

# Protecting the Human Rights of People Living with HIV/AIDS: A European Approach?

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## Keywords

HIV/AIDS; HUMAN RIGHTS-BASED APPROACH; VULNERABILITY; NON-DISCRIMINATION; NON-REFOULEMENT

## Abstract

HIV/AIDS is a medical matter as well as a human rights issue.

Recent developments in the interpretation of the European Convention on Human Rights (ECHR) have contributed to better define the level of protection that people living with HIV/AIDS may currently derive from it. Thanks to the recognition of the condition of vulnerability suffered by this group, the European Court of Human Rights (ECtHR) has been able to apply the non-discrimination complementary provision (Article 14) to contrast the social stigma and prejudice associated with HIV/AIDS in Europe and, in some situations, to develop positive obligations.

A different restrictive approach has been adopted towards a specific part of the ECHR, that is the prohibition of refoulement. While this approach can be reassessed, taking into account the interpretation of the ECHR as a 'living instrument' and the necessity to read the ECHR as a coherent whole, recently the European Court of Justice has expressly referred to it to define the level of protection provided by European Union (EU) law to people living with HIV/AIDS in the field of migration. As a result, it reinforced the emerging divide between substantial guarantees and procedural obligations, which grant a wide protection pending expulsion and are defined in light of the special needs of people living with the infection, as required by a vulnerability approach.

If a common 'European approach' to the issue of HIV/AIDS and human rights is thus emerging, until now it seems to have been guided by conflicting views. At the same time, in relation to some issues, the mutual influence between ECHR and EU law has served to narrow the protection to people living with HIV/AIDS instead of setting higher standards through an inclusive interpretation of human rights.

This article explores a human rights-based approach to HIV/AIDS and whether the emerging European attitude matches it or not. While it calls for enhancing the role of vulnerability in the interpretation of the fundamental rights catalogue taken as a whole, it investigates the possible evolution within the two European systems of protection when the needs of this specific group are at stake, especially in the fields of non-discrimination and migration. The result does not provide given solutions but suggests a methodology for a consistent and genuine 'European approach' which, in turn, may positively influence the evolution of the international response to HIV/AIDS.

## I. Introduction

According to statistics recently published by UNAIDS, the international response to AIDS has reached a defining moment globally, leading to the fall of new HIV infections and of AIDS-related deaths.<sup>1</sup> At a deeper level, this optimistic picture hides the fact that rates of newly diagnosed cases of HIV infection vary widely in the different regions of the world. In particular, as for Europe, the same report shows an increasing trend in new infections; although, from 2000 to 2014 there was a 20% drop in 28 of 47 Member States of the Council of Europe (CoE). At the same time, a similar trend has been reported in some non-European countries, where many people are forced to escape their home country to seek international protection or decide to emigrate to Europe. What is certain is that, thanks to scientific research, a person who is infected with HIV has a longer life expectancy than in the past, provided that therapies are available and accessible in his or her country.

The move from an epidemic emergency to a life-long condition in a society that has to coexist with the virus has progressively changed the target of the international answer to HIV/AIDS, directly calling into question international human rights law. In fact, the first attempts to break the silence around this phenomenon at an international level have gone side by side with the identification of the groups most exposed to the virus.<sup>2</sup> While this focus was instrumental to a better control of the spread of HIV/AIDS worldwide, it has indirectly contributed to attaching a stigma to already vulnerable groups that, today, is at the heart of most human rights violations suffered by people living with HIV/AIDS. Hence, the current challenge is the need to grant adequate qualitative standards of life to those living with the infection, starting with the extension of the prohibition of discrimination to remove obstacles to their full participation in society.<sup>3</sup>

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<sup>1</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS), REPORT: *How AIDS Changed Everything – MDG6: 15 Years, 15 Lessons of Hope from the AIDS Response*, New York, 2015, at <unaids.org/en/resources/documents/2015/MDG6\_15years-15lessonsfromtheAIDSresponse> (accessed 13 November 2015). UNAIDS was established by UN Economic and Social Council Resolution 1994/24 and it is the first – and so far the only – co-sponsored joint program of the United Nations (UN) system. It is worth noting that data may understate the true extent of the epidemic as a large number of HIV infections and AIDS cases are never reported at a national level, partly because a significant number of people are not aware of their HIV status.

<sup>2</sup> UN Security Council, *Resolution on HIV/AIDS and International Peace-keeping Operations*, 17 July 2000, (4172nd meeting), S/RES/1308 (2000). The first related to a health issue identified expressly as posing 'a risk to stability and security', (Res. no. 1308/2000). In the same year, the fight against AIDS, together with tuberculosis and malaria, became one of the eight international development goals (MDG6). The UN Security Council has addressed the topic on two other occasions: in 2003 through Resolution 1460 on *Children in Armed Conflict* and in 2011 with Resolution 1983 on *HIV and Peacekeeping Operations*.

<sup>3</sup> As the President of the CoE's Parliamentary Assembly (PACE) put it,  
*Mais la particularité du SIDA reste toujours d'être beaucoup plus qu'un problème médical ; c'est aussi une maladie de société, tant elle est liée à la honte, à la discrimination et à la stigmatisation. La discrimination reste présente partout : de la part des employeurs, des membres de la famille ou des amis et même des prestataires de santé.*

[Translation: However, the peculiarity of HIV/AIDS lies in the fact that it is more than a mere medical problem: it is also a social disease, for being attached to shame, discrimination and stigma. No place is free from discrimination: it comes from employers, family members, friends and even health providers.]: Proceedings of the Conference *VIH/Sida – L'humanité n'est pas divisible*, Zurich, 14 November 2012, at <website-pace.net/web/apce/bureau/-/asset\_publisher/9ZEIfGQwSswb/content/2012-11-14-zurich-french-only-

It is therefore not surprising that the European Court of Human Rights (ECtHR) is increasingly involved in examining alleged violations of the human rights enshrined in the European Convention on Human Rights (ECHR) by people living with HIV/AIDS. At the same time, the European Court of Justice (ECJ) has also recently been faced with questions related to the virus providing significant interpretation of EU law thanks to the application of the EU Charter of Fundamental Rights (CFR or the Charter).<sup>4</sup>

This article argues that these developments can be identified as parts of a broader European common strategy to face HIV/AIDS in light of the promotion at an institutional level, by the CoE and the European Union (EU), of a rights-based approach to HIV/AIDS as the best method to tackle most concerns surrounding affected people. Starting from an analysis of the specific rationale and of the basic content of this approach (Part II), it investigates the influence between the two European systems of protection that has not always proven effective in achieving genuine protection of people living with HIV/AIDS. For this reason, two main areas will be examined comparatively: first, an ambit of mutual positive influence, ie. the prohibition of discrimination and its likely evolution to address the needs of this specific group, especially in relation to those instruments that do not expressly refer to HIV/AIDS (Part III); second, an ambit where the reciprocal influence proved to be dangerous for the definition of genuine standards of protection, ie. the interpretation of the prohibition of *refoulement* (Part IV).

While this analysis calls into question the current relationship between the ECHR and the CFR, it suggests the application of a human rights-based approach to HIV/AIDS in the interpretation of these European instruments taken as a whole. Indeed, if a common European approach is under construction, it should be built keeping in mind the specific social, as well as medical, conditions experienced by affected people, instead of relying on the idea of minimum standards of protection as an easy way out.

## II. A human rights-based approach to HIV/AIDS

Although several declarations have been elaborated by different international bodies in relation to HIV/AIDS,<sup>5</sup> cooperation agreements and soft law instruments only

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<sup>4</sup> European Union, *Charter of Fundamental Rights of the European Union* (2012) OJ C326/02. As confirmed by the ECJ in *Åklagaren v Hans Åkerberg Fransson*, the Charter obliges EU institutions to respect human rights *while* exerting the competences provided to the Union by the founding Treaties as well as EU Member States *when* they implement EU law: ECJ, C-617/10, *Åklagaren v Hans Åkerberg Fransson*, 26 February 2013. On the Charter, see generally, Peers, S, Herve, T, Kenner, J and Ward, A, eds, *The EU Charter of Fundamental Rights: A Commentary* (Hart Publishing, Oxford, 2014).

<sup>5</sup> For example, the UN General Assembly (UNGA) adopted the *Declaration of Commitment on HIV/AIDS* (2 August 2001, A/RES/S-26/2) in 2001, followed by the *Political Declaration on HIV/AIDS* (15 June 2006, A/RES/60/262) in 2006 and the *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (8 July 2011, A/RES/65/277) in 2011; UN Commission on Human Rights, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, 3 March 1995, Resolution 1995/44; UN High Commission for Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Discrimination in the context of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)*, 24 August 1995, (35th meeting) Resolution 1995/21; UN Human Rights Council, *The*

“constrain” domestic authorities to act in this field from a human rights perspective.<sup>6</sup> At the international level, the leading instrument is a non-binding guideline that generally recommends national authorities to address discrimination against people living with HIV/AIDS, both in public and private life, and to set up effective mechanisms for reparation.<sup>7</sup> Notwithstanding the positive impact of these soft law tools for raising awareness worldwide, a more effective attempt was made by some international human rights committees: the Committee on Economic, Social and Cultural Rights (CESCR); the Committee on the Rights of the Child (CRC); and the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW).<sup>8</sup> However, while they successfully addressed some problematic human rights issues caused by the spread of the virus, their efforts have not provided a wide framework and a consistent rationale for the consideration of the consequences of the spread of the virus from a holistic human rights perspective.

For this reason, the recent developments that have occurred within the European systems may shape a milestone in this ‘evolving’ human rights challenge.<sup>9</sup> Interestingly, the ongoing European process seems able to address what may be analytically summarised as the following: 1. identifying the interests at stake and the rights whose enjoyment is problematic; 2. providing the rationale for actions in this field; and 3. setting the procedural steps for overcoming potential human rights violations. The examination of these three main issues will set the stage for the analysis of the European Courts’ approach to HIV/AIDS.

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*protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)*, 13 April 2011, (16th session) A/HRC/RES/16/28, followed by the UN High Commissioner for Human Rights, REPORT: *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)*, 2011, A/HRC/19/37.

<sup>6</sup> For example, the tools developed by UNAIDS, *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes. A Resource for National Stakeholders in the HIV Response*, New York, 2009 at <unaids.org/en/resources/documents/2009/20090401\_jc1521\_stigmatisation\_en.pdf> (accessed 13 November 2015). Therefore, each country has its own strategy that may address HIV/AIDS-related issues in a global way or by considering only specific aspects. See, for a global account, UN Secretary General, *Report on the Protection of Human Rights in the context of HIV and AIDS*, 2010 (16th session of the Human Rights Council) A/HRC/16/69. The case of the United States (US) is significant for the recent change based on a human rights perspective: while some HIV-specific restrictions on entry, stay and residence have been lifted recently, a wider strategy has been adopted for granting a ‘just and equitable life’: US Government, *Strategy on AIDS*, July 2015 at <aids.gov/federal-resources/policies/national-hiv-aids-strategy> (accessed 13 November 2015).

<sup>7</sup> UNAIDS and UN High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights*, consolidated version, 2006 at <ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf> (accessed 13 November 2015).

<sup>8</sup> CESCR, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights*, 2 July 2009, E/C.12/GC/20, where HIV status is mentioned as a specific ground; CRC, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, 17 March 2003, CRC/GC/2003/3; CRC, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4; CEDAW, *General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, 1990, A/45/38; CEDAW, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, para 18.

<sup>9</sup> For a first comprehensive study on the relationship between human rights and HIV/AIDS, taking into account the situation before the developments in medical care, see Gostin, L and Lazzarini, Z, *Public Health and Human Rights in the HIV Pandemic* (Oxford University Press, Oxford, 1997); Danish Centre on Human Rights, *AIDS and Human Rights* (Akademisk Forlag, Copenhagen, 1988).

## II.1 Which rights?

Without calling into question the application of the whole human rights catalogue to people living with HIV/AIDS as a basic and starting principle, the most important task of a human rights-based approach to HIV/AIDS seems to be the identification of those rights, whose protection creates specific concerns for affected people, and that are more likely to be violated. Taking into account both the ECHR and the Charter, in Europe such an effort has been made mainly at an institutional level.<sup>10</sup>

First, the prohibition of torture and inhuman and degrading treatment (Article 4 CFR and Article 3 ECHR) comes into play. It protects against treatment that may amount up to torture when the basic needs of people living with HIV/AIDS are not addressed. For instance, it applies in the context of detention, provided that, according to available statistics, detainees include a high percentage of HIV-positive people. The same prohibition also enshrines the principle of *non-refoulement*. When a person living with HIV/AIDS is involved, it applies due to the risk that he or she may be exposed to torture or inhuman or degrading treatment in his or her country because of his or her health conditions. In fact, the infection itself may generate this risk in case he or she would not be able, in the country of destination, to get the necessary medication and therapy.

Second, specific attention should be given to the right to respect for private and family life, and for personal data (Articles 7 and 8 CFR and Article 8 ECHR).<sup>11</sup> While the right to respect for private and family life can be restricted by a public authority for the protection of public safety and health, personal data – including health information – must be processed fairly for specified purposes and with the consent of the person involved. These aspects may be particularly relevant in the context of blood donations. However, as with any other limitation in the exercise of these rights, when HIV/AIDS is the reason for interfering in their enjoyment, a necessity test applies, concerning the legitimate aim and proportional measures.

Third, where it also effects the prevention of the spread of the virus,<sup>12</sup> the prohibition of discrimination may apply in at least three ways (Article 21 CFR and Article 14

<sup>10</sup> Within the CoE, these attempts have been made since the 1980s with an increasingly inclusive catalogue: PACE, *AIDS and Human Rights*, 29 September 1989, (21st sitting) Recommendation 1116; PACE, *HIV/AIDS in Europe*, 25 January 2007, (8th sitting) Resolution 1536 and Recommendation 1784; CoE, Committee of Ministers, *HIV/AIDS in Europe: Reply from the Committee of Ministers*, 1 October 2007, (1005th meeting of the Ministers' Deputies) Document 11389. Within the EU, the question has been addressed more recently: European Parliament, *A Rights-based Approach to the EU's response to HIV/AIDS*, 8 July 2010, Resolution P7\_TA(2010)0284; EU Agency for Fundamental Rights (FRA), Factsheet: *A Rights-based Approach to HIV in the European Union*, 2010 at <fra.europa.eu/sites/default/files/fra\_uploads/945-AIDS\_2010\_FRA\_factsheet.pdf> (accessed 13 November 2015).

<sup>11</sup> Although the Charter is explicit in affirming respect for personal data while the ECHR is not, the ECtHR has interpreted Article 8 ECHR as also encompassing this protection. See, for example, ECtHR, *Z v Finland*, 22009/93, 25 February 1997; ECtHR (Grand Chamber), *S and Marper v United Kingdom*, 30562/04 and 30566/04, 4 December 2008; ECtHR, *Avilkina and Others v Russia*, 1585/09, 6 June 2013. Therefore, the disclosure of medical information of a HIV-positive person, in the context of proceedings concerning a sexual assault, can give rise to a violation of the right to respect for private life if his or her identity is revealed.

<sup>12</sup> On 'non-discrimination as prevention', see Kjaerum, M, *Discrimination Aspects and their Potential Contribution to the Spread of HIV*, AIDS World Congress 2010, Wien, at <fra.europa.eu/sites/default/files/fra\_uploads/958-MK\_Speech\_AIDS\_Satellite\_Session.pdf> (accessed 13 November 2015).

ECHR). A primary development should lead to the recognition that HIV/AIDS can in itself put affected people in a disadvantaged position. Hence, such an approach calls for the inclusion of HIV/AIDS status within the prohibited grounds on which a differential treatment can be based. However, where this development is not possible due to the formulation of the prohibition of discrimination itself, the inclusion of HIV/AIDS through other prohibited grounds should be investigated. An interesting proposal looks at the notion of disability, which is expressly protected by the prohibition of discrimination both under the ECHR and the CFR. While this possibility will be tested below in relation to the application of the relevant EU secondary law to people living with HIV/AIDS, an important consequence of such a development is the possibility to apply to them the obligation to take positive action in favour of people with disabilities (Article 26 of the Charter).<sup>13</sup>

Two more rights, expressly affirmed in the CFR, acquire a specific importance for people living with HIV/AIDS. First, the right of access to preventive health care and the right to benefit from medical treatment can play a significant role (Article 35 CFR). Indeed, the Charter recognises expressly this right to ‘everyone’, thus preventing – if it applies – limitations based on European citizenship or on other grounds. Second, attention should be paid to the right to move and reside freely within the territory of a European State, which may be seriously limited because of a person’s HIV-positive status.<sup>14</sup> As a consequence, any ban or restriction on entry to a European State’s territory of a third-country national, due to his or her health condition, should be considered in conflict with the Charter. Both situations may also be covered by the protection of the ECHR through its prohibition of discrimination, as explored below.

## II.2 Which rationale?

A central point in the application of a rights-based approach to HIV/AIDS is the identification of the reasons behind it. Depending on their content, the interpretation of human rights law may follow different paths for the rise of negative or positive obligations or for requiring a more intense scrutiny on contracting States’ behaviour. In other words, the rationale seems to be itself a guide to how the needs of people living with HIV/AIDS should be addressed under human rights law.

At the European level, perhaps in an attempt to follow the indications expressed in the soft law international texts dedicated to the topic, this rationale corresponds to the recognition of the condition of vulnerability experienced by people living with HIV/AIDS. The concept of vulnerability has been used to identify common personal characteristics as worthy to be treated as suspected grounds in order to apply the prohibition of discrimination. Perhaps more importantly, it is used to focus attention on the specific experience of the group involved within the wider social context. A number of factors have been referred to in order to understand if a person is a member of a

<sup>13</sup> The ECHR does not include a similar provision but, since HIV/AIDS has been recognised as an autonomous factor (see below), there is no need for such an interpretation. Interestingly, these two European developments may coexist leading to a cumulative protection against forms of multi-discrimination, ie based on HIV/AIDS and disability. On the other hand, in some cases, the ECtHR has also gone beyond the negative prohibition, developing positive obligations: ECtHR, *Kjartan Ásmundsson v Iceland*, 60669/00, 12 October 2004; ECtHR, *Budina v Russia*, 45603/05, 18 June 2009.

<sup>14</sup> Wormann, T and Kramer, A, “Communicable Diseases” in Rechel, B, Mladovsky, P, Deville, W, Rijks, B, Petrova-Benedict, R and McKee, M, eds, *Migration and Health in the European Union* (Open University Press, Maidenhead, 2011) 121–137.

vulnerable group: 1. the history of past discrimination; 2. the prejudices attached to his or her personal characteristics; 3. the feelings of humiliation, anxiety, fear or inferiority experienced; and 4. the social context to which he or she belongs.<sup>15</sup> Considered together, all of these elements may help to define, both at a substantive and a procedural level, the most appropriate actions to overcome the disadvantaged position suffered by the group and to combat prejudice. Put in this way, the condition of vulnerability of people living with HIV/AIDS does not derive from the health condition itself, but mostly from the stigma associated with it. While this concept appears to be essentially connected to the prohibition of discrimination, it can inform the interpretation of other rights and freedoms enshrined in human rights instruments.

This aspect of a rights-based approach to HIV/AIDS can be clarified by referring to *Kiyutin v Russia* which, for the first time, has given the ECtHR the possibility to investigate the relationship between HIV/AIDS status and the ECHR. On that occasion, the applicant questioned the legitimacy of restrictions imposed on the freedom of movement of people living with HIV/AIDS.<sup>16</sup> The Court was asked to apply the prohibition of discrimination in conjunction with Article 8 ECHR, since the alleged discriminatory treatment was hampering the applicant's enjoyment of the right to respect for family life.<sup>17</sup> According to its case-law,<sup>18</sup> the ECtHR could easily limit its evaluation to the alleged violation of Article 8 alone, relying on the need to balance the competing interests at stake: the applicant's exigency to maintain family unity opposed to the defendant State's right to control its boundaries. Instead, while affirming that HIV/AIDS status is covered by the prohibition of discrimination, the ECtHR explained the rationale behind this interpretation:

From the onset of the epidemic in the 1980s, people living with HIV/AIDS have suffered from widespread stigma and exclusion ... As the information on ways of

<sup>15</sup> For an initial comprehensive analysis of this concept as well as a review of some critical elements in relation to the ECHR, see Timmer, A and Peroni, L, "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law", 4 *International Journal of Constitutional Law* (2013) 1056. More broadly, Fineman, MA and Grear, A, *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate, Farnham, 2013). Although being aware of its problematic aspects, as analysed by these authors, here the attention is placed on the positive effects of a vulnerability approach to address the needs of people living with HIV/AIDS.

<sup>16</sup> ECtHR, *Kiyutin v Russia*, 2700/10, 10 March 2011. Mr Kiyutin married a Russian woman and applied for a residence permit in her country. Being obliged to undergo a medical examination, he was found HIV-positive and, as a consequence, his request was refused. According to a UN report, similar restrictions concern at least 50 States worldwide: see UNAIDS, *Mapping of Restrictions on the Entry, Stay and Residence of People Living with HIV*, 2009 at <[unaids.org/en/resources/documents/2009/20090818\\_jc1727\\_mapping\\_en.pdf](http://unaids.org/en/resources/documents/2009/20090818_jc1727_mapping_en.pdf)> (accessed 13 November 2015). At least seven CoE Member States impose restrictions on entry and residence because of a person's HIV status.

<sup>17</sup> As is well known, Article 14 has no independent existence because it applies only when a situation falls within the ambit of one or more of the rights and freedoms safeguarded by the ECHR and its Protocols. See, among others, Wintemute, R, "Within the Ambit: How Big is the 'Gap' in Article 14 European Convention on Human Rights?", 4 *European Human Rights Law Review* (2004) 366; Schokkenbroek, J, "The Prohibition of Discrimination in Article 14 of the Convention and the Margin of Appreciation", 19 *Human Rights Law Journal* (1998) 20; Livingstone, S, "Article 14 and the Prevention of Discrimination in the European Convention on Human Rights", 1 *European Human Rights Law Review* (1997) 25.

<sup>18</sup> ECtHR, *Hamidovic v Italy*, 31956/05, 4 December 2012; ECtHR, *Udeh v Switzerland*, 12020/09, 16 April 2013.

transmission accumulated, HIV infection has been traced back to behaviours – such as same-sex intercourse, drug injection, prostitution or promiscuity – that were already stigmatised in many societies, creating a false nexus between the infection and personal irresponsibility and reinforcing other forms of stigma and discrimination, such as racism, homophobia or misogyny ... The Court therefore considers that people living with HIV are a vulnerable group.<sup>19</sup>

As a consequence, justifications relying on stigma and prejudices for maintaining people living with HIV/AIDS in a disadvantaged position cannot be accepted as reasonable. Thus, against the Russian Constitutional Court's decision that confirmed the proportionality of such restrictions as being in line with international human rights law, the ECtHR rejected what the domestic legislation took as its premise: 'HIV has grave socio-economic and demographic consequences for the Russian Federation, [and] poses a threat to personal, public and national security, and a threat to the existence of humankind'.<sup>20</sup> Relying on international scientific recommendations, the ECtHR found that Russian restrictions on entry and residence have the dangerous effect of reinforcing prejudices and foster social exclusion, because the presence of people living with HIV/AIDS in a country's territory cannot lead to a greater spread of the virus.

On that occasion, maybe as in a few others, the Court powerfully affirmed the need to combat all kind of stereotypes and prejudices aimed at hampering a person from living his or her everyday life in equality with others. To this end, it gave important guidance on how to combat the identified condition of vulnerability: instead of relying on general assumptions, it suggested the need to individualise the evaluation of the situation of people living with HIV/AIDS. While it may include health conditions as one of the elements for consideration, other relevant aspects of one's personal life cannot be certainly excluded.

### II.3 How can the Recognised Protection be Granted?

Having explored the primary rationale for a rights approach to HIV/AIDS, a third point should be addressed: how the recognised protection can be granted.

While all European institutions have recommended that domestic authorities adopt specific measures to address the needs of people living with HIV/AIDS, setting the stage for the rise of positive obligations, other ways can be envisaged here. In particular, as suggested by the ECtHR, a rights-based approach to HIV/AIDS requires the refusal of reasons based on a negative bias against this specific group. Concretely, this attempt may follow two – cumulative – paths. First, it applies when people experience violations of human rights directly based on their HIV/AIDS status. In those circumstances, applicants did not have an additional vulnerable background other than living with HIV/AIDS. Second, it may apply to unveil covert prejudices, embedded in widespread social habits. This kind of stigmatisation appears as more complex and involves those minority groups, already identified as socially vulnerable, that are associated with HIV/AIDS.

Taking into account the wider backlash that this specific method to overcome vulnerability may grant, it is necessary to recall these minority groups. At the international level, all relevant organisations refer to people who experience human

<sup>19</sup> ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 64.

<sup>20</sup> *Id.*, paras 16-18.



rights violations more frequently: detainees, men who have sex with other men (MSM),<sup>21</sup> ethnic minorities, sex workers, injecting drug users (IDUs), immigrants, and, often, women. According to them, being already exposed to social exclusion, their health situation may not be adequately monitored and/or access to medical treatment may be restricted or hampered by discriminatory treatment.<sup>22</sup> Hence, the violation of these basic rights can itself expose them to a higher risk of being infected with HIV and, in turn, can indirectly contribute to the spread of the virus.

It is therefore surprising that, in the attempt to face this topic, international human rights mechanisms have not taken in due account the situation of groups at risk of social exclusion. Interestingly, a study made on the activity of the most important human rights bodies found that although a gradual engagement has emerged with a high number of texts adopted (89 recommendations and 127 reports), international human rights bodies have dealt mainly with the rights of children and women while lacking consistency in relation to other groups, especially MSM, IDUs or sex workers.<sup>23</sup> At the same time, no attempts have been made to verify whether, thanks to recent trends and scientific progress, this classification of people at risk is still valid or is grounded on outdated common beliefs.

Instead, a more consistent approach seems to have been adopted at European level, where the attention to more “traditional” groups of people, such as children and women, has gone hand by hand with specific consideration to other minorities already subjected to social stigma.<sup>24</sup> For example, since the 1980’s, CoE’s institutions have called for a coordinated European health policy to prevent the spread of HIV in prisons<sup>25</sup> and have

<sup>21</sup> This terminology is used to avoid referring only to homosexuals, with the consequence of identifying their sexual orientation with an easier exposure to the virus: Saavedra, J, Izazola-Licea, JA and Beyrer, C, “Sex Between Men in the Context of HIV: The AIDS 2008 Jonathan Mann Memorial Lecture in Health and Human Rights”, 11 *Journal of the International AIDS Society* (2008) 9.

<sup>22</sup> For example, at the European level, research conducted by the FRA on the situation of Roma has revealed that almost 20% of the interviewees have been discriminated against when using health services: FRA, *The Situation of Roma in 11 EU Member States*, May 2012 at <fra.europa.eu/en/publication/2012/situation-roma-11-eu-member-states-survey-results-glance> (accessed 13 November 2015). Additional risks concern: irregular or illegal immigrants, who can be prevented from accessing health structures because of the danger of expulsion if intercepted; detainees, who in some States live in overcrowded detention facilities with negative consequences for the spread of the infection; sex workers who, being often criminalised, may have to face a hostile environment when accessing health facilities.

<sup>23</sup> The study was reported during a Conference at the Kaiser Family Foundation, Wien, on 20 July 2010: UN Special Rapporteur on torture, *What Have You Done for HIV/AIDS Lately? The Role of Human Rights Mechanisms in Advancing the AIDS Response*, at <kff.org/global-health-policy/event/aids-2010-what-have-you-done-for-hiv-aids-lately-the-role-of-human-rights-mechanisms-in-advancing-the-aids-response/> (accessed 21 October 2015).

<sup>24</sup> To this regard a significant statement was made by the Rapporteur of the explanatory memorandum of the PACE report on HIV/AIDS and women in Europe: ‘The lack of ability [...] to control the spread of the disease is to some extent linked to these moralistic debates. ... It is only recently that the WHO has started imposing a non-discriminatory attitude towards prostitutes as the only way HIV/AIDS can be successfully prevented’: Council of Europe, Committee for Equal Opportunities for Women and Men, REPORT: *The Spread of the HIV/AIDS Epidemic to Women and Girls in Europe*, Doc 11108, 15 December 2007, at <assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewHTML.asp?FileID=11367&Lang=EN> (accessed 21 October 2015), para 8.

<sup>25</sup> Among others things, it invited CoE’s Member States to: providing regular information to all prison staff and to prisoners about HIV infection and its consequences; making HIV tests and counselling available to all prisoners; ensuring that hygiene and food in prisons are of such a standard as not to increase the risk of developing AIDS in prisoners who are already HIV-positive: Council of Europe,

stressed the importance of a horizontal approach to combating AIDS, making it clear that human rights should not be jeopardised on account of the fear aroused by the virus.<sup>26</sup> More recently, they have addressed the specific concerns experienced by migrants - taken generally as a group but also specifically through the identification of sub-groups who may suffer multiple forms of discrimination and stigmatisation, including in accessing HIV prevention and treatment – women, MSM, sex workers, undocumented migrants and refugees.<sup>27</sup> Most importantly, when those institutions have dealt with the more “traditional” group composed by girls and women, they have embedded “non-traditional” perspectives considering, for instance, the consequences of domestic violence and gender inequality for the spread of the virus.<sup>28</sup> The same is true for the EU, whose institutions have asked national authorities to protect the human rights of the most disadvantaged groups – detainees, immigrants, MSM, ethnic minorities, sex workers, and IDUs, while adopting positive measures for people already living with HIV/AIDS. Interestingly, the EU Parliament has recommended that the EU Council and Commission also take legislative action to remove the main economic, legal and social obstacles to a rights-based approach strategy.<sup>29</sup>

Although this “added value” of the European approach to HIV/AIDS has not yet questioned the prudence of the classification of most exposed groups itself, which has had the consequence of indirectly reproducing certain stereotypes,<sup>30</sup> the application of a human rights-based approach to HIV/AIDS by European Courts seems to have slightly overshot the mark, as analysed below.

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Parliamentary Assembly, *Acquired Immune Deficiency Syndrome (AIDS)*, 23 November 1983, Resolution 812(1983); and *A Co-ordinated European Health Policy to Prevent the Spread of AIDS in Prisons*, 30 June 1988, Recommendation 1080(1988).

<sup>26</sup> Among positive actions, CoE’s Member States were invited to: adopting laws to define national standards of protection; disseminating information in schools; banning compulsory HIV/AIDS screening for people applying for travel visas, asylum and jobs. Council of Europe, Parliamentary Assembly, *AIDS and Human Rights*, 29 September 1989, Recommendation 1116(1989).

<sup>27</sup> Council of Europe, Parliamentary Assembly, *Migrants and Refugees and the Fight against AIDS*, 23 May 2014, Resolution 1997(2014); and annexed Report.

<sup>28</sup> Council of Europe, Parliamentary Assembly, *The Spread of the HIV/AIDS Epidemic to Women and Girls in Europe*, 25 January 2007, Recommendation 1785(2007).

<sup>29</sup> EU Parliament, *A Rights-based Approach to the EU’s Response to HIV/AIDS*, *supra* nt 10. However, until today, only broad strategies were adopted by the Commission: see European Commission, *Action Plan on HIV/AIDS in the EU and Neighbouring Countries 2014-2016*, 14 March 2014, at <ec.europa.eu/health/sti\_prevention/docs/ec\_hiv\_actionplan\_2014\_en.pdf> (accessed 21th October 2015). Among the suggested measures, we may recall: fostering the access to work and to education and professional training; promoting the participation of people living with HIV/AIDS in the elaboration or evaluation of the actions adopted in their favour; decriminalising the transmission of HIV as well as of the use of illegal drugs.

<sup>30</sup> See for example the content of the EU Commission’s 2014 Action Plan, *ibid*. It is interesting that also Advocate General P. Mengozzi, in his exam of the preliminary ruling in *Leger*, *infra*, has indirectly addressed this point when he noticed that the CoE’s Resolution CM/RES(2013) of 27 March 2013 on sexual behaviour of blood donors has still referred to ‘MSM as a high risk group’. This has led the French Government to use before the ECJ the CoE’s resolution as a way of justification for a permanent exclusion of MSM from blood’s donation. However, the same Advocate General seemed to stigmatise sex workers for the alleged role in spreading the virus. See his *Conclusions*, 17 July 2014, points 36 and 45.

### III. Building Bridges: The Prohibition of Discrimination as a Cross-cutting Guarantee between ECHR and EU Law

Having defined the rationale and the possible content of a human rights approach to HIV/AIDS, we should verify whether and how it has been applied by the ECtHR and the ECJ or, alternatively, what solutions are available for an interpretation of European human rights law in line with it.

The prohibition of discrimination seems a good starting point. It works as a Trojan horse: once HIV/AIDS status is identified as worthy to be covered by this prohibition, it may serve also as an interpretative tool for other human rights enshrined in the ECHR and the Charter.

In general terms, we have mentioned that the prohibition of discrimination can be applied in this field either by the addition of HIV/AIDS status to the grounds of protection or through the re-interpretation of another factor already expressly covered. The first hypothesis applies both to Article 14 ECHR and Article 21 CFR, in light of its open formulation. In fact, in line with the forward-looking proposal of the CoE's Parliamentary Assembly to reinforce the non-discrimination clause in ECHR 'either by adding health to the prohibited grounds of discrimination or by drawing up a general clause on equality of treatment before the law',<sup>31</sup> the ECtHR stated in *Kiyutin*:

The Court notes the view of the United Nations Commission on Human Rights that the term "other status" in non-discrimination provisions in international legal instruments can be interpreted to cover health status, including HIV infection .... This approach is compatible ... with the United Nations Convention on the Rights of Persons with Disabilities which imposed on its States Parties a general prohibition of discrimination on the basis of disability .... Accordingly, the Court considers that a distinction made on account of an individual's health status, including such conditions as HIV infection, should be covered – either as a disability or a form thereof – by the term "other status" in the text of Article 14 of the Convention.<sup>32</sup>

On many occasions, the ECtHR has already found that the list of grounds contained in Article 14 is not exhaustive and, relying on other international human rights treaties as well as on Article 21 CFR, has gradually expanded them. Hence, thanks to this interpretation of the Convention as a 'living instrument' able to catch developments in society, all 'identifiable, objective or personal characteristic, or 'status', by which persons or groups of persons are distinguishable from one another' may receive protection under the ECHR.<sup>33</sup> Even more importantly, since these grounds are not limited to

<sup>31</sup> CoE, *supra* nt 3, para 8. The general clause has been added through ECHR's Protocol no. 12 but, although it entered into force, a low number of CoE's Member States have ratified it. However, taken into account the developments occurred in the ECtHR's case law, the lack of a general clause has been overcome through an inclusive interpretation of Article 14. See recently Arnardóttir, OM, "Discrimination as a Magnifying Lens: Scope and Ambit under Article 14 and Protocol No. 12", in Brems, E and Gerards, J (eds), *Shaping Rights in the ECHR: The Role of the European Court of Human Rights in Determining the Scope of Human Rights* (Cambridge University Press, Cambridge, 2013).

<sup>32</sup> ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 57.

<sup>33</sup> For instance, disability (ECtHR, *Glor v Switzerland*, 13444/04, 30 April 2009, para 80); gender identity (ECtHR, *P.V. v Spain*, 35159/09, 30 November 2010); genetic characteristic (ECtHR, *G.N. and Others v Italy*, 43134/05, 1 December 2009, para 126).

characteristics that are “innate”, it was not difficult to conclude that treatment based solely on HIV status is also covered by the prohibition of discrimination.<sup>34</sup> When other vulnerable groups sharing a common characteristic already covered by Article 14 are at stake, this interpretation is nonetheless important because it allows attention to be focused directly on HIV/AIDS status, when this is the reason for treating people differently without an adequate justification.

Although the ECJ has not yet been called upon to apply Article 21 CFR in relation to HIV/AIDS, its formulation does not raise any doubt on its potential application. It contains a general prohibition of discrimination ending with an open clause which allows the progressive inclusion of such characteristics as may become socially intolerable reasons for distinctions. Therefore, the Charter also covers HIV/AIDS status. Going even further from the ECHR, the CFR’s prohibition of discrimination expressly includes all grounds associated with the mentioned groups most exposed to infection, such as sex, race, colour, ethnic or social origin, genetic features, birth, disability and sexual orientation. However, if EU Member States are bound by the Charter only when implementing EU law, an effective protection for people living with HIV/AIDS may be better realised through those EU directives that were adopted to give concrete expression to Article 21 CFR and/or to the general principle of EU law having the same content.

Clearly, a shared European approach in this field cannot be limited to a common understanding of the prohibition of discrimination. In light of this general framework, a more composite picture of legal consequences and reciprocal influences may be defined: first, it seems necessary to investigate how Article 14 ECHR and Article 21 CFR can be applied to grant the protection envisaged by a rights-based approach to HIV/AIDS and, second, how it is possible to “build bridges” to reach a similar, if not higher, standard of protection through the application of EU secondary law. In both contexts, we will consider the group composed of people living with HIV/AIDS as well as other mentioned vulnerable groups.

### III.1. A Common Aim: Fighting against Stigma

In line with the defined approach to HIV/AIDS, both European Courts have used the principle of non-discrimination to unmask stigma and to prohibit treatment based on prejudice. After, the ECtHR confirmed this perspective in *I.B. v Greece*,<sup>35</sup> related to an employee dismissed because of his HIV status. Significantly, a similar path has been followed by the ECJ through the application of Article 21 CFR to a group usually associated with the virus, as it can be seen in *Léger*.<sup>36</sup>

In *I.B.* the applicant alleged that he was dismissed because his colleagues refused to work with him after his health conditions became public knowledge. Although the employer did not agree, they pressed him to fire Mr. I.B.. According to the ECtHR, while it is true that the ECHR does not directly protect working conditions, the applicant’s dismissal could be nonetheless evaluated under the Convention because the alleged

<sup>34</sup> Gerards, J, “The Discrimination Grounds of Article 14 of the European Convention on Human Rights”, 13(1) *Human Rights Law Review* (2013) 99, 109.

<sup>35</sup> ECtHR, *I.B. v Greece*, 552/10, 3 January 2014.

<sup>36</sup> The preliminary ruling concerned the interpretation of Directive 2004/33/CE implementing Directive 2002/98/EC of the European Parliament and of the Council as regards certain technical requirements for blood and blood components, especially point 2.1 of Annex III on the criteria for permanent exclusion from donation: CJEU, C-528/13 *Geoffrey Léger v Ministre des Affaires sociales, de la Santé et des Droits des femmes and Établissement français du sang*, ECLI:EU:C:2015:288, 29 April 2015.

violation fell within the ambit of Article 8. Hence, since ‘all the issues related to HIV/AIDS fall within the ambit of private life’,<sup>37</sup> the prohibition of discrimination as protected in the ECHR can apply to every situation of the life of people living with HIV/AIDS when this status is the reason for their stigmatisation. Perhaps most importantly, although *I.B.* concerns employment, the procedural steps defined by the Court can be applied to any other kind of differential treatment. In fact, when a distinction is made, only very serious reasons may be advanced and no room can be granted to stereotypes as justification. Thus, in *I.B.* the ECtHR could not accept that the applicant’s dismissal was necessary to maintain a peaceful working environment, as claimed by domestic authorities. The refusal of other employees to work with the applicant relied on prejudices against HIV-positive people and the decision to fire him only had the effect of reinforcing the negative bias towards people suffering from the virus. While the ECtHR called on national authorities to prevent similar treatment, it also suggested how to balance competing interests when HIV/AIDS is involved. Accordingly, the specific condition of vulnerability suffered by this group justifies the recognition of a different and greater weight of their needs. Therefore, as for Mr. I.B.’s case, other employees’ interests and the necessity to ensure a pleasant working environment could not exceed the “human right-based interest” to maintain the vulnerable position of employees living with HIV/AIDS.

As a result, the identified rationale for protection of people living with HIV/AIDS has concrete consequences in the evaluation of alleged violations of the ECHR. First, it calls for the application of the same approach elaborated for other “traditional” grounds such as sex, race/ethnic origin or sexual orientation, because of the history of past discrimination suffered by groups sharing these characteristics. This means that, in the evaluation of mistreatment based directly or indirectly on HIV/AIDS status, only very weighty reasons can be submitted as justification and, perhaps more importantly, the margin of appreciation of contracting States in establishing distinctions is considerably narrow.<sup>38</sup> For instance, in *Kiyutin*, although the aim pursued by Russia – ie. the defence of public health – was legitimate, the measures adopted did not satisfy the necessity test.<sup>39</sup> In the same way, the dismissal of Mr. I.B. was not necessary to protect other employees’ health since, moving from general assumptions to individualised evaluations, it was clear that his general conditions did not have any effect on the execution of his tasks, and neither were they contagious. Second, if we look beyond the procedural aspects, the recourse to vulnerability has consequences on the concept of discrimination itself. Indeed, it downsizes the relevance of discriminatory treatment as a comparative concept. If the aim of sanctioning discrimination is overcoming a situation of historical

<sup>37</sup> *I.B. v Greece*, *supra* nt 35, para 70. This finding may, nonetheless, be problematic for fostering the rights of people living with HIV/AIDS. While it is instrumental for the application of Art. 14, it may also prove to be an obstacle to a rights approach if it is finally understood as limiting HIV/AIDS to the “closet” of private matter downsizing its public social dimension.

<sup>38</sup> See, among others, ECtHR, *Kozak v Poland*, 13102/02, 2 June 2010. Among others, Gerards, J, “Pluralism, Deference and the Margin of Appreciation Doctrine”, 17(1) *European Law Journal* (2011) 80-120; Danisi, C, “How Far Can the European Court of Human Rights Go in the Fight against Discrimination? Defining New Standards in its Non-discrimination Jurisprudence”, 9(3-4) *International Journal of Constitutional Law* (2011) 793.

<sup>39</sup> Interestingly, the defendant State referred also to economic reasons due to the hypothetical higher expenditure in public care. The Court found that they do not apply because when such resources are at stake a case-by-case analysis must be preferred rather than a general ban. See also, ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 70.

disadvantage, there is no need to search for comparable situations. In other words, why should we establish a comparable situation *if* the discrimination suffered by the vulnerable group has prevented individuals from reaching the majoritarian living condition or from sharing in all the experiences which the life of the community can provide them?

Interestingly, a similar approach in the application of the principle of non-discrimination has been explored by the ECJ in the identification of more deeply-rooted stigma associated to HIV/AIDS. The *Léger* case – a preliminary ruling on the compliance with EU law of domestic measures adopted to prevent the spread of the virus – brought to the attention of the ECJ the issue of the permanent refusal of blood donation by MSM. In the national referring Tribunal's view, it was not clear if EU law allowed for a permanent refusal of blood donation instead of a temporary deferral when a donor reports such a sexual behaviour. In fact, while the applicable French law provided for a blanket exclusion of the MSM group, interfering with Mr. Léger's life, the relevant EU Directives (2004/33/CE and 2002/98) do not include any kind of classification for the purpose of exclusion. Both Directives bind instead Member States to monitor donations in light of the sexual behaviour of donors because it may expose them to a higher risk of being infected by HIV.

Considering that the relevant French law was meant to implement EU law, the Charter applied and the ECJ referred expressly to it for protecting human rights of MSM while granting an appropriate level of concern for public health. Through an anti-stereotyping approach, the EU Court has focused its attention on the risk behaviour rather than on the classification of people for their alleged role in the spread of the virus. In this way, the ECJ has avoided to equate a risk behaviour with a specific group and, in turn, with a specific sexual orientation. Accordingly, the fact that a man has or may have sex with another man cannot lead automatically to the conclusion that all MSM are at a high risk of infection, and thus of transmitting, HIV. Instead, in the same way other risky sexual activities are treated,<sup>40</sup> a person like Mr. Léger can be prevented from donating blood permanently or for a limited period of time *only if* it is verified that a very serious risk for transmitting infectious diseases exists *and* while 'respecting the fundamental rights recognised by the EU legal order'.<sup>41</sup>

Two considerations follow from this premise. First, this high risk must be demonstrated by reliable data as well as scientific and medical knowledge. Thus, the ECJ called upon the referring Tribunal to verify whether the information provided by the French Government was trustworthy and relevant *at the moment* the domestic law was effectively applied. Second, according to the Charter, any permanent or temporary refusal of blood donation for MSM must respect, specifically, Article 21 as far as it enshrined the prohibition of discrimination based on sexual orientation. In fact, through a direct reference to MSM, the domestic law made a distinction based on the sexual orientation of potential donors and put homosexual people in a disadvantaged position. Such a distinction must be justified to be in compliance with EU law.

<sup>40</sup> The Advocate General, P. Mengozzi, referred on the different treatment provided for unprotected sexual conduct, occasional sexual activities and relationships with more than a partner: for all these sexual behaviors, necessarily involving heterosexual people, the French law provided only a temporary exclusion from donations (four months). Thus, he suggested the application of a similar limitation for 'those MSM' who, after an individual screening, have been exposed to high risk sexual behaviors. Interestingly, he found also a potential discrimination on the ground of sex, since only male donors were excluded, while no limitation was in place for lesbian women. See his *Conclusions*, issued on 17 July 2014, points 44 and 56-62.

<sup>41</sup> *Léger*, *supra* nt 36, points 39-40.

Going perhaps even further than what Article 52.1 CFR provides, the ECJ has defined a kind of strict scrutiny test to the treatment established by French law, similar to the one elaborated on by the ECtHR in its case law. Since the French exclusion does not call into question the principle of non-discrimination as such and is aimed to protect public health, proportionality *in terms of necessity* becomes the decisive point in ECJ's view. Not only should it be demonstrated that there are no other ways to detect HIV with the goal of granting high standards of protection of public health, but the practical consequences of such a limitation must also not put an entire group in an extremely disadvantaged position. For these reasons, the ECJ has envisaged at least two ways to eliminate such a disadvantage. Thanks to scientific progress, people who have undertaken high-risk behaviour can undergo through new and more effective examinations in order to ascertain the presence of the virus in the donated blood. Then, if these techniques are not available yet, a deeper investigation into a donor's personal history, through specific and clear-cut questions, can be realised by competent medical staff, thus obtaining the same level of protection of public health without imposing any form of exclusion from donation.

Briefly, in the same way as that used in *Kiyutin* and *I.B.*, the application of the prohibition of discrimination to people usually identified as being a danger for public health has been used to "individualise" the risk connected with the spread of HIV/AIDS. Even without expressly mentioning it, EU judges have *de facto* refused prejudice as a way of justification of a suspect discrimination. Thanks to a rights-based approach, they have been able to identify the harmful categorisation of a specific group embedded in French law on blood donation and have rehabilitated an entire, already vulnerable, group. Significantly, this result has been achieved even without any reference to the prohibition of discrimination as interpreted by the ECtHR in line with the usual way of reasoning of the ECJ when a right affirmed in the Charter has the same meaning of the corresponding right set forth in ECHR, as it is the case for Article 21 CFR.<sup>42</sup> The reason for such an approach likely depends on the fact that this (higher) standard of protection could be set more appropriately through an autonomous interpretation of the Charter.

### **III.2. The Relationship with Other Rights: The Rise of Positive Obligations under the ECHR**

The interpretation of the prohibition of discrimination in this field is not limited to covering HIV/AIDS as a protected ground or to the refusal of prejudice as justification for discrimination. As anticipated, the condition of vulnerability associated with the virus obliges domestic authorities to take an active involvement in addressing the special needs of people living with HIV/AIDS but also in fighting stigma looking at the consequences for groups at high risk of infection. Notwithstanding the relevant recommendations of European institutions, the ECtHR and the ECJ have not yet developed a clear case law, at least from the standpoint of the principle of non-discrimination. However, new developments in this field may be expected in line with a rights-based approach to HIV/AIDS, especially if we look at the relationship to other rights enshrined in the ECHR or, as analysed in the following paragraph, to other grounds of discrimination as far as EU law is concerned.

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<sup>42</sup> Explanations relating to the Charter of Fundamental Rights 2007/C 303/02 (2007) OJ C303/17.

A first important signal emerges from the *I.B.* case. Considering that the violation was perpetrated by an individual, Mr. I.B.'s employer, the Court found that the respondent State had failed in fulfilling its (positive) obligations under the Convention. Indeed, it did not prevent the employer from dismissing the applicant because of his HIV-positive status. At the same time, through legislative acts, it failed to ensure that the interests of workers living with HIV/AIDS could be correctly balanced with other workers' interests, thus indirectly permitting their exclusion from employment in violation of Article 14 ECHR. In other words, the ECtHR recognised that the condition of vulnerability in employment cannot be broken up without the active involvement of domestic authorities.

Other indications may be derived from the case law developed by the ECtHR in connection with applicants suffering from different forms of marginalisation, including those arising from their HIV/AIDS status. On different occasions, the ECtHR has faced the needs of people living with the virus by calling on the respondent States to find appropriate solutions for respecting the specific rights at issue. In this way, although it is not explicitly stated, it may be possible to avoid discrimination on HIV/AIDS status. As such, these attempts entail the question of the relationship between the particular right involved and the prohibition of discrimination, especially when groups exposed at higher risk of infection are involved. In order to clarify this point, it seems useful to refer to the ECtHR's role in addressing HIV-positive prisoners' needs through the interpretation of the prohibition of torture and cruel, inhuman and degrading treatment (Article 3 ECHR), read alone or in conjunction with the prohibition of discrimination.<sup>43</sup>

From a number of judgments, it follows that the lack of appropriate medical care for prisoners living with HIV/AIDS amounts *in itself* to a form of inhuman and degrading treatment in contrast with the Convention.<sup>44</sup> As a consequence, respondent States failing to ensure prompt and accurate diagnosis as well as regular and systematic supervision for HIV/AIDS sufferers, *in addition* to appropriate living standards in prisons, do not fulfil the obligations deriving from the Convention. In fact, although it cannot impose a general obligation to release detainees on health grounds, Article 3 ECHR entails nonetheless an obligation to protect the physical well-being of prisoners, especially when they have already developed AIDS because of the risk of exposing prisoners to other associated serious diseases.

The recent judgment in *Martazaklis and Others v Greece* confirms the assumed relationship between the obligations derived by Article 3 taken alone and the positive obligations that may result from the prohibition of discrimination when HIV/AIDS is

<sup>43</sup> See the relevant proposals issued by the Madrid recommendation, World Health Organization, *Health protection in prisons as an essential part of public health*, 2010 at <euro.who.int/\_\_data/assets/pdf\_file/0012/111360/E93574.pdf> (accessed 20 November 2015). It is not surprising that the rate of people living with HIV/AIDS is higher in prisons. Many groups considered at higher risk of infection, such as sex workers and IDUs, are more likely to be imprisoned being their conduct often criminalised. It is not coincidence that a human rights-based approach calls for their decriminalisation.

<sup>44</sup> Among others, ECtHR, *Kozhokar v Russia*, 33099/08, 14 December 2010; ECtHR, *Khudobin v Russia*, 59696/00, 26 October 2006, para 93; ECtHR, *A.B. v Russia*, 1439/06, 14 October 2010; ECtHR, *Logvinenko v Ukraine*, 13448/07, 17 June 2006. For an analysis of the standards set out by the CoE's Committee for the Prevention of Torture (ECPT), see Emma-Alexia Casale-Katzman (ed), "Preventing Torture in the 21st Century: Monitoring in Europe Two Decades On, Monitoring Globally Two Years On", 6(2) *Essex Human Rights Review* (2010) at <projects.essex.ac.uk/ehrr/Vol6No2.html> (accessed 22 October 2015).



involved.<sup>45</sup> The case was brought before the ECtHR by several detainees who were placed in a specific area of the prison's hospital, together with other prisoners with infective diseases, where no specialised medical staff and medications were available and no individualised therapies were prescribed. Instead of focusing only on the precarious conditions of detention of the applicants, which amounted to a violation of the prohibition of degrading and inhuman treatment, the ECtHR deemed it appropriate to examine the alleged violations from the standpoint of Article 3 read in combination with the prohibition of discrimination. Interestingly, the Court accepted that a contracting State is allowed under the Convention to treat prisoners living with HIV/AIDS differently in order to improve their health conditions by separating them from other detainees. However, if no appropriate measures are simultaneously adopted to pursue this legitimate aim, such a separation only reinforces an already widespread belief of the alleged necessity to ghettoise people living with HIV/AIDS. As such, it is in contrast with the prohibition of discrimination.

Stated differently, HIV/AIDS may be the reason for requiring contracting States to provide additional standards of protection when an already vulnerable group is involved, going beyond the specific right at stake to raise an issue under Article 14 ECHR. Put this way, the positive obligations defined through the substantive provisions of the Convention may be a first step towards the elaboration of the same kinds of obligations from the standpoint of the prohibition of discrimination itself. As the ECtHR's case law on other suspect grounds shows<sup>46</sup>, the very reason lies in the need to treat situations that are not similar differently when a personal condition, which defines a vulnerable group, is involved.

### III.3. The Relationship with Other Grounds: The Potential Application of EU Secondary Law

A different path may be envisaged for the rise of positive obligations in EU law. Although Article 21 CFR may cover HIV/AIDS status, it does not contain any obligation of this kind, nor has it been given this meaning by the ECJ. At the same time, the prohibition of discrimination which was affirmed by the ECJ as 'a general principle of the EU legal order' does not provide for positive obligations since it works, also after the entering into force of the Charter, as a primary tool for legitimacy of EU law.<sup>47</sup> Therefore, it seems necessary to look at the relationship between HIV/AIDS and other grounds covered by the prohibition of discrimination as expressed in relevant EU secondary law.

An interesting proposal may come from the broadening of the notion of disability that has occurred within the EU order. Indeed, if disability is interpreted as encompassing HIV/AIDS status, at least two important consequences may be derived in terms of obligations for the EU's institutions and Member States. First, regarding the Charter,

<sup>45</sup> ECtHR, *Martazaklis and Others v Greece*, 18748/91, 9 July 2015. See also ECPT, *Report on Greece*, CPT/Inf (2014) 26, 5 July 2013 at <cpt.coe.int/documents/grc/2014-26-inf-eng.pdf> (accessed 22 October 2015).

<sup>46</sup> For example, ECtHR, *Orsus and Others v Croatia*, 15766/03, 16 March 2010.

<sup>47</sup> See, in relation to gender, CJEU, *Test-Achats ASBL and Others v Conseil des Ministres*, C-236/09, [2011] ECR I-00773.

Article 26 provides for a strong basis for the adoption of positive actions since it affirms that the Union ‘recognises and respects the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community’. Second, among the grounds of discrimination taken into account by Article 19 of the Treaty on the Functioning of the European Union (formerly Article 13 of the Treaty on the European Community), the question of disability has attracted a wide consensus on the need for an active involvement of the European Union itself.<sup>48</sup> For similar reasons, it has also been granted protection through EU secondary law by Directive 2000/78, ie. the so-called horizontal anti-discrimination directive establishing a general framework for the prohibition of discrimination in employment and working conditions.<sup>49</sup> Although its scope is limited to this specific field and covers only treatment based on disability, sexual orientation, age, religion or beliefs, the Directive addresses the specific needs of people with disabilities through an obligation for EU Member States to act for their full inclusion in employment.

Since the EU complements national efforts in relation to disability issues, it is no coincidence that it decided to adhere to the UN Convention on the Rights of Persons with Disabilities (CRPD),<sup>50</sup> thereby taking a greater commitment to respect and protect the rights enshrined in the Convention and – we may add – the provisions of the EU law providing protection for people living with disabilities.<sup>51</sup> Since the latter should be read in line with the UN Convention (Article 216.2 TFUE), interestingly the first point for broadening the notion of disability to include HIV/AIDS status for the purpose of positive obligations comes from the same CRPD.<sup>52</sup> A second insight emerges from the ECJ’s case-law that seems to pave the way for granting people living with HIV/AIDS the additional protection that Directive 2000/78 may provide them.

<sup>48</sup> Ellis, E and Watson, P, *EU Anti-discrimination Law* (2nd ed, Oxford University Press, Oxford, 2012); Bell, M et al, *Developing Anti-discrimination Law in Europe: the 25 EU Member States Compared* (EU Commission, Bruxelles, 2007).

<sup>49</sup> Directive 2000/78/EC of the European Council of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, OJ L303/16. On the ECJ’s related case law: Eriksson, A, “European Court of Justice: Broadening the Scope of European Non-discrimination Law”, 7(4) *International Journal of Constitutional Law* (2009) 731.

<sup>50</sup> UN General Assembly, *Convention on the Rights of Persons with Disabilities* (2008) 2515 UNTS 3. See EU Council, *Decision concerning the conclusion, by the European Community, of the UN Convention on the Rights of Persons with Disabilities*, 2010/48/CE, in OJ, 27 January 2010, L23/35. The EU is bound by the Convention from 22 January 2011, only to the extent of its competences. On EU and disability issues, Mabbett, D, “The Development of Rights-based Social Policy in the European Union: The Example of Disability Rights”, 43(1) *Journal of Common Market Studies* (2005) 97.

<sup>51</sup> It is worth mentioning that, even before the ratification, the EU Commission’s strategy to disability issues included the same priority areas characterising the CRPD: accessibility; participation; equality; employment; education and training; social protection; health; external action. Interestingly, the core elements of this strategy recall the EU rights-based approach to HIV/AIDS: see comparatively the EU, European Commission, *European Disability Strategy 2010-2020*, 15 November 2010, at <eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0636:FIN:en:PDF> (accessed 14 October 2015) and EU, European Commission, *Action Plan on HIV/AIDS in the EU and neighbouring countries:2014-2016*, at <ec.europa.eu/health/sti\_prevention/docs/ec\_hiv\_actionplan\_2014\_en.pdf> (accessed 14 October 2015).

<sup>52</sup> Although today a more consistent reasoning may support such a proposal, it is worth recalling that a similar approach has been advanced by the UN Human Rights Commission before the elaboration of the UN Convention. See UNAIDS, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *HIV/AIDS and Disability*, 1996. On the relationship between HIV/AIDS and disability, see Hanass-Hancock, J and Nixon, SA, “The Fields of HIV and Disability: Past, Present and Future”, 12 *Journal of the International AIDS Society* (2009) 28.

As for the UN Convention, it has outlined for the first time in a binding instrument that disability is not only a matter of social welfare, but also a human rights issue. While HIV/AIDS status can be relatively easy to define in medical terms, no specific definition of disability can be found in the CRPD. Interestingly, avoiding any medical definition, it has been thought of as an “evolving concept”<sup>53</sup> to be read in with the preamble of the Convention: ‘disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’ (subsection e). Therefore, the CRPD applies where a person’s impairments and attitudinal barriers limit his/her participation in the life of his/her community. However, nothing is said on the *nature* of such impairments. As a consequence, it cannot be excluded that they may also derive from an illness or a disease, as well as from the HIV-positive status. Indeed, enjoying a margin of discretion on the real ambit of the notion of disability, from contracting States’ practice, it seems that in some countries HIV-positive people are covered by the legislation protecting disability.<sup>54</sup> At the same time, other countries may recognise disability-related benefits gradually and only at a late stage of the infection a full disability status, ie. when AIDS has already developed (for instance, Italy).

Although HIV/AIDS status has not come directly into play yet, the suggested application of the notion of disability is supported by the ECJ’s interpretation of Directive 2000/78. In one of the first judgments – *Chacón Navas*,<sup>55</sup> the Court excluded that sickness may be covered by the concept of disability because this must be understood as referring to a long-term limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life. As the ECJ put it, although the EU recognises and respects human rights as general principles of the EU legal order, the protection provided by the Directive could not be extended by analogy to any factor on which a discriminatory treatment is based. As a consequence, if sickness is the only reason for receiving a disadvantageous treatment in employment, Directive 2000/78 cannot apply.

While it became clear that the horizontal non-discrimination Directive’s list of grounds is exhaustive, the ECJ did not exclude that the included grounds – disability, sexual orientation, age, religion or beliefs – may evolve. Therefore, as for disability, after the EU ratification of CRPD, the ECJ redefined its previous position on the very first occasion. In *HK Danmark*,<sup>56</sup> when asked if the Directive applies in relation to ‘a state of health of a person who, because of physical, mental or psychological impairments, cannot or can only to a limited extent carry out his work, at least for a long time’, the ECJ affirmed that the Directive might apply in case this state of health has the same consequences envisaged in the UN Convention’s preamble for disability. This is why the concept of disability contained in Directive 2000/78 refers also to ‘a condition caused by

<sup>53</sup> On the definition(s) of disability, see Human Resources Development Canada, REPORT: *Defining Disability: A Complex Issue*, Ottawa, 2003, at <publications.gc.ca/collections/Collection/RH37-4-3-2003E.pdf> (accessed 14 October 2015).

<sup>54</sup> We may refer, for instance, to Canada, USA, Germany, United Kingdom, Norway. Other countries have adopted separate legislations for HIV/AIDS status and disability, such as South Africa and Russia. See Elliot, R, Utyasheva, L and Zack, E, “HIV, Disability and Discrimination: Making the Links in International and Domestic Human Rights Law”, 12 *Journal of the International AIDS Society* (2009) 29.

<sup>55</sup> ECJ, *Sonia Chacón Navas v. Eurest Colectividades SA*, C-13/05, 11 July 2006, paras 43-45.

<sup>56</sup> ECJ, joined cases, *HK Danmark v Dansk almennyttigt Boligselskab* and *HK Danmark v Dansk Arbejdsgiverforening*, C-335/11 and C-337/11, 11 April 2013, points 38-39, 41.

an illness medically diagnosed as curable or incurable', where that illness entails a long-term limitation resulting *in particular*, from physical, mental or psychological impairments, which in interaction with various barriers may hinder the full and effective participation of the person concerned in professional life on an equal basis with other workers. As later confirmed in *FOA*, in relation to that state of health corresponding to obesity,<sup>57</sup> the Court does not rely anymore on the physical, mental or psychological impairments hampering the inclusion of a person in professional life but on 'interaction' as the central element of the 'social' concept of disability underling the CRPD. In fact, it is the relation with the outside environment, specifically defined for persons without disabilities, that limits the participation of people with disabilities in many spheres of life, including employment.

Having also regard to the reasoning followed by the ECtHR in *Kiyutin*, where it has associated disability to HIV status, Directive 2000/78 may thus apply to the situation of people living with HIV/AIDS through the prohibition of discrimination based on disability. To this end, it seems essential that their state of health, in interaction with physical or social barriers, must limit their effective participation in professional life. Although this can lead to the conclusion that HIV-positive people may experience this limitation only at a late stage of AIDS, it cannot be excluded that these limitations may be also experienced by the entire group of people living with HIV in light of the effects produced by the stigma associated with the virus. Furthermore, not only such limitations can hamper people's interaction since the beginning of the infection, but it may also regard groups that are simply associated with AIDS without effectively being HIV-positive<sup>58</sup>.

If Directive 2000/78 applies, EU Member States will be bound by EU law, among other things, to ensure that people living with HIV/AIDS are not dismissed or denied a promotion, to assure the reversal of the burden of proof when a discriminatory treatment is alleged and always if their condition amounts to disability, to ensure that 'reasonable accommodations' are adopted when needed. This fundamental obligation refers to all effective and practical measures that all employers, public as well private, must put in place to enable the person concerned to access, participate and advance in employment (Article 5 Directive 2000/78). Adapting premises and equipment, providing training or integration resources, establishing a different distribution of tasks, as well as reducing working hours, are different examples of reasonable accommodations. Interestingly, as the ECJ affirmed in *Commission v Italian Republic*, being a general obligation, it applies to all persons with disabilities, without reference of any kind to the level of disability resulting from medical classification as it happens, in some countries, also for people living with HIV/AIDS.<sup>59</sup>

Clearly, in addition to Directive 2000/78, the whole EU secondary law providing protection for people living with disability may come into play for people living with

<sup>57</sup> ECJ, *FOA*, C-354/13, 18 December 2014.

<sup>58</sup> If it is correct, this interpretation may in turn lead to foster the application the CRPD to people living with HIV/AIDS. As a consequence, specific obligations would be derived also from the UN Convention. Other than the general duty to remove all obstacles in every-day life and to operate for tackling the prejudices and social disfavour, the CRPD binds contracting States to respect: the right to life; the right to privacy and respect for private and family life; the right to health; the right to work; the right to take part to the public, political and cultural life of the country; the right to adequate living standards and the freedom of movement. See Office of the High Commissioner of Human Rights, World Health Organization and UNAIDS, *Disability and HIV*, April 2009, at <who.int/disabilities/jc1632\_policy\_brief\_disability\_en.pdf> (accessed 14 October 2015).

<sup>59</sup> ECJ, *European Commission v Italian Republic*, C-312/11, 4 July 2014.

HIV/AIDS, including the new Directive implementing the principle of equal treatment outside employment when it will be adopted.<sup>60</sup> In addition to the prohibition of direct and indirect discrimination, as well as harassment in the access to social protection, goods and services, health care and education, the new instrument will require EU States to take a proactive role in eliminating in these fields of all unjustified differential treatment on the grounds of disability, as well as sexual orientation, age, religion or belief. Perhaps more importantly, the new EU instrument is intended to prohibit also multi-discrimination, ie. when a person is treated less favourably on the grounds of two or more factors covered by the Directive. Interestingly, this situation can be directly experienced by people living with HIV/AIDS when they belong to other vulnerable groups, like for instance “MSM”, who may be discriminated against cumulatively on the grounds of their effective or alleged HIV-positive status (through disability) and sexual orientation.

#### IV. Setting Common Standards: The Interpretation of the Prohibition of *Refoulement*

With this emerging common framework in mind, we turn now to the analysis of a less clear obligation for European States when a person living with HIV/AIDS is involved.

It is well-known that, until today, the ECtHR has given an extremely restrictive interpretation of the prohibition of *refoulement* that downsizes the relevance of the specific health and social condition of the person subject to expulsion, return or rejection in a third or another European State, while giving more weight to his or her *status* as ‘irregular migrant’.<sup>61</sup> While a more consistent position is gaining strength within the ECtHR itself, the ECJ has recently decided to follow the ECtHR’s indications in the interpretation of the relevant EU secondary law. As a result, the ECJ has followed a different path when compared to the *Léger* case, where the Charter played an “autonomous” role, thus relying to the ECHR to define what standards of protection the EU law may provide.

While this development may seem like an attempt to reach a common approach with a clear preference for European minimum standards, from the perspective of people concerned and their need for protection under human rights law, it raises the question of *which* European approach to HIV/AIDS is under construction. In fact, leaving a wide margin of appreciation to European States, it neglects the specific needs of people living with HIV/AIDS and excludes the possibility to grant an individualised examination of a person’s health condition in contrast with the developments in the interpretation of other substantive rights.

In other words, it is not clear whether the condition of an irregular migrant taken alone may explain the preference for an interpretation which sets general common

<sup>60</sup> See, for the other relevant pieces of legislation, European Union, Commission, *First Report on the Implementation of the UN CRPD by the EU*, 26 June 2014. The draft of the new Directive is available at <eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0426:FIN:IT:PDF> (accessed 14 October 2015).

<sup>61</sup> Although the terms expulsion, return and rejection are clearly different in meaning, for the purpose of this analysis they are used in an interchangeable way because the focus is placed on their equal effect on the person involved. Among others, Da Lomba, S, “Vulnerability, Irregular Migrants’ Health-Related Rights and the European Court of Human Rights”, 21(4) *European Journal of Health Law* (2014)339.

standards at their lowest content only for some rights, rejecting the idea of a holistic approach based on the specific vulnerability of this group.<sup>62</sup>

Although it is generally referred to as a monolithic interpretation of the prohibition of *refoulement*, in case of expulsion of irregular ill migrants some distinctive elements have emerged in both systems of protection when people living with HIV/AIDS are involved. These elements may set the stage for a more genuine development which will be able to grant a more consistent interpretation of the whole (European) human rights catalogue, as recommended by CoE's institutions. Indeed, moving from the universal nature of the right to health, the Parliamentary Assembly stressed the condition of vulnerability of people living with HIV/AIDS having a migratory background and the need for special treatment to overcome the multiple forms of discrimination and stigmatisation to which they are exposed. Moreover, after rejecting the myth of "health tourism" through an analysis of available data, it called for adequate and individual assurances on the effective availability of health care in the country of destination as an essential precondition for sending them back.<sup>63</sup>

This is why we investigate in this section, how the interpretation of the prohibition of *refoulement* may evolve in light of the new rights approach to the virus when the person to be returned is living with HIV/AIDS.

#### IV.1. People Living with HIV/AIDS or Irregular Migrants?

Both the ECHR (Article 3) and the Charter (Article 4) enshrine the prohibition of torture and inhumane and degrading treatment in absolute terms. It is a well-established principle of international law that States cannot escape this obligation by sending people to a country where they may suffer such treatment. In general terms, for evaluating the existence of the risk at stake, a person must show that the general situation of the country of destination, coupled with his or her specific condition, would expose him/her to a serious degree of suffering. When the risk is directly connected to a person's health condition, a very high level of pain is required to apply the guarantees provided by the principle of *non-refoulement*.<sup>64</sup>

Within the ECHR system, *D. v UK* was the first case involving a person living with HIV, who alleged a violation of Article 3 in case of expulsion to Saint-Kitts.<sup>65</sup> Despite being dangerous to suspend or to stop medical treatment, the relevant British authorities rejected his request aimed to obtain a permit to stay on humanitarian grounds. In the ECtHR's view, while contracting States have the right to control and protect their

<sup>62</sup> According to S. Da Lomba, in this specific field related to health needs, irregular migrants are not regarded as vulnerable subject because 'their immigration status locates them outside the national community', *Id*, 360. However, the same author founds the variety of approaches of the ECtHR when migrants are involved being also identified as vulnerable, especially when they are asylum seekers: see ECtHR, *M.S.S. v Belgium and Greece*, 30696/09, 21 January 2011.

<sup>63</sup> See Council of Europe, Parliamentary Assembly (PACE), *Migrants and Refugees and the Fight against AIDS*, 23 May 2014, Resolution 1997, points 7; 9.1.3, Council of Europe, Committee on Migration, Refugees and Displaced Persons, *Migrants and refugees and the fight against AIDS*, Doc 13391, 22 January 2014, points 4,6, and PACE, *Refugee and the Fight against AIDS: Motion for Resolution*, Doc 12867, 1 February 2012.

<sup>64</sup> See Webster, E, "Medical-related expulsion and interpretation of article 3 of the ECHR", 6(1-2) *Inter-American and European Human Rights Journal* (2013) 36; Battjes, H, "In search of a fair balance: the absolute character of the prohibition of *refoulement* under Article 3 reassessed", 22(3) *Leiden Journal of International Law* (2009) 583.

<sup>65</sup> ECtHR, *D. v United Kingdom*, 30240/96, 2 May 1997.

boundaries, they are obliged nonetheless to protect 'one of the fundamental values of democratic societies'. In fact, when the prohibition of *non-refoulement* is at stake, the evaluation of the situation in the country of destination cannot be limited to public authorities' intentional acts or to their inability to prevent the prohibited treatment. Therefore, in order to reaffirm its absolute nature, the ECtHR declared to be free to consider all relevant circumstances of a person subject to expulsion, including the kind and the seriousness of his/her illness. As a result, in that case, taking into account the stage reached by the infection, the consequences of ending medical treatment in a healthy environment and the lack of social and moral support in the country of origin, the ECtHR concluded that the applicant's expulsion would have caused a violation of the Convention.

Interestingly, even if the Court tried to narrow the implications of this judgment underlying the exceptional circumstances of the case, some points can be highlighted. First, HIV/AIDS played a key role in the definition of what the applicant required in the UK as well as in St. Kitts, going beyond the simple medical treatment and including *social* support. Second, the ECtHR found inconsistent the idea that the family could replace the State of destination's protection or, even worse, that its existence excludes *per se* a serious level of suffering. Third, irrespective of the situation in St. Kitts, it was the *deprivation* of an appropriate environment for the applicant's personal HIV condition that amounted to an inhumane treatment.<sup>66</sup>

It is this background that explains the reason for the adoption of a more restrictive approach in *N. v UK (N.)*.<sup>67</sup> In fact, the Grand Chamber gave its own interpretation of the *D.*'s judgment reversing the reasoning followed in that case. First, it tried to define a general approach to expulsion of ill persons, irrespective of the disease at stake. Being oversimplified, no considerations were made as to the social consequences of being a person living with HIV/AIDS in the country of arrival or to the kind of complex environment needed by the applicant. As a result, the availability of medical treatment *per se* became the main focus. Second, while defining the applicant's defence as speculative, the Court itself used speculation to affirm that, in the country of origin, she could rely on family support or have access to expensive medical treatment. Third, the Grand Chamber did not consider the responsibility of the defendant State for the deprivation caused to the applicant through the expulsion and the related transfer from a safe environment. Instead, it stressed her capability to travel.

Most importantly, in *N.* the Court was able to make a subtle change of paradigm. If in *D.* the aim was to confirm the absolute nature of the prohibition of *refoulement* and the provision of medical and social care was only a mean among many others to realise it, in *N.* the essential issue became the lack of an obligation under the ECHR to grant free and unlimited health care to aliens. This aspect has led the ECtHR to combine the exam of the existence of an individual risk of torture or inhumane and degrading treatment with general considerations on the 'natural' origin of the harm, both in terms of *natural* disease

<sup>66</sup> For similar reasons, the European Commission of Human Rights found a violation of the principle of *non-refoulement* in *B.B. v France*, 47/1998/950/1165, 7 September 1998, related to a Congolese national living with AIDS. For the Commission, it was impossible for the applicant to maintain human dignity, 'as the disease ran its course', in his country of origin.

<sup>67</sup> ECtHR, *N. v United Kingdom*, 26565/05, 27 May 2008.

and of *natural* historical and economic differences between contracting States and countries of destination.<sup>68</sup>

With one significant exception, it is worth noting that all the following applications did not involve people living with HIV/AIDS, but different kinds of curable diseases.<sup>69</sup> In these cases, the evaluation of the ECtHR focused on the appropriateness of the measures designed for the execution of the expulsion having regard to the applicants' particular needs. Although put in a different way, this attention is the reaffirmation of the responsibility of the contracting State for a direct perpetration of a prohibited treatment.<sup>70</sup>

In light of the Grand Chamber's interpretation in *N.*, the ECJ evaluated the *M'Bodj* case,<sup>71</sup> involving a Mauritanian national who was seriously ill but, interestingly, was not living with HIV/AIDS. This preliminary ruling does not concern the principle of *non-refoulement* in itself but the question whether a permit to stay on the grounds of serious illness may be granted through the recognition of subsidiary protection as provided by EU law. It is clear that, if such protection is refused, the person may risk being exposed to ill-treatment according to his/her specific situation. The ECJ's reasoning has been mainly aimed at identifying the harm to which an ill alien would be exposed if returned to his/her country of origin. In its view, Directive 2004/38 on the standards for the recognition of the refugee status and subsidiary protection is designed for granting protection against serious pain caused, directly or indirectly, *by* the State of destination. Put in these terms, only when a deliberative deprivation of medical treatment is at stake, a third-country national may raise a claim for the recognition of protection under EU law. For the same reasons, this conclusion cannot be reversed by the obligation to respect Article 19.2 of the Charter, related to the principle of *non-refoulement*, if read in combination with the ECtHR's case-law. Recalling *only* the ECtHR's well-known statement on the inexistence in international law of a right to stay in a European country to benefit from medical treatment, EU judges focused the attention on the availability of these treatments in the country of destination as sufficient to reject the claim. As a result, they set at its highest point the distinction between the condition of a human having a disease *versus* the status of non-citizen, in the same way it has already emerged in the ECtHR's case-law. It has been thus easy to rule that, while Member States may autonomously allow seriously ill aliens to stay in their territories on humanitarian grounds, they are not obliged to grant them subsidiary protection nor the rights to social or health care as provided by Directive 2004/38.

As a consequence, the ECJ has not questioned at all the kind of risk a seriously ill person is exposed to when returned to his/her country. At the same time, the idea that a protection cannot be grounded on any harm which does not take place in the country of destination disregards the implications of depriving a person of his or her basic needs. It rules out even the possibility that the transferal itself may amount to a serious pain for the purpose of EU law. Moreover, no attention was paid to the specific illness at stake nor to

<sup>68</sup> This point was made by the House of Lord in its consideration of the case and it is now a recurring argument in the ECtHR's case-law: *id.*, para 17.

<sup>69</sup> For the last recent judgments: ECtHR, *M.T. v Sweden*, 1412/12, 26 February 2015, and ECtHR, *Tatar v Switzerland*, 65692/12, 14 April 2015, both related to mental health; ECtHR, *A.S. v Switzerland*, 39350/13, 30 June 2015, related to post-traumatic stress disorder.

<sup>70</sup> Therefore, once the countries involved grant adequate and specific arrangements for the transferal, the ECtHR considered that the risk to be subjected to ill treatment contrary to Article 3 could not be said to be real anymore. See an example of this kind of reasoning involving the same person with mental health problem: ECtHR, *Aswat v United Kingdom*, 17299/12, 16 April 2013, compared to the following ECtHR, *Aswat v United Kingdom*, 62176/14, 6 January 2015.

<sup>71</sup> ECJ, *M'Bodj v Belgium*, C-542/13, 18 December 2014.



the condition of vulnerability suffered by the people seeking protection. In sum, taking for granted the interpretation of the principle of *non-refoulement* given by the ECtHR, it did not investigate the possibility to develop EU-specific standards through Article 19 CFR, thus giving to the relevant Directive a wider scope through the prohibition of *refoulement*.<sup>72</sup>

## IV.2. A Starting Point: The Recognition of Specific Needs Pending Expulsion

In light of this background, it is striking that both European Courts have recently reached a “common” interpretation of procedural rights to be granted under both systems to people living with HIV/AIDS facing expulsion. The *ratio* underling these developments is the specific kind of “irreversible” harm to which these people may be exposed, ie. the condition of vulnerability related to their specific health conditions and not to their status of irregular migrants trying to exploit European States’ economic and social resources. As such, they can be viewed as a potential first step for the application of a rights-based approach to HIV/AIDS also to the interpretation of the prohibition of *non-refoulement* itself. Notwithstanding a common conclusion, it is worth noting that the ECJ went even further thanks to an autonomous application of the Charter.

In *S.J. v Belgium (S.J.)*, after acknowledging that the lack of adequate medical care for people living with HIV/AIDS deprived of their liberty pending expulsion amounts to a degrading treatment,<sup>73</sup> the ECtHR has evaluated their condition under the standpoint of Article 13, read in combination with Article 3.<sup>74</sup> The application was submitted by a Nigerian asylum seeker who was diagnosed with HIV after arriving in Europe, where she gave birth to three children. Although she was hosted with her children by an association specialised in social and medical support to people living with HIV/AIDS and she was in need of continuous care, Belgian authorities refused to deliver a permit to stay on health grounds. Instead, they asked Malta to evaluate her asylum request in compliance with EU law. After being assured that all necessary medical treatment were available in that country as well as in Nigeria, and that her life was not a risk in case of transferal, Belgian authorities adopted an order of expulsion. Although the ECtHR reiterated that the applicant’s situation did not amount to a critical stage and did not raise an issue from the

<sup>72</sup> The ECJ has already proven to be ready to interpret the relevant Directives in light of present day’s conditions. Thus, a protection under EU law has been granted when persecution is based on sexual orientation irrespective of its inclusion in the Geneva Convention: see ECJ, *X., Y. and Z. v Minister voor Immigratie en Asiel*, joined cases C-199/12 to C-201/12, 7 November 2013. Although it is true that the UNHCR has not yet elaborated standards on HIV/AIDS status, the ECJ is not prevented to define higher standards through subsidiary protection. In fact, although this form was designed to complement the protection provided by the refugee Convention, its definition is not bound by that international Convention. As it was affirmed for the ECHR, we may notice that the refugee Convention ‘does not constitute, as long as the EU has not acceded to it, a legal instrument which has been formally incorporated into EU law’: *supra* nt 4, Fransson, para 44.

<sup>73</sup> ECtHR, *Yoh-Ekale Mwanje v Belgium*, 10486/10, 20 December 2011.

<sup>74</sup> ECtHR, *S.J. v Belgium*, 70055/10, 27 February 2014. Perhaps, it is the recognition of the condition of vulnerability of the applicant at the heart of the decision to reconsider the case before the Grand Chamber. Among others, Marguenaud, JP, “L’éloignement des étrangers malades du sida: la Cour européenne des droits de l’homme sur «les sentiers de la gloire»”, *Revue trimestrielle des droits de l’homme* (2014) 977.

standpoint of Article 3, it reckoned the specific condition of people living with HIV/AIDS affirming that ‘the deprivation of medical treatment itself can lead even to their death’.<sup>75</sup> This is why, taking into account the *irreversible nature* of the harm to which they may be exposed as well as their condition of vulnerability, the ECHR required that the remedy for the review of the expulsion decision must have a suspensive effect on its execution.

Relying on this finding, also the ECJ gave an interpretation of EU law that goes well beyond the restrictive general approach adopted in *M’Bodj*.<sup>76</sup> Interestingly, the ruling involved a Nigerian national living with HIV/AIDS who also was denied a permit to stay on health grounds. This decision led, in turn, to an end of the free provision of social assistance and health care previously granted. In this context, the ECJ was asked if EU law requires to ensure an effective remedy with suspensive effect, as well as the free provision of social assistance and health care until the appeal against expulsion is evaluated. In the EU Court’s view, the need to protect the fundamental rights and individual dignity of people waiting expulsion is at the heart of the application of Directive 2008/115 on common standards and procedures in Member States for returning illegally staying third-country nationals. Although it is true that this Directive does not impose on Member States to put in place a remedy against expulsion with suspensive effects when there is a risk of sending a person to a country where he/she would be exposed to torture or inhuman and degrading treatment, such an effective remedy is required.

Hence, in line with the ECtHR, also for the ECJ it is the nature of the danger which is not excluded *a priori* that justifies a high standard of protection. As the Advocate General stated in his conclusions, the obligation to suspend the execution is paramount to grant a seriously ill person to have his primary needs taken into account. As a result, at least indirectly, it is recognised that part of the harm suffered by the applicant comes from the serious deterioration of his already precarious health condition that may be caused by the deprivation of social and medical support received in the hosting States. Going even further, the ECJ Member States have to provide not only urgent care, but also all basic needs when a person is not able to meet them because of his or her health conditions. In addition to the appropriate medical treatment, this obligation entails the provision of sufficient means to grant a decent and adequate standard of living for a person with specific health needs. Although national authorities enjoy discretion on how concretely they provide these means, they must respect the Charter.

In sum, when they focus on people as human beings with specific health needs, both courts are able to recognise that the enjoyment of fundamental rights cannot depend on their migratory status.<sup>77</sup> If the circumstances for exposing people living with HIV/AIDS to degrading treatment had not been so exceptional as it emerges from *N.* onwards, there would have been no need to provide such a level of protection. Instead, these developments are inspiring and are intended to reaffirm the absolute character of the prohibition of *refoulement*. Hence, this sets the stage for a further move consistently with a rights-based approach to HIV/AIDS.

<sup>75</sup> *Id.*, para 123.

<sup>76</sup> ECJ, *Centre public d’action sociale d’Ottignies-Louvain-la-Neuve v Moussa Abdida*, C-562/13, 18 December 2014. See also the AG’s Conclusions, 4 September 2014.

<sup>77</sup> These developments are therefore consistent with the previous “common” case-law where vulnerability played a central role: *M.S.S. v Belgium*, *supra* nt 62, especially para 251; ECJ, *N.S. v Secretary of State for the Home Department*, C-411/10, 21 December 2011. Among others, Mink, J, “EU Asylum Law and Human Rights Protection: Revisiting the Principle of Torture and Other Forms of Ill-Treatment” 14(2) *European Journal of Migration and Law* (2012) 119.

### IV.3. Moving Forward

If also in this field a common approach seems under construction, the European Courts have defined the standards of protection through a different balancing of the interests at stake. At the same time, a division in treatment is emerging between the protection of people waiting for expulsion and those who are held ‘apt’ to be returned.

At least four points may be advanced for moving beyond the idea of minimum standards of protection, setting them more in line with the rest of the emerging common European approach to HIV/AIDS. Although both systems are equally concerned, a special attention should be given to EU law, which could play a wider role influencing, in turn, a more genuine interpretation of the ECHR.

#### a) *Embedding Vulnerability*

A first step for the application of a rights-based approach to HIV/AIDS calls for a clear distinction that takes into account the complex situation of HIV-positive people. It does not lead to the simplistic conclusion that every member of this group must not be returned to his or her country of origin or to a third State. Instead, it calls for a more composite evaluation that goes beyond the availability of medical treatment as the only relevant element.

After *Kiyutin*, the identification as a vulnerable group has made clear that the suffering experienced by people living with HIV/AIDS is not only related to their health status but also by the exposure to social stigma. Until today, the cases of return of members of these groups have not included any considerations on the existence of a general climate of discrimination in the receiving country. However, it is common for both European Courts to consider that certain groups are more exposed than others to serious violations of human rights in the country of destination. For instance, when evaluating the existence of a hostile environment in case of expulsion for the purpose of Article 3 ECHR, the ECtHR usually refers to all information at its disposal to verify whether the person is a member of a vulnerable group. In this case, a presumption of exposing him or her to prohibited treatment as a matter of principle is often raised.<sup>78</sup> As a consequence, the sending State is called to demonstrate that the risk is inexistent, providing either general and verified information on the complex situation suffered by the involved group in the country of destination and specific assurances on the situation of the applicant.<sup>79</sup>

In other words, in the same way that stereotypes are refused as justification, general assumptions cannot be deemed sufficient to deny the existence of a risk of exposure to degrading and inhuman treatment when the condition of vulnerability is embedded in the evaluation. For example, as for the fear of imposing an excessive burden to contracting States, the economic consequences and the excessive demand on the publicly funded

<sup>78</sup> For the most recent case laws, see ECtHR, *A.A. v France* and *A.F. v France*; *Id.*, ECtHR, *Khamrakulov v Russia*; *Id.*, ECtHR, *Mukhitdinov v Russia*, 20999/14, 21 May 2015. See also ECtHR, *Soering v UK*, 14038/88, 7 July 1989.

<sup>79</sup> For instance, although it does not involve a person living with HIV/AIDS, it is worth noting the partial dissenting opinion in *Tatar*, *supra* nt 69, where Judge Lemmens applied a vulnerability approach to the situation of a severely mental ill person finding ‘incumbent’, in case of expulsion, the reception of assurances from receiving authorities on the ‘special protection’ required by his condition. Interestingly, also in *S.J.*, *supra* nt 75, in his concurring opinion the same Judge invited the Belgian authorities to ‘use their discretionary power’ to give ‘the due weight’ to humanitarian aspects of the case.

health-care system should be clearly demonstrated, considering also the kind of national health-care scheme as the ECtHR pointed out in *Kiyutin*.<sup>80</sup> Interestingly, in light of CoE's rejection of the myth of health tourism as unfounded, the idea of wasting resources should be analysed to ensure that this fear is not motivated by prejudices, like the need to remove a 'danger' from the community.<sup>81</sup>

Hence, also in relation to the prohibition of *refoulement* a rights-based approach requires an individualised evaluation. Clearly, this analysis has not prearranged conclusions or solutions but may be influenced by the level reached by the infection as well as by the specific needs in terms of social support. Moreover, it must include a consideration of the background of the person living with HIV/AIDS and whether, simultaneously, he/she belongs to an already vulnerable group, such as asylum seekers.

In sum, the focus on vulnerability seems to fill the gap that emerged in *N.* where, following an ambiguous identification of the harm, no clear criteria were defined for evaluating the risk at stake resulting in a wide discretion for European States.<sup>82</sup> Consequently, it calls for a different qualification of prohibited treatment for the purpose of the principle of *refoulement*.

### **b) Redefining the Treatment**

From the previous analysis, it seems that the ECtHR reviewed its initial interpretation of what is inhuman and degrading treatment when a person living with HIV/AIDS is involved for considerations that are more connected with its legitimacy *vis-à-vis* contracting States than with the harm itself. That Court is worried to impose 'a too great burden' on them, thus acknowledging that the treatment *per se* raises an issue under Article 3 ECHR. However, due to the absolute nature of the prohibition of torture, the ECtHR's approach has always been characterised by pushing the threshold of severity in light of present-day conditions and of the greater firmness in assessing breaches of the fundamental values of democratic societies.<sup>83</sup> Moreover, the qualification of the harm has always depended on the specific circumstances of the person concerned, such as sex, age or health conditions. As a consequence, the question is how the expulsion impacts on the person *in light of* her or his health conditions and of *present-day* standards in human rights protection.

Taking into account their special needs, the *deprivation* of what is necessary for a person's integrity caused by expulsion is at the heart of the violation of the prohibition of torture when people living with HIV/AIDS are involved.<sup>84</sup> Both asylum seekers and detainees have thus been protected by this part of the Convention *without* any consideration of budgetary constraints or the availability of a family/social network that

<sup>80</sup> ECtHR, *Kiyutin*, *supra* nt 16, para 70.

<sup>81</sup> See the dissenting opinion of Judge De Albuquerque in *S.J.* (dec.), *supra* nt 75, where he refers to 'undesirable illness': '*ils deviennent alors des parias dont les gouvernements s'emploient à se débarrasser au plus vite*', para 12.

<sup>82</sup> Webster, *supra* nt 64, 45. According to this author, the lack of clear criteria derives from the ambiguity of the ECtHR's reasoning in *D.* However, as explained above, the Grand Chamber in *N.* seemed aimed by the desire to restrict *D.* consequences providing in that occasion its own reading of the previous case. Therefore, the absence of 'a clear and transparent is the outcome of a deliberate interpretative strategy.

<sup>83</sup> See ECtHR, *Selmouni v France*, 25803/94, 28 July 1999, para 101.

<sup>84</sup> In this regard, the dissenting opinion in *S.J.*, *supra* nt 74, of Judge Power Ford is worth noting: '*Le fait crucial qui déterminera si elle vivra ou mourra est l'exécution de la décision d'expulsion prise par l'État*'. Interestingly, the Judge applies a vulnerability approach taking into account the applicant's condition.

could alleviate the suffering provoked by national authorities. Instead, the ECtHR was firm in recalling that, as a general principle of international law, contracting States cannot rely on the lack of economic resources to justify the violation of their human rights obligations.<sup>85</sup>

As already stated in *D.*, expulsion may exacerbate physical and mental pain deriving from illness. Being a starting point of a redefinition of the treatment from a rights approach to HIV/AIDS, this consideration focuses on the condition of the person as having special needs and looks at the expulsion as being in itself a form of deprivation for which contracting States are directly responsible. As a consequence, *only* clear and specific information from the authorities of the receiving country about the availability of medical and social support during the transferal and *in loco* are useful to eliminate the risk of exposure to degrading or inhuman treatment.<sup>86</sup> Clearly, the level of pain required seems nonetheless proportional to the stage reached by the infection. As such, expulsion *as* deprivation applies – certainly, although not exclusively – in those situations where a critical stage of AIDS has been reached. In some very serious cases, even the availability of clear and specific assurance cannot be enough to eliminate a potential violation of the principle of *non-refoulement*.

When the expulsion does not exacerbate the suffering to a level amounting in itself to a violation of the prohibition of inhuman or degrading treatment, a more composite exam is required by a rights approach to HIV/AIDS. In this case, the aim becomes reconciling the right of the State to control immigration with the respect of the absolute nature of the prohibition of torture. In this evaluation, the environment where the person with specific health and social needs is expected to return must be a central issue. In fact, in light of the special development of the infection, a complex environment is needed to avoid significant harm and it can be dependent on the societal acceptance of people living with HIV/AIDS.<sup>87</sup> To use the words of the Grand Chamber in *N.*, the ‘exceptional circumstances’ cannot arise from the forthcoming (and certain) death but from a situation of widespread discrimination that may prevent the person to access medical treatment and social care and, more importantly, to what is essential for satisfying his/her basic needs.<sup>88</sup> As a result, the care provided by contracting States is not the recognition of

<sup>85</sup> Among others, ECtHR, *Tchokontio Happi v France*, 65829/12, 9 April 2015, para 50.

<sup>86</sup> The ECtHR has already accepted this solution in a case involving a terrorist, suffering of serious mental problems, who had to be extradited to the USA for being tried: ECtHR, *Aswat v UK*, *supra* nt 70, para 57. See the following decision, issued on 6 January 2015, which excludes the risk of violation of Article 3 ECHR *after* having received very specific information on the special treatment to be granted by the US Government.

<sup>87</sup> Interestingly, faced with the issue at stake, the Inter-American Commission on Human Rights paid due attention to this aspect: ‘conditions for people with HIV in Jamaica have improved since 2002, but the country’s health care system is still insufficient to meet Ms. Mortlock’s medical needs. Moreover of greater concerning, are the reports that people with HIV/AIDS in Jamaica suffer from stigma and discrimination’, concluding that sending the applicant back ‘would constitute a *de facto* sentence to protracted suffering and unnecessarily premature death’ in contrast with ‘a civilized State’. See Inter-American Commission on Human Rights, *Andrea Mortlock v USA*, *affaire* 12.534, 25 July 2008, paras 91, 94-95.

<sup>88</sup> The UNHCR has recognised that, in some countries, violence and discrimination may be based on a person’s HIV-positive status: UNHCR, *Guidelines no. 9: Refugee Claims Relating to Sexual Orientation and Gender Identity*, 23 October 2012, HCR/GIP/12/09, para 3. As reported by dissenting Judge De Albuquerque in *S.J.* (dec.), *supra* nt 82, it is not surprising that Ms. N. died right after her transferal in Uganda.

economic or social rights to aliens but the essential *means* for reaffirming a legitimate aim: the absolute prohibition of *refoulement*.

Again, the ECtHR's case law has already investigated appropriate solutions. For instance, in *Aswat* the Court considered that the deterioration in mental and physical health caused by the extradition would have reached Article 3's threshold because in the country of destination he would have been placed in a 'different and more hostile' environment, although some medical treatment was available. Interestingly, the Court examined the case requiring *certainty* as to the conditions of destination. Provided that this deterioration could not be alleviated 'by the demonstration of' supporting family and friends, the ECtHR deemed appropriate for the applicant to remain in the host European State 'for his own health and safety'.<sup>89</sup> At the same time, when a hostile environment exists against a specific group, the ECtHR has already held that, in some circumstances, the risk may stem from the receiving "society" as a whole<sup>90</sup> while, in others, discrimination may be so serious as to constitute in itself degrading treatment.<sup>91</sup> This may be the case when discriminatory treatment causes prolonged deplorable living conditions, humiliation and debasement<sup>92</sup> and, irrespective of the availability of economic resources, the country of destination's authorities does not try to prevent them.<sup>93</sup>

### c) *Weighing Other Rights*

As pointed out, a rights approach to HIV/AIDS calls for a holistic perspective that puts the consequences of the return of the person concerned even beyond the prohibition of *refoulement* itself. This aspect is particularly important because, as shown, an evaluation which entails vulnerability as a specific element can lead also to the conclusion that the expulsion does not cause degrading or inhuman treatment. However, this does not mean that the person concerned will not be affected in the enjoyment of other human rights. In this regard, the specific situation of people living with HIV/AIDS is also covered by the right to respect for private life, taking into account the interpretation given to Article 8 ECHR.

On more than one occasion, the ECtHR held that a measure may breach Article 8 in its private component where it has sufficiently adverse effects on the physical and moral integrity of the person concerned.<sup>94</sup> As the protection afforded by this provision is wider than that provided by Article 3 ECHR, the level of adverse effects does not have to reach the same minimum sufferance. Even more radically, it was affirmed that the preservation of moral – as well as physical – stability is a precondition for the effective enjoyment of that right.<sup>95</sup> Moreover, considering other facets of the right to respect for private life, Article 8 has been interpreted as protecting the right to establish and develop relationships with other human beings and the outside world and also as embracing an

<sup>89</sup> ECtHR, *Aswat v UK*, *supra* nt 70, para 56. See also the dissenting opinion of Judges Tulkens, Bonello and Spielmann in *N.*, *supra* nt 67, paras 5-8.

<sup>90</sup> ECtHR, *N. v Sweden*, 23505/09, 20 July 2010, para 62.

<sup>91</sup> European Commission of Human Rights, *East African Asians v UK*, 3 EHRR 76, 14 December 1970.

<sup>92</sup> ECtHR, *Moldovan and Others v Romania* (2), 4113/98 and 64320/01, 30 November 2005, paras 110-111.

<sup>93</sup> All these considerations may have played a role for stopping the expulsion of Ms. S.J. before her case could be ruled by the Grand Chamber: see, ECtHR, Grand Chamber, *S.J. v. Belgium* (dec.), *supra* nt 81.

<sup>94</sup> ECtHR, *Costello-Roberts v UK*, 13134/87, 25 March 1993, para 36.

<sup>95</sup> ECtHR, *Bensaid v UK*, 44599/98, 6 February 2001, para 61.

individual's social identity.<sup>96</sup> Considering the situation of a person that has lived in the hosting country for a sufficient period of time before been subject to expulsion, the totality of his/her social ties and the community where he/she has lived is also covered by Article 8 ECHR.

Put in these terms, it is undisputed that the harm generated by an expulsion has adverse effects on a person living with HIV/AIDS, irrespective of the time she/he has spent in the country. In light of his/her condition of vulnerability and the further damage to the health, the person's moral and physical integrity can be substantially affected to a degree as to constitute an issue under Article 8 ECHR, as well as under Article 7 CFR if read in the same terms. Moreover, when a person living with HIV/AIDS is involved, the availability of medical treatment in the host State is often accompanied by social support. Since the situation may be further aggravated in the country of destination by a climate of widespread discrimination, the compliance of a measure under the ECHR and the CFR should also be assessed in light of the consequences of the return to a State without a functioning social network.<sup>97</sup>

As a result, it seems that an expulsion of a person living with HIV/AIDS must be evaluated as an interference in the enjoyment of the right to respect for private life,<sup>98</sup> which requires an appropriate justification, instead of from the standpoint of positive obligations under the same provisions.

Taking into account the conditions provided by Article 8 ECHR, two points should be carefully assessed through a case by case analysis. First, the legitimacy of the aim pursued cannot be given as granted. The protection of the rights and freedoms of others or the protection of the health or morals should not play any role if we do not accept, from an anti-stereotyping perspective, that their presence creates damage in regard to them. Nor does the wellbeing of the country seem appropriate to be advanced considering the minor level of economic burden requested. Therefore, only national security, public safety or the prevention of disorder or crime may come into play if sufficient elements, especially relating to the irregular presence in the territory, are demonstrated. In such a scenario, the necessity in a democratic society of the expulsion becomes the second essential point of the analysis to be undertaken. It is acknowledged that contracting States enjoy a margin of appreciation in balancing the rights of the community with the rights of the individual. If the more compelling interest of the community is certainly the right of the State to control its boundaries, only an evaluation that includes the specific situation suffered by a person living with HIV/AIDS may grant that his or her expulsion does not deprive the right to respect of private life of its essential meaning and effect. Again, the *hypothetical* availability of medical treatment or family support exposes European judges to the same level of speculation that is often reproached to applicants and cannot be part of a thoughtful evaluation.<sup>99</sup>

<sup>96</sup> ECtHR, *Khan v Germany*, 38030/12, 23 April 2015, para 37.

<sup>97</sup> ECtHR, *Emre v Switzerland*, 5056/10, 22 May 2008, para 83.

<sup>98</sup> See ECtHR, *S.J.*, *supra* nt 75, para 145, where the evaluation in these terms of the Court was dependent on the alleged violation of the right to respect for family life.

<sup>99</sup> For example, in *Yoh-Ekale Mwanje*, *supra* nt 74, the ECtHR found that the necessary treatment was available in Cameroun only for 2% of the people in need. Nonetheless, it concluded that expulsion could not expose the applicant to degrading or inhuman treatment. No evaluation from the standpoint of Article 8 was laid out.

#### d) *The Role of the EU Charter*

As shown above, in the interpretation of the principle of *non-refoulement* protected by Article 19.2 CFR, the ECJ decided to follow the ECtHR's ambiguous indications emerged in HIV/AIDS-related cases. Thus, it followed Article 53.2 CFR which grants the Charter's provisions the same meaning and scope of the corresponding rights enshrined in the ECHR. In other words, the ECJ deemed to be satisfied with a minimum level of protection derived by the interpretation given to Article 3 ECHR *without* questioning the *rationale* underling the ECtHR's case law. Referring generally to expulsions of seriously ill people, in *M'Bodj* the EU Court seems to have limited even further the entire issue to the consideration of the availability of medical care in the country of destination.<sup>100</sup> As a result, the ECJ did not take advantage of the second part of the same Article 53.2 CFR that admits the possibility for Union law to provide a more extensive protection than the one guaranteed by the minimum standards defined by the ECtHR.<sup>101</sup>

However, if we consider *Léger* and *Abdida*, the ECJ moved from a different perspective focused on the vulnerability of involved groups, thus granting an inclusive protection. The reason cannot be reduced to the inexistence of previous judgments in the ECtHR's case law on the same issue. Instead, in *Léger* it was the need to respect the Charter at the heart of the application of the prohibition of discriminatory treatment against a group most exposed to prejudice and social stigma. In the same way, in *Abdida* it was the precarious condition of people waiting for expulsion that set the starting point for the interpretation of EU law. In this case, in line with the Charter the ECJ went beyond the protection already granted by the ECHR because, as analysed above, it read EU law as imposing the obligation to satisfy all needs of a person living with HIV/AIDS where he or she lacks the means to make such provision for him or herself.

More importantly, *Abdida* seems to suggest three points. First, in contrast with *M'Bodj*, EU judges did focus on the effect of the expulsion that may exacerbate the health conditions of the person concerned *independently* of the availability of medical treatment in the country of destination. Second, it did not consider economic consequences or the fear of imposing an excessive burden on EU Member States. Instead, the provision of the means for an adequate standard of living to all people in the same situation of Mr. Abdida is only instrumental to achieve the primary aim of protecting their fundamental rights.<sup>102</sup> Interestingly, although the Charter includes also social rights, it is no coincidence that solely the provision related to the principle of *non-refoulement* was

<sup>100</sup> ECJ, *M'Bodj*, *supra* nt 71, point 39. By contrast, no references were made to the conditions of transferal which in the ECtHR's case law have a significant role.

<sup>101</sup> See ECJ, *McB.*, C-400/10 PPU, 5 October 2010, point 53; *Id.*, *Melloni*, C-399/11, 26 February 2013; *Id.*, *Åkerberg on*, *supra* nt 4, on which see Hancox, E, "The meaning of "implementing" EU law under Article 51(1) of the Charter: Åkerberg Fransson", *Common Market Law Review* (2013), 1429. See also, den Heijer, M, "*N.S.*", *Common Market Law Review* (2012), 1749 who, considering the ECJ's decision in *N.S.* in light of the ECtHR's *M.S.S.*, highlights how the EU Court is reticent in giving Article 19.2 an autonomous scope.

<sup>102</sup> The ECtHR took a similar approach in *Airey v Ireland*, 6289/73, 9 October 1979, para 26: 'the Convention must be interpreted in the light of present-day conditions and it is designed to safeguard the individual in a real and practical way as regards those areas with which it deals. Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. [...] the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an interpretation; there is no water-tight division separating that sphere from the field covered by the Convention'.



recalled. Third, in light of the interpretation given in *Abdida*, the ECJ seems aware of the need to provide specific response to people living with HIV/AIDS. The acknowledgement that a person in the condition of Mr. Abdida cannot be able to satisfy his basic needs is, at least implicitly, a recognition that the deprivation of the means imposed to Member States by EU law can amount to a degrading treatment prohibited by Article 4 CFR.

Provided that the Charter applies in this field, from these premises the ECJ can provide its own interpretation of Article 19.2 CFR when people living with HIV/AIDS are involved. Considering the aim of this provision, it has already made clear in *M'Bodj* that, in defining the risk for the purpose of the principle of *non-refoulement*, the role of receiving authorities cannot be the same as the one required for the recognition of refugee status or other forms of international protection. If read in light of Articles 1 to 4 of the Charter, the ECJ can define other specific criteria for the application of the principle of *non-refoulement*, thus granting a uniform level of protection in EU Member States. Since an interpretation in line with a human rights approach to HIV/AIDS does not call necessarily for an obligation to grant a permit to stay on humanitarian grounds, the ECJ may leave it to Member States to decide the forms through which Article 19.2 CFR is respected when a person living with HIV/AIDS cannot be returned to his/her country.<sup>103</sup> In doing so, not only the ECJ would operate within the 'constitutional framework' set for the interpretation and the application of fundamental rights in the EU,<sup>104</sup> but would also (at least indirectly) realise what Article 35 CFR imposes to the Union. As immigration and asylum are EU policies, this part of the Charter obliges Union's institutions to guarantee a high level of protection of human health. As already pointed out, this provision has not been placed under the head of citizenship because its primary aim is to recognise the right to access and benefit from medical treatment to 'everyone'.

In other words, the adoption of a rights-based approach to HIV/AIDS calls the ECJ to question the indications elaborated by the ECtHR instead of simply following them, especially when they are not in line with its well-established case-law on the necessity for individual evaluation in expulsion decisions. If the ECJ will be able to develop substantial standards before the ECtHR will review its own,<sup>105</sup> not only would it give consistency to the emerging European common approach to HIV/AIDS but would also set a significant development in the relationship between the ECHR and the Charter.

## V. (Why) An European Approach?

<sup>103</sup> See, eg. the recent case of: ECJ, *H.T. v Land Baden-Württemberg*, C 373/13, 24 June 2015.

<sup>104</sup> ECJ, *Opinion no. 2/2013*, 18 December 2014, points 155-176.

<sup>105</sup> For instance, although it is not obliged to follow ECtHR's case law, it is common for the Inter-American Commission of Human Rights to refer to the ECtHR. However, when it was called to evaluate the issue of expulsion of a person living with AIDS, it went beyond ECtHR's indication stating that:

While Ms. Mortlock's case is not one dealing with the dignity of death, it would be illogical to confine the scope of relief to such cases. [...] due to the recent medical advancements, HIV/AIDS can be effectively and indefinitely treated by the administration of antiretroviral drugs and, therefore, in most cases while the treatment is being delivered the patient will be found in good health. However, stopping the treatment would lead to a revival of the symptoms and an earlier death. Therefore [...] the effects of terminating the antiretroviral treatment may well be fatal.

See Inter-American Commission on Human Rights, *Andrea Mortlock*, *supra* nt 88, para 90.

Considering the change in the effects of the infection, HIV/AIDS has moved from a “security threat” to a human rights issue. European institutions, including the ECtHR and the ECJ, have mostly adopted an anti-stereotyping approach that intends to overcome the condition of vulnerability of people living with HIV/AIDS through also the elaboration of positive obligations. As a result, they seem to fill the existing gap in international human rights law due to the lack of any binding holistic instrument specifically aimed to protect the ‘new’ needs of HIVpositive people.

As explored, new positive developments may be expected in both European systems of protection. Indeed, after setting the stage for an inclusive interpretation of ECHR and EU law, the issue is now to identify *which* European approach adheres better to the human rights *rationale*. If the prohibition of discrimination has worked within the ECHR as a ‘Trojan horse’ to include HIV/AIDS-related needs, and the same may apply to EU law directly and indirectly through the protection of disability, the interpretation of the prohibition of *refoulement* is still problematic in this field. The focus of the European Courts on the migratory status instead of the health conditions of those people living with HIV/AIDS to be expelled has generated different levels of protection. While procedural rights were granted in light of the primary aim of respecting fundamental rights and of addressing the condition of vulnerability, from a substantial point of view the definition of prohibited treatment remains unclear. Relying on the interpretation provided by the ECtHR to Article 3 ECHR, the ECJ failed to give its own interpretation to the relevant CFR’s provisions and to influence, in turn, the development of higher standards of protection within the ECHR system itself.

Hence, while the European Courts have been able to incorporate the principles promoted through soft law instruments into the interpretation of the European human rights catalogue, they are now called on to take those additional steps that can grant consistency to what is emerging as a genuine common European approach to HIV/AIDS.

Fostering a human rights approach based on vulnerability may pave the way for such developments. It requires to re-focus the attention on the person in need of protection within the social context to which he or she belongs and suggests a method rather than pre-arranged solutions. It 1. addresses the issue from an holistic perspective, irrespective of the right at stake; 2. requests special treatment, unmasking prejudice and fighting stigma; and 3. demands for an individual evaluation, that looks also at the intersection with the rights of those people usually identified as most exposed to infection.

If successful, the European efforts may, in turn, be the grounds for a change in the worldwide response to the human rights issues raised by the spread of the virus.

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