# TOWARDS A CLIMATE OF TOLERANCE AND RESPECT: LEGISLATING FOR HIV/AIDS AND HUMAN RIGHTS IN PAPUA NEW GUINEA

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## INTRODUCTION

From the time some 12-15 years ago when the Papua New Guinea public first became aware of HIV/AIDS, it was felt that there needed to be "some laws" on the subject. However, no-one at that stage had much idea of the possible content or direction of those laws. Occasionally the media carried (largely apocryphal) stories of attempts at deliberate transmission (through rape, or blood-filled syringes, for example) which would prompt calls to proscribe such acts. Various compulsory testing policies were instituted ¾ by the Defence Force for its personnel; by one or two private companies for employees; by the Department of Foreign Affairs for intending residents.[1] Proposals along the lines of "lock them up and throw away the key", or "ship them off to an isolated island" were bandied about. All of these suggestions and initiatives were derived piecemeal from classical public health disease management models of detection and containment¾ by physical segregation, if necessary. But it was not until the *PNG National HIV/AIDS Medium Term Plan 1998-2002*[2] (the MTP) was developed, through a long process of discussion, research and intensive work on the part of the coordinating-committee and working-group members, that the possibility of law reform in the context of HIV/AIDS came to be approached in a systematic and rational way.

For the first time, HIV/AIDS law reform in PNG was viewed predominantly as a process of protecting and upholding human rights, when the third of the five Goals of the Plan was declared to be:

> To create a supportive legal and ethical environment for HIV/AIDS prevention and care and to uphold the human rights of those individuals infected and affected by HIV/AIDS.[3]

The first of the four Area Objectives was:

> To advocate for and support legislation and policies regarding HIV/AIDS based on the ethics of compassion and non-discrimination.[4]

A comprehensive list of strategies was developed, some of which clearly mandated legislative intervention, some of which simply indicated support for legislative reform in more generalised areas, and some of which were purely policy initiatives. But all strategies clearly took as their mandate the importance of 'a climate of tolerance and respect for human rights'.[5]

The timing was excellent. Just two years previously in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the United Nations High Commissioner for Human Rights (UNHCHR) had promulgated the HIV/AIDS and Human Rights International Guidelines (the

International Guidelines), resulting from the Second International Consultation on HIV/AIDS and Human Rights.[6] The overwhelming thrust of the International Guidelines is towards the protection of human rights. Guideline 3 advises reviewing public health laws to ensure that 'their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations'. Guideline 4 requires review of criminal and correctional laws and systems in the same light. Guideline 5 specifically calls for HIV/AIDS anti-discrimination laws, and Guideline 9 calls for education, training and media programmes to assist in changing discriminatory attitudes. And finally, Guideline 11 advises monitoring and enforcement mechanisms specifically to guarantee HIV-related human rights.

The following year, the South Pacific Commission released the *Regional Strategy for the Prevention and Control of STD/AIDS*.[7] This was followed in 1999 by the *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (the Handbook), a joint publication of UNAIDS and the Inter-Parliamentary Union,[8] which fleshed out many of the Guidelines. The way was clear to start a comprehensive HIV/AIDS law reform exercise for Papua New Guinea, and the task became one of augmenting existing rights law and devising new law to fill any gaps. The opportunity came when the AusAID-funded National HIV/AIDS Support Project (NHASP) commenced work late in 2000 to provide assistance to the newly-established National AIDS Council of Papua New Guinea (NAC). The NAC/NHASP work was able to build on much excellent exploratory work done in the predecessor to NHASP, the Sexual Health Project, which had been providing assistance to the Department of Health for several years previously.

Consultation was undertaken with and through the Council's Legal and Ethical Advisory Committee, which held a number of workshops and consultations with stakeholders in 2001 and 2002, and many informal discussions were held with people involved with the issue in various ways. The result of the process was the *HIV/AIDS Management and Prevention Act* (the Act) which was passed by the National Parliament in July 2003.

## HIV/AIDS AND HUMAN RIGHTS

What then are the possibilities for enhancing legal protection of rights in the context of HIV/AIDS? And in fact, why human rights at all?

The international community had already noted the widespread abuse of human rights associated with the epidemic,[9] and it was alarm over this situation which led to the association of UNAIDS and UNHCHR which produced the International Guidelines. The MTP acknowledged this, in its introduction to the Legal and Ethical Strategy:

> It is well-established that laws and policies based on the ethic of compassion for people with HIV/AIDS increase the effectiveness of prevention programs and minimise social stigmatisation.... Laws that uphold human rights, protect privacy and prohibit discrimination against people with HIV/AIDS create an environment where people come forward for voluntary testing and treatment and are encouraged to make changes in their behaviour. Alienating and discriminating against people with HIV only reinforces the social and economic conditions that allow the virus to spread.[10]

And as the National AIDS Council has pointed out:

> There are two reasons why the HIV/AIDS epidemic must be managed within a framework of human rights. The first .... [is] that States have a legal duty to comply with their international

> obligations. The second is more pragmatic: namely, that the prime lesson learnt in two decades of attempts at epidemic management is that discriminatory measures and failure to observe human rights fuel the epidemic, rather than containing and decreasing it.[11]

But, not surprisingly, this point was proving as hard to get across in Papua New Guinea as elsewhere in the world. It seems that universally, the fundamental human fear of an invisible, incurable threat to life gives rise to an unreasoning, panicked "fight *and* flight" reaction which overrides any amount of rational argument to the contrary. And despite all rhetoric to the contrary, it is also a fundamental of political life that policies, while providing useful guides to action, do not carry in themselves the means of their enforcement. And so in Papua New Guinea it appeared necessary to ensure that the upholding of rights and the unlawfulness of discrimination in the context of HIV/AIDS receive the backing of the force of the law.

## RIGHTS LAW IN PAPUA NEW GUINEA

The proclamation of human rights, and the means to uphold and enforce them, is not new to Papua New Guinea. The *Constitution* adopted at Independence in 1975 was at the time one of the lengthiest and most comprehensive in the world. It is notable for its entrenchment of human rights and freedoms, largely following upon the Universal Declaration of Human Rights. All constitutional rights and freedoms are enforceable by the National and Supreme Courts, either on the court's own initiative or on application by any person interested in the protection or enforcement of the right, both upon cases of actual or imminent infringement and situations of a reasonable probability of infringement[12]. Additionally, the Supreme Court has original jurisdiction 'as to any question relating to the interpretation or application of any provision of a Constitutional Law' (including the*Constitution*)[13] and its binding opinion on such questions may be sought by courts and other specified bodies with an interest in upholding the*Constitution*.[14]

The *Constitution*, however, makes little direct reference to discrimination, or its absence. Section 55 makes the following guarantee, for citizens only:

> 55. Equality of citizens.
> (1) Subject to this Constitution, all citizens have the same rights, privileges, obligations and duties irrespective of race, tribe, place of origin, political opinion, colour, creed, religion or sex. [15]
> (2) Subsection (1) does not prevent the making of laws for the special benefit, welfare, protection or advancement of females, children and young persons, members of underprivileged or less advanced groups or residents of less advanced areas.

Other provisions relevant to the protection of rights in relation to HIV/AIDS are the fundamental Right to Life (section 35), and the Right to Privacy (section 49) which the Supreme Court decided in the *Medical Privilege Case*[16] extended to communications between a patient and a health care worker.

The rights in the *Constitution* are based on the traditional civil and political rights originally enshrined in the UN Charter and the Universal Declaration of Human Rights. More recently, a range of international conventions and declarations have focussed more on the social, economic and cultural aspects of human rights. Hence the rights and freedoms in the *Constitution* do not make specific reference to, and indeed may not even catch, a range of rights and freedoms which should on principle be guaranteed to people with HIV/AIDS, their families, associates and communities, such as the right to marry and found a family, the right to education, the right to an adequate standard of living, the rights of minorities and

disadvantaged groups.

Despite the generalised nature of these constitutional rights and freedoms, however, and the limited anti-discrimination provisions, it nevertheless appeared possible to apply constitutional rights safeguards to various acts of discrimination in the context of HIV/AIDS. But although situations have arisen which could have provided good test cases for HIV/AIDS discrimination, none so far has actually been pursued as far as court.[17]

## DEVISING THE LAW

But with the National AIDS Council law reform project under way, there was no need to wait for test cases. Using the International Guidelines, the Handbook and national legislation of other jurisdictions as a guide, Papua New Guinea could embark on its own law reform exercise in a manner which both suited the circumstances of the country and accorded with the existing body of statute law.

Meanwhile, reports were increasing of violations of human rights caused by HIV/AIDS.[18] Disturbing reports, of people thrown out of their houses, dismissed from their jobs of many years, subjected to medical tests without their consent, denied access to their children ¾ and most disturbing, tales of people drowned, burnt to death or otherwise murdered. And the number of orphans and abandoned babies was clearly on the rise. Despite counter-stories of incredible compassion and support, it was evident that the epidemic was creating an urgent need for enhanced protection of human rights. Some of the provisions of the *HIV/AIDS Management and Prevention Act* 2003 are based not merely on guidelines from international and national literature, but on perceived needs which are derived from these and other reports.

### Amendment or new legislation?

The first question that arose for the reformers was the approach. Should current statutes – the *Public Health Act* [Cap 226], for example, and the *Criminal Code* [Cap 262] – be amended one by one as proposed by the International Guidelines? And if so, how could this be done considering the requirements for reform were spread over a number of different pieces of legislation?

Until the reform process actually began, it was assumed, based on experience of other countries, that HIV/AIDS management was a public health issue. Even despite the establishment of the National AIDS Council as a multi-sectoral statutory authority, Ministerial responsibility was still vested in the Minister for Health. However the Council was keen to emphasize the multi-sectoral dimensions of the problem. In February 2001, it endorsed the preparation of a Management Bill as a new and separate piece of legislation. As well as emphasizing the multi-sectoral approach to epidemic management, this would have the practical effect of enabling the qualification of a range of existing Acts without actually undertaking the lengthy legislative process of amending each statute. Given the highly compartmentalised view of ministerial responsibilities in Papua New Guinea, and the comparatively weak control of Prime Ministers over their coalition cabinets, a stand-alone Bill seemed a pragmatic solution to a complex problem.[19]

The only major matter directly connected to HIV/AIDS which was not ultimately included in the management Bill was that of the blood supply (and also organ and tissue donation, though this is rare in Papua New Guinea) in relation to guarantees of purity and the avoidance of liability where the safety of the supply had been secured. As this was a purely medical matter, unlike the other matters contained in the Bill, it was done by amendment to the *Public Health Act* [Cap 226], which already contained a Part devoted specifically to blood transfusion.

### HIV/AIDS only or general disability discrimination legislation?

The International Guidelines suggest in Guideline 5 (Anti-Discrimination and Protective Laws) that HIV/AIDS anti-discrimination laws should be enacted within a framework of general disability discrimination laws. Certainly, this has been the course followed in many Australasian and Asian jurisdictions.[20] Such jurisdictions already had or were in the process of enacting disability discrimination legislation, and HIV/AIDS was covered simply by including in the definition of 'disability' the factor: 'the presence in the body of organisms causing disease or illness or capable of causing disease or illness' ¾ the typical wording used. [21] This approach did have the advantage of rendering the law applicable to discrimination for other diseases such as hepatitis-C. But this was not an issue in Papua New Guinea.

However, Papua New Guinea did not have general disability discrimination, nor was it likely to consider such legislation in the foreseeable future. More pressing problems occupied the minds and energies of the nation's legislators. Even if such legislation were to be considered, the vexed question of Ministerial responsibility would again arise. Disability discrimination laws would need to involve at least one other government department, possibly more, meaning lengthy negotiations with understaffed governmental bodies that were only minimally interested and possibly antagonistic to the concepts of anti-discrimination for HIV/AIDS anyway.[22] And Papua New Guinea had already taken the bold initiative of establishing a multi-sectoral body with responsibility for HIV/AIDS management. The obvious solution was to draw up an HIV/AIDS-specific law.

### Scope of discrimination in the Act

The International Guidelines were used to determine who was to be protected against discrimination, and the sectors and ways in which the prohibited discrimination might occur. The Guidelines, principally at Guideline 5, go into great detail as to the types of discrimination to be covered, and the people to be protected.

As to the sectors of discrimination, they:

> should be as broad as possible, including health care, social security, welfare benefits, employment, education, sport, accommodation, clubs, trades unions, qualifying bodies, access to transport and other services[23]

Those to be protected include:

> people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face.[24]

Guideline 5 goes on to make special mention of rights to privacy and confidentiality, workplace rights, protection of human participants in research including HIV-related research, and protection of women, children and men having sex with men.[25]

## RIGHTS AND THE ACT

### Rights and discrimination

The Act commences with a Preamble which leaves no doubt as to its scope, and its emphasis on human

rights, as follows:

> BEING an Act to give effect to the Basic Rights acknowledged in the Preamble to the Constitution, in particular the rights and freedoms of—
>
> (a) life, liberty, security of the person and the protection of the law; and
> (b) freedom from inhuman treatment; and
> (c) conscience, of expression, of information and of assembly and association; and
> (d) employment and freedom of movement; and
> (e) protection for the privacy of homes and other property,
> in providing for—
> (f) the prevention of the spread of HIV/AIDS; and
> (g) the management of the lives and protection from discriminatory practices of people living with HIV/AIDS and of people who are affected by or believed to have HIV/AIDS; and
> (h) the protection of public health....

**Discrimination and stigmatisation**

The term "discrimination" is not specifically defined in the Act (other than to ensure that where used it includes harassment). But then nor is it in the *Interpretation Act* or even the *Constitution*, where it is used several times in different contexts. The *Discriminatory Practices Act* [Cap 269] contains a definition of 'discriminatory practice',[26] but this is aimed more at describing the basis and circumstances of discrimination than at the action itself. These were designed to cope with the very different circumstances that pertained in the colonial and immediate post-colonial era, and had little relevance to HIV/AIDS discrimination.

But definitions are not always necessary. It is a basic principle of statutory interpretation that where a definition is not provided, the ordinary dictionary meaning of the word will be assumed.[27] Instead, new parameters are set in the Act for the scope and objects of HIV/AIDS discrimination.

The scope of the term is set out at section 6, where it is made clear that the discriminatory action is detrimental; it must exceed discriminatory action (such as refusal of insurance) in respect of someone with a similar life-threatening medical condition; and even where the discriminatory action is carried out for a combination of reasons, if one of those reasons, not necessarily the dominant one, is the ground of HIV/AIDS, then that is considered HIV/AIDS discrimination. This last ensures that even covert HIV/AIDS discrimination is caught by the provisions of the Act.

Stigmatisation, an associated concept used in the Act, is however defined in section 2 (Interpretation), as:

> ...to vilify, or to incite hatred, ridicule or contempt against a person or group on the grounds of an attribute of the person or of members of the group....

The objects of discrimination are drawn widely. Section 6 refers to a person 'infected or affected by HIV/AIDS'. This is defined in section 2 by a process which can be likened to a series of widening circles, as follows:

- First is a person with HIV or AIDS.
- Then comes a person presumed to have HIV or AIDS. One of the presumptions relates to a person who has in some way been involved with an HIV test, especially including a person who has refused a test.
- In the next circle is a relative or other associate of a person with HIV or AIDS.
- Then come relatives and associates of people presumed to have HIV or AIDS.

• And last comes a particularly important category, that of people who are or are presumed to be members of or associated with groups, activities or professions, or living in environments, which are associated or presumed to be associated with HIV infection or transmission.

This last category is so important because it provides a "back-door" way of protecting those involved in or with criminalised or stigmatised activities and groups, such as sexworkers, men having sex with men, urban "squatter settlement" residents, even as broad a social category as "women".

The areas of discrimination are also drawn very widely, by making them open-ended, although details of the most likely areas and ways of discrimination are given at section 7, and include discrimination in the workplace, education and training, in prisons, in the provision of accommodation and access to goods, services and public facilities (including health care) and in the treatment of subjects of surveillance and research. Stigmatisation on the other hand is limited to the "publication" (which in legal terms means any form of communication to a person other than the person stigmatised) of stigmatising or vilifying matter. This is subject to certain non-adverse exceptions, in line with defamation law.

A subset of action which might be called discriminatory, and which at the very least infringes on people's right to protect themselves from the life-threatening danger of HIV infection, is prohibited by section 11. This is the denial of access to a means of protection from infection. This provision was considered particularly important in the light of reports of refusal by health-care workers to issue condoms; the banning of HIV/AIDS awareness materials in many situations including educational and training institutions; the policy in some prisons that prisoners share razors; and the practice in some health care facilities of re-using needles and syringes without sterilisation between uses. Given the limited resources and the problems with their delivery in Papua New Guinea, though, reasonable excuse for denial of access, which would include non-availability, is a defence.

**Confidentiality of information**

Given that there is so much discrimination and stigmatisation in Papua New Guinea at present, it is essential that the right to privacy and confidentiality in relation to HIV status is ensured. The International Guidelines at Paragraph 30(c) propose general confidentiality and privacy laws, which are wider in scope than simply confidentiality of medical records.

The *Constitution* couches section 49 (Right to Privacy) in understandably general terms, as pertaining to a person's right to privacy in respect of 'his private and family life, his communications with other persons and his personal papers and effects'. This is amplified in section 18 of the Act to extend to any information not only of a person's HIV status but also, similarly to the discrimination provisions, information as to the associates and associations of a person. However, it is neither feasible nor desirable to place the obligation of confidentiality on the entire community. Accordingly, the obligation is limited to those who acquire the information while operating in a professional capacity. Privacy in court proceedings is ensured by section 19.

The vexed question of the breach of confidentiality required for contact-tracing and partner-notification by carers is dealt with in section 20. Understandably, provision is first made for alternative avenues of partner notification, starting with intensive counselling. But this may not always work, particularly if the person to be counselled is, for example, a faithful wife, and the partner to be notified is her philandering husband. Also, efforts at contact-tracing and partner-notification have occasionally resulted in anger, compensation demands against both private persons and the government[28] and the potential for violence. Although the*Public Health Act* contains provisions for partner-notification in the case of 'venereal disease', HIV/AIDS is definitely not such a disease. As the Handbook for Legislators puts it:

> In many communities there is a history of medical professionals having an ethical and

> sometimes legal obligation to protect others from infection by tracing contacts of those infected by serious diseases... On the other hand, patient confidentiality is a central part of the doctor-patient relationship under the law... The issue of patient confidentiality also applies to other health-care professionals, such as nurses, welfare workers and counsellors, with confidentiality obligations. It is recognized that coercive strategies are inappropriate ...[29]

Hence section 20 gives the power of partner-notification to carers and counsellors, but it is completely within their discretion as to whether to proceed or not.

**Testing**

One of the most important requirements of the MTP is that there shall be absolutely no mandatory testing. It forms the very first strategy within the Legal and Ethical Issues area (3.1.1), as a directive to:

> Support the ratification of a policy on HIV testing based on voluntary informed consent, confidentiality and the provision of pre and post test counselling, and ensure that any form of HIV testing in violation of the policy will not be permitted.

The Act enables the introduction of this policy in sections 13-17, which set out a detailed regime for testing, notification of results and accumulation of data. The policy is also reflected in section 9 (Unlawful Screening) which prohibits not only coerced testing but also any requirement imposed on a person to undergo questioning or produce proof of negative status. Voluntary informed consent to testing is so important that section 9(2) declares that consent to medical testing or review does not constitute consent to an HIV test. This is not mere nitpicking. Stories abound[30] of employers in Papua New Guinea sending employees off for "medical testing" which includes a hidden HIV test, and then accessing the results themselves, so that affected employees first learn of their HIV status via their dismissal notices.

**Qualification of other Acts**

As mentioned above, the preparation of an Act for which responsibility was vested in the National AIDS Council and the Minister for Health enabled a number of indirect exclusions to be made in respect of other legislation, without actually intruding into that legislation by the amendment process. This was done in section 3 (Application of Other Acts. These exclusions are:

• in relation to public health law ¾ HIV and AIDS are not infectious or venereal diseases unde the *Public Health Act*, or quarantinable diseases under the *Quarantine Act*;

• in relation to censorship and criminal law, HIV/AIDS awareness materials are not pornography, or subject to censorship;

• condoms and lubricant are not obscene or pornographic articles under the criminal law.

**Reckless and deliberate transmission**

From the point of view of the Papua New Guinea public, one of the most important matters to be included in the Act was the idea of banning deliberate and reckless transmission. Urban myths abound,[31] and no matter how fanciful or illogical they may be, they are staunchly believed and their power to terrify and appal is undiminished by reason, and they have prompted repeated calls over the years for "an offence" of deliberate transmission.

However, the advice of the International Guidelines is that:

> ...legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases.[32]

It may have been possible to omit all mention of transmission offences, and rely instead upon use of the many relevant offences in the *Criminal Code* should the need arise. However, despite the advice of the Public Prosecutor that proving a case of deliberate transmission would be extremely difficult if the charge were to be contested, it was clear from the many consultations that some reference should be made to transmission offences in the Act. This was seen by some as the main purpose of the Bill, and the inclusion of transmission offences therefore became yet another tool to ensure its successful passage through Parliament.

So section 23 declares that intentional transmission or attempted transmission is an assault occasioning bodily harm, or where death has already occurred, an act of unlawful killing, within the meaning of the *Criminal Code* [Cap 262]. Although prosecutions in terms of the offence of causing grievous bodily harm have been successful in other common law jurisdictions, the Public Prosecutor advised that proving grievous bodily harm in Papua New Guinea usually requires demonstrating visible physical damage, and so the lesser offence of assault occasioning bodily harm was referred to. This is not to say, however, that other charges, such as rape and sexual assault, may not still be proffered, depending on the circumstances.

Successful prosecution is made even more difficult by the defences necessarily offered by the Act:

> (a) the other person was aware of the risk of infection by HIV and voluntarily accepted that risk; or
> (b) the other person was already infected with HIV; or
> (c) where the transmission or attempted transmission is alleged to have occurred by sexual intercourse—

(i) a condom or other effective means of prevention of HIV transmission was used during penetration; or

(ii) the accused person was not aware of being infected with HIV.[33]

Moreover, the duty to take reasonable care under section 286 of the *Criminal Code* is discharged by a person who knows he or he is infected provided reasonable precautions are taken during sexual intercourse, and the partner is informed of the person's HIV status. The same applies in situations of sharing skin penetrative instruments.

For reckless behaviour possibly resulting in transmission or the risk of transmission, a modified version of the recommendations in the Handbook for Legislators was employed.[34] Any form of isolation, detention or quarantine in Papua New Guinea is simply not practicable. A notice system was therefore drawn up, with breach of the notice being made an offence (section 25).

## DEALING WITH INFRINGEMENTS OF THE LAW

The International Guidelines and the Handbook for Legislators both recommend the establishment or strengthening of national bodies for the protection of human rights generally. If HIV/AIDS discrimination is included in general disability discrimination legislation, then presumably some form of anti-discrimination tribunal is already in place. But this is not the case in Papua New Guinea, nor is there a general Human Rights Commission per se.[35] And the establishment of a specialised body to deal with HIV/AIDS discrimination was logistically impossible. The National AIDS Council Secretariat itself was already overworked and under-resourced, and would be incapable of conducting the mediation and adjudication required.

Theoretically, it would be possible to send many matters to court, in the same way that section 57 of the

*Constitution* provides that anyone can take a case of infringement of constitutional rights to the National Court. But the courts of Papua New Guinea are already overloaded in their criminal jurisdictions, and have little time left for civil matters.

This state of affairs very probably pertains in other Pacific jurisdictions as well. However, Papua New Guinea is fortunate in having an excellent alternate forum in the form of the Ombudsman Commission. The establishment of the Ombudsman Commission is governed by the *Constitution*, and its jurisdiction is somewhat wider than the traditionally accepted one of an ombudsman, that of scrutiny of the actions of public officials and governmental bodies. This classic function is provided for in section 219(1)(*a*) of the *Constitution*. But section 219(1)(*c*) gives the Commission a further, little-known power:

> to investigate, either on its own initiative or on complaint by a person affected, any case of an alleged or suspected discriminatory practice within the meaning of a law prohibiting such practices...

The reason for this was the Constitutional Planning Committee's concern over the failure of the (then) *Discriminatory Practices Ordinance* to adequately address racial discrimination, through lack of an adequate enforcement mechanism.[36] A supervisory and watchdog body was needed to investigate complaints and deal with discriminatory action administratively.[37] And so the power was given to the Ombudsman Commission, newly established under the *Constitution* at Independence. Since then, it has been decided that section 55 of the *Constitution* was a law which prohibited discriminatory practices, thereby widening the scope of the jurisdiction. This provided a rationale for the further expansion of the scope of the section, which was achieved in the Act by employing the somewhat old-fashioned terminology of "unlawful act", and declaring in section 27 that all unlawful acts are discriminatory practices within the meaning of *Constitution* section 219(1)(*c*).

Although the Commission's powers of enforcement are limited to 'publicity for its proceedings, reports and recommendations, to the making of reports and recommendations to the Parliament and other appropriate authorities as provided by an Organic Law, and to the giving of advice',[38] nevertheless over the years the Commission's staunchly independent stand, the high calibre of its work, the publicity given to its reports and its power to make recommendations to individuals as well as to government bodies, and to the Public Prosecutor where appropriate[39] have gained it considerable respect. Its recommendations are taken seriously and usually acted upon, especially in the private sphere.

Over the years, the Ombudsman Commission has often adjudicated allegations of discriminatory practices within the meaning of the *Discriminatory Practices Act* and *Constitution* section 55, and made recommendations which are usually acted upon, although this facet of its operations has not attracted the same amount of public attention as its work in other areas of its jurisdiction, notably investigations of breaches of the Leadership Code. However, the Commission is now in the process of establishing a Human Rights Desk which will be able to give fuller attention to rights violations and discriminatory practices, including those under the *HIV/AIDS Management and Prevention Act*.

This is not the only avenue of redress under the Act. Under sections 27-29 in Part V of the Act, criminal prosecution is still possible, and where a professional is involved in the infringement, it may be considered professional misconduct. Recourse may be had to the National or District Court, by the same processes as for infringements of constitutional rights. These courts have the power under section 28 to make a wide range of declarations and orders appropriate to the circumstances of the case. Finally, the taking of action by any one of these avenues does not preclude the taking of further or alternative action by any other means possible under the Act.

## THE OMISSIONS

Despite the wide scope of the Act, and its apparent success in dealing with many of the matters proposed in the framework of human rights and anti-discrimination law, there are nevertheless some matters which have not been dealt with. This is partly because these matters would not properly fall within the responsibility of the National AIDS Council and the Minister for Health,[40] and partly because some of them are highly contentious "hotspots" in Papua New Guinea today.

### Empowerment of women

The International Guidelines, both at Guideline 5 (Anti-Discrimination and Protective Laws) and Guideline 8 (Women, Children and Other Vulnerable Groups) stress the importance of addressing gender inequalities and reducing rights violations. A Legislative Reforms Workshop held in Port Moresby in 2001, when the Act was being prepared, acknowledged the importance of reducing sexual violence. But it could do no more than recommend action by other responsible bodies (action which has been proposed for over a decade but still not implemented in legislation).

Similarly, the Workshop considered the question of decriminalising sex-work, which had already been recommended by the National AIDS Council. But this would be a matter for amendment to the *Criminal Code* (Chapter 262) and the *Summary Offences Act* (Chapter 264), and would need to attract the attention of the Attorney-General's Department. Such a move would in all probability elicit much emotional public outcry.[41]

Lastly, in relation to the rights of women, the International Guidelines make specific reference to the rights of women to make their own independent reproductive choices and to have access to safe and legal abortion. Abortion is illegal in Papua New Guinea, and although the Workshop recommended that consideration be given to the possibility of giving HIV-positive women the choice of abortion, it declined to take the matter further. Meanwhile, increasing numbers of babies are being abandoned in hospitals. A country in which babies had always found secure adoptive or foster-care is now facing the entirely novel phenomenon of AIDS-orphans, and has negligible capability to deal with this.

Overall, the call to enhance the status of women is an ideal which cannot reasonably be achieved in the short term, and certainly not by legislation alone. Women's empowerment is a long-term social goal which few developing nations have tackled with any high degree of success, and the HIV/AIDS epidemic has only served as a set-back in this regard. However, a little progress is better than none, and if it is assumed that HIV/AIDS discrimination is likely to be higher against women who are already the disadvantaged in society, then successful action in respect of that discrimination must be an advance, however small.

### Men who have sex with men

The International Guidelines recommend under Guideline 5, Paragraph 30(h):

> Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men, including in the context of HIV/AIDS, in order, inter alia, to reduce the vulnerability of men who have sex with men to infection by HIV and to the impact of HIV/AIDS... Laws and police practices relating to assaults against men who have sex with men should be reviewed to ensure that adequate legal protection is given in these situations.

In Papua New Guinea, sex between males, regardless of age, is an offence. Despite a large body of anthropological literature on homosexual practice in Papua New Guinea, modern society largely denies

that it goes on, denies that it ever went on, denies that it was ever part of traditional culture. Expatriate homosexuals are blamed for introducing HIV to Papua New Guinea.[42] It seems unlikely that moves to decriminalise homosexuality in Papua New Guinea will achieve much success at this stage.

However, the provisions of the Act enabling action to be taken in respect of persons who are or are presumed to be members of or associated with groups or activities commonly associated with transmission of HIV[43] provide a "backdoor" approach to protecting those engaging in or thought to be engaging in homosexual activity. This also applies to other groups who are unlikely to be decriminalised in the near future, such as sex-workers.

## CONCLUSION

The *HIV/AIDS Management and Prevention Act* 2003 represents a significant advance in promoting the role of human rights in relation to the HIV/AIDS epidemic in Papua New Guinea. Although it is acknowledged that legislation alone cannot effect changes in human behaviour, the Act can assist in providing an enabling environment for management where none existed before. If the Act does nothing more than promote a turnaround in some of the worst excesses of discrimination and stigmatisation, then it will have achieved some of its purposes. Assistance can also come through its giving jurisdiction to the Ombudsman Commission, a much-respected and highly effective body in Papua New Guinea.

Unfortunately, however, the Act is not yet in operation, the reason given being that training and education in the use of the Act has not yet been completed.[44] But such a delay in commencement is not really necessary. The operation of the Act itself can prove to be a training process, as well as facilitating persuasion as to policy development and reform. As with most new legislative regimes, one or two good test cases or inquiries by the Ombudsman Commission may well ensure general compliance thereafter. For example, the Act if in force could have been used to initiate an Ombudsman Commission inquiry into the much-publicised police raid conducted recently on an alleged brothel in Port Moresby, where women and girls were beaten, robbed, publicly humiliated, locked up for more than 24 hours and possibly raped as well, on the grounds that they were sex-workers and in danger of contracting and spreading HIV/AIDS. Revision of workplace policies and practices which insist on inclusion of mandatory testing could be ordered. Sacked employees could be reinstated. Reluctant prison commanders could be persuaded to permit condoms in prisons. And so on. However, while commencement of the Act is delayed, rights abuses continue in Papua New Guinea, and the epidemic spreads.

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[1] See the examples cited in National AIDS Council of Papua New Guinea, *Review of Policy and Legislative Reform relating to HIV/AIDS in Papua New Guinea* (2001) 26.

[2] Government of Papua New Guinea, *Papua New Guinea National HIV/AIDS Medium Term Plan 1998-2002* (1998).

[3] Ibid. p.1.

[4] Ibid. p.34.

[5] Area Objective 3.2. Ibid. p.35.

[6] UNHCHR/UNAIDS, 'HIV/AIDS and Human Rights: International Guidelines' (1996) Second international consultation on HIV/AIDS and human rights, Geneva, 23-25 September 1996 Available at http://www.unaids.org/en/resources/publications.asp

[7] South Pacific Commission *Regional Strategy for the Prevention and Control of STD/AIDS in Pacific Island Countries and Territories* (1997) available at http://www.spc.org.nc/

[8] UNAIDS/IPU (1999) *Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact* (1999) Available at http://www.unaids.org/en/resources/publications.asp

[9] UNHCHR/UNAIDS above n 6, at p.6.

[10] At p.34. See also South Pacific Commission (1997) p.34, UNAIDS/IPU (1999) at pp.24-25.

[11] National AIDS Council (2001) above n 1, p.28.

[12] *Constitution* section 5.

[13] *Constitution* section 18.

[14] *Constitution* section 19.

[15] This largely repeats the provisions of the *Discriminatory Practices Act* [Cap 269], restyled from the pre-Independence *Discriminatory Practices Ordinance* 1963, which applies to:

> '...discrimination either of an adverse or of a preferential kind practiced by a person or group of persons against or in favour of another person or group of persons for reasons only of colour, race or ethnic, tribal or national origin, and in particular includes—
>
> (a) the setting aside of portion of any premises, vessel, aircraft or vehicle the subject of a licence for the exclusive use of persons or a class of persons of a certain colour, race or ethnic, tribal or national origin; and
> (b) the failure to attend to persons in the order that those persons enter or approach any premises, vessel, aircraft or vehicle the subject of a licence; and
> (c) the selling or buying of goods at different prices or on different terms to different persons or classes of persons; and
> (d) a course of conduct which—

(i) distinguishes between persons or classes of persons of differing colours, races or ethnic, tribal or

national origins; and

(ii) may reasonably be expected to result in mental distress or suffering by a person or a member of that class of persons;'

(Section 1, definition of 'discriminatory practice').

[16] *S.C.R. No.2 of 1984: Re Medical Privilege* [1985] PNGLR 247.

[17] For example, action by the Censorship Board in 1992 to ban supply of graphic instructions for condom use was proposed as a case for arguing that the right to life was infringed through the withholding of essential life-saving information. A case of non-consensual HIV testing by a construction company followed by dismissal of those believed to be positive arose in 2000. Preparatory documents were forwarded to the Solicitor-General but no further action has yet been taken. However, the matter of treatment of a number of women and girls during a recent police raid on an alleged brothel in March 2004, which was carried out with the expressed intention of assisting to prevent the spread of HIV/AIDS, is being pursued at present by the Ombudsman Commission.

[18] Many of these reports were verbal only, but from reliable sources. For the most recent published report, see posting on behalf of Lawrence Hammar to AIDSTOK (aidstok@lyris.spc.int) 28th June 2004, Ms. in files of author, reported (somewhat inaccurately) in the Post-Courier newspaper, 'Beaten and Shunned because she had AIDS' http://www.postcourier.com.pg Wednesday 7th July 2004.

[19] So acute is this problem that when the Minister for Community Development in 2002 wished to amend the *Criminal Code* and the *Evidence Act*, both the responsibility of the Minister for Justice, in respect of sexual offences, she was obliged to bring the amendments to Parliament as private member's Bills.

[20] See for example the Australian Commonwealth *Disability Discrimination Act* 1992; the NSW *Anti-Discrimination Act* 1977; the Hong Kong *Disability Discrimination Ordinance* (Cap. 487); the New Zealand *Human Rights Act* 1993.

[21] See for example the Australian Commonwealth *Disability Discrimination Act* 1992 s.4, Hong Kong *Disability Discrimination Ordinance* [Cap 487] s.1, definition of 'disability'.

[22] This is not idle speculation. Despite a lengthy program designed to present conclusive arguments against mandatory testing, participants at a public sector workplace policy workshop in 2002 doggedly insisted on testing the entire Public Service, regularly at 3-monthly intervals if necessary, with the results to be accessible to top management i.e. themselves.

[23] UNHCHR/UNAIDS (1996) above n 6, para .30(a), p.12.

[24] Ibid.

[25] Not all of the Guidelines' recommendations could be included in the Act. For a discussion of omissions, see below.

[26] See note 15 above for the wording of this definition.

[27] The so called literal rule of statutory interpretation, that calls for words to be given their ordinary meaning is, however, subject to some modifications in order to avoid absurdities or to prevent the purpose

of the legislation being defeated. See Catriona Cook *et al*, *Laying Down the Law* (5th ed, 2001) 208 ff.

[28] As to compensation demands, see the story which opens the article by Christine Stewart and Pascoe Kase, 'Law, Custom and the HIV/AIDS Epidemic in Papua New Guinea' in Robert Glick (ed.), *Law, Ethics and HIV* (1993).

[29] At p.45.

[30] This process, and the subsequent dismissal of workers, by a construction company working on an AusAID-funded project in 2000 was to become the subject of a test case based on infringement of human rights. Unfortunately the case appears to have lapsed in the Attorney-General's Department. Similar tales about other employers were confidentially communicated to the author in 2001-2002, while the Bill was being prepared.

[31] I have heard tales, over the years, of youths circulating through Gordon's Market with syringes full of blood; visiting expatriate women who lure young Papua New Guinean men to their hotel rooms for sex and reveal their positive status afterwards; bags of blood being transported to the Highlands to be mixed into supermarket meat supplies; and so on.

[32] Guideline 4, para. 29(*a*), p.11. And see also Elliott, Richard and Miriam Maluwa, 'Criminal Law, Public Health and HIV Transmission: A Policy Options Paper' Geneva 2002.

[33] Section 23(3).

[34] UNAIDS/IPU, above n 8, pp. 45 ff.

[35] Proposals for such a Commission for Papua New Guinea, although worked on for many years, eventually foundered on the shoals of totally inadequate financial and human resources.

[36] Only a minor level of offence with small penalty was provided in the legislation.

[37] Final Report of the Constitutional Planning Committee 1974, p.11/5 para. 43.

[38] *Constitution* section 219(6).

[39] *Organic Law on the Ombudsman Commission* section 22(2).

[40] For a description of the problems of legislating in a cross-portfolio, see note 19 above.

[41] Nevertheless, the National AIDS Council is currently working on this specific matter.

[42] This is given some street-credence by the fact that the first person to die of AIDS in Papua New Guinea was an expatriate homosexual. But the argument clearly overlooks all the other obvious avenues of introduction of HIV into Papua New Guinea.

[43] See above for discussion of objects of discrimination.

[44] Information from Dr. N. Moiya, National AIDS Council Secretariat Director, posted to AIDSTOK (aidstok@lyris.spc.int) 27/3/04, Ms. in files of author.

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