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Legislation contagion: the spread of problematic new HIV laws in Western Africa

Model legislation can be a useful tool for fighting HIV/AIDS, but only if it is based on sound human rights principles. In 2004, AWARE-HIV/AIDS prepared a model law on HIV for use in Western Africa. Several countries in the region have already drafted national laws based on the model law. In this article, Richard Pearshouse reviews some of the key provisions in the model law, identifying a number of human rights concerns that should be addressed before such legislation should be considered as a model to be implemented by national legislatures.

Introduction

It has been almost 20 years since the Australian High Court judge Justice Michael Kirby warned of the spread of a dangerous kind of a virus, “highly inefficient laws.”¹ Even at that early stage of the epidemic, Kirby identified what he described as “variant strains” of highly inefficient laws, such as laws providing for the mandatory testing of vulnerable groups, or restrictions on the freedom of movement of people living with HIV.

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Trilingual issue

This issue has been published in three languages: English, French and Russian — a first for the *Review*! The Russian version is located in the middle of this volume, and its page edges are shaded grey.

Special Section: Law and Health Initiative

This issue of the *Review* includes a special section which contains a series of articles describing interventions in Africa and Eastern Europe that link AIDS and human rights. These interventions were piloted by the Law and Health Initiative of the Open Society Institute Public Health Program.

See page 59.

Выпуск на трех языках

Данный выпуск журнала публикуется на трех языках: английском, французском и русском – впервые в истории Обзора! Русская версия расположена в середине данного тома; края страниц русской версии окрашены в серый цвет.

Legislation contagion: the spread of problematic new HIV laws in Western Africa

cont'd from page 1

He noted that

the virus of which I speak is not detectable under the microscope. It is nonetheless a tangible development, which may be detected in a growing number of societies. In some ways, it is as frightening and dangerous as the AIDS virus itself. It attacks not the body of an individual but the body politic.²

In the twenty years since this warning, a considerable number of countries across the globe have chosen to adopt national laws on HIV/AIDS. Frequently, these are general HIV laws – i.e., wide-ranging, “omnibus” laws specifically about HIV.

(Not all countries have adopted general HIV laws. Some jurisdictions have chosen to revise existing laws, such as those relating to public health or anti-discrimination — while others have not adopted specific legislation, but instead have established a national response in a framework policy document, such as a national strategic plan.)

While there is no established format per se for the general HIV laws, there are now enough examples that it is possible to identify common features, positive and negative. Often, such laws establish a national body to co-ordinate activities on HIV/AIDS and undertake surveillance; mandate education and information activities; provide for the safety of blood, tissue and organ supplies; establish the legal principles underpinning HIV testing and counselling; contain protections

against HIV-related discrimination; and include guarantees regarding the confidentiality of HIV status. HIV laws can also provide for criminal penalties for certain breaches of the law, and may even include specific offences of transmission of, or exposure to, HIV.

Practically unnoticed by those outside the region, Western Africa has witnessed a proliferation of national HIV laws in the last few years. Since 2005, seven national HIV laws have been passed in the region (in Benin, Guinea, Guinea-Bissau, Mali, Niger, Togo and, most recently, Sierra Leone).³ According to one observer, a further six countries currently have national HIV bills under development.⁴ These developments make Western Africa one of the most “legislated” regions in the world (if not *the* most legislated) when it comes to HIV.

The development of so many HIV laws so quickly has not come about by chance. Rather, it is a consequence of a project to promote a model law on HIV in the region.⁵

Model law

In September 2004, a small project, Action for West Africa Region–HIV/AIDS (AWARE–HIV/AIDS), held a workshop in N’jamena, Chad. Based in Ghana, AWARE–HIV/AIDS operates across Western Africa. It receives USAID funding, and is implemented by Family Health International with additional funding from US-based organizations such as

Population Service International and the Constella Futures Group.⁶

The stated purpose of the workshop held in N’jamena was to adopt a model law on HIV. A large number of parliamentarians from the region attended. Over the three days of the meeting, a model law on HIV/AIDS for West and Central Africa (the model law) was adopted by the participants, together with a plan to promote the model law throughout the region.

Model laws are only useful if they are substantively good laws; otherwise, the problems and errors risk being repeated in laws based on the model law.

Model legislation is a relatively common tool for law reform. It involves the development of a legislative “template” which individual jurisdictions are free to modify and adopt. Model legislation offers the advantages of sharing experiences and avoiding the duplication of drafting separate laws in each jurisdiction.

The UN, for example, has model legislation against racial discrimination.⁷ Model legislation is also effective in standardizing legal approaches across jurisdictions with similar legislative frameworks, including within countries that have a federal system of government.

However, model laws are only useful if they are substantively good laws; otherwise, the errors and problems contained in the model risk being repeated in laws that are based on the model law.

The AWARE- HIV/AIDS model law is described in press releases as addressing the need for “human rights legislation in that region to protect those who are infected and exposed to HIV.”⁸ In its introduction, the model law notes that

[t]he irrational fear of this infection is fuelled by ignorance, leading to prejudices, discrimination and stigmatisation of PLWHA and those related to them. The violation of the human rights of people affected or infected by HIV/AIDS is of critical concern in the prevention, treatment and management of HIV/AIDS.⁹

There are several positive features of the model law, including:

- provisions guaranteeing pre- and post-test counselling;
- provisions guaranteeing health care services for people living with HIV/AIDS (PLHIV);
- protections of medical confidentiality; and
- prohibitions of discrimination on the basis of actual or perceived HIV status, including in the workplace, in educational facilities, in health care settings, and in relation to credit and insurance coverage.

However, when examined through a human-rights lens, the model law contains a number of problematic provisions.

The AWARE-HIV/AIDS model law through a human-rights lens

There exists specific guidance on how human rights should be incorporated into HIV legislation. For example, the *International Guidelines on HIV/AIDS and Human Rights* (International Guidelines), which were developed at an series of expert consultation meetings convened by the U.N. High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), contain 12 specific guidelines on how human rights should be promoted and protected in the context of the HIV/AIDS epidemic.¹⁰

The *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (Handbook for Legislators), developed by the Inter-Parliamentary Union and UNAIDS in 1999,¹¹ presents concrete measures that legislators and state officials can take to implement the International Guidelines.

Unfortunately, many parts of the model law run counter to this guidance.

Education and information

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

Such an approach is at odds with the reality of the age of first sexual intercourse in many countries. In Mali and Guinea, for example, the median age of first intercourse for girls is 16.¹² Children’s access to health education should not be determined by what their parents think is appropriate.

Rather, comprehensive education programs that provide complete, factual and unbiased information about HIV prevention, including information about the correct and consistent use of condoms, are crucial for adolescents and young adults in such contexts. Access to information about HIV/AIDS is a human right.

The *International Covenant on Civil and Political Rights* (ICCPR) guarantees that all people have the right to “seek, receive and impart information of all kinds,” including information about their health.¹³ The right to education is guaranteed by numerous international legal instruments, including the *Convention on the Rights of the Child*.¹⁴

The International Guidelines call on states to take positive steps to “ensure the access of children and adolescents to adequate health information and education, including information related to HIV/AIDS prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively with their sexuality.”¹⁵

Disclosure obligations and the “duty to warn”

Article 26 of the model law requires a person diagnosed with HIV to disclose his or her HIV status to a “spouse or regular sexual partner” as soon as possible and at most within six weeks of the diagnosis. The

testing centre shall be required to disclose to spouses or sexual partners after six weeks, “provided all efforts are made to enable to partners to have full understanding of the situation.”

This requirement is overly broad. Why is disclosure required by law, without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner — regardless of such things as the sexual conduct in question, whether precautions to prevent transmission are taken, the PLHIV’s ability to disclose safely, and the PLHIV’s concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse.

Disclosure of HIV-positive status can be difficult for various reasons, not least the stigma and shame that often surround a diagnosis of HIV infection.

Disclosure of HIV-positive status can be particularly difficult for various reasons, not least the stigma and shame that still too often surround a diagnosis of HIV infection. In some cases — particularly for women — fear of violence may be a reason for not notifying a partner. Some jurisdictions include screening for domestic violence or referral to specialized

services for victims of domestic violence as part of the partner notification process.¹⁶ The International Guidelines recommend voluntary partner notification, but with provision for exceptional circumstances:

Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counselled;
- Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
- The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
- A real risk of HIV transmission to the partner(s) exists;
- The HIV-positive person is given reasonable advance notice;
- The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice;
- Follow-up is provided to ensure support to those involved, as necessary.¹⁷

HIV testing issues

Article 18 of the model law prohibits mandatory HIV testing, but creates a number of specific exceptions:

- “when a person is indicted for HIV infection or attempt to infect another person with HIV”;
- when a person is indicted for rape;

- “when determining HIV status is necessary to solve a matrimonial conflict”;
- organ, cell or blood donations; or
- “when a pregnant woman undergoes a medical checkup.”¹⁸

Because of the invasive nature of mandatory and compulsory HIV testing, such testing violates an individual’s right to privacy and right to bodily integrity.¹⁹ HIV testing without consent is almost never justified²⁰ and, as with other infringements of human rights, requires careful scrutiny of the justifications claimed.

Compulsory testing of people indicted on charges of rape and HIV infection or attempted infection

Legislating compulsory HIV testing of people accused of such crimes should be undertaken with extreme caution. The primary reasons are that such testing:

- does not provide timely or reliable information about the sexual assault survivor’s risks of contracting HIV infection;²¹
- is a misdirected, potentially negative approach to addressing the needs of a sexual assault survivor;²²
- infringes on the rights of an accused to bodily integrity, privacy and human dignity; and²³
- might not facilitate the survivor’s psychological recovery.²⁴

The presumed goal of compulsory testing of accused sexual offenders is to provide an opportunity for victims to receive post-exposure prophylaxis (PEP) where they may have been exposed to HIV. However, the

law should ensure that all victims of sexual offences are given access to PEP and counselling about PEP, regardless of whether compulsory testing of sexual offenders is mandated.

Compulsory testing to resolve a marital dispute

Rarely, if ever, will the resolution of a matrimonial conflict require forced HIV testing. Moreover, it is not recommended that HIV status be a ground for voiding a marriage because this would increase stigma against people living with HIV.

Compulsory testing of pregnant women

A UNAIDS policy statement on HIV testing and counselling states that

[r]egardless of the presence of risk factors or the potential for effective intervention to prevent transmission, [pregnant] women should not be coerced into testing, or tested without consent. Instead, they should be given all relevant information and allowed to make their own decisions about HIV testing, reproduction and infant feeding.²⁵

The routine *offer* of HIV testing to pregnant women (as distinct from routine testing, where testing is done automatically unless the person explicitly refuses), accompanied by counselling and informed consent, is an appropriate response that seeks both to advance public health objectives and to respect, protect and fulfil human rights.

Criminalisation of HIV transmission or exposure

Article 36 of the model law addresses the issue of criminalization of

HIV transmission or exposure. Unfortunately, particularly given the complexity of this issue, Article 36 is awkwardly drafted and unclear. For no apparent reason, the order of the sub-paragraphs is reversed in the French and English versions, and there are clear discrepancies between the texts of each version.

One portion of Article 36 of the model law creates an offence of “wilful transmission.” It states, “Any person who is guilty of wilful transmission of HIV shall be sanctioned with ... [penalty].” “Wilful transmission” is defined in Article 1 as transmission of HIV “through any means by a person with full knowledge of his/her HIV/AIDS status to another person.” “HIV transmission” is also defined, with the clarification that infection “can occur through sexual intercourse, blood transfusion or the sharing of intravenous needle[s], skin piercing instruments or through [m]other-to-child transmission.”

To the extent that criminal law is used in the context of HIV, the International Guidelines recommend that:

[c]riminal and/or public health should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.²⁶

With respect to this section of Article 36, it is appropriate to include actual knowledge of HIV infection as a necessary precondition of criminal liability.

However, the phrase “through any means” casts the net too widely, particularly in light of how “HIV transmission” is defined in the model law. The effect might be to impose criminal penalties in situations where:

- a person practices safer sex, regardless of whether the person disclosed to the sexual partner and regardless of the actual risk of transmission;
- a person takes steps to disinfect an intravenous needle or other skin-piercing instrument, again regardless of whether there was disclosure and regardless of the actual risk of transmission; and

The model law does not address any of the social, cultural, economic and legal factors that make women more vulnerable to HIV infection.

- a mother transmits HIV to a child, including *in utero* or during labour and delivery, regardless of precautions taken to reduce the risk of transmission and regardless of the actual risk of transmission.

Omissions in the model law

Women

Among the “principles” enunciated in the model law are the following:

The government shall vigorously address conditions which increase the transmission of HIV infection including poverty, gender inequality, traditional practices....

The government shall recognize the increasing vulnerability of women and children and take actions to address their specific needs.

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

Prisoners

Article 8 of the model law provides that information on HIV be provided "in the most appropriate way" in all prison institutions. It gives the Ministries of Justice, Interior and Health the power to implement this article. Although it is implicit that certain details are to be established by subsidiary legal regulations, Article 8 provides no direction as to what such regulations should include. To be effective, information about HIV needs to be accompanied by the actual provision of materials to prevent HIV in prison settings, such as condoms and sterile injecting equipment.

Other vulnerable persons

There is very little in the model law on vulnerable persons or on programs to be directed towards them.

National HIV laws

Proponents of model law often cite the sovereignty of states as a "check and balance" on model law. In other words, states remain free to adopt,

adapt, modify or reject the template legislation in accordance with their specific context and needs.

Given the experience of the N'djamena model law, such a view is naïve. Despite the numerous provisions that are problematic from a human rights perspective, the model law is presented as model (i.e., ideal or best practice) legislation. Indeed, all of the national HIV laws in Western Africa have clearly been influenced by the model law. One of them, the law recently passed in Guinea-Bissau, replicates the model law almost word for word.

What usually happens is that the national laws are based closely on the provisions of the model law — with certain modifications, additions and omissions, but following the same general legislative framework. For example, the provisions on partner notification and a health care professional's "duty to warn" in the laws from Niger, Mali and Togo are substantially the same as the corresponding model law provisions discussed above.

Sometimes, the national laws contain additional provisions that are an extension of the same legislative intent behind the model law. Where the model law's provisions have ignored human rights law and principles, the corresponding provisions in national laws may compound such problems. For example:

- Article 2 of the Guinean law adds a further restriction (to the text found in the model law) on HIV/AIDS education and information by specifically providing that it is forbidden to give HIV/AIDS education to children under 13.

- Article 28 of the Guinean law requires mandatory HIV testing before marriage.
- Article 50 of the Togolese law provides for periodic mandatory testing of sex workers for HIV and sexually transmitted diseases.²⁷

Despite the recommendation in the International Guidelines that there be no HIV-specific offences,²⁸ all the national HIV laws establish offences of "wilful HIV transmission."²⁹ None of the laws define "wilful," which omission runs counter to the caution in the International Guidelines that in the case of criminal transmission or exposure offences, states "should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties."³⁰

Only the law of Togo provides some guidance as to the requisite mental element in establishing criminal guilt: Article 53 of this law says that it is a criminal offence for a person to have "unprotected sexual relations with the *intention* of transmitting the virus or any other activity to *wilfully* spread the virus."

If a provision on criminal transmission is to be included in law, the application of criminal sanctions should be limited to conduct that shows this high level of malicious intent, thus limiting the scope of the state's most serious legal tool and penalties to those cases which are clearly deserving of such treatment.

Other national laws are far more vague with respect to the conduct they would criminalize. For example:

- Article 27 of the Benin law makes it a crime for any person

who knows she or he has “the AIDS virus [sic]” to engage in “unprotected sexual relations” without disclosing her or his infection to the sexual partner. No actual transmission of HIV is required.

- Article 14 of the law in Togo imposes an obligation upon all persons to use male or female condoms “in all risky sexual relations.” In effect, it makes any vaginal or anal sex without a condom an illegal act, regardless of the circumstances. Article 13 specifically targets PLHIV, prohibiting them from any “unprotected sex” — regardless of whether they have disclosed their infection to a sexual partner who is consenting, and regardless of the HIV status of their sexual partner.

Some national laws appear to treat mother-to-child transmission of HIV as a criminal offence.

- In the law from Guinea, the basic crime of “wilful HIV transmission” arises out of both Article 35 (which makes transmission through sex or blood an offence) and the underlying definition in Article 1 of the term “wilful HIV transmission.” The definition appears to include not only those

circumstances in which the virus is actually transmitted through HIV-contaminated substances, but also any exposure to such substances regardless of the consequences.

This definition also appears to impose criminal liability, for transmission and even for exposure, without regard to: (a) whether the person knew she or he had HIV or was aware of the risk of transmission; (b) the actual risk of transmission associated with the activity; (c) whether the PLHIV disclosed to the other person, or the other person was aware in some way of the HIV infection; (d) whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting equipment); and (e) whether in the circumstances the PLHIV had control over the degree of risk (e.g., use by husband or partner of a condom).

- The definition of “HIV transmission” in some laws (e.g. Guinea, Guinea-Bissau, Mali, Niger) include mother-to-child transmission (MTCT): Certain definitions of “HIV transmission” refer explicitly to MTCT; others would appear to include MTCT as a form of transmission by way of blood. Because such definitions could be determinative in establishing the offence of “wilful HIV transmission,” these laws appear to establish that MTCT is a criminal offence.
- The law in Sierra Leone contains two distinct articles establishing an offence of “HIV transmission.” Article 21(1) establishes

that a person who is infected with HIV (and aware of the fact) must “take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of a pregnant woman, the foetus.” According to Article 21(2), a person who is infected with HIV (and aware of the fact) must not knowingly or recklessly place another person (“and in the case of a pregnant woman, the foetus”) at risk of becoming infected with HIV, unless that person knew of the fact and voluntarily accepted the risk of being infected.³¹

There are several problems with these provisions. First, they would violate the right to medical treatment with voluntary, informed consent. Informed consent to undergoing antiretroviral therapy to reduce MTCT is important because the treatment may affect the health of the pregnant woman.³²

Second, it is not specified what “all reasonable measures and precautions” would include. Indeed, it is not at all clear that such measures and precautions are clearly enough articulated and understood by health care professionals and pregnant women in a way that would make it appropriate to apply criminal sanctions for a departure from those measures and precautions. To cite just one example, would HIV transmission that occurred during breastfeeding attract criminal liability?

Third, fear that giving birth in a health care facility could expose women to criminal liability risks driving women away from health care facilities and particularly maternity care. Fourth, it is

doubtful that criminal punishment of a mother would be in the best interests of her newly-born child.

Conclusion

The pressure on legislators and governments in jurisdictions across the globe to produce a legal response to HIV is enormous.³³ However, laws pertaining to HIV, even those dressed in the garb of human rights, are not always progressive. These laws can be instrumental in promoting effective initiatives to address the HIV/AIDS epidemic, but they can also impede such initiatives.

A detailed framework of human rights principles (the International Guidelines) exists to guide legislators in the process of legislating in relation to the pandemic. To contribute constructively to reducing the impact of HIV, national laws need to establish a genuinely supportive environment for people living with the virus or those most vulnerable to infection. Far too often, this point seems to have been ignored in recently adopted HIV laws in Western Africa.

— Richard Pearshouse

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³ The "Law on prevention, care and control of HIV/AIDS" (No. 2005-31 of 5 April 2006) in Benin; the "Law on prevention, care and control of HIV/AIDS" (No. 2005-25) in Guinea; the "Framework law relating to the prevention, treatment and control of HIV/AIDS" in Guinea-Bissau; the "Law establishing rules relating to the prevention, care and control of HIV/AIDS" (No. 06-28 of 29 June 2006) in Mali; the "Law relating to the prevention, care and control of Human Immunodeficiency Virus (HIV)" (No. 2007-08 of 30 April 2007) in Niger; "The Prevention and Control of HIV and AIDS Act (2007)" in Sierra Leone; and the "Law on the protection of people with respect to HIV/AIDS" (No. 2005-012) in Togo.

⁴ According to Professor Amsatou Sow Sidibe at the University of Cheikh Anta Diop in Dakar, these countries are Cameroon, Chad, Mauritius, Senegal, Côte d'Ivoire and Cabo Verde; A.S. Sidibe, "Étude régionale des cadres législatifs relatifs aux VIH/SIDA," presentation at the consultative meeting on the HIV legal framework addressing human rights and gender; Hotel N'gor Diarama, Dakar, Senegal, July 24–25, 2007.

⁵ One press release from July 2007 describing the adoption of the most recent law in the region is titled "Seven down, eleven to go: Sierra Leone seventh country to adopt HIV/AIDS law with help from Constella Futures": Constella Group, July 17, 2007. At www.constellagroup.com/news/impact/2007/hiv_aids_model_law_071707.php.

⁶ See www.fhi.org/en/HIVAIDS/country/WestAfrica/wafri-capartners.htm; AWARE-HIV/AIDS, *Regional Workshop to Adopt a Model Law for STI/HIV/AIDS for West and Central Africa – General Report*, September 2004 (copy on file with author); Constella Group.

⁷ OHCHR, *Model National Legislation for the Guidance of Governments in the Enactment of Further Legislation Against Racial Discrimination*. At www.unhchr.ch/html/menu6/2/pub962.htm. For examples of legislation on illicit drug control, see www.unodc.org/unodc/en/legal_advisory_common.html.

⁸ Constella Group.

⁹ AWARE-HIV/AIDS.

¹⁰ UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated version. Available at www.ohchr.org/english/issues/hiv/guidelines.htm.

¹¹ UNAIDS and the Inter-Parliamentary Union, *The Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999. Available at www.ipu.org/PDF/publications/aids_en.pdf. At the time of writing, an updated second edition of the handbook was in preparation.

¹² M. Bozon, *At What Age Do Women and Men Have Their First Sexual Intercourse? World Comparisons and Recent Trends*, Institut National d'Études Démographiques (France) (drawing on DHS surveys), 2003.

¹³ *International Covenant on Civil and Political Rights*, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), article 19.

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

¹⁵ International Guidelines, para. 38(g).

¹⁶ A. Medley et al, "Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child

transmission programmes," *Bulletin of the World Health Organization* 82 (2004): 299–307.

¹⁷ International Guidelines, Guideline 3(g).

¹⁸ For an unknown reason, the provision establishing compulsory testing of pregnant women in pre-natal care appears in the English version of the model law, but not the French version.

¹⁹ See, e.g., art. 17 of the ICCPR.

²⁰ The one exception to the prohibition on mandatory testing is the case of blood and human tissue or organ donation, where there is an obvious health imperative to perform HIV testing and where the state owes a duty of legal care towards potential recipients.

²¹ An accused's negative HIV test result does not conclusively prove that the victim was not exposed to HIV because alleged offenders may be tested during the "window-period" during which HIV tests do not detect infection: Legal Assistance Centre (LAC), *A Case Against Mandatory HIV Testing of Rapists*, 1997; AIDS Law Project (ALP), Centre for Applied Legal Studies, *Submission on the Compulsory HIV Testing of Alleged Sexual Offenders Bill*, February 6, 2003.

²² Regarding the potential for negative impact, the LAC report (see previous note) states that if mandatory testing is pursued in order to charge rapists with additional crimes, rape victims could be made vulnerable to questions regarding their sexual history and their HIV status prior to the assault. Privacy surrounding victims' HIV status post-trial could also become problematic.

²³ *Ibid.*

²⁴ The ALP's report (see note 21) states that "the vast majority of alleged offenders are not apprehended within a short period." This means that victims will most often not have the benefit of test result information when making decisions regarding the initiation of antiretroviral therapy.

²⁵ UNAIDS, *UNAIDS Policy on HIV Testing and Counselling*, 1997, p. 1. The International Guidelines emphasize that "States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose": International Guidelines, para. 38(f).

²⁶ International Guidelines, Guideline 4, para. 21 (a).

²⁷ The International Guidelines oppose mandatory testing of sex workers and recommend a broader, non-coercive prevention approach: International Guidelines, para. 29(c).

²⁸ International Guidelines, Guideline 4, para. 21 (a).

²⁹ In practice, most of the provisions criminalize exposure to, rather than transmission of, HIV.

³⁰ *Ibid.*

³¹ Rather than being derived from the model law, Article 21 of the Sierra Leone law appears to be based on Article 24 of Kenya's *HIV and AIDS Prevention and Control Act (2006)*, although the explicit mention of MTCT is unique to the Sierra Leone law.

³² See Center for Reproductive Rights, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, briefing paper, August 2005. At www.reproductiverights.org/pdf/pub_bp_HIV.pdf.

³³ M.D. Kirby.

¹ M.D. Kirby, *The New AIDS Virus — Ineffective and Unjust Laws*, unpublished paper for the International Symposium on AIDS, Paris, 23 October 1987, reprinted in *Washington Post*, February 2, 1988, p. 14.

² *Ibid.*