter.[338] In addition, "in cases of massive violations, the state will be presumed to have notice of the violations within its territory. The pervasiveness of these violations dispenses with the requirement of exhaustion of local remedies, especially where the state took no steps to prevent or stop them."[339]

The Preamble of the CRC[340] incorporates the International Bill of Rights' requirements of nondiscrimination.[341] In addition, CRC Article 2

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334. ACHPR, *supra* note 93, art. 2. Article 2 provides, "Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth *or other status*." *Id.* (emphasis added).

335. African Comm'n on Human and Peoples' Rights Communications: Rencontre Africaine pour la Defense des Droits de l'Homme v. Zambia, Communication No. 71/92 (1996); Union Inter Africaine des Droits de l'Homme, Federation Internationale des Ligues des Droits de l'Homme and Others v. Angola, Communication No. 159/96 (1997); Organisation Mondiale Contre la Torture and Others v Rwanda, African Commission on Human and Peoples' Rights, Communication Nos. 27/89, 46/91, 49/91 and 99/93 (1996).

336. African Commission on Human and Peoples' Rights, Commission Nationale des Droits de l'Homme et des Libertes v Chad, ¶ 20, Comm. No. 74/92 (1995).

337. *Id.* ¶ 21.

338. *Id.*

339. Nsongurua J. Udombana, *So Far, So Fair: The Local Remedies Rule in the Jurisprudence of the African Commission on Human and Peoples' Rights*, 97 AM. J. INT'L L. 1, 24 n.195 (2003) (citing Communication 27/89, 46/91, 49/91, 99/93, *supra* note 335, ¶ 17).

340. CRC, *supra* note 96, pmbl.

341. *Id.*

> Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein,

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prohibits discrimination against the child either based on the child's "other status,"[342] or, notably, because of the "status" of the child's parents, guardians or family members.[343] The Committee on the Rights of the Child has implemented this broader protection from discrimination, effectively recognizing that violations against children can occur as a trigger effect. It has expressed concern about discrimination against children "infected with" or "affected by" HIV/AIDS. For example, in 1997, the Committee noted discrimination against children with HIV/AIDS and orphans in its concluding observations on Ethiopia,[344] expressing concern at "the persistence of discriminatory social attitudes against vulnerable groups of children, such as the girl child, disabled children, children born out of wedlock and children affected by or infected with HIV/AIDS, including orphans."[345] In 2000, the Committee considered CRC Article 2 vis-à-vis HIV/AIDS in its concluding observations on Cambodia's initial report: "With regard to article 2 of the Convention, the Committee expresses its concern at the existing patterns of discrimination on the grounds of gender, ethnic origin, HIV/AIDS status and disability."[346] It broadly recommended "that the State party ensure that all the rights enshrined in the Convention are enjoyed by all children, without any distinction."[347]

> without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status* . . . ."

Id. (emphasis added).

342. *Id.*, art. 2(1).

343. *Id.*, art. 2. Article 2 provides,

> 1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of *the child's or his or her parent's or legal guardian's* race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, *disability*, birth *or other status*.
>
> 2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of *the status*, activities, expressed opinions, or beliefs *of the child's parents, legal guardians, or family members*.

Id. (emphasis added).

344. COMM. ON RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on Rights of the Child: Ethiopia*, U.N. DOC. CRC/C/15/Add.67 (Jan. 24, 1997).

345. *Id.* ¶ 14.

346. COMM. ON RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child: Cambodia*, ¶ 27 U.N. DOC. CRC/C/15/Add.128 (June 28, 2000).

347. *Id.* ¶ 28.

In 2001, with respect to Lesotho, the Committee expressed a number of concerns: "that there continues to be serious discrimination in the State party, which has a negative impact on respect for children's rights and particularly on the rights of girls"; "that married women have the legal status of minors and this situation can, in certain circumstances, negatively affect respect for the rights of their children"; "that the State party has not taken measures to address discrimination against children who are born out of wedlock, those affected by HIV/AIDS, children in remote rural areas, children born of incestuous relationships, institutionalized children, pregnant girls, children with disabilities, street children and children of ethnic minority groups"; "that many children do not have adequate or equal access to education and health services, in particular children in the vulnerable groups mentioned above."[348] The described discrimination occurs at various points along the HIV/AIDS continuum; it affects many rights; it demonstrates primarily and secondarily impacted rights; and, it illustrates the need for an "environment" approach as recommended by the Guidelines.

In 2003, the Committee addressed discrimination and HIV/AIDS in its concluding observations on several countries' reports. Regarding Jamaica, the Committee expressed concern that Jamaica's Constitution was inconsistent with CRC Article 2 (i.e., it did not prevent discrimination on grounds of disability or other status), and that "[c]hildren who are known to be infected with HIV/AIDS are discriminated against at school by some teachers."[349] Thus it recommended that Jamaica protect "children infected or affected by HIV/AIDS" by amending its legislation and Constitution to comply with Article 2.[350] Addressing HIV/AIDS specifically, the committee noted HIV/AIDS' impact on a range of rights and nondiscrimination, for children "infected with or affected by

348. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child, Lesotho*, ¶ 25 U.N. DOC. CRC/C/15/Add.147 (Feb. 21, 2001).

349. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child, Jamaica*, ¶ 23(d), U.N. DOC. CRC/C/15/Add.210 (July 4, 2003) [hereinafter COMM. ON THE RIGHTS OF THE CHILD, *Jamaica*].

350. *Id.* ¶ 24. The Committee recommended that Jamaica

> amend its legislation, including the Constitution, to ensure that it fully corresponds to the provisions of article 2 of the Convention and to ensure the full implementation of non-discrimination provisions, giving special attention to children infected or affected by HIV/AIDS, children with disabilities, equality between boys and girls and racial discrimination.

Id.

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HIV/AIDS."[351] The Committee recommended the incorporation of children's rights in Jamaica's HIV/AIDS policies, to protect children "infected with and affected by HIV/AIDS."[352] Similarly, with regard to Romania, the Committee expressed concern at the impact of HIV/AIDS on the principle of nondiscrimination for children, and on a range of rights.[353] The Committee reiterated its previous recommendations on addressing discrimination, "in particular towards children belonging to the above-mentioned vulnerable groups"; it recommended full and effective implementation of existing legal measures; and, it recommended that Romania ensure its Constitution's conformity with CRC Article 2.[354] Concerning Sri Lanka, the Committee noted persistent "societal

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351. *Id.* ¶ 44.

> The Committee . . . remains concerned about the increasing incidence of the infection. The Committee is deeply concerned at the very serious impact of HIV/AIDS on the cultural, economic, political, social and civil rights and freedoms of children infected with or affected by HIV/AIDS, including the Convention's general principles and with particular reference to the rights to non-discrimination, health care, education, food and housing, as well as to information and freedom of expression.

Id.

352. *Id.* ¶ 45.

> The Committee recommends that the State party further integrate respect for the rights of the child into the development and implementation of its HIV/AIDS policies and strategies on behalf of children infected with and affected by HIV/AIDS, as well as their families, including by taking into consideration the recommendations the Committee adopted at its day of general discussion on children living in a world with HIV/AIDS (CRC/C/80, para. 243), and involve children when implementing this strategy.

Id.

353. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on Rights of the Child: Romania*, ¶¶ 25-26, U.N. DOC. CRC/C/15/Add.199 (Mar. 18, 2003). Specifically, the Committee expressed concern

> that the principle of non-discrimination is not fully implemented for all children in all parts of the State party, and that unequal enjoyment of economic, social, cultural, civil and political rights persists (i.e. for children with disabilities, children living with HIV/AIDS, children in care institutions, children in detention, asylum-seeker and refugee children, foreign children, children between 16 and 18 years, children from poor households, and children belonging to Roma and other minority groups.)

Id. ¶ 25.

354. *Id.* ¶ 26.

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discrimination" "against vulnerable groups of children, including children with disabilities, adopted children, children displaced by conflict, children infected with and affected by HIV/AIDS, and children of ethnic and religious groups."[355]

In 2004, the Committee made several observations regarding Botswana's obligations vis-à-vis "children affected or infected by HIV/AIDS," expressing concern: that Botswana's Constitution was inconsistent with the CRC's provision on nondiscrimination; that there was persistent "societal discrimination" "against vulnerable groups of children, including children with disabilities, street and rural children, children born out of wedlock, orphans and fostered children and children affected or infected by HIV/AIDS"; and expressing deep concern "at the situation of girls, in particular adolescent girls who, as acknowledged by the State party, suffer marginalization and gender stereotyping, compromising their educational opportunities and are more vulnerable to sexual violence, abuse and HIV/AIDS."[356]

Discrimination violations at various points on the HIV/AIDS continuum thus affect the protection of other rights; for example, education, information, the right to benefit from scientific advances, health, and life. Such discrimination can occur based on the child's status or on the status of others around the child.

The resolution establishing the new Human Rights Council also recognizes the principle of nondiscrimination: "Emphasizing the responsibilities of all States, in conformity with the Charter, to respect human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language or religion, political or other opinion, national or social origin, property, birth *or other status.*"[357]

Courts around the world have examined prohibitions against discrimination in the context of HIV/AIDS, on the basis of national constitutions and legislation. In some places, advocates of vulnerable groups have achieved increases in national antidiscrimination protections. Generally speaking, this is probably the area of HIV/AIDS and human rights law that is the most developed and has been most compared, to date.

For the purposes of this Article, a brief mention will suffice. Notably, these examples concern post-infection discrimination. For instance, Australian courts have considered discrimination in local government

355. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child: Sri Lanka*, ¶ 25, U.N. DOC. CRC/C/15/Add.207 (July 2, 2003).

356. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child: Botswana*, ¶ 27, U.N. DOC. CRC/C/15/Add.242 (Nov. 3, 2003).

357. G.A. Res. 60/251, UN Doc. A/RES/60/251 (Apr. 3, 2006) (emphasis added).

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decisionmaking,[358] dismissal from military based on serostatus,[359] and the legality of exclusion of women from clinical trials.[360]

The Canadian HIV/AIDS Legal Network recently published an overview of the legal framework for nondiscrimination in Canada; the work also compares a selection of discrimination cases from around Canada.[361] In a Namibian labor court, the applicant successfully challenged exclusion of military recruits based on HIV status, "where such person is otherwise fit and healthy unless such person's CD4 count is below 200 and his viral load is above 100 000."[362] South Africa's Employment Equity Act prohibits discrimination based on HIV status.[363] The UK Disability Discrimination Act prohibits discrimination against people with diseases that affect major life activities.[364] In *Bragdon v. Abbott*, the U.S. Supreme Court affirmed that HIV-positive status, from the moment of infection, constitutes a disability under the Americans with Disabilities Act, similarly prohibiting discrimination.[365]

In general, discrimination should be considered in more depth all along the HIV/AIDS continuum, that is, at: the prevention; education; care,

358. I.W. v. City of Perth (1997) 191 C.L.R. 1, *cited in Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 273-74.

359. X v. Commonwealth of Austl. (1999) 167 A.L.R. 529, *cited in Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 274.

360. Stephenson v. Human Rights & Equal Opportunity Comm'n (1996) 139 A.L.R. 678, *cited in Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 274.

361. Richard Elliott & Jennifer Gold, *Protection Against Discrimination Based on HIV/AIDS Status in Canada: The Legal Framework*, 10 HIV/AIDS POL'Y & L. REV. 20-30 (2005).

362. *Nanditume v Minister of Defence*, Case. No. LC 24/98, Labour Ct. of Namibia, at 12 (decision of May 10, 2000) (ruling on unfair discrimination under § 107 of Namibia's Labour Act (Act 6, 1992), http://www.lac.org.na/alu/Pdf/haindongo.pdf. *Cf.* X v. Commonwealth of Austl. & Human Rights and Equal Opp. Comm'n (1999) 200 C.L.R. 177 (finding by High Ct. of Austl. that an HIV-positive employee's discharge from Australian Defence Forces, based on inability to perform inherent work requirement, was lawful).

363. *See Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 379 (discussing S. Africa's Employment Equity Act, "which aims to rectify the legacies of apartheid by ensuring, through affirmative action, the equitable representation of blacks, women, and people with disabilities in the workplace" and "protects against unfair discrimination on the grounds of 'HIV status'").

364. *See Global Aspects of AIDS*, 2006 Supp., *supra* note 246, at 385 (discussing the UK Disability Discrimination Act (1995), § 4, which prohibits discrimination against people with diseases that affect major life activities unless such discrimination may be justified under § 5 of the Act).

365. Bragdon v. Abbott, 524 U.S. 624 (1998) (finding HIV to be a disability under the Americans with Disabilities Act (1990), 42 U.S.C. §§ 12181(7)(f) & 12182(a), which prohibits discrimination in the professional office of a health care provider). The Court found that HIV could be considered a physical or mental impairment, since it creates blood abnormalities and progressively detracts from hemic and lymphatic systems, and, it substantially limits a major life activity, by limiting the major life activity of reproduction. *Id.* at 637.

treatment and support; and post-mortem stages. Such possible actions would include challenging policies that result in disproportionate prevalence among marginalized populations, or unequal access to health care once someone is sick or dying, and discriminatory protection of rights for people secondarily impacted by others' deaths. The continuum approach can increase the possibilities for responses.

D. *Life: International Protections and Their Interpretation Vis-à-Vis HIV/AIDS*

The right to life is listed among "the human rights principles relevant to HIV/AIDS" in the Guidelines,[366] but is not further elaborated in the section providing examples of "[t]he application of specific human rights in the context of the HIV epidemic."[367] Thus, the Guidelines provide little direction for international and municipal human rights enforcement bodies interpreting the widely protected right to life. Considering the numbers of people dying from AIDS, this right deserves much more urgent attention. The right to life cannot merely protect healthy people, prisoners on death row, or the dead.

Life is protected in many international human rights instruments, for example, in UDHR Article 3[368] and ICCPR Article 6.[369] In interpreting ICCPR Article 6, the Committee has recognized that the right to health inheres in the ICCPR rights to life[370] and freedom from torture or inhuman or degrading treatment, for example, it has recognized "the right to life and

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366. *See Guidelines*, *supra* note 1, ¶ 102.

367. *Id.* § III.C.

368. UDHR, *supra* note 93, art. 3. Article 3 provides, "Everyone has the right to life, liberty and security of person." *Id.*

369. ICCPR, *supra* note 94, art. 6(1). Article 6(1) provides, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." *Id.*

370. *Id.* art. 6. *See* HRC, General Comment No. 06. The right to life (art. 6): 30/04/82 (1982), ¶ 5. The right to life requires prevention of epidemics:

> 5. Moreover, the Committee has noted that the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.

Id.

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health of all detained persons as provided for in articles 6 and 7."[371] This is tantamount to recognizing the inseparability of rights—because it recognizes that health (a so-called "second-generation" right) is inherent in life and freedom from torture or inhuman and degrading treatment (so-called "first-generation" rights).

In addition to such recognition of the connection between such rights, the Committee has made several key observations on Article 6 and HIV/AIDS, specifically. In respect of Kenya, it expressed itself "concerned about the extremely high rate of deaths resulting from AIDS, and the unequal access to appropriate treatment for those infected with HIV (article 6 of the Covenant)" and recommended that Kenya "take measures to ensure that all those infected with HIV have equal access to treatment."[372] Unequal access to treatment can therefore violate the right to life as protected by Article 6.[373] With regard to Lithuania, the Committee expressed concern at the risk HIV/AIDS poses to young women's right to "life and health (art. 6)"; it recognized the effect of states' provision of sex education on health and life.[374] One can see that

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371. *See id.* art. For example, the Committee expressed concern at the high number of deaths of detainees in police stations and prisons in Georgia, many from tuberculosis, and recommended that Georgia

> take urgent measures to protect the right to life and health of all detained persons as provided for in articles 6 and 7 of the Covenant. Specifically, the State party should improve the hygiene, diet and general conditions of detention of and provide appropriate medical care to detainees as provided for in article 10 of the Covenant.

HUMAN RIGHTS COMM., *Concluding Observations of the Hum. Rights Comm.: Georgia*, ¶ 7, U.N. DOC. CCPR/CO/74/GEO (Apr. 19, 2002). This finding thus concerns the second crossover area identified by health and human rights scholars, that of the impact of human rights violations on health. *See id. See also Comments by the Gov't of the Rep. of Georgia on the concluding observations of the Hum. Rights Comm.*, ¶¶ 14-24, U.N. DOC. CCPR/CO/74/GEO/Add.1 (May 14, 2003). According to the WHO, the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment enshrined in ICCPR article 7 is directly linked to the right to health, while the right to life enshrined in article 4 is indirectly linked to the right to health. WHO, Fact Sheet, International Covenant on Civil and Political Rights (May 2006) at 2, *available at* http://www.who.int/hhr/activities/factsheets/en/index.html.

372. HUMAN RIGHTS COMM., *Kenya, supra* note 315, ¶ 15.

373. The Eur. Ct. H.R. has made a similar observation under ECHR Article 2. *See infra* text accompanying note 391.

374. HUMAN RIGHTS COMM., *Concluding Observations of the Human Rights Comm.: Lithuania*, ¶ 12, U.N. DOC. CCPR/CO/80/LTU (May 4, 2004).

> While noting the information provided orally by the delegation on sex education in schools, the Committee is concerned at the high rate of unwanted pregnancies and abortions among young women between the ages of 15 and 19, and the high

health education engages the rights to education, health, and life, showing again how rights are interrelated. With regard to Namibia, the Committee found inadequate Namibia's response to combat HIV/AIDS, under Article 6, and recommended increased efforts to "protect its population from HIV/AIDS."[375]

It is possible to compare the Committee's approach with that of the CERD, though the treaties obviously contain different protections. But the latter recognized HIV/AIDS as one of the "factors and difficulties" impeding implementation of ICERD, which it clearly is. This portrays states as victims of HIV/AIDS and, impliedly, of a lack of international cooperation; yet, at the same time, states are responsible for any human rights violations. The crux of the matter is that there is a two-way causal relationship between HIV/AIDS and states' efforts to protect human rights, complicated by the need for action by other states. While HIV/AIDS does impede states' implementation of their human rights obligations, at the same time, implementation of those obligations affects the extent of HIV/AIDS. By contrast, the Committee's recommendation implies needed action at various points of the continuum, to improve prevention, access, care and treatment. It recognizes the adverse effect on the right to life of inadequate access to ART. In addition, as properly interpreted previously, the requirement under the right to life in Article 6 for a States Party to protect its population from HIV/AIDS is inseparable from the right to health (e.g., in ICESCR Article 12(2)(c), which requires States Parties to take the necessary steps to protect health of "the prevention, treatment and control of epidemic, endemic, occupational and other diseases").[376]

The Committee again recognized the impact on the Article 6 right to life caused by a States Party's inadequate provision of access to medical services, including ART, with respect to Uganda. The Committee blamed

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> number of these women contracting HIV/AIDS, with consequent risks to their life and health (art. 6).

Id.

375. HUMAN RIGHTS COMM., *Namibia*, *supra* note 289, ¶ 10.

> The Committee appreciates the efforts undertaken by the State party to combat HIV/AIDS, and to provide wider sexual education in this regard. However, these efforts are not adequate to the magnitude of the problem. (art. 6).
> The State party should pursue its efforts to protect its population from HIV/AIDS. It should adopt comprehensive measures encouraging and facilitating greater number of persons suffering from the disease to obtain adequate antiretroviral treatment.

Id.

376. ICESCR, *supra* note 93, art. 12(2)(c).

Uganda's "measures" taken concerning HIV/AIDS for this impact on Article 6.[377]

Concerning Kenya, the Committee recognized the adverse impact on the Article 6 right to life as evidenced by (1) many deaths and (2) unequal access to treatment: the Committee was "concerned about the extremely high rate of deaths resulting from AIDS, and the unequal access to appropriate treatment for those infected with HIV (article 6 of the Covenant)"; it recommended Kenya "take measures to ensure that all those infected with HIV have equal access to treatment."[378]

To sum up the Committee's approach to the right to life in Article 6 vis-à-vis HIV/AIDS, significantly, it has recognized the need to protect human rights along a continuum. It has recognized the inseparability of the rights to health (including prevention, access to medical care, access to ART) and life. Such failure at different points along the continuum of the right to health can constitute a violation of the right to life, a "first-generation" right. It has recognized the effect on the right to life resulting from a States Party's inadequate "measures" taken to combat HIV/AIDS. It has recognized states' inadequate protection of the right to life in Article 6 as evident from an "extremely high rate of deaths resulting from AIDS."

While the ICESCR does not explicitly protect life, its Preamble, which indicates that civil and political rights must be simultaneously protected with economic, social, and cultural rights, therefore ties the protection of such rights to the right to life. The right to health, as included in the ICESCR, is inseparably tied to the right to life as protected by ICCPR Article 6(1). It becomes evident how arbitrary the division between such categories of rights can be. The right to an adequate standard of living, also protected as an "economic" right in the ICESCR, also affects the protection of an individual's right to life, as ICCPR Article 6(1) requires. In addition, discrimination in the protection of many other rights, or a

377. HUMAN RIGHTS COMM., *Uganda, supra* note 289, ¶ 14.

> 14. While the Committee takes note of the measures taken by the State party to deal with the widespread problem of HIV/AIDS, it remains concerned about the effectiveness of these measures and the extent to which they guarantee access to medical services, including antiretroviral treatment, to persons infected with HIV (art. 6).
>
> The State party is urged to adopt comprehensive measures to allow a greater number of persons suffering from HIV/AIDS to obtain adequate antiretroviral treatment.

Id.

378. HUMAN RIGHTS COMM.: *Kenya, supra* note 315, ¶ 15.

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nondiscriminatory, blanket failure to protect such rights along the continuum, can amount to an arbitrary deprivation of life in contravention of ICCPR Article 6(1).

ECHR Article 2 provides that the right to life shall be protected by law, and prohibits the state's intentional deprivation of life except in certain circumstances (since altered by developments concerning the death penalty).[379] As the European Court of Human Rights held in *L.C.B. v. United Kingdom*,[380] Article 2 imposes positive obligations: it requires a contracting state "not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction."[381]

The European Court of Human Rights has dipped a cautious toe in the waters, when asked to consider the application of Article 2 to the provision of health care. In *Powell v. United Kingdom*,[382] which concerned alleged medical malpractice and post-death cover-up, the Court cited *L.C.B. v. United Kingdom* to reiterate that Article 2 imposes positive obligations on ECHR-bound states.[383] The Court then warily noted, "The Court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2."[384] Significantly, the Court acknowledged that acts or omissions at the policy stage could violate the Article 2 right to life. This is consistent with a continuum approach. Such Article 2-violating acts or omissions could presumably encompass policy failures to protect health and life at different points of the continuum, for example, failing to provide sufficient prevention,

379. ECHR, *supra* note 139, art. 2. Article 2 provides, in relevant part, "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law." *Id.*

380. *L.C.B. v United Kingdom*, App. No. 14/1997/798/1001, 27 Eur. H.R. Rep. 212, 228 (1998), 1998-III Eur. Ct. H.R. 1390, 1403, ¶ 36.

381. *Id.*

382. Powell v. the United Kingdom (dec.) 2000-V Eur. Ct. H.R. 397 (inadmissible).

383. *Id.* at 421, ¶ 1.

> Admittedly the first sentence of Article 2 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction .... [citing L.C.B.] The Court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2.

Id.

384. *Id.*

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disproportionate prevalence, or insufficient access to medical care. The Court also reiterated that, in addition to such (nonexcludable) positive obligations, Article 2 also includes the procedural requirement for states to have adequate mechanisms in place for investigating medical malpractice.[385] However, the Court found inadmissible the applicants' Article 2 claim for lack of Article 34 victim status, since they had accepted compensation from a civil claim.[386]

The Court similarly backed away from considering the scope of a state's positive obligations under Article 2 in the provision of health care in *Cyprus v. Turkey*.[387] In that case, the applicant government alleged, inter alia, that restrictions on the ability of enclaved Greek Cypriots and Maronites to receive medical treatment, and a failure to provide or to permit receipt of adequate medical services, violated Article 2.[388] The European Commission of Human Rights had previously considered this question, but had found no violation of Article 2.[389] However, the commission had noted that Article 2 covers access to medical services, but had declined to find such a violation in the instant case despite possible "shortcomings" in individual access.[390]

In its judgment, the Court observed that "an issue may arise under Article 2 of the Convention where it is shown that the authorities of a Contracting State put an individual's life at risk through the denial of health care which they have undertaken to make available to the

385. *Id.* After *Powell*, the Court again reiterated that states must ensure that their hospitals have regulations to protect their patients' lives and to establish mechanisms to determine hospital liability for patient deaths. *See, e.g.*, *Nitecki*, App. No. 65653/01, The Law, ¶ 1.

386. Powell, 2000-V Eur. Ct. H.R., The Law, ¶ 1.

387. Cyprus v. Turkey, [Grand Chamber] (Judgment), No. 25781/94, 2001-IV Eur. Ct. H.R., 1.

388. *See id.* ¶¶ 216-17.

389. Eur. Comm'n of Human Rights, Report, adopted June 4, 1999, annexed to Court's judgment of May 10, 2000, 2001-IV Eur. Ct. H.R. 133, 187-8, ¶¶ 432-35.

390. *Id.* ¶ 433.

> The Commission considers that the respondent Government's responsibility under Article 2 of the convention would indeed be engaged if the authorization system operated by their subordinate local administration in northern Cyprus to movements of Greek Cypriots for purposes of medical visits had been applied in a manner endangering their life and health. However, the Commission has found no indication of an administrative practice during the period under consideration which could be said to have had such effects. There may have been shortcomings in individual cases, but in general access to medical services, including hospitals in southern Cyprus, has been available to the persons concerned.

Id.

population generally."[391] Thus, this is another possibility under Article 2. The Court was not explicitly examining a claim of discrimination. Ultimately, the Court found no violation of Article 2 from the alleged denial of services, noting that the people in question could have accessed some health facilities in the north, albeit of allegedly lesser quality.[392] On this point, the Court explicitly left aside the issue of "the extent to which Article 2 of the Convention may impose an obligation on a Contracting State to make available a certain standard of health care."[393]

In *Nitecki v. Poland*[394] (which did include a discrimination claim), the Court considered the respondent state's refusal to reimburse a pensioner suffering from amyotrophic lateral sclerosis[395] the full price of a lifesaving drug. The applicant argued that the 30% contribution, which he would have had to make toward the cost of the drug under the national insurance scheme, was prohibitive.[396] He alleged violations under Articles 2, 8 and 14.[397] The Court first recalled that Article 2 entails positive obligations, that is, "to take appropriate steps to safeguard the lives of those within its jurisdiction."[398] Citing Powell (discussed previously), it noted: "It cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under Article 2."[399] The Court further noted that it had previously considered states' positive obligations in the context of medical malpractice.[400] Citing Cyprus v. Turkey (mentioned previously), the Court noted:

> with respect to the scope of the State's positive obligations in the provision of health care, the Court has stated that an issue may arise under Article 2 where it is shown that the authorities of a Contracting State put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally.[401]

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391. *Cyprus*, [G.C., judgment May 10, 2001], ¶ 219.
392. *Id.* ¶ 221.
393. *Id.* ¶ 219.
394. *Nitecki*, App. No. 65653/01.
395. ALS, or Lou Gehrig's disease.
396. *Nitecki*, App. No. 65653/01, The Facts, A.
397. *Id.* Complaints.
398. *Id.* ¶ 1.
399. *Id.*
400. *Id.*
401. *Nitecki*, App. No. 65653/01, ¶ 1.

However, the Court found the Article 2 complaint to be ill-founded, noting that the pensioner had benefited from the system "over many years" and had received "the standard of care available to all patients."[402] Arguably, the Court penalized the applicant for being old, and for having already received other benefits that he needed, that is, sick. In other words, he was entitled to life-saving drugs (and protected by the right to life), up until that last percentage that he could not afford.

The Court found the applicant's Article 14 complaint to be equally ill-founded; it offered a short paragraph referring to the "difficult choices" involved, but found no arbitrariness.[403] Thus, under ECHR Article 2, there are at least two foreseeable kinds of cases with respect to HIV/AIDS. The first kind of case would be one concerning allegations that the state's "nonexcludable" positive obligations, to safeguard the right to life, have been breached. One could argue that to make the right to life practical and effective, a person is entitled to prevention, testing, treatment, medicines, care, support, adequate state measures for all of the above, an adequate

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402. *Id.*

> The applicant, like other entitled individuals, has access to a standard of health care offered by the service to the public. In fact, it appears that over many years he benefited from medical treatment and drugs paid for by the public health service.
>
> The applicant was refused the full refund of a drug prescribed to him for the first time in June 1999. Under the standard of care available to all patients, the drug refund scheme provided for a 70% refund while the remaining 30% had to be paid by the applicant.
>
> Bearing in mind the medical treatment and facilities provided to the applicant, including a refund of the greater part of the cost of the required drug, the Court considers that the respondent State cannot be said, in the special circumstances of the present case, to have failed to discharge its obligations under Article 2 by not paying the remaining 30% of the drug price.
>
> Accordingly, the Court . . . concludes that the complaint under Article 2 of the Convention is manifestly ill-founded. . . .

Id.

403. *Id.* ¶ 3.

> The Court recalls that Article 14 only prohibits differences in treatment which have no objective or reasonable justification. However, the Court finds such justification to exist in the present health care system which makes difficult choices as to the extent of public subsidy to ensure a fair distribution of scarce financial resources. There is no evidence of arbitrariness in the decisions which have been taken in the applicant's case. Accordingly, this part of the application is also manifestly ill-founded. . . .

Id.

response to HIV/AIDS and to protect the population, and nondiscrimination in all of the above. But (to be clear), discrimination would not have to be present for there to be a violation. Thus, the other kind would be a case alleging violations of Articles 2 and 14, involving discrimination. For example, such violations could occur at the health policy or delivery level. Public and private health sector decisions based on "other status" (or age, sex, location, disability, serostatus, socioeconomic status, health, having already received other needed benefits) can impact life.[404] Discrimination can also form a negatively acting background against which specific violations of Article 2 could occur. Consideration should be given, in each kind of case to states' obligations along the continuum of HIV/AIDS, and, for people primarily and secondarily impacted. Thus as the Court has indicated, positive obligations as to health, under the right to life, are "nonexcludable"—that is, they exist. This is consistent with developments on universal access, and the interrelatedness of the rights to health and life (as well as dignity and equality, as universally protected in other human rights texts).

Difficult choices notwithstanding, giving states an overly wide latitude in health policy (for example, only requiring that a person have access to the "same standard" generally available) is undesirable in terms of responding to HIV/AIDS. HIV/AIDS shows that polices are too often at the expense of the vulnerable. Different visions of equality (or lack of arbitrariness), fairness and efficiency go into these difficult choices, which can result in, *inter alia*, disproportionate prevalence, lack of prevention, education, testing, counseling, care, treatment, or support, and many deaths. Thus the Court may well have to examine alleged violations of these and other rights that occur along the HIV/AIDS continuum.

Nitecki v. Poland (a short admissibility decision) therefore demonstrates the potential tension between public health policy, in which states' discretionary decisions among would-be beneficiaries leave some people to the side, and a human rights approach encompassing universal access, in which states cannot in theory choose between which binding rights to protect. Human rights require that all, and especially the most vulnerable—the sick, the old, the young—deserve equal rights. Rather than distort human rights protections to acknowledge implicitly or explicitly the real difficulties of public health policy, however, it would seem better to acknowledge that rights exist for all, but are not being protected. States must take positive steps to ensure rights for everyone alike.

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404. *Compare, Patients 'Will Die' Over Culling Waiting List,* NEW ZEALAND HERALD, May 13, 2006 (concerning New Zealand health authority's decision to remove groups of patients, including patients with undiagnosed bowel cancer, from hospital waiting lists).

The ACHR protects the right to life in Article 4.[405] The Inter-American Commission has considered that a state can violate Article 4 when it violates detainees' and prisoners' Article 5 right to human treatment, by failing to protect their health. Again, the right to health is inseparable from the first-generation rights to human treatment and life. The Commission observed that acts or omissions to care for prisoners' health could violate Articles 4 and 5.[406]

States must therefore protect the rights to health, human treatment and life of everyone, regardless of serostatus, in detained or imprisoned populations, with respect to HIV/AIDS.

The ACHPR protects the right to life in Article 4, which provides, "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right."[407] The Commission has emphasized that States Parties have positive obligations with respect to the Article 4 right to life, in the context of enforced disappearances:

> The Commission would also like to reiterate a fundamental principle proclaimed in Article 1 of the charter that not only do the States Parties recognize the rights, duties and freedoms enshrined in the Charter, they also commit themselves to respect them and to take measures to give effect to them. In other words, if a State Party fails to ensure respect of the rights contained in the African charter, this constitutes a violation of the Charter. Even if the State or its agents were not the perpetrators of the violation.[408]

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405. ACHR, *supra* note 267, art. 4. Article 4, Right to Life, provides in part, "1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life." *Id.*

406. *Third Report on the Human Rights Situation in Colombia*, INTER-AM. C.H.R., ¶ 33, OEA/Ser.L/V/II.102, Doc. 9 rev. 1 (1999).

> [I]t is the State's responsibility to care for the physical and mental health of all persons in its custody. The State, in its capacity as administrator of the detention facilities, is the guarantor of the rights of the detained . . . . If the State does not fulfill its obligation, by action or omission, it violates Article 5 of the Convention and, in cases of deaths of prisoners, violates Article 4 of the Convention.

Id.

407. ACHPR, *supra* note 93, art. 4.

408. Mouvement Burkinabé des Droits de l'Homme et des Peuples v. Burkina Faso, Comm. No. 204/97, ACHPR, Annual Activity Report 2000-2001, ¶ 42.

The Commission has not considered Article 4 in light of HIV/AIDS, although it has found violations in other contexts.[409]

The CRC protects the right to life in Article 6.[410] The Committee on the Rights of the Child has considered the impact of HIV/AIDS on Tanzania's protection of children's right to life.[411]

There, the Committee took the approach of viewing HIV/AIDS as an impediment to state obligations rather than focusing on the other causal relationship, that consisting of a state's duty to protect health and life in the context of HIV/AIDS, "socio-economic realities" notwithstanding.

With respect to the child's "Right to life, survival and development" in Malawi, the committee again seemed to consider HIV/AIDS as a socio-economic difficulty.[412] Considering HIV/AIDS to be more a socioeconomic difficulty, and not partly a result of state failures to protect human rights, shifts state responsibility more than is desirable. While an epidemic does worsen, and is exacerbated by socioeconomic difficulties, AIDS is a preventable disease from which a state must take steps to protect people. Socioeconomic difficulties clearly hamper states' abilities to do this; such difficulties, and the international community's responsibilities, could be considered, to some extent, mitigating factors when determining state responsibility for some potential HIV/AIDS-related human rights violations. But this should be expressly stated.

The right to life is protected in many international instruments, national constitutions, and legislation. State actions or omissions can violate the

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409. *See* Communication 64/92, 68/92, 78/92, *supra* note 272, ¶ 6.

410. CRC, *supra* note 96, art. 6. Article 6 provides, "1. States Parties recognize that every child has the inherent right to life. 2. States Parties shall ensure to the maximum extent possible the survival and development of the child." *Id.*

411. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child: Tanzania*, ¶¶ 30-31, U.N. DOC. CRC/C/15/Add.156 (July 9, 2001).

> 30. The Committee expresses concern that the severe impact of HIV/AIDS, mounting economic challenges and other socio-economic difficulties continue to threaten the right to life, survival and development of children within the State party.
>
> 31. The Committee encourages the State party to take all effective measures to provide greater protection and support to children whose right to life, survival and development is unduly threatened by the difficult socio-economic realities of the state. In this connection, the Committee recommends that the State party take all effective measures to strengthen its technical cooperation with, among others, UNICEF.

Id.

412. COMM. ON THE RIGHTS OF THE CHILD, *Concluding Observations of the Comm. on the Rights of the Child: Malawi*, ¶¶ 27-28, U.N. DOC. CRC/C/15/Add.174 (Apr. 2, 2002).

right to life, or, can constitute violations in conjunction with violations of other rights. Health and life demonstrate the need to protect rights along a continuum. When a state fails to protect a person's right to health, for instance by failure to control the spread of a preventable disease, and commits failures further along the continuum by failing to provide adequate health care or drugs to the ill, the right to life is impacted.[413]

VI. CONCLUSION

Key international developments all show the need to protect rights vis-à-vis HIV/AIDS, including long-standing trade exceptions to protect human life and health. Further, specific elaboration of human rights obligations vis-à-vis HIV/AIDS (which may make necessary the use of TRIPS flexibilities) is needed to help prevent and mitigate violations, and to facilitate the creation of legislation required by the Declaration of Commitment. The content of rights in the context of HIV/AIDS must be given due weight in relation to the use and interpretation of trade rules, and in establishing any hierarchy of norms for trade and human rights.

To clarify state human rights obligations requires examining state control of factors affecting vulnerability and access to relevant resources. States must eliminate the underlying conditions creating vulnerable groups, and be held responsible for life-threatening, and rights-threatening cultural, behavioral, and social norms especially to the extent that they result in widespread violations.

At the beginning of this Article, it was observed that the international community is insufficiently aware of the many rights being violated, the cumulative effect of these violations, and how HIV/AIDS constitutes a global human rights crisis. A continuum approach offers a simple framework for examining state responsibility in respect of obligations at all stages of HIV/AIDS, and broadens the pool of possible human rights responses for those primarily and secondarily impacted. In addition, this approach can help create more consistent protection of impacted rights at all stages, in various international and municipal fora.

Finally, further study of the impact of HIV/AIDS on human rights is needed, in tandem with increased human rights responses. Such study can

413. *See also Mr. X v. Hospital Z*, Sup. Ct. (Ind.), decision of Sept. 21, 1998, A.I.R. 1999 S.C. 495 (discussing the right to life and HIV/AIDS, and indicating that the right to life includes the right to healthy life. In that case, the Court considered this right of the appellant's fiancée to trump the appellant's rights to privacy and marriage, finding that the respondent hospital (which had alerted the fiancé of the appellant's HIV-positive status) was not bound to keep private the appellant's HIV status)).

be done (1) by treaty, (2) by region, (3) by country, (4) by specific impacted right, or (5) by vulnerable group, keeping in mind the need to consider how each right is impacted at every stage of HIV/AIDS. Keeping in mind also the problems of misleading statistics, such study and responses are needed for and by all states. More fully elaborated standards for documentation of ongoing violations and additional documentation are also needed.[414] Globally speaking, increased clarification of the responsibility of *all* states to prevent and mitigate HIV/AIDS-related violations is needed.

414. Concerning ongoing efforts to develop such standards, see UNAIDS, *Report of the Meeting on Development of Index on Human Rights, Stigma and Discrimination by and for People Living with HIV* (Geneva, Switzerland, Aug. 22-23, 2005), *available at* www.unaids.org.

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