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## Courting Rights:

Case Studies in Litigating the Human Rights  
of People Living with HIV

UNAIDS BEST PRACTICE COLLECTION



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Case Studies in Litigating the Human  
Rights of People Living with HIV



Canadian | Réseau  
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## Preface

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One of the greatest lessons we have learned in the HIV epidemic is that people, even if they are aware of the modes of transmission of HIV, cannot simply be expected to change their most intimate behaviour to protect themselves or others from HIV. Nor can people be expected to treat people living with HIV with dignity, compassion or respect. Rather, we have learned that people must be empowered and supported to protect themselves and others in the context of the epidemic, whether it is from infection from the virus or from the stigma and discrimination that attach to the virus or from the life-threatening consequences of becoming ill with AIDS-related disease.

The best way to empower people to face HIV and AIDS is to protect their human rights—all their rights—civil, economic, political, social and cultural. The best way to enforce these rights is for people to draw them down in the form of concrete demands and advocate or, if necessary, litigate for their fulfillment in their countries and communities.

This volume presents examples where a whole range of people—from people living with HIV, to activists, to prisoners—have demanded that human rights related to HIV be recognized and enforced in national courts of law. By doing so, they have not only presented powerful examples of courage and solidarity but in some cases have also changed the whole context of the national response to HIV. Because of successful court cases in some countries, discrimination against people living with HIV is no longer tolerated in employment or the military. The right to health enshrined in national constitutions has been interpreted to mean the right to treatment for HIV; and it has been recognized that prisoners, like everyone else, have the right to HIV prevention, treatment and support.

The law can be a slow and imperfect tool by which to respond to HIV, and bad law can make for a bad response to HIV. But when the law supports the rights of those affected by the epidemic, it helps to create the kind of enabling environment that leads to effective HIV responses. It is our hope that this volume and the cases presented here will stimulate others to use the law and the courts, if necessary, to ensure that human rights are the foundation of the national response to HIV.



Dr. Peter Piot  
Executive Director  
UNAIDS

## Foreword

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Protecting, promoting and fulfilling the human rights of people living with and vulnerable to HIV remain central challenges in the global response to AIDS. Yet a “human rights based approach” to addressing HIV has too often been an empty phrase; there are few well-conceived or funded programmes designed explicitly to address the human rights abuses faced by people living with and affected by HIV. This is so even though it is clear from more than two decades of experience that inattention to the rights of those affected by HIV undermines the effectiveness of HIV policies and programmes; and the marginalization and discrimination experienced by various groups continue to fuel the pandemic. Among others, these groups include people living with HIV, women and girls, orphaned children, men who have sex with men, sex workers, prisoners and injecting drug users. In light of this, it is urgent that there be developed tools which countries and those affected by HIV can use to make “rights-based approaches” more than just words.

National law is one tool for the protection, promotion and fulfillment of human rights. But, as this volume demonstrates, the law can either be protective of human rights or can be an impediment to the realization of rights. Over the years, people living with or affected by HIV have sometimes enjoyed the protection of the law and at other times have had to challenge the law in the courts to make it embody the strong human rights protections that they, like all people, deserve. This volume illustrates the ways in which litigation has succeeded—or not—in strengthening the human rights foundations of national law. It provides examples of HIV-related litigation from all over the world in order to help legislators, jurists, advocates and policy-makers understand and use the law to the greatest advantage in response to AIDS.

The United Nations *International Guidelines on HIV/AIDS and Human Rights* encourages all countries to ensure that their laws are supportive to the protection, promotion and fulfillment of the human rights of people living with and vulnerable to HIV. It is our hope that the real experiences recounted in this volume and the lessons drawn from them will assist countries in working towards the goal of national law that embodies respect for the human rights of people affected by HIV and thereby becomes a powerful tool in the response to HIV.



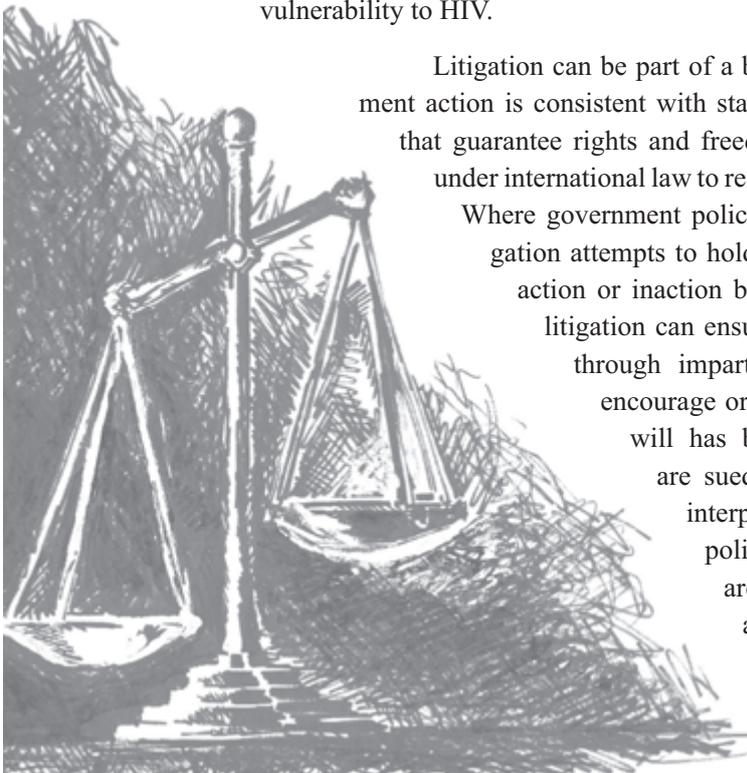
Joanne Csete  
Executive Director  
Canadian HIV/AIDS Legal Network

## Introduction

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HIV and AIDS have raised a multiplicity of legal questions, and prompted a “juridical outburst” in many quarters.<sup>1</sup> One aspect of the response to the viral epidemic has been an “epidemic” of laws and policies. As early as 1991, the World Health Organization listed 583 laws and regulations concerning HIV infection and AIDS from different countries. In some cases, legislation has been helpful and proactive in addressing some of the factors, be they structural or individual, which sustain or fuel the epidemic. In other cases, sadly, legislation has perpetuated or even compounded the problem.

It is not surprising that such a proliferation of legislation should be paralleled by litigation. From the outset of the epidemic, responses to HIV and AIDS have often been based on misinformation, prejudice or political opportunism, with the result that human rights have been infringed. Similarly, lack of attention to the interests and welfare of those who are socially excluded, economically marginal and/or politically unpopular has resulted in the denial of human rights. Demands for redress, and for change, can be pursued through various fora and strategies. The *Universal Declaration of Human Rights* recognizes that: “Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.”<sup>2</sup> The exercise, or attempted exercise, of this right is one important mechanism for defending or promoting the human rights of people living with HIV and those for whom marginalization and the denial of human rights heightens vulnerability to HIV.



Litigation can be part of a broader effort to ensure that government action is consistent with states’ obligations under national laws that guarantee rights and freedoms, as well as states’ obligations under international law to respect, protect and fulfil human rights.

Where government policies or practices are challenged, litigation attempts to hold governments accountable for their action or inaction before an independent body. Ideally, litigation can ensure the necessary tempering of laws through impartial and principled review or can encourage or compel state action where political will has been lacking. When private actors are sued or prosecuted, litigation tests the interpretation and enforcement of public policy, as it determines which interests are to prevail in private interactions, and can lead to policy change that may protect or achieve a more just society. On occasion, litigation can empower the socially disadvantaged, including groups

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1 Justice Michael Kirby (High Court of Australia). Presentation at the Symposium international de réflexion sur le SIDA, Paris, 22-23 October 1987. See also: M Kirby. The New AIDS Virus—Ineffective and Unjust Laws. *Journal of Acquired Immune Deficiency Syndromes* 1988; 1: 304–312.

2 Universal Declaration of Human Rights, UN General Assembly Resolution 217 A (III) (1948), UN Doc A/810: Article 8.

most vulnerable to HIV—and even where such actions fail, litigation can shine a spotlight on areas for legal and policy reform, contributing to a larger process of social change.

Research undertaken for this publication revealed widely divergent patterns in HIV-related litigation. Some jurisdictions have witnessed a great number of court or tribunal decisions dealing with a range of legal questions posed by HIV and AIDS cases. In particular, there is an extensive body of HIV-related case law from numerous high-income countries. Conditions in such settings are conducive to such an outcome: there exist detailed legal and regulatory regimes and civil society organizations with the resources to undertake litigation as a method of influencing law or policy. In such countries, it is also more common to find extensive documentation of national-level litigation, including publications that regularly report new developments in HIV-related jurisprudence. In many other countries, for reasons of history, culture or resources, HIV-related law and policy have received less attention and HIV has less frequently been the subject of legal proceedings. In some jurisdictions, courts have yet to decide a single case addressing legal issues related to HIV. There are, of course, some notable exceptions; several of these are reflected in the case studies presented here.

In addition, advocates are too often unaware of developments in other jurisdictions—including the legal victories that have been achieved and that could inspire or assist in achieving similar gains in their own setting. Often, court and tribunal decisions from less well-resourced jurisdictions are not easily accessible in the public domain, nor do advocates in such settings necessarily have access to the databases, internet resources or other tools needed to learn of precedents from other jurisdictions.

Consequently, this compilation is consciously biased towards discussing cases from developing countries, with a view to giving such cases greater prominence. Cases were identified through legal databases, internet sources, media reports and contact with individuals and organizations in numerous countries who work on HIV-related legal and policy issues. The publication does not purport to be comprehensive, either thematically or geographically. The much larger task of creating a global repository of HIV-related case law remains. Rather, as an initial contribution, this publication summarizes selected cases in three thematic areas where there has been considerable litigation aimed at protecting and promoting the human rights of people living with HIV, namely:

- HIV-related discrimination;
- access to HIV-related treatment; and
- HIV prevention and care in prisons.

This publication has been produced *by* HIV and human rights advocates and activists *for* HIV and human rights advocates and activists. It aims to expand advocates' knowledge base and to highlight how litigation has been used in a variety of countries as a strategic tool for human rights advocacy, whether successfully or unsuccessfully. Although laws and legal systems vary from country to country, the legal issues for people living with and affected by HIV are in many cases strikingly similar. Sharing experiences of HIV-related litigation can lead to a greater understanding of non-legal barriers to using litigation as a tool for human rights, such as stigma; the creative use of laws and legal mechanisms to protect the vulnerable and advance human rights; and the limitations of the law as a human rights tool, and thereby the importance of linking litigation with broader social mobilization and other forms of human rights activism.

# I. HIV-related discrimination



# Canada: Court rules discrimination against HIV-positive soldier is unconstitutional

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## **Canada (Attorney General) v. Thwaites, [1994] 3 FC 38 (Federal Court of Canada – Trial Division, 1994)**

### **Court and date of decision**

The Canadian Human Rights Tribunal issued its original decision on 7 June 1993.<sup>3</sup> Upon judicial review, the Federal Court of Canada (Trial Division) issued its judgement on 25 March 1994.

### **Parties**

The complainant was Simon Thwaites, a master seaman in the Canadian Armed Forces. He filed a complaint against the CAF alleging discrimination because it had terminated his employment and restricted his duties and opportunities based on his HIV-positive status.

### **Remedy sought**

Under the *Canadian Human Rights Act*, the complainant sought an order that the Canadian Armed Forces had engaged in unlawful discrimination based on his disability of HIV infection, compensation for past and future lost wages (approximately CD\$150 000 or US\$ 130 000), special compensation (CD\$5000 or US\$ 4300) and legal costs.

### **Outcome**

The Federal Court upheld the original ruling by the Canadian Human Rights Tribunal that the Canadian Armed Forces had engaged in unlawful discrimination based on disability and that awarded damages to Thwaites.

### **Background and material facts<sup>4</sup>**

Thwaites had served with the Canadian Armed Forces for approximately nine and one-half years from June 1980 to 23 October 1989, when he was medically discharged from the Canadian Armed Forces for being HIV-positive. At the time of his discharge, he operated large weapons and electronic surveillance equipment on a variety of warships.

In 1986, he discovered that he was HIV-positive. From May 1986 until November 1987 the progression of his disease was uneventful, yet in the fall of 1986 he was removed from his final qualifying course to become a full Master Corporal and at the same time his security clearance was downgraded. (It was as a result of a tribunal hearing in 1992 that he discovered that these actions were taken because of his sexual orientation and not his HIV-positive status.<sup>5</sup>) In late October and during November of 1987, he began developing symptoms of HIV,

<sup>3</sup> *Thwaites v. Canada (Canadian Armed Forces)*, [1993] CHR D No. 9 (QL).

<sup>4</sup> This summary and some of the commentary below is adapted from: R Ellis & P Engelmann. HIV/AIDS and the Military in Canada. *Canadian HIV/AIDS Policy & Law Newsletter* 1995; 1(3): 1, 14-15.

<sup>5</sup> *Thwaites v. Canada (Canadian Armed Forces)*, [1993] CHR D No 9 (Canadian Human Rights Tribunal, Decision No. 9/93) (QL).

including night sweats and a reduced T-cell count. In March 1988, military doctors conducted a medical assessment based on Thwaites' medical records only (i.e., no in-person, physical assessment), at which time his medical category was downgraded. As a result, in November 1988, the Canadian Armed Forces decided to release him, effective 23 October 1989.

In October 1989, following his discharge, Thwaites filed a complaint with the Canadian Human Rights Commission. This complaint alleged that he had been discriminated against based on his disability.

## Legal arguments and issues addressed

In June 1993, after a lengthy inquiry in 1992, the Canadian Human Rights Tribunal upheld Thwaites' complaint. It found that the Canadian Armed Forces had an obligation to assess properly the risks involved in retaining him, including the risks of his going to sea, far from hospital facilities. The military was also required to consider various options other than outright release. These included using medical assistants on ships in conjunction with military doctors to assist Thwaites, as well as transferring him to another military occupation.

The Tribunal held that the military had discriminated against Thwaites as a result of his disability (i.e. HIV infection), contrary to the federal *Canadian Human Rights Act*. It also held that the military failed in its legal duty to accommodate his disability and to assess individually his capabilities in the context of the risk that he potentially posed to himself and others. It also held that the increased risk posed by retaining a person with a disability in the Forces had to be more than a minimal risk before the Forces could justify outright dismissal.

As part of its award, the Tribunal ordered the military to pay back wages as well as some future amounts that would have been owing to Thwaites had he been retained in the Canadian Armed Forces. The Tribunal awarded the maximum amount possible for hurt feelings (CD\$ 5000 or approximately US\$ 4300) and its total compensation totalled more than CD\$ 160 000 (or approximately US\$ 139 000). It also awarded his legal and actuarial expenses.

The military applied to have this decision judicially reviewed by the Federal Court of Canada (Trial Division). It also applied to the Federal Court for an interim order allowing it to withhold payment to Thwaites pending the outcome of the judicial review. In September 1993, the Federal Court refused to grant the interim order, saying that Thwaites "should be allowed to live his remaining days in dignity."

In March 1994, the Federal Court dismissed the military's judicial review application in its entirety. In its ruling, the Court expressed some reservations about some of the Tribunal's technical legal reasoning about the fine distinctions in Canadian anti-discrimination law in the employment context as it was understood at the time. However, on the basic conclusions and outcomes, it found that the Tribunal had ruled correctly; therefore, there was no basis to interfere with its order.

## Commentary

It is interesting to note, as did the Tribunal, that the military's approach to HIV had become significantly more rigid since 1985, when its first policy was introduced. Initially, military medical authorities favoured a flexible approach geared towards an individual member's needs after his or her abilities had been assessed. In 1988, however, the military opted for a more category-driven approach, which automatically labelled people living with HIV as being medically unfit for service.

The latter approach was modified in 1991 to provide for automatic medical discharge only if a person was either symptomatic or asymptomatic but with a T-cell count below 500. It should be noted, however, that such a policy would lead to the discharge of many asymptomatic individuals, despite their good health. Commenting on this new directive, the Tribunal in *Thwaites* stated that “the CAF cannot escape its responsibility for dealing with such members as individuals.” They said that it “is inappropriate to specify an across the board medical category for infected persons.”

*Thwaites* was one of the first decisions in the world to address the issue of discrimination within the military against people living with HIV. As can be seen from some of the other cases summarized here, courts in numerous other jurisdictions have not taken such a human-rights focused approach to cases of discrimination against HIV-positive military personnel. Aside from the issue of HIV-related discrimination in the specific context of the military, the *Thwaites* decision set an important precedent in Canadian law for those who continue to work while living with HIV.

## Colombia: Constitutional Court rules that dismissal violated worker's rights to equality, employment, privacy, health and social security

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### ***XX v. Gun Club Corporation et al., Constitutional Court, Judgement No. SU-256/96 (1996)***

#### **Court and date of decision**

The full bench of the Constitutional Court issued this judgement on 30 May 1996.

#### **Parties**

The plaintiff “XX”, whose identity was suppressed by a Court order, was an ex-employee of the Gun Club Corporation. The defendants were the Gun Club Corporation (“Gun Club”), the Institute of Social Security (ISS) and a physician retained by the Gun Club to provide medical services to employees. The plaintiff was represented by counsel from the Colombian League to Fight AIDS (Liga Colombiana de lucha contra el Sida).

#### **Remedy sought**

The lawsuit challenged the legality of the decision by the Gun Club Corporation to terminate the employment contract of XX after he tested HIV-positive. The plaintiff sought various orders to compensate him for the benefits lost as a result of his dismissal, including preserving his entitlement to an illness pension from the Institute of Social Security. The plaintiff requested that the Court:

- order the Gun Club Corporation to pay the basic monthly payment for a period of fourteen months until the start of XX’s illness pension from the Institute of Social Security;
- order the Gun Club Corporation to continue making payments to the Institute of Social Security until the latter accepted responsibility for XX’s illness pension;
- condemn the violation of a patient’s right to privacy by the Institute of Social Security and the defendant physician, and order both to pay damages to XX;
- send a copy of the judgement to the National Public Prosecutor in order that the conduct of the circuit court judge who heard the case at first instance be investigated; and
- order the District Health Secretary and the Ministry of Health to investigate two other companies with whom XX had sought employment for requesting an HIV test of prospective employees.

## Outcome

On 30 May 1996, the majority of the full bench of the Constitutional Court upheld XX's appeal from lower court decisions, recognizing his rights to equality, dignity, employment, health and social security. The Constitutional Court ordered that:

- the Gun Club indemnify the plaintiff XX for damages caused by his dismissal;
- the plaintiff be covered by the Institute of Social Security's benefits scheme to the same extent as he was before being dismissed;
- the Institute of Social Security provide the plaintiff with an illness pension following the date from which he became ill with symptoms of AIDS; and
- copies of the judgement be sent to the Medical Ethics Tribunal.

## Background and material facts

The plaintiff XX worked at the Gun Club Corporation from 16 March 1992 onwards. During this period, XX received medical services from Dr. Álvaro Murra Erazo, the third defendant in this case, who was associated with the Club and who provided XX with medical services on the premises of the Club. Acting on behalf of the employer Gun Club, physician ordered XX to have an HIV test on 28 April 1994. According to XX, the physician advised him to leave the Club when the test indicated he was HIV-positive. The same day, XX was called to the office of the Director of the Club and made to sign a prepared letter requesting he be suspended with pay for a period of 30 days. The Club subsequently provided him with another month's paid suspension on 1 June 1994. On 1 July 1994, the date on which the second period of paid suspension ended, XX received a letter from the management of the Club stating that his employment contract was terminated.

XX and the Gun Club attended a conciliation hearing before the 10<sup>th</sup> Labour Court of the Santafé de Bogotá Circuit on 3 August 1994. As a result of this conciliation process, the Gun Club agreed to pay to the plaintiff a monthly amount of \$170. According to the plaintiff, this decision was contrary to the law, which provided for any such settlement sum to be paid in full immediately. Subsequently, when XX approached the Director of the Club to receive this payment, he was told that the Club had no responsibility towards him. During this period, XX was unable to gain employment as two potential employers demanded an HIV test prior to starting employment.

## Legal arguments and issues addressed

At first instance, XX's suit was heard by the Criminal Bench of the Superior Court of the Judicial District of Santafé of Bogotá. On 24 August 1995, this court issued an interim order to avoid irreparable harm to the plaintiff's rights to life and health. The court ordered the Gun Club to pay for the medical services of the plaintiff while the matter was before the courts. The court eventually found that XX's right to life and health had indeed been violated by the Gun Club, but that it was not possible to conclude that the Institute of Social Security and the defendant physician had violated the right to privacy. Both XX and the Gun Club appealed this decision.

The first appeal was heard by the Criminal Appeal Bench of the Supreme Court of Justice, which overturned the decision at first instance and denied the suit invoking XX's fundamental rights. The court found that because XX had newly obtained employment with the

company Wimpy Colombiana Ltd., and was consequently able to access medical services and claim a disability pension, there was no evidence of an irredeemable prejudice to XX that would allow him to proceed with a claim based on the rights to life and health.

The appeal from this decision was heard by the full bench of the Constitutional Court. The Constitutional Court considered that, as a guiding principle, it could not allow discrimination against people living with HIV or AIDS. It stated that “[t]he extent of a society’s civilization is measured, among other things, by the manner in which it assists the weak, the sick and in general the more needy, and not, to the contrary, by the manner in which it permits discrimination against them or their elimination.” The Court held that the state could not permit discrimination against people who live with HIV or AIDS for two reasons:

Firstly, because human dignity prevents any legal subject from being the object of discriminatory treatment because discrimination is an unjust act *per se* and the rule of law is founded in justice, the basis of the social order. Secondly, because the right to equality, in accordance with article 13 [of the Constitution of Colombia], places an obligation on the State to especially protect those who are in a position of manifest weakness.

With regard to the Labour Court’s conciliation between XX and the Gun Club Corporation, the Constitutional Court found that conciliation was only valid when it did not override fundamental rights. It therefore turned to consider the rights in question.

The Court found that the Club did not enjoy absolute liberty to terminate an employment contract. The court held that while there was no obligation on an employer to preserve an employment contract forever, an employee “may not be dismissed for being HIV-positive, as this motivation implies a serious social segregation, a form of medical apartheid and ignorance of the equality of all citizens and the right to non-discrimination.”

The Constitutional Court held that it was not appropriate, on the facts of the case, to order that XX be reinstated in his previous job. It noted that XX had not requested that form of relief, that his reinstatement would not repair the damage done to his dignity and that reinstatement could be a dangerous situation for XX, given that his ex-employers and colleagues were aware of his medical status.

Rather, the Constitutional Court concluded that the most effective way to give effect to XX’s rights was to compensate him financially for his loss and to restore his entitlement to social security (which was dependent upon contributions based on employment). It ordered the Gun Club to pay what had been previously agreed upon at the conciliation hearing before the Labour Court and to indemnify XX for his damages, with the amount to be fixed by the Criminal Appeal Bench of the Supreme Court of Justice. It also ordered that XX be reinstated with the Institute of Social Security and declared that he was entitled to an illness pension from the point at which progression of his illness qualified him for such benefits.

The Constitutional Court also found that Dr. Murra, the defendant physician, had a close association with both the Institute of Social Security and the Gun Club, and that this association allowed XX’s HIV status to become known by the Club. The court found that this disclosure of XX’s health information to his employer was a violation of the patient’s right to privacy. The court confirmed the request for investigation into the doctor’s conduct and ordered that a copy of its judgement be sent to the Medical Ethics Tribunal for this purpose.

Finally, the Constitutional Court found that XX had other avenues of relief to explore in any action against the two companies that had discriminatorily requested XX to undergo pre-employment HIV testing.

## Commentary

The decision of the Constitutional Court makes use of constitutional rights, such as the rights to privacy, equality, employment, health and social security. The application of these laws reflects international human rights law and standards.

The decision of the Constitutional Court represents an application of the anti-discrimination provisions within Colombian law. International human rights law guarantees freedom from discrimination on any grounds, including unfair dismissal due to disclosure of HIV status. Discrimination is prohibited by Articles 2 and 26 of the *International Covenant on Civil & Political Rights*. Article 26 states:

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, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.<sup>6</sup>

The UN Commission on Human Rights has confirmed that “other status” in non-discrimination provisions in international human rights treaties is to be interpreted to include health status, including HIV/AIDS.<sup>7</sup>

Dismissal of an employee based on HIV-positive status is clearly contrary to the right to non-discrimination in international law, and states must legislate against such conduct and provide adequate remedies. Similarly, the exclusion of HIV-positive patients from medical care or from the system of medical pensions is also unlawful discrimination. In addition, denial of such health benefits also violates the right of everyone to the enjoyment of the highest attainable standard of health under Article 12 of the *International Covenant on Economic, Social and Cultural Rights*. That article mandates that steps be taken to guarantee that access “shall include those necessary for...the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”<sup>8</sup> In its General Comment 14, the UN Committee on Economic, Social and Cultural Rights explained that “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”<sup>9</sup> These grounds include “health status (including HIV/AIDS).”<sup>10</sup>

This case also raised a situation in which an individual was ordered to undergo an HIV test by his physician, the results of which were then disclosed to the employer and others in the patient’s workplace. Such conduct breaches the right to privacy recognized, for example, in the 1948 *Universal Declaration of Human Rights* as well as subsequent treaties. Article 12 of

<sup>6</sup> International Covenant on Civil and Political Rights, Article 26.

<sup>7</sup> UN Commission on Human Rights. Resolutions 1995/44 (3 March 1995) and 1996/43 (19 April 1996), among others.

<sup>8</sup> International Covenant on Economic, Social and Cultural Rights, Article 12(d).

<sup>9</sup> UN Committee on Economic, Social and Cultural Rights. The right to the highest attainable standard of physical and mental health. (General Comment 14), UN Doc. E/C.12/2000/4 (2000), para 12(b).

<sup>10</sup> *Ibid.*, para 18.

the Declaration states: “No one should be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks on his honour or reputation. Everyone has the right to the protection of the law against such interferences or attacks.”

The right to privacy is of particular relevance in the health context, and particularly in relation to HIV, which remains heavily stigmatized. In the context of HIV, protection of the right to privacy is vital to enable individuals to seek HIV testing and treatment with lessened fear of discrimination. This means that, as a matter not only of respecting the right to privacy, but as a matter of sound public health policy and of realizing the right to health, states must take steps to ensure adequate privacy protections for people living with HIV. Given the conduct of the physician in this case, which was quite rightly censured by the Constitutional Court, it should be noted that both General Comment No. 14 on the right to health under the *International Covenant on Economic, Social and Cultural Rights*, and the UN’s *International Guidelines on HIV/AIDS and Human Rights*, recommend that “government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.”<sup>11</sup>

Finally, failure to provide adequate pre- and post-HIV-test counselling constitutes a limitation on the human right to receive essential information on health. The right to the enjoyment of the highest attainable standard of health includes the “right to seek, receive and impart information concerning health issues”<sup>12</sup> and entails a positive obligation on states to take steps necessary for the “prevention, treatment and control of epidemic, occupational, and other diseases.”<sup>13</sup> In order to fully implement these obligations with regard to HIV/AIDS, the *International Guidelines* advise that “public health legislation ... [should] ensure, whenever possible, that pre- and post-test counselling be provided in all cases”<sup>14</sup> because counselling ensures the voluntary nature of HIV testing and contributes to the effectiveness of subsequent care or HIV prevention.

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<sup>11</sup> UN Committee on Economic, Social and Cultural Rights, General Comment 14, para 18; Office of the UN High Commissioner for Human Rights and Joint UN Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines* (1998), para 10.

<sup>12</sup> UN Committee on Economic, Social and Cultural Rights, General Comment 14, para 12(b) (iv).

<sup>13</sup> UN Committee on Economic, Social and Cultural Rights General Comment 14, para 18; *International Guidelines*, para 10.

<sup>14</sup> *International Guidelines*, para 28(c).

# India: Court rules against employer's policy of refusing to hire people living with HIV

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## **MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997)**

### **Court and date of decision**

This judgement issued in 1997 from the High Court of Judicature at Bombay.

### **Parties**

The petitioner, MX, was a casual labourer with the respondent company, ZY, a public sector corporation controlled by the national government of India. The government was named as a second respondent in the proceeding.

### **Remedy sought**

MX sought a court order remedying the company's discriminatory decision to deny him any further employment because of his HIV-positive status, including through quashing the company's discriminatory policies and reinstating him with benefits and back wages.

### **Outcome**

The High Court granted the petition. It ordered that he be reinstated, that he be taken into regular employment if further medical examination showed he was still fit, and awarded him 40 000 Rupees (or US\$ 900) in compensation for lost income.

### **Background and material facts**

In 1986, MX was interviewed by company ZY and employed as a casual labourer from that point until about 1994. Company policy and practice required that casual labourers sign a register and be placed on a waiting list. Those determined to be medically fit were eventually employed on a permanent basis. In 1990, MX was directed to attend a medical examination with a doctor retained by the company. The medical exam included various tests, and nothing adverse was detected. MX continued to be designated as a casual worker, while he alleged that others off the waiting list, both above and below him in length of service, were appointed to regular employment positions to fill vacancies.

In 1993, MX was again asked to undergo a medical exam, which included an HIV test. MX tested HIV-positive, but in all other respects was deemed healthy. The examining physician certified that MX was fit for duty as a labourer. Notwithstanding this medical assessment, the company ZY removed MX from its waiting list of registered labourers.

MX wrote to the company pointing out that he was fit to perform his job and that he was the sole source of income for his family. He also wrote to the director of health services in the state government, outlining his circumstances and requesting the authority to direct ZY Company to allow him to continue to work at least as a casual labourer. The director wrote to ZY pointing out there was no medical justification for refusing to employ MX and requesting

ZY to allow him to continue as a casual labourer. The director also drew the company's attention to the guidelines produced by the National AIDS Control Programme, which stated that HIV-positive status was not an acceptable basis on which to dismiss an employee.

The HIV/AIDS Unit of the Lawyers Collective, an organization providing legal aid services to people living with HIV/AIDS and undertaking research and advocacy on HIV-related legal issues, investigated the matter further. It discovered that the company had issued written circulars mandating that current and prospective employees be tested for HIV and that those testing HIV-positive would not be hired and current employees could be dismissed. The Lawyers Collective filed a petition on MX's behalf alleging that the company had violated his constitutional rights and challenging his removal from the waiting list, as well as seeking his reinstatement with seniority, back wages and benefits.

### Legal arguments and issues addressed

The petitioner MX argued that, under Article 21 of the Constitution of India, which protects the right to life, he had a constitutional right to a livelihood, which previous jurisprudence had established as an important facet of the right to life. Furthermore, any deprivation of this right must be justified in light of constitutional protection of the right to equality (Article 14). This required that any differential treatment must be rationally connected to the object sought to be achieved by the challenged policy and must be otherwise fair, just and reasonable.

The company ZY argued that the petitioner MX had no legal right to be taken on as a permanent labourer. It further argued that it was legitimate for the company to insist that candidates meet medical requirements in order to be eligible for employment, and that it was entitled to refuse an applicant whom a medical examination has shown was suffering from a serious disease. It also argued that taking such a person into service would impose financial and administrative consequences that it should not have to bear.

The Court rejected the company's arguments and agreed with the petitioner MX. It found that

the impugned rule which denies employment to the HIV-infected person merely on the ground of his HIV status irrespective of his ability to perform the job requirements and irrespective of the fact that he does not pose any threat to others at the workplace is clearly arbitrary and unreasonable and infringes the wholesome requirement of Article 14 as well as Article 21 of the Constitution of India. Accordingly, we hold that the [employer's] circular ... in so far as it directs that if the employee is found to be HIV-positive by ELISA test, his services will be terminated is unconstitutional, illegal and invalid and, therefore, is quashed.<sup>15</sup>

The Court went on to stress the importance of non-discrimination in responding to HIV/AIDS:

In our opinion, the State and public corporations like [ZY] cannot take a ruthless and inhuman stand that they will not employ a person unless they are satisfied that the person will serve during the entire span of service from the employment till superannuation. As is evident from the material to which we have made detailed reference in the earlier part of this judgement, the most important thing in respect of persons infected with HIV is the requirement of community support, economic support and non-discrimination of such persons. This is also necessary for prevention and control of this terrible disease. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn the victims of HIV infection, many of whom may be truly unfortunate, to certain economic death. It is not in the general public interest and is impermissible under the Constitution. The interests of the HIV-positive persons, the interests of the

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<sup>15</sup>MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997), at para. 54, available via [www.lawyerscollective.org](http://www.lawyerscollective.org).

employer and the interests of the society will have to be balanced in such a case. If it means putting certain economic burdens on the State or the public Corporations or the society, they must bear the same in the larger public interest.<sup>16</sup>

Given its conclusions that constitutional rights had been breached, the Court turned to the issue of remedy. In addition to quashing the discriminatory workplace policy of ZY company, the Court ordered that MX be immediately reinstated on the panel of casual labourers and be provided with work as and when available. Given the passage of time between his initial dismissal and the date of the judgement, the Court also ordered that he resubmit to any reasonably required medical tests to assess his fitness and ordered the company to accept him as a permanent labourer should he prove fit. Finally, it ordered the company to pay MX back wages for the estimated amount of income lost since the date of his illegal dismissal.

## Commentary

This case set a very positive precedent in Indian law for the right of people living with HIV to equality in employment, and is consistent with widely accepted international human rights norms. Although the High Court did not refer expressly in its ruling to any international human rights instruments addressing discrimination, it did refer at length to a number of policy statements from outside India on the issue of HIV and employment—including the World Health Organization resolution passed by the Member States, the International Labour Organization and the Southern African Code on HIV/AIDS and Employment. It also cited the National HIV Testing Policy published in 1995 by the National AIDS Control Organisation, which falls under the jurisdiction of the Indian Ministry of Health and Family Welfare. All of these provided clear guidance that mandatory HIV testing in the employment context is irrational and unjustified, and amounts to an infringement of human rights.

Unfortunately, while the decision overall was very positive, the High Court did not explicitly prohibit pre-employment HIV testing, a point which was made in several of the sources cited. In fact, the High Court's judgement left the door open to such testing. In stating that the petitioner may have to resubmit to medical tests to establish current fitness for the position, the Court made reference to such tests "including for HIV", even though it had declared his HIV status irrelevant to the employment decision. In this regard, the question of whether pre-employment HIV testing (or even demands for testing during employment) infringes human rights was left to be challenged in another case.

As a side matter, in this case, the High Court also considered the petitioner's request for an order suppressing his identity. The Court considered jurisprudence from the Supreme Court of India and from Australian courts in concluding that such an order was appropriate and "in the interests of the administration of justice", in light of the widespread societal stigma still attached to HIV and the ostracism and discrimination still experienced by people living with HIV. This was also a welcome development in Indian law, since it addressed one barrier, among many, to people with HIV using the law and the court system to protect and promote their human rights.

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<sup>16</sup> *Ibid.*, at para. 56.

# India: Supreme Court denies right to marry for people living with HIV, then resiles from this conclusion

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***Mr. X v. Hospital Z*, (1998) 8 SCC 296, varied 2002 SCCL.COM 701 (Civil Appeal No. 4641 of 1998), Supreme Court of India (1998 & 2002)**

***A, C & Others v. Union of India & Others*, High Court of Judicature at Bombay [Mumbai], Writ Petition No. 1322 of 1999**

## Court and date of decision

The initial decision of the Supreme Court of India in *Mr. X v. Hospital Z* was issued on 21 September 1998. On 10 December 2002, the Supreme Court reconsidered certain aspects of its original judgement that had gone beyond the issues originally before it and that had denied the right to marry to people living with HIV. In the interim, the High Court in Bombay [Mumbai] issued its judgement in the *A, C & Others* proceeding in 1999, which sought an interpretation of the Supreme Court's original 1998 judgement in a manner that clearly respected and protected human rights.

## Parties

The appellant Mr. "X" was a person living with HIV whose confidentiality had been breached by the respondent hospital "Z".

## Remedy sought

The appellant sought damages for breach of confidentiality which had led to his marriage being cancelled and ostracism by his community.

## Outcome

The Supreme Court denied Mr. X's claim for damages, absolving the hospital and its physician of any liability for having breached his confidentiality, saying this was justified in the interests of preventing harm to Mr. X's fiancée. Unnecessarily, it went on to rule that India's penal code, which criminalize negligent and malignant acts likely to spread an infectious disease dangerous to life, imposed a positive legal duty on a person with HIV not to marry. The Supreme Court was asked to reconsider this issue; in its subsequent judgment, it distanced itself somewhat from these statements.<sup>17</sup>

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<sup>17</sup>Supreme Court of India (2002). 2002 SCCL.COM 701.

## Background and material facts

Mr. X was a doctor in a government service who was asked to accompany a relative of a Nagaland State government minister to a hospital in Madras to undergo surgery. During the surgery, the patient needed a blood transfusion. Mr. X agreed to donate some and was subjected to various tests. Although his blood was not used for transfusion, it was discovered that Mr. X was HIV-positive. Some weeks later, Mr. X proposed marriage to Ms. “Y”, with the marriage scheduled for a few months later. For some reason, the physician who had attended to the minister’s relative during the surgery in hospital informed the minister that Mr. X was HIV-positive. The minister in turn informed Mr. X’s sister. Mr. X later returned to the hospital, and his HIV-positive status was confirmed with additional tests. Mr. X met with Ms. Y and her family, and it was agreed they would call off the marriage. However, the news of Mr. X’s status became widely known in the community, and the resulting ostracism was so great that Mr. X eventually decided to leave his home state and move to Madras.

Mr. X filed a petition with the National Consumer Disputes Redressal Commission for damages against Hospital Z on the ground that the hospital doctor had breached his legal duty to keep Mr. X’s HIV status confidential, with the resulting harms to Mr. X. The Commission dismissed his petition on the grounds that he could seek his remedy in a civil court. He initiated proceedings in the Civil Appellate Division of the Supreme Court of India.

## Legal arguments and issues addressed

As set out in the Supreme Court’s judgement, under the *Indian Medical Council Act*, the Council is authorized to prescribe legally binding standards of professional conduct for medical practitioners. Under these provisions, the Code of Medical Ethics prohibits doctors from disclosing “the secrets of a patient that have been learnt in the exercise of your profession.” The exception is that such secrets “may be disclosed only in a Court of Law under orders of the presiding judge.”

The Court accepted the basic principle that the doctor’s duty to maintain secrecy corresponded to a right of the patient to such confidentiality. The Court elaborated that a “right” is an interest the violation of which would be a legal wrong. Respect for that interest is a legal duty. However, it also took the view that such a correlation is not absolute; not every right may have a corresponding duty. It ruled that, in this case, there was an exception to the rule of confidentiality binding the doctor:

The argument of ... the appellant [Mr X], therefore, that the respondents [Hospital Z and the doctor] were under a duty to maintain confidentiality on account of the Code of Medical Ethics formulated by the Indian Medical Council cannot be accepted as the proposed marriage [to Ms Y] carried with it the health risk to an identifiable person who had to be protected from being infected with the communicable disease from which the appellant suffered. The right to confidentiality, if any, vested in the appellant was not enforceable in the present situation.<sup>18</sup>

The Court agreed that provisions such as the right to personal liberty (Article 21 of the Indian Constitution) have been interpreted previously to establish a right to privacy and cited numerous Indian and US constitutional decisions in support of this point. However, it then revisited the question of confidentiality “in the context of marriage”. It pointed to the fact that in all of the legal regimes governing marriage in India (*Hindu Marriage Act, Dissolution of*

<sup>18</sup>Mr. X v. Hospital Z. (1998) 8 SCC 296 (Supreme Court of India), available via [www.lawyerscollective.org](http://www.lawyerscollective.org).

*Muslim Marriages Act, Parsi Marriage and Divorce Act, and Special Marriage Act*) there were provisions allowing for dissolution or divorce on the ground that the other spouse is “suffering from venereal disease”. The Court then reasoned that:

Once the law provides the ‘venereal disease’ as a ground for divorce to either husband or wife, such a person who was suffering from the disease, even prior to the marriage cannot be said to have any right to marry so long as he is not fully cured of the disease.... Moreover, so long as the person is not cured of the communicable venereal disease..., the right to marry cannot be enforced through a court of law and shall be treated to be a suspended right.<sup>19</sup>

The Court also invoked the *Indian Penal Code* (sections 269–270), which provides for criminal penalties in the event of a “negligent act likely to spread infection of disease dangerous to life” and “malignant act likely to spread infection of disease dangerous to life”. The Court asserted that these statutory provisions “thus impose duty upon the appellant not to marry as the marriage would have the effect of spreading the infection of his own disease, which obviously is dangerous to life, to the woman he marries apart from being an offence.” Finally, returning to the issue of the hospital doctor’s breach of confidentiality—the principal issue before it – the Supreme Court asserted that, in the face of these Penal Code provisions, had the doctor maintained strict secrecy, he would have become a party to a criminal offence. In the Court’s view, the doctor’s action was aimed at preserving the right to life of Mr. X’s fiancée, taking precedence over Mr. X’s right to privacy; therefore, it could not be that his breach of confidentiality gave rise to liability.

The Supreme Court concluded its judgement with the following:

“AIDS” is the product of indisciplined [*sic*] sexual impulse. This impulse, being the notorious human failing if not disciplined, can afflict and overtake anyone how high soever [*sic*] or, for that matter, how low he may be in the social strata. The patients suffering from the dreadful disease “AIDS” deserve full sympathy. They are entitled to all respects as human beings. Their society cannot, and should not be avoided, which otherwise, would have bad psychological impact upon them. They have to have their avocation. . Government jobs or service cannot be denied to them... But, “sex” with them or possibility thereof has to be avoided as otherwise they would infect and communicate the dreadful disease to others. The Court cannot assist that person to achieve that object.<sup>20</sup>

## Commentary

The application of this justification to absolve the hospital physician on the facts of this particular case was most troubling. First, it should be noted that the hospital physician did not notify Mr. X himself of his HIV-positive test result, even though he was the first and, arguably the only, person to whom this information should have been conveyed. Rather, the hospital physician notified the government minister to whose relative Mr. X had been willing to donate blood (although ultimately it was not used in the surgery). Through a circuitous route, the information made its way to Mr. X’s fiancée, the person whom the Court considered at risk of infection and whose well-being it invoked in order to justify the physician’s egregious breach of confidentiality. It was illogical to absolve the physician and hospital of liability for breaching Mr. X’s confidentiality on this basis. Only after taking the basic step of first informing Mr. X of his test result would it have been permissible to consider whether it was necessary or justifiable to disclose his HIV-status to his fiancée. There was nothing in the judgement suggesting

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

any plausible reason as to why the hospital doctor should have given this confidential health information about Mr. X to the government minister.

Second, the Supreme Court seems to have ignored the explicit language of the Code of Medical Ethics adopted by the Indian Medical Council. The Code expressly says that patient secrets may be disclosed “only” in a court under a judge’s order. There was no such court order in this case. Rather, the Supreme Court simply noted that there was a similar exception in English law, and then went on to say that English law also permits disclosure, “in very limited circumstances, where the public interest so requires. Circumstances in which the public interest would override the duty of confidentiality could, for example, be ...where there is an immediate or future (but not a past and remote) health risk to others.” It also noted that the guidelines provided by the General Medical Council of Great Britain on HIV disclosure allowed for disclosure “when there is a serious and identifiable risk to a specific person, who, if not so informed would be exposed to infection.” On this basis, the Supreme Court of India concluded that the Code of Medical Ethics “also carves out an exception to the rule of confidentiality and permits the disclosure in the circumstances enumerated above under which public interest would override the duty of confidentiality, particularly where there is an immediate or future health risk to others.” Yet, the Indian Code of Medical Ethics does not, in fact, refer to such an exception, and says clearly on its face that disclosure is “only” permitted under judicial order. The Supreme Court apparently chose to create such a new exception in the common law of India, but it was incorrect to say that it flows from the existing Code of Medical Ethics.

The Supreme Court also appeared to endorse the view that the law denies people living with HIV the right to marry. In so ruling, the Court went beyond addressing any issue about breach of confidentiality that was squarely before it on the facts, and created a new discriminatory provision in Indian law. Whatever legitimate concerns the Court may have had regarding the potential for transmission from one spouse to another, it was not necessary to adopt such a position, in which the outright denial of a basic right, based on HIV-positive status, was at odds not only with basic international human rights principles but also India’s own jurisprudence on equality.

The case highlighted a tension between different human rights concerns. The Court offered little justification for its far-reaching declaration flatly denying the right to marry to people living with HIV, even though the right to marry is recognized as a basic human right. Yet a number of women’s organizations in India, concerned about the widespread and entrenched gender inequality that leaves many Indian women with little autonomy when it comes to marriage decisions or engaging in sexual relations with their husbands, welcomed the decision as a measure that would protect women from HIV and AIDS.

Following the Supreme Court’s decision, advocates initiated further legal proceedings [*A, C & Others v. Union of India & Others*] to challenge the court’s statement that people living with HIV or AIDS do not enjoy the right to marry. Represented by the Lawyers Collective HIV/AIDS Unit, four people (two of them living with HIV) filed a petition in the High Court of Judicature at Bombay asking the court to declare:

- that a person living with HIV or AIDS has the right to marry and this right is not lost or suspended on account of the person’s HIV status;
- that a person with HIV who enters into marriage with a willing partner after disclosing this fact does not commit an offence under Indian Penal Code; and

- the overriding duty of physicians is to preserve the confidentiality of information about their patients, save for very limited, exceptional cases in which the law may require them to disclose certain information, such as when a third party appears to be in imminent danger of harm.

The petitioners argued that the right to marry is a basic human right recognized in various international instruments (e.g. the *Universal Declaration of Human Rights* and the *International Covenant on Civil and Political Rights*), in the Indian Constitution and in various judgements of the Supreme Court itself, and can only be abridged by a valid law enacted by the competent legislature. They argued that there was no justification for the state to deny people living with HIV the right to marry or to subject them to criminal prosecution, if their spouse is aware of their status. Furthermore, they argued that suspending fundamental rights of people with HIV will drive people underground and away from testing, thereby ultimately contributing to the spread of HIV. Finally, they pointed out that HIV transmission can be prevented by adopting safer sex practices, and that the risk of mother-to-child transmission can be significantly reduced through appropriate interventions.

In response, the federal Solicitor General sought to uphold the original Supreme Court decision. In addition to repeating the reasoning set out previously by the Court, the Solicitor General also argued that a complete prohibition on the right of persons with HIV to marry was justified in order to protect women's human rights. The court summarized the government's position as follows:

According to the learned Additional Solicitor General for India, the proposition urged on behalf of the Petitioners that an HIV-positive individual would have the right to marry subject only to disclosure of the HIV status to a prospective spouse, would be too broad to merit acceptance. According to him, such a consent as an attribute may have relevance to a society with high levels of literacy, education and one that is individualistic. He has submitted that in our Society the Court has to be mindful of that position of women in society and the peculiar disabilities faced by women, and that the regard will have to be had to the impact of such social circumstances like poverty, illiteracy and socioeconomic pressures which operate upon women. According to him the mere requirement of consent is not sufficient to protect against the exploitation of women as a class extremely vulnerable to the transmission of HIV infection.<sup>21</sup>

A similar argument was advanced by an intervener Majlis Manch, a nongovernmental organization providing legal aid and advocacy to women in distress. The intervener argued that the denial of the right to marriage to people living with HIV was a reasonable restriction in order to protect the rights of women who are vulnerable to infection from their male partners:

[I]t is rather optimistic to presume that an order from this court permitting marriage of HIV-positive persons is likely to benefit women, and men will willingly marry ailing and afflicted women. On the other hand, it is likely to adversely affect a large number of women who might be forced into marriage with afflicted men. [...]

The right of HIV-positive [persons] to marry, even with consent, needs to be contextualized within this social reality, where the terms like 'disclosure' and 'consent' lose their significance for a vast number of women. In the Indian setting, rarely the bride is provided with an opportunity of giving informed and valid consent. ... [A]ny judgement of this Hon'ble Court which gives a right to marry for HIV+ persons can only be construed as a death trap for the vast majority of women. [...]

<sup>21</sup> *A, C & Others v. Union of India & Others*, High Court of Judicature at Bombay [Mumbai], Writ Petition No. 1322 of 1999, at para. 19, available via [www.lawyerscollective.org](http://www.lawyerscollective.org).

India is one of the few countries which has still not granted legal recognition to marital rape. So in the Indian context a consent to marriage in effect implies a consent to daily and recurrent sexual intercourse. While the parents may have given their consent to marry off their daughter to an HIV-positive man, or the girl herself may have done so, within the existing legal scheme, this consent automatically gets translated into a consent to repeated sexual intercourse endangering her life. A consent to marriage cannot be construed as a consent to a virtual suicide.<sup>22</sup>

The intervener therefore argued that the Court should declare that all agencies providing counselling and health care to HIV patients had a legal obligation to reveal their clients' HIV status to the spouse and counsel the couple together regarding unprotected sex. It also urged the Court that, if it were to allow an HIV-positive person to marry an HIV-negative person, this should be permitted only after application to the Court, and after the Court has had the chance to determine the consent of the HIV-negative spouse to the marriage.

While the case was before the Bombay High Court, Mr. X initiated further proceeding before the Supreme Court seeking a clarification on these very points and challenging the Court's ruling. Consequently, the Bombay High Court dismissed the petition by "A", "C" and the others, on the ground that it was more appropriate that the matter be dealt with directly by the Supreme Court. Consequently, the matter was brought on before that Court, where the same basic arguments were presented. In its decision, the Supreme Court reiterated the correctness of its original decision on the issue of justifying the doctor's actions in revealing Mr. X's HIV diagnosis "to persons related to the girl whom he intended to marry". However, it admitted that, since this disposed of the claim before it,

there was no need for this Court to go further and declare in general as to what rights and obligations arise in such context as to right to privacy or confidentiality or whether such persons are entitled to be married or not or in the event such persons marry they would commit an offence under law or whether such right is suspended during the period of illness. Therefore, all those observations made by this Court in the aforesaid matter were unnecessary, particularly when there was no consideration of the matter after notice to all the parties concerned. In that view of the matter, we hold that the observations made by this Court, except to the extent of holding as stated earlier that the appellant's right [to privacy] was not affected in any manner in revealing his HIV-positive status to the relatives of his fiancée, are uncalled for.<sup>23</sup>

In the result, the Supreme Court distanced itself from the statements in its earlier ruling that appeared to deny marriage rights to all people living with HIV. It did not, however, explicitly disavow or correct them, which would have been preferable. Furthermore, the initial judgement with its overly permissive approach to excusing doctors' breaches of confidentiality remained intact.<sup>24</sup>

<sup>22</sup> Application for Intervention by Majlis Manch, 6 April 2000, on file. For some further commentary on the issue of gender and HIV/AIDS in India, see: M Dhaliwal. Creation of an enabling and gender-just legal environment as a prevention strategy for HIV/AIDS among women in India. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 86-89, available via [www.aidslaw.ca](http://www.aidslaw.ca).

<sup>23</sup> *Mr. X v. Hospital Z*, 2002 SCCL.COM 701 (Supreme Court of India, 2002), at para. 6, available via [www.lawyerscollective.org](http://www.lawyerscollective.org).

<sup>24</sup> The full text of the two Supreme Court rulings in *Mr. X v. Hospital Z* (1998, 2002) and the ruling in *A, C & Others v. Union of India & Others*, as well as a comment by the Lawyers Collective HIV/AIDS Unit, can be found via [www.lawyerscollective.org/lc-hiv-aids/index.htm](http://www.lawyerscollective.org/lc-hiv-aids/index.htm) (under "Judgements").

# Venezuela: Court upholds military policy denying active duties to personnel with HIV, but orders defence minister to protect privacy and health

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## ***JRB et al. v. Ministry of Defence, Case No. 14000, Supreme Court of Justice of Venezuela (Political-Administrative Bench) (1998)***

### **Court and date of decision**

The proceeding was initiated in September 1997. The Supreme Court of Justice (Political-Administrative Bench) issued its judgement on 20 January 1998.

### **Parties**

The petitioners were four members of the Venezuelan armed forces (with the National Guard, the military police, the army, and the military academy, respectively), who were diagnosed with HIV. The respondent in the proceeding was the Ministry of Defence.

### **Remedy sought**

The petitioners brought an *amparo* proceeding<sup>25</sup> alleging that the Ministry of Defence had violated several of their human rights, contrary to international law and the Venezuelan Constitution, in removing them from their positions and failing to provide adequate medical benefits. In particular, they alleged violations of their rights to: dignity and personal integrity; privacy; work; health; and freedom from discrimination and equality before the law. They sought an order compelling the Ministry to respect those rights and take steps to give effect to them. They also sought orders reinstating them in their positions and striking down the Ministry's directive regarding the compulsory removal from active duty of personnel living with HIV.

### **Outcome**

The Supreme Court granted the petitioners' request in part. The Court agreed that the Ministry had breached the petitioners' rights to privacy and to health. However, it rejected the claim that the rights to work, to dignity, and to non-discrimination and equality before the law had been infringed, and upheld the Ministry's policy preventing HIV-positive personnel from continuing their active duties and imposing "medical leave".

### **Background and material facts**

As a condition of entry into the armed forces, each petitioner was required to be tested for HIV. In each case, the petitioner tested HIV-negative at the time and began his employment

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<sup>25</sup>The *amparo* action is a remedy in some Latin American civil law systems best described in the terms of a common law system as a "constitutional injunction" —that is, an injunction obtained urgently to redress an existing, or prevent an imminent, breach of constitutional rights. It is similar to a writ of habeas corpus, but with a broader application than simply challenging the legality of a person's detention or imprisonment. The equivalent proceeding is referred to as a *tutela* action in some other jurisdictions in Latin America.

with the forces. However, three of the petitioners were tested for HIV again when later seeking medical treatment; the fourth was subjected to another test upon applying to transfer to a new unit within the army.

Upon testing HIV-positive, each petitioner was removed from their ordinary, active duties and compelled to go on medical leave, notwithstanding that each of them was asymptomatic. This was in accordance with a directive issued by the Minister of Defence stating that HIV infection or AIDS was “incompatible” with the functions required of military personnel and that enlisted personnel infected with HIV would be terminated from their positions immediately. The directive also stated that, in the event that any member of a unit was to be identified as HIV-positive, a further search for other cases of HIV-positive personnel was to be conducted. (It is not directly specified in the reported judgement, but presumably this would have involved the imposition of mandatory HIV testing to conduct such an investigation.)

In addition, the petitioners’ HIV-positive diagnoses became known to their superior officers and eventually to other personnel in their workplaces (including, in at least one case, publication of the person’s status on a billboard in the regiment). As a result, the petitioners experienced harassment and other forms of discrimination from other personnel, including harassing conduct based on the perception or allegation of sexual activity with other men.

While ostensibly receiving benefits while on “medical leave”, including health care from the military hospital, the petitioners received only vitamin E supplements and no medications (such as antiretroviral drugs or treatment to prevent opportunistic infections), and it was anticipated that their access to the hospital would end once terminated from their employment.

## Legal arguments and issues addressed

The petitioners based their claims on provisions in such instruments as the:

- Universal Declaration of Human Rights
- American Declaration on the Rights and Duties of Man
- American Convention on Human Rights
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights; and
- Constitution of the Republic of Venezuela.

The Court reviewed each of the human rights claims advanced by the petitioners, with reference to the evidence the parties had submitted.

With respect to the *right to privacy*, the Court found that this right included privacy with respect to one’s intimate life and state of health. In this case, it found that the disclosure of the petitioners’ HIV-positive status by commanding officers had resulted in the harassment they experienced from other personnel in the armed forces, damaging their dignity, honour and reputation. The Court took note of “the reality of Venezuelan society” that HIV or AIDS are something not to be discussed and people living with HIV are generally isolated, with HIV perceived as deserved punishment for immoral conduct. The Court explicitly rejected this view, but given this unfortunate social reality of disrespect for the human rights of people with HIV, found the Ministry liable for failing to provide directions to its officers prohibiting disclosure of the petitioners’ health status. In its defence, the Ministry pointed to a policy stating that all information on cases of AIDS is classified as confidential and should be treated in accordance with its general directive on classified material. However, the Court considered this inadequate; the Ministry had

failed to provide sufficient detail regarding measures to protect the confidentiality of soldiers with HIV. This omission had resulted in the infringement of the petitioners' right to privacy.

With respect to the *right to health*, the Court noted that this right carried a corresponding obligation on the part of the State to assist the person with HIV with respect to the physical, psychological, economic and social dimensions of achieving the highest attainable standard of health, including recognizing the dignity of the person with the disease. The Court found that the petitioners' right to health, as set out in the Constitution, the Universal Declaration of Human Rights and the American Declaration of the Rights and Duties of Man, was infringed by the Ministry's failure to supply the necessary medical attention that they should have received in light of their HIV status.

With respect to the *right to work*, the Court stressed that the right is fundamentally connected to personal dignity and personal development. However, citing material submitted by the Ministry, the Court took the view that HIV infection "is incompatible with active military functioning". The Court pointed in particular to material with broad generalizations about the impact of HIV on the armed forces, with statements such as "all military personnel infected with HIV put their own health and that of others at risk". Consequently, the Court concluded that the Ministry had not infringed the petitioners' right to work in removing them from ordinary daily duties and ordering them to go on medical leave. The Court took the view that this measure protects the health of the petitioners and of others (from the "risk of contamination"), and also safeguards "the security of the State". It therefore rejected the petitioners' claim on this ground.

With respect to the rights to *dignity*, *non-discrimination* and *equality before the law*, the Court analysed these closely related claims together, but also rejected the petitioners' arguments. They argued that the harassment which they experienced infringed their right to dignity and to freedom from discrimination; they also alleged that they were discriminated against compared to other people living with HIV (in relation to the failure to supply adequate medical treatment). The Court did explicitly make the point that, when speaking of the infringement of human rights, there is no need to show intent to infringe; it is sufficient if this is the effect of the conduct.

Nonetheless, it said, to impute the infringement of the petitioners' dignity and right to non-discrimination to the Minister based on the conduct of the force's personnel "would be to go very far", and would hold the Minister responsible for widespread societal attitudes about HIV/AIDS, which is beyond his control. The Court took the view that, in order for there to be liability, there should be some direct nexus between the person whose right to dignity has been infringed and the person alleged to be responsible for that harm.

With respect to the right to equality before the law, the Court simply referred back to its reasoning in relation to the right to work, concluding that for the same reasons put forward there—protection of the petitioner, of other armed forces personnel, and national security—the Ministry had not violated the petitioners' rights. It offered no further discussion of what the right to equality might require. It also dismissed, without any analysis, the petitioners' claim that they were discriminated against in comparison with other people living with HIV. The judgement suggested that there was little put forward in the way of evidence on this point.

In the result, the Court partially granted the petitioners' *amparo* claim. It ordered the Minister of Defence to:

- immediately prepare directives to protect the confidentiality of the personnel living with HIV/AIDS, including the petitioners;

- immediately guarantee adequate medical treatment for the petitioners through the military's benefits plan;
- within one month, issue a directive to educate all personnel of the armed forces about HIV, including the need for ethical treatment and solidarity with people living with HIV; and
- solicit funds from the national Congress to implement measures to prevent HIV within the armed forces as well as to ensure treatment for those personnel in need.

## Commentary

From a human rights perspective, this was a mixed ruling. There were some positive elements in the judgement. The Court found the State liable for failing to protect the privacy of its employees' personal health information, ordered it to ensure adequate medical treatment for personnel with HIV and AIDS, and ordered proactive measures aimed at challenging discriminatory attitudes and improving HIV prevention, care, treatment and support within the armed forces. It squarely described and rejected the stigma surrounding HIV, instead calling on the State and Venezuelan society generally to act in a spirit of solidarity. However, the Court did not support the petitioner's claim to a right to serve in the armed forces. The Ministry of Defence put before the Court various publications in which concern was expressed about the overall challenge that high rates of HIV infection among personnel presents for armed forces. The publications also made broad statements such as the concern about HIV prevalence among military and police officers, given that these groups are often important sources for blood donations. From these generalizations, the Court drew the blanket conclusion that HIV infection is incompatible with a military career. Similarly, it failed to give serious consideration to whether the individual petitioners in this case had been discriminated against when removed from their positions, even though there was no evidence that they were unable to fulfil their duties. In this respect, the decision falls short in protecting the human rights of individual people living with HIV.

This ruling is at odds with more recent, and encouraging, developments from other jurisdictions in Latin America. For one example, see the Colombian case of *XX v. Ministry of National Defence* (Constitutional Court, 2003) summarized in this document. More recently, in a precedent-setting case, a Mexican court ruled in 2004 that a law making HIV/AIDS a basis for discharge from the military was discriminatory and unconstitutional. The ruling came in the case of a sergeant living with HIV who alleged he was discriminatorily discharged when he sought medical attention for himself and his family. The litigation lasted five years. The Cuarto Tribunal Colegiado en Materia Administrativa, the court that ruled on this case, cited the Mexican constitution, other federal laws, and six international treaties in support of its ruling that the armed forces law permitting discharge based on HIV status could not stand because these other instruments guaranteed access to health and freedom from discrimination. At the time, it was reported that this was the first ruling of its kind in Mexico and that it set a precedent that would likely encourage similar cases by other military personnel who had experienced discrimination.<sup>26</sup>

<sup>26</sup> The original court judgement could not be obtained by the time of publication. However, information about the case was reported in various media, including the following articles: Justicia mexicana condena despidos a militares con VIH, *Mural.com*, 30 May 2004; D Cevallos. Mexico: Court rules military cannot discharge HIV-positive soldier. *Inter Press Service*, 1 June 2004; D Devellos. Mexico: Jueces amparan a militares con VIH. *Inter Press Service*, 1 June 2004; Ordena Tribunal restituir derechos a militares con VIH/sida, *Letra S*, 3 June 2004; A Medina. Triunfo legal para militares con sida: El caso de un suboficial dado de baja abre el precedente para la revision de otros casos. *La Jornada*, 7 June 2004.

# Namibia: Exclusion of HIV-positive man from defence force is discriminatory

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## ***Haindongo Nghidipohamba Nanditume v. Minister of Defence, Case No. LC 24/98, Labour Court of Namibia (2000)***

### **Court and date of decision**

The Labour Court of Namibia delivered its judgement on 10 May 2000.

### **Parties**

The applicant was a man living with HIV. The respondent was the Minister of Defence.

### **Remedy sought**

N applied to the Court for an order directing the Namibian Defence Force to stop discriminating against him on the basis of his HIV-positive status and to process his application for enlistment without regard to his status.

### **Outcome**

The Court found that the Namibian Defence Force was guilty of unfair discrimination. However, it also ordered more expanded HIV-related testing as part of the medical examination of recruits and permitted the exclusion from the Namibian Defence Force of applicants who failed to meet certain thresholds on CD4 and viral load tests. In N's specific case, it ordered him to undergo these additional tests, and it ordered the Namibian Defence Force to enlist N if he met these thresholds.

### **Background and material facts**

Under the *Defence Act*, recruits to the Namibian Defence Force were required to undergo a medical examination. The applicant N was a former member of the national liberation struggle in the South-West Africa People's Organization who had received military training while in exile. In September 1996, he sought to enlist. As part of that process, he was tested for HIV. Two weeks later, he was informed by a Namibian Defence Force medical officer that he had tested positive and, as a result, would not be accepted by the Force. A comprehensive medical report, completed one month later, showed that he was otherwise in good health, and the examining physician explicitly agreed that N did not have any medical condition that would be likely to interfere with the proper performance of duty as a government service official. His HIV-positive status was the sole basis for his exclusion from enlistment in the Namibian Defence Force.

### **Legal arguments and issues addressed**

The applicant argued that the Namibian Defence Force had breached the 1992 *Labour Act* (section 107) which prohibited discrimination in employment "in an unfair manner"

and also prohibited discrimination on the grounds of disability. The Namibian Defence Force admitted that it had rejected N solely on the grounds that he was HIV-positive, but denied that this amounted to unfair discrimination. It admitted that there were certainly military personnel in the Namibian Defence Force who were HIV-positive because HIV testing was not part of the recruitment process when the Force was established and also because some personnel may have acquired HIV after enlistment. In fact, the evidence put forward by the Namibian Defence Force regarding how it followed a “policy of non-discrimination as far as possible” when a Namibian Defence Force member was diagnosed as having HIV, indicated that the Force included a large number of personnel with HIV/AIDS. Evidence also indicated that personnel were not tested for HIV after enlistment.

In addition to the provisions of the *Labour Act*, the Court also had regard to the “Guidelines for the Implementation of a National Code on HIV/AIDS in Employment” issued by the Government in 1998. Although they did not have the force of law, the Court nonetheless found them instructive. In particular, the Court quoted the instruction that there should not be pre-employment tests for HIV, and that employees should be given “the normal medical tests of current fitness for work and these tests should not include testing for HIV”. In addition, the Guidelines directed that employees with HIV “should work under normal conditions so long as they are fit to do so and if they can no longer do so, they should be offered alternative employment without prejudice to their benefits.”

The Court found that an HIV test alone would not determine a recruit’s fitness to serve in the forces, noting that: “If the military does not and will not do [testing for CD4 count and viral load] then the HIV test should also be abandoned. It will not achieve the purpose for which medical examinations are held.” The Court ruled that HIV status was not a reasonable criterion on which to exclude a person from enlisting in the armed forces, and that an HIV test alone did not indicate the person’s current state of fitness for the job. The Court accordingly held that the applicant’s exclusion from the Namibian Defence Force solely because of his HIV status amounted to “discrimination in an unfair manner”, contrary to the *Labour Act*.

However, the Court did not rule out all pre-employment HIV testing for the Namibian Defence Force, but rather ordered that their required medical examination for all recruits should include not only an HIV test, but also a CD4 count test and viral load test. It referred back to evidence from medical experts that:

an HIV-positive person can be as fit and healthy as any other normal person in similar circumstances, but as that person’s CD4 count decreases and the viral load increases, such person’s well-being progressively deteriorates... A combination of these two indicators can serve as a prognosis as to the time period that will elapse before a person will suffer from AIDS proper. The two medical experts were in agreement that a person with a CD4 count below 200 and a viral load in excess of 100 000 would probably be incapable of participating in the strenuous and exacting work as required in the fighting units of the military.

Consequently, the Court decided to order that no person should be excluded from the Namibian Defence Force solely because of their HIV status if they are otherwise fit and healthy, unless their CD4 count is below 200 and viral load exceeds 100 000.

The respondent initially stated it would appeal against the judgement, but subsequently withdrew their application, indicating it would abide by the Labour Court’s decision.

## Commentary

The ruling set an important precedent by rejecting the Namibian Defence Force's policy of simply excluding recruits based on their HIV status alone, finding that this was not rationally connected to the objective of assessing fitness for training and service as a member of the Namibian Defence Force. However, in an attempt to address this objective more directly, the Court ended up ordering additional pre-employment tests for those who are HIV-positive, asserting that CD4 and viral load levels would serve as suitable indicators of fitness.

It is questionable whether extending the scope and intrusiveness of medical testing *before* employment was the best way forward. The Namibian Defence Force acknowledged its policy of transferring existing HIV-positive personnel, when necessary in light of their health, to different divisions or duties within the Force not involving physical and mental stress. However, it also explained that the assignment of a recruit to a particular division or activity only happened *after* each recruit had completed the basic training, which was quite strenuous. The Court appears to have accepted this procedure, and was of the view that CD4 and viral load testing, as indicators of HIV disease progression, would be suitable markers for the Namibian Defence Force to use in determining whether a recruit was capable of completing basic training.

On the face of its judgement, the Court did not consider whether insisting on such a training prerequisite for any position within the Namibian Defence Force was itself discriminatory by creating a barrier to suitable employment for people with HIV (or other disabilities). For example, it could be the case that an HIV-positive person could fulfil the duties of various jobs within the Namibian Defence Force even if their CD4 count fell below 200 and/or their viral load exceeded 100 000. What is required is an individual assessment of abilities in relation to the duties of the particular job. Of the personnel who were already HIV-positive and being accommodated accordingly in their job duties, some must certainly have been in this position. Indeed, where antiretroviral (and other) treatment is available to people living with HIV, the significant improvements in health would likely mean that a greater number of HIV-positive personnel could continue to perform the essential duties of their job. This highlights the argument that a blanket exclusion of all people living with HIV is neither warranted nor justified and should properly be seen as discrimination contrary to law.

In the end, the Court allowed the Namibian Defence Force to maintain their procedure of demanding strenuous basic training of all would-be recruits— even though this requirement may not be rationally connected to fitness for certain kinds of employment within the Namibian Defence Force— and, on this basis, ordered *more* extensive HIV-related medical testing. Arguably, this replaced one form of unjustified discrimination (i.e. blanket exclusion based on HIV-positive status) with another discriminatory barrier, albeit one that is more subtle and likely more difficult to challenge.

It was anticipated that the ruling in this case could have positive implications for armies throughout the southern African region where HIV prevalence among defence force personnel is a significant concern and HIV-related discrimination remains widespread, including discriminatory policies similar to those challenged here. In February 2001, the Namibian Ministry of Defence hosted a regional seminar to identify and define an HIV/AIDS policy. Defence ministries from seven other countries in the Southern African Development Community were invited to take part. The seminar participants agreed that exclusion of recruits from defence forces

because of HIV status alone was irrational and adopted a set of recommendations that would accommodate the specific needs of militaries without unfairly discriminating against people with HIV.

However, a few weeks later, the Namibian government introduced the Defence Amendment Bill, 2001 which contradicted these recommendations. Under the bill, the Namibian Defence Force “shall not appoint any person who suffers from a disease or ailment which is likely to deteriorate to the extent that it will impair his or her ability to undergo any form of training required to be undertaken or to perform his or her duties as a member of the Defence Force.” The Bill was approved by the National Assembly in March 2001 and by the National Council in May 2001. As a result, the *Defence Amendment Act* now appears to require the Namibian Defence Force to exclude people solely because of their HIV status, undermining the human rights advance achieved in this case.<sup>27</sup>

Similar policy approaches have persisted, or been adopted, in some other countries in the region. For example, in December 2004, the Government of Swaziland announced a new policy of HIV testing for all defence force personnel and that all those testing HIV-positive (including those in such positions as pilots, aircraft engineers and air traffic controllers) would be relieved of their duties, and new recruits would be accepted only if they test HIV-negative.<sup>28</sup>

Such policies are at odds with the prohibition in international law of discrimination based on HIV status. The *International Covenant on Civil and Political Rights* (Article 26) provides that the law shall guarantee to all persons equal and effective protection against discrimination on a variety of explicitly named grounds and on “other status”. The UN Commission on Human Rights has repeatedly reaffirmed that this provision prohibits discrimination based on HIV/AIDS status.<sup>29</sup> The *International Guidelines on HIV/AIDS and Human Rights* advise that states should enact or strengthen anti-discrimination legislation to protect people living with HIV/AIDS, including from discrimination in employment and that the areas covered should be as broad as possible. They specifically recommend that laws should guarantee “freedom from HIV screening for employment, promotion, training or benefits.”<sup>30</sup>

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<sup>27</sup> This commentary is based, in part, on M Figueira. Namibian Parliament Overrides SADC Panel, Labour Court on Military Testing. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 42-43.

<sup>28</sup> Swaziland: Army unveils HIV/AIDS policy. *IRIN PlusNews*, 24 December 2004.

<sup>29</sup> UN Commission on Human Rights, “The Protection of Human Rights in the Context of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS),” Resolution 1995/44. See also subsequent Resolutions 1996/43, 1999/49, 2001/51, 2003/37, and 2005/84.

<sup>30</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & Joint United Nations Programme on HIV/AIDS, 1998: Guideline 5.

## South Africa: Court prohibits HIV-based discrimination by airline

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### ***Hoffmann v. South African Airways, Constitutional Court of South Africa, Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC)***

#### **Court and date of decision**

The order of the Constitutional Court of South Africa was issued on 28 September 2000. The case was an appeal from a decision of the High Court issued in 2000.

#### **Parties**

The appellant in the case was a man living with HIV. The respondent was South African Airways, owned by a corporate enterprise of the Republic of South Africa. South African Airways had a policy under which it refused to hire HIV-positive people as airplane cabin attendants. The AIDS Law Project, a nongovernmental organization advocating for the human rights of people living with HIV, sought and was granted leave to be admitted as *amicus curiae* in support of his appeal.

#### **Remedy sought**

The appellant sought a court order that South African Airways employ him as an airline cabin attendant.

#### **Outcome**

The Constitutional Court ordered South African Airways to offer to employ Hoffmann as a cabin attendant. South African Airways was also ordered to pay Hoffmann's costs in both the High Court and in the Constitutional Court.

#### **Background and material facts**

In September 1996, Hoffman applied for employment as a cabin attendant with South African Airways. At the end of the interview process he was found a suitable candidate for employment and underwent a pre-employment medical examination including an HIV antibody test. The medical examination found him to be clinically fit and suitable for employment. The HIV antibody test returned a positive result. As a result, the medical report was altered to read that Hoffmann was unsuitable for employment because he was HIV-positive.

South African Airways policy prohibited the employment of HIV-positive people as cabin attendants. This prohibition was allegedly in place because cabin attendants had to be fit for worldwide duty, which required them to be vaccinated against yellow fever in accordance with National Department of Health guidelines. South African Airways stated that HIV-positive persons may react negatively to this vaccine. Further, South African Airways stated that HIV-positive people are prone to contracting opportunistic infections and, as a result, would not be

able to perform required emergency and safety procedures. Finally, South African Airways stated that the life expectancy of people who are HIV-positive was too short to warrant the costs of training them. South African Airways' policy did not exclude HIV-positive persons from all employment with the airline, only from cabin crew positions.

South African Airways' medical expert gave evidence that only those persons whose CD4+ cell count had dropped below 300cells/microlitre were prone to medical, safety and occupational hazards. According to South African Airways' medical expert, at the time of Hoffman's medical examination, there was nothing to indicate that he had either reached the asymptomatic yet immuno-suppressed stage of HIV infection or had developed AIDS.

The AIDS Law Project, in its role as a friend of the court, provided medical evidence considered by the Constitutional Court. That medical evidence, with which the South African Airways' expert concurred, demonstrated that an asymptomatic HIV-positive person can perform the work of a cabin attendant. It also demonstrated that even immuno-suppressed persons are not prone to opportunistic infections and may be vaccinated against yellow fever as long as their CD4+ cell counts were above a certain level.

## **Legal arguments and issues addressed**

Before the High Court, Hoffmann challenged the constitutionality of the refusal to employ him. He alleged that the refusal constituted unfair discrimination, and violated his constitutional rights to equality, human dignity and fair labour practices. In response, South African Airways argued that the decision not to employ Hoffmann was based on its policy, and that its policy was justified by medical, safety and operational considerations. South African Airways also argued that if it were obliged to employ people with HIV, the public perception about it would be seriously impaired and it would be seriously disadvantaged as against its competitors (private corporations to whom the Constitution did not apply) who had a similar policy of not hiring HIV-positive cabin crew. The High Court accepted South African Airways' arguments, finding that its policy did not unfairly discriminate against people living with HIV.

On appeal to the Constitutional Court, faced with the uncontroverted medical evidence, South African Airways conceded that its practice of refusing to employ cabin attendants because of their HIV-positive status was medically unjustified and was thus unfair. Instead, South African Airways argued that its "true" policy was to refuse employment to HIV-positive cabin attendants where their HIV infection had progressed such that South African Airways believed the person unsuitable for employment.

The Constitutional Court refused to consider the legality of South African Airways' "true" policy for two reasons. First, this policy was different than the blanket prohibition on employment of HIV-positive people as cabin attendants that had been considered by the High Court. Second, the Labour Court, as a specialist tribunal with statutory power to deal with labour and employment issues, was the appropriate forum to consider the issue of medical testing to determine suitability for employment.

The Constitutional Court went on to consider Hoffmann's constitutional claims. The Constitution applied to South African Airways since it was owned by a statutory body under control of the state. The Court based its judgement solely on the right to equality under the South African Constitution (section 9). When deciding claims the Constitution's equality rights clause, a court must engage in three basic enquiries:

- First, does the challenged law make a differentiation that bears a rational connection to a legitimate government purpose? Where there is no rational connection, then section 9 has been breached.
- Second, where there is a rational connection, does the differentiation amount to unfair discrimination?
- Third, if the differentiation does amount to unfair discrimination (and if it is found in a law of general application), can the differentiation be justified under the provision in the Constitution that permits limitations on constitutional rights) (section 36)

With respect to the first inquiry, Hoffmann argued that South African Airways' employment practice was irrational since it excluded all HIV-positive applicants, despite the fact that objective medical evidence showed that not all HIV-positive people are unsuitable for employment as cabin attendants. Hoffmann also argued that it was irrational to apply the policy to applicants, but not to existing cabin attendants. The Court agreed with Hoffman that South African Airways' employment practice was irrational: the fact that some HIV-positive people may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify the exclusion of all people who are living with HIV from that position.

With respect to the second inquiry, the Court found that South African Airways' policy discriminated unfairly against Hoffman because of his HIV status. It stated that people living with HIV were one of the most vulnerable groups in South African society, and that they faced prejudice and stereotypes despite medical evidence about how HIV is transmitted. Thus, any discrimination against HIV-positive people was a "fresh instance of stigmatization" and an "assault on their dignity". The Court further remarked that HIV-positive people enjoy special protection from discrimination under the *Employment Equity Act* because of the impact of employment discrimination on their ability to earn a living.

The Court also considered the commercial interests of South African Airways, given that other airlines had a similar policy of excluding all HIV-positive people from being employed as cabin attendants, yet were not subject to the Constitution. It found that South African Airways' commercial interest was not legitimate. It was based on fear, ignorance and stereotypes of the supposed dangers posed by HIV-positive people, regardless of their individual circumstances. It stated that "the constitutional right of the appellant not to be unfairly discriminated against cannot be determined by ill-informed public perception of persons with HIV", nor determined by policies of other airlines not subject to the Constitution.

Because the South African Airways policy was not a "law of general application," it did not embark on the third enquiry under the Constitution's equality rights clause.

Having found that South African Airways had engaged in unfair discrimination, the Constitutional Court turned to the issue of the remedy. The Court ordered South African Airways to offer Hoffmann employment forthwith, but if Hoffmann failed to accept the offer within 30 days of the date of the offer, the order would lapse. Because Hoffmann had not previously put South African Airways on notice that he would be seeking retroactive pay, and that there was no evidence before the Constitutional Court as to his actual lost income as a result of being denied the job, it refused to make its order retroactive. South African Airways was also ordered to pay Hoffmann's costs in both the High Court and in the Constitutional Court.

## Commentary

The ruling affirms that the blanket exclusion of HIV-positive people from employment infringes the constitutional guarantee of equality. Individual job applicants should be evaluated in terms of their individual circumstances, including their ability to perform the essential duties of a job, rather than on the fact they are HIV-positive. As the Constitutional Court pointed out, people living with HIV cannot be “condemned to economic death” by the denial of equal opportunity in employment. In the words of the Constitutional Court, the ruling is a validation of the principle of *ubuntu*—a Zulu word conveying the recognition of the human worth and respect for dignity of every person. Given the stature of the South African Constitutional Court, this judgement is of considerable importance both domestically and internationally, particularly to the extent that it may influence the judiciary in other African countries in extending legal protection against discrimination to people living with HIV.

In the domestic context, the Constitutional Court’s mention of the *Employment Equity Act* was also significant. Relatively few employers are subject to the Constitution. HIV-positive South Africans who do not work for the state or state-owned businesses must rely on the *Employment Equity Act* for protection from discrimination in employment. The Constitutional Court’s analysis of discrimination in this case provided guidance to the Labour Court and other courts deciding cases under the Act.

This case also highlights the importance of remedial issues for people living with HIV who turn to litigation to defend their rights. In this case, the Court refused to make an order that South African Airways compensate the applicant for any income he may have lost as a result of the denial of employment as a cabin attendant, because there was no evidence before the Court on this point. While the legal principles developed through court decisions may have far-reaching impact, the interests at stake for the individual litigant must also be protected and specific evidence in support of individual’s claim must also be introduced.

# Colombia: Constitutional Court rules military cadet school violated rights of HIV-positive student

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## ***XX v. Ministry of National Defence ("General José María Córdova" cadet school), Case No. T-707205, Third Appeal Bench of the Constitutional Court (2003)***

### **Court and date of decision**

The Third Appeal Bench of the Constitutional Court issued this decision on 5 June 2003.

### **Parties**

The plaintiff, whose identity was suppressed by a court order, was a student at the "General José María Córdova" cadet school with the rank of second lieutenant. The defendant in this case was the cadet school.

### **Remedy sought**

XX brought suit challenging the legality of the cadet school's decision to expel him following a positive HIV test result. At the time he was expelled, the plaintiff was two months short of being promoted to the rank of sub-lieutenant. The plaintiff filed suit on 28 October 2002, alleging that his rights to life, equality, work, privacy, health and the freedom to choose his profession or occupation had been violated. In his complaint to the Third Appeal Bench of the Constitutional Court, the plaintiff requested the Court to order that:

- he be reinstated as a regular student of the "General José María Córdova" cadet school as a second lieutenant with the same rights and prerogatives as if the decision to expel him had never been taken;
- his promotion to the rank of sub-lieutenant be authorized;
- he be assigned to a post in accordance with his HIV-positive status; and
- he be provided with the level of medical care as set out in Decree 1543 of 1997.<sup>31</sup>

### **Outcome**

On 5 June 2003, the Third Appeal Bench of the Constitutional Court overturned the decision at first instance of the Civil and Land Appeals Bench of the Supreme Court of Justice. The Constitutional Court ordered the cadet school to:

- reinstate XX in the course of studies for sub-lieutenant within 48 hours of the parties being notified of the decision;
- recognize XX's rank of sub-lieutenant within 10 days of the parties being notified of the decision, in the case that he fulfils all the requirements;

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<sup>31</sup> Decree 1543 of 1997 is the national law of Colombia which "regulates the management of infection by Human Immuno-deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and other Sexually Transmitted Illnesses (STIs)". Official Gazette No. 43, 062, 17 June 1997.

- assign XX to a post in accordance with his situation within the ordinary activities of the school or as a sub-lieutenant of the Army; and
- provide him with the necessary medical care, as determined by the competent doctors in this case.

## Background and material facts

The plaintiff XX had entered the “General José María Córdova” cadet school on 3 September 1999. His medical exam upon entry found him to be in good physical condition. He was promoted from cadet to second-lieutenant and was in line to be promoted to the rank of sub-lieutenant of the National Army. After donating blood on 24 May 2002, he was diagnosed by the Medical Work Team of the Armed Forces as being HIV-positive on the 16 September 2002. He was asymptomatic and had no cough, nor had he lost weight. Despite his being asymptomatic, the decision of the Medical Work Team declared that XX was not fit for military service because he suffered a “100% diminution of his work capacity.” On 30 September, the cadet school decided to expel him, despite the fact that he only required a further two months to obtain the rank of sub-lieutenant.

XX filed the suit 28 October 2002 and the case was heard at first instance by the Civil Bench of the Superior Court of Neiva. The decision of 19 November 2002 upheld the independence of the Medical Work Team to decide the issue. XX then appealed to the Civil and Land Appeals Bench of the Supreme Court of Justice, which upheld the decision at first instance in a decision dated 16 December 2002 and held that XX still had an avenue of appeal to the Military Health Tribunal. As all avenues to seek relief within the Armed Forces had not been exhausted, the court held that the plaintiff’s decision to file suit was premature.

XX then appealed to the Third Appeal Bench of the Constitutional Court. The Constitutional Court held that it could hear the Plaintiff’s suit, notwithstanding the fact that the Military Health Tribunal had not pronounced on the matter, because the case involved the violation of fundamental rights and any recourse to the Military Health Tribunal would be administrative in nature, not judicial. The Court found it had jurisdiction to hear the Plaintiff’s suit.

## Legal arguments and issues addressed

The Constitutional Court found that institutions of higher education (including those of the Armed Forces) are not exempt from the obligation to respect constitutional rights. In support of this proposition, the Court cited cases in which it had upheld the rights of female officials in the Armed Forces to be admitted into specialist courses offered by the administration of the Army. The Constitutional Court also held that different and prejudicial treatment of those living with HIV violates the Constitution. It cited a previous case in which it held:

[I]t is necessary to remember that the person ill with AIDS or the person who is HIV-positive is a human being and, as such, enjoys, in accordance with Article 2 of the Universal Declaration of Human Rights, all the rights proclaimed in the international human rights instruments, without the possibility of being the object of discrimination, nor of arbitrary decisions, by reason of their status. It would be illogical for a person who has an illness to be treated in a manner harmful for their physical, moral or personal integrity.<sup>32</sup>

<sup>32</sup>Constitutional Court of Colombia, Decision SU-256 (1996).

The Court upheld a further finding from this case, namely that “the situation of being healthy and HIV- positive cannot be qualified as an illness.”<sup>33</sup> Hence, the Constitutional Court considered that the Medical Work Team’s decision that XX had lost 100% of his capacity to work, while still diagnosing him as asymptomatic, was a decision based on prejudice which did not reflect an objective diagnosis of the patient. The Court found that the decision to expel the student was discriminatory. It also found that the decision “violated the right to education and the right to choose a profession or occupation of the plaintiff because it prevented him from continuing with the course of studies he was pursuing, without valid justification.”

The Constitutional Court found that, to fully guarantee the plaintiff’s right to integrity and to protect his personal dignity, it would be necessary to assign XX to an appropriate activity that would reduce the risk that his medical condition would deteriorate and would permit him to receive antiretroviral or other prescribed treatment. The Court considered that the plaintiff’s right to health required that the cadet school had an obligation to provide him with the medical attention that he required, including antiretroviral treatment.

## Commentary

The Constitutional Court made use of constitutional rights, such as the rights to life, equality, work, privacy, health and the freedom to choose one’s profession or occupation. The decision of the Constitutional Court also represented an application of the anti-discrimination provisions within Colombian law. The application of these laws reflected international human rights law and standards.

International human rights law guarantees freedom from discrimination on any grounds. Discrimination is prohibited by articles 2 and 26 of the International Covenant on Civil and Political Rights, which guarantees equal rights to all persons: “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, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”<sup>34</sup> In 1995, although it had implicitly signalled this previously, the UN Commission on Human Rights first explicitly confirmed that discrimination on the basis of AIDS or HIV status is prohibited in that it is covered by the term “or other status” in the International Covenant and other instruments,<sup>35</sup> a conclusion that it has subsequently reiterated several times.<sup>36</sup> Accordingly, the *International Guidelines on HIV/AIDS and Human Rights* recommends that States enact or strengthen anti-discrimination and other laws to protect people living with HIV and other vulnerable groups from discrimination in public or private sectors.<sup>37</sup>

<sup>33</sup> Decision SU-256 of 1996.

<sup>34</sup> *International Covenant on Civil and Political Rights*, Article 26.

<sup>35</sup> UN Commission on Human Rights, “The Protection of Human Rights in the Context of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS),” Resolution 1995/44.

<sup>36</sup> UN Commission on Human Rights, “The Protection of Human Rights in the Context of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)”, Resolutions 1996/43, 1999/49, 2001/51, 2003/37, and 2005/84.

<sup>37</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & UNAIDS (1998), para 30.

## South Africa: Court dismisses case against school for deferring application for enrolment of child living with HIV

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### ***Karen Perreira v. The Buccleuch Montessori Pre-School and Primary (Pty) Ltd et al., High Court of South Africa, Case No. 4377/02 (2003)***

#### **Court and date of decision**

The High Court of South Africa (Witwatersrand Local Division, Johannesburg) handed down its judgement on 22 October 2003.

#### **Parties**

The applicant Karen Perreira initiated her suit on behalf of her daughter who was living with HIV. The AIDS Law Project acted on her behalf. She alleged discrimination by the respondent Buccleuch Montessori School, a private pre-school and primary school. The Sister Helga Creche (Pty) Ltd, the Minister of Education and the Minister of Social Development were also named as respondents. (No relief was sought against the Ministers, save for costs in the event that they opposed the application, which they did not.) The proceedings against the second respondent, Sister Helga Creche, were separated from the proceedings against Buccleuch Montessori School, by agreement between the parties.

#### **Remedy sought**

The applicant Perreira sought an order declaring that Buccleuch Montessori School had engaged in discriminatory and unlawful conduct, contrary to the constitution, in refusing to enrol her daughter.

#### **Outcome**

The Court dismissed Perreira's application with costs.

#### **Background and material facts**

The plaintiff Perreira applied to enrol her foster daughter, at the defendant school in January 2001, which she was told had three vacancies at that time. At the time of application, Perreira informed the school principal that her daughter, then 2½ years of age, was living with HIV, believing it to be in the best interests of her child for the school to be aware of her medical condition.

She was subsequently told that a teachers' meeting had taken place to discuss her foster daughter's enrolment, and that serious concerns had been expressed about the school's readiness to deal with HIV-positive students and about the risk of HIV transmission in the school setting. The school told Perreira that it wanted to defer her application until her foster daughter was three years old and "past the biting stage."

Perreira explained to the principal that her daughter's HIV status did not pose any threat to any of the other students or teachers. However, it was clear to Perreira that her daughter was not going to be accepted at the school because she was HIV-positive. The following day, Perreira delivered a letter to the school complaining about the exclusion of her foster daughter from the school based on her HIV status. She and her daughter did not return for a further appointment with the school. The school never responded to her letter.

The Buccleuch Montessori school denied that the child was rejected outright, but rather that it was justified in delaying her enrolment until a later date, given the concerns expressed by teachers. The school expressed fears about the risks of transmission to other children as a result of biting, scratching insect bites and sharing sweets. The school also indicated that it did not consider itself equipped to admit a child with HIV as none of its teachers had received any training on how to deal with children with HIV.

## Legal arguments and issues addressed

The applicant argued that the school had infringed Perreira's foster daughter's right to equality under the Constitution (section 9), as well as the constitutional provisions on children's right to education. She filed expert affidavits dealing with the risks of HIV transmission in the school setting, evidence regarding the non-discrimination policy of the Department of Education and international case law.

The school conceded that, if it had discriminated against the child based on her HIV status, then this would be unconstitutional. The Court affirmed this point. However, the parties disputed whether the child's application for admission was in fact rejected based on her HIV status. The school conceded, however, that it had recommended the application be deferred until such time as the school deemed itself ready to admit children with HIV and until her foster daughter was "past the biting stage". The applicant argued that this conduct, on its own, constituted unfair discrimination against the child. The Court found that the school principal's suggestion that the child's enrolment be deferred

...did not constitute a final decision. It is clear on the objective facts that the first defendant [Buccleuch Montessori School] was still prepared to consider the application for the enrolment of the minor child. In the result I am of the view that the first respondent had not taken a decision to exclude the minor child from the school simply because of her HIV status. Accordingly the application ought to be dismissed with costs.

Perreira filed an appeal against the judgement, although later decided not to proceed.

## Commentary

As the AIDS Law Project pointed out, the judgement was disappointing in its approach to the question of unfair discrimination because it failed to deal with the implications of the school's deferral of Perreira's foster daughter's application:

In the AIDS Law Project's (ALP) view, the judgement is a precarious one as it allows a school to effectively exclude a child with HIV as long it "defers" the application, rather than to reject the child outright. The judgement provides no guidance as to the basis on which such a deferral may take place, how long the application may be deferred and what steps a school should take to accommodate children with HIV. The judgement may also serve as a precedent for other settings where service providers wish to exclude PWAs.<sup>38</sup>

<sup>38</sup> AIDS Law Project. Note re Buccleuch Montessori Nursery School, undated, available via [www.alp.org.za](http://www.alp.org.za).

Indeed, the concerns about possible HIV transmission expressed by the school were not reasonable, given the very small risk of transmission; as such, it amounted to what should be understood as unfair discrimination contrary to law. The judgement also leaves uncertain the acceptability of the other justification put forward by the school—namely, that it was not equipped to handle a child with HIV. The AIDS Law Project expressed its concern as follows:

The judgement fails to give any guidance to what nursery schools need to do to ensure that they are able to admit children with HIV and further, fails to comment on and deal with the fact that it is unreasonable for any school in South Africa to consider themselves unequipped to admit children with HIV.... [T]he AIDS Law Project had hoped that the court would send a strong message to nursery schools that a failure to admit children with HIV is unconstitutional and unlawful.<sup>39</sup>

Despite these concerns about the possible use of the judgement, Perreira and the AIDS Law Project decided not to proceed with an appeal of the judgement. The case itself had generated important publicity regarding the issues, and upon further assessment, they concluded that it was unlikely the judgement could be used to exclude children living with HIV from schools.

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<sup>39</sup> AIDS Law Project. Press statement: Karen Perreira v Buccleuch Montessori Nursery School, 22 October 2003, available via [www.alp.org.za](http://www.alp.org.za).

# Botswana: Employee cannot be dismissed for refusing compulsory HIV antibody test

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## ***Diau v. Botswana Building Society (BBS), Case No IC 50/2003, Industrial Court of Botswana (2003)***

### **Court and date of decision**

The order of the Industrial Court of Botswana was issued in December 2003.

### **Parties**

The plaintiff Sarah Diau was employed by the defendant Botswana Building Society before being terminated shortly after refusing to undergo an HIV antibody test.

### **Remedy sought**

The plaintiff sought reinstatement and compensation for unfair dismissal and humiliation. She also sought a declaration that her rights under the *Employment Act* and the *Constitution* had been violated.

### **Outcome**

The Industrial Court ordered the defendant to reinstate the applicant and to pay her compensation equivalent to four months' salary.

### **Background and material facts**

In a letter dated 18 February 2002, Diau was offered probationary employment as a security assistant with Botswana Building Society. The letter stated that her employment was conditional on her undergoing and passing a full medical examination conducted by a physician selected and paid by Botswana Building Society. Diau started work on 25 February 2002. In a letter dated 27 August 2002, Botswana Building Society told Diau that she was required to submit a certified document regarding her HIV status, as part of the employment medical examination. The applicant responded with a letter dated 7 October 2002 in which she refused to provide such a document. Botswana Building Society then told her, in a letter dated 19 October 2002, that she would not be offered permanent employment. Diau initiated legal proceedings.

### **Legal arguments and issues addressed**

The Industrial Court was called upon to determine whether the termination of Diau's contract by the respondent was unlawful or wrongful, either under the *Employment Act* or the Bill of Rights in the *Constitution of Botswana*.

The court first examined the question of whether, at the time of her dismissal, Diau had completed her probationary period. The court decided that she had and was, therefore, a permanent employee of the respondent at the time she was dismissed. Therefore, Botswana Building Society was not entitled to dismiss her without a valid reason. The court found that

Botswana Building Society acted in a procedurally and substantively unfair way when it terminated the applicant: she was not subject to a fair procedure and was not given a reason for her dismissal.

The court found, as a matter of fact, that Diau was dismissed because she refused to undergo an HIV test. The court decided that she was entitled to disobey the instruction to undergo an HIV test as it was “irrational and unreasonable to the extent that such a test could not be said to be related to the inherent requirements of the job.”

The court characterized the requirement for the HIV test as “compulsory post-employment testing,” and considered whether the employer Botswana Building Society had infringed Diau’s constitutional rights by demanding such a test and then dismissing her for her refusal. Diau relied on the rights to privacy, non-discrimination, not to be subject to inhuman and degrading treatment, and liberty, as set out in the constitutional Bill of Rights. In response, Botswana Building Society argued that the constitution did not apply to it, since it was not a government or public entity. The court characterized the respondent building society as a “private organization that certainly operates in the public domain,” not a “state organ as ordinarily understood in constitutional law.”

The court rejected the employer’s arguments. It ruled that the constitutional Bill of Rights applied to Botswana Building Society in the circumstances of the case for two reasons. First, the Constitution of Botswana was not intended by its framers to be limited to organs of the state. Second, the Constitution should be given a large and liberal interpretation, one which takes into account the realities of modern life. Accordingly, the Bill of Rights should be applied to private entities where there is an exercise of superior social or commercial power outside the traditional domain of the state. In the employment setting, employees are in a comparable position vis-à-vis their employer as individuals are to the power of the state.

The court went on to determine whether Botswana Building Society had infringed Diau’s rights under the Constitution. It concluded that her right to privacy had not been infringed: because the HIV testing had not actually been done, no actual invasion or infringement took place.

The court also decided that the respondent had not acted in a discriminatory manner within the meaning of the Bill of Rights because it had not been proved that the applicant had been treated differently. In other words, it had not been proved that she was dismissed because of the suspicion or perception that she may be HIV-positive. The court did however recognize that the ground of HIV status or perceived HIV status was one of the “unlisted” grounds on which the Constitution prohibits discrimination.

The court decided that Diau’s right not to be subject to inhuman and degrading treatment had been infringed. “To punish an individual for refusing to agree to a violation of her privacy or bodily integrity is demeaning, undignified, degrading and disrespectful to the intrinsic worth of being human.” The court remarked that this conclusion was particularly warranted in the context of HIV, “where even the remotest suspicion of being HIV/AIDS [*sic*] can breed intense prejudice, ostracization and stigmatization.” The court stated that punishing an employee with termination for failing to take an HIV test was “a form of economic death.” In the court’s view, people should be encouraged through education to undergo voluntary HIV testing, based on informed consent, as encouraged by Botswana’s National HIV/AIDS Policy and a number of international legal instruments.

Finally, the court decided that Botswana Building Society had infringed Diau's right to liberty insofar as the requirement of an HIV test with a penalty of termination for refusal was an "irrational demand, it being wholly unrelated to the inherent requirement of the job."

The court decided that the appropriate remedy was to order Botswana Building Society to reinstate Diau as of 12 January 2004, and to pay her four months' salary as compensation. The court specified that the amount of compensation was not salary, and thus the respondent should make no deductions from the amount. The court did not make an order as to who should pay the costs of the case.

## Commentary

From a human rights perspective, there are positive and negative aspects to this decision. On the positive side, the decision affirms the "horizontal" application of the Botswana constitution to entities other than state organs. According to the court, private actors who wield significant economic and social power, and who therefore have a great deal of power over the lives of individual citizens, are not beyond the reach of the Constitution. In legal systems where there are no specific human rights laws applicable to private actors, and the only human rights protections are to be found in constitutional provisions, the application of the constitution to actors other than the state may offer people living with HIV a measure of protection for their fundamental human rights.

Another positive element of the decision was the willingness of the court to view Botswana's National HIV/AIDS Policy, to the extent that its provisions are consistent with the values espoused by the constitution, as an important interpretive aid in its constitutional analysis. The policy was not binding on the court since it is not law, but was important given that Botswana had not passed legislation regarding HIV testing.

The final positive element was the court's willingness to examine international human rights instruments, the constitutions of other countries, HIV-related decisions from other countries and other international sources of guidance on HIV—some of which reflect human rights. Specifically, the court examined World Health Organization best practices, International Labour Organization covenants, the *International Guidelines on HIV/AIDS and Human Rights* produced by UNAIDS and the Office of the UN High Commissioner on Human Rights, the constitutions of Canada, India, Namibia, Sri Lanka and South Africa, and South African court and administrative tribunal decisions regarding HIV testing.

A significant negative aspect of the decision was the court's characterization of the HIV test as "compulsory post-employment testing," rather than compulsory testing as a condition of employment. The respondent made the specific, written demand for a certified document of HIV status more than six months after the applicant commenced employment. However, it was clear from the evidence that the plaintiff's employment was conditional on successful completion of a medical examination which included an HIV test or certified document of HIV status. As a result, the decision does not address whether HIV testing as a condition of employment is legal under Botswana law. In a country such as Botswana, with an exceedingly high rate of HIV infection in the working-age population, the law must strive to protect individual human rights by preventing infringements, not merely by providing remedies where infringements have already occurred.

A second, related limitation of the decision was the court's narrow analysis of the question of HIV-related discrimination. It is encouraging that the court recognized that discrim-

ination based on a person's real or perceived HIV-positive status is constitutionally prohibited in Botswana. But its approach to the question of demanding HIV testing as a condition of employment fell short of fully protecting against such discrimination. It has been recognized in many jurisdictions that it amounts to prohibited discrimination in employment to require information such as a job candidate's marital status, religion, sexual orientation, race or ethnicity, to name just a few grounds. Similarly, inquiring into an employee's HIV status is also recognized in many jurisdictions as constituting, in itself, a discriminatory practice that is prohibited by law. This case presented a good opportunity for the court to establish proactively that it is discriminatory *per se* under the Constitution of Botswana to impose HIV testing as a condition of employment. This would have been consistent with the court's declaration that "the language of the constitution must be given a broad and purposeful interpretation, so as to give effect to its spirit, and this is particularly true of those provisions that are concerned with the protection of fundamental human rights."

Finally, the court did not order full compensation for the plaintiff. Under the authority of the *Trade Disputes Act*, the court could have awarded the applicant six months' monetary wages. In light of the court's conclusion that the circumstances of the plaintiff's dismissal were "most unfair, involving an unjustified assault on her dignity and her right to liberty", there is a strong argument that maximum compensation should have been awarded.

## II. Access to HIV-related treatment



## Colombia: State has constitutional obligation to ensure HIV treatment

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### ***Alonso Muñoz Ceballos v. Instituto de Seguros Sociales, Constitutional Court of Colombia, Judgement No. T-484-92 (1992)***

#### **Court and date of decision**

At first instance, judgement granting an interim injunction was issued by the Juzgado Cuarto Superior de Tulua Valle on 25 March 1992. The Constitutional Court issued its final decision regarding the merits of the application on 11 August 1992.

#### **Parties**

The applicant, Alonso Muñoz Ceballos, initiated a proceeding (*acción de tutela*) against the Institute of Social Security of Colombia.

#### **Remedy sought**

The applicant filed an application for a writ of protection of fundamental constitutional rights (*acción de tutela*), seeking an order that he was entitled to continue to receive necessary medical treatment, including for HIV and AIDS, paid for by the Institute of Social Security. The application also included a request for an interim order preventing the hospital from discontinuing his benefits pending a final judgement on the merits of his case.

#### **Outcome**

To avoid irreparable harm to his health, the court granted interim relief by ordering the Institute of Social Security to continue providing medical treatment to Muñoz beyond the 180-day limit it had imposed, until the Institute of Social Security or a competent judicial authority could decide the merits of his claim. It gave the applicant four months to file a more detailed application with the court responsible for “contentious” matters; at the end of that period, if no such application had been filed, the interim order would cease to be effective.

Muñoz filed the more detailed application. Ultimately, the Constitutional Court ruled that the Institute of Social Security had 15 days from the date of judgement to clearly define the medical and hospital services to which the applicant was entitled, either as the recipient of disability coverage or some other applicable programme, and in conformity with the Court’s directions regarding the nature and extent of the rights to health and to non-discrimination. The Institute of Social Security was also ordered to inform the lower court that first dealt with the case of the Institute’s determination, which determination could be open to further judicial challenge if the Institute failed to respect the Court’s instructions. In the interim, the Institute of Social Security was also ordered to continue providing the services which the applicant had previously been accessing.

## Background and material facts

As a result of his employment history, the applicant had been eligible for some time, prior to his diagnosis with HIV, for medical benefits provided by the Institute of Social Security via a public health facility. He was informed that the facility would discontinue his free medical treatment within 180 days. Needing to continue accessing these benefits, including medications, the applicant initiated legal proceedings seeking an urgent order to protect against imminent breach of his human rights.

## Legal arguments and issues addressed

The Court addressed two important questions of human rights:

- (i) the interpretation of the right of access to health care services, as set out in Colombian law;
- (ii) the right of people living with HIV and AIDS to freedom from discrimination.

In addressing these two questions in the context of the applicant's claim, the Court began its analysis with the relevant provisions of the Constitution of Colombia.

With respect to the *right to health*, the Constitution (Article 49) declares that the State is responsible for health as a public service, guarantees everyone's "access to services for the promotion, protection and recovery of health", and declares that every person has the right to seek comprehensive care for his or her own health and that of his or her community. It further provides that it is the State's duty to organize, regulate and manage the delivery of health services to residents, in accordance with the principles of efficiency, universality and social solidarity. The State's responsibility also includes establishing policies governing health services provided by private entities and monitoring and controlling those providers. Finally, the Constitution states that the law shall establish the terms on which basic health care for all residents is free and obligatory.

Furthermore, the Constitution (Article 13) declares the *right to freedom from discrimination* on a number of grounds. It provides that the State shall promote the conditions necessary for equality to be real and effective, and shall adopt measures in favour of groups that are marginalized or experience discrimination. It also places a special obligation on the State to protect people who are "debilitated" by their economic, physical or mental condition and to redress abuse of mistreatment against such persons. (There is no reference to health status or disability in the list of grounds upon which discrimination is prohibited, such as sex, race, national origin, religion, etc., nor is there any express mention of HIV or AIDS. However, the Court's judgement clearly is premised on an assumption that such constitutional provisions apply to protect people living with HIV/AIDS.)

In its ruling, the Constitutional Court agreed with the lower court that the constitutional rights to access health care services and to freedom from discrimination meant that the Institute was legally required to cover Muñoz's medical treatment.

The Court noted that the right to equality is in the chapter of the Colombian Constitution dealing with "fundamental" rights, whereas the right to have access to health services appears in a separate section on "economic, social and cultural rights". The Court explained that, because health is inherent in the concept of a dignified human existence, it is constitutionally protected, especially in the case of persons who are vulnerable as a result of their economic, physical or

mental condition. Understood in this fashion, the right to health is aimed at ensuring the fundamental right to life (as protected by Article 11 of the Constitution), which must be given priority and preferential treatment by the State in order to effectively protect it. This is reflected in the fact that the Constitution declares health to be a public responsibility of the State and guarantees access for all to the means of protecting and promoting health. This includes the constitutional obligation of the State to implement policies to this end, including regulating providers of health care services, and to define by law the circumstances in which health services shall be accessible free of charge.

According to the Court, the right to health may be considered to consist of various elements, which are not always distinct. In some cases, the right to health amounts to an immediate expression of the right to life, such that an attack on a person's health is also an attack on his or her very life. In this sense, the right to health is a fundamental right. However, in other respects, the right to health is understood as encompassing rights to assistance. Under the Colombian constitution, the state is defined as having social functions. In recognizing the right to health services, the Constitution requires specific concrete actions by the state, including through the development of legislation, to ensure not only medical attention but also access to hospitals, laboratories and pharmaceuticals. While the distinction between health as a fundamental right and as a right to assistance is imprecise and may shift depending on the circumstances of each case, the Court concluded that, in principle, "the right to health is fundamental when it is linked to protecting life."

In this case, the Court recognized the severity of the applicant's illness and that denial of access to necessary health care services, which he had previously been receiving through the Institute of Social Security, would infringe his fundamental right to health. While the Institute of Social Security is subject to certain regulations and legal procedures that must be observed, there is nonetheless a general duty on the part of the State to guarantee access to health services for those in such circumstances. It was this ultimate outcome that was the ultimate concern of the Court. It therefore ordered the Institute of Social Security to clearly define Muñoz's entitlements to health-care services, either through disability benefits or some other programme, within a short period of time and to inform the lower court of the details so that it could be subject, if necessary, to further judicial consideration. In the interim, the Institute of Social Security was required to continue providing the services that he had previously been accessing.

## Commentary

The Court primarily focused on two human rights provisions in the national Constitution, particularly the article which explicitly recognizes positive obligations on the part of the State to protect and promote health, including ensuring free access to health services for those in need. In stressing the fundamental status of such a right (and the corresponding obligations), the Court cited the *International Covenant on Economic, Social and Cultural Rights* (Article 12), which expressly recognizes the right of every person to enjoy the highest attainable standard of physical and mental health. But this was a passing reference only, without any further detailed analysis of how the right set out in this international treaty has been interpreted by either Colombian or other bodies. While the decision is welcome in that it applies this international treaty, it is unfortunate that the Court did not lay out more of its thinking on this point, as this could have been helpful in advancing this right in Colombian law.

The right to equality is also mentioned, and in the context of discussing access to health-care services, the Court emphasized the particular obligation on the part of the State towards those who are “debilitated” by poverty or “physical or mental condition” (i.e., disability). The Constitutional provision itself does not explicitly prohibit discrimination based on disability and does not expressly insist on the right of people with disabilities to equal treatment; rather, it reflects more of a “humanitarian”, charitable approach. Within this limitation, however, the Constitutional Court does, in effect, insist that people living with HIV are entitled to equal access to the health-care benefits provided by the Institute of Social Security and remedies the discriminatory decision of the Institute to cut off such services.

This is one of the first cases in Latin America to consider the content and enforceability of the right to health in the context of a claim by a person living with HIV challenging the discriminatory denial of health care coverage. While it does not refer specifically to the issue of antiretroviral drugs, just such a claim was initiated in the same year in Costa Rica (see the following case study). While unsuccessful in the end, that Costa Rican proceeding laid some of the groundwork for future advocacy efforts, including litigation which, a few years later, proved a breakthrough for treatment access in the region.

# Costa Rica: Social Security must cover antiretroviral drug costs for people living with HIV

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***Luis Guillermo Murillo Rodríguez et al. v. Caja Costarricense de Seguro Social, Constitutional Chamber of the Supreme Court of Justice, Decision No. 6096-97 (1997)***

***William García Álvarez v. Caja Costarricense de Seguro Social, Constitutional Chamber of the Supreme Court of Justice, Decision No. 5934-97 (1997)***

## Court and date of decision

The judgement of the Constitutional Chamber of the Supreme Court of Justice of Costa Rica in the *García* case was issued on 23 September 1997. A similar judgement was issued by the same court on 26 September 1997, three days later, in the *Murillo* case. (Although the *Murillo* proceeding was started sooner, the greater urgency of the subsequently initiated *García* case prompted a faster response by the court.)

## Parties

In each of these cases, the applicants were people living with HIV who were in need of antiretrovirals and eligible for health benefits covered by the Costa Rican Social Security Fund (CCSS: Caja Costarricense de Seguro Social). Activists with the Agua Buena Human Rights Association were responsible for initiating the proceeding. The CCSS was the respondent.

## Remedy sought

In both cases, the applicants brought *amparo* proceedings<sup>40</sup> seeking, on an urgent basis, a court order to compel the Fund to extend coverage to antiretroviral drugs to protect their human rights to life and to health.

## Outcome

On 23 September 1997, the Court ordered the Costa Rican Social Security Fund to immediately begin supplying William García with the necessary antiretroviral medicines. Three days later, on 26 September 1997, the Court issued a similar decision in the case of Guillermo Murillo and the other two original applicants, ordering that the Social Security Fund provide antiretroviral combination therapies appropriate to their clinical condition, as prescribed by

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<sup>40</sup>The *amparo* action is a remedy in some Latin American civil law systems best described in the terms of a common law system as a “constitutional injunction” – that is, an injunction obtained urgently to redress an existing, or prevent an imminent, breach of constitutional rights. It is similar to a writ of habeas corpus, but with a broader application than simply challenging the legality of a person’s detention or imprisonment. The equivalent proceeding is referred to as a *tutela* action in some other jurisdictions in Latin America.

their responsible physicians. It also ordered the Fund to pay the costs and damages incurred by the applicants.

## Background and material facts

Costa Rica's nationalized health-care system, funded by the national Social Security Fund ("Caja Costarricense de Seguro Social"), covers health care for most residents. The Fund is principally supported by both employer and employee contributions, representing a percentage of each paycheck. Contributions by any employed person entitle his or her immediate family members to coverage. Unemployed persons could affiliate with the Fund by purchasing "voluntary insurance", for a (subsidized) fee, which provided limited coverage for serious health needs.

In 1992, several people living with HIV unsuccessfully applied for a court order compelling the Social Security Fund to cover the antiretroviral drug AZT (Supreme Court, Judgement No. 280-92, 7 February 1992). In rejecting the application, the Court cited the fact that AZT is not a cure for HIV infection and its benefits were "inconclusive", and also noted the high costs. It questioned why, if it were to order coverage for this drug for this set of patients, it should not also cover costs for other patients with serious or terminal illness. (The Court did not attempt to answer this important question or consider whether there might indeed be some obligation on the Costa Rican state, under the rubric of the human right to health, to take reasonable steps to address such needs.)

Several years later, following the advent in 1996 of protease inhibitors, a new class of antiretroviral drugs showing considerable promise to dramatically improve the immune systems and health of people living with HIV, Costa Rican AIDS activists renewed and intensified their efforts to obtain Social Security coverage for the medicines needed by people living with HIV. Despite repeated requests and lobbying, in 1997, the Costa Rican Social Security Fund flatly stated to a group of people living with HIV and AIDS and their advocates that it would not provide coverage for antiretroviral drugs needed to treat HIV disease.

In response, three individuals living with HIV (including Guillermo Murillo, the first person in Costa Rica to publicly declare his HIV-positive status to the public at large), all in need of antiretroviral treatment, initiated a legal proceeding in the Constitutional Court in August 1997 seeking an urgent remedy for the violation of their constitutional right to life. A few weeks later, one of the activists who had worked to help launch the proceeding was contacted by William Garcia, a former acquaintance, who had HIV, had been hospitalized with pneumonia, and was close to death. The urgency of his case prompted the submission of another petition to the Constitutional Court, with the hope that the Court would be compelled to act in the face of his imminent death as a result of the lack of access to antiretroviral medicines.

## Legal arguments and issues addressed

The applicants in both cases argued that the government's refusal to cover antiretroviral drugs under its Social Security fund threatened to infringe their right to life, given that they would die without these medications.

In its decision, the Court emphasized that the rights to life and health are "supreme values", citing both the national Constitution as well as international instruments to which Costa Rica subscribes, such as the *Universal Declaration of Human Rights*, the *American Convention on Human Rights*, the *American Declaration of the Rights and Duties of Man*, and the *International Covenant on Civil and Political Rights*. The Court also explicitly cited the

right to enjoy the highest attainable standard of health as set out in the *International Covenant on Economic, Social and Cultural Rights* (Article 12).

In its discussion of the Social Security Fund, the Court affirmed that a national social security system was “a fundamental pillar of the national democratic system”. In Costa Rica, the Social Security Fund was something to which most of the population contributes, and from which most were entitled to benefit when in need of medical care. The Court stressed the “crucial, fundamental” mission of the Fund and its contribution to “national solidarity”.

In this case, the Fund argued that it was financially impossible for it to provide the antiretroviral drugs demanded by the applicants, and that to compel coverage for such medications could represent “the beginning of the end of the social security system.” However, the Court said the Fund could not validly argue financial constraints as a justification for not complying with the very reason for the Fund’s existence, namely to provide coverage for needed medical care. It cited one of its earlier decisions (Judgement No. 5130-94) as follows:

If the right to life, and consequently the right to health, is especially protected in every modern legal state, any economic criteria that purport to render null the exercise of such rights must give way because ... without the right to life all other rights are useless.... Of what use are all other rights and guarantees, the institutions and programs, the advantages and benefits of our system of liberties, if even one person cannot be guaranteed the right to life and to health?

The Court further noted that, if it were simply a question of cold financial analysis, then it would not be acceptable to examine solely the cost of supplying antiretrovirals; it would also be just as pertinent to consider the costs, direct and indirect, of withholding medicines from those who then become sick.

As noted above, the Court also resiled from its 1992 decision (Judgement No. 280-92, 7 February 1992) in which it had refused to order the Social Security Fund to cover the antiretroviral drug AZT for people living with HIV, based on its high costs and the limited evidence of its benefits. The Court noted that treatment for HIV had changed significantly since that earlier 1992 decision, with considerable demonstrated benefit of the new antiretroviral treatments on reducing morbidity and mortality. It also noted that, from an epidemiological perspective, AIDS is a major cause of death in Costa Rica, “which fact alone required immediate action by national authorities.”

The Court therefore decided to modify its previous jurisprudence in light of new, urgent circumstances. It therefore concluded that “providing effective medical assistance to people living with AIDS is an obligation of the Costa Rican state, arising from the principles of justice and solidarity that infuse the social security regime set out by the Constitution and the mission of the Social Security Fund.”

The Court recognized that its decision might cause “distress” to the authorities responsible for the Social Security Fund, but expressed its view that, “in light of [the Fund’s] experience over half a century of existence as well as its proven capacity to respond to the challenges of protecting public health, this decision would serve to spur the new responses for which people living with HIV, and Costa Rican society in general, are waiting.”

In the result, the Court ordered the Costa Rican Social Security Fund to immediately begin supplying the applicants with the antiretroviral combination therapies appropriate to their clinical condition, as prescribed by their responsible physicians. It also ordered the Fund to pay the costs and damages incurred by the applicants.

## Commentary

Within one week of the decision, dozens of people living with HIV had indicated their intention to file petitions to obtain access to medicines. Facing the possibility of hundreds of such applications, the Court ordered the Social Security Fund to develop a plan to provide coverage to all people living with HIV in need of antiretrovirals, which it did within a few weeks. Costa Rica thereby became the first Central American country to include coverage of antiretroviral drugs within its national health insurance plan. Largely as a result of expanded access to treatment, the number of deaths from AIDS in Costa Rica fell from 102 in 1997 to 44 in 1998, even as the number of cases of AIDS diagnosis increased over this time.<sup>41</sup>

These cases have also helped stimulate activism beyond Costa Rica's borders. For example, in April 1998, an organization advocating for the rights of people living with HIV in Panama filed an application with the Supreme Court in Panama seeking an order compelling coverage for antiretroviral drugs by the Social Security Fund, similar to what had been achieved in Costa Rica. In December 1998, the Court rejected the application on technical grounds, with no consideration of its substantive merits. However, the Court did signal that the Social Security Fund was responsible for ensuring appropriate health care.

Even though the Panamanian Supreme Court did not take the same approach as in Costa Rica, nonetheless the decision of the Costa Rican Supreme Court set a precedent that has been politically important at the regional level. The dismissal of the petition by the Panama court did not end the matter. In May 1999, under pressure from an ongoing campaign of legal action, lobbying and demonstrations (including blockades of downtown streets), the Panamanian Social Security Fund (Caja de Seguro Social) announced that it would extend coverage under its health-care plan to include antiretroviral drugs for those covered by the plan, as well as those with no health insurance. While ultimately it was political protest that led to change in government policy in Panama, the Costa Rican court decisions in *Murillo* and *García*, and the consequent change in Costa Rican government policy, certainly contributed to the growing momentum of treatment activism in the region.

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<sup>41</sup> R Stern. Activists win Supreme Court challenge in Costa Rica. HIV/AIDS and Human Rights: Stories from the Frontlines. International Council of AIDS Service Organizations, June 1999, p. 17.

# United Kingdom: European Court of Human Rights rules deportation of man with AIDS to country without adequate treatment constitutes inhuman treatment

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## ***D v. United Kingdom, European Court of Human Rights, Case No. 146/1996/767/964 (1997)***

### **Court and date of decision**

The European Court of Human Rights issued its judgement on 2 May 1997.<sup>42</sup>

### **Parties**

The applicant “D” was a Saint Kitts citizen facing deportation from the United Kingdom. The respondent was the Government of the United Kingdom.

### **Remedy sought**

The applicant D sought an order prohibiting the UK from deporting him to Saint Kitts, arguing this would amount to a violation of various human rights under the *European Convention on Human Rights*.

### **Outcome**

The European Court of Human Rights ruled in favour of one of D’s four arguments, finding that his deportation would amount to inhuman or degrading treatment contrary to Article 3 of the *Convention*.

### **Background and material facts**

D was a citizen of Saint Kitts. He arrived in the United Kingdom in 1993, seeking leave to enter for two weeks as a visitor. At the airport, he was found in possession of cocaine and refused permission to enter. He was, however, held in custody and prosecuted. A few months later, he pleaded guilty to fraudulently evading the prohibition on importing a controlled drug, and was sentenced to six years in prison. In August 1994, while in prison, he suffered an attack of pneumocystis carinii pneumonia (PCP), a common opportunistic infection, and was diagnosed as HIV-positive. As of August 1995, his T4 cell count was below 10, and he was diagnosed as having AIDS, suffering from recurrent anaemia, bacterial chest infections, malaise, skin rashes, weight loss and periods of extreme fatigue.

In January 1996, having been of good behaviour, he was released on licence from prison; immediately prior to his release, the immigration authorities ordered that he be deported to Saint Kitts. Therefore, upon release, he was placed in immigration detention pending

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<sup>42</sup>*Reports of Judgements and Decisions 1997-III*, p. 795, § 59; (1997), 24 EHRR 423 (European Court of Human Rights). The judgement is also available on the Court’s website via [www.echr.coe.int](http://www.echr.coe.int).

removal. Several months later, with legal proceedings still underway, he was released to reside in a special accommodation for people with AIDS, operated by a charitable organization that provided accommodation, food and services free of charge. He was given antiretroviral drugs and pentamidine to prevent a recurrence of pneumonia. A few months later, shortly before his case was heard before the European Court of Human Rights (see below) he was admitted to hospital and his prognosis was uncertain.

A few days after the order for his removal, D's lawyers requested that the Secretary of State grant him leave to remain in the UK on compassionate grounds since his removal to Saint Kitts would entail the loss of medical treatment he was currently receiving, thereby shortening his life expectancy. The consulting physician in the UK indicated that D's "life expectancy would be substantially shortened if he were to return to Saint Kitts where there is no medication; it is important that he receives pentamidine treatment against PCP and that he receives prompt antimicrobial therapy for any further infections which he is likely to develop." The prognosis was that D's life expectancy was likely 8–12 months, which would be reduced to less than half this time in the event of withdrawal of proven effective therapies and proper medical care. Information from the Red Cross and the High Commission for the Eastern Caribbean States indicated that medical facilities in Saint Kitts did not have the capacity to provide the medical treatment D would require, and that there was no health care service providing drugs for treatment of AIDS in Saint Kitts. D had no family home or close family in Saint Kitts who would be able to care for him.

UK law made a distinction between leave to *enter* the country and leave to *remain*, a distinction important in the case of people living with HIV. Official government policy providing guidance to immigration officers stated that in the case of applications for leave to enter the UK, any person with HIV or AIDS who does not qualify under the Immigration Rules is refused. In the case of applicants for leave to remain, however, the policy provided for a discretion outside the Rules, which may be exercised to permit a person, who is otherwise inadmissible to remain in the UK, to remain on compassionate grounds. The policy stated: "...there may be cases where it is apparent that there are no facilities for treatment available in the applicant's own country. Where evidence suggests that this absence of treatment significantly shortens the life expectancy of the applicant it will normally be appropriate to grant leave to remain."<sup>43</sup>

However, the Chief Immigration Officer refused the request within two days. The letter of refusal stated:

While we are saddened to learn of Mr. D [...]’s medical circumstances, we do not accept, in line with Departmental Policy, that it is right generally or in the individual circumstances of this case, to allow an AIDS sufferer to remain here exceptionally when, as here, treatment in this country is carried out at public expense, under the National Health Service. Nor would it be fair to treat AIDS sufferers any differently from others suffering medical conditions...

D applied unsuccessfully to the High Court for leave to apply for judicial review of this decision. The Court of Appeal also dismissed a further application, stating that the decision of the Chief Immigration Officer was "one which was well within the bounds of his discretion, and thus is not one with which the Court can properly interfere."

D therefore filed an application with the European Commission on Human Rights, alleging the UK's decision to deport him contravened various provisions of the *European*

<sup>43</sup> Immigration and Nationality Department of the Home Office, Policy Document BDI 3/95 (August 1995), para. 5, as cited in European Court of Human Rights, Judgement, para 28.

*Convention on Human Rights*. In June 1996, the Commission ruled that the case was admissible, meaning it could proceed to be adjudicated by the European Court of Human Rights.<sup>44</sup> The Court received the case in October 1996 and issued its judgement in May 1997.

## Legal arguments and issues addressed

D argued that his deportation from the UK to Saint Kitts would place him at risk of a reduced life expectancy, and would amount to inhuman and degrading treatment and an invasion of his physical integrity since he was suffering from AIDS and would be exposed to a lack of adequate medical treatment and living conditions. He argued, therefore, that under the *European Convention on Human Rights*, the deportation would amount to a violation of:

- the right to life (Article 2);
- the prohibition against inhuman and degrading treatment (Article 3); and
- the right to respect for private life (Article 8).

The *prohibition against inhuman and degrading treatment* (Article 3) was the main focus of the Court's judgement. D argued that removing him to Saint Kitts would condemn him to spending his remaining days in pain and suffering in conditions of isolation, squalor and destitution. The UK argued that he would not be exposed to any form of treatment breaching the standards of the Convention. As the Court summarized the UK's argument:

His hardship and reduced life expectancy would stem from his terminal and incurable illness coupled with the deficiencies in the health and social-welfare system of a poor, developing country. He would find himself in the same situation as other AIDS victims in Saint Kitts. In fact he would have been returned in January 1993 to Saint Kitts, where had spent most of his life, had it not been for his prosecution and conviction. ... Even if the treatment and medication fell short of that currently administered to the applicant in the United Kingdom, this in itself did not amount to a breach of Article 3 standards.<sup>45</sup>

In its earlier ruling on the admissibility of the case, the European Commission had concluded that deporting D to Saint Kitts would engage the responsibility of the UK under Article 3 of the Convention, even though the risk of inhuman and degrading treatment arose from factors for which the UK authorities could not be held responsible. The Court took a similar view. It stated that Article 3

...enshrines one of the fundamental values of democratic societies. It is precisely for this reason that the Court has repeatedly stressed in its line of authorities involving extradition, expulsion or deportation of individuals to third countries that Article 3... prohibits in absolute terms torture or inhuman or degrading treatment or punishment and that its guarantees apply irrespective of the reprehensible nature of the conduct of the person in question.<sup>46</sup>

The Court determined that because D was physically present in the UK and within its jurisdiction since 1993, it was the UK's obligation to secure his rights under Article 3 regardless of the seriousness of his offence of drug smuggling.

<sup>44</sup> Decision as to the admissibility of Application No. 30240/96 by DG against the United Kingdom, 26 June 1996.

<sup>45</sup> European Court of Human Rights, Judgement, paras. 42-43.

<sup>46</sup> *Ibid.*, para. 47 [references to previous judgements omitted].

The Court admitted that its previous judgements had dealt only with situations in which the risk of the individual being subjected to torture or inhuman or degrading treatment emanated either from intentional acts by public authorities in the receiving country or from the inability of state authorities to protect the individual from non-state actors. However, it declared that it “must reserve to itself sufficient flexibility to address the application of [Article 3] in other contexts which might arise.”<sup>47</sup> In D’s case, the Court noted that:

The applicant is in the advanced states of a terminal and incurable illness. ... The abrupt withdrawal of these facilities [currently being accessed in the UK] will entail the most dramatic consequences for him. It is not disputed that his removal will hasten his death. [...] In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant’s final illness, the implementation of the decision to remove him to Saint Kitts would amount to inhuman treatment by the [UK] in violation of Article 3. ... He has become reliant on the medical and palliative care which he is at present receiving and is no doubt psychologically prepared for death in an environment which is both familiar and compassionate. Although it cannot be said that the conditions which would confront him in the receiving country are themselves a breach of the standards of Article 3, his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment. ... [I]n the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of Article 3.

With respect to the *right to life* (Article 2), the Court agreed with the European Commission on Human Rights that it was not necessary to examine D’s complaints under this article, since they could not be separated from the substance of his complaint regarding the prohibition against *inhuman or degrading treatment* (Article 3). Similarly, the Court decided that it was not necessary to further analyse D’s additional argument that the harm to his physical integrity that would flow from his deportation to Saint Kitts would also amount to a violation of his *right to respect for his private life* (Article 8).

## Commentary

As suggested by the other cases described in this publication, the majority of “access to treatment” cases have sought to directly enforce obligations of the State in relation to such rights as the right to health or to life. This case is unusual in that access to treatment, both in the form of medicines but also more broadly understood, was protected using the human right to be free from inhuman or degrading treatment.

It is a significant achievement that a judicial body such as the European Court of Human Rights was willing to rule that denial of access to adequate medical care, at least in the final stages of disease progression, could amount to inhuman and degrading treatment, thereby staying the hand of the State in deporting those illegally within a country. However, although not stated explicitly, the Court appeared afraid to open the floodgates to an influx of “medical tourism” or “medical refugees” from developing countries to those wealthier ones with a publicly funded health system capable of delivering access to life-saving or life-extending care. It was, therefore, at great pains to point out that its ruling was heavily dependent on the compassionate circumstances of this particular case. As such, it did not establish a precedent that is likely to be widely applicable beyond the small number of people whose situation might be as dire as that of the applicant.

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<sup>47</sup> *Ibid.*, para. 49.

Subsequent experience bears out the limits of this judgement. There have been some further cases seeking to build on the ruling. Those cases have been unsuccessful on their facts, demonstrating the Court's unwillingness to expand any further the applicability of Article 3 of the *Convention* to protect people with serious health conditions from removal to developing countries with limited access to adequate medical care.

For example, in 1998, the European Commission on Human Rights found that the deportation from France to the Democratic Republic of Congo (formerly Zaire) of a person infected with HIV would violate Article 3, where the infection had already reached an advanced stage necessitating repeated hospital stays and where the care facilities in the receiving country were precarious. However, the Court subsequently struck out the application.<sup>48</sup> Two years later, in the case of a Zambian woman living with HIV facing deportation from Sweden,<sup>49</sup> the European Court affirmed its judgement in *D v. United Kingdom* but went on to reject her complaint on the facts. It pointed out that: she was only HIV-positive (and had not progressed to a likely terminal stage of AIDS); she had only just recently begun antiretroviral therapy; according to the Swedish Embassy, AIDS treatment is available in Zambia; and her children and other family members live in Zambia. Given these circumstances, the Court did not find that removing her from Sweden to Zambia would amount to inhuman treatment contrary to Article 3 of the *Convention*.

Most recently, in May 2005 the UK House of Lords issued a ruling setting out a very restrictive interpretation of the European Court's judgement in *D v. United Kingdom*. In *N (FC) v. Secretary of State for the Home Department*,<sup>50</sup> the House of Lords rejected an appeal of a deportation order filed by a 30-year-old woman living with HIV, who argued that expelling her to Uganda, a country where access to HIV medication and medical care was uncertain, was in breach of the European Convention. She had travelled to the United Kingdom in 1998 and claimed asylum based on her experience of being kidnapped and raped by members of both the Lord's Resistance Army and a faction of the Ugandan security forces. She was diagnosed as HIV-positive upon her arrival in the UK; as a result of medication and medical care, her condition stabilized over the years she remained in the UK. Her asylum application was eventually refused by the Secretary of State, but an adjudicator allowed her appeal, finding that her expulsion would amount to torture or to inhuman or degrading treatment, contrary to Article 3 of the *European Convention*. Eventually, the House of Lords overturned this decision and reinstated the deportation order.

In their judgement, the Lords were at pains to construe the judgement in *D v. United Kingdom* as narrowly as possible. They started from the principle that states have the right to control the entry, residence and expulsion of "aliens". Yet, in exercising this right, the State must not violate the *European Convention's* prohibition on torture or cruel, inhuman or degrading treatment. However, aliens facing deportation cannot claim an entitlement to remain in the State in order to benefit from continuing medical or other assistance. The scope of Article 3 in the *European Convention* could be extended to address medical or humanitarian concerns only in "exceptional circumstances"—such as the imminent death that was facing *D* in the European Court's 1997 decision. In the case of *N*, the court found she was healthy and her death was

<sup>48</sup> *BB v. France*, Application No. 30930/96, Decision of 9 March 1998; case subsequently struck out by the Court on 7 September 1998.

<sup>49</sup> *SCC v. Sweden*, European Court of Human Rights, Case No. 46553/99, 15 February 2000 available via [www.echr.coe.int](http://www.echr.coe.int).

<sup>50</sup> [2005] UKHL 31, available at [www.parliament.the-stationery-office.co.uk/pa/ld200405/ldjudgmt/jd050505/home.pdf](http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldjudgmt/jd050505/home.pdf).

not imminent; therefore, her situation could not be considered “exceptional”. The House of Lords allowed the deportation order to stand, but also noted that the Home Secretary could exercise his discretion not to deport her to Uganda. As a result, under UK law the availability of treatment and health care in an applicant’s country of origin are virtually irrelevant to a claim under Article 3 of the *European Convention*; only those who are gravely ill will likely be protected from deportation. The House of Lords was clearly afraid of establishing a precedent that would open the floodgates to “other foreign AIDS sufferers aspiring to these benefits [of treatment and associated welfare]” in the United Kingdom.<sup>51</sup>

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<sup>51</sup> *Ibid.*, para. 92.

# Venezuela: Constitutional Court orders extensive action by government to fulfil constitutional right to medicines and treatment

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## ***Cruz del Valle Bermudez et al. v. Ministry of Health and Social Action, Supreme Court of Venezuela (Political-Administrative Chamber), Decision No. 916, Court File No. 15.789 (1999)***

### **Court and date of decision**

The Political-Administrative Chamber of the Supreme Court of Venezuela issued its judgement on 15 July 1999.<sup>52</sup>

### **Parties**

Almost 170 people living with HIV in need of antiretroviral medication and accompanying clinical examinations, but without coverage under the employment-linked national “social security” scheme, brought the proceeding against the Ministry of Health and Social Action. The applicants were represented by lawyers from the human rights advocacy group Citizen Action Against AIDS (Acción Ciudadana Contra el SIDA). In the result, given the ultimate decision of the Court, the *de facto* beneficiaries of the proceeding were not just the individual applicants but included all people living with HIV resident in Venezuela.

### **Remedy sought**

The applicants brought an *amparo* action alleging that, by failing to supply prescribed antiretroviral drugs, the Ministry was infringing a violation of their rights to life, health, liberty and security of the person, equality, and the benefits of science and technology. They sought a court order instructing the government to take the steps necessary to respect and fulfil those rights.

### **Outcome**

The Supreme Court ruled in favour of the applicants. It set out a number of specific steps required of the government, which went beyond simply supplying medications, and further ordered the Ministry to seek the necessary budget allocations. Very importantly, the Court also declared that the remedy was not limited simply to benefiting the individual applicants named in the proceedings, but extended to benefit all Venezuelans in a similar situation.

### **Background and material facts**

Venezuelan courts, including the highest court in the country, had repeatedly recognized that the government must take positive action to ensure that people living with HIV have access to antiretroviral drugs, to medicines for the treatment of opportunistic infections, and to

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<sup>52</sup> *Bermudez et al. v. Ministerio de Sanidad y Asistencia Social*, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (15 July 1999).

specialized laboratory tests necessary for the effective treatment of HIV infection and opportunistic infections. The courts founded this obligation on the right to life, the right to health, and the right to the benefits of scientific progress.<sup>53</sup>

The decision in this case, *Cruz Bermudez*, was preceded by a number of other important cases that laid the groundwork for this far-reaching Supreme Court decision.

In May 1997, a trial court recognized the right of social security recipients to an uninterrupted provision of antiretrovirals (including protease inhibitors), and ordered the Venezuelan Social Security Institute to provide such treatment for eligible people with HIV/AIDS.<sup>54</sup>

Later the same year, the Venezuelan Social Security Institute settled a case brought by over 300 people living with HIV eligible for coverage under the national “social security” administration, by agreeing to cover HIV-related medical expenses.<sup>55</sup>

In August 1998, in *NA v. Ministerio de Sanidad y Asistencia Social*, the Supreme Court ruled against the Ministry of Health which failed to ensure coverage for HIV and AIDS medications through the public health-care system. This system is the option of last resort in the sense that it provides care for those who are not eligible for coverage under the national “social security” scheme administered by the Venezuelan Social Security Institute, which is tied to contributions based on employment earnings. In *NA*, the Court ordered the provision of medications.<sup>56</sup>

The decision in *Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social* built on these precedents, but was of particular significance given the remedy ordered by the Supreme Court. In *Cruz Bermudez*, the Supreme Court was considering the same issue as in the previous *NA* case the year before: the question of whether the public health care system was required to provide antiretroviral medications to those not covered by “social security”.

The applicants founded their claim on five different human rights statements recognized in international and Venezuelan law. They argued that the failure of the public health-care system to provide

needed medicines to those who were not eligible for social security benefits from the Venezuelan Social Security Institute constituted a violation of their rights to:

- life;
- health;
- liberty and security of the person;
- freedom from discrimination; and
- access to the benefits of science and technology.

The Court dismissed the claim invoking liberty and security of the person, as well as the equality rights argument, citing its earlier decision on similar arguments in the 1998 case of

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<sup>53</sup>For more detailed discussion, see: Mary Ann Torres. The Human Right to Health, National Courts and Access to HIV/AIDS Treatment: A Case Study from Venezuela. *Chicago Journal of International Law* 2002; 3(1): 105.

<sup>54</sup>Edgar Carrasco. Acción Ciudadana Conral el SIDA (ACCSI), Venezuela. “Derechos Humanos y el Acceso a Antirretrovirales en América Latina y el Caribe,” January 2001, at p. 5.

<sup>55</sup>Mary Ann Torres. Access to Treatment as a Human Right: A Discussion of the Aspects of the Right to Health under National and International Law in Venezuela. LL.M. Thesis, University of Toronto Faculty of Law, 2000 (on file).

<sup>56</sup>*NA et al. v. Ministerio de Sanidad y Asistencia Social*, Case No. 14.625, Supreme Court of Justice of Venezuela, 14 August 1998.

*NA v. Ministerio de Sanidad y Asistencia Social* (noted above). The Court reiterated the view that the personal liberty protected by the constitution is “physical liberty” such as protection against arbitrary detention or confinement, and does not extend so far as to compel the government to ensure access to health care. It took a similarly narrow view of “security of the person”, simply saying that it did not see anything in the government’s conduct that affected this right. Nor did the government’s conduct amount to torture or inhuman or degrading treatment, as those terms are defined in the *Convention Against Torture* because there was no intention to cause pain or inflict damage on people living with HIV or to undermine their dignity. The Court similarly rejected the applicants’ claim based on non-discrimination. As in its earlier 1998 judgement, the Court declared that the health system as a whole was suffering from inadequate resources and that it was not proved that people living with HIV were being treated differently from those with other conditions.

However, the Court did base its decision in favour of the applicants on the closely linked rights to life, health and the benefits of science and technology, affirming its approach in the 1998 case. It declared that the right to life is a “positive right” and, therefore, the State must have public health policies aimed at guaranteeing this right, including measures for both HIV prevention and treatment:

We believe that all the citizens—including the plaintiffs in this case—have the right to receive protection of their health, and that there is a correlative duty on the State to oversee that such right is realized accordingly, especially when the citizen lacks sufficient means to afford health care.<sup>57</sup>

The Ministry did not deny that people living with HIV were not receiving medications prescribed by their physicians, but argued that because of the cost “it is evident that we cannot satisfy all the necessities of the HIV/AIDS patient.”<sup>58</sup> The Court recognized this challenge, but nonetheless declined to accept this as sufficient justification for the violation of the applicants’ rights. By way of remedy for the infringement of these rights, the Supreme Court ordered the Minister to seek the necessary budget allocations to comply with its legal obligations as set out in the judgement. It also went on to order that, for all Venezuelan citizens and residents, the Ministry must:

- regularly supply antiretroviral drugs as prescribed and take measures necessary to ensure uninterrupted supply;
- cover all tests necessary for using antiretroviral drugs and for treating opportunistic infections;
- provide medications necessary for treating opportunistic infections;
- develop a policy of information, treatment and comprehensive medical assistance for people living with HIV or AIDS who are eligible for social assistance; and
- undertake research on HIV and AIDS in Venezuela, for the purpose of developing programmes and infrastructure to prevent HIV transmission and provide care for those infected.

<sup>57</sup> *Ibid.*, as translated by Mary Ann Torres and reproduced in David P. Fidler. *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence*. Transnational Publishers: Ardsley, New York, 2000, at p. 321.

<sup>58</sup> *Ibid.*

## Commentary

This case came after repeated actions against the State for failing to include the medicines needed by people living with HIV in its benefits programmes. Given this history, the Court decided in *Cruz Bermudez* that the remedy granted in an *amparo* action need not be limited to the specific petitioners, but could be extended to benefit all those in a similar situation, as described by the Court. In this respect, this case was not only a victory for people living with HIV but also set a precedent in Venezuelan law important for the protection of constitutional rights more generally. The Court's approach seemingly reflects a frustration with continuing to address the same issues repeatedly in a series of individual applications, and a preference to issue a more proactive decision that anticipates problems and sets out clearly the extent of actions required by the state to adequately respond to the treatment needs of people living with HIV.

While the *Cruz Bermudez* decision was an important milestone in this regard, unfortunately subsequent developments have illustrated that court victories secured through litigation do not automatically translate into concrete benefits for people whose rights are at stake as the implementation of court-ordered government obligations can fall short of the mark.<sup>59</sup> As a result, activists initiated further legal proceedings in an effort to compel government compliance with remedies already affirmed by the Court.

For example, in April 2001, the Supreme Court issued another ruling, in the case of *López et al. v. Instituto Venezolano de los Seguros Sociales*.<sup>60</sup> In this case, 29 people living with HIV brought another *amparo* action against the Venezuelan Social Security Institute alleging it had failed to supply antiretroviral drugs prescribed for them by medical specialists, had failed to supply them in a regular manner as required by the specialists, and/or had supplied only transcriptase inhibitors and not the protease inhibitors necessary for effective combination therapy. They also alleged the Institute had failed to pay disability pensions to which they were entitled, with serious consequences for emotional and physical health, and for the health and economic well-being of their families, some of whom were also HIV-positive. Finally, they alleged the Institute had refused to cover the costs of specialized laboratory tests (e.g. lymphocyte count, viral load) necessary for the proper administration of combination therapy.

As in previous cases, they invoked a number of human rights, both in the Venezuelan Constitution and in international law (e.g., the *Universal Declaration of Human Rights*; the *International Covenant on Economic, Social and Cultural Rights*, and the *International Covenant on Civil and Political Rights*). They argued the failure to provide uninterrupted treatment results in deterioration of the immune system, viral drug resistance, opportunistic infections, mental suffering and death, in breach of their rights to life, health, and liberty and security of the person. They also alleged the Venezuelan Social Security Institute had breached their right to social security by denying access under the programme to the health-care services needed. Finally, they alleged the Venezuelan Social Security Institute had breached their right to the benefits of scientific progress and its applications—which they alleged was an inherent right of the human person (although not expressly stated in the Constitution) and was guaranteed by the *International Covenant on Economic, Social and Cultural Rights* (Article 15)—by failing

<sup>59</sup> For a similar experience, see the discussion below regarding multiple instances of litigation in Argentina through which activists have fought for effective, uninterrupted access to adequate antiretroviral treatment.

<sup>60</sup> *Lopez et al. v. Instituto Venezolano de Seguros Sociales*, Supreme Court of Venezuela (Constitutional Chamber), Judgement No. 487-060401 (6 April 2001).

to provide medications and failing to cover necessary laboratory tests for effective treatment of persons living with HIV (e.g. ELISA, Western blot, viral load, tests necessary for treatment of opportunistic infections).

The Supreme Tribunal affirmed that the Venezuelan Social Security Institute had infringed the petitioners' human rights, and as in the previous *Cruz Bermudez* case, also expanded the scope of the *amparo* remedy to protect all those people living with HIV eligible for coverage by the Venezuelan Social Security Institute. It ordered the Venezuelan Social Security Institute to:

- provide transcriptase and protease inhibitors to patients as prescribed by medical specialists;
- pay for specialized tests necessary for accessing antiretroviral combination therapy (e.g. viral load testing) and other specialized tests reasonably available in the country necessary for treatment of HIV and AIDS and opportunistic infections; and
- provide the medications necessary for the treatment of opportunistic infections.

Noting the language of the national Constitution (Article 83), the Court concluded that the right to health was constitutionalized as a fundamental social right, and not simply as a State objective. The Court ruled that the failure to provide an uninterrupted supply of the necessary medications, and the failure to cover specialized laboratory tests needed for the use of antiretroviral drugs and the treatment of opportunistic infections, was in violation of the petitioners' rights to health and threatened their rights to life, to the benefits of science and technology, and to social security.

Between the *Cruz Bermudez* and *Lopez* decisions, it became well established in Venezuelan law that both the national social security scheme (providing health coverage for those eligible as a result of employment-based contributions) and the general public health-care system (for those without such eligibility) must include coverage for the treatment needs of people living with HIV. Nevertheless, such treatment has not always been accessible or adequately financed or delivered. Litigation has proven an important and necessary tool for advancing human rights, but certainly not one that has been sufficient on its own.

# El Salvador: Inter-American Commission on Human Rights issues first order that State must provide antiretroviral treatment

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## ***Jorge Odir Miranda Cortez et al. v. El Salvador, Inter-American Commission on Human Rights, Report No. 29/01, Case 12.249 (2001)***

### **Court and date of decision**

The Inter-American Commission on Human Rights issued an interim order on 29 February 2000. It issued its decision on the admissibility of the complaint on 7 March 2001.<sup>61</sup>

### **Parties**

Jorge Odir Miranda Cortez, president of Atlacatl (the Salvadoran association of people living with HIV), and 26 other people living with HIV filed a petition alleging that the Government of El Salvador had violated their rights under the *American Convention on Human Rights* by failing to provide antiretroviral therapy necessary to prevent death and improve quality of life. The parties were assisted by activists from the Agua Buena Human Rights Association (in Costa Rica) and the Foundation for Studies for the Application of Law.

### **Remedy sought**

The petitioners sought an interim order from the Commission of “precautionary measures” (*medidas cautelares*) aimed at preventing or reversing the infringement of human rights by compelling the Government of El Salvador to provide antiretroviral drugs for people living with HIV on an interim basis while the underlying merits of their claim could be investigated and assessed by the Commission.

### **Outcome**

Without prejudging the merits of the case, the Commission granted the interim order of precautionary measures, requesting that the government provide antiretroviral medications and other necessary medical care to the 27 petitioners pending the determination of the merits of their complaint (which was, at the time, also pending before the Supreme Court of El Salvador). Subsequently, it also issued a decision that the complaint was admissible before the Commission, the preliminary step to consideration of the petition on its merits.<sup>62</sup>

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<sup>61</sup> The full text of the Inter-American Commission’s decision is available online at: [www.cidh.org/annualrep/2000eng/chapteriii/admissible/elsalvador12.249.htm](http://www.cidh.org/annualrep/2000eng/chapteriii/admissible/elsalvador12.249.htm).

<sup>62</sup> Ultimately, if the Commission deems a complaint admissible, it will proceed to investigate and assess the merits, and then produce a report with recommendations, which is privately provided to the State in question with a stated period of time for complying with the recommendations. If the State does not comply within that period, the Commission may either issue a second report which may eventually be made public, or may choose to refer the case to the Inter-American Court of Human Rights. For additional information about the Commission see [www.cidh.oas.org](http://www.cidh.oas.org) and for information about the Court see [www.corteidh.or.ca](http://www.corteidh.or.ca).

## Background and material facts

At the time this case was brought, there were at least an estimated 1500 Salvadorans living with HIV, the majority of whom did not have access to antiretroviral treatment, and only a minority of whom were eligible for medical benefits under the public social security system which itself was not providing access to such medicines. The petitioners had previously initiated *amparo*<sup>63</sup> proceedings in the courts of El Salvador. Although the Supreme Court (Constitutional Division) accepted the petition in June 1999, it delayed in rendering any decision on its merits. This delay frustrated the petitioners' efforts to seek a remedy under domestic legislation; hence the resort to a petition with the Inter-American Commission on Human Rights.

## Legal arguments and issues addressed

The petitioners argued that the state of El Salvador had violated, and continued to violate, their rights to life, humane treatment, equal protection before the law, judicial protection, and economic, social and cultural rights, as recognized in the *American Convention on Human Rights*. In addition, they alleged violation of the 1988 *Protocol of San Salvador* which supplements the Convention. Article 10 of the *Protocol* guarantees the right to enjoy the highest level of health and requires ratifying states to take a variety of measures to realize this right. Finally, they invoked provisions in the *American Declaration of the Rights and Duties of Man* and other human rights instruments. The basis of the complaint was the State's failure to provide them with combination antiretroviral therapy necessary to prevent death and improve quality of life. They further alleged that the failure to provide the necessary treatment constituted discrimination against them based on their HIV-positive status by the Salvadoran Social Security Institute.

In January 2000, activists informed the Commission that 10 of the original 36 members of the group who had initiated the proceedings before the El Salvador courts had died while the court delayed issuing a judgement. On 29 February 2000, as an interim measure, the Inter-American Commission ordered the Salvadoran government to:

...provide medical attention necessary to protect the life and health of Jorge Odir Miranda Cortéz and the other 25 [petitioners]... In particular the Commission solicits that your illustrious government provide antiretroviral medications necessary to avoid the death of the aforementioned persons, as well as hospital attention, other medications and nutritional support which strengthen the immune system and impede the development of illnesses and infections.<sup>64</sup>

The order was valid for 6 months while the legal proceedings continued before the Commission (but presumably was subsequently extended given the date of the eventual decision by the Commission). After further submissions and consideration, on 7 March 2001 the Commission declared the case admissible, noting that almost two years had elapsed since the Salvadoran Supreme Court had received the petition but with no decision yet released.

<sup>63</sup> *Amparo* is a remedy in Latin American civil law systems best described in the terms of a common law system as a "constitutional injunction" – that is, an injunction sought urgently to redress an existing, or prevent an imminent, breach of constitutional rights. It is similar to a writ of habeas corpus known to common law systems, but with a broader application than simply challenging the legality of a person's detention or imprisonment.

<sup>64</sup> Atlacatl & Asociación Agua Buena. "Inter-American Human Rights Commission Orders El Salvador to Provide Antiretroviral Therapy" [media release], 1 March 2000; R Stern. "La Comisión Interamericana de Derechos Humanos Ordena a El Salvador Que Suministre Medicamentos Contra el HIV." *Artículos, Agua Buena Asociación*, 1 March 2000, available at: [www.aguabuena.org/articulos/salvador.html](http://www.aguabuena.org/articulos/salvador.html).

Shortly thereafter, in April 2001, presumably prompted by the Inter-American Commission's criticism, the Supreme Court of Justice of El Salvador issued a ruling on Miranda's *amparo* claim, based on his claims to right to life and to health, ordering the Salvadoran Social Security Institute to provide him with antiretroviral therapy. The complaint before the Inter-American Commission was rendered moot and did not proceed to a hearing on its merits.

## Commentary

The April 2001 decision by the Supreme Court in El Salvador appeared to have been, at least in part, finally taken as a result of the pressure brought to bear by the Inter-American Commission's decision the previous month. In this sense, the activists' resort to litigation before an international human rights tribunal was successful in advancing an already existing human rights claim. It should also be noted that El Salvador's "HIV law" introduced later the same year was no doubt influenced by the rulings of the Commission and the domestic Supreme Court. While several provisions of the legislation appear to breach a variety of human rights, the *Law on the Prevention and Control of the Infection caused by the Human Immunodeficiency Virus* did affirm the right of every person living with HIV and AIDS to "health care, medical, surgical and psychological treatment", as well as counselling and "preventive measures to impede the progress of the infection."<sup>65</sup>

Beyond its relevance to advancing human rights in El Salvador, this case was particularly significant in that it resulted in the first detailed decision by the Inter-American Commission on Human Rights on the question of access to medicines and the human right to health as articulated in the instruments of the inter-American human rights system. As such, it contributed to treatment activism throughout the region, complementing high-profile cases before a number of domestic courts. There had been a handful of previous cases in which the right to health had been considered by the Commission, but in those cases the right to health, and the specific issue of access to medicines, had been but one consideration among several complaints before the Commission and the subject of passing comment only.<sup>66</sup>

The decision in *Odir Miranda et al* was the first case on the issue of access to medications for treating people living with HIV to proceed before any regional human rights mechanism. As such, the Inter-American Commission's decision that the case was admissible, and its interim decision to order precautionary measures even before examining the legal merits of the claim, set a very significant and positive precedent.

<sup>65</sup> *Law on the Prevention and Control of the Infection caused by the Human Immunodeficiency Virus* (Decree No 588, 24 October 2001), Article 5(a).

<sup>66</sup> See also the Ache Tribe Case (1977): Case 1802—Paraguay, in Annual Report of the Inter-American Commission on Human Rights 1977, 20 April 1978, OEA/Ser.L/V/II.43; the Yanomani Tribe Case (1985): Resolution No. 12/85, Case 7615—Brazil, in Annual Report of the Inter-American Commission on Human Rights 1984-1985, 5 March 1985, OEA/Ser.L/V/II.66; and the Cuba Cases (1982)—*Valladares v. Government of Cuba*, in Annual Report of the Inter-American Commission on Human Rights 1981-1982, OEA/Ser.L/V/II.57 (Doc 6, rev 1); *Alemany Pelaez et al. v. Cuba*, Case 4677—Cuba (1981), in Annual Report of the Inter-American Commission on Human Rights 1981-1982, OEA/Ser.L/V/II.54 (Doc 9, rev 1); *Capote Rodriguez et al v Cuba*, Case 4429—Cuba (1981); *Political Prisoners of Combinado del Este Prison v. Cuba*, Case 4402—Cuba (1981), in Annual Report of the Inter-American Commission on Human Rights 1980-1981, OEA/Ser.L/V/II.54 (Doc 9, rev 1).

## South Africa: Intervention by AIDS activist group advances human rights analysis of patents, defends law for affordable medicines

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### ***Pharmaceutical Manufacturers' Association and 41 Others v. President of South Africa and 9 Others, High Court of South Africa, Transvaal Provincial Division, Case No. 4183/98 (2001)***

#### **Court and date of decision**

The High Court was originally expected to deliver its ruling on 18 April 2001. At the start of that session, the parties indicated that they were close to reaching a settlement and requested to meet in chambers with the presiding judge. Following that discussion, the court postponed hearing further argument until the following day. On 19 April 2001, the parties announced to the court that they had reached a settlement.

#### **Parties**

The applicants were the Pharmaceutical Manufacturers' Association of South Africa (an industry association representing patent-holding pharmaceutical companies, largely multinational in their scope of operation), and 38 pharmaceutical companies. The *de facto* respondent was the government of the Republic of South Africa; the named respondents included President Nelson Mandela (no longer in office by the time the case settled), the national Minister of Health, the Speaker of the National Assembly, the Registrar of Patents, the chair of the Medicines Control Council, and the Premier and health minister of the province of Gauteng. The Treatment Action Campaign, a grassroots civil society group fighting for access to treatment and health care for people living with HIV, sought and was granted *amicus curiae* standing permitting it to intervene in the proceeding.<sup>67</sup>

#### **Remedy sought**

The applicants sought a declaration that certain amendments to South African legislation regulating medicines, specifically certain provisions regarding pharmaceutical patents and prices, were unconstitutional and contrary to South Africa's obligations under international law (i.e. the *WTO Agreement on Trade-Related Aspects of Intellectual Property Rights*) and were therefore invalid. The Treatment Action Campaign sought to defend the legislation as valid and in accordance with the government's constitutional obligations, as well as reflecting its obligations under international human rights law.

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<sup>67</sup> For a detailed commentary on the case, from one of the key activists involved in shaping the legal and political strategy, see: M Heywood. Debunking "Conglomo-talk": A Case Study of the *Amicus Curiae* as an Instrument for Advocacy, Investigation and Mobilization. *Law, Democracy & Development* 2002; 2: 133-162. This article, and numerous other Treatment Action Campaign documents related to the case, are also available on the Treatment Action Campaign website at [www.tac.org.za](http://www.tac.org.za) (in the "Documents" section under "Medicines Act Course Case"). The discussion here draws heavily on Heywood's analysis.

## Outcome

The case was ultimately settled by an agreement between the Pharmaceutical Manufacturers' Association and the South African government. (As an intervener, and not a full party to the proceeding, the Treatment Action Campaign was not a party to the settlement.) In the settlement, the Pharmaceutical Manufacturers' Association agreed to withdraw its court action and the government reiterated its intention to honour its obligations under the WTO Agreement. (The government had insisted that the legislation being challenged by the applicant was consistent with the WTO Agreement, and this was the nearly universal consensus of all informed observers; the settlement, therefore, largely amounted to a simple withdrawal by the applicant of its action.) The government also promised to consult with the patented pharmaceutical industry in drafting the regulations that were to follow under the Act once it came into force, something that would have been standard practice in any event.

## Background and material facts

In line with its obligations under the new, post-apartheid Constitution, the national government had taken a variety of measures in the 1990s related to health and pharmaceutical policy aimed at improving access to health-care services and ensuring more equitable access in South Africa.

On 31 October 1997, the National Assembly passed the Medicines and Related Substances Control Amendment Act, No. 90 of 1997 (commonly referred to as the "Medicines Act"). The Act was approved by the provinces and signed by President Nelson Mandela in November 1997. As the name suggests, this legislation amended the 1965 Medicines and Related Substances Control Act to introduce a range of measures aimed at making medicines more affordable.

Some aspects of the legislation were strongly opposed by the patented pharmaceutical industry. On 18 February 1998, the Pharmaceutical Manufacturers' Association and forty multinational drug companies filed a Notice of Motion and Founding Affidavit with the Pretoria High Court. They sought an order declaring certain sections of the Act unconstitutional, on the basis that it infringed their property rights which are protected under the Constitution. It also requested an interim order prohibiting the President and Minister of Health from bringing specific sections into force. As a result of this court action, and numerous other developments, the implementation of the Act was delayed for several years. The applicant did not proceed quickly with prosecuting its case; it focused instead on bringing political pressure to bear to block implementation of the legislation. The case increasingly attracted attention, not just in South Africa but around the world.<sup>68</sup>

In the months following the filing of its court papers, the pharmaceutical industry successfully lobbied to have the US Trade Representative place South Africa on the American government's annual list of countries which, in its view, do not adequately protect the intellectual property of US companies and may be subject to potential trade retaliation. This move attracted vocal, ongoing criticism from HIV and AIDS activists, especially in the US where activists dogged the US Vice-president during his election campaign the following year, criti-

<sup>68</sup> See: A Gray A et al. *Analysis of the Drug Policy Process in South Africa, 1989-2000*. Center for Health Policy University of the Witwatersrand, May 2001; P Bond. Globalization, Pharmaceutical Pricing and South African Health Policy: Managing Confrontation with US Firms and Politicians. *International Journal of Health Services*, 1999; 4: 765-792.

cizing his administration for threatening South Africa over a law that would increase access to medicines in a country facing an exploding HIV epidemic. As a result of this activism, then US President Bill Clinton signed an “Executive Order” recognizing the rights of African countries to enact legislation, without US interference, that complies with the WTO *Agreement on Trade-Related Aspects of International Property Rights* and seeks to improve access to medicines.

During this same time, the Treatment Action Campaign was launched on 10 December 1998 (International Human Rights Day). Over the coming years, the Campaign organized numerous demonstrations demanding the applicants withdraw their case, while simultaneously forging links with treatment activist allies around the world. That collaboration proved crucial in mobilizing when the matter finally came back before the courts in 2001.

In 2000, to raise awareness about the patent and pricing barriers to more affordable medicines for South Africans living with HIV, the Treatment Action Campaign undertook a targeted campaign in which it challenged Pfizer Inc. to reduce the price of its anti-fungal medicine fluconazole (under patent in South Africa and marketed under the trade name Diflucan). The Treatment Action Campaign attracted widespread attention when its chairperson illegally imported 5000 tablets of generic, bioequivalent fluconazole from a Thai manufacturer, available for a small fraction of the price being charged in South Africa by Pfizer. Treatment Action Campaign organized a press conference to announce it was beginning a “defiance campaign” against the pharmaceutical industry that it accused of abusing patents by engaging in excessive pricing. Treatment Action Campaign challenged the industry and the government to take legal action against them for breaking patent laws. These tactics, and the attention they garnered, helped raise the profile of the issue of drug patents and their impact on access to affordable medicines in South Africa, which in turn set the stage for the subsequent showdown over the Pharmaceutical Manufacturers’ Association’s outstanding legal proceedings against the Medicines Act amendments. More immediately, the pressure Treatment Action Campaign brought to bear through the defiance campaign was critical to Pfizer’s eventual decision to donate Diflucan for use in the South African public sector of the health system by people with certain AIDS-related opportunistic infections.

Meanwhile, the Pharmaceutical Manufacturers’ Association action in the courts had been stalled since 1998, as was any action by the government to bring the Medicines Act amendments into force. The government, lacking the capacity to respond in a timely manner to the filings from the Pharmaceutical Manufacturer’s Association, requested postponements. As a result, the legislation enacted by the National Assembly and signed into law by the President was not brought into force.

On 10 November 2000, the Pharmaceutical Manufacturers’ Association finally set the matter down, with the hearing scheduled for March 2001. On 11 January 2001, a Pharmaceutical Manufacturers’ Association official informed the Treatment Action Campaign of the dates. The Campaign decided to apply for the Court’s permission to intervene as an *amicus curiae* (“friend of the court”) to advance arguments based on the human or constitutional rights of South Africans living with HIV that were being undermined by the failure to implement the legislation’s measures to reduce the price of medicines. To focus international attention on the matter, and to draw attention to the upcoming court dates at which the Pharmaceutical Manufacturers Association intended to press its case to block the legislation, the Campaign held a press conference on 16 January 2001 to announce that it would seek to intervene in the case. It also launched an international campaign calling on the Pharmaceutical Manufacturers Association to abandon

its challenge to the legislation. On 6 March 2001, the day after various cities around the world witnessed press conferences and demonstrations against the pharmaceutical companies, the High Court granted *amicus* standing to the Campaign. It postponed the hearing until 18 April 2001 to allow the Campaign time to file its argument and related material, and time for the Pharmaceutical Manufacturers Association and the government to file their responses.

## Legal arguments and issues addressed

### *Pharmaceutical companies' complaints about the legislation*

The Pharmaceutical Manufacturers' Association alleged legal deficiencies with almost every part of the legislation. However, in the end, the focus of the debate centred on four key measures aimed at making medicines more affordable.

First, much was made of the issue of *compulsory licensing*, the practice of overriding a patent to give someone other than the patent holder (e.g. a generic drug company) the legal authorization to also make or import the patented medicine without being liable for patent infringement. It is important to note, contrary to much of the media coverage about the case, that the issue of compulsory licensing was not really raised by the disputed legislation itself. Rather, the *Patent Act* already included provisions for compulsory licensing of patented medicines. This was not a new feature introduced into South African law by the *Medicines Act* amendments, nor was it being challenged by the Pharmaceutical Manufacturers' Association in this proceeding. Not surprisingly, however, the broader political debate over patents and access to cheaper generic medicines that was sparked by this court case (and the Treatment Action "defiance campaign" of infringing Pfizer's patent on fluconazole) often included reference to compulsory licensing, an important mechanism for bringing down medicine prices by introducing competition from generic drug companies into the marketplace. But strictly speaking, compulsory licensing was not at issue in the legal proceeding, nor was it a focus of Treatment Action Campaign's intervention in the proceeding.

Second, the new Medicines Act (section 15C) did allow for *parallel importation*, namely the importation of a patented medicine into South Africa by someone other than the patent holder, after the product has been put on the market in another country by the patent holder or with its consent. In other words, parallel importation allows the purchaser to take advantage of the drug company charging a cheaper price for the medicine in another country. Parallel importation does not involve access to generic versions of the medicine; it simply means shopping around for the best world price offered by the manufacturer of the patented brand-name drug.

Third, the new Medicines Act (section 22F) provided for *generic substitution*—the practice of mandating pharmacists to substitute, where available, an equivalent but cheaper generic medicine for the brand-name product prescribed by a physician. The legislation stated that generic substitution would not be done if the physician had expressly indicated that no substitution is to be made.

Finally, the new Medicines Act (section 22G) authorized the Minister of Health to make regulations on a *transparent pricing system* with a *single exit price* which "shall be the only price at which manufacturers shall sell medicines... to any person other than the State" (i.e., in the private sector). In other words, the legislation enabled the creation of a scheme of direct price control on medicines.

In challenging these provisions, the Pharmaceutical Manufacturers' Association focused its arguments on the right to property clause in the Constitution (section 25), which states: "No one may be deprived of the right to property except in terms of law of general application, and no law may permit arbitrary deprivation of property." The Pharmaceutical Manufacturers' Association also argued that Act was in contravention of South Africa's obligations under the World Trade Organizations' *Agreement on Trade-Related Aspects of Intellectual Property Rights*.

*The Treatment Action Campaign's intervention*

The Treatment Action Campaign's purpose in intervening in the case was to defend the human rights of South Africans needing more affordable medicines, a perspective that had not been put forward by the government in its defence of the legislation. In addition to filing additional evidence challenging the Pharmaceutical Association's characterization of the legislation and its implications for South Africa, the Campaign also drew upon the South African Constitution, jurisprudence from other jurisdictions, and international human rights law in defending the Medicines Act sections challenged by the applicant.

Treatment Action Campaign focused on making the case as to why the three measures of parallel importation, generic substitution and the pricing system, were needed and defensible:

TAC's main arguments were that access to health is a human right that trumps rights to private property—particularly when these rights are being abused. Specifically, TAC argued that patented antiretroviral medicines (needed by millions in Africa) bear out the main contentions of the Respondents: that patents were being used to gouge prices. Some of the measures in the Act, specifically section 15C [parallel importation], could be used to bring down prices of patented medicines. However, as important to TAC's argument was the impact that S22F (the requirement for generic substitution of off-patent medicines) would have on making medicines that treat and prevent opportunistic infections more affordable—as well as the potential benefits for the health system as a whole.<sup>69</sup>

[...]

The TAC's legal argument was that none of the three contested clauses were unconstitutional. Indeed, TAC argued that they were dictated by a positive duty on the Government to "progressively realize" rights of access to health care services<sup>70</sup> and to protect rights such as dignity,<sup>71</sup> life,<sup>72</sup> equality<sup>73</sup> and the duty to act in the best interests of the child<sup>74</sup>—rights which are dependent on measures to improve socioeconomic conditions.<sup>75</sup> Poor people, the TAC alleged, were: "directly dependent on the State's ability to fulfil its constitutional duty to bring about the progressive realization of their rights of access to health care services."<sup>76</sup>

<sup>69</sup> M Heywood. Debunking "Conglomo-talk": A Case Study of the *Amicus Curiae* as an Instrument for Advocacy, Investigation and Mobilization. *Law, Democracy & Development* 2001; 5(2): 133. The text of this paper, originally presented at *Health, Law and Human Rights: Exploring the Connections – An International Cross-Disciplinary Conference Honoring Jonathan M. Mann*, Philadelphia, PA, 29 Sept – 1 Oct 2001, is available on the ALP website at [www.alp.org.za](http://www.alp.org.za) (under the topic "Access to treatment").

<sup>70</sup> Constitution of the Republic of South Africa, section 27.

<sup>71</sup> *Ibid.*, s. 10.

<sup>72</sup> *Ibid.*, s. 11.

<sup>73</sup> *Ibid.*, s. 9.

<sup>74</sup> *Ibid.*, s. 28.

<sup>75</sup> In this line of argument Treatment Action Campaign can claim support of the President of the Constitutional Court: "... how can there be dignity in a life lived without access to housing, health care, food, water or in the case of persons unable to support themselves, without appropriate assistance? But social and economic policies are preeminently policy matters that are the concern of government. In formulating such policies the government has to consider not only the rights of individuals to live with dignity, but also the general interests of the community concerning the application of resources. Individualized justice may have to give way here to the general interests of the community." See: Arthur Chaskalson, Human Dignity as a Foundational Value of Our Constitutional Order, The Third Bram Fischer Lecture, *SA Journal on Human Rights*, 2000 (16) , 193-205.

<sup>76</sup> Heywood, *supra*, citing Treatment Action Campaign's founding affidavit (para 13).

In the alternative, even if some aspects of the Act were found to be an unconstitutional infringement of property rights, Treatment Action Campaign argued that

under South Africa's constitution certain rights may be limited as long as the infringements are "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom" [section 36 of the Constitution]. . TAC argued that should any of the Act's measures be found to limit property rights, these could be justified on the grounds of the government's obligations to improve access to health care services, as well as other duties arising from international treaties.

The reference was to international treaties on human rights ratified by South Africa and imposing binding legal obligations upon the state. Treatment Action Campaign also disputed the Pharmaceutical Manufacturers' Association suggestion that the legislation was in violation of South Africa's treaty obligations under the WTO's *Agreement on Trade-Related Aspects of Intellectual Property Rights*. The Agreement (Article 6) makes it clear that countries are free to permit parallel importation under their domestic law. Nor does it prohibit generic substitution policies or regulation of pharmaceutical prices. Treatment Action Campaign submitted evidence and argument showing that such policies are common practice in many countries, including industrialized ones.

Treatment Action Campaign also sought to use the opportunity of its intervention in the case to raise a more fundamental challenge to the case being put forward both in the court papers and to the public at large. As explained by Heywood:

Finally the TAC provocatively attacked one of the main tenets of the PMA's legal and media case: that the Act was a violation of intellectual property rights that would rob private investors of just rewards for invention and research, and thereby undermine preconditions for future research into disease and medicine. [As stated in TAC's filed affidavit:]

The research and development costs borne by the applicants have been recouped many times over. The Amicus Applicant has on a number of occasions challenged, for example, Glaxo Wellcome, one of the applicants, and Pfizer, a member of the First Applicant to state what its R&D costs are in relation to antiretroviral and other drugs. The information was never provided.

The Founding Affidavit listed a number of medicines essential for the treatment of HIV and its opportunistic infections, and tempted the PMA bear to come out of its lair and do battle on where they originated from, and how much public and private money was invested in them. They did just that.<sup>77</sup>

## Commentary

The Treatment Action Campaign employed a number of strategies that revealed the important and powerful human dimensions of the legal issues being addressed. Campaign representatives explained that their objective "was to turn a dry legal contest into a matter about human lives—this was important for education of the Court, as well as for public opinion."<sup>78</sup> By filing a wide range of affidavits describing personal experiences of people living with HIV and physicians struggling in the face of medicines priced out of reach, they were able to argue

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<sup>77</sup> Heywood, *supra*.

<sup>78</sup> *Ibid*.

effectively against the abstract legal arguments presented by the Pharmaceutical Manufacturers' Association. This strategy succeeded and added critical persuasive dimensions to the case.

Through collaboration with the Congress of South African Trade Unions, the country's largest trade union federation with nearly two million members, the Campaign enhanced its ability to mobilize thousands for demonstrations at key moments and in locations across the country. In addition, given the historic partnership between the African National Congress and the Congress of Trade Unions, this increased pressure on the African National Congress government. Through regular exchange of information and the cultivation of relationships with AIDS activists and nongovernmental organizations in many countries, the Campaign benefited from global support in its campaigning, from demonstrations targeting the pharmaceutical companies at their global headquarters to a "drop the case" petition initiated by Médecins Sans Frontières and signed by over 250 000 individuals worldwide.

According to Mark Heywood of the Treatment Action Campaign and the AIDS Law Project, the two organizations that spearheaded the amicus intervention and the related political mobilization, the Campaign's involvement in the proceedings and its campaigning succeeded on multiple fronts.

A three-year legal battle had dissolved, freeing the government to implement the Act. Internationally, the intense focus on medicines, prices, patents and rights to health greatly broadened the support-base of an incipient movement that seeks to treat health as a human right and to promote the idea that commodities such as medicines, that are essential for health, should be treated differently under patent law to commodities that do not have any intrinsic link to human dignity and well-being. This conviction undoubtedly had an impact on the negotiations around TRIPS which took place at the World Trade Organization's (WTO) Ministerial Conference in Doha in November 2001. The Declaration on TRIPS (which recognizes that "Each member has the right to grant compulsory licences") reflects the greater confidence of developing countries to defend rights to health against incursions by multi-national companies based on their interpretation of trade rules.<sup>79</sup>

The efforts by the Campaign had significant repercussions at the national level as well, such as mobilizing civil society to demand socioeconomic rights, pressuring the pharmaceutical companies to lower prices for antiretroviral drugs, and holding out the promise that implementation of the Act's provisions could lead to further price reductions. As Heywood explains, it also led to the important statement under oath by government representatives that affordability was the sole barrier to the use of antiretrovirals. Such a statement meant that it would be difficult for the government to resist calls for implementing access to antiretroviral treatment nationwide if activists could succeed in significantly reducing their cost.

Notwithstanding that this case never resulted in a judgement, it had an enormous impact in South Africa and elsewhere. Buoyed by this victory, the Treatment Action Campaign pressed on to others—including subsequent litigation against the government and pharmaceutical companies. Two such examples are further described below—the court case compelling the government to make the antiretroviral drug nevirapine accessible to pregnant women to reduce mother-to-child transmission of HIV and the use of competition law to compel two companies to licence their drugs to generic manufacturers.

<sup>79</sup> Declaration on the TRIPS Agreement and Public Health, Ministerial Conference, Fourth Session, (WT/MIN(01)/DEC/W/2)

# Argentina: Court orders Ministry of Health to take steps to ensure uninterrupted supply of antiretroviral medicines

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## **AV & CM v. Ministerio de Salud de la Nación, Federal Civil & Commercial Court (No. 7), 26 April 2002**

### **Court and date of decision**

The judgement of the Federal Civil & Commercial Court (No. 7) was issued on 26 April 2002.

### **Parties**

Two people living with HIV and AIDS, Ms. AV and Mr. CM, brought an application in their own right and on behalf of all persons in the same situation. They were represented by the Centre for Legal and Social Studies (Centro de Estudios Legales y Sociales). The application was brought against the national Ministry of Health.

### **Remedy sought**

The two representative petitioners brought an *acción de amparo* in which they requested a court order of “protective measures” (“medidas cautelares”) on behalf of all people living with HIV who receive antiretrovirals from the AIDS Programme of the national Ministry of Health. The protective measure they sought was a court order requiring the government to take immediate steps to ensure that the AIDS Programme could guarantee an uninterrupted supply of the medicines.

### **Outcome**

The Supreme Court granted the order sought by the petitioners the same day the application was filed.

### **Background and material facts**

This case arose against the backdrop of previous litigation aimed at securing access to treatment for people living with HIV. In 1996, eight Argentinean nongovernmental organizations brought an *amparo* action against the National Ministry of Health and Social Welfare for its failure to supply medicines to people living with HIV and AIDS. Within three days, the court ordered the Ministry to provide the medication.<sup>80</sup> In early 1998, nongovernmental organizations brought a second *amparo* proceeding on behalf of numerous people living with HIV against both the Ministry and the social security system (which cover medical care for different segments of the population) for failure to supply antiretrovirals. Both the court of first instance and the appellate court granted the request and ordered that authorities provide medicines in a

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<sup>80</sup> M Bianco et al. Human rights and access to treatment for HIV/AIDS in Argentina. Series of Case Studies on Human Rights. Latin American & Caribbean Council of AIDS Service Organizations (LACCASO), 1999, p. 15.

timely and uninterrupted fashion to people living with HIV eligible for coverage under these programs. These two decisions were affirmed by the Supreme Court of Justice in February 1999.<sup>81</sup>

Notwithstanding these orders, difficulties in accessing medicines continued for people living with HIV, prompting further resort to the courts. On 1 June 2000, the Supreme Court of Justice upheld lower court decisions in yet another *amparo* proceeding brought by a coalition of nongovernmental organizations responding to AIDS.<sup>82</sup> The Supreme Court ordered the Minister of Health to ensure a regular, timely and uninterrupted supply of medications to people living with HIV through the public health system, as required to give effect to the right to health, described as part of the right to life. The right was expressly recognized in the national constitution, in the national law on AIDS, and in the *Universal Declaration of Human Rights*, the *American Declaration of the Rights and Duties of Man*, and the *International Covenant on Economic, Social and Cultural Rights*. The Supreme Court rejected the government's argument that the lower courts had overstepped their authority by treading on the power of the executive to make budgetary decisions.

However, a series of administrative obstacles, including the failure of the Ministry to act in a timely fashion in acquiring medicines and a dispute over the costs, led to the stock being depleted, with consequent interruption in the supply to patients. In 2002, the matter was brought before the courts yet again, via this urgent application to protect the constitutional rights of people with HIV needing medicines.

## Legal arguments and issues addressed

The Federal Civil & Commercial Court, a court of first instance, noted the earlier June 2000 judgement (in *Asociación Benghalensis*) in which the Supreme Court had granted the applicants' request that the government ensure an uninterrupted supply of antiretroviral drugs. It stated that delay by the government agencies responsible was unjustifiable when the health and lives of people were at stake. Therefore, the judge ordered the Ministry of Health to immediately provide the prescribed efavirenz (EFV), stavudine (d4T) and lamivudine (3TC) to the two petitioners. On the same basis, with respect to other people living with HIV whose interests were represented in the collective *amparo* action, the court ordered the Ministry to take the necessary steps within two days to ensure a regular and uninterrupted supply of medicines for the treatment of HIV.

## Commentary

The case was one in a string of decisions in which people living with HIV have been successful in obtaining court orders directing the government to take positive steps to secure access to treatment with antiretroviral drugs. However, the experience in Argentina, as in several other countries, underlines the point that legal victories, while necessary, were not sufficient to protect and fulfil the right to enjoy the highest attainable standard of health. As long as governments were unable or unwilling to dedicate the necessary resources, or to address systemic problems in the administration of programs, judicial pronouncements endorsing the human rights of people living with HIV would not produce needed action. Court proceedings

<sup>81</sup> Ibid.

<sup>82</sup> *Asociación Benghalensis y otros v. Ministerio de Salud y Acción Social*, Supreme Court of Justice of Argentina, Fallos 323:1339 (1 June 2000), available at <http://cuadernos.bioetica.org/fallos12.htm>.

can provide a focus for broader advocacy efforts, and if successful can provide a major boost if used strategically. However, without complementary human rights activism and a culture of respect for rights and the rule of law, judgements will simply remain theoretical victories.

In July 2003, the Argentinean Network of People Living with HIV/AIDS issued a short report documenting ongoing inadequacies with access to HIV testing and treatment in Argentina, including interruptions in the supply of medications, concerns about the quality of medicines provided, inadequate facilities and supplies for HIV diagnostic testing as well as testing viral load and CD4 counts. Based on this information, the Centre for Legal and Social Studies initiated another proceeding before the courts, which ordered the Ministry of Health to urgently comply with the previous order to regularize access to medicines, failing which it would be fined US\$ 1000 per day (with the funds to be directed to implementing the national AIDS plan) and could face possible criminal charges for disregarding the court's order.<sup>83</sup> The court described the State's attitude as an "illegal and arbitrary threat to the right to life and to preservation of health". It also explicitly rejected the State's argument that there was a fiscal emergency, saying that "public health could not be subjected to the vicissitudes of the market or to the wait for an improvement in the country's economy."<sup>84</sup> Subsequently, an investigation into possible contempt of court charges was launched.<sup>85</sup>

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<sup>83</sup> "Intiman al Ministerio de Salud a regularizar la entrega de medicamentos contra el VIH/SIDA." *Boletín CELS: Derechos Humanos Argentina* August 2003; 1(1), available via [www.cels.org.ar](http://www.cels.org.ar).

<sup>84</sup> CELS. "Condenan al Ministerio de Salud por no garantizar el tratamiento de las personas que viven con HIV," summary dated 15 March 2004, available via [www.cels.org.ar](http://www.cels.org.ar).

<sup>85</sup> *Ibid.*

# South Africa: Court orders government to implement plan for antiretroviral drugs to reduce mother-to-child transmission of HIV

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## ***Minister of Health and others v. Treatment Action Campaign and others, Constitutional Court of South Africa, CCT 8/02 (2002)***

### **Court and date of decision**

The Constitutional Court issued its judgement on 5 July 2002. This was an appeal from an earlier judgement of the High Court (in Pretoria).

### **Parties**

The original applicants (respondents at the Constitutional Court) were the Treatment Action Campaign, the Children's Rights Centre, and a physician (Dr. Haroon Saloojee). The original respondents (appellants before the Constitutional Court) were the national Minister of Health and the provincial ministers of health from each province (except the Western Cape Province). There were also three interveners in the case: the Institute for Democracy in South Africa, the Community Law Centre, and Cotlands Baby Sanctuary.

### **Remedy sought**

Treatment Action Campaign and the other applicants sought a court order compelling the government to ensure access to the antiretroviral drug nevirapine for all pregnant women with HIV in South Africa, so as to reduce the risk of mother-to-child transmission of HIV.

### **Outcome**

The High Court granted the Treatment Action Campaign's request. The government appealed that decision. The Constitutional Court dismissed the government's appeal. It ordered the South African government to make the antiretroviral drug nevirapine available in public hospitals and clinics for the purposes of preventing mother-to-child transmission of HIV. The Court also ruled the government had a constitutional obligation to implement a programme to realize the right of pregnant women and their newborn children to access health services to prevent transmission.

### **Background and material facts<sup>86</sup>**

The South African government had chosen not to roll out a national programme to reduce the risk of transmission of HIV from mother to child. Instead, it had identified two sites per province that were to participate in a study that would test various aspects of the program. It

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<sup>86</sup>This summary and the commentary below are marginally adapted from the following original text: L Gerntholtz. South Africa: Highest Court Orders Government to Provide Antiretrovirals to Prevent Mother-to-Child Transmission. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 50-52 (available via [www.aidslaw.ca](http://www.aidslaw.ca)).

also declined to make the antiretroviral drug nevirapine available to sites that did not fall within the study and prohibited hospitals outside the pilot sites from prescribing and administering nevirapine to mothers with HIV.

After four years of lobbying, advocacy and public mobilization, the Treatment Action Campaign and other applicants brought their application to the High Court in Pretoria in August 2001, seeking to compel the government to ensure access to nevirapine for all HIV-positive pregnant women and their newborn children. In December 2001, the High Court ruled in the Campaign's favour.<sup>87</sup> The government appealed to the Constitutional Court.

## Legal arguments and issues addressed

The judgement concentrated in particular on two constitutional rights of South Africans: the right to access health-care services, including reproductive health care (section 27), and children's right to basic health-care services (section 28).

### *Section 27: Right to Access Health-Care Services*

The court found that there was no need to consider whether socioeconomic rights are enforceable, as "clearly they are."<sup>88</sup> Therefore, the question before the court was whether Treatment Action Campaign had demonstrated that the programme adopted by the government to "provide access to health-care services for HIV-positive mothers and their newborn babies fall[s] short of its obligations under the Constitution."<sup>89</sup> The court reduced the issues between the Treatment Action Campaign and the government to two key issues—namely, whether it was reasonable for the government to restrict nevirapine to the pilot sites, and whether the government had in fact a "comprehensive policy for the prevention of mother-to-child transmission."<sup>90</sup>

The government advanced four reasons for its refusal to allow nevirapine to be prescribed outside the pilot sites:

- (i) concerns about the *efficacy* of nevirapine where the so-called comprehensive package of care provided at the pilot sites was not available;
- (ii) the question of whether the provision of the single dose of nevirapine to mother and child would lead to *resistance* to nevirapine and other antiretrovirals at a later stage;
- (iii) the *safety* of the drug itself; and
- (iv) whether *capacity* existed in the public sector to provide the full package of care.

The court dealt carefully and comprehensively with each of these issues. Dealing first with the question of *efficacy*, the court found unequivocally that it was clear "from the evidence that the provision of nevirapine will save the lives of a significant number of infants even if it is administered without the full package and support services that are available at the research and training sites."<sup>91</sup> The court went so far as to state that even where mothers did not have access to breast milk substitutes (which are provided at the pilot sites) or elected to breastfeed, the benefits of nevirapine were not lost.<sup>92</sup>

<sup>87</sup> High Court of South Africa (Transvaal Provincial Division), Case No. 21182/2001, 14 December 2001. The court papers and the judgement are available online at [www.tac.org.za](http://www.tac.org.za), and a summary can be found at: L Gerntholtz. Preventing mother-to-child transmission: landmark decision by South African court. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 1, 20-24.

<sup>88</sup> Judgement, para. 25.

<sup>89</sup> *Ibid.*

<sup>90</sup> *Ibid.*, para. 47.

<sup>91</sup> *Ibid.*, para. 57.

<sup>92</sup> *Ibid.*, para 58.

The court also rejected the argument concerning drug *resistance*, saying that this risk was well worth taking, given the alternative of suffering and death because of HIV infection. On the evidence, the court also found that concerns about the *safety* of the drug were no more than hypothetical, with the drug recommended without qualification by the World Health Organization for the purpose of preventing mother-to-child transmission and registered for this purpose by the South African Medicines Control Council.

With respect to the question of *capacity*, the court acknowledged that limited resources and a lack of adequately trained personnel were relevant to government's ability to make a "full package" of care available throughout the public sector. However, this was not relevant to the question of whether nevirapine should be used at public hospitals and clinics outside the research sites, where the necessary testing and counselling facilities existed.

The court then considered whether the policy of confining nevirapine to the pilot sites was reasonable. It found that the policy

fails to address the needs of mothers and their newborn children who do not have access to these sites. It fails to distinguish between the evaluation of programmes for reducing mother-to-child transmission and the need to provide access to health-care services required by those who do not have access to the sites.<sup>93</sup>

The court examined the decision not to provide nevirapine outside the pilot sites against the criteria developed in its earlier *Grootboom* decision,<sup>94</sup> and found that the policy failed to deal with the needs of those who were most in need, was "an inflexible one,"<sup>95</sup> and was in breach of section 27(2) of the Constitution.

The court then examined whether a comprehensive plan existed to combat mother-to-child transmission of HIV. It found that these issues were closely related to the policy to prohibit the prescription of nevirapine outside the pilot sites. It carefully examined all the evidence presented by both the applicants and the respondents, and concluded that the full package of treatment for the prevention of mother-to-child transmission provided at all pilot sites included: counselling and testing; nevirapine, where medically indicated; the provision of formula feed as a substitute for breastfeeding; and aftercare, including the provision of vitamins and antibiotics and monitoring of the progress of the children. At all public hospitals other than the pilot sites, nevirapine would not be available. However, the court found that evidence showed that many public facilities already had programmes in place to provide testing and counselling, including counselling on feeding options. Some of these facilities also provided formula feed, although many did not.

The court found that the program, as it was, did not meet the constitutional standard, as it again failed to include "those who could be reasonably included where such treatment is medically indicated to combat mother-to-child transmission of HIV."<sup>96</sup>

The government had argued vehemently that the court had no power to make an order that would have the effect of requiring it to pursue a particular policy. To do so would effectively undermine the doctrine of separation of powers, a fundamental concern of a consti-

<sup>93</sup> *Ibid.*, para. 67.

<sup>94</sup> *Government of the Republic of South Africa and others v. Grootboom and others*, 2001 (1) SA 46 CC; 2000 (11) BCLR 1169 (CC).

<sup>95</sup> Judgment, para. 80.

<sup>96</sup> *Ibid.*, para. 125.

tutional democracy. In dealing with this argument, the court found that “although there are no bright lines that separate the roles of the legislature, the executive and the courts from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not the others.”<sup>97</sup> However, this did not preclude the court from making a decision that would have an impact on policy.

*Section 28: Children’s Right to Basic Health-Care Services*

The court did not deal with the rights of children in much detail in the judgement. However, it did retreat somewhat from the position advanced in the *Grootboom* decision, where the court had ruled that the obligation to provide health care to children rested primarily on their parents and not on the State. In this case, the court found that the State does have an obligation to children being cared for by family, but left the question open as to the exact nature and extent of the obligation.

*Court’s order*

The court ordered the government to immediately remove all restrictions on the provision of nevirapine in hospitals that fell outside the pilot sites and to devise a comprehensive programme to reduce the risk of mother-to-child transmission of HIV.

## Commentary

The Constitutional Court’s eagerly anticipated judgement was handed down in early July 2002, on the eve of the XIVth International Conference on AIDS in Barcelona, and drew considerable attention from media and civil society worldwide. Unusually, the judgement was delivered unanimously by the eleven judges rather than ascribed to any particular justice, a mark of the seriousness with which the highest court in South Africa viewed this case. Indeed, *TAC v. Minister of Health* has become one of the world’s leading cases on the justiciability of the right to health. Treatment activists had hoped this decision would prove to be the final judgement in this matter between the national Minister of Health and the Treatment Action Campaign, with no further litigation needed on this front to secure at least this form of HIV treatment. However, while certain provinces did significantly increase access to nevirapine, many did not. After the legal victory, many women were still unable to take steps to ensure that their children were protected from HIV infection, and many children continued to be infected. Several months after the decision, Treatment Action Campaign met with the Deputy President of South Africa to discuss the development and implementation of a national plan for prevention of mother-to-child transmission, pursuant to the court order. But the relationship between treatment activists and the government remains strained, and there have been threats of further legal proceedings to compel government action on improving treatment access.

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<sup>97</sup> *Ibid.*, para. 98.

## South Africa: AIDS activist group uses competition law to challenge pricing by pharmaceutical company, forces settlement leading to voluntary licences on patented antiretrovirals

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### ***Hazel Tau & Others v. GlaxoSmithKline and Boehringer Ingelheim, Competition Commission of South Africa (2003)***

#### **Court and date of decision**

The proceeding took the form of a complaint to the Competition Commission of South Africa, filed in September 2002, alleging excessive pricing in South Africa of four antiretroviral medicines by the pharmaceutical companies GlaxoSmithKline and Boehringer Ingelheim. On 16 October 2003, after completing its investigation into the complaint, the Commission issued its (non-binding) conclusions and decided to refer the complaint to the Competition Tribunal for a hearing and a binding ruling. To avoid such an outcome, the respondents settled shortly thereafter.<sup>98</sup>

#### **Parties**

The original complainants were eight individuals (four people living with HIV, a nurse, and three physicians), the Treatment Action Campaign, the Congress of South African Trade Unions, and the Chemical, Energy, Paper, Printing, Wood and Allied Workers Union. In February 2003, two additional complainants were added: the national AIDS Consortium and a Treatment Action Campaign volunteer who subsequently died of an AIDS-related illness in June 2003.

The respondents were the multinational pharmaceutical companies GlaxoSmithKline and Boehringer Ingelheim. Specifically, the respondents included: GlaxoSmithKline South Africa (Pty) Ltd. (the South African representative of the GlaxoSmithKline group of companies, with the exclusive right to market certain patented antiretrovirals in South Africa); the Glaxo Group Ltd. (a group of pharmaceutical companies headquartered in the United Kingdom); Boehringer Ingelheim (Pty) Ltd. (the South African operation of the CH Boehringer Group, a group of pharmaceutical companies headquartered in Germany, with the exclusive right to market the patented antiretroviral nevirapine in South Africa); Ingelheim Pharmaceuticals (Pty)

<sup>98</sup> Competition Commission of South Africa. Media Release (No. 29 of 2003): Competition Commission finds pharmaceutical firms in contravention of the Competition Act, 16 October 2003, available via [www.compcom.co.za](http://www.compcom.co.za). For most of the official documentation submitted to the Competition Commission in the case, see the website of the Treatment Action Campaign at [www.tac.org.za](http://www.tac.org.za) (on the "Documents" page, look under "Competition Commission Complaint against GlaxoSmithKline and Boehringer Ingelheim"). For a comprehensive discussion of this case, and the political context within which it formed part of the ongoing treatment activism in South Africa, see: AIDS Law Project & Treatment Action Campaign. *The Price of Life: Hazel Tau and Others vs GlaxoSmithKline and Boehringer Ingelheim*. Johannesburg: ALP, 2002 (available online via [www.alp.org.za](http://www.alp.org.za)).

Ltd (another South African company, holding the registration for nevirapine with the national Medicines Control Council); and Boehringer-Ingelheim International GMBH.

## Remedy sought

The applicants requested that, after investigation, the Commission refer the complaint to the Competition Tribunal, with a recommendation that the Tribunal exercise its statutory powers to:

- order the respondents to stop their excessive pricing practices;
- declare the respondents' conduct to be a "prohibited practice" that would found a claim for damages by all persons who could establish they had suffered loss or damage as a result of the practice; and
- order an administrative penalty of 10% of the firm's annual turnover in South Africa and from exports during the preceding financial year.

## Outcome

On 16 October 2003, the Competition Commission announced that it had decided to refer the complaint to the Competition Tribunal for a hearing. The Commission concluded, after its investigation, that GlaxoSmithKline and Boehringer Ingelheim had contravened the *Competition Act* by engaging in excessive pricing to the detriment of consumers, denying a competitor access to an essential facility, and engaging in an exclusionary act. The Commission's decision prompted a settlement between the complainants and the respondent companies, under which GlaxoSmithKline and Boehringer Ingelheim agreed to grant voluntary licences on their patented medicines in exchange for a royalty.

It should also be noted that, in September 2003, shortly before the Commission released its decision, the Treatment Action Campaign's Treatment project and the Generic Antiretroviral Procurement Project asked the company Boehringer Ingelheim for voluntary licences to import generic nevirapine; if these were not forthcoming, the two projects planned to apply to the Commissioner of Patents for compulsory licences. The subsequent Commission decision, strengthening the case for a compulsory licence, placed further pressure on Boehringer Ingelheim to settle the matter before matters reached that stage and that possible outcome.

## Background and material facts

South Africa is among the countries hardest hit by HIV, with several million people living with HIV and the disease ranking among the leading causes of death nationwide. Most South Africans rely on the public sector for their health care, but this system does not provide comprehensive treatment for people living with HIV—and in particular, it does not provide universal access to antiretroviral treatment. Around the time of the proceeding, it was estimated that only 20 000 people in South Africa were accessing antiretroviral treatment through the private sector. In this case, treatment activists sought to build on earlier victories by using the country's competition law to directly challenge the prices being charged in South Africa by the manufacturers of four patented antiretroviral treatments.

## Legal arguments and issues addressed

South Africa's *Competition Act* of 1998 prohibits a firm that is dominant in the marketplace from charging "an excessive price to the detriment of consumers." The Treatment Action Campaign and the other complainants argued that GlaxoSmithKline and Boehringer Ingelheim had engaged in excessive pricing of antiretrovirals to the detriment of consumers, contrary to the provisions of the *Act*, with the direct consequence of premature, predictable and avoidable deaths from AIDS. The complaint of excessive pricing was specifically in relation to the antiretroviral drugs:

- zidovudine (AZT, branded as Retrovir®);
- lamivudine (3TC, branded as 3TC®);
- the combination of zidovudine and lamivudine in one pill (AZT+3TC, branded as Combivir®); and
- nevirapine (branded as Viramune®).

At the time of the case, the first three of these were under patent by GlaxoSmithKline, and the last was under patent by Boehringer Ingelheim.

The complainants put forward detailed evidence, for each drug, comparing four prices:

- the latest available price charged by GlaxoSmithKline and Boehringer Ingelheim to the private sector in South Africa;
- the latest international best price offered to developing countries by GlaxoSmithKline and Boehringer Ingelheim;
- the best price offered by generic pharmaceutical manufacturers of equivalent products that had been found acceptable, by the World Health Organization's "pre-qualification" process, for procurement by UN agencies; and
- the best price offered by generic pharmaceutical manufacturers producing a generic equivalent of the ARVs concerned.<sup>99</sup>

The complainants pointed to the dramatic differences in price between what was charged to the private sector generally in South Africa and prices available outside South Africa for generic alternatives. However, those generics were not available in South Africa because the patents held by GlaxoSmithKline and Boehringer Ingelheim on the medicines in question gave them the exclusive right to market those products in the country. As a result of this market exclusivity, and the fact that, in general, antiretrovirals cannot be substituted for each other, GlaxoSmithKline and Boehringer Ingelheim enjoyed a dominant position in the market. The complainants argued, however, that this patent protection "does not entitle a firm to charge a price which bears no reasonable relation to the economic value of the good concerned."

The complainants outlined how the high prices charged by GlaxoSmithKline and Boehringer Ingelheim limited access to life-saving and life-enhancing treatment in both the public and private sectors. This included creating a further barrier to government adopting a comprehensive public sector HIV and AIDS treatment plan. In the case of those who had to pay

<sup>99</sup>The complainants provided this last set of prices with the caveat that this category included products from generic manufacturers that had not yet been approved for sale in South Africa by the Medicines Control Council or pre-qualified by the WHO. The complainants therefore indicated that they were not relying upon these further for the purposes of the complaint to the Competition Commission.

for their own medicines in the private sector or had limited coverage under medical insurance plans (e.g. through their employment), such high prices also resulted in a lack of treatment, substandard treatment or limited appropriate treatment options. The complainants argued that the pricing practices in question therefore operated “to the detriment” of consumers, one of the factors to be demonstrated under the *Competition Act*—and particularly to their constitutionally protected rights to life, dignity, equality and access to health-care services under the South African Constitution.

Under the *Competition Act*, the price being charged by the dominant firm must not only be to the detriment of consumers but must also be shown to be “excessive”. The statute defines an “excessive price” as one which bears “no reasonable relation to the economic value” of the good or service in question. The complainants argued that, in determining what constitutes a “reasonable” price, regard should be given to what the price of the good would be in a competitive market (i.e. in the absence of patent protection) including a normal rate of profit, and in that context;

- a reasonable allowance for the recovery of research and development costs, relevant to the production of the good concerned, which other producers and sellers of the equivalent good in a competitive market would not have incurred;
- some allowance for additional profit as an incentive for innovation and any unusual entrepreneurial risk;
- the nature and extent of the detriment to consumers that results from the high price (e.g. taking into account that high prices cause avoidable loss of life and unnecessary suffering, as well as the extent and severity of the health problem in question); and
- the adverse impact of the high prices on constitutionally protected and internationally recognized rights.

Considering these factors, the complainants argued that the prices charged by GlaxoSmithKline and Boehringer Ingelheim were “grossly disproportionate to the economic value of the goods, even when taking into account the cost of production, research and development costs and an appropriate rate of profit.” Among other things, the complainants pointed to the publicly available information regarding rates of return for the patented pharmaceutical industry (while noting that the additional, company- and product-specific information necessary for a more accurate assessment could be obtained by the Commission in the exercise of its investigatory powers). The complainants also demonstrated, based on the assumptions most favourable to GlaxoSmithKline and Boehringer Ingelheim regarding research and development costs and a “normal” rate of return, that there was at least powerful evidence suggesting grossly excessive pricing by these companies. While working on the basis of generous estimates regarding research and development costs, the complainants also submitted evidence of the extent to which public funding contributed towards these costs with respect to the antiretrovirals in question, and proposed that the Commission, in the course of its investigation, compel disclosure by GlaxoSmithKline and Boehringer Ingelheim of the actual research and development costs, as this information was known only to the companies.

On 16 October 2003, the Commission issued its decision, which found merit to the complaint filed by Treatment Action Campaign and others, but also went beyond this. Not only did the Commission agree that GSK and Boehringer Ingelheim had engaged in excessive pricing, it also reported that it had found evidence of two other contraventions of the *Competition Act*,

regarding the companies' refusal to grant licences to generic manufacturers. The Commission indicated that it would ask the Competition Tribunal to grant compulsory licences to generic competitors to facilitate access to a sustainable supply of less expensive antiretrovirals for South Africans.

## Commentary

This invocation of national competition law by Treatment Action Campaign led to concrete outcomes that promised to improve access to more affordable medicines not only in South Africa but throughout the entire sub-Saharan region. As such, it powerfully demonstrated the benefit of combining tactical litigation with a broader civil society mobilization.

Following the filing of the complaint with the Competition Commission, but before this decision in October 2003, both GlaxoSmithKline and Boehringer Ingelheim had granted voluntary licences to Aspen Pharmacare, a South African generic company, to produce nevirapine, AZT and 3TC. However, these licences were limited. In the case of nevirapine, Boehringer Ingelheim only granted Aspen permission to manufacture and sell a generic version to the government (and not to pharmacies or medical schemes). In the case of AZT and 3TC, GlaxoSmithKline granted Aspen permission to manufacture and sell generic versions only to government, to nongovernmental organizations and to employers who provide ARV treatment for those of their employees that do not belong to medical schemes. The licences did not permit the generic manufacturer to compete generally in the private sector, where a majority of South Africans accessed health-care goods and services. Nor was Aspen permitted to compete in any market other than South Africa.

As a result of the Commission's findings, GlaxoSmithKline and Boehringer Ingelheim came under intensified pressure to reduce the prices of their medicines in the South African market and to grant licences to generic manufacturers to produce these products. On the same day the Commission released its decision, GlaxoSmithKline amended its licence to permit Aspen to sell AZT and 3TC to the private sector and to export these products to all countries in sub-Saharan Africa. GlaxoSmithKline also further reduced its prices to the public sector, nongovernmental organizations and companies providing their employees with treatment. However, neither company was willing to grant licences to any other generic manufacturers, limiting the extent to which competition could lower medicine prices.

On 10 December 2003 (International Human Rights Day and the fourth anniversary of the Treatment Action Campaign's founding), the Campaign and the other complainants announced they had reached agreements with GlaxoSmithKline and Boehringer Ingelheim to settle the Competition Commission complaints. The effect of the agreements was to allow a previous deal negotiated by the Clinton Foundation, announced a week after the Commission's decision in October 2003, to be implemented, meaning that four generic pharmaceutical companies would sell triple-drug antiretroviral therapy to governments in sub-Saharan Africa at US\$140 per patient per year. Under the deal, both companies agreed to:

- extend their voluntary licences with Aspen Pharmacare to allow sales in the private sector as well, and to permit export to sub-Saharan African countries (including agreeing not to enforce any relevant patents in those countries);
- grant equivalent licences to two other entities; and
- not charge any royalties in excess of 5% of the net sales of the product.

In addition, GlaxoSmithKline also further agreed to grant equivalent licences to Thembalani Pharmaceuticals (a joint venture of the South African subsidiary of Ranbaxy, a large Indian generics manufacturer, and Adcock Ingram Holdings). Finally, the Generic Antiretroviral Procurement Project and the Treatment Action Campaign Treatment Project secured an agreement from Boehringer Ingelheim that it would grant them each a non-exclusive, royalty-free licence to import and distribute nevirapine in South Africa.

## Thailand: People living with HIV challenge company's patent on antiretroviral drug

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### ***AIDS Access Foundation et al. v. Bristol Myers-Squibb Company and Department of Intellectual Property, Central Intellectual Property & International Trade Court, Black Case No. Tor Por 34/2544, Red Case No. 92/2545 (2002)***

#### **Court and date of decision**

Judgement was issued by the Central Intellectual Property & International Trade Court on 1 October 2002.<sup>100</sup>

#### **Parties**

The plaintiffs were two people living with HIV, and the AIDS Access Foundation, a Thai nongovernmental organization, seeking access to a lower-cost, generic version of the antiretroviral didanosine (ddI). The complaint was brought against both the multinational pharmaceutical company Bristol Myers-Squibb, which held the patent on the drug in Thailand, and the Thai government's Department of Intellectual Property.

#### **Remedy sought**

The plaintiffs sought to have the Bristol Myers-Squibb patent claim on ddI invalidated, at least in part, to permit the production and distribution of a less expensive generic version of this medicine in Thailand.

#### **Outcome**

The court ruled for the plaintiffs. It found that Bristol Myers-Squibb had attempted to assert exclusive ownership of this pharmaceutical product beyond the dosage range originally specified in the patent registration, by deleting the limiting phrase "from about 5–100 mg per dose" from Bristol Myers-Squibb's patent claim. The intended and actual effect was to inhibit generic production of the product and ensure its monopoly on ddI in Thailand. The court found this limiting phrase had been unlawfully deleted and ordered the Department of Intellectual Property to restore it to the patent legitimately claimed by Bristol Myers-Squibb. The Court also ordered Bristol Myers-Squibb to pay the plaintiffs' costs of bringing the proceeding.

#### **Background and material facts**

Through the state-run Government Pharmaceutical Organisation, the Thai Ministry of Public Health provided high-quality, generic versions of a few antiretroviral drugs at a reasonable cost. However, where such production was blocked by patents on antiretroviral drugs,

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<sup>100</sup> The information presented here has, in part, been adapted from K Kaplan et al. "Thailand: Successful Challenge to Invalid Patent Claim on Antiretrovirals". *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 60-61 (available via [www.aidslaw.ca](http://www.aidslaw.ca)). The authors of that summary have also prepared an unofficial English translation of the original Thai judgement (on file). See also: K Ahmad. Thailand court forces reversal of drug firm antiretroviral patent. *Lancet* 2002; 360: 1231.

the Government Pharmaceutical Organisation was not able to legally produce a lower-cost generic version without infringing the patent, and the Thai government had been reluctant to issue compulsory licences or authorize government use of these patents to expand the range of medicines available from the Organisation. Because of their price, antiretroviral drugs other than those supplied by the Organisation remained out of reach for most people living with HIV in Thailand. In this context, Thai treatment activists pushed for total coverage of antiretroviral therapy under the universal health-care system, as well as meaningful participation in enhancing comprehensive HIV-related services at hospitals around the country.

Bristol Myers-Squibb, the manufacturer of the drug ddI, held a number of Thai patents on the drug, thereby enjoying the exclusive right to manufacture, import or sell it in Thailand. This included a patent claim covering the buffered tablet formulation of the drug. AIDS activists in Thailand publicly challenged the validity of the patent on buffered ddI on the grounds that adding an antacid to buffer the compound, a common practice among pharmacists, did not constitute an innovation that was eligible for patent protection.

In 1999, activists demanded the government grant a compulsory licence to permit the Government Pharmaceutical Organisation to produce the drug generically. Such a measure was permitted under the *Agreement on Trade-Related Aspects of Intellectual Property Rights*. Specifically the *Agreement* allows for compulsory licensing of patented inventions subject to certain conditions, including the payment of “adequate remuneration” to the patent-holder (Article 31). The United States government, which had previously communicated its opposition to compulsory licensing by the Thai government, stated to Thai AIDS activists that it would not object if the Thai government decided to issue a compulsory licence to address its AIDS crisis, provided it complied with the *Agreement*.<sup>101</sup>

However, Thai Public Health and Commerce ministry officials declined to respond officially to the activists’ request or to issue a compulsory licence. As a result, Bristol Myers-Squibb remained the sole source of buffered ddI in Thailand. At the time of the proceeding, Bristol Myers-Squibb was charging 44 Thai baht per 100 mg buffered tablet of ddI (42 Thai baht = US\$1 at the time). Thai people living with HIV who could not afford the patented ddI tablet resorted to taking generic ddI produced in powder form by the Government Pharmaceutical Organisation. This product was more difficult to take because, for example, it was more awkward to carry than tablets, it is harder to take a powder formulation more discreetly as it requires mixing with a liquid, and it also carried greater side effects such as diarrhoea. The added complexity interfered with adherence to a treatment regimen combining different antiretroviral drugs.

When the original patent claim on this product had been filed, Bristol Myers-Squibb specified that the patent was in relation to a buffered tablet that contained between 5–100 mgs of the active ingredient. Subsequently, Bristol Myers-Squibb and the Department of Intellectual Property within the Thai government removed this limitation for the entry in the patent register, thereby purporting to extend Bristol Myers-Squibb’s patent to cover any formulation containing more than 100 mg per dose. Such a patent blocked a generic producer, such as the Government Pharmaceutical Organisation, from producing any buffered tablet version of ddI.

## Legal arguments and issues addressed

On 9 May 2001, the plaintiffs initiated their legal challenge to Bristol Myers-Squibb’s patent claims in relation to ddI. The plaintiffs claimed that the patent registration for its buffered

<sup>101</sup> Letter from Joseph S. Papovich, US Trade Representative to Paisan Tan-Ud, founding Chairman of the Thai Network of People Living with HIV/AIDS (TNP+), dated 27 January 2000.

tablet formulation of ddI was illegally amended in an attempt to claim a wider monopoly than the patent description justified.

Bristol Myers-Squibb and the Department of Intellectual Property argued that because the plaintiffs were not drug manufacturers and/or competitors of Bristol Myers-Squibb, they could not be recognized under the law as parties who had been injured by the extended patent claim, and therefore had no basis to initiate the legal proceeding. The court rejected this argument, finding the plaintiffs were interested (and injured) parties entitled to make their claim. The court further stated, “medicine is essential for human life, as distinct from other products that consumers may or may not choose to consume,” and “the treatment of life and health transcends the importance of any other property.” The court noted that “this was recognized internationally” in WTO’s *Agreement on Trade-Related Aspects of Intellectual Property Rights* and Public Health. The court concluded that the parties injured by the illegal amendment of the patent could not be limited to just competing manufacturers or vendors of the medicine protected by the patent.

Having resolved this preliminary—but important—issue, the court considered the merits of the allegation. It found that Bristol Myers-Squibb and the Department of Intellectual Property had unlawfully deleted the phrase “from about 5–100 mg per dose” from the patent claim, which was the basis on which they purported to block the entry into the market of any generic competitors selling lower-cost versions of the drug.

The court ordered that the limiting phrase regarding the dosage, which had been deleted unlawfully from the patent claim, be restored. . The court ordered Bristol Myers-Squibb to pay the plaintiffs’ costs of bringing the lawsuit.

## Commentary

This case was the first such proceeding of its kind in Thai legal history and was driven entirely by civil society activists who saw an opportunity and a need to use the law to challenge excessive patent protection that was blocking access to a needed medicine for most Thai people living with HIV.<sup>102</sup> It was significant that the court directly cited the WTO’s Doha Declaration and explicitly interpreted it as support for the conclusion that the rights to life and to health can take precedence over mere property rights. Some states and commentators have suggested that the Doha Declaration is of no legal significance, and is “merely political”, but this is arguably incorrect as a matter of law, and this case provides a useful example of how the Declaration has influenced judicial decision-making at the national level as well.

Following the decision, activists in Thailand called on the Government to order the state-owned pharmaceutical organization to immediately start producing generic buffered ddI in tablet form containing more than 100 mg. The Government Pharmaceutical Organisation representatives said they could manufacture the drug in a buffered tablet form at half the price charged by Bristol Myers-Squibb. On 16 October 2002, the Government Pharmaceutical Organisation announced that it would produce a generic version of the buffered tablet in dosage ranges outside those covered by Bristol Myers-Squibb’s patent on 5–100 mg formulations, if it was certain that Bristol Myers-Squibb would not be appealing the ruling.<sup>103</sup> At the time of publication, no appeal proceeding had been reported.

<sup>102</sup> For some further commentary, see: N Ford et al. The role of civil society in protecting public health over commercial interests: lessons from Thailand. *Lancet* 2004; 363: 560-63.

<sup>103</sup> P Thepumpant. Thailand takes on US giant over AIDS drug. Reuters, 9 October 2002; Thai government to begin producing didanosine. Kaiser Daily HIV/AIDS Report, 18 October 2002 (with reference to Financial Times, 17 October 2002); S Sivaram. Patient rights win over patent rights. Inter Press Service, 20 October 2002.

## Ecuador: Tribunal orders government to ensure supply of antiretrovirals

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### ***Edgar Mauricio Carpio Castro et al. v. Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Pública, Constitutional Tribunal (Third Chamber), Decision No. 0749-2003-RA (2004)***

#### **Court and date of decision**

In September 2003, the applicants initiated their proceeding before the court of first instance, which issued its decision on 7 October 2003. The matter was appealed, and the Constitutional Tribunal issued its ruling on 28 January 2004.

#### **Parties**

The applicants were four people living with HIV in need of antiretroviral medicines. Their application was brought against the Minister of Public Health and the Director of the National Programme on HIV/AIDS and Sexually Transmitted Infections.

#### **Remedy sought**

The applicants brought an application for protection of constitutional rights (*acción de amparo constitucional*). They sought an order that the State immediately reinstate the provision of the antiretroviral medicines, in the quantity, doses and frequency prescribed by their physicians, and that it also provide viral load testing, CD4/CD8 testing, and genotypic and phenotypic testing, in order to be properly treated with antiretrovirals.

#### **Outcome**

The court of first instance granted the application, concluding that the State had violated the applicants' constitutional rights to life and to health, and ordered the Minister of Health and the Director of the National HIV/AIDS and STIs programme to take urgent measures to provide adequate treatment and testing (viral load, CD4/CD8 testing). However, the Attorney General and the Minister of Health appealed the decision to the Constitutional Tribunal. The Tribunal upheld the lower court decision, ruling in favour of the applicants.

#### **Background and material facts**

Between July and September 2002, dozens of people living with HIV in Ecuador filed applications with the Inter-American Commission on Human Rights seeking an order for "precautionary measures" (*medidas cautelares*) given the failure or refusal of the State to ensure access to medically necessary antiretroviral medicines. Such petitions followed the precedent established the previous year, by the case of *Odir Miranda et al. v. El Salvador*, summarized above.<sup>104</sup> The Commission ordered precautionary measures in the cases of 153

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<sup>104</sup> Jorge Odir Miranda Cortez et al. v. El Salvador, Inter-American Commission on Human Rights, Report No. 29/01, Case 12.249 (2001).

applicants. (Three out of the four applicants in this case had been among those 153 for whom precautionary measures had been ordered by the Commission.)

As a result of those orders, the Government of Ecuador moved to offer health services in public hospitals to people living with HIV in Ecuador, including antiretroviral therapy. As a result, the applicants in this case received medical attention, laboratory tests and antiretroviral drugs and medicines for opportunistic infections. However, in May 2003, one of those antiretroviral drugs (indinavir) was suspended, and as of September 2003, only one antiretroviral drug was being dispensed. It was this failure to supply needed medicines that gave rise to this proceeding.

## Legal arguments and issues addressed

The applicants argued that the denial of these medicines infringed:

- the right to life, as recognized in the national Constitution (Article 23.1), which stated that the State guarantees the “inviolability of life”;
- the right to health, as recognized in the Constitution (Articles 42 & 43), which established that the State guarantees to protect health and declared that public health programmes and measures will be free; and
- the right to free HIV/AIDS treatment, as set out in both the national “Law on HIV/AIDS Prevention and Comprehensive Care” (*Ley para la Prevención y Asistencia Integral del VIH/SIDA*, Article 6b) and the accompanying “Regulation on care for people living with HIV/AIDS” (*Reglamento para la Atención a las personas que viven con el VIH-SIDA*, Article 3).

The Constitutional Tribunal started its analysis with the proposition that the State of Ecuador must protect the right to health of its people, as recognized in the 1948 *American Declaration of the Rights and Duties of Man* (Article XI) and in the 1988 *Protocol of San Salvador* that supplements the original 1969 *American Convention on Human Rights*. In the *Protocol* (Article 10), states that are parties have agreed that everyone has the right to health, that health is a “public good”; they also legally committed to adopting measures on, among other things, “prevention and treatment of endemic... and other diseases” and “satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.”

The Court affirmed that “without prejudice to its own independent status, the right to health is part of the right to life.” Furthermore, the Court reasoned that the right to health not only gave citizens the right to demand that the State adopt policies, plans and programmes related to health in general terms, but also independently obliged the State to create norms, undertake research, establish public policies, create relevant entities and put them at the disposition of the population to protect and promote health. The Tribunal noted that the Constitution declared that the State shall guarantee the promotion and protection of health (Article 42), and that public health programmes and measures shall be free for all, while public medical care services will be for those who need them (Article 43).

Beyond the over-arching constitutional norms, the Court also considered a number of ordinary statutes dealing with HIV and AIDS and with health. It noted that the objective of the 2002 *Ley Orgánica del Sistema Nacional de Salud* (Organic Law of the Health System) was

to guarantee equitable and universal access to comprehensive health-care services, through a network of decentralized services, and that this legislation reflected the principle of social solidarity to address the health needs of the most vulnerable part of the population. This accorded with the *Código de la Salud* (Health Code), which stated that the National HIV/AIDS and STI Programme was part of the State's obligatory effort to promote individual and collective health, with the obligation to provide medicines to all hospital and public health centres (Article 96). This was further complemented by the obligation of the Ministry of Health to acquire medicines for distribution, as contemplated in the 2000 *Ley para la Prevención y Asistencia Integral del VIH-SIDA* (HIV/AIDS Prevention and Comprehensive Care Act) and the 2002 *Reglamento para las personas que viven con el VIH-SIDA* (Regulation applicable for persons living with HIV/AIDS).

Interestingly, the Constitutional Tribunal also expressly noted that Ecuador had adopted the *Declaration of Commitment on HIV/AIDS* from the 2001 UN General Assembly Special Session on HIV/AIDS, in which all Member States of the Assembly committed to ensuring access to treatment for all and to establishing or strengthening effective systems for supervision, promoting and protecting human rights of people living with HIV.

Having surveyed the applicable legal provisions, the Tribunal expressly stated that, under Ecuadorian constitutional law, the State had positive obligations in relation to social rights; these norms gave rise to immediate obligations, had "full juridical force", and could be applied by the courts. The Tribunal also recognized that, in this case, the right to health was an economic right directly claimable by the applicants. Based on the record before it, the Tribunal concluded that the Ministry of Health had failed in its obligation to ensure the supply of needed antiretroviral drugs, which had caused grave harm to the applicants with HIV and had violated their rights as protected by the national constitution and international instruments ratified by Ecuador. The Ministry had breached the fundamental rights to life and to health of the applicants. The Tribunal therefore granted their application and ordered the Ministry of Health to take immediate steps to ensure access to the necessary antiretroviral drugs whose supply had been interrupted and to ensure access to related testing services to inform the use of these treatments.

## Commentary

This case set an important landmark for Ecuador, although it dealt with arguments that had, by this time, been addressed in numerous other Latin American jurisdictions. It is typical of judgements from courts in this region in its references to regional human rights instruments. Certainly instruments such as the *Protocol of San Salvador*, and specifically the reference to the right to health, received considerably more attention and active application by Latin American courts than those in North America. Similarly, it is significant in that the Court actively invoked the UN General Assembly's *Declaration of Commitment on HIV/AIDS*, a resolution that is not legally binding, in support of its conclusions, revealing that the Declaration can sometimes be a useful tool for civil society and human rights advocates.



### III. HIV prevention and care in prisons



# Colombia: Court upholds rights of HIV-positive inmates

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## ***Pedro Orlando Ubaque v. Director, National Model Prison, Constitutional Court of Colombia, Decision No. T-502/94 (1994)***

### **Court and date of decision**

The court of first instance, Bogota Municipal Criminal Court No. 79, issued its original decision on 24 May 1994. On appeal, the Constitutional Court judgement was given 4 November 2004.

### **Parties**

The plaintiff, Pedro Orlando Ubaque, brought a complaint against the Director of the National Model Prison.

### **Remedy sought**

The plaintiff Ubaque requested that the HIV-positive inmates of Wing 3 of the National Model Prison be relocated to another part of the prison where they could “live with more dignity”.

### **Outcome**

The Constitutional Court ordered that the Director of the prison had three months to conclude works to improve No. 3 Wing (the “HIV/AIDS wing”). The decision as to whether the inmates could be moved to another section of the prison while these works were being carried out was left to the discretion of the Director.

### **Background and material facts**

At the time of the proceeding, the existing information on HIV prevalence in Colombia’s prison population was incomplete and unreliable. Some reports mentioned prevalence rates of between 1–3% although observers commented that the actual prevalence rate was likely to be between 10–35 times that acknowledged in official statistics.<sup>105</sup>

The plaintiff was an inmate of No. 3 Wing of the National Model Prison, the “HIV/AIDS wing” on which all prisoners known to be living with HIV were located. The plaintiff claimed that the living conditions of the wing were so bad as to make the cells uninhabitable. Specifically, the inmate claimed that:

...the wing where we are located is uninhabitable because of the humidity which is caused because we are above a water cistern which dispenses water for all the prison population. Water leaks to some cells and in those where it doesn’t leak, the humidity has caused the cells to deteriorate and this affects our health and causes respiratory allergies and pain in our bones

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<sup>105</sup> Liga Colombiana de Lucha Contra el SIDA. “Informe preliminar sobre la situación de los privados de la libertad y el VIH/SIDA en Colombia” (undated), available at [www.laccaso.org/pdfs/prisioncol.pdf](http://www.laccaso.org/pdfs/prisioncol.pdf).

because of the cold in our rooms, given that we are in a closed corner of the prison and hardly any air reaches us.

The plaintiff claimed that the Director of the prison had full knowledge of these conditions because he had inspected the wing. According to the plaintiff, the Director had promised to relocate the prisoners to another part of the prison within eight days while the wing was to be repaired but no action had been taken.

## Legal arguments and issues addressed

At first instance, the municipal court rejected the plaintiff's complaint. The court found that there had been some improvements in the conditions of the cells. The court also found that it was not desirable to move the inmates to another part of the prison on the basis that it was not good policy to have HIV-positive prisoners living with other prisoners. The court stated that:

Given the fact that the AIDS virus is a threat to public health, [and] the illness is an epidemic which is lethal and without treatment until now, this requires that fundamental protection is provided by all necessary means to these people in the National Model Prison; in addition, this obliges the Management to take necessary precautions to avoid spreading this very real and growing threat to public health.

The plaintiff appealed the municipal court decision. As a preliminary matter, the Constitutional Court was asked to decide whether the plaintiff could bring the action not only in his own name but also on behalf of three other prisoners in the same wing of the prison. The Court rejected the plaintiff's efforts, saying there was no basis on which the plaintiff could represent his fellow inmates.

On the substantive issue of the case, the Constitutional Court was asked to decide on whether conditions of imprisonment, particularly the environmental conditions in the cells, were a threat to the rights of the plaintiff, particularly his right to life and his right to health. The Court agreed that the prison authorities had indeed attempted to provide HIV-positive inmates with certain special conditions, mainly related to medical and dental services and the provision of a rest area so that they could enjoy a particular quality of life. However, the Court found that the Wing of the prison where the plaintiff was located had humidity levels which affected the health of the inmate and put his life in danger, given the special sensitivity or predisposition of HIV-positive people to contract illnesses because of the deficiency of their immune systems. The Court found that "in spite of the fact that the prison authorities have carried out some work and intend to do more work to improve the physical, sanitary and environmental conditions in the wing," the Director was required to carry out further improvements, within a set period of time, if the plaintiff's rights to health and to life were to be respected.

The Court cited with approval a previous decision<sup>106</sup> which held that those who were HIV-positive or ill with AIDS enjoy the same rights as are recognized for other people and that due to the nature and gravity of the illness, authorities are obliged to give HIV-positive people special protection in order to guarantee their human rights and their dignity and to avoid all forms or acts of stigma or discrimination against them.

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<sup>106</sup> Constitutional Court of Colombia, Decision No. T-505/92 (2002).

The Court did not directly address the issue of segregating HIV-positive prisoners. Instead the possibility of relocation of the prisoners was left to the prison Director's discretion, which had to be exercised "within rational criteria".

## Commentary

The Constitutional Court decision discussed prison conditions through a consideration of the right to life and the right to health. The *UN Standard Minimum Rules for the Treatment of Prisoners* (1955) state that:

All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of the air, minimum floor space, lighting, heating and ventilation.<sup>107</sup>

This decision went further than the widely accepted principle from the *UN Rules* that prisoners are entitled to at least the level of care available in the community, and recognized that HIV-positive prisoners required special measures of protection because of their susceptibility to various illnesses, infections and diseases, particularly when confined in an unsanitary living environment. However, the Court did not take the opportunity to consider the policy of segregation of HIV-positive inmates from the general prison population. The 1993 *WHO Guidelines on HIV Infection and AIDS in Prison* state:

Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds...<sup>108</sup>

The United Nations *International Guidelines on HIV/AIDS and Human Rights* state that the isolation and segregation of HIV-positive inmates is contrary to human rights norms. Guideline 4 recommends that measures to be taken with respect to prisoners include:

Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.<sup>109</sup>

It would have been more encouraging had the Court decided to consider the human rights question of segregation of prisoners living with HIV and provided more direction, based on these international standards, to the prison Director and other government officials responsible for prison policy in Colombia.

<sup>107</sup> UN Minimum Standard Rules for the Treatment of Prisoners (1955): Article 10.

<sup>108</sup> World Health Organization. Guidelines on HIV infection and AIDS in prisons (1993): at para 27.

<sup>109</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & Joint UN Programme on HIV/AIDS, 1998, para 29.

# Hong Kong: Compassionate sentence reduction for prisoners living with HIV

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***R v. Lo Chi Keung, (1996) 3 HKCA 155***  
***HKSAR v. Vasquez Tarazona Jesus Juan, (2001) 941 HKCU 1***

## **Court and date of decision**

The first case, *Lo Chi Keung* was decided by the Court of Appeal in 1996. The second case, *Jesus Juan*, was decided by the High Court of the Hong Kong Special Administrative Region Court of First Instance in 2001.

## **Parties**

In both cases, the applicants were convicted prisoners. Given the timing, in the first case, the respondent was the British Crown, as Hong Kong remained a British colony at the time. The second case arose after Hong Kong returned to China, meaning the government of the Hong Kong Special Administrative Region was the respondent.

## **Remedy sought**

In both cases, the applicants sought to have their sentences reduced on compassionate grounds because they were HIV-positive. In the first case, the 27-year-old applicant had been convicted of an arms-related offence and was serving an eight-year sentence in Stanley Prison. In the second case, the applicant, a Chilean national, had been convicted of conspiracy and false instruments offences (making a false passport) and was serving a 13-month sentence at Stanley Prison, concurrent to a sentence already being served.

## **Outcome**

In both cases, the court denied the request for a reduction of sentence. The court judgements were similar in their approach.

## **Background and material facts**

Hong Kong, a former British colony, officially became a “Special Administrative Region” of the People’s Republic of China in 1997 with the departure of the last British governor. Hong Kong had recognized the HIV epidemic and taken overt steps to develop policy in response. It also had for some time a thriving group of civil society organizations working on HIV. Thus, the first of these two cases was heard in a Crown court and at a time when antiretroviral therapy would not have been available to a prisoner in Hong Kong. The second case was heard in a judicial system still more British than Chinese. But Hong Kong’s experience in responding to HIV experience was being watched carefully by an emerging civil society that was taking a leadership role in the struggle against HIV in the People’s Republic of China.

## Legal arguments and issues addressed

In both cases, the fundamental issue was whether sentences of imprisonment should be reduced on compassionate grounds because of a prisoner’s HIV-positive status; both applicants sought such a reduction. In both cases, the applications were contested by the state.

In the first case, *Lo Chi Keung*, though a letter from one of Stanley Prison’s medical officers confirmed the applicant’s HIV status, the court noted there was no evidence about whether the applicant was near or at the terminal stage of his disease and whether Stanley Prison could provide “suitable and proper facilities” for his care. Leaving the door open for a reconsideration if the applicants’ status deteriorated, the court stated: “We can find no justification for considering a reduction of the sentences passed on the applicant on compassionate grounds.... We rest assured that the authority will closely monitor the applicant’s condition so as to permit special procedure for an early release of a man of his affliction to be duly invoked.”

A similar observation was made in the decision in the second case, *Jesus Juan*, where it was also noted that deterioration in the state of health of the applicant might warrant another look at the application. In this case, the court noted that the applicant’s “unfortunate medical condition” was one factor in his case that provoked “human sympathy” but asserted it was the court’s duty to “deal reasonably firmly with crime” in sentencing decisions.

A later case before the Court of Appeal in Hong Kong<sup>110</sup> resulted in a similar decision handed down to an applicant who was convicted of drug trafficking but applied for reduction of his eight-year sentence because he was suffering from thyroid cancer. In this case, the ill-effects of the condition and treatment included hypocalcaemia (with nausea and vomiting) for which the applicant had been hospitalized. The court in this case noted:

[The applicant’s] medical history avails him little when it comes to sentence. His was a pre-existing illness and it is well-established that, except in the rarest of cases, an accused’s medical condition is not a matter to which the court will have regard in mitigation. The prison authorities will ensure he receives proper treatment as they have been doing since his remand.

The court noted that the thyroid cancer in this instance should have been taken into account by the court that imposed the original sentence. In this case, similarly to the HIV-related cases above, the court noted:

Ill health is generally not a matter for mitigation of a perfectly proper sentence, particularly for crimes of gravity.... We do not, however, disagree with the suggestion that in appropriate and extreme cases, the court is entitled to take such matters into account, properly balancing public interest and the regard for the exceptional hardship suffered by an accused.

The court held that the graver the crime, the greater the public interest—and the greater the need to maintain a strict sentence. Drug trafficking was cited as an example of an offence at the serious end of the spectrum.

## Commentary

Compassionate leave cases may be said to be less about human rights than about humanitarian values. The *International Covenant on Civil and Political Rights* (Article 7) prohibits cruel and unusual punishment, which might be cited as grounds in cases involving

<sup>110</sup> *HKSAR v. Tsang Wai Kei*, [2003] HKEC 1056.

compassionate release for ill prisoners, though it apparently was not used in these cases. The *UN Standard Minimum Rules for the Treatment of Prisoners* does not directly address reduction of sentences on compassionate grounds, but notes that medical officers should report to prison directors whenever they consider “that a prisoner’s physical or mental health has been or will be injuriously affected by continued imprisonment,” which suggests the possibility that action may be taken in such circumstances. The UN *International Guidelines on HIV/AIDS and Human Rights* recommend that “compassionate early release of prisoners living with AIDS should be considered,”<sup>111</sup> but this is not a legally binding instrument.

Compassionate early leave cases do not necessarily pose the “right to health” issues that are raised, for example, in a judicial application for a certain kind or quality of medical care for a prisoner or for prevention services such as clean injecting equipment. Cases where the HIV infection predates the original prison sentence, as in these Hong Kong cases, also cannot bring into evidence any wrongdoing on the part of the state in failing to prevent the infection. Cases such as these raise more subjective matters such as the judgement of the degree of suffering associated with a prisoner’s condition and the degree to which a prison medical system can alleviate that suffering, as well as perhaps the discretionary nature of sentencing more generally. Nonetheless, it should be noted that HIV-positive prisoners may be largely asymptomatic for long periods, and the case might be made that waiting for their condition to deteriorate before courts extend a compassionate release is a violation of their right to health if the disease could be better monitored or treated more promptly outside of prison. That argument was not made here.

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<sup>111</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & Joint UN Programme on HIV/AIDS, 1998, para 29(e).

# United Kingdom: Provision of condoms to prisoners

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## ***R. v. Secretary of State for the Home Department ex parte Glen Fielding* [1999] EWHC Admin 641 (High Court of Justice, Queen’s Bench Division)**

### **Court and date of decision**

High Court of Justice, Queen’s Bench Division, July 1999 (appeal decided in January 2000).

### **Parties**

The applicant in the case was a gay man incarcerated in Littlehey correctional facility, a government-run prison, where he was unable to obtain condoms. His legal proceeding was contested by the Home Department of the UK government, which has jurisdiction over prisons.

### **Remedy sought**

While in Littlehey, the applicant had managed to have condoms sent to him from outside the prison, but they were confiscated and placed under the control of the prison medical service, which refused him access to them. He was later moved to a privately run prison, where he was provided with condoms without difficulty. He was subsequently released, but pursued the case. By the time the case was heard by the court, he was no longer seeking access to condoms because he was no longer in Littlehey Prison. Rather, he sought a change in the Home Department policy allowing prisoners access to condoms only through prison doctors.

### **Outcome**

The Home Department policy was upheld in the 1999 decision and on appeal in 2000—that is, it was confirmed that condoms would be available only through a prison doctor’s prescription.

### **Background and material facts**

The Home Department put forward a policy on condoms in prison in a 1995 letter instructing prison doctors that they were free “in the exercise of their clinical judgement” to prescribe condoms for individual prisoners. The letter noted that prisoners should not have access to condoms except through the prison medical service. It went on to state that the intent of the policy was to preserve health, particularly in light of the risk of HIV transmission, and not to “encourage homosexuality”. The letter added that the “burden of our legal advice is in fact that there may be a legal risk in not providing condoms in the relevant set of circumstances through a failure in the duty of care” and that doctors should thus be encouraged to prescribe both condoms and lubricants “when in their clinical judgement there is a known risk of HIV

infection as a result of HIV risk sexual behaviour.” In 1997, however, when the applicant was in Littlehey Prison and requested access to condoms, the prison medical officer, recognizing his right to issue condoms in “rare and exceptional circumstances,” determined that there was no clinical evidence to warrant such an exceptional measure in the applicant’s case.

## Legal arguments and issues addressed

The applicant argued that because prisoners may not know whether they themselves or their sexual partners are HIV-positive—even if HIV tests were available, the “window period” between infection and detectable seroconversion was such that HIV might not be detected on a given test—they should have regular access to condoms. He argued that if an inmate presented himself to the authorities to request condoms, one must conclude that he intended to have penetrative sex, which by definition would “carry with it the risk of the spread of HIV and... therefore no question of the clinical judgement of a doctor arises.” Counsel for the applicant also put forward the lack of access to condoms as an infringement of respect for the applicant’s private life under the *European Convention on Human Rights*. He further asserted that there could be no “public policy reason” why prisoners who choose to take steps to protect themselves by acquiring condoms on their own should not be permitted to do so. He argued that it was “irrational” to deny prisoners who could afford them the possibility of acquiring condoms through private means.

The court readily allowed that the medical director of Littlehey Prison may have misinterpreted the Home Department policy on condoms, being “significantly more restrictive...than a fair reading” of the policy would have warranted in denying the applicant access to condoms. As to the applicant’s case that the policy was “irrational,” the court was unsympathetic and made several arguments, including these:

Providing condoms on demand might reasonably be seen to be an encouragement of homosexuality, and the court said the Prison Service was entitled to avoid a policy that might give this impression.

“[C]ondoms have uses other than those for which they were designed,” and therefore some level of control of condoms as a commodity should be the prerogative of the Prison Service.

“The mere fact that a person asserts that he wants a condom does not mean that he is a genuine homosexual, nor does it mean that he is necessarily intending to engage in penetrative or other dangerous sexual activity, nor does it necessarily mean that he is in truth a consenting party to whatever activity is anticipated.” Therefore, whether the condom is requested for “genuine health reasons” is best left to doctors.

The court also noted that the applicant is entitled in principle to respect under the *European Human Rights Convention* for his sexual orientation “and its practical consequences” but noted that unlike the majority of prisoners (presumably meaning heterosexuals), “imprisonment does not prevent him from expressing his sexuality at all.” But, said the court, the real issue here is health, not the right to have sex.

The court also asserted that the Home Department should come up with a clearer statement of its policy to avoid overly restrictive interpretations of it. This view was reiterated by the appeals court that upheld the ruling against the applicant’s complaint.

## Commentary

The UN *International Guidelines on HIV/AIDS and Human Rights* recommend the provision of condoms in prison. Lack of access to condoms for prisoners would seem to contradict one of the fundamental principles of the *UN Standard Minimum Rules for the Treatment of Prisoners*,<sup>112</sup> that prisoners have access to the same level of services as those outside prisons. Condoms are a readily accessible and affordable commodity in the UK. This equivalency principle was reiterated by the World Health Organization in its 1993 *Guidelines on HIV Infection and AIDS in Prisons*, which also assert that “condoms should be made available to prisoners throughout their period of detention.”<sup>113</sup>

Condoms have come to be understood as an essential element of HIV prevention and thus can easily be construed to be part of the “highest attainable standard of health” services guaranteed in the *International Covenant on Economic, Social and Cultural Rights* (Article 12), to which the UK is a party. The UN Committee on Economic, Social and Cultural Rights, which is the expert body mandated to monitor and promote states’ compliance with the obligations under the *Covenant*, has issued a “General Comment” on the human right to health. It notes that states which are parties to the *Covenant* are obliged to respect the right to health by “refraining from denying or limiting equal access for all persons, including prisoners or detainees” and refraining from “limiting access to contraceptives and other means of maintaining sexual and reproductive health.”<sup>114</sup>

According to the UK Prison Service at the time of publication, the condom policy in UK prisons remained that a doctor’s prescription was the only way for prisoners to obtain condoms. Nongovernmental organizations in the UK have argued that, while obtaining condoms through prison doctors is possible in theory, in practice in most prisons this makes it almost impossible for prisoners to confidentially obtain condoms or protect their right to privacy, a right guaranteed by the *International Covenant on Civil and Political Rights* (Article 17). In addition, nongovernmental organizations have reported that condoms’ value in preventing transmission of HIV or other sexually transmitted infections has been undermined by long delays between the time prisoners apply to medical officers for condoms and the time they receive them.

<sup>112</sup>UN Standard Minimum Rules for the Treatment of Prisoners (1955).

<sup>113</sup>World Health Organization. *Guidelines on HIV infection and AIDS in prisons* (1993), p. 5.

<sup>114</sup>UN Committee on Economic, Social and Cultural Rights. *The right to the highest attainable standard of physical and mental health*. (General Comment 14), UN Doc. E/C.12/2000/4 (2000), paras 34 & 35.

## Australia: Litigation leads to change in policy on condoms in prisons

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### ***Prisoners A-XX Inclusive v. State of New South Wales (1995)*** **38 NSWLR 622.**

#### **Court and date of decision**

The court of first instance issued its judgement on 5 October 1994. On appeal, the Court of Appeal, Supreme Court of New South Wales issued its judgement on 29 June 1995. On further appeal, the High Court of Australia delivered its judgement on 23 November 1995.<sup>115</sup>

#### **Parties**

The plaintiffs were fifty inmates of New South Wales prisons who filed a statement of claim against the State of New South Wales. The action was instituted by the Aboriginal Legal Service.

#### **Remedy sought**

The prisoners sought a mandatory injunction to force the New South Wales government to reform its policies regarding condoms in prisons. The application sought:

- an order that the state of New South Wales, through the Commissioner of Corrective Services and the Director General of the Department of Corrective Services, must permit the plaintiffs and other male prisoners in New South Wales prisons to possess and use condoms;
- a declaration that the decision not to supply or permit the possession or use of condoms by male prisoners was made in breach of the duty of care owed by the state of New South Wales to the plaintiffs; and
- an order that the state of New South Wales supply, and permit the possession and use of, condoms by the plaintiffs and other male prisoners in New South Wales prisons.

#### **Outcome**

The court of first instance dismissed two of the three claims advanced by the plaintiffs and ruled that the third claim had to be redrafted so as to be brought solely on behalf of the four aggrieved plaintiffs, rather than as a class action on behalf of the larger group of prisoners. On appeal, the state appellate court upheld this ruling. The High Court of Australia denied leave to appeal.

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<sup>115</sup>The text of the judgement from the Court of Appeal of New South Wales may be found at [www.austlii.edu.au/au/cases/nsw/supreme\\_ct/unrep110.html](http://www.austlii.edu.au/au/cases/nsw/supreme_ct/unrep110.html) and the transcript of the proceeding in the High Court of Australia may similarly be found through a search via [www.austlii.edu.au](http://www.austlii.edu.au). For additional information about this case, see: R Jürgens. Australia: Prisoners Sue for the Right to Condoms. *Canadian HIV/AIDS Policy & Law Newsletter* 1994; 1(1): 5; R Jürgens. Australia: Update on Prison Condom Case. *Canadian HIV/AIDS Policy & Law Newsletter* (1993) 1(3): 3; I Malkin. The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody, in: *HIV/AIDS in Prisons*. Montreal, Canadian HIV/AIDS Legal Network, 1996 (Appendix 1), available at [www.aidslaw.ca/Maincontent/issues/prisons/APP1.html](http://www.aidslaw.ca/Maincontent/issues/prisons/APP1.html).

## Background and material facts

Until the mid-1990s the policy of the New South Wales Department of Corrective Services (like that of the majority of other Australian systems) was to oppose condom distribution. Although the authorities were aware that sexual activity occurred in prisons, reliance was placed on education as the primary HIV prevention measure. While ultimately unsuccessful in the courts, this case placed pressure on the government to change its policy.

## Legal arguments and issues addressed

The prisoners argued that the decision not to supply condoms or permit their possession or use by male prisoners

- was so unreasonable as to constitute an improper exercise of power;
- gave rise to a writ of habeas corpus (a written order requiring the investigation of the legitimacy of a person's detention); and
- constituted a breach of the duty of care owed by the Department to the prisoners.

At first instance, the judge dismissed the first two grounds. With respect to the third ground—that the policy constituted a breach of the duty of care owed by the Department to the prisoners—the judge held that the statement of claim must be redrafted, to be brought in the name of four aggrieved inmates rather than as a class action on behalf of 50.

The prisoners appealed the judge's decision, arguing they should be able to:

- rely on the writ of habeas corpus;
- rely on the Magna Carta; and
- continue their proceedings as a class of 50 rather than amend their pleadings and claims.

The New South Wales Court of Appeal dismissed *habeas corpus* arguments after canvassing British, Canadian and American decisions. It also dismissed arguments premised on the contravention of the Magna Carta. Finally, it dismissed the third ground of appeal, concluding that the lower court's reasons for restricting the number of plaintiffs involved a proper exercise of discretion. These reasons were to ensure that an appropriate variety of factual issues be litigated, that guidelines consequently be set for future litigants and cases, and that the case be managed efficiently.

The inmates applied to the High Court of Australia for special leave to appeal, on the ability to rely on the writ of *habeas corpus* and the question of the Magna Carta. The High Court held that there was no sufficient reason to doubt the correctness of the Court of Appeal's decision and declined to grant special leave to appeal.

Although all three grounds in the appeal to the New South Wales Court of Appeal were dismissed (which ruling was upheld on appeal to the High Court) the Supreme Court's decision did not foreclose continuation of the proceedings: the arguments based on negligence remained intact.

The judge was unwilling to allow a challenge to the "policy decision" not to provide condoms in prisons, arguing that judicial review of an issue involving "political considerations" would lead to "political power [passing] from the parliament and the electorate to the

courts.” However, he continued by saying that “different considerations would apply if the prisoners claimed a breach of the duty owed to them as individuals”. Although a policy decision in itself may not be reviewable by the Court, its effect—a breach of duty of care owed to the prisoners—is.

If a duty of care were established, an injunction to restrain the tort of negligence might, although novel, be available. However, the Court pointed out that there might be problems with proving a duty of care in this case: it could be held that the prisoners were contributorily negligent or that they voluntarily assumed the risk of being harmed. Nevertheless, even if they were held to have been negligent, the negligence of the government would remain. Further, any consideration of the voluntary assumption of risk “must surely be tempered by questioning how much of a prisoner’s actions are relevantly voluntary.”

While the Court of Appeal cited the judge’s decision on this point in some detail, it did not in any way criticize the substance of what he said. Referring to his decision, the Court of Appeal stated (at paragraph 8):

His Honour saw no reason why in an appropriate case the Court would not grant an injunction to restrain the tort of negligence, even without proof of damage. Accordingly, if the appellants were able to establish by evidence that the failure by the Department to permit their use of condoms constituted a breach of the duty of care owed to them, they might be entitled to injunctive relief.

The Court of Appeal concluded (at paragraph 39): “What remains to be done is for the appellants to apply to the Common Law Division to amend their statement of claim in a way which accords with the judge’s orders and the conclusions I have reached.”

Interestingly, in oral arguments before the High Court, the Solicitor-General for the State of New South Wales accepted the judge’s ruling that four of the plaintiffs could run claims in the tort of negligence. He foreshadowed that there would be a defence based on policy considerations.

## Commentary

“Given the increasing dangers posed by HIV and hepatitis in prisons, brought into focus by cases of seroconversion in custody, there is more reason than ever to utilize a legal approach involving an old, somewhat flexible proceeding in the attempt to achieve substantive change in correctional policy: prisoners may be able to demonstrate the need for changes in prison authorities’ and governments’ behaviour by instituting an action in negligence.”<sup>116</sup> The legal importance of this case lies in the fact that it provides recognition, albeit limited, that such a claim of negligence could be brought in the future.

International guidelines reflecting public health evidence assist in establishing the appropriate standard of care that should be met by prison officials in responding to HIV. According to WHO’s 1993 guidelines, the case for provision of condoms in prisons is clear:

[A]ll prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. [...] Since penetrative sexual intercourse occurs, in prison, even

<sup>116</sup>I Malkin. “The Role of Law of Negligence in Preventing Prisoners’ Exposure to HIV While in Custody”, Appendix 1 in: *HIV/AIDS in Prisons*. Canadian HIV/AIDS Legal Network, 1996, available at [www.aidslaw.ca/Maincontent/issues/prisons/APP1.html](http://www.aidslaw.ca/Maincontent/issues/prisons/APP1.html).

when prohibited, condoms should be made available to prisoners throughout the period of detention.<sup>117</sup>

This case brought about important policy changes in relation to condom provisions for prisoners in New South Wales. In 1996, at least in part because of the legal action, the New South Wales government decided to make condoms available in all prisons after evaluation of an initial, successful trial condom-distribution scheme in a few New South Wales prisons.

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<sup>117</sup>WHO Guidelines on HIV infection and AIDS in prisons. (original version 1993, republished in 1999), UNAIDS/99.47/E, pp. 4-5.

## South Africa: Access to antiretroviral treatment for prisoners

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### ***Van Biljon and Others v. Minister of Correctional Services and Others (1997) 50 BMLR 206, High Court (Cape of Good Hope Provincial Division)***

#### **Court and date of decision**

This judgement issued from the High Court (Cape of Good Hope Provincial Division) in 1997.<sup>118</sup>

#### **Parties**

The plaintiffs were four HIV-positive inmates of Pollsmoor Prison in Cape Town. The primary respondents, who had responsibility for the prisoners' incarceration, included the Minister of Correctional Services, the Commissioner of Correctional Services and the Commander of Pollsmoor Prison. The Minister of Health and Welfare of Western Cape Province was also a respondent but with responsibilities less relevant to the complaint.

#### **Remedy sought**

The applicants sought a declaration that they were entitled to receive antiretroviral medication at the state's expense.

#### **Outcome**

The first two applicants succeeded in their claims. In cases where combination antiretroviral treatments had been prescribed medically to specific prisoners, those prisoners had the constitutional right to an adequate standard of medical treatment, which included the provision of these drugs at state expense. The third and fourth applicants' claims were dismissed.

#### **Background and material facts**

At the time of this case, there was no government-supported provision of antiretroviral medicines in the Republic of South Africa, but some medicines were available in private clinics for those who could afford them. There was consensus among clinicians that antiretrovirals should be provided to an HIV-positive person with a CD4 count below 500 if the person was symptomatic.

A few years before this judgement, following an earlier complaint with respect to the provision of antiretrovirals, the first applicant (van Biljoen) had been prescribed a combination therapy including AZT as a result of an agreement reached with prison authorities. While on parole, he was supplied with AZT by a hospital and paid for it himself. Convicted again and sentenced to six years' imprisonment, he was initially refused antiretroviral drugs, but they were eventually provided at state expense. He later escaped. While at large, he did not access

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<sup>118</sup> Note that the case is sometimes cited as *Biljon v. Minister of Correctional Services* or *B v. Minister*.

antiretrovirals because of lack of funds. Once re-arrested, he was detained at Pollsmoor, where he did not receive antiretroviral drugs. Assessed by a private practice general practitioner as having a CD4 count of 298, it was recommended that he receive AZT with ddC or 3TC, a recommendation later echoed by a hospital-based physician outside the prison, but he did not receive this therapy. This claim was his third application against the authorities.

The second applicant, serving a ten-year sentence, had a CD4 count of 148. His medical condition was deteriorating. He had been prescribed AZT and ddI. Although he had been able to buy the drugs at his own expense for a period of time, he could no longer afford to do so.

The third and fourth applicants also had low CD4 counts, but they had not been prescribed antiretroviral drugs. At the time of the complaints and the decision, the Department of Correctional Services did not have firm guidelines concerning HIV-positive prisoners and access to antiretroviral drugs.

### **Legal arguments and issues addressed**

This case raised three important questions implicating the constitutional rights of people living with HIV and AIDS in South Africa:

- whether HIV-positive prisoners who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500 are entitled to receive appropriate ARV treatment;
- whether the cost of this treatment should be borne by the state; and
- more tangentially, whether State failure to provide treatment to HIV-positive prisoners would be unconstitutional.

It was readily noted by the court that the plaintiffs, like all prisoners, had a right to medical treatment and care at state expense. The court therefore focused its analysis on the scope of this right and the corresponding obligations on the correctional system.

On the question of whether prisoners with CD4 counts below the clinically accepted threshold should receive antiretroviral therapy, the court noted that this was a decision for medical experts. On these grounds, the cases of the third and fourth applicants did not proceed further since no medical expert had ever determined that they should receive antiretroviral therapy. For the first two applicants, who had been prescribed antiretroviral drugs, the court proceeded to consider whether the state had to bear the cost of these therapies. The argument here was over what amounts to “adequate medical treatment”, as guaranteed by the Constitution and as had been considered in some previous cases on prisoners’ rights.

The respondent correctional authorities argued that prisoners should not be entitled to more than what is available generally in the community. They argued that “adequate” treatment for prisoners did not include antiretroviral drugs because people outside prison in the same medical condition as the applicants were not entitled to state-funded antiretroviral drugs. They asserted, moreover, that such decisions in the regular health system depended on the discretionary judgement of public authorities based on available resources and other demands on them.

The court rejected this argument, noting that the claim of a lack of funds is not a satisfactory answer to a prisoner’s claim for adequate medical treatment, which is constitutionally protected. The South African Constitution grants prisoners the fundamental right to medical

care. No similar guarantee is provided to those outside prison. Significantly, the court asserted that "...the state indeed owes a higher duty of care to HIV-positive prisoners than to citizens in general who suffer from the same infection."<sup>119</sup> According to the court, the standard of adequate medical treatment is not conclusively determined by what the State provides to HIV patients outside prison.

Furthermore, noting the over-crowded and unhygienic conditions in which prisoners live and the risks thus posed to their health, the court declared:

Even if it is ... accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the state for patients outside, this principle can ... not apply to HIV-infected prisoners. Since the state is keeping these prisons in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the state must provide them must be treatment which is better able to improve their immune systems than that which the state provides for HIV patients outside.<sup>120</sup>

In the court's view, the treatment claimed by the first and second applicants (who had been prescribed antiretroviral drugs) amounted to "no more than adequate medical treatment"<sup>121</sup> to which they had a constitutional right. Therefore, the first and second applicant had to be provided with the antiretroviral therapy already prescribed to them on medical grounds, for as long as it was prescribed.

## Commentary

As one commentator later noted, the case appeared to be a major victory for HIV-positive prisoners in South Africa, but it ultimately turned out to be less of a practical victory—perhaps because the case was not followed up with further lobbying<sup>122</sup> or because the antiretroviral situation in the country more generally was bleak. These particular plaintiffs were in the end unable to receive all the drugs they had been prescribed, and correctional authorities soon developed an HIV and AIDS policy that was criticized as falling short of the standard suggested by the decision. In the end, the correctional system could control who would and would not get antiretroviral treatment in prison because they controlled prisoners' access to medical doctors with prescribing authority.

This judgement not only reflected, but actually improves upon, the long-accepted principle from the *UN Standard Minimum Rules for the Treatment of Prisoners* (1955) that prisoners are entitled to at least the level of care available in the community. The court's decision was not only respectful of this principle, but made the cogent point that prisoners may be disadvantaged by harmful conditions not present in the community and thus may require an even higher standard of care to compensate for these harms.

At least on its face, the decision was also remarkably pioneering in suggesting that for prisoners the State must take on a greater responsibility than "progressive realization" of the "highest attainable standard" of health—as recognized in Article 12 of the *International Covenant on Economic, Social and Cultural Rights* and other international human rights

<sup>119</sup> *Van Biljon*, para 51.

<sup>120</sup> *Ibid.*, para 54.

<sup>121</sup> *Ibid.*, para 60.

<sup>122</sup> Prof. Pierre de Vos. "Prisoners' Rights Litigation in South Africa Since 1994: A Critical Evaluation." Civil Society Prison Reform Initiative Research Paper, Series No 3 (November 2003), available via [www.nicro.org.za/CSPRI](http://www.nicro.org.za/CSPRI).

treaties. Budgetary constraints are the most common defence that any State would make in explaining an inadequate level of publicly provided health services, an argument allowed them by the *International Covenant's* provision that the rights enshrined in the Covenant are realized progressively "to the maximum of available resources" (Article 2). In this case, the budgetary constraint argument, with respect to hospitals inside and outside the prison health system, was rejected by the court, in recognition of the complete reliance by prisoners on the care of the State. For the two plaintiffs who had medical prescriptions for antiretroviral drugs and thus could demonstrate an expert assessment of their condition, the court clearly established a right to the highest attainable standard of care.

While this case did not prove to be the landmark for the right to health of prisoners that it might otherwise have been, the reliance of the court on the human rights principles behind the right to health as provided in the South African Constitution was noteworthy and created an important precedent for future advocacy for the health rights of all prisoners.

# Canada: Prisoner wins change in prison policy, expands access to methadone maintenance therapy

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## ***Strykiwsky v. Mills and Canada (Commissioner of Corrections and Correctional Service of Canada), Federal Court of Canada – Trial Division, Court File No. T-389-00 (2000)***

### **Court and date of decision**

The case was heard on 30 April 2002 by the Federal Court of Canada – Trial Division. On 2 May 2002, the case was settled before a judgement was rendered.

### **Parties**

The applicant Strykiwsky was a prisoner in a federal institution who sought access to methadone maintenance treatment to treat his addiction to opiates. The respondent Mills was the warden of the institution where Strykiwsky was incarcerated. The other respondents were the Commissioner of Corrections (the administrative head of the Correctional Service of Canada) and the Correctional Service of Canada itself.

### **Remedy sought**

The applicant sought access to methadone maintenance treatment for himself and all prisoners within federal prisons who were medically eligible and wished to receive the treatment. The respondents refused his request. He brought an application for judicial review of that decision and the Correctional Service of Canada's ongoing refusal to implement a broader methadone maintenance programme within federal prisons. He sought an order declaring that the Correctional Service of Canada had a legal duty to provide access to methadone for medically eligible inmates, and compelling the Correctional Service of Canada to provide him with this treatment and to implement the program.

### **Outcome**

The parties agreed to settle the case because the Correctional Service of Canada adopted a policy of expanded access to methadone maintenance therapy, two days after the applicant's case was heard by the court.

### **Background and material facts**

The Correctional Service of Canada is responsible for the care and control of prisoners in Canadian federal prisons (i.e. those who are serving sentences of incarceration of two years or more). Data indicate that injecting drug use was substantially more common in prisoners than in the general Canadian population.<sup>123</sup> In a 1995 survey of prisoners, 11% indicated that they

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<sup>123</sup> See Centre for Infectious Disease Prevention and Control, Health Canada, and Correctional Service of Canada. *Infectious Disease Prevention and Control in Canadian Federal Penitentiaries 2000-01*. Ottawa: CSC, 2003; Canadian Public Health Association. *A Health Care Needs Assessment of Federal Inmates in Canada*. *Canadian Journal of Public Health* 2004; 95 (Supp 1):S1-S63, available at [www.cpha.ca/shared/cjph/archives/CJPH\\_95\\_Supp\\_1\\_e.pdf](http://www.cpha.ca/shared/cjph/archives/CJPH_95_Supp_1_e.pdf).

had injected drugs while incarcerated. Among prisoners, rates of infection with HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) were substantially higher in injecting drug users than in non-users.<sup>124</sup> At the end of 2000, 1.66% of all federal prisoners were known to be HIV-positive; 19.2% were known to be HCV-positive.<sup>125</sup> These statistics may represent an underestimation, since testing was voluntary and stigma and discrimination, including within prisons, remained barriers to testing.

At the time Strykiwsky brought his case, the Correctional Service of Canada had guidelines on prisoners' eligibility to receive methadone maintenance treatment. Under the Phase 1 guidelines, prisoners who were previously accessing treatment in the community were eligible to be considered for it in prison. There were also "exceptional basis" guidelines applicable to prisoners who were not previously on the treatment before incarceration. Under those guidelines, it had to be shown that

- (i) available treatments and programmes had failed;
- (ii) the prisoner's health continued to be seriously compromised by addiction; and
- (iii) there was a dire need for immediate intervention. Strykiwsky and many other opiate dependent prisoners, who were not accessing MMT before imprisonment, were not able to access MMT under Phase 1 or the exceptional criteria.

## Legal arguments and issues addressed

Strykiwsky argued that the Correctional Service of Canada and the other respondents had acted illegally by not implementing the planned expansion of the methadone maintenance treatment program, the so-called Phase 2 of the methadone maintenance treatment guidelines. He also argued that the respondents had acted illegally by denying him essential health care, namely the treatment program and all related health care services. The application was brought as a judicial review, under which a court review has the authority to review the decision of a statutory actor based on the principles of administrative law and on other legal grounds. Strykiwsky relied on the *Corrections and Conditional Release Act*. In particular, section 86 of that Act states that the Correctional Service of Canada shall provide every inmate with essential health care, and reasonable access to non-essential health care that will contribute to an inmate's rehabilitation and successful reintegration into the community. The Act also states that health care must conform to professionally accepted standards. He also relied on three sections of the Canadian *Charter of Rights and Freedoms*, which is part of the Constitution. Section 7 of the Charter guarantees the right to life, liberty and security of the person. Section 12 guarantees the right not to be subjected to any cruel and unusual treatment or punishment. Section 15 guarantees the right to equality.

Under the Minutes of Settlement, the respondents acknowledged that prisoners with opiate addictions have a "right to receive methadone maintenance treatment as essential health care" in accordance with the new methadone maintenance treatment guidelines.

On 2 May 2002, the Correctional Service of Canada expanded access to methadone under new guidelines, and deleted the Phase 1 and exceptional guidelines.<sup>126</sup> The methadone

<sup>124</sup> For much of the data in this section, see the summaries provided in: Canadian HIV/AIDS Legal Network. "HIV/AIDS in Prisons" (3d ed, 2004), a series of 13 info sheets on the topic, available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm).

<sup>125</sup> Canadian HIV/AIDS Legal Network. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal, 2002, at pp. 3-4, available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm).

<sup>126</sup> Correctional Service Canada. *Methadone Treatment Guidelines*. Commissioner's Directive 800-1 (2 May 2002), available at [www.csc-scc.gc.ca/text/plcy/cdshtm/800-1-gl\\_e.shtml](http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-1-gl_e.shtml).

maintenance treatment programme was officially referenced in the health service guidelines. The new methadone maintenance treatment guidelines set out criteria for admission to the program, and criteria for priority admission. Priority admission was made available to opiate-addicted prisoners who were pregnant (including where there is a high risk of relapse), HIV-positive, required treatment for hepatitis C, or had a recent history of life-threatening overdose or illness related to their addiction. Priority was also given to prisoners who would be released within six-months time and who had plans for accessing a methadone provider in the community upon release.

## Commentary

As a direct result of this case, and the policy change it precipitated, opiate-dependent prisoners in Correctional Services of Canada have enjoyed greatly expanded access to methadone maintenance treatment. Treatment access criteria for prisoners were essentially equivalent to criteria under similar programmes in the community. Although the case was brought by one prisoner, it resulted in a far-reaching policy change. Prior to this case, the Correctional Service of Canada regularly settled such cases by giving treatment to the individual prisoner. As a result, there was no court decision upon which other prisoners could rely. Strykiwsky explicitly included “all federal inmates medically eligible and wishing to receive” treatment in his application, and refused to settle the case on his own behalf. Thus, the Correctional Service of Canada could not resolve the case by offering to put Strykiwsky alone on treatment. It had to choose between expanding treatment access and letting the court decide the appropriate order.

The case is also significant because Strykiwsky was represented by a public interest law centre. The availability of publicly funded legal assistance has been crucial for changing prison policies through legal cases. Traditionally, prisoners have had poor access to legal assistance, especially in countries where financial resources are limited, or where private bar lawyers are not willing to represent prisoners *pro bono*.

# South Africa: Former inmate awarded landmark settlement after being infected with HIV in prison

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## ***PW v. South Africa Department of Correctional Services (1997–2003)***

### **Court and date of decision**

Litigation was initiated in 1997 and an out-of-court settlement was reached in February 2003.

### **Parties**

The plaintiff (known as PW) sued the South Africa Department of Correctional Services.

### **Remedy sought**

The plaintiff, who was infected with HIV while incarcerated, sued for future medical expenses, loss of earnings and general damages for such things as pain and suffering. Media reports stated that the plaintiff claimed over 1.1 million rand (approximately US\$ 179 000).<sup>127</sup>

### **Outcome**

The suit was settled out of court and the terms of the agreement were confidential. Media reports stated that the plaintiff settled for 150 000 South African rand (approximately US\$ 25 000 at the time). It is known that the Department of Corrections “denied any liability” for PW’s infection but admitted that prisoners were not allowed to have condoms until 1996.

### **Background and material facts**

The South African Department of Correctional Services has estimated a prevalence rate of 3% of the prison population, although it has admitted that this figure was “unrealistically low”.<sup>128</sup> The Institute of Security Studies has estimated the HIV prevalence rate in prisons at 45%.<sup>129</sup>

The inmate PW was incarcerated at Pollsmoor Prison from November 1993 to December 1994, and repeatedly tested HIV-negative over most of this period. He had a sexual relationship with an HIV-positive man while in prison. He stated that he was unaware of his partner’s HIV status at the time of their relationship. He alleged that the responsible authori-

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<sup>127</sup> Former South African prison inmate awarded “landmark” court settlement after being infected with HIV in prison. Kaiser Daily HIV/AIDS Report, 14 February 2003; Former inmate suing South African prison over HIV infection. Kaiser Daily HIV/AIDS Report, 10 June 2002.

<sup>128</sup> KC Goyer. South Africa, HIV/Aids in Prison: Problems, Policies and Potential (Monograph No. 79). Institute for Security Studies, February 2003 available at [www.iss.co.za/Pubs/Monographs/No79/Content.html](http://www.iss.co.za/Pubs/Monographs/No79/Content.html) at Chapter 3.

<sup>129</sup> Ibid.

ties ignored and tolerated the practice of sexual relationships in prisons, while prohibiting all prisoners from having access to condoms. PW tested positive for HIV on 27 November 1994, shortly before his release from prison.

## Legal arguments and issues addressed

The plaintiff PW sued the South Africa Department of Correctional Services in 1997. In court papers, PW alleged that the prison authorities knew that sex among prisoners was “common” and that a “material portion” of the prisoners were HIV-positive. PW further alleged that the authorities did nothing to prevent sex between prisoners nor did they provide sexually active inmates with access to condoms to reduce the risk of HIV infection. The Department of Correctional Services admitted these facts.

PW argued that this policy prohibiting condoms was not necessary for the achievement of any of the purposes for which the responsible authorities were vested with their powers of control and management of the prison. He noted that the policy was revoked in 1996 without any ill-effect. The Department of Correctional Services admitted the policy had been changed, but did not concede that it was unnecessary.

PW argued that had prison policies been different, he would not have been able to have such a relationship or would have been able to reduce his risk of acquiring HIV by using condoms. In his claim, he asserted that the conduct of the prison authorities amounted to negligence at common law and also breached the *Correctional Services Act of 1959*. He further argued that the DCS had violated his rights under the Constitution, in particular:

- his right to be detained under conditions consistent with human dignity, and to be provided with adequate medical treatment at State expense;
- his right to freedom and security of the person;
- his right not to be subjected to torture of any kind, whether physical, mental, or emotional, and not to be subjected to cruel, inhuman, or degrading treatment or punishment;
- his right to life; and
- his right to respect for and protection of his dignity.

## Commentary

Because the case settled, there was no judicial decision considering the merits of PW’s legal arguments nor did this litigation set a legal precedent. However, it illustrated the use of litigation to hold a government accountable for the impact of its policies and its actions on people’s health. In 1996, the Department of Correctional Services developed a new policy on managing HIV and AIDS in prisons. In 2000, this policy was supplemented by a Management Strategy on HIV/AIDS in Prisons. The Management Strategy covered both prisoners and prison staff.

The World Health Organization in its 1993 *Guidelines on HIV Infection and AIDS in Prisons* states that “condoms should be made available to all prisoners for the duration of their detainment.” The WHO Guidelines helped influence the Department of Correctional Services to change its policy. It is also likely that the case of PW’s infection while incarcerated and the obvious possibility of legal liability played some role in prompting a shift in policy. As noted earlier, the *International Guidelines on HIV/AIDS and Human Rights* state that

Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care....<sup>130</sup>

In its written policy, the Department of Correctional Services made a commitment to provide HIV education and condoms to prisoners “on the same basis as condoms are provided in the community”.<sup>131</sup> While this element of the policy is in accordance with international guidelines, the next paragraph states:

A prisoner may not receive condoms before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of “high risk behaviour.” The fact that a prisoner received counselling must be recorded on his/her medical file.<sup>132</sup>

This provision has prevented condom availability in prison from being provided in the same manner in which condoms are available in the community. The requirement that prisoners must talk to medical staff or health-care workers has created effective limitations to prisoner’s access to condoms. Sello Cornelius, the chairman of the HIV/AIDS Council at the Local Prison in South Africa—a prisoner-run body conducting awareness and education campaigns, and support groups—has suggested that prisoners are “uncomfortable” with the fact that they must talk to the prison medical officer in order to get condoms. Consequently, very few prisoners approach the health care workers to this end. “They are suspicious of the [lack of] privacy,” Cornelius has stated.<sup>133</sup> Other research has supported the criticism that, in practice, few prisoners have requested condoms.<sup>134</sup>

<sup>130</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & Joint UN Programme on HIV/AIDS (1998), Guideline 4, para 29(e).

<sup>131</sup> Department of Correctional Services, *Management Strategy: AIDS in Prisons: Provision of Condoms to the Prison Population*, Pretoria, 17 May 1996, cited in: Goyer, *supra* (in Chapter 3).

<sup>132</sup> *Ibid.*

<sup>133</sup> South Africa feeling the impact of HIV in prisons. IRIN PlusNews (undated), available at [www.plusnews.org/webspecials/HIV-in-prisons/SouthAfrica.asp](http://www.plusnews.org/webspecials/HIV-in-prisons/SouthAfrica.asp).

<sup>134</sup> Goyer, *supra*.

## South Africa: Parole for terminally ill prisoners

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### ***Stanfield v. Minister of Correctional Services & Others, (2003)*** **12 BCLR 1384 (High Court – Cape of Good Hope Provincial Division)**

#### **Court and date of decision**

The decision of the High Court (Cape of Good Hope Provincial Division) was rendered in 2003.

#### **Parties**

The plaintiff Stanfield was a 48-year-old inmate who had served about one third of a six-year sentence and who was terminally ill. The respondents were officials of the Correctional Services Department.

#### **Remedy sought**

The applicant sought immediate release on parole in view of the short time remaining in his life, which he wished to spend with his family. .

#### **Outcome**

The court granted the applicant's request for parole. Prison medical authorities tried to overturn this ruling, but the court rejected this attempt.

#### **Background and material facts**

The plaintiff Stanfield was judged by several medical experts to have at most one year to live because of small-cell carcinoma complicated by advanced ischemic heart disease. While the plaintiff had a terminal illness other than AIDS, the court's ruling in this case considered many issues of direct relevance to the situation of prisoners living with HIV in South Africa.

The level of HIV prevalence in South African prisons has been a matter of public dispute. The Institute of Security Studies, a non-profit research centre in South Africa, estimated in 2003 that as many as 45% of South Africa's 175 000 prisoners were HIV-positive.<sup>135</sup> The Department of Correctional Services has used the figure of 3%, though it has, at times, admitted this figure is an underestimate. The inspecting judge of prisons in 2003 suggested that the figure might be as high as 60%, a view contested by correctional authorities. A 1999 study of South African prisons found that 90% of deaths of persons in custody were related to HIV and AIDS. In most countries, HIV prevalence is higher in prisons than in the general population; HIV prevalence among adults in South Africa is estimated to be over 20%.<sup>136</sup>

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<sup>135</sup> KC Goyer. South Africa, HIV/Aids in Prison: Problems, Policies and Potential (Monograph No. 79). Institute for Security Studies, February 2003 (available at [www.iss.co.za/Pubs/Monographs/No79/Content.html](http://www.iss.co.za/Pubs/Monographs/No79/Content.html) at Chapter 3).

<sup>136</sup> For data cited in this paragraph, see references in Goyer, *supra*.

It is little wonder that in this case, the presiding judge noted that the case would be of keen interest to the thousands of HIV-positive detainees in the country even though the plaintiff was not himself HIV-positive.

## Legal arguments and issues addressed

South Africa's *Correctional Services Act of 1959*, the relevant statute in this case, allowed for medically justified parole: "A prisoner serving any sentence in prison who suffers from a dangerous, infectious or contagious disease...or whose placement on parole is expedient on the grounds of his physical condition, may at any time, on the recommendation of the medical officer, be placed on parole by the Commissioner" (section 69). The legal issues in this case that are most relevant to HIV/AIDS among prisoners were:

- the applicant's assertion that he had the human right to die in dignity;
- the assertion of one of the prison authorities that the applicant's parole should be refused because he appeared to be in good health, was not bed-ridden, and was physically still capable of committing a crime;
- the importance of the prison environment as a source of rampant infection for a prisoner for whom a reasonable standard of medical care requires being in an environment with a low risk of exposure to infectious disease, and
- the capacity of the prison system to provide the standard of care necessitated by the terminal illness.

The court made a number of observations on the above issues that are particularly relevant to people living with HIV.

First, the court accepted that the applicant had the right to die with dignity, relying on the Bill of Rights in the South African Constitutions (section 10), which referred to the inherent dignity of every human being.

Second, the court was highly critical of the view of one of the prison officials that at the moment of the application Mr. Stanfield was not bed-ridden and appeared to be in good health, at least to the degree of being able to commit another crime. This prison official had noted that releasing the applicant while he was in this state might well have a negative effect on other prisoners who had been diagnosed with terminal illnesses, particularly HIV. As paraphrased by the court, the prison official argued:

Like the applicant, their physical condition was, at least temporarily, such that they could continue living a normal life and could, indeed, revert to committing crimes...[It was] not inconceivable that such convicted criminals who now know that they are suffering from a terminal illness would be even less inhibited from committing further crimes should they be released prematurely.<sup>137</sup>

For this reason, this same official noted that the numerous HIV-positive persons in South African prisons were "anxiously awaiting" the decision in this case.

In strong language, the court rejected this argument, noting that the outward physical wellness of the applicant was temporary, and judging his condition on outward appearance was, in any case, disrespectful and wrong. In addition, to insist that he remain in prison "until he

<sup>137</sup> Stanfield, para 34.

has become visibly debilitated and bedridden can by no stretch of the imagination be regarded as humane treatment in accordance with his inherent dignity.” In fact, the court noted, this idea gives the impression “that the applicant must lose his dignity before it is recognized and respected.”

Third, the court considered the question of whether the prison environment would have a further negative effect on the applicant’s health. The Court discussed at length the capacity of prison hospitals to provide the specialized treatment required for the applicant’s carcinoma, finally concluding that the prison hospitals were not up to this job. This analysis would obviously be particularly relevant to any consideration of the care received by HIV-positive prisoners in South Africa. In addition, the court considered the fact that the applicant needed to be in an environment as free of infection as possible, especially of respiratory infection, particularly in view of the fact that a respiratory infection “in his immune-depressed condition, is likely to dramatically shorten his life.” Tuberculosis is probably the most important opportunistic infection of HIV in South Africa, and certainly in South African prisons. It undoubtedly “dramatically shortens” the lives of many prisoners with HIV. The court took particular note of the applicant’s immune-depressed state, which was particularly dangerous “in the unhygienic and crowded conditions prevailing in our prisons.”

Nonetheless, the court took special care to note the difference between this applicant’s condition and HIV: “The applicant’s condition was irreversible and incurable...and could not be compared with tuberculosis or HIV/AIDS, where the life expectancy with treatment could be 15 to 25 years.” The phrase “with treatment” should be noted as an important qualifier of this assertion by the court, particularly given the general lack of access to antiretroviral treatment in South Africa and the additional barriers to accessing treatment that are often faced by HIV-positive people in prisons the world over. The court, did, however, seem to consider the possibility that people living with HIV in prison might enjoy the benefit of compassionate parole if they are in terminal stages:

Despite the huge increase in the prevalence of HIV/AIDS and other terminal diseases in our prisons, only the tiniest percentage of prisoners suffering from such diseases were released on medical grounds during 2002....the release of terminally ill prisoners should receive far more attention. The alternative is grotesque: untold numbers of prisoners dying in prisons in the most inhuman and undignified way.<sup>138</sup>

## Commentary

The court relied on language in international human rights law with respect to protection from “cruel, inhuman and degrading treatment,” echoing Article 7 of the *International Covenant on Civil and Political Rights*—language which was also repeated in the South African Constitution. The decision also relied on language very similar to Article 10 of the Covenant, which guarantees that all “persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”

The court’s attempt to distinguish the illness of the applicant in this case from HIV rests on the assumption that persons living with HIV and in need of treatment for their illness would receive it in South African prisons. Insofar as South African prisoners living with HIV continue to be unable to realize their right to be treated for their illness, many of the arguments

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<sup>138</sup> Stanfield, para 128.

made in favour of this applicant should also be pertinent to their rights and entitlements. At the time of publication of this document, treatment for HIV unfortunately also remained beyond the reach of many persons in South Africa who are not in prison; some judicial authorities might find this to be an argument for not supporting the right of prisoners living with HIV to treatment for their illness. Such arguments must be weighed against the eventuality, noted so graphically by the court, of “untold numbers of prisoners dying in prisons in the most inhuman and undignified way”.

# United States of America: Inadequate medical care for HIV-positive prisoners is a violation of rights

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## ***Leatherwood et al. v. Campbell, United States District Court for the Northern District of Alabama, Case No. CV-02-BE-2812-W (2004– )***

### **Court and date of decision**

The United States District Court for the Northern District of Alabama issued a decision on 24 June 2004 (summarized here). Litigation in this matter was ongoing at the time of publication.

### **Parties**

The plaintiffs were inmates at Limestone Correctional Facility who filed a class action suit in the federal court in Birmingham, Alabama in November 2002. The defendants were the Commissioner of the Alabama Department of Corrections, the Director of Treatment for the Alabama Department of Corrections, the Limestone Security and Medical Staff, and NaphCare, Inc., the private company (previously) under contract to provide medical services to inmates.

### **Remedy sought**

The lawsuit challenged the legality of the living conditions and medical care provided at Limestone Correctional Facility. In their complaint, filed with the court in November 2002, the plaintiffs requested, among other forms of relief, that the court:

- declare unconstitutional and unlawful the medical treatment and living conditions of HIV-positive inmates incarcerated at the Limestone Correctional Facility; and
- enter preliminary and permanent injunctions ordering defendants, their successors, agents, employees, and all other persons acting in concert with them to immediately provide HIV-positive inmates at Limestone Correctional Facility with access to competent medical specialists, adequate and appropriate emergency care, adequate end-of-life treatment, and adequate diagnosis and medical treatment for opportunistic infections.

### **Outcome**

In June 2004, the magistrate of the US district court approved a settlement between the plaintiff prisoners and the state of Alabama, pursuant to which the Department of Corrections would:

- (i) be prohibited from housing HIV-positive prisoners in dormitories;
- (ii) clean the prisoners' cells; and

- (iii) ensure that its medical provider (such as a private corporation) hires a full-time nurse as an HIV coordinator, responsible for an infection-control program, education for prisoners on HIV and STD prevention, and arranging medical care for prisoners living with HIV.

## Background and material facts

At the time of this case, Alabama kept inmates with HIV segregated from other inmates within the correctional system. Limestone Correctional Facility (Limestone) in Harvest, Alabama was responsible for housing all HIV-positive inmates in the state. All prisoners in Alabama are mandatorily tested for HIV.

As part of the proceeding, the Atlanta-based Southern Center for Human Rights released a report in August 2003 by an infectious disease specialist on the medical treatment and living conditions of inmates at Limestone. The 125-page report provided a detailed case summary of the deaths of 38 HIV-positive inmates between 1999 and 2002 and concluded that the unit's medical care system was substandard. According to the physician's report, in nearly all of the 38 deaths, "death was preceded by a failure to provide proper medical care or treatment" and "preventable illnesses" caused all of the deaths. In addition, the report said that the "overcrowded," side-by-side, head-to-toe bunk beds of the facility "placed these immune-compromised patients and the staff at an undue risk of acquiring contagious diseases".<sup>139</sup>

According to the plaintiffs and the Southern Centre for Human Rights, the approximately 240 inmates of Limestone were held in a vast converted warehouse filled with rows of beds. The lawsuit claimed that the warehouse was often too hot or too cold and that it was infested with spiders, rats and birds. Most inmates could not take work and training programmes that were offered to other prisoners in other correctional facilities. As a consequence, HIV-positive inmates could not earn good-behaviour credit time and typically served longer sentences than HIV-negative inmates.

According to the Southern Centre, in May 2003, the Alabama Department of Corrections cancelled its contract with NaphCare, the private company it had contracted to provide medical services to inmates. No reasons were publicly stated. (NaphCare was subsequently dismissed as a defendant from the lawsuit in January 2004.) In October 2003 the contract was awarded to another company, Prison Health Services.

In early October 2003 the prison inmates were moved out of the converted warehouse and into cellblocks. In early 2004, Alabama began to integrate HIV-positive prisoners into in-prison programs, although the policy and practice of segregated housing remained.<sup>140</sup> However, health conditions and practices at the facility remained poor. In March 2004, the same infectious disease specialist issued a second report, saying that "one of the most egregious medical failures at Limestone is the number of preventable deaths. Patients continue to die because of the failure of the medical system."<sup>141</sup> In this second report, the physician detailed the deaths of

<sup>139</sup> Expert Report of Stephen Tabet, MD, MPH, in *Leatherwood v. Campbell*, 26 August 2003, available at [www.schr.org/prisonsjails/press%20releases/limestone\\_report.8-26-03\\_web.doc](http://www.schr.org/prisonsjails/press%20releases/limestone_report.8-26-03_web.doc). For additional documentation about this case, see the prisons section of the website of the Southern Centre for Human Rights at [www.schr.org/prisonsjails/](http://www.schr.org/prisonsjails/).

<sup>140</sup> The only state prison system other than Alabama to retain total HIV segregation into the 1990s was Mississippi. Mississippi took steps to integrate its educational and vocational training programs in 2001 and again in 2004. Recent developments in Mississippi are discussed below.

<sup>141</sup> Supplemental Report of Stephen Tabet, MD, MPH, in *Leatherwood v. Campbell*, 11 March 2004, available at [www.schr.org/prisonsjails/press%20releases/Tabetsupprpt.pdf](http://www.schr.org/prisonsjails/press%20releases/Tabetsupprpt.pdf).

five prisoners who died between October 2003 and March 2004. He found, for example, that one prisoner literally suffocated in front of medical staff without treatment, while another lost more than 170 pounds without medication and a proper diet. A third HIV-positive prisoner with tuberculosis was placed in a dormitory with other prisoners with HIV, exposing more than 200 prisoners with compromised immune systems to tuberculosis before he died.

On 2 June 2004, the magistrate judge approved a settlement in the case that the parties had reached in April 2004. The magistrate judge found that:

[T]he evidence demonstrates an absence of efforts to save lives by taking ameliorative actions such as conducting mortality reviews and ascertaining obvious problems in the medical system and then resolving these problems. HIV prisoners died without necessary intervention by the Limestone medical staff or Alabama Department of Corrections. The lack of ameliorative action on the part of the defendants and others demonstrates a sufficient disregard of human life and therefore provides a likelihood that the plaintiffs would succeed on the merits at a trial...<sup>142</sup>

The settlement required the Department of Corrections' medical provider to hire a full-time nurse to serve as an HIV coordinator charged with directing an infection-control programme and arranging medical care for HIV-positive prisoners, including monitoring treatment progress and educating prisoners on HIV, AIDS and sexually transmitted infections. The settlement also prohibited the Department from housing HIV-positive prisoners in dormitories and mandated that the Department clean the prisoners' cells. In August 2004, the United States District Court for the Northern District of Alabama accepted the magistrate's report and recommendation and approved the settlement agreement.

However, problems persisted. On 17 February 2005, attorneys from the Southern Center for Human Rights, acting on behalf of the HIV-positive inmates, filed a motion against Alabama Department of Corrections officials for their failure to comply with provisions of the settlement agreement relating to the provision of health care for the inmates.<sup>143</sup> The motion requested that the US District Court hold the defendants in contempt of court. The terms of the agreement had provided, among other provisions, that an HIV specialist and a doctor would provide treatment at the Limestone Treatment Facility. Since the settlement agreement, the two doctors at the facility have resigned. In her resignation letter in February 2005, one of the HIV specialists cited lack of organizational and administrative support from Prison Health Services.<sup>144</sup> At the end of April 2005, the Alabama Department of Corrections and Prison Healthcare Services asked the court to dismiss what it referred to as "misleading and inaccurate complaints" about medical care in the inmates' contempt motion. At the time of writing, the case was ongoing in the United States District Court.

## Commentary

The *Leatherwood v. Campbell* litigation compelled the Alabama Department of Corrections to agree to take a number of steps to improve the living conditions at Limestone. The ongoing litigation is intended to force compliance with that agreement. The fact that further

<sup>142</sup> The magistrate's report is available at [www.schr.org/prisonsjails/press%20releases/Magistrate%20Report%20Recommendation.pdf](http://www.schr.org/prisonsjails/press%20releases/Magistrate%20Report%20Recommendation.pdf).

<sup>143</sup> Southern Center for Human Rights. "Motion for contempt filed on behalf of HIV-positive inmates," 17 February 2005. See media release and motion documents via [www.schr.org/prisonsjails/press%20releases/press\\_limestone\\_contempt.htm](http://www.schr.org/prisonsjails/press%20releases/press_limestone_contempt.htm).

<sup>144</sup> Paul von Zielbauer. "Company's Troubled Answer for Fragile Inmates," *New York Times*, 1 August 2005, pp., 1, 11

litigation has been necessary illustrates that the ultimate success of strategies using courts and tribunals to defend and promote human rights will depend in part on whether there is a culture of respect for the rule of law in the jurisdiction in question, as well as watchdog agencies.

The *UN Basic Principles for the Treatment of Prisoners*, adopted as a resolution by the UN General Assembly, established that prisoners have the right to the same standards of health care as available in the community.<sup>145</sup> The United Nations *International Guidelines on HIV/AIDS and Human Rights* recommend certain measures with respect to prisoners:

Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners.<sup>146</sup>

The *Leatherwood v. Campbell* litigation did not end Alabama's policy of segregation of HIV-positive prisoners from the general prison population. This policy is counter not only to the *International Guidelines on HIV/AIDS and Human Rights*, but also to the WHO Guidelines on HIV infection and AIDS in prison. The relevant part of that policy states:

Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds...<sup>147</sup>

At odds with this common approach from expert bodies in the fields of both health and human rights, the Alabama policy of segregation of HIV-positive inmates has been upheld by US courts. A federal court upheld mandatory testing and segregation in the Alabama state prison in 1990 and stated that prisoners who requested AZT treatment were not entitled to "state of the art" treatment, but only reasonable care according to the community standard.<sup>148</sup> Given subsequent developments in the widely accepted standard of care for treatment of people living with HIV, theoretically this position denying antiretroviral treatment would no longer withstand challenge.

However, the policy of segregation has continued to attract support from higher courts in recent times. In 1999, in *Davis v. Hopper*,<sup>149</sup> the US Court of Appeals (11th Circuit) ruled that the State of Alabama's total segregation of inmates with HIV did not violate the *Americans with Disabilities Act* or the 1973 *Rehabilitation Act*. The court concurred with the prison officials' argument that, because of prisoners' unpredictable behaviour and the fatal nature of AIDS, all inmates with HIV pose a "direct threat" to other inmates and corrections officers and thus

<sup>145</sup> *UN Basic Principles for the Treatment of Prisoners*, UN General Assembly Resolution 45/111, 45 UN GAOR Supp (No 49A) at 200, UN Doc A/45/49 (1990), Articles 5 and 9.

<sup>146</sup> *HIV/AIDS and Human Rights: International Guidelines*. Office of the UN High Commissioner for Human Rights & Joint UN Programme on HIV/AIDS (1998), Guideline 4, para 29.

<sup>147</sup> World Health Organization. Guidelines on HIV infection and AIDS in prisons (1993), para 27.

<sup>148</sup> L Gostin and L Porter. AIDS litigation project II: a national survey of federal, state and local cases before courts and human rights commissions. Objective description of trends in AIDS litigation. Washington, DC: Department of Health and Human Services, Public Health Service, National AIDS Programme Office, 1991.

<sup>149</sup> Case No. 98-9663.

may be categorically excluded from prison programs. In January 2000, the US Supreme Court refused to consider an appeal by Alabama inmates who challenged their segregation in that state's prisons, and let stand the decision in *Davis v. Hopper*. These decisions are at odds with international standards.

These decisions are also at odds with developments in Mississippi, the only other US state to maintain a policy of segregation of HIV-positive inmates into the 1990s. A lawsuit was filed in 1990 in the case on behalf of the inmates at the Mississippi State Penitentiary in Parchman.<sup>150</sup> In a preliminary judgement in 1999, a magistrate judge ordered that prison inmates were entitled to the quality of HIV medical care outlined in treatment guidelines issued by the National Institutes of Health, and that the Mississippi Department of Corrections had an obligation to provide HIV-positive inmates with combination antiretroviral medication. In 2001 Mississippi integrated its educational and vocational training programmes so that HIV-positive inmates were permitted to participate in in-prison programs, although they were still excluded from community corrections programs. In June 2004, the same magistrate judge ordered an injunction requiring the Mississippi Department of Corrections to allow HIV-positive prisoners to participate in community work programs. This injunction was lifted in March 2005, as the magistrate no longer considered it necessary because the conditions of HIV-positive inmates had improved sufficiently.<sup>151</sup>

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<sup>150</sup> *Gates v Fordice*, US District Court (Northern District of Mississippi, Greenville Division), Case No. 4:71CV6-JAD, consolidated with *Moore v Fordice*, Case No. No 4:90CV125-JAD, available at <http://sunset.backbone.olemiss.edu/~llibcoll/ndms/jul99/99D0090P.html>.

<sup>151</sup> Federal Judge Removes Injunction on Mississippi Dept. of Corrections Regarding Treatment of HIV-positive Inmates. *Kaiser Daily HIV/AIDS Report*, 4 April 2005.



The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
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### **Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV**

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As the case studies in this volume demonstrate, the law can be protective of human rights, but can also impede their realization. Over the years, people living with or affected by HIV have sometimes successfully claimed the protection of the law. In other instances, courageous activists have challenged the law to embody the human rights protections they deserve. This volume presents 30 summaries of court or tribunal proceedings aimed at defending or securing the human rights of people living with, or vulnerable to, HIV. With an emphasis on cases from developing countries, this volume examines key litigation efforts to advance a "human rights-based approach" to HIV on three fronts: discrimination, access to treatment, and prevention and care for prisoners. Understanding the ways in which litigation has been used in the struggle for human rights, successfully or otherwise, helps legislators, jurists, advocates and policy-makers to understand and use the law optimally in the response to AIDS.

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