Tilburg University – Tilburg Law School

LL.M. in International and European Public Law

Balancing Rights and Public Health Concerns: Mandatory Sexual Health and HIV Testing of Sex Workers in International Human Rights Law

Master's Thesis

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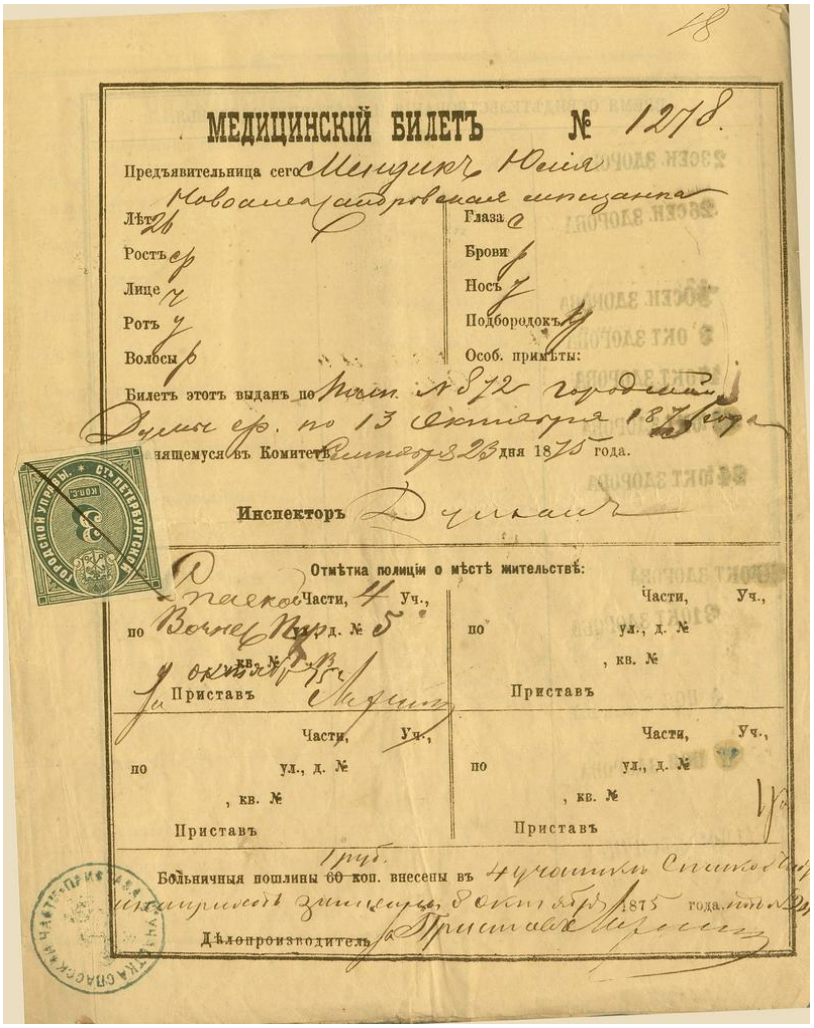
'Like civilization, the hospital is an artificial locus

in which the transplanted disease

runs the risk of losing its essential identity.'

Michel Foucault. *The Birth of the Clinic*. 1963.



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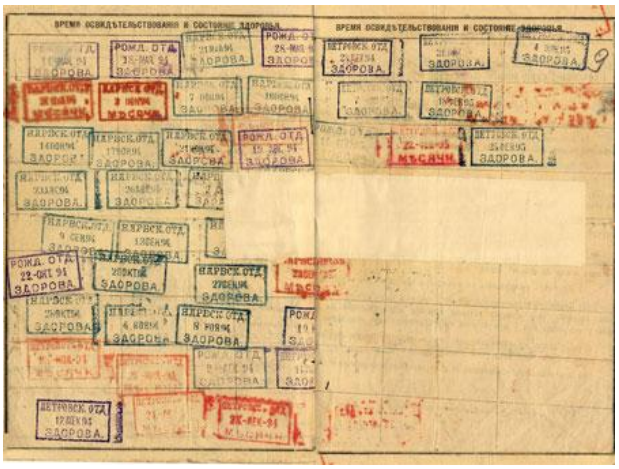

Sex worker passport in Russia before the revolution
Source: Sex worker migration exhibition in Berlin and Bremerhaven

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INTRODUCTION

The purpose of this research is to provide a better understanding of the current issue of mandatory sexual health and HIV testing of sex workers[1], while underlining the relation between such measures and the international human rights framework. The following pages will analyse how mandatory sexual health and HIV testing has been applied in practice by some national laws and policies, and examine whether implementing mandatory testing has grounds in international human rights law. Thus, conclusions will be drawn based on the central research question: does mandatory sexual health and HIV testing have legal grounds under international human rights law?

Additionally, the intention is to approach this topic from the public health and human rights perspectives at the same time. There are two reasons for this. The first is that public health concerns are at the heart of the problem. The second is that human rights are hardly absolute (limitations of these rights are allowed with respect to the principles of proportionality, necessity, and legality). What states are not allowed to do is violate human rights.

The right to the highest attainable standard of health ('right to health'), one of the core rights to be elucidated in this work, is strongly connected to public health concerns and to other human rights. It is in a very delicate position, since it demands not just great effort on the part of states in order to fully realise it, but also a correct balance between protection of vulnerable members of society from health-related discrimination and society's public health aspirations and concerns. Moreover, it is not always crystal clear in which way states can realise this right. In relation to mandatory testing of sex workers, Anand Grover, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, wrote that:

> "Mandatory, compulsory and, in some circumstances, routine testing and treatment approaches fail to address the effects of stigma, discrimination, violence and power imbalances on a sex worker's ability to negotiate protection during sex or seek health services. Rather than changing or even challenging the subordinate

[1] This study follows the technical language used by international organisations working in this field. Therefore, the term 'sex work' will be used as a preferred term to 'prostitution' and 'commercial sex work'. Due to its definition as work, it will be dealt with in this study as a profession, even where there is an express prohibition of sex work in the framework of national laws. The UNAIDS guidance note on HIV and sex work (2009) defines sex workers as "female, male and transgender adults and young people [18 years and above] who receive money or goods in exchange for sexual services, either regularly or occasionally." However, when referring to specific law provisions, and other legal documents, the term 'prostitution' will be used instead, since the laws refer to it as such.

> position of sex workers, mandatory testing and treatment can reinforce their stigmatization."[2]

Stigmatisation takes us to vulnerability. Sex workers are well-known for being a vulnerable group, which means that their risk of violence and HIV/STI infection is higher than that of the general population.[3] Studies prove that violence *per se* increases sex workers' vulnerability to HIV/STI infection.[4] Moreover, stigma, discrimination, and lack of access to health services are added factors that increase this group's vulnerability to violence and HIV/STI infection.[5]

In this context, state laws have the duty to protect sex workers' rights by enabling an environment in which they are able to fulfill their fundamental rights, and be free from practices that put them at risk.[6] Vulnerability is a phenomenon that can be reduced by applying good practices in governance and lawmaking, which are in line with international standards of health, safety, and well-being. Vulnerability in society also has the effect of generating vulnerability before the law.[7] Where sex workers are more vulnerable, they normally have less access to justice, and face institutional repression instead of protection.

In spite of sex workers' marginalisation, stigmatisation, and multiple vulnerabilities, especially to HIV/STI infection, some states, in response to the mushrooming public health challenges of the HIV/AIDS epidemic, have been developing laws and policies aimed at halting the spread of the infection by means of compulsory testing. Within this context, mandatory sexual health and HIV testing among sex workers will be examined in order to

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[2] UN General Assembly, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: note / by the Secretary-General*, 10 August 2009, A/64/272.

[3] According to the World Aids Day Report 2012, 'HIV continues to have a disproportionate impact on sex workers (…). A recent review of data in 50 countries showed that 12% of female sex workers are living with HIV and the chance of women who engage in sex work being infected is 13.5 times higher than others' (UNAIDS, 2012, p. 36). Some other reports highlight the high prevalence of HIV infection of sex workers in different countries of the world (UNGASS, 2010, India, Thailand). High and disproportionate levels of violence and discrimination against sex workers are also very well-reported. Nevertheless, it is important to recall that "when assessing the risk of HIV infection for prostitutes, it is also important to consider the rate of infection among the general population" M Laffont, S Day, and H Ward, *HIV infection: Screening, treatment, and support* in Final Report of the European Network for HIV/STD Prevention in Prostitution 1998-2000.

[4] WHO, 2012, p. 8.

[5] INDOORS, Outreach in indoor sex work settings: A report based on the mapping of the indoor sector in nine European cities, 2012.

[6] WHO, 2012, p. 8.

[7] This conclusion was based on the writings of the anthropologist, Dolores Juliano, which reads: *'Las personas que cuestionan en la práctica estas conductas, supuestamente naturales, sufren presiones sociales, discriminación y violencia simbólica y material'* (Juliano, 2004, p. 14). It is well-documented that those who question social norms, such as sex workers, will be targets of discrimination and violence instead. This effect is remarkable not just in the societal level, but also in the institutional level. Several human rights' reports denounce abuses committed by public authorities against sex workers, which reflects their history of struggle against institutional repression.

identify whether it is useful to stop new infections. On top of that, punitive and discriminatory laws against people with and at risk of acquiring HIV will be analysed by taking into consideration international human rights law.

Legal systems that apply mandatory sexual health and HIV testing have been highly criticised for not being able to effectively address their public health goals, nor to justify the human rights violations that arise from it. According to the final report of the Global Commission on HIV and the Law (2012),

> "Nations have squandered the potential of the legal system. Worse, punitive laws, discriminatory and brutal policing, and denial of access to justice for people with and at risk of acquiring HIV are fueling the epidemic."[8]

Based on this report, it can be concluded that punitive and discriminatory laws do not favour a preventive environment; instead they create a feeling of insecurity and injustice among the target group, which puts effective prevention measures at risk.

On this matter, the South African Law Commission pointed out the argument that links coercive testing to public health concerns:

> "The arguments in favour of mandatory testing usually revolve around public health concerns, most specifically the spread of HIV infection to the 'general' population by means of infected prostitutes transmitting the virus to their clients, who may in turn transmit it to their wives, girlfriends or non-paid casual sexual partners."[9]

Under this argument, states implement mandatory testing regimes in order to respond to the public health needs and concerns of halting the HIV/AIDS epidemic. Moreover, it is the duty of the states under international law to prevent and control the epidemic.[10] In this sense, some states report this measure as a way to fulfill the right to heath. The question is whether mandatory testing is the most effective strategy for reaching such public health goal and in which way can this strategy be implemented without violating the rights of those who are most-at-risk.

[8] UNDP, 'HIV and the Law: Risks, Rights & Health', 2012, p. 7.
[9] South African Law Commission, 2002, p. 178.
[10] ICESCR, Article 12 (c).

Therefore, laws play an important role in the configuration of repressive systems or enabling legal environments to implement effective HIV/STI prevention.[11] Laws can and should reduce sex workers' vulnerability and risk of violence and HIV/STI infection, but some contemporary commentators point out that from the public health perspective, mandatory sexual health and HIV testing may not be the most effective measure.[12] United Nations specialised agencies and their reports also condemn mandatory testing regimes based on public health and human rights arguments.[13]

From the sex workers' perspective, within the framework of the European Conference in Brussels in 2005 on Sex Work, Human Rights, Labour and Migration[14], mandatory sexual health and HIV testing violates their human rights.[15] But why do they claim that their human rights are being violated when states implement mandatory sexual health and HIV testing? What do human rights prescribe on this matter?

Although the arguments for and against mandatory sexual health and HIV testing need to be further outlined in this study, it is important to clarify that this will be analysed from public health and human rights perspectives. The failure of mandatory testing regimes in meeting their public health goals is at the centre of the question of whether mandatory testing does or does not have grounds in international human rights law.

Hence, the first chapter aims at exploring: what constitutes mandatory testing? Why are sex workers tested? What does informed consent mean?

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[11] Laws, police practices and policies in many countries undermine sex workers' enjoyment of their rights. Criminalisation of sex work and the application of non-criminal laws to sex work exacerbate the stigma and moralist approaches towards sex workers. Law and law enforcement practices often leave sex workers open to extra-legal abuses, including sexual and physical abuse by police and violations of due process. Creating a legal and policy environment conducive to sex workers' access to comprehensive HIV services is good practice from both public health and human rights perspectives. Male, female, and transgender sex workers have the right to protect themselves from discrimination, violence, abuse, and disease. Realizing that right, enables them to lead lives of dignity and to be agents of HIV prevention and information with their clients and the larger community. (International HIV/AIDS Alliance and Commonwealth HIV, 2010).

[12] South African Law Commission, 2001.

[13] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2006; UNAIDS, 2012; WHO, 2012, p. 26; UNDP, 2012.

[14] For a full list of recommendations: ICRSE, 'Recommendations of the European Conference on Sex Work, Human Rights, Labour and Migration Brussels' (2005).

[15] 'Registration and mandatory sexual health and HIV testing are a violation of sex workers' human rights and reinforce the stigmatisation of sex workers as a threat to public health and promote the stereotypical view that only they can transmit infections to clients' (ICRSE, Sex Workers Manifesto in Europe, 2005). The Sex Workers Manifesto identifies sex workers' demands and recommendations. These demands are not likely to be covered as rights by international treaties but are considered essential to the creation of a more just and equitable society for all. For more information: http://www.sexworkeurope.org/nl/resources-mainmenu-189/manifesto

Having explained the foundations of mandatory sexual health and HIV testing, the second chapter will briefly introduce the historical development of international human rights law. It is important to frame the main characteristics of the protectionist system, which was born after the Second World War, in order to verify how and why this system may be evoked against abusive state laws and policies.

Having examined that, this chapter will highlight the international human rights treaties relied upon when mandatory sexual health and HIV testing takes place. Because the main focus of this study is the argument around public health concerns which cause some states to apply coercive testing, it will be argued that mandatory testing regimes fail to meet the normative obligations of the right to health. Further, some important principles of law and good governance (accountability, non-discrimination, proportionality, necessity, and legality)[16] will be analysed.

The third chapter is aimed at understanding in which way national laws and policies apply such measures. What are the human rights impacts of these measures on sex workers? Which violations can arise from these measures?

This chapter will provide a comprehensive legal analysis of the actual situation of mandatory sexual health and HIV testing in four European states (Austria, Greece, Latvia, and Hungary) which have laws in place (directly) prescribing mandatory health checks, from now on to be referred to as **institutional mandatory testing regimes**. These regimes also have mandatory testing as an indirect consequence of a set of laws which on one hand do not prescribe mandatory testing, but on the other, favour situations in which non-consensual testing takes place. Laws that criminalise sex work, combined with laws that criminalise HIV transmission, create an institutional environment where indirect forms of coerced testing take place.

Further, some examples of **uninstitutional mandatory testing regimes** will be provided. Under these regimes, mandatory testing is not provided by the law but indirectly by the request of third parties involved in the sex industry, such as controllers, brothel owners, pimps, traffickers, etc.

[16] J F Childress, R R Faden, R D Gaare, L O Gostin, J Kahn, R J Bonnie, N E Kass, A C Mastroianni, J D Moreno, P Nieburg, 2002, p. 172; see also: M Wijers, L Chew, 2010, p. 11.

The concluding chapter will provide the reader with an overall picture of the various interests that are involved in the practice of mandatory testing. Because human rights are rarely absolute, the problematic aspects of this practice should be understood using the logic of public health concerns and human rights. An accurate balance between one and the other can increase the efficacy of HIV prevention programmes as well as reduce human rights violations of sex workers.

METHODOLOGY

The following is a comprehensive legal analysis[17] of mandatory sexual health and HIV testing of sex workers as viewed from the perspective of international human rights law.

The first step of this study was to analyse if mandatory testing has a basis in international human rights law. A human-rights-based approach[18] to sex work and HIV was taken regarding relevant international documents and guidelines, particularly in relation to the right to health.[19]

All available sources of international law on mandatory HIV and sexual health testing were investigated in order to better understand the legal issues involved and develop further legal knowledge on this field. However, it must be clear from the beginning that the legal reasoning regarding this topic in international law is still under development, reason why the gaps must be explored and highlighted.

The second step was to understand how mandatory sexual health and HIV testing of sex workers has been implemented by states. To do this, several national laws and policies involving mandatory testing were reviewed.[20] Only some, however, were selected for this research.[21] This evidence-informed analysis reviews several human rights reports on sex work, health, and HIV.

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[17] This research provides a non-moralistic and non-judgemental approach to sex work and HIV.

[18] "A rights- based approach is a conceptual framework that is based on international human rights standards and directed to promoting and protecting human rights. It integrates the norms, standards and principles of the international human rights system into policies and processes. The norms and standards are those contained in international treaties and declarations. The principles include equality and equity, non-discrimination, accountability, empowerment and participation. A human rights- based approach identifies rights holders and their entitlements and corresponding duty bearers and their obligations, and works towards strengthening the capacities of rights holders to make their claims and of duty bearers to meet their obligations." (M Wijers, L Chew, 2010, p. 70).

[19] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2006; UNAIDS, 2012; WHO, 2012; UNDP, 2012. Noteworthy, the Joint United Nations Programme on HIV/AIDS (UNAIDS) is composed by a significant number of United Nations organizations such as WHO, UN WOMEN, UNFPA, UNODC, ILO, UNDP, UNICEF, World Bank, among others. Its documents and guidelines reflect, consequently, the consensus of the United Nations family in relation to health and HIV.

[20] The following passage clarifies the differences between laws and policies: "Laws: are national and laid down in law books, such as the Penal Code or the Civil Code. To change them you have to go through politicians, the parliament, etc. Policies: a policy is a purposive course of action followed by an actor or a set of actors. Policies are instituted to enforce laws, solve problems, or achieve a positive benefit. They are often laid down in official documents and are implemented by civil servants, the police, etc. Policies can be national, regional or local. They are easier to influence than laws" (M Wijers, L Chew, 2010, p. 15).

[21] Mainly: Austria, Greece, Latvia and Hungary.

This analysis also verifies the content of specific human rights (right to health, right to freedom from torture and cruel, inhuman, and degrading treatment, and right to privacy) laid down in international treaties that relate to mandatory sexual health and HIV testing.

This is to say that analysis was conducted at both national and international levels, through a method that selects significant national laws and policies that apply mandatory sexual health and HIV testing and relates them to the international human rights framework. The link between international human rights laws and principles and national implementation of mandatory sexual health and HIV testing of sex workers constitutes the core line of argumentation of this study.

In addition to hard international law and consensus documents, many subsidiary sources of international law were used for this study: UN Human Rights Council special procedures (Special Rapporteurs, working groups, expert meetings), human rights work of UN specialised agencies, and NGO reports. General Comments and Concluding Observations made a significant contribution to the clarification of the contents of the rights and principles investigated.

In conclusion, this work focuses mainly on the legal issues around non-consenting medical testing; however, it will be impossible to dissociate the legal matters from the sociological and anthropological perspectives involved. The literature of this study does include in-depth studies of the structural situation of sex workers in society, their vulnerabilities, as well as their role in the history of fighting against state control of adult sexuality and HIV epidemics.

CHAPTER ONE: The Foundations of Mandatory Testing

Introduction

This chapter introduces the reader to the main concept of the measure being analysed: mandatory sexual health and HIV testing. The purpose of this first chapter is to clarify a) what constitutes mandatory testing, b) why sex workers are tested, and c) what informed consent means. The answers to these questions are fundamental to analyse, later on, the human rights impacts of this measure.

What Constitutes Mandatory Testing?

In relation to mandatory sexual health and HIV testing (hereafter referred to as mandatory or compulsory testing) it can be said that four important terms are being discussed in this concept. Each one of these terms has a specific connotation that must be explained.

The first term, 'mandatory', comes from the Latin word '*mandatum*', meaning 'something commanded'.[22] The second one, 'sexual health', means, according to the World Health Organization (WHO), 'a state of physical, mental, and social well-being in relation to sexuality'.[23] The third term, 'HIV', is used in preference to 'HIV/AIDS', 'HIV virus' or 'AIDS virus' (unless specifically referring to AIDS)[24] and it means human immunodeficiency virus.[25] Finally, the fourth term, 'testing', is understood in this context as producing a specified result in a medical test.[26]

In the context of these terms, we are referring to a practice whereby an individual's sexual health and HIV status are ordered to be tested. Therefore, the focus will be on the various forms of non-consensual testing which target sex workers.

Hence, the order can be ***institutional***, coming from law enforcement agents and public doctors, but also ***non-institutional***, coming from controllers, brothel owners, pimps, and traffickers. Whilst the former has the legal authority to require someone to undergo testing for

[22] See definition: http://oxforddictionaries.com/definition/english/mandatory?q=mandatory
[23] See link: http://www.who.int/topics/sexual_health/en/
[24] HIV refers to the virus; AIDS instead refers to the disease.
[25] See link: http://www.who.int/topics/hiv_aids/en/
[26] See definition: http://oxforddictionaries.com/definition/english/test?q=to+test#test__18

HIV/STIs under a specific legal provision, the latter gains its authority through the lack of laws protecting sex workers from third parties involved in the sex business.

The variety of forms in which sex can be sold is also an important component of this analysis. Because the term 'sex work' implies several forms of selling sex, it is wise to recall that not all forms of sex work will be equally affected by mandatory testing. As will be explained further on, those who work outdoors are more often affected by coercive public health measures. This has to do with the fact that they are more easily identified and reached by law enforcement agents.[27]

Why are Sex Workers Tested?

There is a single and wide-spread belief that sex workers are a 'pool of contagion', as promoted in the media:

> "As of Wednesday morning, Bolivia's "night workers" are on strike. Up to 35,000 prostitutes across the country have refused to report for the medical checkups required every 20 days to legally work the streets. By continuing to serve clients without ensuring they're disease free, the sex workers' action raises the risk to public health."[28]

The media is not the only disseminator of this belief. Governmental authorities also often refer to sex work as a danger to public health. Recently, the Ministry of the Interior of Kyrgyzstan created a law proposal aimed at criminalising sex work on the basis of public health concerns. According to the Ministry, sex work is "often accompanied by the spread of dangerous venereal diseases, including HIV" as well as "serious violent crimes against the life and health of individuals."[29]

The association between sex workers' sexual health and public health concerns is well documented by the media and is embedded in political and general public opinion, as

[27] Human Rights Watch report recalls that street-based sex workers are often targets of condom confiscation by authorities as evidence of prostitution. See: Human Rights Watch, 'Sex Workers at Risk. Condoms as Evidence of Prostitution in Four US Cities' (2012).
[28] See article: http://www.time.com/time/world/article/0,8599,1675348,00.html#ixzz28Qgjhllw
[29] See Human Rights Watch, 'Human Rights Watch Kyrgyzstan: Letter to Kenjebek Bokoyev, Chairman of Parliamentary Committee on Rule of Law, Order and Fighting Crime' (2012).

explained above. Sex workers are normally seen as an eminent threat to public health, instead of partners in the fight against HIV/STIs.[30]

From another perspective, the Collective of Prostitutes of Ottawa-Gatineau says, in response to this claim, that:

> "Sex workers use safer sex supplies such as condoms at a higher rate than the general population. Criminalization increases our vulnerability to HIV and other STIs. For example, when sex workers are given drug and paraphernalia conditions upon arrest they can be charged for carrying clean needles or other harm reduction equipment. When condoms are unofficially used as evidence of sex work[31], there is a disincentive to carrying barrier protection. In order to maximize the health of sex workers as well as the general population, we must support harm reduction and decriminalization."[32]

In this sense, from the perspective of the sex worker organisations and their allies[33], sex work *per se* is not responsible for high rates of HIV prevalence among sex workers in some regions. The main reasons for HIV infection are the lack of structural conditions to work in safe environments, without violence, and with free access to condoms.[34] Stigma and discrimination against sex workers, many times arising from criminalization of sex workers, also reduces their access to HIV prevention, care, and treatment.[35]

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[30] The Sonagachi project has become internationally famous for its achievements, and the UN has used the project as a 'best practice' model for other sex worker projects across the world. This project takes into consideration peer education and involvement of sex workers in prevention activities. See report: http://www.undp.org/content/dam/india/docs/a_writing_pad_that_chronicles_the_response_to_hiv_and_aids.pdf; In one statement, Elena Reynaga, the executive director of the Network of Latin-American and Caribbean Sex Workers, summarized what should be enhanced: '*No somos el problema, somos parte de la solución*'. This means, "we are not the problem, we are part of the solution". Read: http://www.redtrasex.org.ar/RedTraSex-1997.html. Elena Reynaga also criticised many programmes developed by UNAIDS for not considering sex workers as partners: "*No hay ninguna evidencia científica de que los programas llamados "de rehabilitación del trabajo sexual" sirvan para frenar el VIH. ¿Cómo puede ser entonces que recursos para prevención del VIH vayan a parar a estos programas? Mientras tanto, según cifras de ONUSIDA una de cada tres trabajadoras del sexo no recibe los servicios de prevención o de tratamiento del VIH. Las trabajadoras y trabajadores del sexo están muriendo por falta de servicios de salud, por falta de condones, por falta de tratamiento, por falta de derechos… ¡no por falta de máquinas de coser!" - durante su exposición en la XVII Conferencia Mundial de Sida en México.*

[31] The Pros Network; Sex Workers Project, 'Public Health Crisis – The Impact of Using Condoms as Evidence of Prostitution in New York City ' (2012); and Human Rights Watch, 'Sex Workers at Risk. Condoms as Evidence of Prostitution in Four US Cities' (2012)

[32] POWER, 2012, pp. 5-6.

[33] See link: www.nswp.org

[34] According to the report '*Sex Work and the Law: the case for decriminalization*': The link between violence and HIV is well-documented. Many sex workers work in violent and dangerous circumstances – particularly in countries where sex work is illegal. Many sex workers experience frequent and high levels of violence and rape from their clients and non-paying partners as well as the police. In this situation, the risk of contracting HIV is high. NSWP, 'Sex Work and the Law. The Case for Decriminalization' (2010).

[35] UNAIDS, 'Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses' (2012, p. 5).

From the public health (medical) perspective, however, "sexual intercourse is one of the main ways that HIV is passed from one person to another. Concurrent, multiple sexual partnerships (MCP) are one of the key drivers of the HIV epidemic."[36] Therefore, if sex workers and their clients do not practise safer sex, they are highly at risk of contracting HIV. For some states, this is the main reason why mandatory testing should be a strategy in the fight against HIV. It is important to note that sex workers are not alone in being a high-risk population, and according to many studies do not even comprise the highest-risk group.[37]

In spite of the different arguments and perspectives around the role of sex workers in the spread of HIV/STIs, mandatory testing laws were introduced into some legal systems in the heat of the discussion on sex workers' responsibility regarding the spread of HIV. As it will be explained in Chapter Two, this is due to states' obligation to provide the highest attainable standard of health to its citizens. Other laws (including criminal laws) were also presented as alternatives to halting the epidemic, though not all of them specifically targeting sex workers. Mandatory testing, however, is not a new phenomenon. Long before the appearance of AIDS, the history of other sexually transmitted diseases proved to be no different:

> "The Contagious Diseases Acts in Great Britain (1864) are a highly debated example of a public health policy that focuses on the control of sex workers. The Contagious Diseases Acts consisted of legal decrees on the control of contagious diseases, particularly sexually transmitted diseases. Under the pretence of a concern for public health, sex workers were subject to arbitrary treatment by the officials, mandatory medical examinations, arrest and compulsory commitment to hospitals for 'rehabilitation'."[38]

In the history of HIV/AIDS, key populations also known as most-at-risk populations ('MARP'), such as sex workers, had to carry (and still carry) the burden for the spread of HIV. The reasons that increase sex workers' vulnerability to HIV were not considered by many states; instead of exploring holistic and comprehensive approaches to halt the epidemic, many states focused only on mandatory testing as a means to resolve this issue. Laws that were supposed to protect citizens, especially the most vulnerable, from HIV/STI infection, actually turned out to be more repressive towards the target groups. Laws aimed at reducing

[36] NSWP, 'Sex Work and the Law. The Case for Decriminalization' (2010, p. 15).
[37] There are five 'key populations' that have a disproportionately high prevalence of HIV infection when viewed across countries globally: men who have sex with men (MSM), sex workers and their clients, people who use drugs, prisoners and transgender people. See more through the link: http://www.hivcode.org/silo/files/final-key-populations-.pdf
[38] TAMPEP, 2009.

HIV transmission became a powerful weapon in the informal fight against prostitution[39], considering that sex workers were seen as a threat to public health.

Furthermore, vulnerability to HIV/STI infection suddenly became something to blame, shame, and punish. The epidemic that killed nearly 30 million people through AIDS-related causes[40] became one sex workers' main struggles in the fight for the affirmation of their rights.[41] Not because they have (or should have) any special rights before the law, but because as 'sex workers', many of their fundamental rights as citizens are often denied to them by shortsighted states.

This disempowered position occupied by sex workers in any society (some sex workers more than others) makes them an easy target of public health interventions. That is to say that public health interventions (especially those making use of coercive testing) unevenly impacted different MARPs. Clients of sex workers, for example, were rarely a target of mandatory testing laws and policies, because they don't share the same underprivileged position in society as sex workers do.

In some countries where mandatory testing law proposals were presented, such as in Canada, the lack of proven efficacy of this method fuelled the discussions. The Ontario Law Reform Commission, for instance, pointed out that it is not clear that mandatory testing of sex workers can deter high-risk activity.[42] According to the Canadian Commission, two factors contributed to their conclusion: i) large percentages of sex workers report using condoms with clients; and ii) the risk of female-to-male transmission is lower than the risk of male-to-female or male-to-male transmission.[43]

This takes us to the fact that the large majority of people selling sex are female, and for this reason, the risk of HIV transmission to their clients is lower, rather than the other way

[39] For instance, legal systems that allows confiscation of condoms as an evidence of prostitution.
[40] UN Joint Programme on HIV/AIDS, *World AIDS Day report: Results* (2012).
[41] "The AIDS epidemic has added another layer of stigma and discrimination against sex workers – one in which they are often blamed for spreading the virus to the rest of society. This combination of violence and AIDS-related stigma and discrimination also undermines HIV prevention efforts by affecting the psychological well-being of sex workers" (WHO, 2005, p. 2-3).
[42] Ontario Law Reform Commission, 1992, p. 53.
[43] This suggests that female prostitution, by itself, is not a significant factor in the transmission of HIV. Ontario Law Reform Commission, 1992, p. 54.

around.[44] Therefore, female sex workers are less likely to pass the virus, and should not be seen as the main vector of transmission by public health policy.

In spite of the way each state responded to the HIV epidemic[45], much research was done to understand the efficacy of non-consensual forms of testing. As a result, key findings from UNAIDS point out that states can take actions to establish legal and policy environments that are conducive to universal access to HIV services for sex workers, as follows:

> "Whatever the legal regime, states should ensure that sex workers are not subjected to mandatory HIV testing or restrictions on their civil liberties, have unimpeded access to all HIV prevention, treatment, care and support programmes and that they participate meaningfully in programme and policy decision-making affecting them. Prevention programmes should ensure access to lubricants as well as condoms. HIV-positive sex workers must be considered a high-priority population for uninterrupted access to treatment services."[46] (Emphasis added)

This research does not take the initiative of further investigating, nor questioning, the key findings of UNAIDS, UNDP, and WHO, and considers this result to be the first step for a human-rights-based approach to sex workers and HIV. These studies[47] rely on extensive research and consultations conducted over the past decades and are based on a participatory model whereby sex-worker-led organisations[48] can give their opinion on policy and lawmaking. They prescribe the most effective way that states can intervene in public health affairs related to HIV/STIs without harming vulnerable populations, and applying unsuccessful strategies.

These key findings highlighted that mandatory testing is a measure that does not enable a policy environment for effective HIV prevention and respect of human rights of key populations. This understanding is a premise for the later analysis on human rights abuses that will constitute the main discussion of Chapters Two and Three.

What Does Informed Consent Mean?

While many argue over whether sex workers consent to sell sex, this study wishes to understand whether they consent to have their sexual health and HIV status tested. It is

[44] South African Law Commission, 'Project 107 Sexual Offences Issue Paper 19 Sexual Offences: Adult Prostitution' (2002).
[45] See state reports: http://www2.ohchr.org/english/bodies/cescr/
[46] UNAIDS, 2012.
[47] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2006; UNAIDS, 2012; WHO, 2012, p. 26; UNDP, 2012; UN Human Rights Council, 2010, A/HRC/14/20.
[48] See NSWP: http://www.nswp.org/

fundamental to understand to what extent sex workers refuse to be tested, for which reasons, and in which contexts. Moreover, this section highlights the ethical framework concerning medical experimentation on human beings.

Regarding the issue of consent, it can be said that mandatory testing, by its very definition, is contradictory to the free will of an individual. Evidence also proves this. During outreach activities in Austria, sex workers revealed their dissatisfaction with the requirement to be tested every three months for HIV[49] and every week for other sexually transmitted diseases.[50] Among the reasons listed by them are: unfriendly public health staff, long hours waiting for medical checks, and negative attitudes towards migrant sex workers.[51] Interestingly enough, there were no complaints in this report about human rights violations.[52]

According to the Global Network of Sex Work Projects (NSWP)[53], the large majority of sex workers consulted were against mandatory testing and affirmed that it violates their rights:

> "Respondents expressed overwhelming disapproval of mandatory testing. Respondents' interpretation of mandatory testing varied. One respondent was uncertain but did express concern that it would result in discrimination against people living with HIV given laws criminalizing HIV positive people who practice safe sex but do not disclose their status. Another respondent was open to the possibility under a legal framework recognizing sex work as work but was strongly opposed to legal penalties for sex workers who did not test. Those who lived under mandatory testing in Latin America and Asia expressed unanimous disapproval. Such testing often was reported to lead to HIV-positive sex workers having to work underground or in a different part of the country as to go undetected by law enforcement. In some countries, mandatory tests were expensive and workers could not choose their health personnel even if they were facing discrimination or inadequate care. Mandatory testing was reported across many countries to be used by police as a threat to increase extortion and control over sex workers."[54]

[49] § 4 AIDS law (AIDS-Gesetz) 1993, as amended on 01.08.2012.
[50] § 1. Of the Official gazette (Bundesgesetzblatt) no. 314/1974: Act of the ministry of health and environment on the health supervision of sex workers.
[51] INDOORS, *Pictures of a Reality* (2012, p. 50).
[52] In reality, mandatory testing is not perceived as a human right violation but as something annoying that sex workers must comply with. The feeling of unworthiness attached to the profession due to social, cultural, and historical barriers, often impede sex workers to take action against things that harm them. With mandatory testing it is no different. During outreach done in Austria, for instance, sex workers often complain about the inefficiency of public health services, the language barriers to communicate with health personnel, but none mentioned that it was a violation to their human rights.
[53] The Global Network of Sex Work Projects (NSWP) exists to uphold the voice of sex workers globally and connect regional networks advocating for the rights of female, male, and transgender sex workers. It advocates for rights based health and social services, freedom from abuse and discrimination, and self-determination for sex workers. See: http://www.nswp.org/page/history.
[54] See link: http://www.nswp.org/sites/nswp.org/files/NSWP-WHO%20Community%20Consultation%20Report%20archived.pdf

Having made clear that lack of consent is one of the pillars of the arguments against mandatory testing, it must be added that just consent is not enough:

> "Informed consent is not mere acceptance of a medical intervention, but voluntarily and sufficiently informed decision (…). Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being".[55]

The consent must at all times be informed and agreed with the person subjected to testing or any other experimentation. The Special Rapporteur on the right to health stands for voluntary counselling and testing (VCT) which implies informed consent. In this way, the person chooses to undergo HIV/AIDS counselling and can make an informed decision about whether to be tested for HIV.

Moreover, informed consent is a requirement and a precondition for the full realisation of the human right to health, as will be explained in Chapter Two, but at the same time an important concept for effective HIV prevention programmes and lawmaking. Mandatory testing clearly harms the requirement of informed consent at all levels, and constitutes one of the main barriers to sex workers' autonomy, self-determination, bodily integrity, and well-being.

Conclusion

To conclude the first chapter, it can be said that the sex workers' rights movement, which is unequivocally for equitable access to optimal quality services and safe working spaces, rejects mandatory testing as a method to halt the HIV epidemic and prevent new infections among sex workers. This rejection is legitimised by the evidence but also by the representation of sex work delegates in several UN meetings held on health issues. To build effective HIV/AIDS programmes, sex workers should be consulted on all matters regarding policy making at local, national and international levels.

The association of sex work with danger to public health is also challenged by this group, particularly because unsafe working environments, high levels of violence against sex workers, and repressive law enforcement actions (e.g. confiscation of condoms, violence) in several regions of the world continue to fuel the HIV epidemic. Human rights abuses against

[55] See UN General Assembly, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: note / by the Secretary-General*, 10 August 2009, A/64/272; see also J W Berg, P S Appelbaum, L S Parker, *Informed Consent: Legal Theory and Clinical Practice* (2001).

sex workers are seen as one of the main barriers for HIV prevention among sex workers, according to the UN.

Finally, consent is fundamental for testing someone, but informed consent is also a requirement to meet ethical guidelines for the right to health. The obligation to test is, in this sense, questionable as a public health measure (since evidence shows that mandatory testing regimes do not work in practice) and questionable as an ethical procedure, since it doesn't comply with a basic requirement for medical experimentation: informed consent.

CHAPTER TWO: International Legal Framework

Introduction

After six decades of extraordinary evolution of international human rights law, this legal sector can be understood to have its own autonomous procedures and specific challenges. Fundamentally, this emerging legal system is focused on the right to protection of human beings, not dependent on membership of a state, or specific citizenship.[56] It is an ultimate form of what Hannah Arendt called "right to have rights" based on the very idea that human beings are part of the same community.

As an outcome of two catastrophic world wars, this new international legal order introduced a system that protects citizens not just against foreign states but also against the states of which they are citizens. It was a human invention in the process of construction and reconstruction[57].

The 1948 Universal Declaration of Human Rights (UDHR) initiated this device of the international human rights regime. It heralded a new moment for the international community that went beyond the recognition of the international relationships between states; it is believed to have created a quasi-constitutional structure of mankind to the international community at large.[58] Human rights norms have a remarkable nature because they are especially "concerned with proclaiming and enforcing certain fundamental guarantees for individuals against the state."[59] Codified or uncodified, they play roles in most democratic constitutions.

In this new international legal order, states are obliged to respect, protect, and fulfill the rights in the treaties they ratified. In other words, by ratifying these treaties they made promises and they can be kept accountable to keep those promises.[60]

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[56] Read the understanding of the Inter-American Court of Human Rights when referring to the nature of human rights obligations: "Their object and purpose is the protection of the basic rights of individual human beings irrespective of their nationality, both against the State of their nationality and all other contracting States."(OC-2/82. The Effect of Reservations on the Entry into Force of the American Convention (Arts 74 and 75), IACtHR Series A No 2 (24 September 1982) paras 29-30.

[57] H Arendt, 1966.

[58] *Conversations with History* 2004, interview with Seyla Benhabib, Institute of International Studies, University of California, Berkeley.

[59] M Daniel, S Sangeeta, S Sandesh, 2010, p. 125.

[60] Customary international law is also a form of keeping states accountable to human rights norms.

This means that the state may not take measures that violate or undermine the human rights of sex workers, or any other group of people. It is the responsibility of the state that the police or other state authorities do not violate sex workers' human rights, but also to protect them from human rights violations by others.[61]

Thus, the following chapters will examine in which ways laws and policies, especially those in relation to mandatory testing and HIV/AIDS, can impact on sex workers' enjoyment of their human rights. The intention is to elucidate, from now on, the international human rights framework in relation to the problem posed above.

Chapter Two, however, will focus mainly on the right to health as it relates directly to mandatory testing and public health concerns. By clarifying first its history and normative content, it can be understood to what extent mandatory testing violates international law.

Nuremberg's Non-Consenting Experimentation

Although the issue of compulsory testing is not recent, it was only with the development of international human rights law, in the second half of the twentieth century, that such an issue started to be dealt with as a violation of human rights in the international arena.

The history of non-consenting medical procedures in contemporary international law begins with the Nuremberg Trials and the conventions that came out of them, as follows: "In the aftermath of the Nuremberg Trials, increased international recognition of patients' rights developed in the twentieth century, defining the responsibility of health-care providers and States' responsibilities to the patient".[62] According to the Nuremberg Code, voluntary consent of the human subjected to medical research is necessary under all circumstances.[63]

To that end, since 1947, compulsory medical procedures were banned by international law and were the subject of other important international documents, such as the Declaration of Geneva (1948), the Declaration of Helsinki (1964), and the World Health Organization Amsterdam Declaration on Patient's Rights (1994).

[61] States should favor a safe environment where sex workers are able to work in freedom from violence and other abuses.
[62] UN General Assembly, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: note / by the Secretary-General*, 10 August 2009, A/64/272.
[63] *Idem.*

The recognition of patients' rights and states' responsibilities towards them was the first step for a human-rights-based approach to non-consenting medical research. The historical and political context that gave rise to such norms, however, diverges from the one that made mandatory testing possible in the second half of the twentieth century and beginning of the twenty-first century. As explained in Chapter One, contemporarily, some states have been implementing mandatory testing using a public health argument, which makes it very different from the experiments practised by the Nazis. Yet, the nature of the practice is the same. People have the right to be free from non-consenting medical interference[64], under any circumstances, because mandatory medical interference undermines human dignity[65]. On top of that, as explained in Chapter One, notions of 'autonomy' and 'informed consent' are fundamental for modern bioethics and, consequently, to (international) law. The appearance of this understanding is rather timid in international law, and must be further developed and investigated.

The second step for a human-rights-based approach to non-consenting medical experimentation was the later development of international human rights (hard) law – those laws which are binding upon ratification of a state. This means that states have more obligations than refraining from forcing sex workers (or any other group) to be tested for HIV/STIs. States have a positive obligation to respect, protect, and fulfill the human rights of sex workers, as other human beings, according to the notions of human rights agreed by them.[66] Human rights obligations are normally codified by treaties, but are not limited to them.[67] Treaties, however, translate the normative content of most human rights norms that should never be violated by states.

[64] According to the General Comment N.14 states have an obligation to refrain from enforcing coercive medical treatment. (CESCR, 2010).

[65] "For the liberal and secular left, it is generally associated with personal 'autonomy' and expanded individual choice. For the conservative and religious right, it is generally associated with the sanctity of "life" and related limits on such choice." The President's Council on Bioethics Washington, D.C., 'Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics' (2008).

[66] "(…) the foundations of contemporary human rights law lie in positivist law, based on state consent". (M Daniel, S Sangeeta, S Sandesh, 2010, p. 105).

[67] The sources of human rights obligations are four, as set out in Article 38 (1) Statute of the International Court of Justice (ICJ Statute): a) international conventions, whether general or particular, establishing rules expressly recognized by the contesting states; b) international custom, as evidence of a general practice accepted as law; c) the general principles of law recognized by civilized nations; d) subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Although the UDHR is not in itself a legally binding document, it gave rise to two core international human rights documents that were signed and ratified by the large majority of states: International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social and Cultural Rights (ICESCR). Based on these two fundamental human rights documents, other human rights treaties and norms were evolved.

In this context, international human rights documents and the United Nations agencies and programmes are powerful tools for guiding states in their obligation to develop effective national public health programmes.[68] As Patterson and London note:

> "(…) human rights law helps states respond appropriately to the challenges of the HIV/AIDS epidemic by providing a framework on which they can formulate laws and policies that integrate public health objectives and human rights standards".[69]

Thus, human rights laws support public health objectives but also provide some guidelines on how this can be done. They increase the efficacy of national laws and policies focused on public health issues and clarify the most appropriate manner for intervening in this sector.

The first right to be analysed from this perspective is the right to health, which is perhaps the most important right to be addressed in this study, considering that public health arguments are at the heart of the problem.

Right to Health

The link between human rights and public health objectives was explained above. The investigation of the right to health (as a human right) reveals the framework under which states can develop their national public health programmes and laws. Although every state has a margin of discretion, not all public health laws and interventions are allowed under international law and guidelines.

In this section, the right to health will be examined in order to understand: 1) to which extent different forms of mandatory testing impact on the enjoyment of sex workers' right to health; and 2) public health concerns related to mandatory testing in light of international human rights law and principles.

[68] On this matter, the General Comment No.14 says "When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO" (CESCR, 2010).
[69] D Patterson, L London, 'International law, human rights and HIV/AIDS ' [2002].

To that end, the normative content, states' obligations, violations, and implementation of the right to health at the national level, fundamentally in relation to mandatory testing of sex workers, will be explored.

The History

Concerns around public health existed throughout history and in different civilisations; however, it was only in the eighteenth century that there was a significant turning point. The importance of health and its social effects was recognised and emphasised while efforts were made to address various public health problems. This was a consequence of several issues such as new urban health problems and the necessity to improve living and working conditions.[70]

Contemporarily, during the United Nations Conference on International Organization held in San Francisco in 1945, health appeared for the first time as one of the fundamental priorities on the international agenda. This conference influenced the writing of article 55 of the UN Charter[71] (which includes "solutions of […] health related problems") under the section "International Economic and Social Co-operation".[72] By then, health was already understood as a common issue for all nations which surely demanded international coordination and cooperation.

In 1946, the World Health Organization (WHO) was created and brought within its constitution the first well-known definition of 'right to health'[73]. The WHO Constitution came to be the first international document to provide a revolutionary definition to the right to health, as follows: "a state of complete physical, mental[74] and social well-being and not merely the absence of disease or infirmity."[75]

It is essential to stress the addition of 'mental health' and 'social well-being' to the definition of such a right. This was an extremely advanced concept for that time, and became a

[70] Toebes, 1999, p. 8.
[71] United Nations, *Charter of the United Nations*, 1945.
[72] Toebes, 1999, p. 15.
[73] UN General Assembly, *Entry into force of the constitution of the World Health Organization*, 1947.
[74] It was during the International Health Conference in New York on 19 June 1946, one month before the creation of the WHO Constitution, that an important reference was made not only to physical, but also to mental health (Toebes, 1999, p. 33).
[75] UN General Assembly, *Entry into force of the constitution of the World Health Organization*, 1947.

fundamental standpoint for the development of other international norms and guidelines on health issues, especially in relation to sexual health and HIV.

The right to health, in this sense, emerged as an international priority after the Second World War with the creation of a specialised UN organisation responsible for adopting conventions, regulations and recommendations[76] in relation to that right – the World Health Organization. Because the Constitution of the WHO is a multilateral treaty, like other constitutions of international organisations, it was the first binding document for signatory states in relation to the issue of health.

History and politics shaped the right to health to be as it is stated in the Constitution of the WHO; however, most of its normative content and obligations were developed later on within international human rights treaties and their respective UN bodies.

The second important international document to stand up for the right to health was the Universal Declaration of Human Rights (Article 25.1) which affirmed:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[77]

The relevance of this non-binding legal provision is the association of the right to health with other social issues, in the framework of the right to an adequate standard of living. The intention behind such a definition was to highlight how the right to health is "closely related to and dependent upon the realization of other human rights".[78]

Next came the ICESCR – the first binding international document in relation to the right to health. It provides the most comprehensive article (12) on the right to health in international human rights law and a monitoring Committee[79] for monitoring, among other things, this article.

[76] Articles 19, 21, 23 of the WHO Constitution.
[77] Article 25(1) of the Universal Declaration of Human Rights.
[78] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14.*
[79] Monitoring of States parties' compliance with treaty provisions is primarily done through the examination of their regular reports on how they are implementing the rights nationally. The Committee examines these reports together with other relevant information submitted by United Nations agencies and civil society organizations (these are also called shadow reports or parallel reports).

In accordance with article 12.1 of the Covenant, States parties recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties (...) to achieve the full realization of this right". The steps are described as follows:

> "(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Item (c) of this article is very significant to this study, since it highlights the obligation of states to take steps in order to prevent, and treat people for, diseases, as well as to control epidemic and endemic diseases. Under article 12.2 (c), some states reported to the Committee that mandatory testing was a step to achieve the full realization of the right to health.

However, CESCR in relation to 12.2(c) does not mention any form of mandatory testing as a strategy to control the epidemic and endemic, but:

> "Requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity."[80]

Lately, with increasing attention paid to sexual and reproductive rights in the international agenda and forums[81], more attention was driven to these rights. Moreover, its indicators and specificities have been shaped by other relevant human rights treaties[82] that have a provision on the right to health. Each article within these treaties describes this right in a certain way, from different perspectives, but further analysis is not necessary for the aim of this study. The main characteristics and obligations posed by this right are defined by the ICESCR.

[80] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 16.
[81] See: UN Population Fund, *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994*, 1995, A/CONF.171/13/Rev.1; and United Nations, *Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women*, 27 October 1995.
[82] International Convention on the Elimination of All Forms of Racial Discrimination (Articles 11.1 (f)); the Convention on the Elimination of All Forms of Discrimination against Women (Article 12); the Convention on the Rights of the Child (Article 24); and several regional human rights instruments.

But to better understand the correct balance between human rights norms, such as the right to health, and public health concerns, it is also important to highlight the normative content and obligations to states set up by the right to health, according its nature and aims.

Nature of Rights

Defining human rights norms is not always an easy task, and with the right to health it is considerably harder since it embraces a set of norms, principles, and ideas behind it. As stated by the CESCR "Health is a fundamental human right indispensable for the exercise of other human rights".[83] Its realisation is also considered a precondition for living a life in dignity.

A handful of scholars and governments[84], however, argue that this right is either not implementable, or unrealistic for all nations. The lack of clarity of its legal provisions, especially in relation to states' obligations, makes up an important point of discussion and examination for this study.

Ida Elisabeth Koch argues that this is due to the differences between civil and political rights (negative rights) from the economic, social and cultural (positive rights) ones. The **tripartite typology**, to respect, protect and fulfil, which was incorporated by the vocabulary of the CESCR, represents the possibility to enforce these rights through a more comprehensive perspective. Although the character of these groups of rights may differ, the tripartite typology applies to all.

> "The tripartite typology is generally considered an adequate substitution for the classical positive/negative dichotomy according to which economic, social and cultural rights—unlike civil and political rights—are regarded merely as programmatic, not justiciable rights."[85]

Therefore, it can be highlighted that the right to health is a positive right which embraces by its very nature different normative contents which support states in protecting, respecting, and fulfilling their promises in relation to the health of citizens.

[83] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14, paragraph 1.*
[84] Toebes, 1999, p. 302-330. Some authors argue that there is no clear obligation towards the states. The vagueness of its provisions is often target of criticism.
[85] See: http://hrlr.oxfordjournals.org/content/5/1/81.abstract

Normative Content

Considering that the human right to health needs to guide states in their formulation and implementation of public health laws and programmes, one must identify the benchmarks to be emulated. For this purpose the CESCR enacted, in 2000, the General Comment N.14 which intends to clarify the normative content of the right to health. Concluding observations of the CESCR, State reports, and shadow reports also help to build up the normative content of such a right. It is important to say that human rights norms are living instruments; they have been constantly shaped, discussed, and agreed by states (not always at the same level).

On top of that, human rights still remains in a very political terrain and, for this reason, the Committees, including the CESCR, normally do not expressly declare that one state has violated human rights. Rather, recommendations are normally issued as an incentive for states to uphold human rights and guidelines established within the UN system.

Universal and Non-discriminatory

The first characteristic of the right to health was already mentioned in the earliest delineation of that right, as in the preamble of the WHO Constitution, "health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[86]

The right to health was developed by international law to be a universal and fundamental right, which every human being is entitled to without discrimination. This affirmation takes us to the conclusion that sex workers, including migrant sex workers, have the right to health since it is inherent to their dignity.[87]

In no way can states jeopardise or violate a fundamental right that is inherent to them. What states can do is limit certain human rights based on some principles of law and good governance to be explained in detail in this chapter. Not always limitations are allowed under

[86] Preamble of the Constitution of the WHO.

[87] "Every human being is entitled to the enjoyment of the highest attainable standard of health conductive to living in dignity" (UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14)*.

international law. And, because this right is indispensable for the exercise of other human rights, it should be dealt with as an international priority.

The Fact Sheet N.31 on this same matter mentions that:

> "The importance given to the 'underlying determinants of health', that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights."[88]

Freedoms and Entitlements

The right to health contains both freedoms and entitlements. The CESCR clarifies the difference and the importance of these normative characteristics:

> "The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"[89] (Emphasis added) .

Noteworthy is that freedom includes, inter alia, the right to be free from non-consensual medical treatment and experimentation. The General Comment N.14 is to be considered one of the core documents to support the argument against any form of mandatory testing.

Although the right to health is considered a positive right[90]; it must be observed that the situation can also be the reverse: whereas civil and political rights can require States to act and to take certain measures, economic, social and cultural rights may just as well require that States refrain from acting. In this case, states should refrain from implementing forced testing.

Progressive and Self-executing

A positive obligation does not mean, however, that states have to realise the right to health from one day to the next, but it implies that the right to health should be realised progressively. Some obligations in relation to this right, however, are of immediate effect[91].

[88] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 6.
[89] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.
[90] Toebes, 1999, p. 7.
[91] In relation to the ICESCR, the General Comment No. 3 recalls that 'while the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations which are of immediate effect'.

This is known as programmatic character of the right to health, since it requires active measures on the part of states for its (progressive) implementation.

Under the normative command of this right, states have the obligation to formulate health programmes and laws that will improve the health of its citizens. Therefore, the process chosen by each state is as important as the results. If the process chosen is not the correct one, the results can do more harm than good to the very people they intended to protect.

Toebes explains the self-executing conditions for the right to health, and frames the idea posed above:

> "The right to health is not only a programmatic goal to be attained in the long term. The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay."[92]

The right to health was developed in a flexible way so that states can undertake their human rights obligations according to their available resources.[93] Some actions, however, can be taken even when a state lacks financial resources. International cooperation also plays a key role in this process. On this, the Fact Sheet N.31 clarifies that,

> "Through their ratification of human rights treaties, States parties are required to give effect to these rights within their jurisdictions. More specifically, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underlines that States have the obligation to progressively achieve the full realization of the rights under the Covenant. This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions. Consequently, some components of the rights protected under the Covenant, including the right to health, are deemed subject to progressive realization."[94]

Social-economic and Inclusive

The right to health cannot be limited to the right to health care. It comprehends "a wide range of socio-economic factors that promote conditions under which people can lead a healthy life".[95] The CESCR can interpret article 12.1 of the Convention as an inclusive one, which extends to the "underlying determinants of health, such as access to safe and potable water

[92] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 5.
[93] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 9.
[94] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 27.
[95] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 4.

and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."[96] Lately, a wide range of literature has also been produced in relation to sexual and reproductive health and reflected in several international documents.[97] There is no need, however, to deepen aspects of sexual and reproductive rights, but it is necessary for this study to emphasise that states are committed to better respond to the health needs of marginalised populations, particularly women.

As an example of that, in the 57th session of the Committee on the Elimination of Discrimination against Women (CEDAW), it was agreed that states should "condemn and take action to prevent violence against women and girls in health care settings, including (…) forced medical procedures, or those conducted without informed consent"[98]. This proves that there is continuous development and recognition of mandatory testing as a practice that increases vulnerability of women to violence and HIV infection.

Examining the indivisibility and interdependence of human rights, especially in relation to the meaning of these norms, Hector Gros Espiell (1986, pp. 16-17) notes that:

> "Only the full recognition of all of these rights can guarantee the real existence of any one of them, since without the effective enjoyment of economic, social and cultural rights, civil and political rights are reduced to merely formal categories. Conversely, without the reality of civil and political rights, without effective liberty understood in its broadest sense, economic, social and cultural rights in turn lack any real significance. This idea of the necessary integrality, interdependence and indivisibility regarding the concept and the reality of the content of human rights that is, in a certain sense, implicit in the Charter of the United Nations, was compiled, expanded and systematized in the 1948 Universal Declaration of Human Rights, definitively reaffirmed in the Universal Covenants on Human Rights approved by the General Assembly in 1966, and in force since 1976, as well as in the Proclamation of Teheran of 1968, and the Resolution of the General Assembly, adopted on December 16, 1977, on the criteria and means for improving the effective enjoyment of fundamental rights and liberties (Resolution n. 32/130)."[99]

[96] *Idem.*
[97] See: UN Population Fund, *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994*, 1995, A/CONF.171/13/Rev.1; and United Nations, *Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women*, 27 October 1995.
[98] See final conclusions of the CEDAW 57th session held in New York between 4 – 15 of March 2013. http://www.un.org/womenwatch/daw/csw/csw57/CSW57_agreed_conclusions_advance_unedited_version_18_March_2013.pdf
[99] Espiell, 1986.

As a consequence of being a social-economic right, the right to health, for instance, is "often found by courts to be non-justiciable at the domestic level".[100] This means that even if this right is recognised at the international level, its national implementation is not always possible or facilitated.

Although this line of argumentation contradicts the CESCR claim that "the right to health includes certain components which are legally enforceable", optimising the justiciability and enforceability of economic, social and cultural rights is not an easy task to do and has proven to be problematic in several countries. The remarkable jurist Flavia Piovesan explains that part of this problem relates to the difficulty of measuring the advances in the implementation of these rights.

> "As the Vienna Declaration of 1993 recommended, it is fundamental to adopt measures to ensure greater justiciability and enforceability for economic, social and cultural rights, such as the elaboration of a Facultative Protocol to the International Covenant on Economic, Social, and Cultural Rights (which introduces the system of individual petitions), as well as of technical/scientific indicators capable of measuring the advances in the implementation of these rights."[101]

Moreover, the lack of effective complaints (reporting) mechanisms to enforce the right to health and other socioeconomic rights still remains a challenge for the correct implementation of this right.[102]

States' obligations

As examined above, the right to health has some specific normative content which has to be taken into consideration by governments when designing public health laws and programmes.

As with any other human right, states have the obligation to respect, protect, and fulfill the right to health of every person, including (migrant) sex workers. This will be explained below.

Respect

States should respect the right to health of all their citizens with no discrimination[103], which means, objectively, that states should "refrain from interfering directly or indirectly with the

[100] Toebes, 1999, p.6.
[101] Piovesan, 2004.
[102] *Idem.*

right to health."[104] States have a negative obligation not to take any measures that result in a violation of a given right.

The CESCR emphasises that:

> "Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include (…) the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health."[105]

Protect

States should protect the right to health of all their citizens with no discrimination, which means objectively that states should "prevent third parties from interfering with the right to health."[106] States need to proactively ensure that persons within their jurisdiction do not suffer from human rights violations at the hands of third parties. The CESCR highlights that:

> "Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others".[107]

Fulfill

States should fulfill the right to health of all their citizens with no discrimination, which means objectively that states should "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health."[108] States should proactively engage in activities that have as a consequence the greater enjoyment of rights. For example, states should "provide information and counselling on health-related issues, such as HIV/AIDS"[109]. When the state fails to do so, it violates the right to health of people.[110]

In conclusion, these are the main obligations placed on the states that ratified the treaties that lay down the right to health provision. For this reason, accountability is a fundamental

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[103] "Abstaining from enforcing discriminatory practices as a State policy" (UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 34).
[104] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 25; and M Daniel, S Sangeeta, S Sandesh, 2010, pp. 130-131.
[105] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 50.
[106] Toebes, 1999, p. 26.
[107] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 51.
[108] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 27.
[109] *Idem.*
[110] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 52.

principle for ensuring that states fulfill their obligations.[111] In this sense, a State should "explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all."[112] Violations of human rights are normally dealt with as a political issue and states are, in general, concerned about the so-called "naming, blaming and shaming" policies.

Through the ratification of international documents such as the ICESCR, it is expected that states "adopt appropriate laws that implement their international undertakings".[113] Moreover, Member States oblige themselves to:

> "Ensure the availability, accessibility, acceptability and quality of health facilities, goods and services, and to guarantee the realization of universal access to health prevention, treatment, care and support (PTCS) services, while taking into consideration the basic principle of non-discrimination and respect for confidentiality."[114]

Next, this study will elaborate what is meant by that.

Availability, Accessibility, Acceptability, and Quality

By respecting and promoting these four elements, states are already in line with international standards of public health and human rights. The following is the definition of each element according to the General Comment N. 14.

Availability. Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

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[111] The Committee on Economic, Social, and Cultural Rights is responsible for monitoring the ICESCR. During sessions, the State reports submitted are examined on the basis of a 'constructive dialogue', with the Committee Members and the State representative concerned entering into a 'mutually beneficial dialogue' regarding the State report submitted to the Committee (Toebes, 1999, p. 91). The consideration of States parties' reports takes the form of a constructive dialogue with representatives of the State party. (UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 36).

[112] UN Human Rights Council, *UN Human Rights Council: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mission to Sweden*, 28 February 2007, A/HRC/4/28/Add.2, paras. 46 and 87.

[113] *Idem.*

[114] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14.*

Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

Balancing Rights and Concerns

Human rights are hardly absolute, and inevitably raise tensions between individual and collective demands.[115] This means that under certain conditions they may be limited (never violated). In other words, "human rights are not simply about upholding absolutes but very often about the complex exercise of balancing individual rights against legitimate social priorities."[116]

This conflict between individual and collective demands becomes evident when taking into consideration the issue of mandatory testing of sex workers. As examined above, the right to health causes several confusions and divergences among states, particularly in the way it can and should be implemented. Violations of this right are often mentioned in various human rights reports, and normally these are linked to vulnerable and marginalised populations.[117]

Thus, on one hand the right to health expresses states' responsibility for the health of the public and, on the other, an individual's right to the highest attainable standard of health is also guaranteed.[118]

The CESCR, in this respect, mentioned that the right to health is "primarily intended to protect rights of individuals rather than to permit the imposition of limitations by States".[119] If the right to health is limited for whatever reason, this falls under the state's authority, and the state "has the burden of justifying such serious measures in relation to each of the elements identified in article 4".[120] The justification of this limitation of the right to health allows the Committee to decide whether there is a violation, unjustified limitation, or necessity to balance that right. The Committee, therefore, acts as a gatekeeper of human rights.

[115] "The vast majority of human rights are not absolute in the sense that they can never be limited" (M Daniel, S Sangeeta, S Sandesh, 2010, pp. 140-141).
[116] *Idem,* p. 143.
[117] See Human Rights' Reports referred in this study.
[118] Toebes, 1999, p. 4.
[119] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 28.
[120] *Idem.*

Although states have the burden to justify their interventions on individuals' right to health, mandatory testing has been reported to the Committee as a measure to achieve the normative goals of that right. Uruguay elucidated that as part of the national programme on AIDS and other sexually transmitted diseases, it had implemented mandatory testing of such diseases and the control of prostitution.[121] Interestingly enough, the Concluding Comment of the CESCR on this State report did not mention anything regarding human rights violations on this matter. Yet this is regarded to be because in the early years of the HIV epidemic (1994) it was still not clear yet in which way states should comply with the right to health in relation to HIV/AIDS.[122]

This reveals that there is a lot of confusion in the way states perform the right to health. And the fact that the majority of states do not explain to the Committee their mandatory testing regimes also raises the question of whether mandatory testing is still seen, by those states, as an efficient method of HIV/AIDS prevention.

The Dutch approach towards the epidemic, as reported to the Committee, was more in relation to health education programmes.[123] The seroprevalence among sex workers in the Netherlands is one of the lowest in the world[124], and this has to do with safer working environments and HIV educational strategies for sex workers.

In relation to the Committee's opinion on this topic, Toebes clarifies that:

> "In more general sense, it can be said that Committee Members disapprove of coercive policies relating to the health of the population. Forcing people to undergo certain treatment, such as (…) HIV/AIDS testing, (…) are generally rejected by the Committee, given the adverse effects that such policies often have."[125] (Emphasis added)

Therefore, the Committee acknowledges that there are adverse effects in countries where mandatory testing is being implemented. This understanding of the CESCR is in line with the latest UNAIDS and WHO guidelines on sex work and HIV and is a step forward in the

[121] Uruguay, UN Doc. E/1990/5/Add.7, para. 207
[122] See full text of the Concluding Comment (1994): http://sim.law.uu.nl/SIM/CaseLaw/uncom.nsf/89e6367c3ac1ba6fc12567b70027d9fb/e61b69d7693f7002c125663c00343b0b?OpenDocument
[123] The Netherlands, UN Doc. E/C.12/1989/SR.14, para 74.
[124] 0.2% in the adult population and 1.8% among female sex workers, see data (UNAIDS): http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NL_Narrative_Report.pdf
[125] Toebes, 1999, p. 143.

analysis of how international law understands mandatory testing. Further, it should be theoretically explored whether states could report mandatory testing to the CESCR as a limitation of human rights of sex workers.

In the words of the Committee:

> "Any restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society".[126]

The possibility of having limitations on the right to health, therefore, has been confirmed by international and domestic case law, but subject to a tripartite test that ensures that the limitations are in compliance with human rights. Thus, limitations to rights have to be justified by the fact that they: (1) are prescribed by law, (2) pursue a legitimate aim, and (3) are necessary in a democratic society.[127] The principle of equality and non-discrimination will also be analysed in this section. The Committee also concludes that limitations must be (always) proportional, necessary, and when applied they must be limited and subject to review.[128]

It is important to bear in mind that "limitations do not grant states the ability to abuse rights; they simply define the actual scope of rights."[129] The human rights cannot be violated, but their scope of application may be limited to another standard.

Proportionality

The first principle to guide this analysis is proportionality. Mandatory testing among sex workers should be – to be acceptable by international law as a form of limitation – proportional to the aim for which it is taken. The aim of this form of testing, as explained in Chapter One, is to halt a serious epidemic that still threatens people's health and lives.

[126] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 28.
[127] M Daniel, S Sangeeta, S Sandesh, 2010, p. 141; RighT Guide says: that States may take measures that restrict a certain right, but only if the measure is proportional to the aim for which it is taken (proportionality), if there are no other means to achieve that aim that do not or less violate the right (necessity), and if the exception is laid down in the law (legality). M Wijers, L Chew, *'The RighT Guide'* (Netherlands 2010).
[128] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 29.
[129] *Idem.*

But this form of testing is also considered to be counterproductive in the fight against HIV, since one of the impacts of this measure is that it drives many sex workers underground, especially those who cannot comply with the conditions for working within the regulatory structures set up by the state. It creates a barrier for public health agents and outreach teams to spread information among those who are most at risk of HIV infection.

For this reason, it can be said that the requirement of proportionality is not being fulfilled. A measure that is counterproductive to its aim cannot be considered an excuse for limiting sex workers' human rights.

Necessity

The requirement of necessity for limiting human rights is an integral part of this work. This means that before limiting a certain group's human rights, states should consider less farreaching methods or activities for reaching the same goal. Throughout the years, different models of successful HIV/STI interventions were tested across the world and none of them make use of coerced testing.

This takes to the fact that sex workers are part of the solution, not the problem.[130] Sex workers play an important role in educating their communities to perform safer sex practices, which includes use of condoms. In order to achieve the aim of such a measure – to halt the epidemic – there are clearly more successful methods. The Sonagachi Project in India, which involves sex workers as peer educators, has proved to be one of the most successful examples of HIV prevention strategy. The methodology of peer education was developed by TAMPEP (European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers) and is recommended as a good practice in the latest UNAIDS report (2012).[131]

Moreover, if the aim of mandatory testing is to prevent people from transmitting the virus, that means that those who are already HIV-positive are prohibited from working in sex work and/or are punished if they do so. Administrative and criminal law against (HIV-positive) sex workers, however, increases their vulnerability and, normally, does not impede them from

[130] Overs, 2002.
[131] UNDP, 2012. See, additionally, the methodology on Peer Education developed by Fenarete Project: http://www.who.int/hiv/topics/vct/sw_toolkit/fenerateeng.pdf

working.[132] Decriminalization of sex work is recommended by UNAIDS as another method of halting the HIV epidemic, as well as universal access to health care, treatment, and support voluntary HIV testing.[133]

Good results in terms of public health could also be defined as guaranteeing universal access to therapy to all sex workers infected by HIV, reducing dramatically their risk of transmitting the virus through unprotected sex with a client. The need to use condoms should be promoted not just to sex workers, but also to clients. Campaigns should educate clients to buy sex with condoms, while mandatory testing leads clients to believe that sex workers are 'clean' from any infectious disease.

This means that any regulation of sex work should incorporate a right-to-health approach. In the International Guidelines on HIV/AIDS and Human Rights, the Office of the UN High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended to governments that:

> "[w]ith regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients."[134]

The requirement of necessity cannot be fulfilled, since there are other more successful and less farreaching means to achieve good public health results.

Equality and Non-discrimination

Equality and non-discrimination together constitute a cross-cutting principle that can be found in most human rights treaties. The WHO explains that discrimination ought to be understood as a barrier to equal enjoyment of human rights:

> "Discrimination means any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms. It is linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society."[135]

[132] See Hungarian situation described in Chapter Three.
[133] UNAIDS, 2012.
[134] Human Rights Watch, 'Human Rights Watch Kyrgyzstan: Letter to Kenjebek Bokoyev, Chairman of Parliamentary Committee on Rule of Law, Order and Fighting Crime' (2012).
[135] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 7.

Moreover, non-discrimination and equality are fundamental human rights principles[136] and critical components of the right to health.[137] To exercise the right to health, one must be free from discrimination.

> "Health services, goods and facilities must be provided to all without any discrimination. Non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health."[138]

Non-discrimination and equality further imply that states must recognise and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases.[139] States should adopt positive measures to ensure that specific individuals and groups are not discriminated against.[140]

In this study, it was explained how and why sex workers are discriminated against in order to achieve public health goals. Not surprisingly, groups traditionally facing discrimination and marginalisation often bear a disproportionate share of health problems.

The fact that mandatory testing norms and policies are intentionally directed at sex workers – a specific group of society – raises the question whether the grounds for this discrimination are legal or with legitimate aim. It is noteworthy that non-discrimination is a "fundamental rule of international human rights law".[141]

Not every differentiation of treatment, however, will constitute discrimination.[142] There are specific grounds on which there can be no discrimination. There are some situations where the Committees understand that "(…) even distinctions made on grounds that are not explicitly listed may engage these provisions."[143] Any criterion may be regarded as either relevant or

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[136] See Declaration on the Principles of Equality: http://www.equalrightstrust.org/ertdocumentbank/Pages%20from%20Declaration%20perfect%20principle.pdf

[137] "States have a special obligation to (…) prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health." (UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, paragraph 19).

[138] UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31*, 2008, p. 4.

[139] *Idem*, p. 7.

[140] *Idem*, p. 11.

[141] UN General Assembly, *Vienna Declaration and Programme of Action*, 12 July 1993, A/CONF.157/23, para 15.

[142] UN Committee on Economic, Social and Cultural Rights (CESCR), *General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, 2 July 2009, E/C.12/GC/20, paragraph 13.

[143] M Daniel, S Sangeeta, S Sandesh, 2010, p. 197.

irrelevant. Considering that the Committee expressly affirmed opposition to mandatory testing regimes, there is no shadow of a doubt that discrimination because of health status (including HIV/AIDS) is prohibited.

Moreover, the difference in treatment must "(1) pursue a legitimate aim and (2) be proportionate, [which] is very similar to the test used in the context of other rights to assess the permissibility of limitations."[144] As explained in this section above, these conditions are not fulfilled (see previous argumentation).

Discrimination is only allowed when "perfectly legitimate because [it is] based on morally acceptable grounds"[145]. Because sex workers are often considered immoral or socially subversive, few would argue against their testing, or call this discrimination.

Discrimination against sex workers in mandatory testing regimes can happen in two ways: directly and indirectly. Laws that request sex workers to get tested are examples of *direct discrimination* against sex workers.[146] Although the category 'sex worker' is not listed as one of the prohibited grounds for discrimination, it can be argued that because there is no legitimate aim for such discrimination, nor does mandatory testing meet the requirements of article 4 ICESCR, such discrimination is unlawful.

Laws that criminalise sex work and HIV transmission ought to be seen as forms of *indirect discrimination* against sex workers.[147] This is because they are often used to arrest sex workers and force them to test. These laws have 'unequal results' if compared to other citizens who are less likely to be arrested, tested and charged.

Laws that disproportionately affect sex workers also disproportionately affect women. Although gender issues are beyond the scope of this study, it should be clarified that any law and/or policy against sex workers is potentially against women's rights. In the HIV/AIDS field, gender is a very significant topic, as outlined by Dr Peter Piot, Executive Director of

[144] M Daniel, S Sangeeta, S Sandesh, 2010, p. 201.
[145] M Daniel, S Sangeeta, S Sandesh, 2010, p. 191.
[146] "Direct discrimination occurs when a person, on account of one or more of the prohibited grounds, is treated less favourably than someone else in comparable circumstances" (M Daniel, S Sangeeta, S Sandesh, 2010, p. 198).
[147] "Indirect discrimination occurs when a practice, rule, or requirement that is outwardly 'neutral', that is, not based on one of the prohibited grounds of distinction, has a dispropocionate impact on particular groups defined by reference to one of these grounds" (M Daniel, S Sangeeta, S Sandesh, 2010, p. 198).

UNAIDS in one of his speeches: "All AIDS strategies should pass the test: does this work for women?"[148]

Finally, it should be clear by this point that "human rights law prohibits both intended and unintended discrimination."[149] Any evaluation of discrimination should start with the impacts and results.

Conclusion

This chapter highlighted states' obligations in relation to the right to health. The arguments of international health organisations and relevant UN bodies' decisions were elucidated to explain how the international legal sphere understands this issue, and how mandatory testing violates international law and impacts on sex workers.

Freedom from non-consensual medical treatment and experimentation is one of the normative contents of the right to health. This means that by applying mandatory testing regimes, states are violating the right to health: 1) because it is legally prohibited, and 2) because it contradicts international ethical and development guidelines that relate to this right.

On one hand, sex workers (and any other persons) are not to be subjected to such coercive medical measures (freedom); on the other, mandatory testing fails to address states' obligation to take steps towards the realisation of this right (entitlement). This sort of evaluation between rights and efficacy of the measures implemented by states is one of the roles of the monitoring bodies of this right, in safeguarding the purpose and goals that should be achieved in relation to public health. Not always this evaluation appears in the concluding observations of the Committees; however, different UN specialized bodies have been devoting much attention to these issues such as UNAIDS, UNDP, and WHO. This suggests that the UN strategy in relation to the right to health and mandatory testing relates, at this stage, fundamentally, to policy development whereas further discussions were not deepened by the Committees.

As a matter of fact, the CESCR reinforces that non-consensual medical treatment and experimentation is forbidden under international human rights law, since it violates the right to health of people. In this sense, states should refrain from enacting laws and developing policies and health programmes that request mandatory testing of sex workers for HIV, unless

[148] UNAIDS, 'Keeping the promise: An Agenda for Action on Women and Aids' (2006, p. 4).
[149] M Daniel, S Sangeeta, S Sandesh, 2010, p. 197.

they can justify to the CESCR that these measures are reasonable and necessary, which is not the case.

Under this scope of analysis, mandatory testing among sex workers should not occur considering that it also constitutes a discriminatory practice which can negatively impact sex workers' right to health, especially the most vulnerable and marginalised sex workers. A holistic and human-rights-based perspective discards mandatory testing as a measure that brings some good to society, and underlines its discriminatory and stigmatizing aspects.

Moreover, the right to health is a social-economic and inclusive right. This element is fundamental for understanding the claim of sex worker organisations, as stated in Chapter One. In their point of view, healthy occupational and environmental conditions for sex workers would decrease their vulnerability to HIV/STIs as well as cases of violence against them. This means that states should not have a limited view in relation to the right to health, but should recognise the broad spectrum of situations which put sex workers at risk to violence and coercion, and consequently to diseases. This is the main policy recommendation of specialised health-related UN agencies.

Another point of consideration is that, in practical terms, it is not easy for sex workers in particular, due to their marginalisation, to claim the violation of their human right to health. Access to justice is not guaranteed to them in equal footing in relation to the general population.

That means that sex workers' right to health is most of the time dependent on national mechanisms and programmes, which are not always available in some states. When they are, some concepts and principles can also be misleading. Moreover, accessing regional and international mechanisms, when this right is denied to them, remains problematic and insufficient. For this reason states should be very careful when implementing public health programmes and laws that negatively impact this population.

In relation to the tripartite typology and the obligation of states to respect, protect, and fulfill the right to health of its citizens, the following can be concluded regarding sex workers and mandatory testing.

In relation to respecting the right to health, state laws have the duty to respect sex workers' rights by enabling an environment in which they are able to fulfill their fundamental rights, and be free from practices that put them at risk.

Additionally, laws that criminalise sex work and HIV transmission directly impact sex workers' enjoyment of the right to health, since they increase sex workers' vulnerability to violence and HIV.

In relation to protecting the right to health, sex workers are often forced to be tested because of lack of laws protecting them against abuses committed by third parties such as pimps, business owners, and traffickers. This refers to situations of uninstitutional mandatory testing, where the state condones the occurrence of mandatory testing by not protecting them.

Moreover, states should "ensure that third parties do not limit people's access to health-related information and services"[150]. Therefore, the recognition of better working conditions to sex workers is fundamental. Where third parties have the power to unofficially force sex workers to be tested for HIV, they also have the power to refuse sex workers' access to health-related services. Consequently, sex workers are working in unsafe settings. Where sex work is legal, such as in the Netherlands, business owners are obliged to favour access to service providers in brothels (including window-brothels) and apartments.[151]

In relation to fulfilling the right to health, mandatory testing of sex workers was challenged by a review of several UN guidelines in relation to sex work and HIV and it was concluded that mandatory testing cannot be regarded as a method (steps) for the realisation of the right to health, as argued by some states. In this sense, mandatory testing is not just an inefficient means to fulfill public health obligations, but it also endangers several human rights that cannot be violated by states, such as the right to health, and others.

The following interrelated and essential elements in relation to the right to health constitute, at the same time, effective alternatives for governments willing to apply HIV prevention measures among sex workers. In relation to each one, it can be argued the following.

[150] Toebes, 1999, p. 26.
[151] For more information see (p.6): http://www.minbuza.nl/binaries/content/assets/minbuza/en/import/en/you_and_the_netherlands/about_the_netherlands/ethical_issues/faq-prostitutie-pdf--engels.pdf-2012.pdf.

Availability. Evidence shows that where services for sex workers are available in quantity, vulnerability to HIV and violence can be reduced.[152] In this sense, there are alternative forms of HIV/AIDS prevention that do not undermine sex workers' self-determination.

Accessibility. Evidence shows that where services for sex workers are accessible, especially for the most vulnerable or marginalised sections of the population without discrimination, vulnerability to HIV and violence can also be reduced. The Sonagachi project in India, already mentioned in this study, is an example of community-based intervention where sex workers have accessible information that corresponds to their needs. Sexual health education and information[153] plays an enormous role in the development of health programmes and laws that assert the right to health.

Acceptability. As discussed in Chapter One, mandatory testing contradicts medical ethics since it does not consider the patient's autonomy and self-motivation. Moreover, sex worker groups strongly fight against HIV/AIDS and all forms of coerced testing imposed upon them, since they do not address structural determinants that put them at risk of HIV and violence.

Quality. Quality is an essential element for the efficacy of HIV prevention programmes. Studies have proven, however, that mandatory testing is not an effective way to combat the HIV epidemic.[154] As such, another element of the right to health is not being taken into consideration by governments that apply mandatory testing regimes.

At the same time, it was argued that the right to health of persons living with HIV/AIDS is undermined by discrimination and stigma. For example, fear of being identified with HIV/AIDS may stop people who suffer discrimination, such as sex workers or intravenous drug users, from voluntarily seeking counselling, testing or treatment.

Halting and reversing global epidemics relies heavily on addressing discrimination and stigma. Importantly, states should prohibit discrimination on the grounds of health status, including actual or presumed HIV/AIDS status, and protect persons living with HIV/AIDS from discrimination. State legislation, policies and programmes should include positive

[152] See the case of Uganda: http://www.who.int/inf-new/aids2.htm.
[153] "Accessibility of information should not impair the right to have personal health data treated with confidentiality." (UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14).*
[154] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2006; UNAIDS, 2012; WHO, 2012, p. 26; UNDP, 2012; and ILO, 2010.

measures to address factors that hinder the equal access of these vulnerable populations to prevention, treatment and care, such as their economic status.

Universal access to care and treatment is also an important component of the right to health for persons living with HIV/AIDS. Equally, it is important to ensure the availability of medicines and strengthen HIV prevention. The International Guidelines on HIV/AIDS and Human Rights provide further guidance on ensuring the rights of persons living with HIV/AIDS.

In conclusion, those states that argue that mandatory testing is a way to execute the right to health and limit the right to health of sex workers for the good of a healthier society are, in reality, not following the main view of the CESCR which is against coerced testing and are in contradiction with current UN policy development on HIV and the principles of law and good governance explained above. Therefore, mandatory testing of sex workers is more likely to be considered a violation (not limitation) to the right to health (of sex workers), instead of a lawful way of executing the right to health (of citizens) and/or limiting the right to health (of sex workers).

CHAPTER THREE: National Implementation

Introduction

National laws and policies play an important role in the development of strategies to combat the HIV epidemic, reduce vulnerability, and scale up universal access to medical care, treatment, and support. Laws can regulate and protect but they can also dispossess people of their dignity. Laws matter because they can negatively impact the specific groups of people they are meant to protect, especially vulnerable populations.

Mandatory testing laws and policies make up (unlawfully) some of the state responses to the public health challenges posed by the HIV epidemic. It can be said that "Whatever the criminal law regime, sex workers may be subjected to mandatory HIV testing and other medical procedures."[155] The method of testing, however, may differ depending on the set of laws regulating prostitution[156] and HIV.

Sex workers under specific legal regimes, for instance, are obliged to test due to the nature of their profession.[157] Thus, testing for HIV and other STIs is normally a requirement for being able to work in sex work (outdoor or indoor).[158] According to this logic, if a sex worker

[155] UNAIDS, 2012.

[156] When referred to the law, the preferable term is 'prostitution' since most laws name it this way. Moreover, According to the Rapporteur Mr Leo Platvoet, of the Group of the Unified European Left, historically three different approaches can be defined: prohibitionist, regulationist and abolitionist. Within the Council of Europe, 'a substantial minority of member states (9) subscribe to the ***regulationist approach***, which seeks to regulate rather than prohibit or abolish prostitution'. It is important to note that not all states that adopt the regulationist approach adopt mandatory testing as a requirement for working in prostitution. As it was mentioned earlier, in the European Union, only four of them adopt a regulationist approach to prostitution with mandatory testing requirement. Both the prohibitionist and the abolitionist approach are fundamentally opposed to the existence of sex work, but attempt to eliminate it using different approaches. The ***prohibitionist approach***, on the one hand, 'prohibits prostitution and penalizes pimps and alike (although not necessarily clients)'. The ***abolitionist approach***, on the other hand, 'seeks to abolish prostitution by penalising procurers and pimps rather than prostitutes'. The latter, believes that prostitutes are all victims and for this reason should not be penalised. For them, prostitution should be eradicated, not prohibited, or tolerated under certain conditions. Council of Europe Parliamentary Assembly, 'Prostitution – Which stance to take?' (2007).

[157] As explained above, providing sexual services implies MCP and sexual contact with the client (not necessarily penetrative or unsafe sex).

[158] *Right to work.* This right, enshrined in article 23 of the Universal Declaration of Human Rights and articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights, entails the right of every person to access employment without any precondition except the necessary occupational conditions. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is dismissed or refused employment on the grounds of a positive result. The right to work further guarantees the right to safe and healthy working conditions. Where a possibility of HIV transmission exists, e.g., in the health sector, States should take measures to minimize these risks, for instance through training and implementation of "universal precaution"

agrees to work in this profession, she or he ought to comply with this requirement; otherwise a fine or other form of punishment might be applicable, depending on the country and the circumstances.

Although not many states apply mandatory testing *directly* in the law, some others apply mandatory testing *indirectly* through laws that criminalise sex workers and HIV transmission. This situation can also be considered an *institutional* form of testing, since the order for HIV testing is constructed by state laws.

Another way that mandatory testing can be applied is through the absence of laws protecting sex workers from the intervention of third parties. Under these situations, sex workers are obliged to test because of an informal order from those who control the sex business. A refusal to undergo testing could expose a sex worker to violence or a lack of work venue. All forms of mandatory testing, however, undermine sex workers' autonomy and personal responsibility, and do not take into consideration sex workers' structural vulnerability to violence and HIV infection.

To better explain this, Chapter Three was divided into two main sections. The first one will discuss institutional forms of mandatory testing. The second will focus on uninstitutional forms of mandatory testing whereby the order to undergo testing for HIV is not given by the state, but is certainly condoned by it. These two main forms of testing will be analysed by taking into account the complexity of norms regulating prostitution and HIV, and will seek to find some patterns in the way mandatory testing is applied. Finally, this chapter will be concluded with an impact assessment of these measures on sex workers.

Institutional Forms of Mandatory Testing

With the rise of the HIV epidemic, many states have created public health measures and norms to effectively address the issue. The reality is that more than 60 countries, however, criminalise the selling of sex and a handful of others criminalise the purchase of sex.[159] Where sex work was an illegal activity there was no space for regulation, or control over the sex workers and sex businesses.

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procedures against all infections, including HIV. UNAIDS 'Handbook on HIV and Human Rights for National Human Rights Institutions' (Geneva 2007).

[159] D Kulick, 2005.

Under these circumstances, states could not apply mandatory testing directly in the law, but they could – and many did – create laws to criminalise HIV transmission.[160] These laws are often used, in combination with laws that criminalise prostitution, to arrest sex workers and force them to test.

Although the HIV epidemic was not the only reason for some countries to legalise sex work[161], it certainly fuelled a process of legalisation[162], either to favour a legal system that supports regulation of prostitution (with or without mandatory HIV/STI testing)[163], and/or to favour a safer working environment for sex workers (with more or less autonomy)[164]. Where sex work became a legal professional activity, mandatory testing could then be adopted directly by the law. In Germany, the legalisation of sex work happened with a parallel regulamentation of the profession which included, in the very beginning, mandatory testing. Later this regulation was amended and mandatory testing was excluded from the law.

> "The regulatory approach adopted by Germany in 2002 was understood by many sex workers' organisations as the state's affirmation of their rights. Especially for the purposes of this paper, it should be considered in tandem with the law addressing infectious diseases, which replaced the prior legislation, a sexually transmitted diseases act on 1 January 2001. As noted by a research institute commissioned by the government to evaluate the legal reforms, the new laws shifted the emphasis from mandatory testing of sex workers – which is no longer a feature of the German approach – to prevention, through public information, and voluntary engagement with sex workers on health and safety issues, including HIV prevention."[165]

In the Netherlands, mandatory testing was not added into the law; however, municipal authorities have specific regulations on health of sex workers.[166] This means that sex workers

[160] Some examples are the Russian Federation and the Ukraine. In both countries, sex work is regarded as an administrative offence. Because HIV transmission is also criminalised, law enforcement authorities often use the combination of these two prohibitions to force sex workers to test for HIV. For more information on these laws and policies, see: http://www.conectaproject.eu/. Also check: GNP+ Global Criminalization Scan: http://www.gnpplus.net/criminalisation/.

[161] Decriminalisation of sex work is also seen as a form of preventing trafficking in persons and other forms of organised crimes.

[162] See: UNDP, 2012; UN Human Rights Council, 2010, A/HRC/14/20; and UNAIDS, 2012.

[163] Although the WHO requires "Member States should review, and change as necessary, their laws, regulations, policies and practices to eliminate any forms of non-voluntary HIV testing" it is clear that some countries used decriminalisation of sex work as a method to apply mandatory testing regimes. Unfortunately, the purpose of such testing is not to provide access to HIV prevention, treatment, care and support, but most often to exclude people with HIV from access to certain services, or otherwise impose restrictions on them (WHO, 2010).

[164] This argument was strongly evoked by the Dutch and German governments while legalising prostitution.

[165] Sukthankar A, 2011, p. 5.

[166] Centre for Infectious Disease Control (CIb), National Institute for Public Health and the Environment (RIVM), the Netherlands, 2007, p. 12.

are working in safer conditions and are less likely to become victims of violence (from the police, clients, or controllers of the sex business), and consequently, to acquire the HIV virus.

The following pages will reflect upon these two fundamental forms of institutional mandatory testing.

Adopted Directly by the Law

Mandatory testing is not an isolated form of state control over prostitution.[167] It is sometimes part of a broader context of laws that are commonly named regulationist approaches.

The regulationist approach seeks to regulate prostitution.[168] Prostitution is then legal under certain conditions determined by the state.[169] As a consequence, states that opted for this sort of approach to prostitution had to first legalise prostitution within their national jurisdictions. States that follow the regulationist approach differ in the ways in which they wish to regulate prostitution, and some (not all) adopted mandatory testing directly in the law.

TAMPEP's report highlights the close relationship between the regulationist approach and mandatory testing:

> "Official State tolerance of what is often understood to be a 'necessary evil' [is expressed] by attempting to control prostitution through government regulatory schemes. Such schemes are either classically regulated by government authorities primarily through legally permitted brothels or by means of a neo-regulatory system whereby indirect mechanisms, such as taxes or mandatory health examinations, regulate prostitution."[170]

The International HIV/AIDS Alliance's report points out, accurately, that:

> "This approach has been adopted in many high-income countries, where regulation focuses on safety standards in brothels and during sexual acts. The approach can be effective in circumstances of good governance, and where there are well-resourced monitoring mechanisms. However, it faces many challenges in

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[167] Other measures could also be described, for example, prohibiting persons who have tested positive for HIV from working as prostitutes or enhancing the penalties for existing prostitution offences when committed by a person with HIV. These two relate to criminal law measures. There are, however, several other policies that could be listed as targeting sex workers.
[168] Council of Europe Parliamentary Assembly, 'Prostitution – Which stance to take?' (2007).
[169] "A country falls under this model if outdoor and indoor prostitution are regulated by the State and therefore not prohibited when exercised according to this regulation" (TAMPEP, 2009, pp. 12-13).
[170] TAMPEP, 2009, pp. 12-13.

> poorer countries with weak infrastructure. There are risks associated with requirements such as mandatory health checks, which may be implemented in a way that is disrespectful of sex workers and that perpetuates the stigma associated with sex work. Where the rule of law is weak, those responsible for monitoring compliance with sex industry regulation may use their positions of power for corrupt practices, such as demanding bribes or sexual services."[171]

Although it is not entirely true that this regulationist approach has been successful in high-income countries (there is a lot of criticism, for instance, of several regulations established by the Netherlands, Germany, Austria, and Switzerland[172]), it is clear that there is a close connection between the implementation of mandatory testing and risks of human rights abuses against vulnerable groups, such as sex workers.[173]

In the regulationist approach to prostitution, sex workers are often required to register with the government in order to perform sex work. Because of fear of stigma, discrimination, or simply because of other specific restrictions[174], many sex workers cannot (or prefer not to) register with the government authorities. In these legal contexts, many sex workers are driven underground, which undermines public health efforts, as can be seen in the following Senegalese example:

> "The legalisation of sex work in Senegal follows the regulatory approach, but is considered to have been unsuccessful. Senegal legalised sex work in 1969 and all sex workers are required to register with the government. Registered sex workers must receive monthly check-ups at specialised health centres, where they can receive condoms and contraception. If they do not comply their registration cards may be revoked. However, many sex workers operate outside the legal industry. Although legal sex workers have access to routine health care, unregistered sex workers do not, and they are persecuted by law enforcement agencies, which drives them further underground and makes outreach and HIV prevention difficult."[175]

Other countries, instead, developed a comprehensive HIV-specific law, such as Papua New Guinea's HIV/AIDS Management and Prevention Act 2003:

> "The act includes a declaration that HIV is not a venereal disease (thereby excluding inappropriate Public Health Act provisions related to venereal disease); forbids HIV-related discrimination; ensures partner notification; forbids

[171] International HIV/AIDS Alliance and Commonwealth HIV, 2010.
[172] Recently, a sex worker from Switzerland filed a complaint before the ECHR claiming that registration of sex workers violates sex workers' right to privacy. The case was admitted by the Court and proves that regulationist systems not always comply with the human rights standards they should.
[173] It will be explained in chapter three that, independently of the GDP of a country, mandatory testing is a problematic measure *per se*, particularly if taken a look on the human rights impacts involved.
[174] Mainly in relation to migrants or specific forms of sex work.
[175] Open Society Institute, 2007; and International HIV/AIDS Alliance and Commonwealth HIV, 2010.

> mandatory testing (except in emergency situations); requires that information about a person's HIV status be kept confidential; and guarantees access to protection from HIV infection (including the use of condoms)."[176]

This sort of act, although rare, is informed by the internationally recognised standards for HIV prevention and human rights.[177] For now, it can be said, based on these international standards, that:

> "Where governments have recognised the legality of sex work, health regulations related to sex work should not require mandatory medical procedures, should respect sex workers' right to meaningful participation in health services, and give priority to measures that empower sex workers to protect themselves from HIV and other sexually transmitted diseases."[178]

In spite of that, in the Council of Europe, there are four EU member states where mandatory testing is stipulated directly by law, namely Austria, Hungary, Latvia, and Greece.

The fact that these countries are member states of the European Union holds important significance for further analysis of the international legal frameworks and their development, especially in the field of human rights. A vast regional human rights protectionist system was developed in Europe, and it is increasingly easy for victims of human rights violations to file a complaint.[179]

Below, the aim is to provide some examples of how mandatory testing is prescribed by the laws and executed by law enforcement measures. For all of them, mandatory testing is a prerequisite for sex workers working in sex work. In other words, without undergoing mandatory health checks, one could not sell sex, regardless of the type of sexual service offered or safer sex practices.[180] The following are classic examples of mandatory testing within regulationist legislations.

Austria

[176] International HIV/AIDS Alliance and Commonwealth HIV, 2010.
[177] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2006; and UNAIDS, 2012.
[178] UNAIDS, 2012.
[179] Council of Europe, *Protocol 1 to the European Convention for the Protection of Human Rights and Fundamental Freedoms*, 20 March 1952, ETS 9.
[180] Some sexual practices, especially non-penetrative ones, are considered to be safer sex practices.

Although sex work in Austria is not a criminal act, "day to day, sex workers face different sorts of regulations across the Austrian provinces, from compulsory registration to mandatory health checks."[181]

Austria applies a contradictory model whereby, on the one hand, sex work is neither recognised as a trade or profession, nor as a gainful occupation, with no possibility to legalise employment relationships based on sex work. On the other hand, it is compulsory for sex workers to be registered with the local authorities (municipal office and in some provinces the police department).

In this regulatory system, sex workers must undergo regular mandatory health checks according to § 4 of the Austrian AIDS Law (AIDS-Gesetz):

> "(1) Persons who have been tested positive of HIV or who have not been tested negative in a definite way according to paragraph 2 are not allowed to accept professional sexual actions done with them or to undertake professional sexual actions with others.
> (2) Apart from the law of sexually transmissible diseases and hereon based acts, persons who are willing to undertake professional actions according to paragraph 1 are obliged to undergo public health examinations. Moreover, persons who undertake a professional action according to paragraph 1 have to undergo a public health examination in order to examine the existence of a HIV infection in periodic time intervals not less than every 3 months.
> (3) The district administration is allowed to issue a certificate according to § 2 of the act, official gazette (*Bundesgesetzblatt*) no. 314/1974 and has to revoke the certificate if:
> 1. the person is infected of HIV
> 2. the public health examination according to paragraph 2 has not been negative in a definite way
> 3. the person refused to undergo a public health examination according to paragraph 2"[182]

This system, however, does not apply to all sex workers. Due to restrictive immigration legislation, only sex workers who are national or EU citizens may officially register as sex workers.[183] This means that sex workers who are not allowed to work in Austria (mainly migrants from other Eastern European countries) are not allowed to register with public authorities for work in sex work. Mandatory testing for sexually transmitted infections

[181] INDOORS, *Capacity Building & Awareness Raising: a European guide with strategies for the empowerment of sex workers* (2012, p. 30)
[182] Free translation of the (*AIDS-Gesetz)* as amended on 01.08.2012.
[183] TAMPEP, 2009.

produces a two-tier system of registered and non-registered prostitutes; the latter having limited access to health care.[184] As a result, they often do not test for HIV/STIs and have to pay high fines when caught by the police. These sex workers normally work in more clandestine and unsafe settings due to police checks and, for this reason, are more vulnerable to HIV/STI infection, as well as their clients.

Hungary

In Hungary, prostitution is legal and regulated by several laws.[185] This does not mean, though, that legislation in the country favours good working conditions or the well-being of sex workers. An important document in the context of this study is the Ministry of Health's decree on mandatory regular health checks.[186]

According to the Hungarian legal system, only self-employed and registered sex workers with the Hungarian Tax Authority are allowed to work[187], but that is not all. Registered sex workers are required to undergo mandatory health examinations in order to perform their profession.

According to TAMPEP's report:

> "It is mandatory that sex workers get screened for the following every three months for Chlamydia, Hepatitis B, HIV, syphilis and gonorrhea. The examination fee is 17,000 HUF (approx. 70 Euros). There is only one place in Budapest offering screenings."[188]

Unlike under the Austrian system (which offers public and free of charge testing), Hungarian sex workers are obliged to pay for their non-consensual health checks. Not all sex workers have enough money though. A recent survey indicates that most sex workers, in Hungary, lack the medical certificate (regular check-ups entitle the sex worker to a health certificate), primarily due to the fact that the mandatory screenings are sparsely available and costly for those who are not covered by national health insurance, and thus not available to most migrant and undocumented sex workers. Mandatory testing obligations, under these conditions, certainly affect the health of migrant sex workers.

[184] TAMPEP, 'Policies on sex work and health' (1999).
[185] Sexual activity, as defined in the Treaty of Rome, has also been incorporated into Hungarian law.
[186] Decree 41/1999 (IX.8.) of the Minister of Health. Only available in Hungarian, content explained in interview by Hungarian lawyer Tamas Arva. Contact: arvairoda@t-email.hu
[187] According to Section 1(3) of Act CXVII of 1995 on Personal Income Tax and Section 2(1) and 6 of Act CXV of 2009 on Self-employment. Only available in Hungarian, content explained by Hungarian lawyer Tamas Arva.
[188] TAMPEP, 2009, p. 95.

In spite of the fact that offering sexual services without a medical certificate is also subject to punishment under Hungarian law[189], and the heavy police monitoring of sex work activities, it was reported (in an interview especially for this study) that only very few sex workers actually possess medical certifications and papers.[190]

Meanwhile, other studies indicate that certain aspects of policies in Hungary may further affect sex workers' human rights[191], as can be read below:

> "Mandatory HIV/STI testing and regular breaches of sex workers' privacy when their medical records are shared with the police may further marginalize sex workers and worsen their access to STI treatment."[192]

The International Covenant on Civil and Political Rights (Article 17) prohibits arbitrary interference with a person's privacy. The International Covenant on Economic, Social and Cultural Rights (Article 12) guarantees protection of the confidentiality of personal health information, as part of the right to the highest attainable standard of health (see Chapter Two). The European Convention on Human Rights (Article 8) guarantees the right to respect for private and family life, and further prohibits any public authority from interfering with this right except as is necessary in a democratic society in order to achieve such objectives as protection of health or protection of the rights and freedoms of others.[193]

The regulationist approach adopted in Hungary and in other countries results in a system where on the one hand, sex workers are 'tolerated' and can work legally (at least some of them), while on the other hand, they must undergo several legal requirements in order to exercise their right to work, which can cause serious breaches of their human rights.

In Hungary, sex work is legal but highly regulated. Some reports recall that:

[189] TAMPEP, 2009, p. 19.
[190] Content explained in interview by Hungarian lawyer Tamas Arva.
[191] The close link between mandatory testing and the right to privacy will be further explored in chapter four.
[192] Central and Eastern European Harm Reduction Network in Central and Eastern Europe and Central Asia, 'Sex Work, HIV/AIDS, and Human Rights' (2005).
[193] Human Rights Watch, 'Open Letter to the Government of Macedonia Regarding Criminal Prosecution of Alleged Sex Workers' (2008).

> "This situation directly conflicts with the law, however, and many observers believe it represents a questionable practice from a human rights point of view – regardless of the merits of the legal, regulated policies governing sex work." [194]

Greece

In Greece, sex work is not considered a profession, but it is a legal 'activity'. The legislation on sex work is linked to employment conditions. Regular health screenings are mandatory in order to obtain a licence to work as a sex worker. As in the two countries above, sex workers in Greece must also undergo non-consensual testing in order to work 'legally' in sex work. This legislation applies to any sex worker with the exception of minors and married women.[195]

It is mandatory that legal sex workers get a free STI screening every 15 days. For migrant sex workers, HIV, syphilis and gonorrhea testing and treatment are free of charge. The services provided by the public authorities offer STI and HIV treatment to undocumented migrants.

Migrants without a legal status in Greece, however, are not permitted to work in sex work.[196] Consequently, migrant sex workers tend to hide from the police by working in hidden areas, where they are often more vulnerable to violence and HIV infection. Those who are caught working in sex work by the police, however, are forced to test for HIV/STIs.

In reality, however, the HIV status of sex workers is often disclosed to public authorities, and they may be criminally charged for spreading the virus. In extreme cases, as it happened in May 2012, authorities publish the pictures of HIV-positive sex workers in the press as a strategy to prevent clients from buying sexual services from these people.[197] This sort of 'societal' punishment, on top of the legal one, has to do with the history of sex workers as carriers of HIV/STIs, as explained in Chapter One.

[194] Human Rights Watch, 'Open Letter to the Government of Macedonia Regarding Criminal Prosecution of Alleged Sex Workers' (2008).
[195] TAMPEP, 2009, pp. 91-93.
[196] *Idem.*
[197] Recent actions (May, 2012) by the Greek authorities involving the arrest, detention, mandatory HIV testing, publication of photographs and personal details, and pressing of criminal charges against sex workers. TGEU, 'Greek Authorities Should Immediately End Ongoing Human Rights Violations Against Sex Workers!' (2012).

Latvia

Latvia strongly regulates prostitution with the aim of reducing the number of people who engage in this profession. Consequently, it also prescribes regular mandatory health checks for sex workers. Adult prostitution (providing sexual services in exchange for money) is allowed but procuring is not.[198]

Prostitution is highly regulated by the 'Provisions Restricting Prostitution' that were amended in January 2008.[199] Compared to the previous regulations (2001), there are even more limitations. Because of these limitations[200], many sex workers end up working irregularly, and if caught by the police within a period of one year, criminal liability is applicable.[201] This means that a sex worker can be charged for a criminal act.

Engaging in prostitution is prohibited for underage persons and persons who do not have a health card. Sex workers must undergo monthly mandatory health checks with a certified dermatovenerologist.[202] As in Hungary, sex workers have to pay for the health checks and the health card. All information about the sex workers' health status is recorded on the health card, can be easily disclosed to public authorities, and should always be presented to clients.

[198] Article 1631 of the Criminal Law provides penalties for the establishment, management, maintenance and financing of a brothel; Article 164 of the Criminal Law provides punishment for involving persons in prostitution and the procuring of persons for prostitution, using their trust in bad faith, or by means of fraud, or by taking advantage of the dependence of the person on the offender or of his or her state of helplessness; Article 165 of the Criminal Law provides punishment for a person who commits taking advantage, for purposes of enrichment, of a person who is engaged in prostitution; Article 1651 of the Criminal Law provides punishment for sexual exploitation of a person with his or her consent.

[199] One of the most substantial laws in Latvia which regulates prostitution is "Regulations on prostitution limitation". First regulations was issued by the Cabinet of Ministers of Republic of Latvia Nr. 427 on 04 November 1998 (Latvijas Vēstnesis, 1998, 336.nr.), further it was added the regulation Nr. 210 on 22nd of May 2001, protocol nr. 24, 20. (Latvijas Vēstnesis, 2001, 80.nr). Since then it was added two times on 13 February 2007, protocol Nr.12 28.§ (Latvijas Vēstnesis 2007, 28.nr.) and second time on 22 January 2008, protocol Nr.5 4.§ (Latvijas Vēstnesis, 14 (3798), 25.01.2008.).

[200] For all limitations, read: the "Regulations on prostitution limitation" from 22 January 2008. Cabinet of Ministers of Republic of Latvia regulations Nr.32. Protocol: Nr.5 4.§. An example of these limitations is that sex workers are allowed to offer or to receive paid sex services only inside of the living places (apartment, flat or house), which is their property or which is rented with the rent agreement. *(CM 22.01.2008. regulation Nr.32 reduction).*

[201] TAMPEP, 2009, pp. 99-101.

[202] Cabinet of Ministers 13.02.2007. Regulation Nr.117.

Furthermore, sex workers are not allowed to continue work while in medical treatment or medical or serological surveillance for an infectious disease.[203] This applies also to HIV-positive sex workers.

The medical card indicates: a) personal identification number of the sex worker; b) health card number; c) name of the medical institution; and d) name of the medical doctor (signature and initials). It also includes a photo of the sex worker. See the example below:

Sample Medical Card in Latvia

Vieta fotogrāfijai	1.	Personas kods □□□□□□-□□□□□
	2.	Izsniegšanas datums (dd.mm.gggg) □□.□□.□□□□
	3.	Veselības kartes numurs _____
	4.	Ārstniecības iestādes nosaukums _____
	5.	Ārstniecības persona _____ (paraksts un tā atšifrējums)

Z.v.

6. Dermatovenerologa apskate			
Datums	Atzinums	Ārstniecības iestādes nosaukums	Ārsta paraksts un zīmogs

Adopted Indirectly by the Law

Mandatory testing is mostly seen as a lawful mechanism adopted by certain jurisdictions under which sex work is a legal activity, in spite the fact that international law points out different understanding. In some countries, however, sex work is an illegal activity, and mandatory testing is done indirectly through laws that criminalise sex work and HIV transmission.

In these countries, when sex workers are arrested by the police they are normally detained for inspection. Whilst in most cases sex workers are released, this does not mean that torture and other degrading and inhuman treatment, including forced sex with policemen, and mandatory testing, did not take place. Human rights reports often point out these violations.[204]

[203] Cabinet of Ministers of Republic of Latvia regulations Nr.32. item 10. Sex workers whose blood is discovered to contain antibodies against HIV or who have been diagnosed with AIDS are further forbidden to work as sex workers.
[204] SWAN, Open Society Foundations, 2011, p. 3, and other Human Rights reports mentioned in this study.

Sex workers across Europe are commonly arrested in the streets, brothels, parks, wherever they work. Outdoor sex workers, however, are more frequently the targets of law enforcement measures. The brutality of law enforcement agents towards vulnerable groups, especially female migrant sex workers, is also well-documented in human rights reports.[205] Mandatory testing in these contexts empowers authorities in opposition to those who are more vulnerable, leaving a margin for abuses to take place.

> "Say you work the highway. A police truck approaches. You are grabbed and forced inside. Of course, they [the police] curse you all the way…Then they bring you to ROVD [a police station operated by the District Department for Interior Affairs], right into the hands of the superior at the antidrugs and prostitution department. It's important to behave yourself, as otherwise you will probably be beaten. The police make you write why you were on the highway "prostituting yourself." They maintain you should admit in writing that you are a prostitute. Sometimes this is when you can try and bribe the officer with an offer of free sex…After you have given a written admission, they can either let you go but keep your passport, or bring you to the STI clinic for compulsory tests. In the STI clinic, if you test positive for one thing or another, you can end up staying there for up to 30 days, and you have to pay for treatment…The police will not touch you for at least three days on the highway, because the STI clinic will not take you again in such a short period of time."[206]

In Europe, the majority of sex workers are migrant women[207] who experience several forms of institutional and gender-based violence.[208] In spite of the fact that all female migrant workers are entitled to the protection of their human rights, in particular the right to be free of degrading and inhumane treatment[209], when they choose to sell sex their rights are normally denied and abused, particularly but not limiting to migrants.

Abuses within the sex industry are not limited exclusively to women's issues. Societal homophobia, laws against homosexuality, and the absence of legal protection from

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[205] See link: http://www.hrw.org/reports/2003/bangladesh0803/6.htm; http://www.opensocietyfoundations.org/sites/default/files/where.pdf.

[206] A sex worker from Tashkent, Uzbekistan. Central and Eastern European Harm Reduction Network in Central and Eastern Europe and Central Asia, 'Sex Work, HIV/AIDS, and Human Rights' (2005)

[207] "Overall, most of the sex workers in Europe most prominently in the West, South and North Regions of Europe, which comprise most of the 14 old EU countries represented in the TAMPEP Network are migrants. Throughout the old member states, an average of approximately 70% of all sex workers are migrants, while some countries such as Italy, Spain, Austria and Luxembourg report that migrants comprise 80% to 90% of the sex worker population, or 60% to 75% in Finland, the Netherlands, Belgium, Germany, France, Greece, Denmark and Norway. The greatest balance between migrants and nationals is found in Portugal (56% migrants) and the UK (41% migrants; with the highest level of concentration in London (80%)." (TAMPEP, *Sex Work in Europe: a mapping of the prostitution scene in 25 countries*, 2009, p.16)

[208] TAMPEP, 2009.

[209] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General recommendation No. 26 on women migrant workers*, 5 December 2008, CEDAW/C/2009/WP.1/R.

discrimination are serious barriers for transgender and male sex workers to be free from violence that puts them at risk.[210]

Thus, countries that criminalize sex work and HIV transmission indirectly create a legal environment that condones violence particularly against sex workers. When arrested and detained, sex workers who did not have the right to work because sex work is illegal (in prohibitionist regimes), are often forced to test for HIV/STIs by state officials based on public health regulations. This happens in spite of the fact that states have the obligation to provide special protection to vulnerable persons.[211]

The ICCPR in its article 7 and the European Convention on Human Rights (ECHR) in its article 3 prohibit the state and its officials from engaging in inhuman or degrading treatment or punishment, as does the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Torture Convention) in its article 16.

Furthermore, there is no permissible limitation on the right to be free from inhuman or degrading treatment or punishment; this right is "nonderogable".[212] These prohibitions encompass not only acts that cause physical pain, but also those that cause mental suffering to the victim.[213]

Therefore, it can be said that arresting and detaining sex workers is not just considered counterproductive to its aim to halt the epidemic[214], but also often violates sex workers' right to be free from inhuman or degrading treatment or punishment.

In Romania, for example, where sex work is an illegal activity, sex workers are often arrested in police crackdowns and forced to test for HIV.[215] Because Romania also has laws that criminalise the transmission of HIV[216], the police are allowed to test them and verify whether

[210] Interview with Dr. Licia Brussa, TAMPEP International Foundation, Amsterdam, 2012.
[211] UN Human Rights Committee, General Comment 20, paragraph 11: Article 7 (prohibition of torture and cruel, inhuman or degrading treatment or punishment), 1992.
[212] UN Human Rights Committee, General Comment 20, paragraph 3: Article 7 (prohibition of torture and cruel, inhuman or degrading treatment or punishment), 1992.
[213] UN Human Rights Committee, General Comment 20, paragraph 5: Article 7 (prohibition of torture and cruel, inhuman or degrading treatment or punishment), 1992.
[214] As explained before, where sex work is criminalised sex workers tend to work underground.
[215] Information collected with the organization ARAS. Interview by phone, 2012.
[216] Applicable law: Article 309, paragraph 2, of the Romanian Penal Code. "Transmission of a venereal disease by sexual intercourse, by sex between same-sex persons or acts of sexual perversion by a person who knows they

they are 'infecting their clients'. This happens in spite of the fact that clients may (also) be transmitting HIV to sex workers. Clients of sex workers are never tested.

Further examples can be found in the literature on this topic. According to the Canadian HIV/AIDS Policy & Law Review:

> "On the night of 20 November 2008, police executed a large-scale raid targeting a well-known sex work zone in Skopje, arresting more than 30 people (the majority of them women alleged to be sex workers) and detaining them overnight. The following day, those detainees accused of being sex workers were subjected to compulsory testing by the police for HIV and hepatitis B and C."[217]

With no respect for their privacy, the media and the Macedonian Ministry of Interior published pictures of those arrested. As stated by the Minister, the objective of the testing was to "find out if the 'arrested prostitutes' were purposely spreading infectious diseases and […] those who tested positive would face criminal charges."[218] In an open letter to the Minister, the Canadian HIV/AIDS Legal Network and Human Rights Watch (HRW) condemned the action taken by the police, as follows:

> "The actions of the police, and of the Minister, and your Government, violate human rights protected under international law, … are inconsistent with sound, ethical public health practice and will likely serve to undermine efforts to protect and promote public health".[219]

The strong protest letter signed by several NGOs strongly suggested that the action taken by the police violated several human rights. Among many other things, the letter pointed out that:

- Detaining individuals in order to conduct forced medical procedures, including testing for HIV and HCV, violates the right to security of the person;
- The conduct of police and the government has also violated the right to privacy of those detained, and constituted inhuman or degrading treatment or punishment; and
- Forcibly testing someone for HIV or HCV is a violation of both bodily integrity and privacy.

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suffer from such disease shall be punished with imprisonment for 1-5 years. Acquired immunodeficiency syndrome transmission - AIDS - by a person who knows they are suffering from this disease is punishable by imprisonment for 5-15 years. If the offense results in death of the victim, the punishment is imprisonment from 7 to 15 years." See: http://www.gnpplus.net/criminalisation/country/romania.

[217] Canadian HIV/AIDS Legal Network, 2009, p.29; See also: NSWP, 'Only Rights Can Stop the Wrongs: The Smart Person's Guide to HIV and Sex Work' (2012, p. 4).

[218] Canadian HIV/AIDS Legal Network, 2009, p.30.

[219] Human Rights Watch, 'Open Letter to the Government of Macedonia Regarding Criminal Prosecution of Alleged Sex Workers' (2008).

Because sex work is illegal in those countries, law enforcement authorities can arrest those who they 'consider to be' a sex worker. Evidence is not always easy to find, and even something as ambivalent as a condom may be used as proof of sex work. Sex workers work at the margins of the law, hiding from the police, and many times supported by corrupt networks of pimps, and contradictorily, police. When caught, sex workers are often sent to hospitals, and tested sometimes without counselling. This procedure is not implemented with any ethical medical guidelines, nor is it based on international standards of human rights.

If a sex worker tests positive, officials present criminal charges. It is noteworthy, however, that the fact that one is HIV-positive, for example, does not imply that unsafe sexual practices are being performed. Many HIV-positive sex workers are aware of their status and for this reason they make sure that safer sex practices are undertaken. The same does not happen with clients. Most of the clients are unaware of their status, and quite often sex workers report that one of the reasons why they practise unsafe sex is because the client demands it, or because they can charge more for the service.[220]

For those countries that apply punitive, criminal, and discriminatory prostitution and HIV laws and policies, UNAIDS recommends "Enabling legal and policy environments - the importance of addressing the criminalisation of sex work and repressive law enforcement practices as barriers to universal access."[221]

Uninstitutional Testing

Mandatory testing is sometimes ordered by third parties, like pimps, traffickers[222], and business owners[223]. In these situations, state officials do not oblige sex workers to test, but they do very little to prevent sex workers from being forced into testing by third parties. In order to fulfill their human rights obligations, states should also protect people against

[220] INDOORS, *Outreach in indoor sex work settings: A report based on the mapping of the indoor sector in nine European cities* (2012).
[221] NSWP; UNAIDS, 'UNAIDS Advisory Group on HIV and Sex Work 2010 Report' (2010, p. 2).
[222] Trafficking in persons is also recognised as a factor for the vulnerability of sex workers to HIV infection (UNODC 'Toolkit to Combat Trafficking in Persons 'Testing and counselling for HIV/AIDS among people vulnerable to trafficking in persons').
[223] 'Business owner' is a term used in preference to 'pimp' in countries where running brothels is legal. According to TAMPEP's glossary, the term 'manager' could also be applicable: "This term is used to describe individuals who run sex businesses but who do not determine an individual's involvement in sex work or the sexual services they provide." For more terms: http://tampep.eu/documents/Reports%20-%20Glossary.pdf.

violations originating from third parties. Thus, mandatory testing is a practice that also happens informally, by order of 'others', and through means that are condoned by the state.

Furthermore, uninstitutional testing may take place under any legal regime governing prostitution and HIV, simply because it is based on the will of third parties to force sex workers to be tested, and not on a state regulation.

Although the large majority of the members of the Council of Europe adopt either the abolitionist or prohibitionist approaches[224] to prostitution, organised sex businesses (brothels, apartments, etc.) can still be found in all of them. They are illegal sex businesses and they operate in spite of the prohibition. Cases of police corruption are also well-documented. In Spain, for example, where pimping is prohibited, the sex-worker-led organisation Hetaira reports that brothel owners require HIV testing in order to provide sex workers with a workplace.[225]

Given high levels of violence against outdoor sex workers (violent clients, police arrests, rapes, etc), many of them prefer to work in indoor settings. This means that sex workers are less autonomous and have to comply with the rules of the pimps. Where sex work is criminalised, pimps are often empowered, and several abusive practices are committed against sex workers.[226] For this reason, some countries, such as the Netherlands, decided to legalise sex work businesses (in addition to sex work), in order to diminish this power imbalance between pimps and sex workers.[227]

In the illegal brothels, however, sex workers often have to undergo a HIV/STI test in order to work, and they are required to pay for these regular checks themselves. This evidence can be read in TAMPEP's report:

> "In some countries, although health checks are not required by law, they are asked for in certain cases. For example, sex workers working in certain brothels in Slovakia are required to regularly provide their employer with proof that they have been checked. For that purpose, some doctors agree – for a fee – to perform

[224] Council of Europe Parliamentary Assembly, 'Prostitution – Which stance to take?' (2007).
[225] INDOORS, *Capacity Building & Awareness Raising: a European guide with strategies for the empowerment of sex workers* (2012, p. 137).
[226] See National Reports of Conecta Project which is implemented both in Ukraine and the Russian Federation: http://www.conectaproject.eu/. In both countries sex work is an illegal offence, reason why they become more dependent on the organisers of the sex industry.
[227] Hotline for Migrant Workers, 'The Legalization of Prostitution: Myth and Reality: A Comparative Study of Four Countries' (2007, p.55).

> the examination and issue a statement. In this way, although they may not be legally prescribed, the concept of mandatory testing and asserting medical control over sex workers has not only created a financially rewarding field of work for medical personnel but also new dependencies for sex workers, and thus also further reinforce their social exclusion and stigmatisation."[228]

It is clear that uninstitutional mandatory testing has to do, in any case, with lack of state support for sex workers by neglecting to ensure they have safe working environments. Ideally, sex workers should be able to work free from abuses by third parties, including mandatory testing. Where power imbalances are high, sex workers do not have the chance to have informed consent regarding their medical examinations.

Conclusion

At this point, it becomes clearer how mandatory testing can be applied by different legal arrangements concerning prostitution and HIV. A key component of this national legislation assessment, however, is to analyse the impact of mandatory health checks on sex workers.

The first impact that can be identified is that mandatory testing, among other reasons, drives many sex workers underground, especially those who cannot comply with the conditions for working within the regulatory structures set up by the state. Institutional mandatory testing applied directly by the law creates, as explained above, a category of sex workers who cannot comply with the regulations, normally migrant (undocumented) sex workers.

Secondly, sex workers who work under prohibitionist legislation also fear police arrest, and consequently tend to work in less accessible areas. This certainly impacts their safety and risk of HIV infection.

Thirdly, any kind of coercive testing has a negative effect because it further marginalises sex workers who are already marginalised. The impact of this is that the HIV/AIDS pandemic is driven underground, which further reduces the ability of the state to respond to public health concerns.

Fourthly, because many sex workers are driven underground, there is a considerable negative impact from a public health intervention perspective, because health personnel and service

[228] TAMPEP, 2009, p. 41.

providers are almost unable to reach them. In an effort to eradicate the HIV/AIDS epidemic, mandatory testing only has the adverse effect.

The fifth impact is that, because outdoor sex workers are more often a target of public health inspections, a shift from outdoor to indoor sex work can be observed.[229] In indoor forms of sex work, sex workers normally have less control over their working conditions, which can immensely reduce their ability to negotiate condom use. Migrants fear police control on the streets, forced health checks, and deportation. They also depend on trafficking networks to be able to work. Trafficking is also considered to be a factor that increases sex workers' vulnerability to HIV/STIs.

The sixth impact – but still a very relevant one – is that mandatory health checks are considered to be, according to the sex worker community, a repressive form of exercising control that reinforces discrimination, stigmatisation and disenfranchisement of sex workers while also undermining the sense of self-responsibility and empowerment of sex workers.[230] It stigmatises sex workers as carriers of HIV/STIs and increases episodes of violence against them. Laws that should protect them are in reality aimed at protecting society from them.

The seventh impact is on the perspective of clients living in those countries that apply mandatory testing. It is a very seductive idea to clients that sex workers are 'clean', and they are also more likely to demand (and pay more) for unsafe sex practices. Recent outreach reports point out that in nine European cities the main reasons given by sex workers for having unsafe sex are: clients pay more for unsafe sex; clients demand it; and rape.[231] These measures increase misconceptions about the sex industry and sex workers, putting at risk not just the safety and well-being of sex workers, but also the health of clients (and their un-paid sexual partners).

Finally, the eighth impact relates to the manner in which these measures are applied. Sex workers are often arrested for verification, regardless of the legal regime. Testing is often

[229] INDOORS, *Capacity Building & Awareness Raising: a European guide with strategies for the empowerment of sex workers* (2012, p. 7)
[230] TAMPEP, 2009, p. 40-41.
[231] INDOORS, *Outreach in indoor sex work settings: A report based on the mapping of the indoor sector in nine European cities* (2012, pp. 19-23).

conducted under inhuman and degrading conditions and with disclosure of health status to police, officials and media.

FINAL CONCLUSIONS

This research examined whether mandatory testing violates international law by understanding the context and laws under which these measures take place. It was argued that the combination of prostitution laws and public health regulations often creates an environment that endangers sex workers' human rights, in particular their right to health.

Furthermore, it clarified that human rights provide a comprehensive legal framework within which states are obliged to base their enacted laws and public health programmes. Moreover, sex workers were constructed as subjects of rights, and public health arguments were challenged at their very root.

The human rights impact analysis of sex workers' rights was balanced against the benefits that mandatory testing could bring to society; however, three things were concluded: 1) mandatory testing expressly violates several human rights norms and guidelines; 2) the human rights of sex workers are being violated by mandatory testing regimes, not limited by mandatory testing regimes; and 3) there are no public health benefits for society or for sex workers themselves in carrying out mandatory testing of sex workers.

This research counted on several international guidelines on HIV/AIDS and human rights that have moved beyond behaviourist perceptions of the epidemics, and now address structural determinants.[232] It should be clearer after this study that structural determinants that put sex workers at risk of HIV/AIDS should be addressed and that protecting, respecting, and fulfilling their human rights is the first step to be taken in order to overcome the epidemic, especially where it remains on the rise.[233]

[232] The International Guidelines on HIV/AIDS and Human Rights promulgated by UNAIDS and the Office of the UN High Commissioner for Human Rights state that:
"Criminal law prohibiting sexual acts (including adultery, sodomy, fornication, and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal.... With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work." (UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 'International Guidelines on HIV/AIDS and Human Rights', 2006, p. 18).

[233] See growing epidemic in Eastern Europe:
http://www.unaids.org/en/resources/presscentre/featurestories/2012/december/20121205warsaw/.

Finally, this research recalled arguments from UN specialist bodies that advocate for the decriminalisation of sex work in order to increase efficacy of HIV/AIDS education and prevention programmes by enhancing sex workers' access to public health interventions, reducing in this way their fear of police harassment, stigma, and discrimination. Where sex workers work in safety, without violence and forced public health interventions (sometimes enforced by the police), there are more likely to take part of health prevention programmes. This strategy is in accordance with human rights principles, respects sex workers' autonomy, and is proved to reduce HIV infections in different parts of the world.

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