United Nations A/HRC/14/20

General Assembly

Distr.: General
27 April 2010

Original: English

Human Rights Council
Fourteenth session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*

Summary

In the present report, submitted in accordance with Human Rights Council resolution 6/29, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health examines the relationship between the right to the highest attainable standard of health and the criminalization of three forms of private, adult, consensual sexual behaviour: same-sex conduct and sexual orientation, sex work, and HIV transmission.

Section I contains a brief introduction. In section II, the Special Rapporteur considers the criminalization of consensual, same-sex conduct between adults, along with criminalization based upon sexual orientation or gender identity. In that section the Special Rapporteur highlights how recent international and national jurisprudence has recognized close connections between the concepts of privacy, equality and dignity, and examines its effects on the enjoyment of the right to health.

In section III, the denial of sex workers' enjoyment of the right to health that results from the criminalization of sex work and related practices (such as solicitation) is considered. Impacts on the right to health, similar to those discussed in section II, are canvassed along with issues particular to sex work. Specifically, the failure of legal recognition of the sex-work sector results in infringements of the right to health, through the failure to provide safe working conditions, and a lack of recourse to legal remedies for occupational health issues. Additionally, the distinction between sex work and trafficking is considered, in particular with respect to legislation and interventions that, by failing to distinguish between these groups, are increasingly infringing sex workers' right to health.

* Late submission.

In section IV the Special Rapporteur examines the impact of the criminalization of HIV transmission with respect to the right to health. The far-reaching impact of criminal laws on the enjoyment of the right to health is considered, along with the failure of such laws to achieve legitimate public health aims or the objectives of the criminal law. The Special Rapporteur concludes that only intentional, malicious HIV transmission can be legitimately criminalized; however, specific criminal laws concerning HIV transmission are generally unnecessary.

Finally, the Special Rapporteur suggests that decriminalization is necessary in response to each of the aforementioned issues, alongside other measures necessary as part of a comprehensive right-to-health approach. Such measures include human rights education, the participation and inclusion of vulnerable groups, and efforts to reduce stigma and discrimination in respect of these groups.

Contents

I. Introduction

1. In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health considers several issues relating to the criminalization of private, consensual sexual behaviour between adults, and the impact of such criminalization on the enjoyment of the right to health. The law concerning health practices and behaviours can protect the health of individuals or create barriers to effective health interventions and outcomes.[1] The Special Rapporteur considers criminalization to include not only laws that are enacted to render certain conduct deserving of criminal punishment, but additionally, the use of pre-existing criminal laws against certain individuals or communities on the basis of certain characteristics (such as sexuality or occupation).

2. The Special Rapporteur believes that the criminalization of private, consensual sexual interaction between adults represents a significant impediment to the realization of the right to health of all persons, particularly those against whom the law is directed. He emphasizes that all human rights are universal, indivisible, interdependent and interrelated.[2] The criminalization of private, consensual sexual conduct between adults infringes on not only the right to health, but also various other human rights, including the rights to privacy and equality. In turn, infringement of these human rights impacts indirectly on the right to health.

3. Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter the "right to health"). This right contains the freedom to control one's own health and body, and specifically provides for sexual and reproductive freedom. Additionally, the right confers entitlements; in particular, the entitlement to a system of health protection that confers equality of opportunity for every person to enjoy the highest attainable level of health. Health facilities, goods and services must be available and accessible for all, especially the most vulnerable or marginalized sections of the population, without discrimination. Additionally, States must take measures to protect these vulnerable or marginalized groups in fulfilling their obligation to protect the right to health.[3]

4. In the present report, the Special Rapporteur considers the impact of criminalization in restricting the enjoyment of the right to health, through the examination of three areas: consensual same-sex conduct (together with sexual orientation and gender identity), sex work and HIV transmission. These three kinds of conduct have, at various times, been considered to impact adversely on the broader population, and States have used the protection of public morality and decency, or the protection of the health of the public at large, as justifications to criminalize such acts. This approach impacts detrimentally on health outcomes for individuals, even if the laws around these practices are not enforced, or enforced infrequently.[4]

[1] L. Gable, L. Gostin and J. Hodge Jr., "A global assessment of the role of law in the HIV/AIDS pandemic" *Public Health*, vol. 123 (March 2009), pp. 260–261.

[2] Vienna Declaration and Programme of Action, para. 5. See also General Assembly resolution 60/1 on the 2005 World Summit Outcome, para. 121.

[3] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

[4] M. Berer, "Criminalisation, sexual and reproductive rights, public health – and justice", *Reproductive Health Matters*, vol. 17, No. 34 (November 2009), p. 4.

5. Domestic criminal law is generally considered to establish and promulgate social norms of appropriate behaviour, and has the objectives of incapacitation (through incarceration), rehabilitation, retribution and deterrence. The Special Rapporteur believes that the criminalization of the areas considered in this report not only fails to achieve these goals, but also significantly undermines public health efforts, while adversely impacting on individual health outcomes. As criminalization often leads to more harm than good, it is important that States recognize the impact that appropriate legislation can have in realizing the right to health of its citizens.

II. Same-sex conduct, sexual orientation and gender identity

6. Criminal laws concerning consensual same-sex conduct, sexual orientation and gender identity often infringe on various human rights, including the right to health. These laws are generally inherently discriminatory and, as such, breach the requirements of a right-to-health approach, which requires equality in access for all people.[5] The health-related impact of discrimination based on sexual conduct and orientation is far-reaching, and prevents affected individuals from gaining access to other economic, social and cultural rights. In turn, the infringement of other human rights impacts on the realization of the right to health, such as by impeding access to employment or housing.[6]

7. These infringements ultimately undermine the inherent dignity of persons upon which the international human rights framework is based. Denying the dignity of individuals through the criminalization of certain conducts substantially diminishes their self-worth and, in doing so, prevents the realization of the right to health. The decriminalization of such conduct is necessary to address the disempowerment that affected individuals and communities face, and to enable full realization of the right to health.

A. Criminalization of same-sex conduct, sexual orientation and gender identity: background

8. Various criminal laws exist worldwide that make it an offence for individuals to engage in same-sex conduct, or penalize individuals for their sexual orientation or gender identity. For example, consensual same-sex conduct is a criminal offence in about 80 countries.[7] Other laws also indirectly prohibit or suppress same-sex conduct, such as anti-debauchery statutes and prohibitions on sex work.[8] Many States also regulate extra-marital sexual conduct through criminal or financial sanctions, which affects individuals who identify as heterosexual but intermittently engage in same-sex conduct. These laws also have a significant impact on individuals engaging in sexual conduct with members of the opposite sex outside of marriage, particularly women, although this is outside the scope of this report.[9]

[5] See Committee on Economic, Social and Cultural Rights, general comment No. 14.

[6] M. O'Flaherty and J. Fisher, "Sexual orientation, gender identity and international human rights law: contextualising the Yogyakarta Principles", *Human Rights Law Review*, vol. 8, No. 2 (2008), p. 211.

[7] D. Ottosson, "State-sponsored homophobia: a world survey of laws prohibiting same sex activity between consenting adults", International Lesbian and Gay Association (ILGA) report, May 2009, p. 5.

[8] See for example Human Rights Watch, "Kuwait: repressive dress-code law encourages police abuse – arrests target transgender people", press release, 17 January 2008. See also K. Connolly, "Poland to ban schools from discussing homosexuality", *Guardian*, 20 March 2007.

[9] See for example Human Rights Watch, "Libya: a threat to society? The arbitrary detention of women

9. These laws represent an infringement of the right to health as outlined in article 12 of the International Covenant on Economic, Social and Cultural Rights. Article 2, paragraph 2, of the Covenant requires that State parties undertake to guarantee that the rights within the Covenant, including the right to health, are exercised without discrimination of any kind, including on the basis of "other status". This is further developed in general comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights, which notes that the Covenant proscribes any discrimination in access to health care and underlying determinants of health, including on the grounds of sexual orientation (para. 18). The Committee also recognizes gender identity as a prohibited ground of discrimination.[10] In its general comment No. 4 (2003), the Committee on the Rights of the Child also confirmed that "other status" extends to sexual orientation (para. 6). Such criminalization impedes the right to health, not only through discrimination, but by denying equal access to health services, as will be demonstrated.

10. Sexual orientation is defined as "each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender".[11] Gender identity refers to "each person's deeply felt internal and individual experience of gender", which may or may not correspond with the sex assigned at birth, including the personal sense of the body … and other expressions of gender.[12]

Interpretation and legal developments

11. The European Court of Human Rights has held that discrimination based on sexual orientation or gender identity is in violation of human rights. In 1981, in *Dudgeon v. United Kingdom*, the European Court of Human Rights determined that the criminalization of private homosexual acts constituted an unjustified interference with the right to privacy enshrined within article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms.[13] The United Nations Human Rights Committee in *Toonen v. Australia* subsequently ruled that "sex" discrimination includes discrimination based upon sexual orientation,[14] noting that criminalization was not a reasonable measure to prevent spread of HIV/AIDS.[15] In *S.L. v. Austria*, the European Court of Human Rights also held that differences in the treatment of heterosexual and homosexual populations based on age of consent had no objective and reasonable justification, and was therefore discriminatory.[16]

12. A number of States now prohibit discrimination on the basis of sexual orientation, following judicial decisions or the introduction of legislation concerning this issue. In the landmark 1998 case *National Coalition for Gay and Lesbian Equality and another v. Minister of Justice and others*, the South African Constitutional Court struck down three separate sodomy laws, noting the right of all people to dignity and equality in concluding

and girls for 'social rehabilitation'", (New York, Human Rights Watch, 2006), p. 2.

[10] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 32.

[11] The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, p. 6. Available from www.yogyakartaprinciples.org/principles_en.pdf.

[12] Ibid. See also Committee on Economic, Social and Cultural Rights, general comment No. 20, para. 32.

[13] European Court of Human Rights, *Dudgeon v. United Kingdom*, judgement of 22 October 1981, Ser. A, No. 45.

[14] Communication No. 488/1992, *Toonen v. Australia*, Views adopted on 31 March 1994, para. 8.7.

[15] Ibid., para. 8.5.

[16] European Court of Human Rights, *S.L. v. Austria*, judgement of 9 January 2003, application No. 45330/99, paras. 44–46.

that discrimination based on sexual orientation was prohibited under the South African Constitution. The Supreme Court of the United States declared Texan sodomy laws unconstitutional in the case of *Lawrence v. Texas*, on the basis that it infringed on the liberty protected under the Fourteenth Amendment to the Constitution through the criminalization of intimate, consensual sexual conduct.[17]

13. In the matter of *Naz Foundation v. Government of NCT of Delhi and Others*, the High Court of Delhi cited the case of *Toonen* and considered the reasoning of the South African Constitutional Court in finding section 377 of the Indian Penal Code unconstitutional.[18] This section of the code criminalized, "carnal intercourse against the order of nature with any man, woman or animal" – wording from colonial rule that is still in use in more than half of the jurisdictions criminalizing sodomy worldwide.[19] The Naz Foundation submitted that by criminalizing private, consensual same-sex conduct, section 377 perpetuated negative and discriminatory beliefs towards same-sex conduct, driving activities underground and crippling HIV/AIDS prevention efforts.[20]

14. In February 2010, Fiji passed a law decriminalizing consensual same-sex conduct, through the National Crimes Decree.[21] Hong Kong Special Administrative Region of China also overturned a long-standing statute banning sodomy in 2005, and since 2007, consensual same-sex acts have also been legal in Nepal.[22]

15. Despite these recent developments in decriminalization, bringing many States into conformity with international human rights obligations, a significant number of countries maintain criminal penalties for consensual same-sex conduct. Some States have taken steps to broaden the application of existing laws, or to impose harsher penalties for same-sex conduct. Section 365A of the penal code of Sri Lanka formerly prohibited male homosexual acts, but was subsequently amended to be "gender-neutral", resulting in the criminalization of female same-sex conduct.[23] The Parliament of Uganda introduced a bill in October 2009 that would allow for the death penalty as punishment for the violation of certain provisions of the anti-sodomy statute. Uganda, praised by HIV/AIDS activists for its treatment programme and policies, will put its campaign to eliminate HIV in great danger should this bill pass.

16. Conversely, an article proposed for inclusion in the penal code of Rwanda that would have carried penalties ranging from 5 to 10 years' imprisonment for any person who "practices, encourages or sensitizes people of the same sex, to sexual relation or any sexual practice" was recently rejected. The Minister of Justice of Rwanda, Tharcisse Karugarama, stated that "… sexual orientation is a private matter and each individual has his or her own orientation – this is not a State matter at all".[24]

---

[17] *Lawrence v. Texas*, 539 U.S. 558.

[18] Decision of 2 July 2009, paras. 55 and 56.

[19] S. Long, "British sodomy laws linger in former colonies", *The Gay and Lesbian Review*, vol. 16, No. 2 (March–April 2009), p. 5.

[20] *Naz Foundation v. Government of NCT of Delhi and Others*, 2 July 2009, p. 7.

[21] Joint United Nations Programme on HIV/AIDS (UNAIDS), "Fiji first Pacific Island nation with colonial-era sodomy laws to formally decriminalize homosexuality", press release, 4 March 2010.

[22] *Sunil Babu Pant v. Nepal Government*, Supreme Court, Division Bench, Order, Writ No. 917 of the year 2064 BS (21 December 2007).

[23] Immigration and Refugee Board of Canada, "Sri Lanka: laws proscribing homosexual acts and whether they are applied in practice – the treatment of homosexuals by authorities, by society at large and by the Muslim community", 17 January 2008.

[24] E. Musoni, "Government cannot criminalize homosexuality – Minister", *New Times* (Kigali), 26 January 2010.

B. Effects of criminalization on the right to health

Poor health outcomes and inhibition of access to health services

17. The Special Rapporteur believes that criminalization has adverse consequences on the enjoyment of the right to health of those who engage in consensual same-sex conduct, through the creation of the societal perception that they are "abnormal" and criminals. This has a severe deleterious impact on their self-regard, with significant, and sometimes tragic, consequences on their health-seeking behaviour and mental health. Rates of suicide attempts amongst youth who engage in consensual same-sex conduct have been variously reported as between three and seven times higher than for youth who identify as heterosexual;[25] the rates are similar for adults.

18. In jurisdictions in which their sexual conduct is criminalized, affected individuals are much more likely to be unable to gain access to effective health services, and preventive health measures that should be tailored to these communities are suppressed.[26] The fear of judgement and punishment can deter those engaging in consensual same-sex conduct from seeking out and gaining access to health services. This is often a direct result of the attitudes of health-care professionals who are not trained to meet the needs of same-sex practising clients – not only in terms of sexual health, but also with regard to health care more generally. Often, health professionals may refuse to treat homosexual patients altogether, or respond with hostility when compelled to do so.[27] Where patients may be guilty of a criminal offence, by engaging in consensual same-sex conduct, this has the potential to jeopardize the obligations of confidentiality that arise during the course of the doctor-patient relationship, as health professionals may be required by law to divulge details of patient interaction.

19. These problems are compounded for persons living with HIV/AIDS. Due to historical circumstances — most significantly, the association of AIDS with the gay community — the enjoyment of the right to health is disproportionately impacted as it pertains to HIV/AIDS diagnosis and treatment.[28] For instance, in the Asia-Pacific region, almost 90 per cent of homosexual men have no access to HIV prevention or care.[29] While this is due to a range of circumstances, a general atmosphere of fear has been the predominant factor in preventing HIV-positive individuals from accessing health services and treatment.[30] This atmosphere of fear also impacts adversely on the wider community. In countries where homosexuality is criminalized, the negative association of HIV/AIDS with homosexuality can result in individuals who do not engage in consensual same-sex conduct avoiding testing and treatment for HIV/AIDS, for fear of being subject to criminal sanctions, violence or discrimination.[31]

---

[25] C. Mahon, "Sexual orientation, gender identity and the right to health", in *Swiss Human Rights Book*, vol. 3, *Realizing the Right to Health*, A. Clapham and M. Robinson (eds.) (Rüffer & Rub, Zurich, 2009), p. 236.

[26] Ibid., p. 238.

[27] C.A. Johnson, *Off the Map: How HIV/AIDS Programming is Failing Same-sex Practicing People in Africa* (New York, International Gay and Lesbian Human Rights Commission, 2007), pp. 57–58.

[28] In virtually all regions outside of sub-Saharan Africa, HIV disproportionately affects men who have sex with men. (UNAIDS, "Report on the global AIDS epidemic 2008: executive summary" (Geneva, 2008), p. 30).

[29] United Nations Development Programme (UNDP), "90 per cent of men having sex with men have no access to HIV prevention and care", press release, 11 August 2009.

[30] Report of the Special Rapporteur on the right to health (E/CN.4/2004/49), para. 35.

[31] Human Rights Watch, "Hated to death: homophobia, violence and Jamaica's HIV/AIDS epidemic" (New York, 2004), p. 14.

Violence and abuse

20. Sanctioned punishment by States reinforces existing prejudices, and legitimizes community violence and police brutality directed at affected individuals.[32] Seven States, or parts thereof, currently retain the death penalty as a possible punishment for sodomy.[33] The Special Rapporteur believes that the imposition of the death penalty for consensual same-sex conduct is not only unconscionable, but further represents arbitrary deprivation of life, constituting an infringement of the right to life recognized in article 6 of the International Covenant on Civil and Political Rights.

21. Many reports indicate instances of violence directed at individuals based on same-sex conduct and gender identity.[34] Violence can inhibit individuals from seeking access to health services out of fear of reprisals and secondary victimization resulting from identification as a victim of such an attack.

Stigmatization

22. Criminalization may not be the sole reason behind stigma, but it certainly perpetuates it, through the reinforcement of existing prejudices and stereotypes.[35] Same-sex conduct was long considered a psychiatric disorder; until recently, the world's major professional psychological classification system retained homosexuality as a psychological disorder, which speaks to how deeply this stigma was embedded.[36]

23. Stigmatization prevents legislative and policymaking institutions from adequately addressing health-related matters in communities that are especially vulnerable to the infringement of the enjoyment of the right to health. Where same-sex conduct is illegal, sexual orientation may be treated as a problem that needs to be corrected, ignored or used to legitimize violence directed towards these individuals. Attempts to "cure" those who engage in same-sex conduct are not only inappropriate, but have the potential to cause significant psychological distress and increase stigmatization of these vulnerable groups.[37]

C. Right-to-health approach

24. As with all human rights, States are required to take steps to respect, protect and fulfil the right to health. The criminalization of private, consensual same-sex conduct creates an environment that is not conducive to affected individuals achieving full

[32] See for example Amnesty International, "Stonewalled: police abuse and misconduct against lesbian, gay, bisexual and transgender people in the U.S." (2005).

[33] Iran (Islamic Republic of), Mauritania, Saudi Arabia, Sudan and Yemen, along with parts of Nigeria and Somalia (Ottosson, "State-sponsored homophobia" (see footnote 7), p. 5).

[34] See for example the United States Department of State, "2008 human rights report: Iran", 25 February 2009, available from www.state.gov/g/drl/rls/hrrpt/2008/nea/119115.htm; Human Rights Watch, "They want us exterminated: murder, torture, sexual orientation and gender in Iraq" (New York, 2009); Human Rights Watch, "Turkey: stop violence against transgender people", press release, 22 February 2010, available from www.hrw.org/en/news/2010/02/19/turkey-stop-violence-against-transgender-people.

[35] Constitutional Court of South Africa, *National Coalition for Gay and Lesbian Equality and Others v. Minister of Home Affairs and Others*, judgement of 2 December 1999, para. 54.

[36] Homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition in 1986. Note, however, that gender identity disorders are still included within the text revision (2000) of the 4th edition of the *Manual*.

[37] A. Bartlett, G. Smith and M. King, "The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation", *BioMed Central Psychiatry*, vol. 9, article 11 (March 2009), seventh page. Available from www.biomedcentral.com/1471-244X/9/11.

realization of their right to health. Health services must be accessible for all, without discrimination, especially for the most vulnerable or marginalized sections of the population. The repeal of laws criminalizing consensual same-sex conduct between adults helps to ensure compliance with this State obligation.

25. Criminalization is not only a breach of a State's duty to prevent discrimination; it also creates an atmosphere wherein affected individuals are significantly disempowered and cannot achieve full realization of their human rights. For instance, States are bound to take steps to establish prevention and education programmes for behaviour-related health concerns such as HIV/AIDS. Decriminalization facilitates the achievement of this obligation because a social atmosphere wherein adult consensual same-sex conduct is accepted constitutes an essential part of structural prevention of HIV/AIDS. A legal framework promoting an enabling environment has been noted as one of the most important prerequisites to achieve this goal, along with combating both discrimination and structural violence.

26. A right-to-health approach requires that States decriminalize same-sex consensual conduct, as well as repeal laws that discriminate in respect of sexual orientation and gender identity, in order to meet core obligations of the right to health and create an environment enabling full enjoyment of the right.

III. Sex work

27. Sex workers remain subject to stigma and marginalization, and are at significant risk of experiencing violence in the course of their work, often as a result of criminalization. As with other criminalized practices, the sex-work sector invariably restructures itself so that those involved may evade punishment. In doing so, access to health services is impeded and occupational risk increases. Basic rights afforded to other workers are also denied to sex workers because of criminalization, as illegal work does not afford the protections that legal work requires, such as occupational health and safety standards.[38]

28. The Joint United Nations Programme on HIV/AIDS (UNAIDS) defines sex workers as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating".[39] It is noted, however, that no single term adequately covers the range of transactions worldwide that involve sex work (the term "sex worker" is increasingly used within the sector, as it is considered less stigmatizing and a better descriptor of workers' experiences than the word "prostitute").[40]

A. Criminalization of sex work: background

29. Historically, sex work has been criminalized in two major ways. First, through the criminalization of the selling of sexual services, with the imposition of penalties upon sex workers themselves. Second, through the criminalization of various practices around sex work: these include, but are not limited to, keeping a brothel; recruiting for or arranging the prostitution of others; living off the proceeds of sex work; solicitation; and facilitating sex work through the provision of information or assistance. Although the former is not directly

[38] UNAIDS, "Guidance note on HIV and sex work" (2009), p. 5.

[39] UNAIDS, "Sex work and HIV/AIDS", UNAIDS Technical Update (2002), p. 3.

[40] Ibid. The term "sex worker" shall be used throughout this report, except where relevant materials use other terminology.

criminalized in many States worldwide, sex workers are nonetheless treated as criminals where activities around sex work are criminalized, or through the use of other pre-existing laws (not specific to sex work) to harass, intimidate or justify the use of force against sex workers.[41] Examples include the use of vagrancy or public nuisance laws to detain or arrest street sex workers, or the use of laws prohibiting homosexual acts in relation to male and transgender sex workers.

30. Alongside the right to health, the International Covenant on Economic, Social and Cultural Rights protects the right to freely chosen, gainful work (art. 6), which the State must take steps to safeguard. Article 6 of the Convention on the Elimination of All Forms of Discrimination against Women does not require States to suppress consensual, adult sex work. Rather, it calls for the suppression of "all forms of traffic in women and exploitation of prostitution of women". The term "exploitation of prostitution" has not been defined within the Convention, but is interpreted to refer to exploitation in the context of prostitution. Additionally, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families applies to a significant number of sex workers who travel between States to engage in sex work.

31. Other international instruments address the trafficking of people, including for the purposes of sexual exploitation. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime defines trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (art. 3 (a)). Exploitation is further defined to include the prostitution of others or other forms of sexual exploitation. Additionally, the Protocol states that the consent of any victim of trafficking is deemed irrelevant where circumstances such as vulnerability or abuse of power exist (art. 3 (b)).

32. Terms such as "vulnerability" and "abuse of power" remain undefined within the Protocol, and have no independent legal meaning. These terms require clarification, as failure to do so could lead to situations in which State responses to trafficking include sex workers who voluntarily enter the sex sector. For instance, the trafficking of women and children to participate in sex work has been conflated with voluntary participation in sex work in Cambodia, where the Law on the Suppression of Human Trafficking and Sexual Exploitation was introduced in 1998.[42] The purpose of this legislation was the suppression of human trafficking and sexual exploitation, as stated in article 1, but the statute includes provisions that prohibit activities around sex work and effectively criminalize the sex sector in its entirety. The law prohibits solicitation, support of prostitution in any manner, sharing of benefits obtained from prostitution, management of an establishment for prostitution, or even selling premises knowing they will be used for prostitution, amongst other activities (chapt. IV). The penalties for breach of these laws are extreme, including the seizure of materials and proceeds, closure of businesses and, alarmingly, the restriction of civil rights (art. 48). This law has led to the detention of sex workers without arrest or imposition of criminal charges, as well as to rape and extortion, following raids.[43]

[41] M.L. Rekart, "Sex-work harm reduction", *The Lancet*, vol. 366 (December 2005), p. 2124.

[42] Approved by the National Assembly of Cambodia on 20 December 2007, and approved by the Senate on 18 January 2008.

[43] United States Department of State, *2009 Trafficking in Persons Report* (2009), p. 96.

33. The trafficking and enforced sexual slavery of any person is abhorrent, and undoubtedly merits criminal prohibition. However, the conflation of consensual sex work and sex trafficking in such legislation leads to, at best, the implementation of inappropriate responses that fail to assist either of these groups in realizing their rights, and, at worst, to violence and oppression.

34. Globally, there have been periods where sex work has been highly regulated or decriminalized, generally to manage certain aspects of sex work or to achieve control of disease, particularly within the military. However, prohibitions against sex work are regarded as "notoriously difficult to enforce"[44] and of questionable utility where enforcement is accompanied by extortion and brutality.[45] In recent times, significant opposition has arisen to the imposition of criminal sanctions against sex workers,[46] and certain nations have amended laws to decriminalize sex work.

35. For example, New Zealand decriminalized sex work in 2003, with the express aim of safeguarding the human rights of sex workers.[47] Prior to decriminalization, sex workers were less willing to disclose their occupation to health workers or to carry condoms.[48] Since decriminalization, sex workers have reported feeling that they have enforceable rights, including the rights to health and security of person, and are increasingly able to refuse particular clients and practices, and negotiate safer sex.[49]

B. Effects of criminalization on the right to health

Poor health outcomes and impediments to access to health services

36. Criminalization represents a barrier to accessing services, establishing therapeutic relationships and continuing treatment regimes, leading to poorer health outcomes for sex workers, as they may fear legal consequences or harassment and judgement. This is particularly concerning given that HIV has been noted to disproportionately affect sex workers in many regions.[50]

37. The use of punitive measures against sex workers, such as antisocial behaviour orders in the United Kingdom of Great Britain and Northern Ireland, has undermined effective health promotion activities. Raids, cautions and arrests generally result in a shift of the sex worker population, often towards unsafe areas, putting sex workers at higher risk.[51] Criminalization has also been noted to diminish the "bargaining power" of sex workers in choosing clients and negotiating condom use.[52]

---

[44] S. Law, "Commercial sex: beyond decriminalization", *Southern California Law Review*, vol. 73 (March 2000), p. 537.

[45] See for example M. Richter, "Sex work, reform initiatives and HIV/AIDS in inner-city Johannesburg", *African Journal of AIDS Research*, vol. 7, No. 3 (2008), p. 325.

[46] Law, "Commercial sex", p. 532.

[47] New Zealand, Prostitution Reform Act 2003, part 1, sect. 3 (a).

[48] J. Jordan, "The sex industry in New Zealand: a literature review" (New Zealand Ministry of Justice, 2005), p. 65.

[49] New Zealand, *Report of the Prostitution Law Reform Committee on the Operation of the Prostitution Reform Act of 2003* (Wellington, 2008), pp. 46–47 and 50.

[50] UNAIDS, "Report on the global AIDS epidemic 2008" (see footnote 28), p. 30.

[51] Workers can shift from familiar, well-lit areas to unfamiliar and more remote locations, in addition to the shift from indoor work to the streets. See for example L. Cusick and L. Berney, "Prioritizing punitive responses over public health: commentary on the Home Office consultation document *Paying the Price*", *Critical Social Policy*, vol. 25, No. 4 (November 2005), pp. 599–600.

[52] K. Blankenship and S. Koester, "Criminal law, policing policy, and HIV risk in female street sex

38. In one study, about 45 per cent of a sample of sex workers operating in illegal circumstances were assessed with negative mental health scores, as compared to 12 per cent of the sample of "legal" sex workers. Although differences in physical health outcomes were not observed, significant patterns of disadvantage and vulnerability were noted amongst the former group.[53] This not only highlights the impact of criminalization, both in terms of the impact of sex work and entry into sex work, but also draws attention to the importance of differentiating between the various types and settings of sex work in devising effective health interventions.

Stigmatization

39. Stigmatization has been cited as the major factor preventing sex workers from accessing their rights. Laws criminalizing or onerously regulating sex work compound the stigmatization experienced by sex workers, adversely affecting health outcomes, often without justification on the grounds of public health. The Geschlechtskrankheitengesetz, a law in Germany designed to combat venereal disease, required prostitutes to undergo mandatory medical examinations.[54] This law legally stigmatized sex workers as being almost solely responsible for the spread of venereal disease, despite the absence of epidemiological studies to support this. The law has since been amended to provide for voluntary, anonymous testing.

40. In China, laws have evolved to allow for the punishment of sex workers through administrative detention; workers are detained for the purposes of re-education, which causes significant psychological suffering, along with stigmatization and shaming of those involved in sex work in the region.[55]

Violence and harassment

41. Violence towards sex workers, often perpetrated by those in positions of authority, is a common aspect of sex work, and an unfortunate corollary of criminalization. According to various studies, about 80 per cent of sex workers have been assaulted in the course of their work.[56] Where sex work is criminalized, the sector is effectively driven underground, which has been noted to create an environment of increased violence.

42. The criminalization of sex work often means that sex workers feel unable to enforce their basic rights, as their status and work are illegal. They "live in fear" of police and clients, and feel unable to report crimes against them due to fear of arrest.[57] Sex workers have reported that they are highly vulnerable to police harassment,[58] particularly in the forms of (a) sex by deception and coercion, (b) extortion and (c) discrimination (including

workers and injection drug users", *Journal of Law, Medicine & Ethics*, vol. 30, No. 4 (December 2002), p. 550.

[53] C. Seib and others, "The health of female sex workers from three industry sectors in Queensland, Australia", *Social Science & Medicine*, vol. 68, No. 3 (February 2009), pp. 476–477.

[54] J. Kilvington, S. Day and H. Ward, "Prostitution policy in Europe: a time of change?", *Feminist Review*, vol. 67 (2001), p. 87.

[55] J. Tucker, X. Ren and F. Sapio, "Incarcerated sex workers and HIV prevention in China: social suffering and social justice countermeasures", *Social Science & Medicine*, vol. 70, No. 1 (January 2010), pp. 122–125.

[56] Law, "Commercial sex" (see footnote 44), p. 533.

[57] A. Crago, *Our Lives Matter: Sex Workers Unite for Health and Rights* (New York, Open Society Institute, 2008), pp. 31–32.

[58] UNAIDS, *HIV and sexually transmitted infection prevention among sex workers in Eastern Europe and Central Asia*, UNAIDS Best Practice Collection (2006), p. 15.

moral punishment, public humiliation and extreme violence driven by contempt).[59] Policing has also been noted as a key issue in shaping the vulnerability of sex workers to HIV.[60]

Working conditions

43. The criminalization of sex work infringes on the enjoyment of the right to health, by creating barriers to access by sex workers to health services and legal remedies. When sex workers are not recognized as engaging in legitimate work, they are not recognized by standard labour laws in many countries.[61] Sex workers often cannot gain access to State benefits, and are not protected by occupational health and safety regulations that routinely protect employees in other industries.[62] The criminalization of selling sex also renders any agreement concluded for sex work illegal or unenforceable by law on the grounds of being contrary to public policy, resulting in no legal recourse for sex workers.

44. Moreover, the criminalization of practices related to sex work can create barriers to the realization of safe working conditions. For instance, where laws exist prohibiting the running of a brothel, those who invariably subvert the law and run such a business can impose unsafe working conditions without difficulty, as sex workers themselves have no recourse to legal mechanisms through which they can demand safer working conditions.[63] Where criminalization in any form exists, the protection offered by a brothel or a manager may become increasingly desirable or necessary, but this also comes at a price: fiscally, through the opportunities created for extortion, and in terms of health.

45. Sex workers should have the right to legal protection, with regard to various hazards such as violence, general occupational risks and labour exploitation.[64] Judicial decisions have, in some instances, resulted in such protection being directly realized. For instance, a court in The Hague found in favour of a Czech immigrant who had been denied permission to reside in The Netherlands for the purposes of prostitution, concluding that prostitution is considered labour according to domestic law, and that the petitioner was therefore entitled to a permit.[65]

C. Right-to-health approach

46. The decriminalization or legalization of sex work with appropriate regulation forms a necessary part of a right-to-health approach to sex work, and can lead to improved health outcomes for sex workers. Any regulation of the sex sector should be implemented in accordance with a right-to-health framework, and should satisfy the requirement of safe working conditions as incorporated into the right to health. Decriminalization, along with the institution of appropriate occupational health and safety regulations, safeguards the rights of sex workers. Where sex work is legally recognized, the incidence of violence may also be reduced, through the enforcement of laws against abuse and exploitation.[66]

[59] T. Rhodes and others, "Police violence and sexual risk among female and transvestite sex workers in Serbia: qualitative study", *British Medical Journal*, vol. 337 (September 2008), pp. 813–814.

[60] M. Biradavolu, "Can sex workers regulate police? Learning from an HIV prevention project for sex workers in southern India", *Social Science & Medicine*, vol. 68 (April 2009), p. 1541.

[61] See for example Richter, "Sex work" (see footnote 45), p. 325.

[62] Crago, *Our Lives Matter*, p. 10.

[63] Ibid., p. 25.

[64] K. Butcher, "Confusion between prostitution and sex trafficking", *The Lancet*, vol. 361 (June 2003), p. 1983.

[65] Kilvington, Day, Ward, "Prostitution policy" (see footnote 54), p. 84.

[66] UNAIDS, "Sex work and HIV/AIDS" (see footnote 39), p. 5.

47. Criminalization represents a barrier to participation and collective action, through the suppression of activities of civil society and individual advocates. The participation of sex workers in interventions has been shown to have significant benefits. Organizations representing sex workers took an early lead in attempting to slow the spread of HIV/AIDS, through the promotion of condom use, the development of AIDS education programmes and inclusive research studies.[67]

48. It is vital that those designing interventions to assist victims of trafficking differentiate between those persons working in the sex sector against their will and those who consensually participate in sex work. Brothel raids that are designed to assist victims of trafficking but fail to discriminate between these individuals can impede the realization of the right to health of both groups in some circumstances. Conversely, evidence from one study indicates that individuals consensually engaging in sex work are well placed to assist trafficked and underage persons engaging involuntarily in this industry. This demonstrates the benefits of participation as part of a right-to-health approach.[68]

49. The right-to-health approach necessarily requires that the aforementioned legislative changes be accompanied by non-legal measures designed to achieve the realization of the right to health, such as adequate education, access to legal aid, and so forth. For instance, one African study found that two thirds of respondent sex workers were unaware that they were at risk of contracting HIV or other sexually transmitted infections if they engaged in unprotected sex.[69] Decriminalization can facilitate the exchange of information, which combats such situations, particularly by reducing fear and stigma, so that health promotion projects that allow for open and frank discussions around sexual risk can be implemented.

50. Decriminalization also assists in appropriately targeting these health promotion projects, as sex workers are more likely to self-identify and voluntarily take part in interventions if the risk of legal repercussion is eliminated. Effective interventions around the health of sex workers and clients should also consider shared responsibility and client behaviour; this is increasingly possible in an environment where clients are not criminalized for using the services of sex workers.

IV. HIV transmission

51. The Special Rapporteur notes that the criminalization of HIV transmission has formed a part of the global response to the HIV/AIDS crisis since its inception. Unfortunately, the public health goals of legal sanctions are not realized by criminalization. In fact, they are often undermined by it, as is the realization of the right to health. The criminalization of HIV/AIDS transmission also infringes on many other human rights, such as the rights to privacy, to be free from discrimination and to equality, which in turn impacts upon the realization of the right to health. The criminalization of HIV transmission, or behaviours around transmission, is generally recognized as counterproductive, and should be reconsidered in the context of any comprehensive HIV/AIDS response framework.

[67] Blankenship and Koester, “Criminal law” (see footnote 55), p. 552.

[68] Crago, *Our Lives Matter*, pp. 14, 36 and 59.

[69] G. Scambler and F. Paoli, “Health work, female sex workers and HIV/AIDS: global and local dimensions of stigma and deviance as barriers to effective interventions”, *Social Science & Medicine*, vol. 66, No. 8 (April 2008), p. 1854.

A. Criminalization of HIV transmission: background

52. The criminalization of HIV transmission predominately takes two forms: first, laws specifically criminalizing transmission of HIV and, second, through the application of existing criminal law to cases involving exposure to or the transmission of HIV (such as assault). Such legislation has included, inter alia, the criminalization of exposure to HIV (including mother-to-child exposure),[70] attempted transmission and failure to disclose HIV status to potential sexual partners.[71] Certain statutes also mandate the imposition of harsher sentencing in cases involving sexual violence where HIV transmission has occurred, essentially treating HIV as an aggravating factor.[72]

53. Article 12 of the International Covenant on Economic, Social and Cultural Rights obliges State parties to, inter alia, take the steps necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases and for the creation of conditions that would assure to all medical service and medical attention in the event of sickness.

54. In paragraph 58 of the Declaration of Commitment on HIV/AIDS,[73] Member States pledged to:

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

Despite these commitments to adopt and enact appropriate legislation concerning HIV, States continue to introduce statutes criminalizing HIV transmission and exposure, thereby undermining HIV prevention, treatment, care and support.[74]

55. As the AIDS response developed, coercion and discrimination were noted to undermine the effectiveness of prevention programmes, and the prevention of discrimination against persons living with HIV/AIDS became central to formulating an effective public health response.[75] Recently, laws criminalizing HIV transmission have again proliferated, generally in response to the perception that HIV prevention strategies are largely failing, and in line with the continued stigma associated with having HIV.[76] However, the imposition of criminal punishment on those who transmit HIV or expose

---

[70] See for example Sierra Leone, The Prevention and Control of HIV and AIDS Act (2007), sect. 21, para. 2

[71] C.L. Galletly and S.D. Pinkerton (2006), "Conflicting messages: how criminal HIV disclosure laws undermine public health efforts to control the spread of HIV", *AIDS Behaviour*, vol. 10 (June 2006), p. 452.

[72] W. Brown, J. Hanefeld and J. Welsh, "Criminalising HIV transmission: punishment without protection", *Reproductive Health Matters*, vol. 17, No. 34 (November 2009), pp. 119 and 122.

[73] Adopted at the twenty-sixth special session of the General Assembly on HIV/AIDS, entitled "Global Crisis – Global Action", resolution S-27/2, annex.

[74] Report of the Secretary-General, "Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals" (A/62/780), para. 55.

[75] J. Mann, "Human rights and AIDS: the future of the pandemic", *The John Marshall Law Review*, vol. 30 (fall 1996), p. 197.

[76] M. Berer, "Criminalisation, sexual and reproductive rights" (see footnote 4), p. 5.

others to the virus fails to achieve the aforementioned aims of the criminal law, and has not been shown to have any public health benefit.

56. Incapacitation of persons living with HIV, through incarceration, does not prevent further transmission of the virus. High-risk practices are common throughout prisons worldwide, such as intravenous drug use and unsafe sex, and access to devices for protection against HIV (such as condoms, clean needles and syringes) is generally limited, so risk is actually increased by imprisonment.

57. The rehabilitative effect of incarceration for those infringing HIV-related laws is questionable, particularly in cases of unintentional transmission, as there is no criminal behaviour amenable to rehabilitation. Furthermore, there is no compelling evidence to suggest that incarceration positively modifies risk factors or behaviours around HIV transmission, diminishes the risk of future transmission or results in similar beneficial outcomes.

58. The criminalization of HIV transmission in the instance of intentional, malicious transmission is the only circumstance in which the use of criminal law in relation to HIV may be appropriate. In such cases, the alleged perpetrator should have acted autonomously, with full knowledge of relevant surrounding circumstances, including but not limited to their HIV status, effectiveness and attempted use of prophylaxis, and so forth. However, the utility of enacting legislation specifically dealing with this circumstance is questionable.[77] In contrast, criminalization is inappropriate where there is a lack of such culpability.

59. However, the delineation between intentional and unintentional transmission is often not clearly made by States – legislation may be unintentionally drafted with such breadth as to allow for the criminalization of unintentional transmission or exposure. For instance, in Zimbabwe the law stipulates that if anyone who realizes "that there is a real risk or possibility" that she or he might have HIV intentionally does anything which he or she realizes involves a real risk or possibility of infecting another person with HIV, he or she "shall be guilty of deliberate transmission of HIV".[78] This implies that a crime can be committed even with an HIV-negative status, that is, based merely on the realization that "there is a real risk or possibility" of a positive status.[79]

60. Similarly, the model law for sexually transmitted infections and HIV/AIDS for West and Central Africa criminalizes the transmission of HIV virus "through any means by a person with full knowledge of his/her HIV/AIDS status to another person". This provision does not require that the person intends to transmit HIV; rather, it requires only that he or she has knowledge of his/her status and fails to take into account relevant circumstances, such as whether the accused individual had knowledge of how HIV is transmitted or used effective precautionary methods,[80] in establishing either the offence or the availability of relevant defences. This law been implemented in at least 15 African countries as of 2009, occasionally with amendments.[81]

61. Where States deliberately impose criminal sanctions on individuals who do not intend to transmit HIV, or inadvertently do so through broadly drafted legislation that fails

[77] See discussion in chap. III, sect. C, above.

[78] Zimbabwe, Criminal Law (Codification and Reform) Act, Act 23 2004, sect. 79, para. 1.

[79] E. Cameron, "HIV is a virus, not a crime: criminal statutes and criminal prosecutions", address at the XVII International AIDS Conference Plenary, Mexico City, 8 August 2008.

[80] R. Pearhouse, "Legislation contagion: the spread of problematic new HIV laws in Western Africa", *HIV/AIDS Policy & Law Review*, vol. 12, Nos. 2/3 (December 2007), p. 8.

[81] P. Sanon and others, "Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso", *Reproductive Health Matters*, vol. 17, No. 34 (November 2009), p. 146.

to achieve its legitimate aims, the right to health is infringed with little justification in terms of the criminal law or public health.

B. Effects of criminalization on the right to health

No impact on behaviour change or HIV spread

62. The Special Rapporteur notes that criminal laws that explicitly regulate the sexual conduct of people living with HIV have not been shown to significantly impact on sexual conduct, nor do they have a normative effect in moderating risk behaviours.[82] Criminal law does not influence the circumstances in which most HIV transmission occurs. In many regions, the majority of people living with HIV are unaware of their positive status[83] and most cases of HIV transmission occur through consensual sex. Private sexual conduct invariably persists in the face of possible prosecution,[84] but when prosecution actually occurs, these behaviours are driven underground, providing less opportunity for regulation and inhibiting access to preventive activities, diagnostic services, treatment and support.[85]

Undermining existing public health efforts

63. Criminalization of HIV transmission or exposure places legal responsibility for HIV prevention exclusively on those already living with HIV, undermining the notion of shared responsibility between sexual partners, and potentially creating a false sense of security amongst those who are HIV-negative.[86] Criminalization also has the potential to discourage HIV testing, which is a core component of successful HIV/AIDS health initiatives. An additional barrier to access to services could be manifested through increased distrust in relationships with health professionals and researchers, impeding the provision of quality care and research, as people may fear that information regarding their HIV status will be used against them in a criminal case or otherwise. As the prevalence of high-risk sexual behaviour is significantly lower in individuals aware of their seropositive status,[87] any laws that discourage testing and diagnosis have the potential to increase the prevalence of risky sexual practices and HIV transmission.

Disproportionate impact on vulnerable communities

64. In jurisdictions where HIV transmissions have been prosecuted, of the very few cases that are prosecuted out of the many infections that occur each year,[88] the majority

---

[82] Z. Lazzarini and others, "Evaluating the impact of criminal laws on HIV risk behavior", *Journal of Law, Medicine & Ethics*, vol. 30 (summer 2002), pp. 247–249.

[83] See for example A. Anand and others, "Knowledge of HIV status, sexual risk behaviors and contraceptive need among people living with HIV in Kenya and Malawi", *AIDS*, vol. 23, No. 12 (July 2009), p. 1565.

[84] S. Burris and others, "Do criminal laws influence HIV risk behavior? An empirical trial", *Arizona State Law Journal*, vol. 39 (2007) p. 468.

[85] UNAIDS, "Criminal law, public health and HIV transmission: a policy options paper" (Geneva, 2002), p. 21.

[86] Ibid., p. 7.

[87] G. Marks and others, "Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs", *Journal of Acquired Immune Deficiency Syndromes*, vol. 39, No. 4 (August 2005), p. 448.

[88] In the United Kingdom of Great Britain and Northern Ireland, for example, there have been only 15 prosecutions since 2001, compared to over 42,000 new HIV diagnoses in the same period (see www.nat.org.uk).

have been noted to involve defendants in vulnerable social and economic positions.[89] Although laws criminalizing HIV transmission and exposure were, on occasion, enacted to provide women with greater protection, applying these laws broadly has also resulted in women being disproportionately affected. For instance, a woman was prosecuted under section 79 of the Zimbabwe Criminal Law (Codification and Reform) Act 23 of 2004 for having unprotected sex while HIV-positive, despite HIV not even being transmitted to the "victim" in question.[90]

65. Women often learn they are HIV-positive before their male partners because they are more likely to seek access to health services[91] and are consequently blamed for introducing the infection into communities. For many women, it is also difficult or impossible to negotiate safer sex or to disclose their status to a partner for fear of violence, abandonment or other negative consequences.[92] Women may therefore face prosecution as a result of their failure to disclose, despite having valid reasons for non-disclosure. These laws do not provide women with any additional protection against violence or assurance of their rights to sexual decision-making and safety, and do not address the underlying socio-economic factors that increase women's vulnerability.

Criminalization of mother-to-child transmission

66. Some countries have enacted laws that criminalize mother-to-child transmission explicitly (see paragraph 54 above) or implicitly due to overly broad drafting of the law.[93] Where the right to access to appropriate health services (such as comprehensive prevention of mother-to-child transmission services and safe breastfeeding alternatives) is not ensured, women are simply unable to take necessary precautions to prevent transmission, which could place them at risk of criminal liability. In 2008, only 45 per cent of pregnant women living with HIV in sub-Saharan Africa and only 25 per cent in South and East Asia had access to prevention of mother-to-child transmission services.[94]

67. In Sierra Leone, a person infected with HIV (and aware of the fact) must "take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of pregnant women, the foetus", with criminal sanctions imposed for failure to do so.[95] It is unclear what "all reasonable measures and precautions" in the case of prevention of mother-to-child transmission would include, and whether such standards are clearly articulated and understood by health-care providers and pregnant women themselves to ensure that an informed decision can be made. Given the complexity of guidance on the suitability of breastfeeding, decisions on infant feeding options involve a complex

[89] See for example M. Nyambe and others, "Criminalisation of HIV transmission in Europe: a rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights" (GNP+ Europe and Terrence Higgins Trust, 2005), p. 18.

[90] E. Cameron, "The criminalization of HIV transmission and exposure", public lecture presented at the 1st Annual Symposium on HIV, Law and Human Rights, Toronto, 12–13 June, 2009, pp. 3–4.

[91] UNAIDS and UNDP, summary of main issues and conclusions of the International Consultation on the Criminalization of HIV Transmission, Geneva, 31 October–2 November 2007, pp. 8–9.

[92] Ibid.

[93] See for example Guinea, Law on Prevention, Care and Control of HIV/AIDS (No. 2005-25) and Guinea-Bissau, Framework Law Relating to the Prevention, Treatment and Control of HIV/AIDS, cited in R. Pearshouse, "A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo" (Canadian HIV/AIDS Legal Network, 2007).

[94] World Health Organization, *PMTCT Strategic Vision 2010–2015: Preventing Mother-to-Child Transmission of HIV to Reach the UNGASS and Millennium Development Goals* (Geneva, 2010), p. 8.

[95] Sierra Leone, The Prevention and Control of HIV and AIDS Act (2007), art. 21, para. 1 (a).

balancing of risks and benefits, and require that the mother be provided with accurate, comprehensible information. In this instance, the criminal law has the potential to punish women for the inadequacy of the government in providing appropriate services and education.

Stigma, discrimination and violence

68. Stigma represents a major impediment to the implementation of successful interventions in respect of HIV/AIDS. Applying criminal law to HIV exposure or transmission can reinforce the stereotype that people living with HIV are immoral and irresponsible, further entrenching HIV-related stigma. People living with HIV/AIDS may, in turn, internalize the negative responses of others. This self-stigmatization affects the sense of pride and worth of individuals, which can lead to depression and self-imposed withdrawal, hampering access to HIV/AIDS treatment and interventions.[96] In this way, criminalization impedes the right to health by constructing barriers to access by creating an environment in which individuals feel as if they are not deserving of treatment.

69. Discrimination against those affected by HIV/AIDS is one of the manifestations of stigma. For those living with HIV, actual and feared discrimination acts as a barrier to HIV-specific health services, including testing, anti-retroviral therapy and services in the prevention of mother-to-child transmission, in addition to broader health services.[97]

70. The Special Rapporteur notes that individuals living with HIV have been convicted of crimes that did not actually inflict physical harm, damage any property or otherwise cause injury.[98] Disproportionate severity in sentencing of those convicted of "HIV crimes" has become evident in a number of cases, the inference being that the defendants' HIV status played a significant role in conviction and imprisonment.[99] Criminal prosecutions, and the publicity stemming from them, have been found to increase stigmatization and have been perceived by people living with HIV as undermining public health efforts encouraging safer sex.[100]

71. The criminalization of HIV transmission also increases the risk of violence directed towards affected individuals, particularly women. HIV-positive women are 10 times more likely to experience violence and abuse than women who are HIV-negative.[101]

C. Right-to-health approach

72. The Special Rapporteur emphasizes that any domestic legislation concerning HIV transmission should be based on a right-to-health approach; that is, States must comply

[96] UNAIDS, *HIV-related Stigma, Discrimination and Human Rights Violations* (Geneva, 2005), pp. 8–9.

[97] K. MacQuarrie, T. Eckhaus and L. Nyblade, "HIV-related stigma and discrimination: a summary of recent literature" (Geneva, UNAIDS, 2009), pp. 5–6.

[98] For example, a 42-year-old man living with HIV in Texas with a history of previous arrests was sentenced to 35 years in jail for "harassing a public servant with a deadly weapon" while being arrested for drunk and disorderly conduct. The "deadly weapon" was saliva. Saliva has never been shown to result in the transmission of HIV. See G. Kovach, "Prison for man with H.I.V. who spit on a police officer", *New York Times*, 16 May 2008.

[99] Cameron, "The criminalization of HIV transmission and exposure" (see footnote 90), p. 8.

[100] C. Dodds and P. Keogh, "Criminal prosecutions for HIV transmission: people living with HIV respond", *International Journal of STD & AIDS*, vol. 17, No. 5 (May 2006), p. 315.

[101] J. Kehler and others, "10 reasons why criminalization of HIV exposure or transmission harms women" (ATHENA Network, 2009), p. 3.

with their obligations to respect, protect and fulfil the right to health through the enactment of such legislation. Most relevantly, the obligation to protect requires States to take measures to protect all vulnerable or marginalized groups of society, and the obligation to fulfil similarly requires steps to assist individuals and communities to enjoy the right to health – particularly those who are unable to realize the right themselves.

73. Any law concerning HIV transmission should therefore be directed at issues around public infrastructure, access to medicines, information campaigns concerning HIV/AIDS and so forth. The criminalization of HIV transmission should not form the mainstay of a national HIV/AIDS response, and its necessity is questionable in any event. Informed individuals take steps to prevent HIV transmission irrespective of criminal laws around transmission, and there is little evidence that specific laws criminalizing HIV transmission deter or modify the behaviour of individuals. With little benefit demonstrated in terms of achieving the aims of the criminal law or public health, and a corresponding risk of alienation, stigmatization and fear, it is difficult to see why the criminalization of HIV transmission is justified at all. Laws that are unnecessarily punitive will undermine any public health response to HIV, rather than assist it.

74. As such, criminalization should be considered permissible only in cases involving intentional, malicious transmission. The criminalization of any lesser *mens rea* is not only inappropriate, but also it is counterproductive in the struggle against the spread of HIV. In the view of UNAIDS:

> Criminal law should not be applied where there is no significant risk of transmission or where the person:
>
> • Did not know that he/she was HIV-positive
>
> • Did not understand how HIV is transmitted
>
> • Disclosed his/her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means)
>
> • Did not disclose his/her HIV-positive status because of fear of violence or other serious negative consequences
>
> • Took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts
>
> • Previously agreed on a level of mutually acceptable risk with the other person[102]

75. Finally, domestic laws prohibiting the deliberate spread of any disease or assault, or laws concerning the age of consent, adequately cover intentional transmission of HIV should the need arise to prosecute cases where this has occurred.[103] The use of these pre-existing laws provides a legal safeguard to potential victims, without unnecessarily stigmatizing and further marginalizing those affected by HIV within the jurisdiction. States should, in addition to using pre-existing laws, issue guidelines to ensure that these laws are only utilized in cases of intentional transmission and that the relevant *mens rea* is to be established beyond a reasonable doubt.[104]

[102] UNAIDS and UNDP, "Criminalization of HIV transmission", Policy Brief (Geneva, 2008), p. 1.

[103] For instance, two cases in Burkina Faso were prosecuted under existing law, despite HIV legislation being introduced (Sanon and others, "Advocating prevention" (see footnote 81), pp. 148–149).

[104] UNAIDS and UNDP, "Criminalization of HIV transmission", p. 1.

V. Recommendations

76. **The Special Rapporteur calls upon States:**

(a) To take immediate steps to decriminalize consensual same-sex conduct and to repeal discriminatory laws relating to sexual orientation and gender identity, as well as to implement appropriate awareness-raising interventions on the rights of affected individuals;

(b) To repeal all laws criminalizing sex work and practices around it, and to establish appropriate regulatory frameworks within which sex workers can enjoy the safe working conditions to which they are entitled. He recommends that States implement programmes and educational initiatives to allow sex workers access to appropriate, quality health services;

(c) To immediately repeal laws criminalizing the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalizing intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases;

(d) To introduce monitoring and accountability mechanisms so as to ensure their obligations to safeguard the enjoyment of the right to health through legislative, judicial and administrative mechanisms, including policies and practices to protect against violations;

(e) To provide human rights education for health professionals, and to create an environment conducive to collective action and participation.