

**THIRD PARTY INTERVENTION  
IN THE EUROPEAN COURT OF HUMAN RIGHTS**

**Application No. 4982/07**

**Between**

**CENTRE FOR LEGAL RESOURCES ON BEHALF OF VALENTIN  
CAMPEANU**

**Applicant**

**and**

**ROMANIA**

**Respondent**

**WRITTEN COMMENTS**

**by Human Rights Watch**

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## **I. Introduction**

1. These written comments are submitted by Human Rights Watch in accordance with the permission granted by the President of the European Court of Human Rights (the “Court”) by letter dated September 12, 2011 in accordance with Article 36 §2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the “European Convention”) and Rule 44 §2 of the Rules of Court of the Court.

2. The present case, *Centre for Legal Resources on behalf of Valentin Campeanu v. Romania*, raises critical questions with regard to the treatment of individuals with disabilities and HIV including: the intersection between disability, HIV, and children’s rights. It presents an opportunity to develop jurisprudence on previously untouched areas of disability discrimination. It is suggested that an account of accepted principles of international law and practice should inform this case.

3. Human Rights Watch aims to assist the Court by providing an international legal context in which to consider the issues presented before it. These written comments draw on rights-based analyses of selected laws and jurisprudence from the international system to illuminate the particular vulnerabilities of persons with disabilities, including particular vulnerabilities with respect to HIV infection and children with disabilities, and the appropriate support for such persons.

4. First, this submission addresses the relevant principles of international law relating to disability and HIV, highlighting the intersection between these two.

5. Second, this submission addresses the relevant principles of international law as applicable to discrimination against HIV-positive children and young people.

6. Last, this submission addresses the distinction between intellectual disability and mental health and the requirements of international law in terms of care, treatment and support for these conditions.

## **II. Interest of Human Rights Watch**

7. Human Rights Watch is an international non-governmental organisation that conducts research and advocacy on human rights. Human Rights Watch has focused on issues surrounding HIV and human rights for many years, and more recently has developed a specialism in discrimination against persons with disabilities. Human Rights Watch has previously submitted comments before the European Court in a number of cases.

8. For the past several years we have monitored the concerns related to children with HIV in Romania. In 2006, Human Rights Watch produced a comprehensive report documenting Romania's failure to protect children and youth living with HIV. Many of the abuses highlighted therein are evidenced in this case.

9. In addition, Human Rights Watch has developed a body of knowledge and expertise on other matters arising from this case. In 2010, Human Rights Watch produced a detailed report relating to the long term institutionalisation of individuals with intellectual and mental disabilities in Croatia, and has continued to monitor issues surrounding prejudice, discrimination, and abuses suffered by individuals with HIV and AIDS in various countries around the world.

10. We have, therefore, consciously focused on HIV as a disability rights issue. This focus is reflected in our recent report on discrimination and violence against women with disabilities in Uganda published in 2010.<sup>1</sup>

## **III. Principles of International Law Relating to Disability and HIV**

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1 Human Rights Watch, "As If We Weren't Human", August 26, 2010, <http://www.hrw.org/node/92610/section/>

11. Fundamental principles of international law relating to the rights of persons with disabilities are enshrined in international instruments, including the Convention on the Rights of Persons with Disabilities (the “CRPD”), the International Covenant on Economic, Social and Cultural Rights (the “ICESCR”), and the International Covenant on Civil and Political Rights (the “ICCPR”). Important principles of international law related to health, including the fundamental human right to the highest attainable standard of health, are also enshrined in these three instruments, as well as in the Universal Declaration of Human Rights (the “Universal Declaration”) and the Convention on the Elimination of all Forms of Discrimination Against Women (“CEDAW”).

**a. CRPD**

12. The CRPD does not define disability, but instead describes persons with disabilities to “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”<sup>2</sup> This approach to disability, and how it is to be defined, is a more progressive and appropriate one based on the “social” rather than the “medical” model. Disability is therefore judged by reference to the impact on usual daily activities rather than on the question of whether there is or is not a clinical diagnosis of a particular kind. While the CRPD does not explicitly designate HIV or Advanced HIV infection (AIDS) as a disability, HIV may impact the ability of people to carry out daily activities and may cause visual or physical disabilities. Indeed, a number of countries recognize HIV infection as a disability for purposes of their national anti-discrimination laws and social benefit schemes.<sup>3</sup>

13. Article 5 of the CRPD provides that persons with disabilities are entitled, without any discrimination, to equal enjoyment of the protections and benefits of the law, including all human rights and fundamental freedoms. Under the CRPD, governments are required to protect a broad range of rights of persons with disabilities, including the

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<sup>2</sup> Art. 1.

<sup>3</sup> These countries include the United States and Australia

rights to education,<sup>4</sup> access to information in appropriate formats,<sup>5</sup> and individual autonomy and independence.<sup>6</sup> Through the provision of habilitation and rehabilitation services and programs, states must also “take effective and appropriate measures . . . to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social, and vocational ability, and full inclusion and participation in all aspects of life.”<sup>7</sup>

14. Article 25 of the CRPD provides that the right to enjoyment of the highest attainable standard of physical and mental health must be upheld “without discrimination on the basis of disability”. States are affirmatively required to provide persons with disabilities with the same quality and standard of health care and related programs as provided to other people, including in the areas of sexual and reproductive health and population-based programs.<sup>8</sup>

15. Article 4(3) of the CRPD provides that in fulfilling their legislative and policy obligations pursuant to the CRPD, which includes planning and carrying out policies and programs related to HIV and AIDS, states must “closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.”

## **b. ICESCR**

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<sup>4</sup> Art. 24.

<sup>5</sup> Art. 21.

<sup>6</sup> Arts. 3, 16, 19, and 22.

<sup>7</sup> CRPD, art. 26.

<sup>8</sup> CRPD, art. 25.

16. The ICESCR provides that all persons, including persons with disabilities, are entitled to a variety of economic, social and cultural rights, including the rights to work,<sup>9</sup> social security,<sup>10</sup> family life,<sup>11</sup> an adequate standard of living,<sup>12</sup> and education.<sup>13</sup> Article 12 of the ICESCR states that all persons have the right to the enjoyment of the highest attainable standard of physical and mental health. The ICESCR obliges governments to take specific, affirmative steps to achieve the full realization of this right, including those steps necessary “for the prevention, treatment and control of epidemic, endemic, occupational and other diseases”.<sup>14</sup>

17. Non-discrimination is a core principle in the ICESCR and imposes upon governments the affirmative obligation to ensure that the rights in the ICESCR are exercised “without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”<sup>15</sup> The Committee on Economic, Social and Cultural Rights (the “ICESCR Committee”), which

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<sup>9</sup> Art. 6.

<sup>10</sup> Art. 9.

<sup>11</sup> Art. 10.

<sup>12</sup> Art. 11.

<sup>13</sup> Art. 13.

<sup>14</sup> Art. 12.

<sup>15</sup> Art. 2.

is charged with interpreting the ICESCR, has expressly stated that persons with disabilities are a protected category within “other status”.<sup>16</sup>

18. The ICESCR Committee has stated that “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds,” including “health status”.<sup>17</sup> The ICESCR Committee explicitly included HIV/AIDS within health status.<sup>18</sup> Physical accessibility requires that health facilities, goods, and services are within safe physical reach for all sections of the population, especially vulnerable and marginalized groups, such as women or children with disabilities. Such equal access may require extra measures on the part of the government.

19. The right to the highest attainable standard of health is subject to “progressive realization”, pursuant to which governments have a “specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right].”<sup>19</sup> States must guarantee the right to health by adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines.

20. The ICESCR Committee, which also monitors implementation of the ICESCR, has provided examples of what may constitute a failure by a government to fulfill its obligations with respect to the right to health. The examples include failing to adopt or implement a national health policy designed to ensure the right to health for everyone, insufficient expenditure or misallocation of available public resources that leads to the

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<sup>16</sup> ICESCR Committee, General Comment No. 5, para. 5.

<sup>17</sup> ICESCR Committee, General Comment No. 14, paras. 12(b) and 18.

<sup>18</sup> ICESCR Committee, General Comment No. 14, para. 18.

<sup>19</sup> ICESCR Committee, General Comment No. 14, paras. 30 and 31.

non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalised, and the failure to reduce infant and maternal mortality rates.<sup>20</sup>

**c. ICCPR**

21. Under the ICCPR, governments must protect the rights of all persons to life,<sup>21</sup> physical integrity,<sup>22</sup> liberty and security of person,<sup>23</sup> and procedural fairness in law.<sup>24</sup>

22. Article 26 of the ICCPR provides that “[a]ll persons are equal before the law and are entitled without any discrimination to the equal protection of the law.” The law must “prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”<sup>25</sup>

**d. Intersection between Disability and HIV**

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<sup>20</sup> ICESCR Committee, General Comment No. 3, paras. 10 and 12.

<sup>21</sup> Art. 6.

<sup>22</sup> Art. 7.

<sup>23</sup> Arts. 9 and 10.

<sup>24</sup> Arts. 14, 16, and 17.

<sup>25</sup> Art. 26.

23. It is often assumed that people with disabilities are at a lower risk of HIV infection than people without disabilities, building on myths that persons with disabilities are asexual, are less likely to use drugs or alcohol, and are at low risk of violent and sexual assault.

24. Recent research, however, indicates that the rate of infection among persons with disabilities globally is up to three times higher than people without disabilities.<sup>26</sup> Persons with disabilities are at higher risk of HIV than the general population because of a lack of information and education, and increased vulnerability to violence, including sexual violence.

25. Individuals with disabilities are as likely to be sexually active as people without disabilities, but are less likely to have access to information about safe sex and methods of preventing HIV, such as condoms.<sup>27</sup> From childhood, persons with disabilities are at an educational disadvantage with respect to sexual health issues because they are often shut out of schools, either actually or effectively. The World Bank estimates that as many as 97% of all individuals with disabilities are illiterate.<sup>28</sup>

26. Other misconceptions about disability and HIV also increase the risk of infection among individuals with disabilities. For example, Human Rights Watch found that people in northern Uganda believe that women with disabilities are asexual and thus uninfected or even that sex with a woman with a disability can cure AIDS.<sup>29</sup>

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<sup>26</sup> World Bank Social Development Department, "Social Analysis and Disability: A Guidance Note, Incorporating Disability-Inclusive Development into Bank-Supported Projects," March 2007,

27. From our research in northern Uganda, there is evidence that women with disabilities are frequently abandoned by their partners, thereby increasing the number of partners that these women have over time and heightening their risk of HIV infection.<sup>30</sup>

28. In northern Uganda, Human Rights Watch found that individuals with disabilities are up to three times more likely to be victims of physical and sexual abuse than persons without disabilities. In addition, persons with disabilities who do become the victims of such abuse often lack access to proper medical care and treatment, including mental health care.<sup>31</sup>

#### **IV. Principles of International Law Applicable to Discrimination against HIV-Positive Children and Young People**

29. The CRPD, the ICESCR, the ICCPR, the Universal Declaration and CEDAW all incorporate protections of children. In addition, the Convention on the Rights of the Child (the “CRC”) specifically addresses human rights in the context of their applicability to children.

##### **a. CRPD**

30. Article 7 of the CRPD provides that states must “take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.” In addition, the CRPD states that “the best interests of the child” is of paramount concern.<sup>32</sup> Article 7 also

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obliges states to “ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.”

**b. CRC**

31. Under the CRC, governments have an obligation to protect the human rights of all children, including children with disabilities. The rights set out in the CRC must be applied without discrimination based on disability.<sup>33</sup>

32. Article 2 of the CRC requires states to take all appropriate measures to ensure that children are protected from discrimination “irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.” The Committee on the Rights of the Child, which is the body that interprets the CRC (the “CRC Committee”), has interpreted “‘other status’ . . . to include HIV/AIDS status of the child or his/her parents(s).”<sup>34</sup>

33. The CRC imposes obligations on states to affirmatively address discrimination and to take steps to prevent it. The CRC Committee has underlined “the necessity of providing legal, economic and social protection to affected children to ensure their access to education, inheritance, shelter and health and social services, as well as to make them feel secure in disclosing their HIV status and that of their family members when the children deem it appropriate.”<sup>35</sup>

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34. Articles 3, 20, and 25 of the CRC address the best interests of the child, children deprived of their family environment, and the review of treatment, respectively. Regarding children affected and orphaned by HIV, the CRC Committee has interpreted these three articles to include the requirement that states provide assistance “so that, to the maximum extent possible, children can remain within existing family structures.”<sup>36</sup> Where this is not possible, the CRC Committee calls on states to provide, “as far as possible, for family-type alternative care (e.g. foster care)” and states that “any form of institutionalized care for children should only serve as a measure of last resort.”<sup>37</sup>

35. Article 19 of the CRC requires states parties to take all appropriate measures to protect children from “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardians(s) or any other person who has the care of the child.”

36. The CRC Committee indicated that children with disabilities are “five times more likely to be victims of abuse,” including mental and physical violence and sexual abuse. The CRC Committee recommends that governments educate parents on the risks and signs of abuse, train hospital and school staff, and take the necessary steps to prevent violence or abuse against children with disabilities.<sup>38</sup>

37. Article 20(1) of the CRC provides that “a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.” This provision reinforces Article 24(1) of the ICCPR,

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which guarantees every child “the right to such measures of protection as are required by his status as a minor.”

38. Article 23 of the CRC recognizes the additional right of a child with a mental or physical disability to special care and, subject to available resources, to appropriate assistance “designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child’s achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.”

39. According to the CRC Committee, the obligation of governments under international law relating to disability and health “extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a basis of non-discrimination.”<sup>39</sup> Expressing concern that “children with disabilities, indigenous children, children belonging to minorities, children living in extreme poverty or children who are otherwise marginalized in society” may not be able to access the HIV-related health services that are available, the CRC Committee has noted that states parties “must ensure that services are provided to the maximum extent possible to all children living within their borders.”

40. Recognizing that adolescents have special health and development needs, the CRC Committee has further emphasized that the right to health obligates states to give “sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development.”<sup>40</sup> This includes the idea that the right of adolescents “to express views freely and have them duly taken into account is also . . . fundamental”.<sup>41</sup> Of particular importance is that “[a]dolescents have the right to access

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adequate information essential for their health and development and for their ability to participate meaningfully in society” and it is the obligation of the government to provide “accurate and appropriate information on how to protect their health and development and practice healthy behaviours.”<sup>42</sup> The government is also required to “provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives . . . [and] the prevention of HIV/AIDS”.<sup>43</sup>

## **V. Distinction Between Intellectual Disability and Mental Health**

41. The terminology used in the disability rights field to describe mental disabilities is often inconsistent and undefined. The following are clarifications of these terms:

- An “intellectual disability” (*e.g.*, Down Syndrome) is a disability that is characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. “Intellectual disability” forms a subset within the larger universe of “developmental disability”, but the boundaries are often blurred as many individuals fall into both categories to differing degrees and for different reasons.
- A “learning disability” (*e.g.*, dyslexia) describes a permanent condition that affects the way individuals take in, retain, and express information. The skills most often affected are reading, writing, listening, speaking, reasoning, and doing math. A learning disability is not indicative of intelligence level.<sup>44</sup>

- A “developmental disability” is an umbrella term that refers to any disability starting before the age of 22 and continuing indefinitely (*i.e.*, likely life-long).<sup>45</sup> A developmental disability limits one or more major life activities such as self-care, language, learning, mobility, self-direction, independent living, or economic self-sufficiency.<sup>46</sup> While this includes intellectual disabilities, it also includes conditions that do not necessarily have a cognitive impairment component (*e.g.*, cerebral palsy, autism, epilepsy and other seizure disorders). Some developmental disabilities are purely physical, such as sensory impairments of congenital physical disabilities. It may also be the result of multiple disabilities.
- A “psychosocial disability” (*e.g.*, depression, bipolar disorder, schizophrenia) is a mental health problem that involves the interaction between psychological differences and social and cultural limits for behavior, including the stigma that society attaches to persons with mental impairments.
- “Mental disabilities” sometimes refer to mental health problems or can be used collectively to refer to intellectual and psychosocial disabilities.

42. Intellectual disability and psychosocial disability/mental health problems are often confused. Whereas psychosocial disability may be temporary in nature and can sometimes be effectively treated, an intellectual disability is a life-long condition. Proper diagnosis and categorization is important (1) because of the different implications of treatment and (2) from an international law perspective, because of the impact on the realization of various protected human rights, especially the rights to the highest attainable standard of health, integration into society, education, and rehabilitation.

## **V. Conclusion**

43. The present case, *Centre for Legal Resources on behalf of Valentin Campeanu v. Romania*, raises critical questions with regard to the treatment of individuals with disabilities and HIV including: the intersection between disability, HIV, and children's rights. It is important that the principles of international law and practice related to disability and HIV inform the Court's decision of this case.