

HUMAN RIGHTS UNDER THREAT: FOUR PERSPECTIVES ON HIV, AIDS AND THE LAW IN SOUTHERN AFRICA

Frans Viljoen and Susan Precious (eds)

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Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa

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Preface

Despite the fact that Southern Africa is the epicenter of the HIV epidemic, there is a shortage of research and reflection coming from the sub-region itself. With the support of Open Society Initiative for Southern Africa (OSISA), the AIDS and Human Rights Research Unit, based at the Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria, in 2006 engaged in a research project to give a voice to Southern African perspectives on issues pertaining to HIV, AIDS, law and human rights. Four researchers were selected to address four human rights-related issues of increasing importance in the context of HIV and AIDS in the sub-region. These issues are: (1) legislation criminalising the wilful transmission of HIV and its potential or actual impact on marginalised and vulnerable groups; (2) policies aimed at routinely testing individuals attending public health facilities; (3) policies and practices aimed at withholding or denying access to HIV-related treatment and prevention to people living with HIV and AIDS, particularly men in prisons; and (4) policies, practices and laws that limit access to medicines, in particular the lack of domestication and use of flexibilities allowed for under the World Trade Organisation's Agreement on the Trade Related Aspects of Intellectual Property Rights (TRIPS).

The four researchers were hosted by four research institutions in Southern Africa, where they prepared four research papers. The four institutions are: the AIDS and Rights Alliance of Southern Africa (ARASA), based in Windhoek, Namibia; the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), based in Gaborone, Botswana; the Law and Development Unit, Faculty of Law, University of Malawi, Blantyre, Malawi; and the AIDS and Human Rights Research Unit, University of Pretoria, Pretoria, South Africa. These papers were first discussed at a regional workshop, held in Pretoria in July 2006, where various stakeholders gave constructive criticism and comments. Thereafter, the papers were further reworked and reviewed, and, in August 2006, they were presented at the International AIDS Conference in Toronto, Canada. This publication brings together these four papers, an introduction, and some useful SADC instruments. An independent peer review of the papers was conducted before publication.

This publication appears in tandem with a collection of country reports on HIV, AIDS and human rights from nine states in Southern Africa (AIDS and Human Rights Research Unit *Human rights protected? Nine Southern African country reports on HIV and the law*). OSISA also sponsored this research and publication.

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Editors
July 2007

List of acronyms and abbreviations

AHRLR	-	African Human Rights Law Reports
AIDS	-	acquired immune deficiency syndrome
ARASA	-	AIDS and Rights Alliance of Southern Africa
ART	-	anti-retroviral treatment
ARVs	-	anti-retroviral medicines
AU	-	African Union
AZT	-	zidovudine
BCLR	-	Butterworths Constitutional Law Reports
BLR	-	Botswana Law Reports
BONELA	-	Botswana Network on Ethics, Law and HIV/AIDS
CDC	-	Centers for Disease Control and Prevention (US)
CESCR	-	Committee on Economic, Social and Cultural Rights
CEDAW	-	Convention on the Elimination of All Forms of Discrimination against Women
CIOMS	-	Council for International Organisations of Medical Sciences
CRC	-	Convention on the Rights of the Child
DRC	-	Democratic Republic of Congo
ELISA	-	enzyme-linked immunosorbent assay
HAART	-	highly active anti-retroviral therapy
HCT	-	HIV counselling and testing
HIV	-	human immunodeficiency virus
HDI	-	Human Development Index
HRC	-	(UN) Human Rights Committee
GIPA	-	greater involvement of people living with HIV and AIDS
GPL	-	Gauteng Provincial Legislature
ICCPR	-	International Covenant on Civil and Political Rights
ICESCR	-	International Covenant on Economic, Social and Cultural Rights
IPU	-	Inter-Parliamentary Union
IRIN	-	(UN) Integrated Regional Information Networks
KAP	-	knowledge, attitudes and practices
LDC	-	least developed country
MMWR	-	Morbidity and Mortality Weekly Report (CDC)
MOHCW	-	Zimbabwean Ministry of Health and Child Welfare
MSF	-	<i>Médecins sans frontières</i>
MSM	-	men who have sex with men
MSP	-	manufacturer's selling price
NDI	-	National Democratic Institute for International Affairs
OAU	-	Organisation of African Unity
OHCHR	-	Office of the High Commissioner for Human Rights
OSISA	-	Open Society Initiative for Southern Africa
PEPFAR	-	President's Emergency Plan for AIDS Relief (US)
PCP	-	<i>pneumocystis carinii pneumonia</i>
PCR	-	polymerase chain reaction
PLWHA	-	people living with HIV and AIDS
PMTCT	-	prevention of mother to child transmission
SA	-	South African Law Reports
SADC	-	Southern African Development Community
SADC PF	-	SADC Parliamentary Forum
SADCC	-	Southern African Development Coordination Conference
STD	-	sexually transmitted disease
STI	-	sexually transmitted infection
TB	-	tuberculosis
TAC	-	Treatment Action Campaign

TRIPS	-	Agreement on Trade Related Aspects of Intellectual Property Rights
UN	-	United Nations
UNAIDS	-	United Nations Joint Programme on HIV and AIDS
UNDP	-	United Nations Development Programme
UNGASS	-	United Nations General Assembly Special Session
USAID	-	United States Agency for International Development
VCLT	-	Vienna Convention on the Law of Treaties
VCT	-	voluntary counselling and testing
WHO	-	World Health Organisation
WIPO	-	World Intellectual Property Organisation
WTO	-	World Trade Organisation
WMA	-	World Medical Association

1 Introduction: Human rights under threat in attempts to address HIV and AIDS

Frans Viljoen and Susan Precious***

- 1 Human rights are not slowing down the response
- 2 Making the same mistake twice
- 3 Towards universal standards of prevention, treatment and care
- 4 The HIV epidemic in Southern Africa
- 5 HIV, AIDS, human rights and the law in Southern Africa – new debates and strategies
- 6 SADC – towards a common approach?

At the closing session of the 16th International AIDS Conference, in Toronto, Canada, the then UN Special Envoy for HIV and AIDS in Africa made the following remarks with respect to male circumcision:¹

Circumcision, as a preventive intervention, should not be subject to bureaucratic contemplation forever. We have enough information now to know that it is an intervention worth pursuing. What remains is a single-minded effort to get the word out, respect cultural sensitivities, and then for those who want to proceed, make certain that we have well-trained personnel to do the operating.

No one would disagree with the Special Envoy's plea to deal with the HIV pandemic as the emergency that it is. It is clear that government response must be stepped up immediately. What appears to creep into the statement above, though, is what is becoming a widely held perception that in cases of public emergencies, human rights are secondary concerns.

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¹ Remarks by Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, to the closing session of the XVI International AIDS Conference, Toronto, Canada (18 August 2006).

The fact of the matter is that we do not yet know enough about male circumcision to warrant no further investigation on the topic,² and we have certainly not fully considered the very real risk of sending out the wrong message – that circumcision alone is an adequate method of protection. This new and hasty push for circumcision as the next great HIV prevention mechanism relied primarily on figures from the Orange Farm Intervention Trial in South Africa, which showed that men who are circumcised are at least 60 per cent less likely to contract HIV than those who are not.³ The problem is that, at best, this only represents a reduced risk of 60 per cent – but what of the other 40 per cent? The unquestioned acceptance of circumcision risks creating a false sense of security and increasing the likelihood of unprotected sex and thus, HIV transmission.⁴ Although this book does not deal with circumcision, the way in which it has been held out as a ‘quick fix’ without giving due consideration to human rights corresponds to the way in which criminalisation of HIV transmission and routine offers of HIV testing have been portrayed as easy solutions. These two issues are discussed in great depth below.⁵

The notion that human rights can be swept aside in cases of emergencies is not new. This was clearly seen in the ‘War on Terror’ where historically and constitutionally entrenched civil and political rights such as the right to a fair trial, to speak to a legal representative, and to be free from torture were suddenly suspended, viewed as secondary, or even as irrelevant, in the face of a threat that was perceived to overshadow the risk to human rights.⁶ This same phenomenon is now gaining momentum in the case of HIV and AIDS.

This introduction attempts to show that, firstly, it is not human rights that are slowing down the response but rather: a failure on the part of many governments to take decisive action, insufficient collaboration between civil society and government, and a failure of the international community to unequivocally and unconditionally

² There are ongoing trials in Kenya and Uganda that are scheduled to end between July and September 2007, the results of which will be important in validating or disproving results from the Orange Farm Intervention Trial that was conducted in South Africa. See World Health Organisation (WHO) ‘Male circumcision update: Ongoing clinical trials are key to validating the link between male circumcision and protection against HIV infection’ (17 August 2006).

³ As above.

⁴ According to a UNAIDS country survey, http://www.unaids.org/en/Regions_Countries/Countries/default.asp (31 January 2007), the percentage of people between 15 and 24 that reported using a condom the last time they had sex with a casual partner was as follows for a number of countries in Southern Africa (percentages are given for men and women separately): Angola (64%, 55%); Botswana (88%, 75%); Lesotho (48%, 50%); Madagascar (12%, 5%); Malawi (47%, 35%); Mozambique (33%, 29%); Tanzania (47%, 42%); Zambia (40%, 35%); and Zimbabwe (57%, 43%). Corresponding figures for the other SADC countries were not available.

⁵ UNAIDS 2006 *Report on the global AIDS epidemic* (2006) 15.

⁶ See RA Wilson (ed) *Human rights in ‘the war on terror’* (2005).

support attempts to effectively address HIV and AIDS. Secondly, there is a failure to recognise that side-stepping human rights risks making the same mistakes twice. We now know that HIV is not just a medical problem in need of a medical solution. The people in society that are most susceptible to infection are those that are most vulnerable to human rights violations. Thirdly, ignoring human rights in cases of public health emergencies carries the implicit conclusion that members of the developing world are somehow less worthy of human rights protection than their counterparts in the developed world. Ultimately, this introduction argues that the protection of human rights is the only real solution to this immediate and pressing crisis.

1 Human rights are not slowing down the response

One of the reasons most often advanced to justify the erosion of human rights is that there is not enough time to deal with human rights issues in the face of an emergency. This reasoning is flawed on two counts. First, there seems to be a perception that the protection of human rights requires too much time. However, it is difficult to see how many of the human rights in the context of HIV and AIDS take up any time at all. A discrimination-free workplace and patient-doctor confidentiality, for example, require no time.

Second, there is an implicit assumption that skipping over the protection of human rights will mean being able to control and reverse the epidemic. However, the solution to the AIDS crisis is not as simple as testing every person and disclosing their status. It is a highly complex crisis that requires deep-rooted and long term changes, such as gender equality, institutional capacity and resources, and an end to poverty. Ignoring these in the short-term will only delay reversing the epidemic, cost more money, and most importantly, cost more lives.

Political leadership can, however, delay a successful response to HIV. In sub-Saharan African countries, the general population is confused because there has not been clarity in declaring HIV a national emergency. Proper responses simply cannot flow until this declaration has been made clearly and publicly and incorporated into all of the relevant national legislation and plans for strategic direction.

The international community has also failed to unequivocally recognise HIV as the human disaster that it is. International assistance

is often short term and tied to conditions that run counter to responsible HIV management programmes.⁷

2 Making the same mistake twice

The HIV pandemic is not just a medical problem, but one that cuts across gender, development and human rights issues. As Mary Crewe, Director of the Centre for the Study of AIDS at the University of Pretoria, has stated:

HIV and AIDS have brutally exposed all the fault lines of our society – poverty, gender inequality, violence, lack of access to education, health care and social service as well as the importance of employment and social security.⁸

In a broader context, Christine Chinkin, professor in international law at the London School of Economics, aptly stated that the ‘denial of human rights is both a cause and a consequence of being poor’.⁹ Her statement is equally applicable in the context of HIV and AIDS. While human rights violations and plummeting human development indicators are painfully visible results of the HIV pandemic, they are also among the key drivers that have caused the epidemic to have spread and ravaged the sub-continent at such a rapid pace.¹⁰ Eroding the human rights of those living with, affected by, or vulnerable to HIV infection will only further marginalise those individuals and propel the epidemic to new heights.

3 Towards universal standards of prevention, treatment and care

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides that state parties recognise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.¹¹ Article 12(2) of the Covenant

⁷ Some countries have tied funding to the condition of non-discussion of condom usage, a concept nearly impossible to eliminate from any reasonable and responsible prevention strategy.

⁸ Statement made by Mary Crewe, Director of the Centre for the Study of AIDS at the University of Pretoria during her presentation ‘AIDS – democracy, development and human rights’ given at the Stakeholder Consultation on Gender, Human Rights and HIV & AIDS: A UNDP-OHCHR Joint Initiative for Southern and Eastern Africa, Rosebank Hotel, Johannesburg, 27-29 June 2006.

⁹ C Chinkin ‘The United Nations Decade for the Elimination of Poverty: What role for international law?’ (2001) 54 *Current Legal Problems* 556.

¹⁰ AIDS and Human Rights Research Unit *A review of regional and national human rights based HIV and AIDS policies and frameworks in Eastern and Southern Africa* Report for the UNDP-OHCHR Joint Initiative for Eastern and Southern Africa (September 2006) 16.

¹¹ Art 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

requires states to take steps to achieve the realisation of this right.¹² General Comment 14 further elaborates on the content of the right to health by explaining that its entitlements include ‘the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health’ and ‘a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health’.¹³ This General Comment further underlines that the right to health includes access to health-related education and information, including education and information on sexual and reproductive health.¹⁴ The General Comment notes that public health issues are sometimes used as justifications to limit the right to health but that the Covenant’s limitation clause is intended for the opposite purpose: to protect the rights of individuals.¹⁵

The right to health is therefore tied to broader socio-economic conditions, systems, facilities and infrastructure, information and education, all of which are directed towards the highest attainable standard of health. Calls to erode human rights protections and lower the standard of care in order to respond to the HIV epidemic, therefore, run completely counter to the right to health.

The call to set aside human rights also highlights the unacceptable belief on the part of some that the human rights of those living in the developing world are more expendable than those living in the West. This asymmetry presented itself plainly in the use of placebos in HIV clinical drug trials conducted in developing countries where researchers (overwhelmingly funded by the West) administer placebos to trial participants despite the fact that treatment is available.¹⁶ A deep-rooted sense that those in need are either not deserving or are not in a position to demand the same level of treatment and standard of care as others elsewhere in the world remains. But how can it ever be justifiable to fall below a minimum standard of care?

4 The HIV pandemic in Southern Africa

Southern Africa remains the epicentre of the global HIV pandemic. Thirty-four per cent of all AIDS deaths occur in the Southern African

¹² Art 12(2) of the ICESCR.

¹³ The right to the highest attainable standard of health: 11/08/2000 E/C.12/2000/4 (General Comments) para 8 & 9.

¹⁴ The right to the highest attainable standard of health: 11/08/2000 E/C.12/2000/4 (General Comments) para 11.

¹⁵ The right to the highest attainable standard of health: 11/08/2000 E/C.12/2000/4 (General Comments) para 28.

¹⁶ See, for example, P Lurie & S Wolfe ‘Unethical trials of interventions to reduce perinatal transmission of the human immunodeficiency virus in developing countries’ (1997) 337(12) *The New England Journal of Medicine* 853-856.

region.¹⁷ Swaziland has the highest HIV prevalence in the world (33.4 per cent of the adult population); and South Africa shares with India the highest number of HIV infected people (some 5.5 million people). The following graph of HIV prevalence rates among adults (aged 15 - 49) in Southern Africa confirms this:

Table A: Estimated HIV prevalence in SADC countries (adults aged 15-49)¹⁸

Country	2003 (%)	2005 (%)
Angola	3.9	3.7
Botswana	37.3	24.1
DRC	4.2	3.2
Lesotho	28.9	23.2
Madagascar	1.7	0.5
Malawi	14.2	14.1
Mozambique	12.2	16.1
Namibia	21.3	19.6
South Africa	21.5	18.8
Swaziland	38.8	33.4
Tanzania	8.8	6.5
Zambia	16.5	17.0
Zimbabwe	24.6	20.1

From the table, it appears that nine countries have an adult prevalence rate higher than 10 per cent,¹⁹ four have rates higher than 20 per cent,²⁰ and Botswana and Swaziland each has a prevalence of close to 40 per cent – the highest in the world. In most Southern African countries, heterosexual sexual intercourse, by far, accounts for the primary method of HIV infection. The epidemic is hitting

¹⁷ UNAIDS (n 5 above) 10.

¹⁸ UNAIDS 2004 Report of the Global AIDS Pandemic; UNAIDS 2006 Report of the Global AIDS Pandemic.

¹⁹ Malawi, Mozambique, Zambia, Lesotho, South Africa, Zimbabwe, Botswana, Swaziland, Namibia.

²⁰ Lesotho, Zimbabwe, Botswana, Swaziland.

women the hardest. In 2006, UNAIDS reported that in South Africa, for example, young women aged 15 - 24 were four times more likely to become infected with HIV than their male counterparts.²¹

5 HIV, AIDS, human rights and the law in Southern Africa – new debates and strategies

The non-compliance with the greater involvement of people living with HIV and AIDS (GIPA) principle plays itself out two dimensionally in Southern Africa: the exclusion of people living with the disease in these countries, and the exclusion of researchers working in and on these issues in the region.

In an effort to rectify this situation, the AIDS and Human Rights Research Unit, based at the Centre for Human Rights and the Centre for the Study of AIDS at the University of Pretoria, launched a project in 2006 with the generous support of the Open Society Initiative in Southern Africa (OSISA) entitled 'HIV/AIDS, human rights and the law in Southern Africa: Defining new debates and strategies'.

As part of the project, four young lawyers were selected to be placed at four organisations across Southern Africa, where they were required to undertake research on four themes involving human rights under threat in the context of HIV and AIDS in the sub-region. These organisations are the following: the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), based in Gaborone, Botswana; the AIDS and Rights Alliance for Southern Africa (ARASA), based in Windhoek, Namibia; the Law and Development Unit of the Faculty of Law at the University of Malawi; and the Centre for the Study of AIDS at the University of Pretoria in South Africa. Under the supervision of those partner organisations, each lawyer examined a theme and wrote a research paper of pressing relevance involving HIV, AIDS and human rights in the Southern African region.

The papers were presented at a regional workshop hosted by the University of Pretoria in July 2006, which was attended by a number of regional experts in the field as well as parliamentarians from the Southern African Development Community (SADC). Thereafter, Peris Jones, researcher of the Norwegian Centre for Human Rights, further reviewed the four papers. Feedback received was incorporated before presenting the papers at a Satellite Session of the 16th International AIDS Conference, Toronto, Canada in August 2006. The four researchers incorporated criticism and suggestions made during the Conference in the final version of their papers.

²¹ UNAIDS (2006) (n 18 above) 11.

This Conference also provided testimony to the need for this research. Despite recurrent acknowledgements that sub-Saharan Africa, generally, and Southern Africa, more particularly, constitutes the epicentre of the epidemic, the Conference programme did not reflect this fact. With the exception of speakers from and sessions dealing with South Africa and Botswana, little attention was devoted to Southern Africa.

The Conference was heralded as marking 25 years of AIDS. The number 'twenty-five' does mark the number of years since AIDS came to light among the gay community of the United States in 1981. However, beyond the seduction of this neat numerology lies the silent memory of the unacknowledged epidemic, which started in Central Africa some time around 1959, the date of the first HIV-positive blood sample from the region, long before 1981.²² Although the HIV test only revealed this much later, the desperate dispatches about an unexplained illness did not cause a ripple on the global public health or epidemiological radar screen for many complex reasons; it took the appearance of similar clinical features in a different context to focus the world's attention on HIV and AIDS.

In the body of work contained in this publication, Southern Africa refers to the 14 member states of SADC, which are: Angola, Botswana, the Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. The terms Southern Africa and SADC will, therefore, be used interchangeably. Geographically located at the southern tip of Africa, these countries represent linguistic and cultural variety and unequal levels of economic development. Even if the papers identify some sub-regional trends, they do not claim to paint a comprehensive 'Southern African' picture. Despite their best efforts, the picture remains skewed in favour of some countries. A few countries, such as South Africa and Botswana, are over-represented, whilst others, such as Madagascar and the DRC, are almost invisible, mainly due to limited access to information pertaining to those states.

Both the constitutions and international law obligations of the SADC states contain clear human rights commitments. The following table provides evidence of the formal adherence by SADC states to international human rights standards:

²² E Hooper *The river: A journey to the source of HIV and AIDS* (1999) ch 2.

Table B: Status of ratification of main UN and AU human rights instruments by SADC countries as at 31 December 2006 (dates of ratification or accession)

Country	International Covenant on Economic Social and Cultural Rights (ICESCR)	International Covenant on Civil and Political Rights (ICCPR)	Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	Convention on the Rights of the Child (CRC)	African Charter on Human and Peoples' Rights (African Charter)	African Charter on the Rights and Welfare of the Child (African Children's Charter)	Protocol to the African Charter on the Rights of Women in Africa (African Women's Protocol)
Angola	10 Apr 92	10 Apr 92	17 Oct 86	4 Jan 91	2 Mar 90	11 Apr 92	
Botswana		8 Dec 00	12 Sep 96	13 Apr 95	17 Jul 86	10 Jul 01	
DRC	1 Feb 77	1 Feb 77	16 Nov 86	27 Oct 90	20 Jul 87		
Lesotho	9 Dec 92	9 Dec 92	21 Sep 95	9 Apr 92	10 Feb 92	27 Sep 99	26 Oct 04
Madagascar	3 Jan 76	23 Mar 76	16 Apr 89	18 Apr 91	9 Mar 92	30 Mar 05	
Malawi	22 Mar 94	22 Mar 94	11 Apr 87	1 Feb 91	17 Nov 89	16 Sep 99	20 May 05
Mauritius	3 Jan 76	23 Mar 76	8 Aug 84	2 Sep 90	19 Jun 92	14 Feb 92	
Mozambique		21 Oct 93	21 May 97	26 May 94	22 Feb 89	15 Jul 98	
Namibia	28 Feb 95	28 Feb 95	23 Dec 92	30 Oct 90	30 Jul 92	23 Jul 04	11 Aug 04
South Africa		10 Mar 99	14 Jan 96	16 Jul 95	9 Jul 96	7 Jan 00	17 Dec 04
Swaziland	26 Jan 04	26 Jan 04	25 Apr 04	6 Oct 95	15 Sep 95		
Tanzania	11 Sep 76	11 Sep 76	19 Sep 85	10 Jul 91	18 Feb 84	16 Mar 03	
Zambia	10 Jul 84	10 Jul 84	25 Jul 85	5 Jan 92	10 Jan 84		
Zimbabwe	13 Aug 91	13 Aug 91	12 Jun 91	11 Oct 90	30 May 86	19 Jan 95	

Against this background, four contentious issues are discussed, each of which challenge the utility and feasibility of a human rights-based approach in the context of HIV and AIDS as a dire public emergency. Often, human rights are under attack in Africa because they are perceived to be overly individualistic, and because they do not take into account countervailing individual duties. Human rights function in a framework of limitations. As Table B shows, all SADC states are party to the ICCPR. Similar to rights in other legal texts, the rights in the ICCPR may be limited if it is established that such limitations are reasonable and justifiable in democratic societies.²³ The arguments in the four papers may be approached from this angle – the erosion of rights may be justified if there is a clearly demonstrable public benefit that outweighs the encroachment of rights.

While the push for legislative activity involving HIV and AIDS in Southern Africa has been relatively slow, one area that has received a fair bit of attention has been the criminalisation of transmission of the HIV virus. In chapter 2 below ('Pandora's Box: The criminalisation of HIV transmission or exposure in SADC countries, with specific reference to its potential and actual impact on marginalised and vulnerable groups'), Patrick Eba examines the context and rationale behind this push, analyses the aims and effect of the legislation and asks whether criminal law has any significant role to play in addressing the HIV pandemic in Southern Africa.

In chapter 3 below ('Routine HIV testing of individuals attending public health facilities: Are SADC countries ready?'), Nyasha Chingore looks at routine testing in Southern Africa. She provides an overview of where countries are at the moment with respect to routine testing, examines the main justifications for the policy, outlining the legal rights that are triggered in this area, and provides recommendations for effective testing policies in the region.

In his contribution, 'The human rights and public health implications of restricting prisoners' access to HIV prevention and treatment in SADC countries' (chapter 4 below), Babafemi Odunsi examines what access prisoners currently have to condoms in prisons as an HIV prevention mechanism. Although Odunsi largely frames the debate around the right to non-discrimination on the basis of sexual preference, the failure to provide condoms to male prisoners also constitutes an infringement of their right to freedom and security, to life, dignity and not to be punished in an inhuman or degrading manner.

²³ As set out in the Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR, UN Doc E/CN.4/1984/4.

In chapter 5 below, ‘The realisation of access to HIV and AIDS-related medicines in Southern African countries: Possibilities and actual realisation of international law obligations’, Dorothy Mushayavanhu examines the complicated web of international human rights law and intellectual property law governing the production and distribution of AIDS medicines. She looks at the current treatment gap between those who need ART and those receiving ART, investigates the barriers to medicines and treatment, and provides recommendations on how to address this gap.

6 SADC – towards a common approach?

Of all the African regional economic communities, SADC has been the most active in responding to the pandemic. This is hardly surprising considering that this region has been struck the hardest by the pandemic than anywhere in the world. In the SADC Treaty, member states commit themselves to uphold ‘human rights, democracy and the rule of law’. Initially silent on HIV and AIDS, after the 2001 amendment the SADC Treaty now includes a commitment to ‘combat HIV/AIDS and other deadly or communicable diseases’ as one of the objectives of the organisation.²⁴

The SADC Protocol on Health was adopted in 1999 and entered into force in August 2004. At the time of writing nine of the 14 SADC member states are parties to the Protocol. According to article 10 of the Protocol, state parties shall harmonise HIV and AIDS policies, standardise surveillance systems and exchange information. State parties shall ‘endeavour to provide high-risk and transborder populations with preventative and basic curative services for HIV/AIDS/STDs’.

In July 2003, the SADC Heads of State and Government meeting in Maseru adopted a Declaration on HIV and AIDS and an HIV and AIDS Strategic Framework (2003 - 2007), replacing an earlier framework (2000 - 2004). The Strategic Framework has as its goal

to decrease the number of individuals living with HIV and AIDS and families affected by the epidemic in the SADC region, so that HIV and AIDS is no longer a threat to public health and the socio-economic development of member states.²⁵

The SADC Secretariat has established an HIV and AIDS Unit within its Department of Strategic Planning, Gender and Policy Harmonisation. The mandate of the HIV and AIDS Unit is to ‘lead, coordinate and manage SADC’s response to the epidemic through the

²⁴ SADC Treaty, art 5(1)(i). See also Annexure A below, for excerpts from the SADC Treaty; for other SADC treaties and declarations, see Annexures B & C below.

²⁵ SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007) 17.

operationalisation of the HIV and AIDS Strategic Framework (2003 - 2007) and the Maseru Declaration'.²⁶ The Unit has four core staff members and additional project staff.²⁷ In November 2004 the Unit published a SADC HIV and AIDS Business Plan for 2005 - 2009.

The SADC Parliamentary Forum (SADC PF) has also been active with regard to HIV and AIDS; in 2004, the SADC PF published a survey of legislative efforts to combat HIV and AIDS in the SADC region.²⁸ Both the HIV and AIDS Unit of the SADC Secretariat and the SADC PF have produced information leaflets dealing with various aspects of the pandemic.

Under its founding Treaty, SADC states also state that one of SADC's objectives is to 'harmonise' socio-economic policies. In our view, this objective should serve as a basis to harmonise their legal response to the epidemic, for example by developing model legislation. By pooling the resources, knowledge and capabilities of member nations in the SADC, the development of one comprehensive HIV and AIDS model legislation would be both possible and beneficial.

Model legislation differs from treaties and declarations. A treaty is open for ratification; all of its provisions become binding on a state upon ratification. A declaration contains normative standards that may guide states; these norms are not binding and are often vaguely formulated. A model law has some of the characteristics of both. As such, a model law is not binding. Its provisions serve as examples and inspiration to domestic law-makers. Domestic legislatures may adopt the whole or parts of the model law, and may adapt the relevant provisions to suit local circumstances, if need be. Model legislation is much more precise than both treaties and declarations, as it is framed in the legal language of law-makers rather than in the rhetorical discourse of lawmakers. Model legislation in a particular region, such as the SADC region, builds on existing best precedents, serves as guidance to legislators in the region and reinforces a commonality of approach.

We hope that the four contributions below will stimulate debate within SADC and inform the drafting of model legislation and other legal responses by SADC and individual member states.

²⁶ SADC HIV and AIDS Business Plan (2004) 12.

²⁷ As above.

²⁸ Survey of legislative efforts to combat HIV/AIDS the SADC region, Report on a survey conducted by the National Democratic Institute for International Affairs (NDI) and the Southern Africa Development Community Parliamentary Forum (SADC PF), November 2004. See also Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria *HIV/AIDS and human rights in SADC* (2004), www.csa.za.org/filemanger/list/10/.

2 Pandora's box: The criminalisation of HIV transmission or exposure in SADC countries

Patrick M Eba*

1	Introduction
2	Biomedical background
3	An overview of criminal law measures providing for the prosecution of HIV transmission or exposure in Southern African countries
4	Impact of criminalisation on vulnerable and marginalised groups
5	Conclusions and recommendations

1 Introduction

1.1 Background

There will be calls for 'law and order' and a 'war on AIDS'. Beware of those who cry out for simple solutions, for [in] combating HIV/AIDS there are none. In particular, do not put faith in the enlargement of the criminal law.¹

This warning captures the reservations about the use of criminal law in addressing HIV. Its relevance for Southern African countries cannot be overlooked, as some of these countries have adopted or are moving towards the adoption of legislation criminalising HIV transmission or exposure.

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¹ M Kirby 'The ten commandments' (1999) (March) [Australian] *National AIDS Bulletin* 30-31, quoted in UNAIDS *Criminal law, public health and HIV transmission: A policy options paper* (2002) 13.

Three major factors, which are common throughout most of Southern Africa, support the perception of criminal law as an important constituent of the structural response to HIV and AIDS in the sub-region. These factors are: the high HIV prevalence rate, the high incidence of sexual violence cases, and the calls for 'tough' government action.² Considering these factors, several commentators perceive criminal law as a regulatory tool that could influence behaviour change and promote the goal of HIV prevention.³

The alarming HIV prevalence rate in Southern African countries, detailed in the introduction of this collection, is compounded by the high level of sexual violence in the region. Sexual violence, particularly rape, increases the risk of HIV transmission.⁴ High numbers of sexual violence cases are reported in most Southern African countries. Statistics reveal that a total of 39 262 cases of rape (including attempted rape) were reported to the South African Police Services in 1999.⁵ This amounts to a ratio of 119 rapes per 100 000 of the population. In Malawi, it is estimated that one third (35 per cent) of women experienced some form of sexual assault in their lifetime.⁶ Eighteen per cent of females in a household survey conducted in Lesotho in 1998 reported falling victim to incidences of sexual offences in the five-year period prior to the survey.⁷ One in eight teenage girls in a study conducted in Zambia in 2002 reported having forced intercourse in the previous year.⁸ Moreover, the myth that sex with a virgin or a young girl will either cure AIDS or prevent HIV infection has allegedly contributed to the increase of child sexual abuse in the sub-region.⁹

There have been calls by various actors and components of society in Southern African countries for the use of criminal law to punish certain harmful HIV-related behaviour, due to the high

² See South African Law Commission Fifth interim report on aspects of the law relating to AIDS: The need for a statutory offence aimed at harmful HIV-related behaviour (2001) 8-19.

³ See, for instance, C Van Wyk 'The need for a new statutory offence aimed at harmful HIV-related behaviour: The general public interest perspective' (2000) 41(1) *Codicillus* 2-10 and DHJ Hermann 'Criminalising conduct related to HIV transmission' (1990) 9 *Saint Louis University Public Law Review* 351.

⁴ See Dunkle *et al* 'Gender-based violence, relationship power, and risk of HIV infection among women attending antenatal clinics in South Africa' (2004) *Lancet*, quoted in UNAIDS 2004 Report on the global AIDS epidemic (2004) 22.

⁵ South African Law Commission (n 2 above) 13.

⁶ E Pelser *et al* *Intimate partner violence: Results from a national gender-based violence study in Malawi* (2005) 17.

⁷ The United Nations African Institute for the Prevention of Crime & the Treatment of Offenders and the United Nations Inter-regional Crime and Justice Research Institute *The International crime (victim) survey in Maseru, Lesotho* (1998) 40.

⁸ UNAIDS *et al* Facing the future together: Report of the secretary general's task force on women, girls and HIV/AIDS in Southern Africa (2004).

⁹ See South African Law Commission (n 2 above) 14. The report reveals that 221 072 cases of rape, attempted rape, statutory rape, indecent assault and incest with persons under the age of 17 were recorded for the period of January to December 1999 in South Africa.

incidence of sexual violence cases, particularly against children, which expose victims to HIV-infection. These calls for 'tough' actions were generally directed at the executive or the legislature to take appropriate steps, namely, the use of the coercive power of the state to deal with those who wilfully or negligently transmit HIV.¹⁰ To address and appease public fears regarding HIV and AIDS, law makers in some Southern African countries have resorted to the use of criminal law as a radical response aimed at preventing the spread of the epidemic and punishing those who put others at risk of infection.¹¹

Proponents of the use of criminal law to address HIV argue that it prevents conduct that is likely to transmit HIV, educates the public on activities likely to spread HIV, and reinforces social norms against behaviour that carries the risk of HIV infection.¹² The relevance of criminal law as a tool for the prevention of HIV transmission, allegedly, rests upon some of its very functions, namely incapacitation and deterrence.¹³

Incapacitation operates through the imprisonment of HIV-positive individuals who expose others to the risk of HIV-infection and, therefore, prevents them from causing harm to the general population during the length of their imprisonment. The value of incapacitation for HIV prevention depends on the extent to which the law can be used to identify and punish those who expose others to HIV infection.¹⁴

Criminal law increases the cost of engaging in illegal behaviour and, as a result, prevents people from pursuing prohibited activities. Both the likelihood of detection and the severity of punishment are believed to modify individual behaviour.¹⁵ Therefore, it is expected that the use of criminal law to punish certain harmful HIV-related behaviour deters people from engaging in the prohibited behaviour.

¹⁰ In South Africa, the enquiry into 'the need for a statutory offence aimed at harmful HIV-related behaviour' was undertaken as the result of mounting public concern and calls by political parties to the legislature to respond to the growing AIDS epidemic. See South African Law Commission (n 2 above) 16. In Zambia, there have been calls to stiffen the laws on sexual offences, see Times Reporter 'Stiffen laws on sexual offences, urges UNICEF' www.times.co.zm/news/view_news.cgi?category=6&id=1121018638 - 16k (accessed 6 August 2006).

¹¹ The need to calm public agitation is also considered to be the rationale behind the adoption of HIV-specific criminal legislation in several countries around the world, see TW Tierney 'Criminalizing the sexual transmission of HIV: An international analysis' (1992) 15 *Hastings International and Comparative Law Review* 511.

¹² Tierney (n 11 above) 487.

¹³ The other functions of criminal law, namely rehabilitation and retribution, cannot be considered to serve any role in the prevention of HIV. See UNAIDS (n 1 above) 20-22.

¹⁴ Z Lazzarini *et al* 'Evaluating the impact of criminal laws on HIV risk behaviour' (2002) 30 *Journal of Law Medicine & Ethics* 249.

¹⁵ Lazzarini *et al* (n 14 above) 250.

1.2 Research questions

The appraisal of the criminal law mechanisms that enable the prosecution of HIV transmission or exposure in Southern African countries and the assessment of their effect on vulnerable and marginalised groups will be informed by the following research questions: What is the nature, content and scope of criminal law measures allowing for the prosecution of HIV transmission or exposure? Is there legislation that specifically deals with HIV transmission or exposure, or do the measures take the forms of public health legislation or general criminal law offences? What types of activities do these offences criminalise? How do vulnerable and marginalised groups perceive the use of the criminal law mechanisms to prosecute HIV transmission or exposure? How have these laws been enforced and what is the impact of their enforcement on vulnerable and marginalised groups? What recommendations can be made concerning this use of the criminal law in view of its impact on vulnerable and marginalised groups? Finally, in the light of its impact on vulnerable and marginalised groups, does the recourse to criminal law to prosecute HIV transmission or exposure constitute a sound policy option for Southern Africa?

1.3 Methodology and scope

The study identifies and collects criminal law provisions that can be used for the prosecution of HIV transmission or exposure in Southern African countries including common law provisions, general criminal law provisions, public health legislation, and specific HIV transmission or exposure laws. These criminal law provisions also include, in some countries, draft legislation providing for the criminalisation of HIV transmission or exposure. The study further relies on news articles, scholarly articles and reports on parliamentary debates related to the criminalisation of HIV transmission or exposure in Southern Africa, Canada, Australia and the United Kingdom. Based on these materials, the study provides an assessment of the normative content of these pieces of legislation and mechanisms in a comparative perspective. Law reviews and law reports, containing court cases related to the enforcement of HIV transmission or exposure offences in Southern Africa and elsewhere, are analysed. Finally, the study analyses articles in specialised public health and other medical journals providing empirical data on the application of HIV transmission or exposure offences and their impact on the HIV pandemic in general, and on vulnerable and marginalised groups in particular.

This study acknowledges the fact that states have statutory alternatives to prosecute individuals for acts risking HIV transmission.¹⁶ Therefore, in an attempt to capture all the criminal law procedures that could be used for the criminalisation of HIV transmission or exposure, this study adopts an extensive approach to the expression ‘criminalisation’ and includes within its scope the specific legislation criminalising HIV transmission or exposure, traditional criminal offences (such as murder, assault, and reckless endangerment) as well as sexually transmitted diseases (STD) provisions. However, the study will exclude from its reach sentence-enhancement measures because in these cases the HIV status of the accused is not an element of the crime.¹⁷

Furthermore, the expression ‘vulnerable and marginalised groups’ needs to be clarified. Vulnerability to HIV infection results from biological, social, cultural, economic, legal and other factors that adversely affect the capacity of an individual to protect himself or herself from the risk of HIV infection.¹⁸ Acting independently or concurrently, these factors make members of groups such as women, especially those in violent relationships, commercial sex workers, and

¹⁶ SV Kenney ‘Criminalizing HIV transmission: Lessons from history and a model for the future’ (1992) 8 *Journal of Contemporary Health Law & Policy* 245 247. Cameron and Swanson distinguish between direct and indirect coercive measures that could be invoked to deal with HIV transmission. The indirect measures limit or prohibit conducts that might lead to HIV transmission such as prostitution, sodomy and extra-marital sexual intercourse. The direct measures target known or presumed HIV-positive individuals by prescribing, among others, quarantine, isolation and criminal prosecution (E Cameron & E Swanson ‘Public health and human rights - The AIDS crisis in South Africa’ (1992) 8 *South African Journal on Human Rights* 201-202). The scope of this study is limited to the criminalisation of HIV transmission which is a direct measure.

¹⁷ Several Southern African countries have adopted legislation enhancing penalties for HIV-positive sexual offenders. These countries include, among others, South Africa (Criminal Law Amendment Act, Act 105 of 1997), Lesotho (Sexual Offences Act of 2003), Namibia (sec 3 of the Combating of Rape Act 8 of 2000), Botswana (sec 142 of the Penal Code, Amendment Act of 1998) and Zimbabwe (sec 16 of the Sexual Offences Act of 2001). In Malawi, the sentence enhancement for HIV-positive rapists results from the practice of the courts in the absence of legislation. See High Court of Malawi, Confirmation case 1299/1994, *Republic v Cidreck*, Malawi Law Report 1995. In addition to these sentence enhancement provisions, at least South Africa has adopted a law providing for the compulsory HIV testing of alleged rapists on the request of the victim or any interested person (Compulsory HIV Testing of Alleged Sexual Offenders Bill of 2002). Furthermore, Botswana has adopted a provision prohibiting bail for HIV-positive sexual offenders (sec 142(1)(i) of Penal Code, Amendment Act of 1998). However, the provision was recently declared unconstitutional by the Court of Appeal. See Court of Appeal of Botswana *Attorney-General’s Reference: In re The State v Marapo* [2002] 2 BLR 26.

¹⁸ UNAIDS *Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways* (1998) 6.

men who have sex with men (MSM)¹⁹ vulnerable to HIV infection.

There is an intricate link between vulnerability to HIV infection and the marginalisation of members of certain groups. Indeed, members of groups such as commercial sex workers and MSM who are marginalised on the basis of factors including sex, sexual orientation, economic and social status are also vulnerable to HIV infection.²⁰ In fact, their marginalisation compromises their access to relevant and necessary HIV prevention, treatment and care messages and services.²¹ Furthermore, people living with HIV are also marginalised on the basis of their HIV status.

Therefore, the expression ‘vulnerable and marginalised groups’, in this study, will specifically refer to women in abusive relationships or women who lack control over their sexual and reproductive health, commercial sex workers, people living with HIV and MSM.

1.4 Overview

This study is divided into five parts. Following this introductory part, part 2 provides an insight into the medical and biological facts regarding HIV transmission that are relevant in the context of criminalisation. Part 3 critically appraises criminal law mechanisms that allow for the prosecution of HIV transmission or exposure in Southern African countries, particularly analysing their nature, content and scope. Part 4 evaluates the impact of the enactment, content and enforcement of HIV transmission or exposure offences on vulnerable and marginalised groups. Finally, part 5 makes concluding remarks and provides recommendations on the relevance or not of the recourse to criminal law in addressing HIV in Southern Africa.

2 Biomedical background

Criticism has been directed at the use of criminal law to punish cer-

¹⁹ The term ‘men who have sex with men’, unlike the expression ‘homosexual’, describes a social and behavioural phenomenon rather than a specific group of people. It includes not only self-identified homosexuals and bisexual men, but also men who engage in male-male sex and identify themselves as heterosexual or who do not self-identify at all, as well as transgender males. See UNAIDS (n 1 above) 110.

²⁰ UNAIDS (n 18 above) 6.

²¹ As above.

tain behaviour that poses no or very low risk of HIV transmission.²² These critics demonstrate the necessity for any discussion on the criminalisation of HIV transmission or exposure to embrace and be based on biologically and medically proven facts about HIV and its mode of transmission.²³ The following discussion attempts to provide an overview of these biological and medical facts.

The first cases of AIDS were reported in June 1981 when the United States' Centers for Disease Control and Prevention²⁴ revealed that five young, homosexual men were treated for *pneumocystis carinii pneumonia* (PCP) in Los Angeles, California in the United States.²⁵ HIV, the virus that attacks and damages the immune system thus leading to AIDS, was identified in 1983.²⁶ Most countries in Southern Africa reported their first AIDS cases between 1982 and 1987.²⁷ While in the early years of the pandemic, the routes of HIV transmission caused public fear and misunderstanding, there is more clarity today about how the virus is transmitted. Despite this knowledge, fear and misunderstanding around HIV are still widespread more than two decades into the pandemic.

HIV has been found in different concentrations in blood, semen and pre-ejaculatory fluid, vaginal and cervical secretions, amniotic fluid, breast milk, alveolar fluid, saliva, tears, throat swabs and cerebrospinal fluid of HIV infected individuals.²⁸ HIV infection may occur when some of these fluids and secretions (particularly blood, semen, pre-ejaculatory fluid and vaginal and cervical secretions) infected with HIV enter the bloodstream or come into contact with mucous membranes (such as the mouth, eyes, urethra, vagina or anus) of an uninfected person. For clarity of the exposé, the study identifies

²² L Gostin 'The politics of AIDS: Compulsory state powers, public health and civil liberties' (1989) 49 *Ohio State Law Journal* 1017, 1020-1021. The author criticises the use of criminal law in the United States to prosecute acts such as biting, spitting, splattering of blood as misplaced because there is no public utility in spending time and money in the prevention of behaviours that pose no or little risk of infection. He further argues that these prosecutions are unfair since other activities such as careless driving pose greater societal risk and often attract no criminal liability.

²³ Gostin (n 22 above) 1020.

²⁴ The Centers for Disease Control and Prevention (CDC), founded in 1946, is the principal agency of the United States government for protecting the health and safety and for providing essential human services in the United States. The CDC is at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats.

²⁵ JM Howe & PC Jensen 'An introduction to the medical aspects of HIV disease' in DW Webber (ed) *AIDS and the law* (1997) 3.

²⁶ H Brett-Smith & GH Friedland 'Transmission and treatment' in S Burris *et al* (ed) *AIDS law today: A new guide for the public* (1993) 21.

²⁷ For instance, first AIDS cases were reported in 1982 in South Africa, 1984 in Zambia, in 1985 in Malawi and Botswana, in 1986 in Mozambique and Namibia and in 1987 in Swaziland and Zimbabwe (Centre for the Study of AIDS & Centre for Human Rights, University of Pretoria *HIV/AIDS and human rights in SADC* (2004)).

²⁸ Howe & Jensen (n 25 above) 15.

two modes of transmission of HIV, namely the sexual mode of transmission and the non-sexual mode of transmission. Furthermore, the detection of HIV infection will be briefly outlined.

2.1 The sexual routes of HIV transmission

Sexual practices carry different levels of risk of HIV infection. Although unprotected penetrative vaginal and anal sexual intercourse is a high risk practice for both partners, it places the receptive partner at highest risk of infection.²⁹ The higher risk of the receptive partner is attributed to the fact that the inserting partner's body fluid remains deposited in the rectum or vagina of the receptive partner.³⁰ Concerning penetrative anal intercourse, it frequently leads to tearing and bleeding of mucous membranes, which increase the likelihood of HIV infection.

In addition to these elements, several other factors increase the probability of HIV infection. The presence of other STD that cause ulcers or open breaks in the skin (such as syphilis, chancroid and herpes) is considered to increase the risk of HIV infection.³¹ Sexual violence, particularly rape, also increases the risk of HIV transmission due to the frequent tearing and bleeding.³² The stage of the HIV infection and AIDS illness also influence the probability of HIV infection.³³ In fact, particularly high risk periods are associated with the time of the infected person's initial sero-conversion and the period just before the onset of AIDS because at these times large amounts of free viruses circulate in the bloodstream.³⁴

Furthermore, the duration of exposure to contaminated body fluids and secretions during a single sexual encounter and also the number of sexual encounters influence the risk of HIV infection.³⁵ Finally, sex during menstruation is thought to increase the risk of HIV transmission for both partners due to the fact that the mucosal barriers of the vagina might be compromised. This situation puts the woman at risk of infection if her partner is HIV positive while her menstrual blood places her partner at risk if she is infected.³⁶

The risk of HIV infection through oral sex whether mouth-to-penis (fellatio) or mouth-to-vagina (cunnilingus) and open mouth kissing (deep kissing or french kissing) is lower than vaginal and anal penetrative sex, but not zero. There have been reports of HIV

²⁹ Brett-Smith & Friedland (n 26 above) 25.

³⁰ As above.

³¹ As above.

³² Dunkle (n 4 above) 22.

³³ Brett-Smith & Friedland (n 26 above) 24.

³⁴ As above.

³⁵ As above.

³⁶ Brett-Smith & Friedland (n 26 above) 25.

infection through oral sex whether through fellatio or cunnilingus.³⁷ Brett-Smith and Friedland note that although there is no documented case of HIV transmission through deep kissing, it cannot be considered risk-free for it involves two mucous membranes.³⁸

In spite of the level of risk of sexual activities, the correct and consistent use of latex condom significantly reduces the probability of HIV infection.³⁹ However, due to breakage and improper use, latex condoms do not provide 100 per cent protection against HIV.⁴⁰

2.2 The non-sexual routes of HIV transmission

HIV can also be transmitted through non-sexual routes including blood transfusion, injecting drug use and from a pregnant mother to her newborn child. Finally, the case of biting, spitting and splattering of infected blood or other body fluids will be examined.

Mother-to-child transmission of HIV is the second highest mode of HIV transmission in sub-Saharan Africa.⁴¹ Mother-to-child transmission of HIV can occur during pregnancy, labour, delivery and later through breast-feeding.⁴² Without any intervention to reduce mother-to-child transmission, between 12 and 30 per cent of infants born of HIV-positive mothers will be infected with HIV.⁴³

The transfusion of blood and blood products is a very effective route of HIV transmission.⁴⁴ However, due to the standard testing of all donated blood, the transmission of HIV through blood transfusion is today extremely low.⁴⁵

HIV is also transmitted through the re-use and sharing of injecting drug equipment contaminated with HIV.⁴⁶ Therefore, abstaining from sharing injecting drugs equipment eliminates the risk of HIV infection through that route and the thorough disinfection of shared injection equipment reduces the risk of infection.⁴⁷ Although the transmission

³⁷ Howe & Jensen (n 25 above) 18.

³⁸ Brett-Smith & Friedland (n 26 above) 25.

³⁹ Howe & Jensen (n 25 above) 19.

⁴⁰ Centers for Disease Control and Prevention 'Fact sheets for public health personnel: Male latex condoms and sexually transmitted diseases' (2003) www.cdc.org (accessed 12 May 2006).

⁴¹ In 2005, around 700,000 children under 15 became infected with HIV mainly through mother-to-child transmission. About 90% of these mother-to-child transmission cases occurred in Africa. See 'Preventing mother-to-child transmission of HIV' www.avert.org/motherchild.htm (accessed 31 January 2007).

⁴² UNAIDS (n 1 above) 88.

⁴³ Brett-Smith & Friedland (n 26 above) 27.

⁴⁴ UNAIDS (n 4 above) 90.

⁴⁵ Nevertheless, the fact that some blood donors might be in the 'window period' when antibodies cannot be detected from their blood is a major risk associated with blood transfusion.

⁴⁶ Howe & Jensen (n 25 above) 19-20.

⁴⁷ As above.

of HIV through drug injection is generally low in Southern Africa, it is the major route of infection in Mauritius.⁴⁸

Spitting, biting, and splattering of blood, urine and faeces are not considered routes of HIV transmission, because in most of these cases (except in some cases of biting) the skin remains intact and saliva, urine and faeces (unlike blood) contain very low or no trace of HIV.⁴⁹ Although the risk of HIV transmission through these activities is extremely low, there have been reported cases of HIV transmission through biting.⁵⁰

2.3 HIV testing

The detection of HIV infection in an individual can be done directly or indirectly. Directly, the procedure is based on the identification of the virus itself through the screening for specific patterns of DNA that are unique to the virus.⁵¹ This test is called polymerase chain reaction (PCR).⁵² The direct detection can also be done through the screening for the presence of a core viral protein p24 in the blood.⁵³ Finally, the direct detection of HIV can be done through the viral culture of blood samples, in which the plasma and the white cells are cultured to see if HIV can be grown from them.⁵⁴ However, these direct tests are very sophisticated and expensive and not available in many poor settings.⁵⁵ They are generally used for research purposes.⁵⁶

The indirect detection of HIV infection is most commonly used. The indirect test does not detect the virus but the antibodies formed by the immune system in reaction to the presence of HIV in the body of the infected person. The two frequently used tests for antibodies are enzyme-linked immunosorbent assay (ELISA) and Western Blot.⁵⁷ However, a major setback of the antibody tests is that they only detect antibodies to HIV while these antibodies generally become detectable between two to four months after infection occurs.⁵⁸ During that period of two to four months referred to as 'window period', antibody tests may yield negative results even though the

⁴⁸ In 2000, HIV prevalence among antenatal care (ANC) attendees in Mauritius was 0.04% while four out of 136 (2.94%) intravenous drug users tested in the same year were HIV positive. See UNAIDS 'Epidemiological fact sheets on HIV/AIDS and sexually transmitted diseases: Mauritius 2' http://data.unaids.org/Publications/Fact-Sheets01/mauritius_EN.pdf (2004) (accessed 10 May 2006).

⁴⁹ Brett-Smith & Friedland (n 26 above) 29.

⁵⁰ Howe & Jensen (n 25 above) 29.

⁵¹ Brett-Smith & Friedland (n 26 above) 32.

⁵² As above.

⁵³ As above.

⁵⁴ As above.

⁵⁵ As above.

⁵⁶ As above.

⁵⁷ Howe & Jensen (n 25 above) 33.

⁵⁸ CR Horsburg *et al* 'Duration of Human Immunodeficiency Virus infection before detection of antibody' (1989) 2 *The Lancet* 637.

person is actually infected with HIV. However, infected individuals can transmit HIV during that period.

The preceding lines provide us with clarity about what constitutes a significant risk of HIV transmission. Therefore, the use of compulsory state powers, as Gostin argues, must only target acts and behaviours that expose others to significant risk of HIV infection.⁵⁹ The criminalisation of acts that pose little or no risk of transmission would thus be irrelevant and counterproductive.⁶⁰ The overview of the criminal mechanisms used to prosecute HIV transmission or exposure in Southern African countries will reveal, among others, if they uphold the relevant distinction between significant risk and little or no risk of HIV infection.

3 An overview of criminal law measures providing for the prosecution of HIV transmission or exposure in Southern African countries

The prosecution of HIV transmission or exposure in Southern African countries may follow three routes. Firstly, individuals may be prosecuted for HIV transmission or exposure under traditional criminal offences provided under common law or statutory law such as murder, manslaughter, rape, and assault. Secondly, criminal law provisions in some countries provide for offences prohibiting ‘exposure to disease’, which may be extended to HIV. Finally, and a more recent phenomenon, specific legislation has been adopted in some countries targeting individuals who wilfully place others at risk of HIV infection. These three categories of criminal measures will be analysed successively.

3.1 The prosecution of HIV transmission or exposure under traditional criminal offences

All Southern African countries presently possess in their criminal law – whether under common law or statutory law – offences that could be used for the prosecution of HIV transmission or exposure. These offences include murder, manslaughter, assault, grievous harm and attempted murder.⁶¹ While South Africa is the only country in the sub-region which is reported to have invoked traditional (or pre-existing)

⁵⁹ Gostin (n 22 above) 1020-1021.

⁶⁰ As above.

⁶¹ The following lines do not intend to exhaust the traditional criminal law offences that could be invoked to deal with HIV transmission or exposure, but to outline some of them with the purpose of discussing their suitability in the context of HIV.

criminal offences to prosecute wilful HIV transmission or exposure,⁶² these offences have been successfully used in jurisdictions outside Southern Africa.⁶³

In countries such as South Africa and Zimbabwe, traditional crimes allowing for the prosecution of HIV transmission or exposure are provided under common law. In others, such as Malawi, Zambia, Tanzania and Botswana, these crimes are spelled out under statutory law in their respective penal codes. Furthermore, all these traditional criminal law offences do not exist in all Southern African countries.⁶⁴

Despite some divergences in their source (common law/statutory law), type (specific offences provided) and content (elements of the offences), traditional criminal offences in Southern African countries generally require similar elements to be established for a conviction to be secured, as will be established below. Traditional criminal offences will be analysed in light of these elements. The suitability of these offences for the prosecution of HIV transmission or exposure will also be assessed.

3.1.1 Murder

Murder is the most serious crime (in terms of its potential punishment) that a person who transmits HIV can be charged with. Murder is defined in South Africa as 'the unlawful and intentional killing of another living person'.⁶⁵ In Botswana, Malawi, Zambia and Tanzania '[a]ny person who, with malice aforethought, causes the death of another person by an unlawful act or omission is guilty of murder'.⁶⁶ Generally, three elements are required to secure a conviction of murder. These elements are: the accused's conduct, state of mind and the causal link between the accused's conduct and the ensuing death.⁶⁷

⁶² There have been two instances of prosecution under traditional criminal offences in South Africa. In the first case, the accused, a man who allegedly had sex with two women knowing he was infected with HIV, was charged with attempted murder in the Pietermaritzburg High Court in 1999. However, the case was withdrawn at the request of the complainant. See South African Law Commission (n 2 above) 11. In the second case, a man who committed a rape while aware that he was HIV-positive was also found guilty of attempted murder. See *S v Nyalungu* [2005] JOL 13 254 (T).

⁶³ Particularly in the United States of America, Canada and the United Kingdom. See for an overview of these cases, South African Law Commission (n 2 above) 146-159.

⁶⁴ For instance, South Africa does not have the offences of 'reckless endangerment' and 'negligent spread of disease'.

⁶⁵ South African Law Commission (n 2 above) 100.

⁶⁶ See sec 202 of the Penal Code of Botswana, sec 200 of the Penal Code of Zambia, sec 196 of the Penal Code of Tanzania and sec 209 of the Penal Code of Malawi.

⁶⁷ M Markus 'A treatment for the disease: Criminal HIV transmission/exposure laws' (1998-1999) 23 *Nova Law Review* 847- 853.

The conduct or *actus reus* could be easy to establish, while the causation and state of mind may present formidable obstacles to the prosecution. The *actus reus* requires proof that the defendant engaged in the conduct that resulted in HIV transmission.⁶⁸ This element can be established by producing evidence that the defendant had unprotected sexual intercourse with the victim.⁶⁹

Secondly, the prosecution has to prove that the conduct was performed with the requisite intent or *mens rea*. This intent, in addition to the knowledge of HIV-positive status on the part of the accused, can take one of three forms, namely a purposeful mind, a knowing mind or a reckless mind.⁷⁰

The initial problem with establishing intent is that most people are not aware of their HIV status, because a very small proportion of HIV-positive people in Southern Africa is estimated to know their status. Even testing does not resolve the issue completely as there is always a likelihood that a person who tests negative may have been in the window period.⁷¹ As a matter of evidence, because most people are tested anonymously, it will be a very difficult task to prove that the accused was aware of his or her HIV infection.⁷²

The purposeful mind will be established when the person, aware of his or her positive sero-status, acted with the actual intent to cause the death of the victim.⁷³ However, because ‘having sex is a “highly indirect *modus operandi* for the person whose purpose is to kill”, this intent will be very difficult to establish’.⁷⁴ The knowing mind will be proved if the accused was aware of his or her positive sero-status, and accordingly knew that his or her behaviour could infect and kill the victim and proceeded to act.⁷⁵ A ‘reckless mind’ (also known as ‘*dolus eventualis*’) will be present when a perpetrator knows that he or she is infected (or may be infected) and that his or her behaviour may transmit the virus and may cause the victim’s death, but regardless of such knowledge, proceeds with the risky behaviour despite the risk of possible transmission.⁷⁶

In order to establish causation, the prosecution should prove that the conduct of the accused led to the infection of the victim. The first hurdle of this element is that it is difficult to establish that the HIV infection was contracted from the accused, especially when the victim has had multiple sexual partners, multiple potential sources of

⁶⁸ As above.

⁶⁹ As above.

⁷⁰ DL McColgin & ET Hey (n 25 above) 266.

⁷¹ See part 2.3 of this study.

⁷² Tierney (n 11 above) 492.

⁷³ Tierney (n 11 above) 491.

⁷⁴ Tierney (n 11 above) 493.

⁷⁵ Tierney (n 11 above) 491-492.

⁷⁶ South African Law Commission (n 2 above) 101.

infections, or belongs to groups that are considered at higher risk of infection.⁷⁷ The accused would have interest in proving that the victim's lifestyle put him or her at risk of infection independently of the charges brought against him or her. This counterclaim will indeed lead to the investigation of the victim's life thus putting him or her in the situation of an 'accused'.⁷⁸ Furthermore, the delay period between infection and sero-conversion (several weeks or months) and most importantly between infection and the onset of symptoms (up to 10 years) increases the problem of proving the causation.⁷⁹

Finally, prosecution for murder requires the death of the victim while death from HIV infection is unlikely to occur until many years after the act of transmission.⁸⁰ By that time, the accused might also be dead, having pre-deceased his or her 'victim'.⁸¹ Furthermore, in several Southern African countries, there is a requirement stating that a 'person is not deemed to have killed another if the death of that person does not take place within a year and a day of the cause of death'.⁸² This limitation makes murder prosecution for HIV transmission even more unlikely to succeed. These examples demonstrate how some laws have failed to keep up with and are out of step with the current reality of HIV and AIDS, and are in need of revision.

Markus⁸³ rightly argues that prosecution for HIV transmission under the offence of murder would be unfair to defendants because they do not protect defendants who made their victims aware of their HIV-positive status, and obtained informed consent from those victims (then sexual partners), since consent is not a defence to murder. Therefore, HIV-positive individuals are banned from engaging in any sexual contact with uninfected individuals since disclosure and consent will not save them from prosecution for murder.⁸⁴

⁷⁷ See Markus (n 67 above) 854. The difficulty of proving causation could be solved by performing a test called phylogenetics or 'evolutionary analysis' that compares the DNA elements of the virus. This test was used in the United States in the case of a medical doctor who was convicted for infecting his lover by injecting her with HIV-infected blood. See B de Boer 'Criminal, deliberate and reckless HIV transmission' www.avert.org/criminal-transmission.htm (accessed 30 November 2006). However, the availability of this complicated and expensive procedure and its use in criminal proceedings in Southern African countries is very unlikely.

⁷⁸ HL Dalton 'Criminal law' in Burris *et al* (n 26 above) 247.

⁷⁹ Markus (n 67 above) 854.

⁸⁰ McColgin & Hey (n 70 above) 266.

⁸¹ McColgin & Hey (n 70 above) 267. Although anti-retroviral therapy (ART) can prolong the lives of PLWHA, its availability and accessibility is limited in most Southern Africa countries. Indeed, as of 2005, less than 10% of those in need of ART were accessing it in Madagascar, Mozambique, Zimbabwe, Angola, DRC and Tanzania. See UNAIDS (2006) *2006 Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition* 153.

⁸² See for example, sec 205(1) of the Penal Code of Tanzania, sec 209(1) of the Penal Code of Zambia and sec 211(1) of the Penal Code of Botswana.

⁸³ Markus (n 67 above) 855.

⁸⁴ As above.

3.1.2 *Manslaughter (culpable homicide)*

Conduct, causation and state of mind are necessary for the offence of manslaughter (or culpable homicide) to be proved. The difficulties of establishing causation in a murder case equally apply in the case of manslaughter. However, unlike murder, manslaughter does not require proof of intent to kill.⁸⁵ Applied to the transmission of HIV, it will mean that the prosecution should show that the accused consciously disregarded a substantial and unjustifiable risk that he or she was HIV-infected, that he or she could transmit the virus, and that the conduct engaged in could do so.⁸⁶

The main problem with this element is that it leaves the jury or the judge with the onus to decide how a 'reasonable person' in the circumstances of the defendant should have acted, resulting in the risk of prejudice and selective enforcement.⁸⁷ For instance, the jury or the judge could convict a defendant (who was unaware of his or her HIV infection) of manslaughter arguing that due to his or her life style, which put her or him at higher risk of HIV infection, any reasonable person in his or her case should have known of his or her potential infection. This situation would most probably have disproportionate impacts on groups, such as commercial sex workers and MSM who are considered at the higher risk of infection and whose lifestyle is generally met with disapproval from the public.⁸⁸ Finally, like in the case of a murder, the consent of the victim is not a defence to a prosecution and conviction for manslaughter.

3.1.3 *Assault*

The prosecution of HIV transmission or exposure under the offence of assault has the advantage that it does not require the death of the victim. However, the requirements of intent and causation are maintained.⁸⁹ Indeed, the prosecution must establish that the accused was aware of his or her HIV-positive sero-status and believed that his or her conduct could transmit HIV.⁹⁰ An important advantage of using assault statutes is that consent, that is participation in a consensual sexual act after full disclosure of HIV-infection, could be a defence against prosecution.⁹¹

⁸⁵ For example, sec 200(2) of the Penal Code of Botswana, sec 199 of the Penal Code of Zambia and sec 195(2) of the Penal Code of Tanzania provide that a person could be convicted of manslaughter if his or her behaviour amounts to 'culpable negligence' whether or not 'accompanied by an intention to cause death or bodily harm'.

⁸⁶ See Tierney (n 11 above) 494.

⁸⁷ Markus (n 67 above) 855.

⁸⁸ Tierney (n 11 above) 494.

⁸⁹ Markus (n 67 above) 856.

⁹⁰ Tierney (n 11 above) 498.

⁹¹ Markus (n 67 above) 856.

Southern African countries generally have two types of assault offences. For instance, the penal legislation of Tanzania, Zambia, Malawi and Botswana differentiate between common assault and assault 'occasioning actual bodily harm',⁹² while the South African law differentiates between assault and assault with intent to do grievous harm.⁹³

At this juncture, it is important to note that a common disadvantage of all these offences (murder, manslaughter, assault) is that they only provide for the prosecution of risky behaviour, which results in the actual transmission of HIV. Therefore, an individual who engages in high risk behaviour and displays the most reprehensible state of mind will go unpunished if HIV transmission does not occur.⁹⁴

3.1.4 Attempted murder

Prosecution for attempted murder presents fewer problems than murder and manslaughter. The advantage of using the charge of attempted murder to prosecute harmful HIV-related behaviour is that the state does not need to prove causation, the death of the victim or the actual transmission of HIV.⁹⁵

However, attempted murder demands the proof of the highest state of mind, namely a purposeful or knowing state of mind.⁹⁶ Therefore, the prosecution will have to show that the defendant acted with the purpose and intent of infecting another.⁹⁷ Similarly to the case of murder and manslaughter, the prosecution for attempted murder does not consider the consent of the victim as defence. Unlike in some other jurisdictions,⁹⁸ the charges of attempted murder in Southern African countries do not consider the defence of impossibility.⁹⁹ Therefore, a person could be prosecuted and convicted for committing an act that carries no risk of HIV

⁹² See secs 253 and 254 of the Penal Code of Malawi, secs 246 and 247 of the Penal Code of Botswana, secs 240 and 241 of the Penal Code of Tanzania and secs 247 and 248 of the Penal Code of Zambia.

⁹³ South African Law Commission (n 2 above) 104.

⁹⁴ See Markus (n 67 above) 856-857.

⁹⁵ Hermann (n 3 above) 365.

⁹⁶ For instance sec 217(b) of the Penal Code of Botswana, sec 215 of the Penal Code of Zambia and sec 211 (b) of the Penal Code of Tanzania require that the person must have acted 'with intent unlawfully to cause the death of another [...] or omit[ed] to do any act, which it is his duty to do, such act or omission being of such a nature as to be likely to endanger human life'.

⁹⁷ Hermann (n 3 above) 366.

⁹⁸ In some states of the United States of America, legal impossibility provides a defence to an accused whose behaviour has been medically proven to be incapable of transmitting HIV infection. See, for example, Arkansas Code Ann, para 5-3-11.

⁹⁹ For instance secs 380(3) of the Penal Code of Tanzania, 388(3) of the Penal Code of Botswana and 389(3) of the Penal Code of Zambia provide that it 'is immaterial that by reason of circumstances not known to the offender it is impossible in fact to commit the offence'.

transmission provided that he or she shows the required state of mind. Indeed, attempted murder charges have been used in the United States to prosecute conducts that pose little or no risk of HIV transmission namely spitting, biting and splattering of blood.¹⁰⁰

3.2 The prosecution of HIV transmission or exposure under offences prohibiting the exposure to diseases

A survey of criminal provisions in Southern African countries reveals two types of offences (based on their sources) that can be used to punish the exposure to diseases including HIV. These offences are provided in the criminal code of these countries, or in their public health legislation, and sometimes in both.

3.2.1 Public health legislation criminalising the exposure to disease

At least three Southern African countries have provisions in their public health legislation, generally passed before the first AIDS case was reported, which could be used to prosecute the exposure to HIV.¹⁰¹ Although none of these provisions specifically refers to HIV, they target ‘sexually transmitted diseases’ or ‘venereal diseases’, which obviously encompass HIV as the HIV virus can be transmitted sexually.¹⁰²

These offences do not require actual transmission of disease, but could be applied when the infected person engaged in ‘any act likely to lead to the infection of any other person with any such disease’.¹⁰³ The prosecution would thus have to prove the likelihood of infection (in this case HIV infection) to happen as a result of the act. It appears that any unprotected vaginal or anal intercourse would satisfy the likelihood requirement.

However, if, taken at face value, this requirement seems straightforward, public fear around HIV, combined with widespread misconceptions, can lead to difficulties. Indeed, there have been

¹⁰⁰ In the case of *State v Haines*, the Indiana Court of Appeals (United States) upheld an attempted murder conviction on the basis of evidence that the defendant was HIV-infected, aware of his condition, believed it to be fatal, and intended to infect others with HIV by spitting, biting, scratching, and throwing blood. In accordance with an Indiana statute the court rejected the defence of impossibility. See Indiana Court of Appeals (1989) *State of Indiana v Haines* (1989) 545 NE 2d 834-839.

¹⁰¹ See sec 57 of the Public Health Act of Malawi, sec 59 of the Public Health Act of Zambia and sec 50 of the Public Health Act of Zimbabwe.

¹⁰² Sec 57 of the Public Health Act of Malawi and sec 59 of the Public Health Act of Zambia refer to ‘venereal disease’ while sec 50 of the Public Health Act of Zimbabwe targets ‘sexually transmitted disease’.

¹⁰³ See sec 57 of the Public Health Act of Malawi, sec 59 of the Public Health Act of Zambia and sec 50 of the Public Health Act of Zimbabwe.

prosecutions elsewhere (especially in the United States) involving spitting, biting, splashing of blood and other acts carrying no or very little risk of HIV-infection.¹⁰⁴ For example, in the case of *Weeks v State*,¹⁰⁵ the jury decided to believe a prosecution expert's opinion that spitting poses a risk of HIV transmission, a view completely at odds with mainstream scientific evidence.¹⁰⁶

In addition, the offences under public health laws allow for both a wilful and negligent state of mind. The wilful state of mind is that of somebody who knew of his infection and wanted to infect the other person. To establish a negligent state of mind, the prosecution would have to show that the accused was HIV-infected and knew or should have known about his or her infection. For example, assume a male commercial sex worker has a past of unprotected anal sexual intercourse (an activity he should know to carry high risk of HIV infection) with past episodes of swollen lymph nodes, Kaposi's sarcoma or tuberculosis (which he should know are symptoms of HIV infection or AIDS disease). If he does not take any step to determine his sero-status and engages in unprotected penetrative or receptive anal or vaginal sexual intercourse, he could be charged with the offence of negligent transmission or exposure to 'sexually transmitted disease' or 'venereal disease'.

The problem with the negligent harm offence is that it envisages a 'reasonable person' who is an imaginary person of ordinary intelligence, knowledge and prudence. However, in the context of Southern Africa where misconceptions and lack of specific information about HIV are widespread, the 'reasonable person' fiction could lead to unfair results and enable courts to target groups and individuals whose lifestyle are deemed sinful and, therefore, blameworthy. An additional problem with public health offences is that like murder offences, they could criminalise individuals despite the disclosure of HIV-infection and the consent of the person

¹⁰⁴ The 'prophetic' decision of the Supreme Court of the United States, in a case related to HIV and employment, urging courts to base their decisions on 'reasonable medical judgements given the state of medical knowledge' and not on 'unfounded fear' retrieves its relevance in this context. See Supreme Court of the United States *School Board of Nassau County v Arline* (1987) 480 US 273.

¹⁰⁵ Texas Court of Appeal, *Weeks v State of Texas* (1992) 834 SW 2d 559.

¹⁰⁶ *McColgin & Hey* (n 70 above) 272. A lower court convicted the defendant, Weeks, of attempted murder and sentenced him to life imprisonment based on the testimony of two 'experts'. The first 'expert', a social psychologist testified that HIV can be transmitted by saliva, mosquitoes and by sharing an enclosed space with an infected person. The second 'expert', a nurse with no training in infectious diseases, testified that the Centers for Disease Control and Prevention were seeking to suppress reports that AIDS can be transmitted through casual contacts. RT Andrias 'Urban criminal justice: Has the response to the HIV epidemic been "fair?"' (1992-1993) 20 *Fordham Urban Law Journal* 497, 499.

exposed.¹⁰⁷ As a result, public health offences condemn people living with HIV to abstinence for the rest of their lives.¹⁰⁸

At least in Zimbabwe, the prosecution under public health law can only proceed if the state can establish that the accused knew that he or she was infected with ‘a sexually transmitted disease’ or ‘a venereal disease’.¹⁰⁹ This knowledge requirement, like in the traditional criminal law offences, can be difficult to establish since most people are tested anonymously and record-keeping in centres offering testing is not always reliable.¹¹⁰

Finally, penalties under public health statutes are considered too lenient.¹¹¹ For instance, a person guilty of an offence under section 59 of the Public Health Act of Zambia is ‘liable to a fine not exceeding six thousand penalty units or to imprisonment for a period not exceeding six months, or to both’. Under the Public Health Act of Malawi, the person found guilty is ‘liable of a fine of £150 and to imprisonment for two years’. Under section 50 of the Public Health Act of Zimbabwe the person is ‘liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment’.

3.2.2 *Penal code provisions criminalising the exposure to disease*

At least Botswana,¹¹² Malawi,¹¹³ Zambia¹¹⁴ and Tanzania¹¹⁵ have provisions in their Penal Codes, which make it an offence to expose others to a disease ‘dangerous to life’. Although none of these provisions specifically target HIV infection, it is clear that HIV, which is a life-threatening disease, is covered under their scope. These provisions generally classify the offence as a misdemeanour.¹¹⁶ However, in the review of the Penal Code, the Law Commission of Malawi expressed concerns about the HIV pandemic and acknowledged the potential use of this provision to target certain HIV-

¹⁰⁷ See for instance sec 50 of the Public Health Act of Zimbabwe, sec 57 of the Public Health Act of Malawi, and sec 59 of the Public Health Act of Zambia.

¹⁰⁸ Markus raises a similar concern about public health offences in the United States (n 67 above) 860).

¹⁰⁹ Sec 50 of the Public Health Act of Zimbabwe.

¹¹⁰ See UNAIDS (n 1 above) 22.

¹¹¹ See LE Wolf & R Vezina ‘Crime and punishment: Is there a role for criminal law in HIV prevention policy?’ (2004) 25 *Whittier Law Review* 821, 859.

¹¹² Sec 184 of the Penal Code of Botswana.

¹¹³ Sec 192 of the Penal Code of Malawi.

¹¹⁴ Sec 183 of the Penal Code of Zambia.

¹¹⁵ Sec 179 of the Penal Code of Tanzania.

¹¹⁶ See, for example, sec 192 of the Penal Code of Malawi and sec 183 of the Penal Code of Zambia.

related behaviour. It also recommended that the penalty be increased to fourteen years.¹¹⁷

For a prosecution to be successful under this offence, the state must show similar elements to those required for the offence existing under public health legislation, namely the likelihood of infection and the wilful or negligent state of mind. The problems related to proving these elements also apply here. Finally, the concerns expressed about the public health offences on the leniency of penalties and the irrelevance of the disclosure and consent apply similarly in the case of penal code provisions criminalising the transmission of disease.¹¹⁸

The obstacles emerging from the application of traditional criminal law offences to HIV transmission or exposure reveal the truth that these offences were not developed with HIV in mind.¹¹⁹ Indeed, traditional criminal law offences are unfair to the accused (as they do not warn him or her in advance about what is prohibited), formidable for the prosecution (which has to establish difficult elements of proof) and as a result, ill-suited to play any effective role in the context of HIV.¹²⁰ These reasons, among others, have prompted some Southern African countries to develop legislation specifically targeting HIV transmission or exposure.

3.3 The prosecution of HIV transmission or exposure under HIV-specific legislation

HIV-specific statutes or legislation (also referred to as HIV transmission or exposure legislation) are statutes that 'specifically criminalise knowingly exposing others to HIV'.¹²¹ These statutes have been praised as the solution to most of the problems related to the use of traditional criminal law offences to prosecute HIV exposure or transmission.¹²² HIV-specific laws are considered fair to the accused, as they provide in advance what acts are prohibited.¹²³ They also generally do not require an intention to transmit the virus, or actual transmission, and hence take away the hurdles of the prosecution in establishing *mens rea* and causation.¹²⁴ The following lines will see to what extent these enthusiastic comments about HIV-specific legislation are true in the case of Southern Africa. Of all Southern

¹¹⁷ Malawi Law Commission Report of the Law Commission on the review of the Penal Code (2000) 50.

¹¹⁸ See part 3.2.1 of this study, above.

¹¹⁹ Dalton (n 78 above) 250.

¹²⁰ As above.

¹²¹ Markus (n 67 above) 862.

¹²² See, among others, Dalton (n 78 above) 250-251, Markus (n 67 above) 871-872, Hermann (n 3 above) 369, McColgin & Hey (n 70 above) 287, Van Wyk (n 3 above) and South African Law Commission (n 2 above) 125-129.

¹²³ Hermann (n 3 above) 370 and Markus (n 67 above) 872.

¹²⁴ Markus (n 67 above) 871 and Hermann (n 3 above) 371.

African countries, only Zimbabwe¹²⁵ and Lesotho¹²⁶ have adopted legislation criminalising HIV transmission or exposure. In addition to these two countries, South Africa¹²⁷ and Swaziland¹²⁸ have developed draft legislation, which provide for the same.¹²⁹

An important feature of these HIV exposure or transmission laws is that they appear to be ‘catch all’ legislation, titled ‘Sexual Offences Act’, that deals with a variety of criminal conduct. This criminal conduct includes rape, the deliberate transmission of HIV, sexual assault against children and the mentally impaired, child prostitution, prostitution and extra-marital sexual intercourse.¹³⁰ Furthermore, unlike the others, the South African and Swaziland laws do not expressly mention HIV but refer to ‘life-threatening sexually transmitted infection’, which obviously includes HIV.¹³¹ Only the Sexual Offences Act of Zimbabwe has a specific provision dedicated to the ‘deliberate transmission of HIV’.¹³² The other legislation, through a sophisticated legal ‘abracadabra’, makes it a rape for an HIV-infected person to have sexual intercourse without informing his partner of his sero-status.¹³³ It is also important to note that all these

¹²⁵ Sexual Offences Act of Zimbabwe, Act 8/2001.

¹²⁶ Sexual Offences Act of Lesotho, Act 29 of 2003.

¹²⁷ Draft Sexual Offences Act 2002 of South Africa. The South African Law Commission in its report on aspects of the law relating to AIDS recommended against the adoption of a legislation criminalising HIV transmission or exposure, see South African Law Commission (n 2 above). However, through the Draft Sexual Offences Act of 2002, the criminalisation of HIV transmission or exposure is about to find its way into the South African legal system through the back door. See South African Law Commission *Report on sexual offences* Annexure A (2002).

¹²⁸ Draft Sexual Offences and Domestic Violence Bill of Swaziland (2006).

¹²⁹ These two draft laws are not yet in force, however, this study will also critically analyse their content for purposes of comparison as they might be passed in the near future. Although they might be sometimes referred to, in this study, as statutes, laws or legislation, it must be borne in mind that they are not yet in force. The provision criminalising HIV transmission was omitted from the last version of the Criminal Law (Sexual Offences and Related Matters) Amendment Bill, adopted by the South African National Assembly (22 May 2007).

¹³⁰ See Sexual Offences Act of Zimbabwe, Sexual Offences Act of Lesotho, Draft Sexual Offences Act of South Africa and the Draft Sexual Offences and Domestic Violence Bill of Swaziland.

¹³¹ See sec 3(4)(c) of the Draft Sexual Offences Act of South Africa and sec 2(4)(c) of the draft Sexual Offences and Domestic Violence Bill of Swaziland.

¹³² Although entitled ‘deliberate transmission of HIV’, the offence does not require actual transmission of the virus as the mere proof that the accused was infected with HIV suffices to secure a conviction.

¹³³ See sec 3(4)(c) of the Draft Sexual Offences Act of South Africa, sec 2(4)(c) of the draft Sexual Offences and Domestic Violence Bill of Swaziland and sec 3 of the Sexual Offences Act of Lesotho. These provisions seem to have been inspired by a Canadian case where the Supreme Court overruling lower court’s decisions found that an ‘individual who knows he is HIV-positive’ and engages in sexual activity that poses ‘a significant risk of serious bodily harm’ without disclosing this condition to his partner is culpable of ‘fraud’ and may be found guilty of assault. See Supreme Court of Canada (1998) *R v Cuerrier*, 127 CCC (3d) 1 and South African Law Commission (n 127 above) 34-36.

statutes apply irrespective of whether the accused is married to the victim.¹³⁴

While the provisions related to HIV exposure are in many respects similar in the cases of South Africa, Lesotho and Swaziland, they greatly differ with the Zimbabwean provision. Despite these variations, the analysis of these pieces of legislation will be articulated around three elements, namely, knowledge of HIV infection, prohibited sexual conduct and consent of the victim.¹³⁵

3.3.1 Knowledge

HIV transmission or exposure laws provide for criminal liability only where the accused knows of his or her HIV infection.¹³⁶ The Sexual Offences Acts of Zimbabwe and Lesotho clearly indicate the necessity to establish the knowledge of infection.¹³⁷ The statutes of South Africa and Swaziland do not expressly require the knowledge of infection.¹³⁸ However, that requirement can be inferred from the fact that these statutes target only a person who ‘intentionally fails to disclose that he or she is infected with a life threatening disease or HIV’.¹³⁹ Indeed, for somebody to ‘intentionally fail to disclose’, he or she must have knowledge of his or her infection.

While these statutes require (expressly or implicitly) knowledge of infection, they are not clear as to what amounts to knowledge of infection. The Zimbabwean statute requires ‘actual knowledge’ without defining what ‘actual knowledge’ means.¹⁴⁰ Does actual knowledge only refer to a positive HIV test? Or does it also include a clinical diagnosis of AIDS by a physician specialising in infectious diseases? It is obvious that this difficulty would have been resolved by clearly defining ‘knowledge’.¹⁴¹

The statutes of South Africa, Lesotho and Swaziland are even more ambiguous about the knowledge requirement. The statutes of South Africa and Swaziland do not provide any information about

¹³⁴ See eg secs 15(1) Sexual Offences Act of Zimbabwe and 3(6) of the Draft Sexual Offences Act of South Africa.

¹³⁵ These three elements are also characteristic of HIV specific legislation in the United States. See Dalton (n 78 above) 250-251 and Markus (n 67 above) 863-864. The analysis below will also include, where relevant, elements of comparison with HIV-specific statutes in the United States.

¹³⁶ Markus (n 67 above) 864.

¹³⁷ See Sexual Offences Act of Zimbabwe, Sexual Offences Act of 2003 of Lesotho.

¹³⁸ See Draft Sexual Offences Act of South Africa and Draft Sexual Offences Act of Swaziland.

¹³⁹ As above.

¹⁴⁰ Sec 15(1) of the Sexual Offences Act of Zimbabwe.

¹⁴¹ The Georgia (United States of America) HIV exposure statute, for instance, solves this difficulty as it stipulates that ‘a confirmed positive HIV test’ or ‘a clinical diagnosis of AIDS’ establishes knowledge that one is infected with HIV. Georgia Code Ann para 84-5501.1(a)(14) (1989).

knowledge. The Lesotho statute states that the person must have acted ‘knowing’ or ‘having reasonable grounds to believe’ he or she was infected with HIV.¹⁴² Therefore, in addition to failing to define what constitutes knowledge, the Lesotho statute introduces the controversial and subjective notion of ‘constructive knowledge’, which is based on the idea that the exercise of reasonable care would have revealed the HIV-infection to that person. Such an ambiguous concept is ill-suited for HIV transmission or exposure statutes due to its potential to lead to unfair judgments based on prejudice and public sentiment.¹⁴³

Finally, unlike other HIV transmission or exposure statutes, which do away with the proof of intent, the Zimbabwean statute requires that the person must have acted ‘intentionally’.¹⁴⁴ This type of provision perpetuates the problems of proof, which arise under traditional criminal offences, by requiring a showing that the actor intentionally engaged in a conduct likely to result in the transmission of HIV.¹⁴⁵

3.3.2 *Prohibited conduct*

HIV transmission or exposure statutes have been welcomed, in general, as providing clarity about the prohibited activities.¹⁴⁶ However, the statutes reviewed in this study provide little evidence to support this optimism. Indeed these statutes refer to ‘sexual act’,¹⁴⁷ ‘act which causes penetration’,¹⁴⁸ or ‘anything’,¹⁴⁹ without providing more information about these activities. These expressions are vague and overly broad.¹⁵⁰ For instance, they could include in their scope acts such as mutual masturbation, which carry no or very low risk of HIV transmission.

This imperfection (lack of definition of the prohibited conduct) is reduced by the fact that in all these statutes (except the Lesotho statute) the conducts are qualified by the reference to ‘circumstances where there is a significant risk of infection’,¹⁵¹ or to

¹⁴² Sec 3 of the Sexual Offences Act of Lesotho.

¹⁴³ See part 3.2.1 of this study, above.

¹⁴⁴ This requirement is similar to that of the Texas (United States of America) statute, which necessitates proof that the person acted with the intention to cause harm. See Texas Penal Code Ann (1989) para 14.

¹⁴⁵ Hermann (n 3 above) 372.

¹⁴⁶ Markus (n 67 above) 867 and Tierney (n 11 above) 511-512.

¹⁴⁷ Draft Sexual Offences Act of Swaziland, Sexual Offences Act of Lesotho.

¹⁴⁸ Draft Sexual Offences Act of South Africa.

¹⁴⁹ Sexual Offences Act of Zimbabwe.

¹⁵⁰ In the United States of America, constitutional challenges have been laid against HIV-specific statutes on the ground that they are vague and overboard. See for instance Washington Court of Appeal (1992) *State v Stark*, 832 P2d 109. The challenge in this case was rejected.

¹⁵¹ See Draft Sexual Offences Act of South Africa and Draft Sexual Offences Act of Swaziland.

the probability of infection to occur.¹⁵² Therefore, except in Lesotho, a sexual practice like mutual masturbation, which does not represent a 'significant risk of infection', will not trigger the application of these statutes. A similar conclusion should also be reached in the case of penetrative vaginal or anal intercourse with a latex condom as it does not represent a 'significant risk of infection'.¹⁵³

3.3.3 *Consent of the victim and the use of protection*

HIV transmission statutes consider the consent of the victim and the use of protection (latex condom) an affirmative defence to the crime or an element of the crime. When the consent of the victim and the use of protection are considered as elements of the crime, it means that the burden of proof is on the prosecution. However, when they are considered as affirmative defences, the burden of proof is shifted onto the defendant.

In terms of the HIV transmission statutes of South Africa and Swaziland, if the defendant informed the victim of his or her HIV infection and engaged in acts (with the consent of the victim) that do not carry a 'significant risk of infection', he or she is not guilty of a crime.¹⁵⁴ Although, the use of protection (for instance latex condom) is not specifically mentioned in these statutes, it seems to be covered because using a condom significantly reduces the probability of infection. Indeed, the statutes of South Africa and Swaziland require the existence of a 'significant risk of infection' for an offence to be committed.¹⁵⁵ The Lesotho statute only requires disclosure of HIV-positive status and consent of the victim for a person to avoid prosecution. It does not have the element of the 'significant risk of infection'.¹⁵⁶ Therefore, a defendant who informs the victim of his or her HIV-positive status and engages in a sexual act without protection but with the victim's consent would not be guilty of a crime. This provision fails to promote the message of safe sex.

In South Africa, Lesotho and Swaziland, disclosure, consent and the use of protection (not in Lesotho) are elements of the crime; therefore, the prosecution must establish them beyond a reasonable doubt in order for the case to succeed. Unlike the other statutes, the Sexual Offences Act of Zimbabwe recognises disclosure and informed consent as affirmative defences, which have to be established by the accused, therefore making the case of the prosecution easier.¹⁵⁷

¹⁵² Sexual Offences Act of Zimbabwe.

¹⁵³ See part 2.1 of this study, above.

¹⁵⁴ See sec 2(4)(c) of the Draft Sexual Offences Act of Swaziland and sec 3(4)(c) of the Draft Sexual Offences Act of South Africa.

¹⁵⁵ As above.

¹⁵⁶ See sec 3 of the Sexual Offences Act of Lesotho 2003.

¹⁵⁷ Sec 15(2) of the Sexual Offences Act of Zimbabwe.

Markus, however, argues that due to the serious consequences of convicting a defendant under HIV transmission or exposure statutes, consent should be made an element of the crime and the burden of proof should remain on the prosecution.¹⁵⁸

In conclusion, it appears that HIV transmission statutes (in force or in draft form) in Southern Africa fail to fulfil the hopes of fairness, clarity and efficiency placed on them. In fact, as illustrated in the case of Zimbabwe, they do not always solve the problem of proving the state of mind. In addition, they refer to nebulous and confusing expressions instead of providing clarity about the prohibited conduct, thereby failing to realise the promise of fairness for the accused. Furthermore, in all these statutes but one (Sexual Offences Act of Zimbabwe) the state has to establish lack of disclosure and informed consent, which could be very difficult to prove due to the intimate nature of sexual intercourse. On this point, these statutes do not attenuate the hurdles of the prosecution but replace the old problems with new ones that are just as formidable. Finally, there is very little evidence of application of these provisions. For instance, five years after its entry into force, only one case related to the application of the provision on deliberate transmission of HIV was reported in Zimbabwe.¹⁵⁹

4 Impact of criminalisation on vulnerable and marginalised groups

Opponents of the use of criminal law as a response against the HIV epidemic in Southern Africa and elsewhere put forward several arguments that make the relevance of criminal law in dealing with the pandemic dubious, to say the least.¹⁶⁰ Firstly, lessons from the past illustrate how the use of coercive measures in dealing with sexually

¹⁵⁸ Markus (n 67 above) 879.

¹⁵⁹ The case involves a disc-jockey who was charged of statutory rape and willful transmission of HIV. He was accused of having sex with a 15 year-old on several occasions, and consciously infecting her with HIV. See W Johwa 'Risky sex and the law – incompatible bedfellows?' (12 August 2004) www.ipsnews.net/africa/interna.asp?idnews=26574 (accessed 10 May 2006).

¹⁶⁰ For Southern Africa, see South African Law Commission (n 2 above), F Viljoen 'Stigmatising HIV/AIDS, stigmatising sex? A reply to Professor Van Wyk' (2000) 41(1) *Codicillus* 13, Cameron & Swanson (n 16 above) 200, S Kanyangarara 'Proposed use of the criminal law to deal with HIV transmission in Zimbabwe' *Canadian HIV/AIDS Policy and Law Newsletter* (1999) 4 (2/3) Amnesty International 'Memorandum to the Government of Swaziland on the Sexual Offences and Domestic Violence Bill (2006)' <http://www.amnestyusa.org/countries/swaziland/document.do?id=ENGAFR550032006> (accessed 10 April 2006). For the United Kingdom see E Power 'HIV/AIDS, sex and the criminal law' in U Schuklenk (ed) *AIDS: Society, ethics and law* (2001) 177-188 and also SM Bird & AJL Brown 'Criminalisation of HIV transmission: Implications for public health in Scotland' (2001) 323 *British Medical Journal* 1174-1177. For the United States, see among others KM Sullivan & MA Field 'AIDS and the coercive power of the

transmitted diseases has proved useless, if not counterproductive.¹⁶¹ Secondly, the exploration of the objectives of the criminal law (incapacitation, deterrence, retribution and rehabilitation) as tools for HIV prevention through the criminalisation of HIV transmission or exposure raises more concern than answers.¹⁶²

The value of incapacitation for HIV prevention is hampered by the very low number of prosecutions and convictions for HIV exposure or transmission.¹⁶³ Traditional criminal law offences, for example, have rarely been used in Southern Africa to prosecute HIV transmission or exposure.¹⁶⁴ This low number of prosecutions raises the question of the relevance of the criminalisation of HIV transmission or exposure in general. As noted by Viljoen,¹⁶⁵ if there was such an urgent need for the criminal law to play a pronounced role, one would at least have expected the traditional criminal law offences to have been used on several occasions. The difficulties in securing a conviction for HIV transmission or exposure under the traditional criminal offences have been invoked to justify the lack of prosecution.¹⁶⁶ If this was indeed the case, then one would have expected that other crimes which are easier to establish (some of which are examined above) would be used abundantly to target HIV transmission or exposure. Any benefit

state' (1998) 23 *Harvard Civil Rights-Civil Liberties Law Review* 139, Dalton (n 78 above), Z Lazzarini & R Klitzman 'HIV and the law: Integrating law, policy and social epidemiology' (2002) 30 *Journal Law, Medicine, and Ethics* 533 and Gostin (n 22 above).

¹⁶¹ See M Brandt 'AIDS in historical perspective: four lessons from the history of sexually transmitted diseases' (1988) 78 *American Journal of Public Health* 367, Kenney (n 16 above) and also JC Cutler & RC Arnold 'Venereal disease control by Health Departments in the past: Lessons for the present' (1988) 78 *American Journal of Public Health* 372.

¹⁶² See UNAIDS (n 1 above) and Lazzarini *et al* (n 14 above).

¹⁶³ Lazzarini *et al* note that in the United States, 'prosecutions for rape, prostitution and other sexual offences were 1 000 to 3 000 times greater in a single year than for the whole 15 years of prosecutions for HIV exposures or transmissions'. See Lazzarini *et al* (n 160 above) 247. This study only identified 2 cases of effective prosecution for HIV exposure or transmission in Southern Africa, namely one case in South Africa (see High Court of South Africa (n 62 above)) and one in Zimbabwe (see Johwa (n 159 above)).

¹⁶⁴ Only South Africa is reported to have used these offences to prosecute HIV transmission or exposure. See High Court of South Africa (n 62 above).

¹⁶⁵ Viljoen (n 160 above) 13.

¹⁶⁶ Van Wyk (n 3 above) 6.

deriving from incapacitation will be 'incapacitated' by the fact that the risk of HIV transmission is redirected into prisons where rape and consensual sex are rampant,¹⁶⁷ and condoms or effective HIV prevention programmes are almost non-existent in most SADC countries.¹⁶⁸ Moreover, in most cases, those serving prison sentences will eventually be released and re-join the community. Therefore, high-risk activities within prisons could jeopardise HIV prevention programmes in the community at large as most of those released inmates remain sexually active and could continue to engage in high risk sexual behaviour.¹⁶⁹

Deterrence has been presented as 'the most important goal of the criminal law' in the context of HIV.¹⁷⁰ Deterrence is based on the idea that the likelihood of detection and the severity of punishment would modify the behaviour of rational individuals and prevent them from transgressing the norm.¹⁷¹ However, the nature of human sexual behaviour 'driven by anguish, despair or passion' makes it difficult for the deterrence argument to hold as individuals might be carried away by less rational considerations.¹⁷²

Retribution, which supports punishment for punishment's sake, does not serve any public health objective.¹⁷³ Indeed, punishment in some HIV transmission or exposure cases could appear unfair, particularly in cases where there is no 'guilty mind' and when the act of the accused does not carry any significant risk of infection.¹⁷⁴

Finally, rehabilitation offers the most difficult case for the justification of the criminalisation of HIV transmission or exposure. It is indeed difficult to argue that prisons in Southern African countries

¹⁶⁷ Lazarrini *et al* (n 14 above) 249. See also KC Goyer 'HIV/AIDS in prison, problems, policies and potential' (2003) www.iss.co.za/Pubs/Monographs/No79/Chap1.html (accessed 5 August 2006); and also African Commission on Human and Peoples' Rights 'Prisons in Malawi, 17-28 June 2001, Report of the Special Rapporteur on prisons and conditions of detention in Africa' www.Penalreform.org/download/rs/malawi_english.pdf (accessed 5 August 2006).

¹⁶⁸ Preliminary results of a study conducted by the AIDS and Human Rights Research Unit of the University of Pretoria in several Southern African countries including South Africa, Malawi, Lesotho, Zimbabwe, Zambia, Namibia and Mozambique found that condoms are only available in South African prisons. In these countries, condoms are denied to prisoners sometimes in the face of clear policy guidelines providing for the availability of condoms in prisons. See AIDS and Human Rights Research Unit *Human rights protected? Nine Southern African country reports on HIV and the law* (Pretoria: PULP, 2007).

¹⁶⁹ UNAIDS (n 1 above) 20.

¹⁷⁰ Gostin (n 22 above) 1056.

¹⁷¹ Lazarrini *et al* (n 14 above) 250.

¹⁷² Gostin (n 22 above) 1056.

¹⁷³ UNAIDS (n 1 above) 20.

¹⁷⁴ UNAIDS (n 1 above) 20-21.

(generally overcrowded and poorly staffed) can offer opportunities for HIV-positive offenders to change their behaviours to reduce the risk of HIV transmission.¹⁷⁵

Following an analysis of the objectives of criminal law with regard to HIV prevention, Lazzarini *et al* concluded that the case for the criminalisation of HIV 'looks weak'.¹⁷⁶ Furthermore, the assessment of the impact of criminalisation on vulnerable and marginalised groups reveals that the recourse to criminal law is ill-directed, irrelevant and a mere expression of 'frustration' of policy makers who are faced with a formidable pandemic.¹⁷⁷

A complex mixture of social, biological, legal or economic factors (sometimes acting together) contributes to marginalising groups such as commercial sex workers, MSM, women and people living with HIV, and renders them vulnerable to HIV infection or to stigma and discrimination. Of the fourteen Southern African countries, at least eight criminalise commercial sex work or activities related to it,¹⁷⁸ and eleven criminalise male-to-male sex;¹⁷⁹ in most of them, the situation of women and girls is appalling.¹⁸⁰ Due to their situation of vulnerability and marginalisation, members of these groups are likely to perceive or experience the criminalisation of HIV transmission or exposure in a way that might be different to that of other members of the community. The analysis below presents the perceived or actual impact of criminalisation on members of vulnerable and marginalised groups. This analysis is conducted at two levels. Firstly, the enactment and the content of HIV transmission and exposure offences on vulnerable and marginalised groups are evaluated.

¹⁷⁵ For instance, the special rapporteur on prisons and conditions of detention in Africa who visited several prisons in Malawi reported that, in addition to the overcrowding, the lack of proper sanitation and the shortage of staff, there 'exists no sustainable programmes aimed to sensitise inmates about HIV and AIDS nor structures for the medical and psychological welfare of the ever increasing number of AIDS infected prisoners.' See African Commission on Human and Peoples' Rights (n 167 above) 29.

¹⁷⁶ Lazzarini & Klitzman (n 160 above) 252.

¹⁷⁷ Viljoen argues that the calls to enlist the criminal law system as a response to the HIV and AIDS pandemic is 'premised on a general *frustration* arising from an inefficiency to combat crime, and *frustration* at the continued spread of the disease' (emphasis added). See Viljoen (n 160 above) 14.

¹⁷⁸ These countries are Botswana, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe and Swaziland. See Hamilton & Zuberi (n 27 above).

¹⁷⁹ D Ottosson (2006) 'Legal survey on the countries in the world having legal prohibitions on sexual activities between consenting adults in private' www.ilga.org/statehomophobia/LGBcrimallaws-Daniel_Ottoson.pdf (accessed 29 July 2006). This study reveals that all Southern African countries except South Africa, Madagascar and the DRC criminalise male-to-male sex.

¹⁸⁰ See UNAIDS *et al* (n 8 above). The report explores the situation of women and girls in the context of the AIDS pandemic in Southern Africa and reveals high levels of violence against women and girls as well as the adverse effects of discriminatory laws and harmful cultural practices on the realisation of their human rights.

Secondly, regard is paid to the impact of the enforcement of these criminal law measures on members of these groups.

4.1 Impact resulting from the enactment and the content of criminal law measures

The enactment of HIV-specific legislation and the publicity about the potential use of the existing criminal offences to prosecute HIV transmission or exposure could jeopardise public health efforts targeting vulnerable and marginalised groups, and increase the vulnerability of certain groups such as women and commercial sex workers.

4.1.1 Public health interventions targeting vulnerable and marginalised groups are undermined

(a) Adverse effects of criminalisation on HIV testing and other HIV-related services

Commercial sex workers, women and girls are among the groups most affected by the HIV pandemic in most Southern African countries.¹⁸¹ Therefore, the national response of these countries as well as their concerted efforts at the sub-regional level are aimed at providing efficient HIV and AIDS-related services in the form of prevention, treatment, care and support to members of these groups.¹⁸²

¹⁸¹ In Angola, 33.3% of commercial sex workers tested in Luanda in 2000 were HIV positive compared to an adult prevalence rate of 3.7% in 2003 in the country. Similarly, in the DRC, 12.4% of commercial sex workers tested in Kinshasa were HIV positive compared to an adult rate of 3.2% in the country. See UNAIDS (n 81 above) 510. In Mauritius, the HIV prevalence among women attending antenatal care was 0.04% in 2000, while 8% of sex workers tested were HIV-positive. See UNAIDS (n 48 above) 2. In addition, women constitute more than half (59%) of adult PLWHA in the sub-region. See UNAIDS (n 81 above) 15.

¹⁸² For example, of national commitments to provide HIV-related services to vulnerable groups see, among others, chapter 5 of the Malawi HIV/AIDS Policy which is dedicated to the 'protection, participation and empowerment of vulnerable populations' including women, girls, commercial sex workers and people who engage in same-sex sexual relations. See Government of Malawi 'National HIV/AIDS policy: a call to renewed action' (2003). Art 4.9 of the Policy Framework on HIV/AIDS Prevention, Control and Management of Lesotho states that 'sex workers should be targeted with appropriate information and education to empower them to use condoms at all times in order to protect themselves and their clients. See Government of Lesotho 'Policy Framework on HIV/AIDS Prevention, Control and Management' (2000). Guiding principles 31 and 32 of the National AIDS Policy of Zimbabwe acknowledge the need to 'apply the most effective policies and strategies to deal with commercial sex-work in order to reduce the transmission of HIV and STIs' and conclude that 'information, education, counselling, male and female condoms and STI care services must be made accessible and affordable to all sex-workers and their clients'. (See Government of Zimbabwe 'National Policy on HIV/AIDS for Zimbabwe' (1999)). At the sub-regional level, the SADC Declaration on HIV adopted by all SADC countries

A fundamental element of HIV prevention efforts is HIV testing and counselling, which relies on people (particularly those at risk of HIV infection) coming forward to be tested and, if found positive, they receive appropriate counselling in order not to put others at risk of infection. If negative, those individuals receive counselling so that they remain negative. HIV testing is also an entry door to a wide range of services such as the prevention of mother-to-child transmission of HIV (PMTCT), anti-retroviral therapy (ART) and drugs for the management of opportunistic infections as well as support.

However, the enactment of HIV-specific legislation and the publicity about the potential use of the existing criminal offences to prosecute HIV transmission or exposure constitutes a serious threat to efforts to provide HIV-related services to members of vulnerable and marginalised groups. In fact, a preliminary requirement for the prosecution of individuals for HIV transmission or exposure is the knowledge of their HIV infection.¹⁸³ This knowledge is generally obtained through HIV testing. Therefore, HIV testing is no longer the life-saving step advocated by public health messages but a self incrimination exercise that might provide the state with a fundamental element of proof for potential prosecution. Based on this reasoning, opponents of criminalisation in Southern Africa and elsewhere have argued that the criminalisation of HIV transmission or exposure will deter people (particularly members of vulnerable and marginalised groups who are most at risk of infection) from seeking HIV testing.¹⁸⁴

The International Guidelines on HIV/AIDS and Human Rights produced by the Office of the UN High Commissioner for Human rights

urges states to strengthen 'initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection'. (See SADC Declaration on HIV, adopted in Maseru on 4 July 2003).

¹⁸³ See part 3 of this study.

¹⁸⁴ See, among others, Gostin (n 22 above), Viljoen (n 160 above), South African Law Commission (n 2 above), Kanyangarara (n 160 above) and Cameron & Swanson (n 16 above).

and UNAIDS and endorsed by most Southern African countries¹⁸⁵ warns that:

People will not seek HIV-related counselling, testing, treatment, and support if this could mean facing discrimination, lack of confidentiality and other negative consequences ... [C]oercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support.¹⁸⁶

Evidence and data related to the discontinuation of anonymous testing and the introduction of name reporting in the United States seems to illustrate that concerns about confidentiality, fear of stigma and discrimination deter people from seeking HIV testing.¹⁸⁷ Although, this data is not specifically related to the criminalisation of HIV transmission or exposure, it seems to suggest that fear of detention with its related stigma and social impacts are pressing factors for people, particularly those more at risk, to avoid HIV testing.¹⁸⁸ More directly, Dwyer reports that 12 000 less people were tested in an Australian state a month after the introduction of a law criminalising HIV transmission.¹⁸⁹

Furthermore, because some offences, such as manslaughter,¹⁹⁰ and statutes like that of Lesotho¹⁹¹ could criminalise even a person who 'has reason to believe' that he or she is infected with HIV, they

¹⁸⁵ The Centre for the Study of AIDS & Centre for Human Rights survey found that all Southern African countries surveyed were aware or have endorsed the International Guidelines on HIV/AIDS and Human Rights (n 27 above).

¹⁸⁶ Office of the UN High Commissioner for Human Rights & the Joint United Nations Programme on HIV/AIDS (1998) HIV/AIDS and human rights: International guidelines, Guideline 4, para 74.

¹⁸⁷ Two studies have been identified on this point. The first study investigates the impact of the availability of anonymous HIV testing on testing demand in Arizona (United States). The study found that a non-anonymous testing policy may discourage persons at elevated risk of HIV infection from seeking testing, and availability of anonymous testing may overcome this deterrent. See D Hirano *et al* 'Anonymous HIV testing: The impact of availability on demand in Arizona' (1994) 84 *American Journal of Public Health* 2010. In the second study, the authors note that the availability of anonymous testing sites as opposed to those providing for the reporting of names to public health officials increases the likelihood of people seeking HIV testing. See LO Gostin & JG Hodge 'The "names debate": The case for national HIV reporting in the United States' (1997-1998) 61 *Albany Law Review* 679 721.

¹⁸⁸ It should also be noted that the relevance of these data could also be qualified by the fact that the studies were conducted in the United States and do not cover the reality of Southern Africa. However, they provide excellent indications about the possible negative impacts of loss of confidentiality, stigma and discrimination on HIV testing, and reaffirm the need to conduct such research in Southern Africa.

¹⁸⁹ JM Dwyer 'Legislating AIDS away: The limited role of legal persuasion in minimizing the spread of the Human Immunodeficiency Virus' (1993) 9 *Journal of Contemporary Health Law and Policy* 167 168.

¹⁹⁰ See part 3.1.2 of this study, above.

¹⁹¹ Sec 3 of the Sexual Offences Act 2003 of Lesotho provides for the prosecution of a person who acted 'knowing' or 'having reasonable grounds to believe' he or she was infected with HIV. See part 3.3.1 of this study, above.

could lead members of vulnerable and marginalised groups to take deliberate steps to avoid all information about HIV. Indeed, ‘any knowledge about HIV is dangerous’ and the less you know, the ‘safer’ you are.¹⁹² This type of provision and the possible reaction to it will actually have a disastrous impact on information and education campaigns about HIV and AIDS.

The reduction of HIV testing particularly among vulnerable and marginalised groups has negative effects on the prevention of HIV and the pandemic in general.¹⁹³ In addition, the lost opportunities for HIV testing have a tremendous impact on access to other HIV-related services namely treatment, care and support. In fact, the entry door for HIV-related services being HIV testing, those deterred by criminalisation (those most in need of care and support) will be unable to access them. In the era of the campaign for universal access,¹⁹⁴ the legitimacy and relevance of the criminalisation of HIV transmission or exposure, which drives people away from HIV-related services, is highly dubious.

(b) Spreading the wrong message about HIV and AIDS

The criminalisation of HIV transmission or exposure has a negative impact on HIV prevention as it spreads several wrong messages with particular impact on members of vulnerable and marginalised groups. Firstly, by targeting certain acts that carry no or very little risk of infection such as spitting, biting, splattering of blood or mutual masturbation, the criminalisation of HIV transmission or exposure frustrates education efforts about HIV and AIDS, and fuels misinformation, hysteria and discrimination surrounding the epidemic.¹⁹⁵

Secondly, the criminalisation of HIV infection or exposure introduces a psychological divide into the society between ‘them’ (those infected with HIV or those perceived to be at high risk of infection due to their activities or sexual orientation, namely commercial sex workers and MSM) and ‘us’ (the non-infected or those who believe themselves not to be infected even when they have not

¹⁹² Viljoen (n 160 above) 15.

¹⁹³ Bird & Brown found that a 25% decrease in uptake of HIV testing by those who are infected could result in more than a one third increase in new sexually transmitted HIV infections. See Bird & Brown (n 160 above).

¹⁹⁴ The ‘Universal Access campaign’ is the result of the commitment made by all United Nations (UN) member states at the 2005 World Summit for scaling up HIV prevention, treatment, care and support, with the aim of coming as close as possible to the goal of universal access to treatment by 2010, for all those who need it. This commitment was reiterated by the UN General Assembly in its 23 December 2005 resolution entitled ‘Preparations for and organization of the 2006 follow-up meeting on the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS’ (A/60/L.43).

¹⁹⁵ See Tierney (n 11 above) 487.

been tested for HIV).¹⁹⁶ On the one hand, this divide creates the fallacy that HIV is spread through a few irresponsible ‘sex predators’, leads to complacency among those who consider themselves not to be infected with HIV and shifts the responsibility for protecting others on those who are infected.¹⁹⁷ Whilst on the other hand, the psychological divide reinforces fear, stigma and discrimination against ‘them’ (people living with HIV or those at high risk of HIV infection) who are considered to endanger the community by their irresponsible lifestyle.

Finally, in some HIV transmission or exposure statutes, the implementation of public health messages (safer sex through the use of a condom or engaging in low risk activities) is not a defence.¹⁹⁸ This situation will also undermine public health efforts because people living with HIV or members of high risk groups might think that the use of precautions is irrelevant as they can be prosecuted even if they use them.¹⁹⁹ It could also lead to a feeling of unfairness among members of vulnerable and marginalised groups if they are prosecuted for behaving in ways encouraged by public health messages.

4.1.2 Increased vulnerability of certain categories of people

HIV-specific statutes and some traditional offences providing for the criminalisation of HIV transmission or exposure admit the disclosure of HIV status by the accused and the informed consent of the victim as a defence to prosecution.²⁰⁰ Therefore, disclosure of the HIV-positive status is the only way people living with HIV who decide to remain sexually active can avoid prosecution. This requirement for disclosure has disproportionate effects on women and commercial sex workers.

Due to the practice of routine testing at antenatal care (ANC) services in several Southern African countries,²⁰¹ women happen to be the first to know about their HIV-positive status. Therefore, in cases where they do not disclose their HIV-positive status to their partners (who are generally unaware of their own HIV status), those women will commit a crime during any sexual intercourse with their

¹⁹⁶ See Viljoen (n 160 above) 16.

¹⁹⁷ Viljoen (n 160 above) 14.

¹⁹⁸ For instance the Sexual Offences Act of Lesotho does not recognise the use of protection such as latex condom as a defence. See part 3.3.3 of this study above.

¹⁹⁹ Lazzarini & Klitzman (n 160 above) 247.

²⁰⁰ Disclosure and informed consent do not constitute a defence in the case of prosecution for murder, manslaughter, attempted murder as well as in case of prosecution under offences prohibiting the transmission of diseases. See part 3 of the study.

²⁰¹ At least Malawi, Zimbabwe, Botswana, Lesotho, Swaziland and South Africa have adopted the policy of routine testing for pregnant women attending antenatal care services. See AIDS and Human Rights Research Unit (n 168 above).

partners.²⁰² The only way these HIV-positive women can avoid prosecution is to disclose their HIV-positive status to their partners.

However, several studies conducted in Southern Africa and elsewhere reveal that following disclosure of their HIV status to their partners, women face negative outcomes ranging from abandonment to physical abuse.²⁰³ Therefore, as a result of the criminalisation of HIV infection, women are ‘trapped’, ‘squeezed’ between the fear of abusive reaction from their partners and the potential prosecution and conviction for HIV transmission or exposure. The only option remaining for women at risk of HIV infection is to avoid antenatal care services or opt out of HIV testing, notwithstanding the danger that these decisions represent for their own health, the health of their unborn babies and the community at large.

The situation of commercial sex workers is no better. Indeed, the only way that commercial sex workers could avoid prosecution under HIV-specific statutes (under the Zimbabwe, South African and Lesotho statutes) is through disclosure and the use of latex condoms.²⁰⁴ However, a study conducted with commercial sex workers in South Africa reveals that the suggestion or the use of condoms by commercial sex workers places them at risk of violence from their clients.²⁰⁵ In this context of abuse and violence, one becomes sceptical about the willingness of commercial sex workers to suggest condoms or even disclose their HIV status to their clients.

4.2 Impact resulting from the enforcement of criminal law measures

The actual enforcement of HIV transmission or exposure offences has specific consequences for members of vulnerable and marginalised

²⁰² See, for instance, the submission of Judge E Cameron on section 3(4) of the draft Sexual Offences Act of South Africa. See South African Law Commission (n 127 above) 34. See also Amnesty International (n 160 above) 6-7 and South African Law Commission (n 2 above) 125.

²⁰³ After reviewing 17 studies on rates, barriers, and outcomes of HIV status disclosure among women in developing countries including South Africa, Tanzania and DRC, Medley *et al* found that the common barriers to disclosure mentioned by study participants included fear of abandonment, rejection and discrimination, violence, upsetting family members, and accusations of infidelity. See Medley *et al* ‘Rates, barriers and outcomes of HIV status disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes’ (2004) 82(4) *Bulletin of the World Health Organisation*. Similarly, North & Rothenberg reveal that women with HIV infection may be at risk of harm from their partners when they inform those partners of their infection. See RL North & KH Rothenberg ‘Partner notification and the threat of domestic violence against women with HIV infection’ (1993) 329(16) *New England Journal of Medicine* 1194-1196.

²⁰⁴ See part 3.3 of this study, above.

²⁰⁵ See QA Karim *et al* ‘Reducing the risk of HIV infection among South African sex workers: Socioeconomic and gender barriers’ (1995) *American Journal of Public Health* 1521.

groups. Although, the situation in Southern Africa provides very few examples of enforcement of HIV transmission or exposure offences, experiences and research conducted on such enforcement elsewhere will be analysed in order to investigate the possible impact resulting from the enforcement of these offences in Southern Africa.

4.2.1 Risk of selective enforcement

A major setback of HIV transmission or exposure offences is that due to the stigma surrounding HIV and AIDS, and the persistence of deep-rooted prejudice against groups such as commercial sex workers and MSM, there is a high risk that criminal prosecution will disproportionately affect those who are already vulnerable and marginalised.²⁰⁶ HIV transmission or exposure offences could become the official and legitimate tools of a ‘witch hunt’ against the scapegoats of the HIV pandemic.²⁰⁷

Members of vulnerable and marginalised groups will be easily targeted not because of their conduct that transmits HIV but simply because they are HIV positive, because of their sexual orientation or even because of their work as prostitutes.²⁰⁸ Data and evidence after 15 years (1986-2001) of prosecution for HIV transmission or exposure in the United States did not disprove the perception of ‘a focus on poor and socially marginalised actors’.²⁰⁹ Similarly, a study conducted in several European countries revealed that most of the individuals convicted for HIV transmission or exposure were in vulnerable social and economic positions, including asylum seekers, unemployed, commercial sex workers and prisoners.²¹⁰ In Zimbabwe, the only reported case of prosecution for deliberate transmission of HIV involved a disc-jockey, considered a member of a group that is socially described as playful and having deviant sexual conducts.²¹¹

4.2.2 Reinforcement of stigma and discrimination against vulnerable groups and sense of unfairness among members of these groups

The enforcement of HIV transmission or exposure offences singles out

²⁰⁶ UNAIDS (n 1 above) 26.

²⁰⁷ Field & Sullivan (n 160 above) 161-162 and Tierney (n 11 above) 489.

²⁰⁸ UNAIDS (n 1 above) 26.

²⁰⁹ Lazarrini & Klitzman (n 160 above) 250.

²¹⁰ See Global Network of People Living with HIV/AIDS Europe (GNP+Europe) and Terrence Higgins Trust (THT) *Criminalisation of HIV transmission in Europe: A rapid scan of the laws and rates of prosecution for HIV transmission within signatory states of the European Convention of Human Rights* (2005).

²¹¹ See Johwa (n 159 above).

members of vulnerable and marginalised groups for the expression of public prejudices and fears.²¹² The prosecution of members of vulnerable and marginalised groups revives deep-rooted stigma and discrimination against individuals from these groups who are presented as a danger to the community.²¹³ For instance, commentators suggested that the most publicised case of HIV transmission or exposure, that of Nushawn Williams,²¹⁴ was fuelled by the fact that he was an African-American in a small, predominantly white community.²¹⁵

The disproportionate effects of the enforcement of HIV transmission or exposure offences on members of vulnerable and marginalised groups could create or reinforce a sense of unfairness among members of these groups.²¹⁶ Indeed, some members of these groups are already distrustful about government's regulation of certain conducts, such as same sex sexual relationships and commercial sex work, and the selective enforcement of HIV transmission or exposure offences could exacerbate this mistrust.²¹⁷

4.2.3 Potential for human rights violations

The enforcement of HIV transmission or exposure laws has the potential of infringing the human rights of people living with HIV. The criminalisation of HIV transmission or exposure particularly threatens the right to a fair trial and the right to privacy. All Southern African countries are parties to the International Covenant on Civil and Political Rights (ICCPR), which, in articles 14 and 17, protects respectively the right to a fair trial and the right to privacy.²¹⁸ Furthermore, the right to a fair trial is guaranteed under article 7 of the

²¹² Lazzarini & Klitzman (n 160 above) 537-538.

²¹³ As above.

²¹⁴ A study found that 727 news articles were devoted to the case of Nashawn Williams. Lazzarini & Klitzman (n 160 above) 246.

²¹⁵ Wolf & Vezina (n 111 above) 871.

²¹⁶ Lazzarini & Klitzman (n 160 above) 249.

²¹⁷ As above.

²¹⁸ International Covenant on Civil and Political Rights, GA Res 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc A/6316 (1966), 999 UNTS. 171, entered into force on 23 March 1976. See annex of this study for status of ratification of the ICCPR by Southern African countries.

African Charter for Human and Peoples' Rights to which all Southern African countries are parties.²¹⁹ In addition to these international documents, the constitutions of most Southern African states guarantee the right to a fair trial and the right to privacy.²²⁰

In terms of article 14 of the ICCPR '[a]ll persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.' However, it appears that the HIV-positive status of a defendant has led to prejudicial and unfair procedures during criminal trials especially in the early years of the epidemic.²²¹ Furthermore, it has been argued that fears and prejudices have also tainted sentences for criminal HIV exposure, which have typically been longer than those for comparable crimes.²²²

The right to privacy protects individuals against 'arbitrary or unlawful interference with [their] privacy, family, home or correspondence, [and] unlawful attacks on [their] honour and reputation.'²²³ The enforcement of HIV transmission or exposure offences can lead to the invasion of the right to privacy. In fact, to prove its case under HIV transmission or exposure offences, the prosecution generally needs to access confidential information about the health of the accused. Although the right to privacy is not absolute, its limitation is justified only if provided for by law in accordance with the provisions, aims and objectives of the ICCPR and, in any event, is reasonable in the particular circumstances.²²⁴ Interpreting the requirement of reasonableness of General Comment 16 in the case of *Toonen v Australia*, the Human Rights Committee stated that any interference with the right to privacy must be

²¹⁹ African Charter on Human and Peoples' Rights, adopted in June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982), entered into force on Oct. 21, 1986. See annex of this study for status of ratification of the ACHPR by Southern African countries.

²²⁰ For instance, sec 10 of the Constitution of Mauritius, sec 10 of the Constitution of Botswana, sec 12 of the Constitution of Namibia, sec 42 of the Constitution of Malawi and sec 12 of the Constitution of Lesotho guarantee the right to fair trial. Sec 13 of the Constitution of Namibia, sec 9 of the Constitution of Mauritius, sec 11 of the Constitution of Lesotho and sec 21 of the Constitution of Malawi guarantee the right to privacy.

²²¹ McColgin & Hey report discrimination in courts against PLWHA or those thought to be infected with HIV including the use of face masks, gowns and rubber gloves by court personnel, and long delays in transportation to courts. See McColgin & Hey (n 70 above) 325-331. Although education efforts have addressed some of the prejudices related to HIV infection, one suspects that the publicity given to HIV transmission cases could resuscitate irrational fears and lead to negative effects on a fair trial for PLWHA in Southern African countries.

²²² Wolf & Vezina (n 111 above) 870-871.

²²³ Art 17 of the ICCPR.

²²⁴ See Human Rights Committee, 32nd session (1988) General Comment 16 on art 17 para 4.

proportional to the end sought and be necessary in the circumstances of any given case.²²⁵ Due to the fact that the criminalisation of HIV transmission or exposure fails to advance the goal of public health, it seems improbable that it can be accepted as a necessary restriction of the right to privacy.²²⁶

Furthermore, there is a great risk that the enforcement of HIV transmission or exposure offences could lead to concerted efforts between some public health and police officials to get rid of the 'undesirables'. For instance, Lazzarini *et al* reveal the case of a programme in which obstetrical staff at a hospital performed drug tests on maternity patients and co-operated with local police to use the tests to prosecute pregnant women who tested positive.²²⁷ The risk of the replication of such programmes in some Southern African countries as well as their impact on human rights should not be underestimated.

5 Conclusions and recommendations

5.1 Conclusions

Criminal law is a powerful tool that may serve several societal goals.²²⁸ It may express a 'collective social view that a particular behaviour is wrong, or be a means through which a social group obtains social validation of its views.'²²⁹ Therefore, the call for its use in an effort to address the alarming HIV pandemic in Southern Africa is understandable.

This study has analysed the reasons, means, outcome and impact (particularly on vulnerable and marginalised groups) of the use of HIV transmission and exposure offences in Southern Africa. The analysis reveals that all the criminal law mechanisms that have been adopted (or that could be adopted) for the prosecution of HIV transmission or exposure raise more difficulties than provide solutions. In fact, the traditional criminal laws offences (whether provided under common law or statutory law) create insurmountable evidentiary hurdles, act counter to the messages of HIV prevention and could be unfair to the accused. The adoption of specific HIV transmission or exposure statutes in a few countries, has failed to address the problem inherent

²²⁵ See Human Rights Committee, *Toonen v Australia*, Communication 488/1992, para 8.4 reprinted in M Sepúlveda *et al Universal and regional human rights protection: Cases and commentaries* (2004) 320-322.

²²⁶ See Viljoen (n 160 above) 15.

²²⁷ The US Supreme Court found that this programme was illegal. See US Supreme Court (2001) *Ferguson v City of Charleston* 532 US 67 cited in Lazzarini & Klitzman (n 163 above) 251.

²²⁸ Lazzarini & Klitzman (n 160 above) 251.

²²⁹ As above.

to the prosecution under traditional criminal law offences. On the contrary, these statutes have replaced old problems with new ones that are just as formidable.

Furthermore, the analysis has revealed that the enactment, content and enforcement of HIV transmission or exposure offences disproportionately affect members of vulnerable and marginalised groups, fuel stigma and discrimination, threaten public health messages and create the potential for human rights violations.

This study should not be understood as denying any role to the criminal law in addressing the HIV pandemic in Southern Africa. It acknowledges that the criminal law can be an effective tool only if it successfully incapacitates and deters those whose behaviour contributes to the HIV pandemic. However, this study notes that due to the difficulties inherent to HIV transmission or exposure offences and the generally low level of enforcement of the criminal law in most Southern African countries,²³⁰ it is very unlikely that those who commit HIV transmission or exposure offences will be prosecuted or even sentenced in order to accomplish the goal of incapacitation. Secondly, this study has found no research in Southern Africa or elsewhere, which illustrates that the use of criminal law actually deters individuals from engaging in high-risk behaviour.

In view of these compelling arguments one question must be asked: Does the criminal law have any significant role to play in addressing the HIV pandemic in Southern Africa?

The response from this study is that the criminal law has only a very minimal role to play in addressing the HIV pandemic in Southern Africa. The study submits that each Southern African country has within its statutory law or common law, offences that could be invoked to deal with the extreme and rare cases of those who wilfully place others at risk of infection through sexual and other conducts. This study argues specifically that the recourse to specific HIV transmission or exposure legislation is unwarranted.

At least one study has advocated for the use of public health powers as an alternative to criminalisation.²³¹ However, public health legislation in Southern African countries was mainly adopted prior to the first HIV and AIDS cases, is outdated and has not undergone review

²³⁰ For instance, a study conducted in Lesotho reveals that dissatisfaction has been expressed concerning the failure of the police to institute arrests and the courts to obtain convictions, delays in courts, prison overpopulation and the cost of running such institutions. See The United Nations African Institute for the Prevention of Crime and the Treatment of Offenders & the United Nations Interregional Crime and Justice Research Institute (n 7 above) 12. Similarly, the South African Law Commission also noted that the creation of HIV-specific offences 'could add to the problem of an overburdened criminal justice system is currently experiencing'. See South African Law Commission (n 2 above) 270.

²³¹ UNAIDS (n 1 above) 28.

to address the specificity of HIV and AIDS.²³² This study therefore argues that the recourse to coercive public health powers in Southern Africa as an alternative to criminalisation will be unnecessary, difficult to implement and counterproductive.²³³

Firstly, the use of public health powers such as quarantine and isolation are irrelevant as well as economically and materially impossible to implement. As expressed by Justice Kirby, ‘we simply do not have enough barbed wire, nor the guards and other paraphernalia to isolate completely the large number of our population who will test positive’.²³⁴ Secondly, name reporting and compulsory notification of partners raise some of the concerns associated with the use of the criminal law, namely driving people away from testing and the risk of violence against women.²³⁵ Finally, public health powers can lead to human rights violations because they are mainly administrative measures and do not provide for procedural and legal guarantees even in the case of isolation and quarantine that could lead to the permanent ostracism of people living with HIV.²³⁶

5.2 Recommendations

This study stresses that we should not allow frustration, fear and prejudice to cloud our mind and drive us away from the responses that have historically and even recently proved efficient in addressing public health challenges.²³⁷ Based mainly on these successful experiences, this study recommends the following actions and programmes:

5.2.1 *Promote HIV prevention information and education targeted at behavioural change for risk reduction*

HIV prevention and education messages can only succeed in curbing the spread of HIV infection in Southern Africa if they translate into behaviour change for risk reduction. Successful HIV prevention programmes include individual or small-group counselling about

²³² For instance, the public health legislation of several Southern African countries including Malawi, Zambia and Zimbabwe do not have any provision specifically dealing with HIV and AIDS. See Public Health Act of Malawi, Public Health Act of Zambia and Public Health Act of Zimbabwe

²³³ Cameron and Swanson reached the same conclusion after a thorough analysis of the public health options to criminalisation available in South Africa. See Cameron & Swanson (n 16 above).

²³⁴ M Kirby ‘The new AIDS virus – Ineffective and Unjust laws’ (1988) 1 *Journal of AIDS* 3 304 308-309 quoted in Cameron & Swanson (n 16 above) 213.

²³⁵ Cameron & Swanson (n 16 above) 227-229.

²³⁶ Cameron & Swanson (n 16 above) 215-216.

²³⁷ See JD Auerbach & TJ Coates ‘HIV prevention research: Accomplishments and challenges for the third decade of AIDS’ (2000) 90 *American Journal of Public Health* 1029 and also Cutler & Arnold (n 161 above).

condom negotiation and use within sexual relationships, sometimes combined with STDs or HIV testing and diagnosis.²³⁸ Voluntary counselling and testing (VCT) interventions focused on couples are reported to have reduced sexual risk behaviour in Kenya, Tanzania and Trinidad.²³⁹ Moreover, HIV prevention messages should focus on the promotion of a culture of responsibility for all members of society, infected and uninfected, about avoiding unsafe sex.²⁴⁰ Southern African countries should consider the introduction of some of these programmes or develop other programmes that could translate into the reduction of risk behaviour.

5.2.2 Address the underlying causes of vulnerability to HIV infection

Violence, negative social values, discriminatory laws, harmful cultural practices, poverty and inequalities are among the underlying causes of the HIV pandemic in Southern African.²⁴¹ Therefore, Southern African countries ‘in collaboration with and through the community should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, especially designed social and health services and support to community groups’.²⁴²

Criminal law is a tool that could be relevant in addressing the causes of vulnerability to HIV infection through the prevention and punishment of domestic violence that places women at risk of HIV infection. The decriminalisation of prostitution will also enhance access to prevention and care for commercial sex workers. The reform of customary laws as well as will and inheritance laws, property laws and other legislation that contributes to the vulnerability of women will prove necessary in the efforts to address HIV and AIDS.

²³⁸ Auerbach & Coates (n 237 above) 1029.

²³⁹ As above.

²⁴⁰ See G Marks *et al* ‘Reducing sexual transmission of HIV from those who know they are infected: the need for personal and collective responsibility’ (1999) 13 *AIDS* 297-306.

²⁴¹ See UNAIDS *et al* (n 8 above).

²⁴² Office of the UN High Commissioner for Human Rights & the Joint United Nations Programme on HIV/AIDS (n 186 above) Guideline 8.

5.2.3 Increase access to HIV-related services

Access to HIV-related services in the form of prevention, treatment, care and support is fundamental to address the HIV pandemic. The population coverage of HIV-related services in most Southern African countries is currently very poor.²⁴³ Therefore, governments in Southern Africa should increase their efforts to provide HIV-related services particularly to vulnerable and marginalised groups and in rural and poor areas.

²⁴³ For instance as of September 2004, only 2000 out of the 56 000 people in need of ART in Lesotho were accessing it. At the end of September 2005, only 30 055 out the 170 000 people in need of ART in Malawi were accessing it. See AIDS and Human Rights Research Unit (n 168 above).

3 Routine testing of individuals attending public health facilities: Are SADC countries ready?

*Nyasha C Chingore**

1	Introduction
2	Arguments in favour of and against routine testing
3	Introduction of routine HIV testing of individuals attending public health facilities in Southern Africa countries
4	HIV testing and human rights
5	Assessment of the routine testing programmes in SADC countries, with specific reference to the requirements of counselling and informed consent
6	Implications of introduction of routine testing policies in Southern Africa
7	Conclusions and recommendations

1 Introduction

1.1 Background

HIV testing has long been a focal point of concern for those committed to the struggle against HIV and AIDS. HIV testing continues to raise human rights concerns that have been relevant since the pandemic began, but with growing availability of treatment and the general move towards scaling up of treatment in order to broaden access to treatment, testing issues are becoming even more complex. There is increasingly a need to conceptualise more specifically the human rights concerns relevant to HIV testing and particularly to consider whether these concerns have changed as a result of recent advances in treatment.

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Despite advances made regarding treatment for HIV and other opportunistic diseases and although the majority of people infected and affected by HIV and AIDS live in Africa, only about eight per cent of the people requiring ART in Africa were on treatment in 2004. This number rose to about 17 per cent in 2005.¹ HIV testing and counselling is recognised as the gateway to treatment, care and support, yet it is estimated that only about ten per cent of the people in Africa have access to testing and counselling services.² This implies that even where treatment is available, only those in this limited testing pool can access it. The fact that those most in need of treatment, care and support cannot access them is unacceptable and requires consideration of models for provision of services to permit broader access for all. One of the ways of doing this, which is under consideration, and in some parts of Southern Africa is already being implemented, is to make HIV testing and counselling services a part of routine healthcare.³

1.2 Research questions

This study explores how the Southern African region, particularly the Southern African Development Community (SADC) countries, have responded to calls for scaling up counselling and testing in this era of scale-up of treatment. I look particularly at the response to calls to provide HIV tests on a more routine and streamlined basis in public health facilities.

The aim of this paper is to examine the existing HIV testing and counselling policies, particularly those aimed at the routine testing of individuals attending health institutions in the SADC region, and to consider the human rights implications of such policies. The study identifies factors within some current policies that may lead to the violation of the human rights of people to be tested for HIV under routine testing policies. Possible solutions to contribute to ensuring that efforts to reach the important goal of scaling-up access to AIDS treatment do not undo hard won gains in the protection of individual rights in the context of HIV and AIDS will also be proposed.

The research also considers the legal environment in which routine testing policies are being introduced in the region. The question is whether this environment is favourable to the protection of the human rights of those to be tested under these policies. The

¹ UNAIDS, 'Consultative meeting on HIV testing and counselling in the Africa region' Johannesburg South Africa (15-17 November 2004) 15.

² n 1 above 5.

³ Being implemented in: the UK See the British Association of Sexual Health and HIV Guidelines of 2006, the US the CDC recommended routine testing in clinical health set-ups in 2004 and has just issued Revised Guidelines on routine testing in July of 2006. In Africa routine testing has been carried out in Botswana since 2004.

paper also briefly considers the developments concerning access to treatment, which in many ways represent something of a catalyst for introducing routine testing in Southern Africa.

1.3 Research methodology

By conducting a literature review, the paper examines whether the national policies on HIV and AIDS and HIV testing policies within the region comply with international human rights standards. It then considers the question of stigma and discrimination through an analysis of national legislation, particularly on the right to non-discrimination for people living with HIV and AIDS, and other relevant human rights, to see whether the legal environment offers any protection in the case that violations do arise out of testing policies.

1.4 Overview

The paper is divided into seven parts. Part 1 delimits the study. Part 2 provides a background to the topic and endeavours to explain the history of HIV testing and how we have ended up where we are, juxtaposing arguments in favour of and cautions about routine testing. Part 3 provides a brief summary of routine testing in the region and highlights at which stage countries are with regard to the introduction of these policies. Part 4 sets out the human rights obligations of states that are relevant to routine testing. In part 5, the focus returns to the specific policies, highlighting compliance with the counselling and informed consent as the core requirements derived from the human rights obligations of states. Part 6 considers the general legal environment within which routine testing policies are being introduced in the region by looking specifically at laws protecting people living with HIV from discrimination. It also considers the protection of women as a particularly vulnerable group and as the group currently most targeted by routine testing policies. Finally, part 7 makes some concluding remarks and recommendations.

1.5 Definition of terms

In this study, 'routine testing' is understood to mean that any person who comes into contact with the health system, for any healthcare problem, is automatically invited and strongly encouraged to take an HIV test.⁴ It is a clinician-initiated discussion, differing from the much more common practice in which patients are expected to initiate such

⁴ P Nieburg *et al* 'Expanded HIV testing: Critical gateway to HIV treatment and prevention requires major resources, effective protections' (January 2005) *Centre for Strategic and International Studies* 9.

discussion unless they exhibit an AIDS-related symptom. With routine testing, HIV testing thus becomes like any other test that can be recommended by the medical practitioner. This is a marked departure from the traditional model where HIV testing has been considered a special case, requiring specific methods of counselling and informed consent before it was carried out.

Generally two models of routine testing have emerged, these are referred to as 'opt-in' and 'opt-out' testing. With 'opt-in' testing, the HIV test is routinely recommended and offered, *and* the patient must explicitly consent to receive the HIV test. With 'opt-out' testing, the HIV test is routinely recommended and provided, the patient is informed of their right to refuse the test, the test is performed after notifying the patient that the test will be done, and consent is inferred unless the patient expressly declines. In 'opt-in' approaches, patients have to specifically agree to the test. In routine offer 'opt-out' approaches they have to specifically decline the test if they do not want it to be performed. The opt-in and opt-out terminology can be quite confusing. Generally the World Health Organisation and UNAIDS recommend that persons will be offered an HIV test and tested unless they specifically decline.

2 Arguments in favour of and against routine testing

2.1 Why now? Arguments in favour of routine testing arising from a changed context

2.1.1 *Improvement in treatment and care*

In the initial stages of the pandemic, policy and programmatic approaches to HIV testing emerged in a context of fear of the virus and concerns about how to prevent HIV infected individuals from transmitting the virus.⁵ There were aggressive calls for punitive and forcible testing of 'high risk' members of the population. However, the realities of stigma, discrimination and the neglect of human rights protections were soon recognised as deterring people from seeking prevention and care. This created fertile ground for people not to get tested and, unaware of their HIV status, to further spread the virus. Over time, community advocates, human rights advocates and public health professionals collectively recognised that voluntary counselling and testing (VCT), with its specific requirements of

⁵ UNAIDS Global Reference Group on HIV/AIDS and Human Rights Issue Paper 'Current debates on HIV testing and counselling' 1, http://w4.unaids.org/in+focus/hiv_aids_human_rights/reference+group.asp (accessed 31 March 2006).

counselling, informed consent and confidentiality, for the most part meet both public health and human rights concerns and are the most effective means to encourage HIV testing.

It must also be noted that at this initial stage, an HIV diagnosis meant nothing to the diagnosed except an admonishment to live a safer sexual lifestyle as well as adopt a healthier lifestyle to avoid opportunistic infections and eventually a painful, pitiful death. With no effective treatment and significant psychosocial drawbacks to a positive diagnosis, routine testing or screening was far more an imposition on the individual, regardless of any gains to the community at large.⁶

In recent years, the prospect of care and treatment of HIV and opportunistic diseases have become more widely available. These factors, combined with technological advances and a reduced cost of testing,⁷ often serve as the basis for arguments in favour of routine testing.⁷

2.1.2 *Small number of people making use of VCT*

Despite advances in treatment and care, very few people who could benefit from testing in order to gain access to this treatment, care and support know their HIV status. It is estimated that only about 10 per cent of people in Africa have access to testing and counselling services.⁸ Concern about this state of affairs, together with the aforementioned advances, has resulted in enormous changes in the perception of, approaches to and content of HIV testing on the part of public health practitioners and policy makers worldwide. There have been increasing calls to move away from the VCT model, most particularly in high prevalence areas where it has apparently not resulted in large numbers of people being tested. The World Health Organisation (WHO) noted:

The time has now come to implement HIV testing and counselling more widely using existing health-care settings, moving beyond the model of provision that relies entirely upon concerned individuals seeking out help for themselves to permit broader access for all. In this new approach, such services will become a routine part of healthcare, for example during attendance at antenatal clinics, or at diagnosis and treatment centres for tuberculosis and sexually transmitted infections.⁹

⁶ MD Wagner 'Back to basics ... Making HIV testing routine' quoting C Manuel 'HIV screening: Benefits and harms' in R Bennett & CA Erin (eds) *HIV and AIDS: Testing, screening, and confidentiality* (1999); (2003) 9(8) *IAPAC Monthly* <http://www.aegis.com/pubs/iapac/2003/IA030802.html#f23> (accessed 18 July 2006).

⁷ WHO 'The right to know: new approaches to HIV testing and counselling' http://www.who.int/hiv/pub/vct/en/Right_know_a4E.pdf (accessed 31 March 2006).

⁸ UNAIDS (n 1 above) 5.

⁹ WHO Report, 'Increasing Access to HIV Testing and Counselling: A Report of a WHO Consultation', Geneva, Switzerland (19-20 November 2002)3.

WHO and UNAIDS first recommended the provider-initiated routine offer of testing in three contexts: (1) sexually transmitted infection clinics – to permit counselling tailored to HIV status, (2) the context of pregnancy – to facilitate an offer of antiretroviral prevention of mother-to-child transmission; and (3) clinical and community-based health service settings where HIV is prevalent and antiretroviral treatment is available.¹⁰ However, the ‘Provider-Initiated HIV Testing and Counselling in Clinical Settings: WHO/UNAIDS Draft Guidelines’ of February 2006 now recommend that HIV testing is routinely offered to every patient unless they decline in order to ensure the best possible care. In Southern Africa, prominent figures like President of Botswana Festus Mogae, as well as renowned HIV activists like Judge Edwin Cameron of South Africa are among those who have also called for routine testing in the region.

It has been suggested that, in light of the abovementioned changes, VCT is too slow or inefficient to help prevent the relentless spread of HIV. An approach in which requirements for pre- and post-test counselling and informed consent are relaxed is being advocated by some. With regard to pre-test counselling, it is being suggested that the question of resources simply makes long drawn out counselling procedures unrealistic in resource-constrained environments. It is also suggested that emphasis on the voluntariness of the HIV test as well as requirements of informed consent and confidentiality are no longer necessary in light of the availability of treatment and may be slowing down and jeopardising curbing the spread of the disease, especially in Africa.¹¹

2.1.3 Avoiding the stigma of stand-alone facilities

It is further argued that there will be further benefit in making HIV testing a more routine part of care in clinical settings because it is generally accepted that some people who are at risk of HIV infection avoid stand-alone voluntary counselling and testing locations as a result of the stigma and discrimination that is associated with being seen at ‘these places’ and being gossiped about as possibly having HIV.

2.1.4 Knowledge of HIV status will lead to behaviour change

Finally, it is also argued that existing programmes do not appear to be inspiring behaviour change nor adequately preventing HIV infection. There is also an unmet need among at-risk populations for greater

¹⁰ UNAIDS/WHO Policy Statement on HIV Testing 2004.

¹¹ KM De Cock *et al* ‘Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century’ (2002) 360 *The Lancet* 70, www.thelancet.com/journal/journal.isa (accessed 27 March 2006).

knowledge of personal infection status.¹² It is believed that many new infections could be prevented if more HIV-infected people were made aware of their status and targeted with safe-sex messages so that they can adopt safer sexual behaviour and greatly reduce the number of potentially HIV-transmitting sex acts.¹³

2.2 Arguments against and concerns about routine testing

2.2.1 Violations of human rights

The move towards expanding provider-initiated testing in the form of routine testing in public healthcare facilities has resulted in the reopening of the assessment of the ethics and human rights implications of HIV testing policies. Proponents of routine testing argue that informed consent to all medical tests, including the HIV test, is implicit by virtue of one seeking healthcare services. Some critics of this approach are concerned about the violations to autonomy, bodily integrity, and privacy that result from corroding pre- and post-test counselling, informed consent and confidentiality.

2.2.2 Gendered implications

In Southern Africa specifically, gender-related issues arise when individuals are offered the test in the public health system. In reality, routine testing in the public health system would be administered more frequently to women than men, since women are more likely to come into contact with formal health services.¹⁴ Women and girls in Africa have faced violence and abuse when they have been known or were suspected to be HIV positive.¹⁵ It has therefore been urged that if governments choose to implement routine opt-out testing, this policy should have well-funded measures for the protection of HIV-positive women and girls from abuse.¹⁶

The fact that routine testing policies usually begin by focusing on women (pregnant women) leads to the further feminisation of the

¹² R Holbrooke 'Sorry, but AIDS testing is critical' *Washington Post* (4 January 2006) <http://www.washingtonpost.com/wp-dyn/content/article/2006/01/03/AR2006010301273.html> (accessed 31 March 2006).

¹³ KM De Cock *et al* 'Unfinished business – Expanding HIV testing in developing countries' (2006) 354 *The New England Journal for Medicine* 440-442 <http://content.nejm.org/cgi/reprint/354/5/440.pdf> (accessed 18 July 2006).

¹⁴ S Rennie & F Behets 'Desperately seeking targets: the ethics of routine HIV testing in low income countries' (2006) 84 *Bulletin of the World Health Organisation* 55.

¹⁵ See F Zuberi "If you (be)come HIV positive, you will lose your human rights." HIV/AIDS stigma and human rights: A localised investigation of Hammanskraal communities - A report of the Tswelopele research project of the Centre for the Study of AIDS' in F Viljoen (ed) *Righting stigma: Exploring a rights-based approach to addressing stigma* (2005) 31.

¹⁶ J Csete *et al* 'Opt-out testing in Africa: A caution' (2004) 363 *The Lancet* 494.

disease. The notion that new infections could be prevented by routine testing programmes if more HIV-infected people were made aware of their status and targeted with safe-sex messages is sometimes problematic for African women. They are often not empowered to make decisions about their sexual behaviour as a result of cultural and social gender inequalities. For many women in the region, knowing their status where there is no access to treatment does not help them in any event.¹⁷

Regarding the 'opt-out' routine testing procedure, the question is how real the 'opt-out' option itself is, considering the power imbalance between the healthcare provider and the one to be tested. In Africa it is usually the poor and uneducated that are most likely to use public healthcare facilities. If information is not adequately provided or explained, there is a risk that a decision may not be informed or made with consent.

These issues deserve in-depth analysis from both health and human rights perspectives. The determination of whether an individual's human rights are being sufficiently respected and protected in the context of testing should particularly be considered if a testing policy is really to have a positive impact on curbing the spread as well as reducing the negative social impact of the virus. Attention needs to be paid to the perceived and actual health or social benefits of the chosen approach to HIV testing, the strength of the evidence on which the decision is being made, and the implications of a chosen testing strategy for particular individuals or populations, in a specified location and at a given time.¹⁸

2.2.3 *Lack of available treatment*

Proponents of routine testing argue that advances in treatment will mean that the more people who test, the more people will have treatment. However, pharmaceutical advances and even reduced costs of medicines have not translated into increased availability of HIV drugs to those who want or need them. There is no guarantee that a tested person will receive ARVs. In most of the countries in this study, testing and treatment roll-out programmes are not universal, often receiving more coverage in urban areas and little or no coverage in rural settings.

In Angola only 30 per cent of the population has access to healthcare in general.¹⁹ There is currently only one state hospital in Angola that provides ART. In 2004, there were ten sites providing

¹⁷ B Boer 'HIV testing in pregnancy' <http://www.avert.org> (accessed 15 May 2006).

¹⁸ UNAIDS Global Reference Group on HIV/AIDS and Human Rights (n 5 above).

¹⁹ WHO summary country profile for HIV/AIDS treatment scale-up: Angola (June 2005) http://www.who.int/3by5/support/june2005_ago.pdf (30 November 2006).

testing and counselling services in Angola; however, most of these facilities are located in the capital.²⁰ Access to ART is also limited in Mozambique, with over 200 000 people in need of ART;²¹ Mozambique is among the 20 countries identified by WHO as having the highest unmet need for ART. As of June 2005, an estimated 11 000 to 13 000 people were receiving ART (5-6 per cent of those in need).²² As of June 2005, only 5 000 - 6 000 out of a possible 230 000 people (2-3 per cent of those in need) in the Democratic Republic of Congo were receiving ART,²³ placing it too among the 20 countries identified by WHO as having the highest unmet need for ART.

Zimbabwe has utilised the state of emergency to allow national companies to manufacture anti-retroviral drugs, although production costs remains expensive. Medicines are, in theory, provided free or are subsidised to those who cannot afford to pay market prices, but most government hospitals have a massive shortage of drugs as a result of the current economic crisis and collapse of the health sector. People in need of medication fear that the country may run out of ARVs. In fact the government has admitted that the state had less than one month's stock of antiretroviral drugs.²⁴

Furthermore, financial charges for CD4 count tests remain prohibitive for most Zimbabweans and, yet, are a requirement for access to treatment. The high cost of user-fees in state hospitals puts access to quality health services well beyond the reach of many Zimbabweans. Health user-fees tripled in March 2006 in state hospitals.²⁵ Private hospitals, doctors and clinics have also increased their fees. Private sector doctors' fees increased in April 2006 by 100 per cent.²⁶ The private health sector is collapsing with many people switching to the already overburdened public sector.²⁷

²⁰ UNAIDS/WHO Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Angola (2006) http://data.unaids.org/publications/Fact-sheet01/Angola_EN.pdf (accessed 30 November 2006).

²¹ As above.

²² WHO 'Progress on Global Access to HIV Antiretroviral Therapy' (19 June 2005) <http://www.who.int/3by5/fullreportJune2005.pdf> (accessed 31 January 2007).

²³ As above.

²⁴ 'ARV's running out' *The Herald* 3 May 2006 <http://www.herald.co.zw/inside.aspx?sectid=2753&cat=1> (accessed 3 May 2006).

²⁵ Basic consultations increasing from Z\$300,000 (US\$3) to more than Z\$1 million (US\$10) for adults and Z\$250,000 (US\$2.50) for children (children under the age of 5 are treated for free).

²⁶ This was the second increase in the year, these fees increased to Z\$5,700,000 (US\$58).

²⁷ Human Rights Watch 'No bright future: Government failures, human rights abuses and squandered progress in the fight against AIDS in Zimbabwe' (July 2006) 18 (5) 39-40.

Zimbabwe has been further crippled by its economic hardships which impact directly upon the nutritional needs of people living with the virus.²⁸ The importance of nutrition for people living with HIV is also an important problem in Zambia. As one man explains,

I am lucky enough to get nutritious food for myself and my family, but I have to share with ten children and my wife. Making my children as spectators as I eat the food is not possible. Food is a problem, not because I am a sick man to ask for food but I am looking after 11 dependents. I belong to the Church and they can provide nutritious soya bean flour, but it is only given to the poor people and not to me who is working. Good quality food is what my body requires. The cost of drugs at K 40,000 is too expensive for me when, on the other hand, I need to get food.²⁹

Indeed, more than 68 per cent of Zambians are food insecure, with 53 per cent being categorised as 'severe' and 15 per cent categorised as 'moderately insecure'.³⁰ Thus, while the treatment and testing costs have been removed in the public sector in Zambia, the heavy burden of nutrition still remains.

Many SADC countries do not have the capacity to improve their healthcare facilities. The scale-up of VCT and ART in all SADC countries mainly relies on international and donor funding from the Global Fund for HIV/AIDS, Tuberculosis and Malaria (Global Fund) and other organisations. Expansion of VCTs, strengthening of healthcare facilities, technology transfer and education awareness are all dependent on financial resources. Because ART requires predictable and sustainable financing, the question is whether ART programmes will remain sustainable once donor fatigue and related complications set in.

Where ARVs are widely available, routine testing can still be problematic where proper counselling and information is not provided. The general requirement is that only HIV-positive people with a CD4 count of less than 200 qualify for ART. Therefore, an HIV-positive test does not necessarily mean immediate access to treatment. Current testing and treatment scale-up campaigns often neglect to make this clear. Often, uninformed people living with HIV may find themselves having to deal with an unexpected load of repeated testing and challenges that they were initially not fully aware of as a result of the simplified counselling. One lady in Botswana expressed

²⁸ 'Zimbabwe: HIV-positive people floundering as economy sinks' IRIN News 10 May 2006 <http://www.irinnews.org/report.asp?ReportID=53274> (accessed 10 May 2006).

²⁹ The International HIV/AIDS Alliance 'Antiretroviral Treatment in Zambia: A study of the experiences of treatment users and healthcare workers' (March 2004) 15-16, <http://www.aidsalliance.org/sw7422.asp> (accessed 31 January 2007).

³⁰ Zambia National AIDS Council 'Overview of Zambia's response to HIV/AIDS' (September 2004) 70, <http://www.zambia-aids.org.zm/> (accessed 31 January 2007).

the view that had she been fully informed of the implications of HIV testing before testing she would probably have opted out, as knowing her status has caused her more anxiety than not knowing.³¹ In another report, a person living with HIV in Botswana also reported not being given much information before his test:³²

I was in great pain – my sister was called for discussions. She consented and because I was in pain I just gave in,’ he said. When the results came back positive, Kgwaane said he felt his whole world was collapsing. ‘To be honest with you, I was not really prepared to get my results, but they were there and I had no choice.

Studies in Botswana have shown that where people are fully informed about the implications of the test they are more careful about accepting it. More work is needed to address the root causes of why people reject an HIV test when they are fully informed in order to ensure a more effective response to the pandemic.³³

Before countenancing an encroachment of human rights (by allowing for routine testing without informed consent resulting from a proper counselling session), policymakers should be certain that the promise of widespread treatment access is a real one and not a dim prospect.³⁴ It is also important that patients fully understand how access to treatment works *before* they take the test in order that they make informed decisions regarding their health.

3 Introduction of routine HIV testing of individuals attending public health facilities in Southern Africa countries

Over the last few years, nine of the 14 SADC countries now carry out some form of routine offer testing, mainly in the PMTCT set-up where pregnant women are routinely offered an HIV test. However, often these practices and programmes are not yet clearly spelled out as a routine testing policy in the countries’ national policies as the majority of these preceded the scaling up of treatment and testing. A

³¹ Woman living with HIV in Botswana speaking at Press Conference ARASA/BONELA Consultative meeting on HIV testing in the African region, Gaborone Botswana 13 March 2006 (notes of this speech and power point presentation on file with author).

³² ‘Botswana: Routine HIV testing not as straightforward as it sounds’ IRIN PlusNews 1 February 2006 http://www.irinnews.org/AIDSreport.asp?ReportID=5647&SelectRegion=Southern_Africa (accessed 12 April 2006).

³³ E Darkoh (Ministry of Health, Botswana) ‘Integrating Testing and Counselling into Clinical Settings: Routine Offer and Diagnostic Testing’ Presentation at the Consultative Meeting on HIV Testing and Counselling in the Africa Region (copy of presentation is on file with author).

³⁴ M Crewe & F Viljoen ‘Testing times: Routine HIV testing – a challenge to human rights’ (unpublished background paper prepared for the International HIV Testing Email Group, February 2005, 12, on file with the AIDS and Human Rights Research Unit).

number of countries that are currently working on national HIV and AIDS policies or updating their current national policies are making provision for routine testing in their new policy document. Profiles of six SADC countries that have introduced routine HIV testing, exemplifying a trend in the region, are given.

3.1 Botswana

In Botswana routine testing is taking place but there seems to be no clear policy regarding how this should be carried out in practice. Guidelines for the implementation of routine testing were introduced but there is still some confusion between how the policy should be and is being implemented on the ground. However, the Ministry of Health reports that since the introduction of routine testing in January 2004 not a single formal complaint on the violations of human rights has been lodged with the ministry.³⁵ Once adopted, the Draft Botswana National Policy on HIV/AIDS (2005) will refer specifically to a policy of routine offer of testing.³⁶

3.2 Malawi

In Malawi clear provision for routine testing has been written into the national policy and national testing guidelines.³⁷ However, the country does not currently have a practical programme of routinely testing or offering a test to all individuals attending healthcare facilities, but, rather, focuses on providing such services at antenatal clinics and treatment centres for sexually transmitted infections.

3.3 Namibia

The Draft National HIV/AIDS Policy Namibia recommends that the government shall ensure that voluntary HIV counselling and testing is routinely offered and is accessible to each patient diagnosed with TB or STI, to all patients with symptoms that can be attributable to HIV, as well as to all pregnant women.³⁸

3.4 South Africa

The South African HIV testing policy does not make provision for routine testing although pregnant women are routinely offered the

³⁵ TW Steen, Ministry of Health Botswana Department of HIV Testing, Presentation at the ARASA/BONELA HIV Meeting on HIV Testing, Gaborone, 13 March 2006.

³⁶ Sec 5(2)(2) of the Draft Botswana National Policy on HIV/AIDS (2005) version 6.

³⁷ National HIV/AIDS Policy (2003) 14; HIV/AIDS Counselling and Testing: Guidelines for Malawi (2004) 4-5 and Guidelines for expanded HIV testing in Malawi (2005) iv.

³⁸ Draft National HIV/AIDS Policy Namibia sec 3(3)(1), January 2006.

HIV test in the context of PMTCT. However, it is reported that the South African government is considering whether to make HIV tests routinely available at public health facilities. The chief director of the national HIV/AIDS unit in the Ministry of Health has stated that health department officials are still deciding whether routine testing would be an appropriate strategy and that the government was hoping to 'learn lessons from Botswana'.³⁹ Influential figures like Edwin Cameron, a Supreme Court of Appeals Judge and HIV activist, and Mark Heywood, Director of the AIDS Law Project and Treasurer of the Treatment Action Campaign, endorse some kind of routine offer of HIV testing in South Africa,⁴⁰ although they differ sharply on the details of how this policy would work in practice. Judge Cameron has identified pre-test counselling as an impediment to effective management of the disease.⁴¹ The Joint Civil Society Monitoring Forum of South Africa recently drafted a proposal that advocates for routine testing in public health facilities but with checks and balances together with respect for human rights.⁴²

3.5 Zambia

There are reports that Zambia has initiated a programme of routine HIV testing at health facilities in a bid to eradicate the stigma associated with AIDS, by transforming it into an 'ordinary disease'.⁴³ There is, however, currently no written policy to this effect. Zambia provides a classic example of how routine testing policies can easily be misunderstood. The National AIDS Council called for mandatory testing in hospitals and clinics as part of the programme to place at least 100 000 people on ARVs by 2005.⁴⁴

3.6 Zimbabwe

The Permanent Secretary for Health in Zimbabwe issued a statement that the 'Ministry of Health and Child Welfare [is] adopting this

³⁹ 'Govt to consider routine testing' IRIN PlusNews, 9 August 2005 http://www.irinnews.org/AIDSreport.asp?ReportID=5647&SelectRegion=Southern_Africa (accessed 19 May 2006).

⁴⁰ 'The HIV testing debate: voluntary or opt-out?' <http://www.haart4africa.com/oid1/pub> (accessed 19 May 2006).

⁴¹ As above.

⁴² 'Scaling up voluntary HIV counselling and testing (VCT) in South Africa: Time for new models' Consensus Statement of the Joint Civil Society Monitoring Forum (JCSMF), The National Meeting (5 October 2006) <http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=318> (accessed 8 January 2007).

⁴³ The country's Health Minister, Sylvia Masebo told delegates at the 42nd Regional Health Ministers' Conference in February 2006 <http://www.news.afrcast.com> (accessed 31 May 2006).

⁴⁴ 'Zambia in a quagmire over Aids testing', The Mail and Guardian (16 September 2004) <http://www.mg.co.za/Content/13.asp?cg=InsightAfrica&ao=1222> (accessed 17 June 2006).

provider initiated strategy where all patients attending health institutions are routinely offered HIV testing but they can opt out if they choose to do so'.⁴⁵ The revised National Guidelines on HIV Testing also make provision for routine testing.⁴⁶ At present, in practice it is mostly pregnant women who are routinely counselled and offered the HIV test in public health facilities. Routine testing for PMTCT was introduced following studies suggesting its acceptability.⁴⁷

4 HIV testing and human rights

4.1 International human rights standards and guidelines for HIV testing

SADC countries have ratified various human rights treaties and conventions, pledging their commitment to protect the human rights of their citizens.⁴⁸ Although the existing international human rights law instruments do not address HIV or AIDS specifically, the rights contained therein generally apply to people living with HIV. Further, the General Comments and General Recommendations issued by some of the human rights treaty bodies, particularly the Committee on Economic, Social and Cultural Rights (ICESCR), the Committee on the Elimination of Discrimination against Women (CEDAW Committee) and the Committee on the Rights of the Child (CRC Committee), explicitly address those treaties in the context of HIV prevention, treatment, care and support.⁴⁹ In addition, UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) have developed international guidelines to address prevention, treatment, care and support for HIV and AIDS in order to control the spread of the disease and to ensure the protection and respect of human rights in the process.⁵⁰ Although these guidelines are not legally enforceable, it is argued that they were drawn from well-researched papers undertaken by experts and they serve as a universal course of action that countries should follow in the fight against the epidemic. It is

⁴⁵ E Xaba (Permanent Secretary MOHCW) Zimbabwe Ministerial Directive issued in April 2005.

⁴⁶ Zimbabwe National Guidelines on HIV Testing (2005) 3-4.

⁴⁷ F Perez *et al* 'Acceptability of routine HIV testing in antenatal services in Zimbabwe' 3rd International AIDS Society Conference on HIV Pathogenesis and Treatment, Rio de Janeiro (24-27 July 2005).

⁴⁸ See table in 'Introduction' above, showing the specific dates when each of the SADC countries ratified the major human rights treaties.

⁴⁹ General Comments 3 of the CRC, General Comment 14 on the ICESCR and General Recommendation 15 of CEDAW. See International Human Rights Instruments, Compilation of General Comments and General Recommendations adopted by Human Rights Treaty Bodies (HRI/GEN/1/REV. 27) 12 May 2004.

⁵⁰ The guidelines were first released in 1998, revised in 2002 and have been consolidated in 2006 under the UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version.

therefore important that national policies, programmes and laws developed to address HIV comply with these internationally accepted standards or guidelines.⁵¹

The constitutions of many Southern African countries together with the human rights instruments ratified by the states, entitle individuals attending public health institutions to a number of human rights, including the rights to equality and non-discrimination, the rights to privacy and autonomy, the rights to security and liberty and the right to health. These rights need to be upheld in any HIV testing policy.

4.1.1 The rights to bodily integrity, autonomy and privacy

The rights to bodily integrity, autonomy and privacy give individuals control over their bodies and enable them to make autonomous decisions. Generally no health service may be provided to a patient without their consent. Human dignity and the right to bodily integrity require that a person be allowed to make all decisions pertaining to their health. The right to privacy and bodily autonomy therefore means that a person cannot be tested or treated for any disease, including HIV, without their knowledge and consent. The requirements of valid consent include that the patient must have knowledge of as well as appreciate and understand the nature and extent of the harm or risk involved and consent to the harm or assume the risk.⁵² The rule on informed consent is based on the fact that the patient is best placed to understand and therefore protect his or her own interests and that there is an intrinsic value in people deciding about and taking responsibility for their own lives.

The right to security and liberty is guaranteed under article 9 of the International Covenant on Civil and Political Rights⁵³ (ICCPR) and article 6 of the African Charter on Human and Peoples' Rights (African Charter),⁵⁴ both of which all Southern African countries are party. An essential element of the right to security and liberty is the right to informed consent prior to any medical procedure. The United Nations General Assembly, in its resolution on the rights of persons with mental illness, defines informed consent as consent to a medical

⁵¹ The Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly in 2001 provides for regular reporting on global progress using indicators developed by, among others, UNAIDS.

⁵² A Strode *et al* 'Scaling up HIV testing in resource-constrained settings: debates on the role of VCT and routine 'opt-in or opt-out' HIV testing' (2005) *The South African Journal of HIV Medicine* 24, quoting *Lambert v Hefer* NO 1955 (2) SA 507 (A) 507 G-H.

⁵³ Adopted by General Assembly Resolution 2200A (XXI), 21 UN GAOR Supp (No 16) at 52, UN Doc A/6316 (1966), 999 UNTS 171, entered into force on 23 March 1976.

⁵⁴ Adopted in June 27, 1981 by the Assembly of Heads of State and Government of the OAU, OAU Doc CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982), entered into force on 21 October 1986.

intervention that is ‘obtained freely, without threats or improper inducements.’⁵⁵ This right supposes that no one will be subjected to compulsory testing and that they will retain the right to refuse any routine test. The genuine consent of any individual attending a public health institution is to be obtained through adequate counselling which covers the benefits and potential adverse effects of proposed procedures, tests and available alternatives.

The right to privacy may be traced back to article 12 of the Universal Declaration of Human Rights (1948). The same right is provided for in article 17 of the ICCPR. The obligation imposed by article 17 of the ICCPR requires that states adopt legislative and other measures to give effect to the prohibition against interferences and attacks on one’s family, home or correspondence as well for the protection of the right to privacy.⁵⁶ In the view of the Committee, this right is required to be guaranteed against all such interferences and attacks whether they emanate from state authorities or from natural or legal persons.⁵⁷

4.1.2 *The right of access to healthcare*

The right to healthcare services has often been interpreted to imply the right to provide conditions conducive to healthcare-access,⁵⁸ that is, it creates a duty on the part of the state to create an *enabling environment* for individuals to be able to access healthcare services. Failure to protect privacy and the ability to give informed consent on decision relating to one’s bodily integrity creates an environment which discourages people from using healthcare facilities.⁵⁹

⁵⁵ United Nations General Assembly, Principles for the protection of persons with mental illness and the improvement of mental healthcare, GA Res. 199, UN GAOR, 46th Sess, Supp No. 49 at Principle 11, 2, UN Doc. A/RES/46/119 (1992), www.unhcr.ch/html/menu3/b/68.htm (accessed 12 April 2006).

⁵⁶ ICCPR General Comment 16.

⁵⁷ As above.

⁵⁸ CESCR Committee ‘The right to the highest attainable standard of health’, 11 August 2000, UN Doc E/C.12/2000/4. (General Comments). The ICESCR in art 12 provides: ‘1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The *creation of conditions* which would assure to all medical service and medical attention in the event of sickness’ (emphasis added).

⁵⁹ This argument sets a basis for states to respect the right to confidentiality and privacy in healthcare and has been advanced in the context of partner notification to HIV/AIDS as an alternative to the confidentiality and privacy argument since the African Charter on Human and Peoples’ Rights does not provide for a right to privacy. In the context of giving informed consent it has been argued that routine testing policies may actually have the effect of discouraging people (particularly women) from using public healthcare facilities.

4.1.3 The rights to equality and non-discrimination

The right to equality and non-discrimination is provided in article 2 of the ICCPR, article 2 of the ICESCR and article 2 of CEDAW.⁶⁰ This right ensures that the HIV status of any individual will not be used as a ground for stigma or discrimination against them from health personnel, their family or the community.

4.1.4 The right to information

Scaling up of testing in the form of routine testing in healthcare facilities has also been justified as a human rights imperative in terms of ‘the right to know’. It is suggested that people not only have a right to information about HIV but also that governments have a duty to ensure that it is possible for people to know their HIV status if they wish to, through the availability of testing sites. This right to know is ultimately linked with the right to life as provided in numerous international human rights instruments. The right to know requires that governments make available and accessible the means to know one’s HIV status, but it does not take away one’s right to choose not to know one’s status by retaining the option to choose not to get tested.

4.2 Regional declarations for the protection of human rights in the context of HIV

At a regional level, heads of African states committed themselves to respecting human rights and ensuring the equal rights of people living with HIV and AIDS through their endorsement of the Abuja Declaration.⁶¹ By adopting the Maseru Declaration, SADC heads of states committed themselves to the upholding of human rights and fundamental freedoms for all, including prevention of stigma and discrimination of people living with HIV and AIDS.⁶² They made specific mention of the respect for privacy and confidentiality.

4.3 The human rights approach to routine HIV testing policies

It is necessary to treat individuals attending public health facilities not only as potentially infected patients but also as rights bearers. Ultimately, respect for the rights of individuals in the context of

⁶⁰ Adopted by General Assembly resolution 34/180 of 18 December 1979 entered into force on 3 September 1981.

⁶¹ Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Disease (2001).

⁶² Maseru Declaration on HIV and AIDS.

testing is a condition for the success of the scaling up of testing and treatment programmes, as well as for prevention programmes.

In accordance with the inherent human rights of all individuals as discussed above, testing should therefore, generally always be voluntary (except in cases of donations of blood, blood products, organs and tissue) and carried out only after the patient has given informed consent. It should also only be done when counselling and education before and following testing are available and offered, and when confidentiality of results or anonymity of testing can be guaranteed. The UNAIDS Policy on HIV Testing and Counselling emphasises the importance of maintaining a voluntary approach to HIV testing.⁶³ The International Guidelines on HIV/AIDS and Human Rights also recommend that states should ensure that HIV testing of an individual is voluntary. Guideline 8, on 'Women, Children and Other Vulnerable Groups,' provides that 'states should ensure that all women and girls of child-bearing age have access to comprehensive information and counselling about the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimise that risk, or proceed with childbirth, if they so choose'.

Under international law as well as under some domestic constitutions, rights may only be limited by way of laws of general application that pursue a legitimate aim responding to a pressing social need, and that are proportionate to that aim. In addition, governments must use the least restrictive means possible to achieve those aims.⁶⁴

As already stated, the WHO and UNAIDS have recommended that, in the context of recent developments regarding HIV, HIV testing and counselling should be offered to and not imposed on patients.⁶⁵ However, many types of routine testing are emerging and some have raised questions regarding the human right to privacy and bodily autonomy, particularly in the prenatal situation. With regard to routine testing, WHO guiding principles for testing and counselling state that routine testing for HIV should be voluntary. However, it has been seen that even if there is agreement that HIV testing must be 'voluntary,' this may nonetheless be open to conflicting

⁶³ UNAIDS Policy on 'HIV testing and counselling' (1997); UNAIDS/IPU, *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) 41-43.

⁶⁴ Art 29 of the Universal Declaration, the Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR.

⁶⁵ See introduction above and WHO, 'HIV Testing and counselling: the gateway to treatment, care and support' (2003) http://www.who.int/3by5/publications/briefs/hiv_testing_counselling/en/index.html (accessed 2 April 2006) and UNAIDS/WHO policy on routine offer of HIV testing (2004) http://www.who.int/ethics/topics/en/hivtestingpolicy_who_unaids_en_2004.pdf (accessed 9 March 2006).

interpretations.⁶⁶ As the potential for slippage from routine offers of testing to routine testing is very high, policies on routine HIV testing must distinguish between routinely offered and routinely imposed testing. To avoid ambiguities, the language of the testing process should be made clear and much more descriptive.⁶⁷ The WHO/UNAIDS Revised Draft Guidelines suggest the use of ‘routinely recommended testing’ rather than routine testing and its opt-in, opt-out variations.⁶⁸

5 Assessment of the routine testing programmes in SADC countries, with specific reference to the requirements of counselling and informed consent

The discussion above illustrates that to be human rights-compliant routine testing must, at the very least, be accompanied by counselling and informed consent. Counselling for routine HIV testing can take at least two forms: the person to be tested may be fully counselled before he or she is given the choice to opt-in or out of a test, or the person may be given very limited or simplified pre-test counselling or information. In practice, routine opt-out testing is frequently proposed along with an incomplete, simplified counselling session, consisting of minimal information, or a mere request by the test-provider that the individual be tested. This is one of the major factors that distinguish it from VCT besides the question of who initiates the testing. The long drawn-out nature of pre-test counselling in VCT has been referred to as a bottleneck to testing.⁶⁹ Minimum information or counselling is also meant to deal with the problem of human resources constraints. The ‘3 by 5’ initiative of the World Health Organisation makes reference to ‘simplified’ consent and counselling.⁷⁰ The UNAIDS/WHO 2004 Policy Statement on HIV Testing, specifically states that there is no need for a full education and counselling session.⁷¹ The pre-test counselling session is ‘simplified’ by being reduced to the following elements: a review of the clinical and prevention benefit of testing, the right to refuse, follow-up services

⁶⁶ UNAIDS (n 1 above) 7.

⁶⁷ UNAIDS Global Reference Group on HIV/AIDS and Human Rights ‘Public Report, Third meeting’ Geneva (28-30 January 2004) 3.

⁶⁸ WHO Provider-Initiated HIV Testing and Counselling in Clinical Settings: WHO/UNAIDS Draft Guidelines, February 2006.

⁶⁹ M Moeti (Regional Adviser, WHO/AFRO) ‘HIV testing and counselling in the context of the ‘3by5’ initiative’ Presentation at the Consultative Meeting on HIV Testing and Counselling in the Africa (2004).

⁷⁰ WHO/UNAIDS ‘Treating 3 Million by 2005: Making it Happen’ (2003) 44, <http://www.who.int/3by5/publications/documents/en/Treating3millionby2005.pdf> (accessed 31 January 2007).

⁷¹ UNAIDS/WHO Policy Statement (2004) point 3.

and the importance of informing someone (a partner) at risk if the test is positive.

In light of the stigma and discrimination that is associated with an HIV-positive sero-status in the SADC region, it is important for an individual to understand fully the purposes, risks, harms and benefits of being tested, as well as those of not being tested, prior to performing an HIV test. This will enable them to make an informed decision about whether or not to test. It is clearly stated by advocates for routine testing that the intention of making a recommendation for simplified counselling is to relieve physicians of the obligation to provide the comprehensive pre-test counselling necessary to ground a person's informed consent to HIV testing. Providers have reported that, in the context of prenatal care and routine testing in public healthcare set-ups, pre-test counselling following standard HIV protocols is too onerous and burdensome particularly in resource constrained set-ups. It is questionable whether the violation of fundamental protections of human rights can be justified because ensuring protection is burdensome. HIV testing still raises special issues of social risk that are not applicable to other tests conducted as a standard component of healthcare, and still justifies special counselling and informed consent especially within the region.

There are currently different practices with regard to how pre-test counselling is carried out and how informed consent is obtained. Informed consent is a requirement for testing according to the policies or programmes in Southern African countries. Policies can generally be grouped into those that require full individual pre-test counselling and express 'opt-in' informed consent and those that do not expressly require it. Policies can also be grouped into those that accept group counselling as sufficient for pre-test counselling and those that do not.

In Botswana and Malawi, scale-up of testing has the implication of reduced or no pre-test counselling and sometimes implied instead of informed consent. In Lesotho and Zimbabwe policies specifically differentiate group 'information' from 'counselling'. In South Africa pre-test counselling is a legal requirement.

5.1 Botswana

Patients presenting themselves at any public healthcare facility in Botswana are assumed to have implicitly consented to an HIV test. Unless there is an express refusal, the test will be carried out on the strength of this implied consent. The principle is that HIV is treated like any other disease. Patients are seen by the doctor and receive a full medical examination; the doctor conducts differential diagnosis and recommends necessary tests. The patient is simply informed of tests that will be performed; the doctor fills out the necessary slip

and then gives it to the patient to take to laboratory.⁷² In PMTCT programmes in Botswana, clinic-based group counselling and video sessions are used as acceptable ways of reducing the length of individual pre-test counselling sessions and acquiring informed consent.⁷³

The concept of implied consent extended this far is questionable from a human rights perspective. One of the justifications for implied consent in Botswana is that Batswana know they can expect an HIV test upon attending any public health facility so anyone who does not want the test knows that they must explicitly mention this. There are, however, many barriers to effective health communication in most southern African countries including: a small number of media outlets, the power of rumours, unfamiliarity with biomedical concepts, and low rates of literacy.⁷⁴ In fact, according to one population-based study on attitudes, practices and human rights concerns with routine testing in Botswana, only about 54 per cent of respondents from five districts of Botswana with the highest number of HIV infected individuals had heard of routine testing before the survey interview. Generally, these were people from urban areas with a better standard of living.⁷⁵ The lack of clarity concerning the specifics of the routine testing programme itself in Botswana, therefore, warrants further questioning of this justification.

The other justification used to support simplified consent and counselling in Botswana is that pre-test counselling is too demanding in resource constrained environments, and that the time required to provide individual pre-test counselling is one of the main factors that has caused the 'failure' of VCT. It is also suggested that too much information 'scared people off HIV testing'. Apparently, 50 per cent of people wanting an HIV test changed their minds after pre-test counselling.⁷⁶

It is reported that 95 per cent of those offered testing in public healthcare facilities in Botswana accept routine offer testing, that is 95 per cent do not explicitly 'opt-out'. In the first few months, it was reported that many women who got tested in antenatal clinics did not return to get their results.⁷⁷ This problem was addressed by ensuring the use of rapid result tests. It is not clear whether the Ministry of

⁷² Steen (n 35 above).

⁷³ UNAIDS Report on the global HIV/AIDS Epidemic (2002) & 'Introduction of routine HIV testing in Prenatal Care – Botswana 2004' (26 November 2004) 53(46) *CDC MMWR* 1083-1086 <http://www.cdc.gov/mmwr/> (accessed 9 April 2006).

⁷⁴ Rennie & Behets (n 14 above).

⁷⁵ S Weiser *et al* 'Routine testing in Botswana: A population based study of attitudes, practices, and human rights concerns' (2006) 3 *PLoS Medicine* 1013 - 1022.

⁷⁶ n 35 above.

⁷⁷ CDC Global AIDS Programme 'Introduction of routine HIV testing in prenatal care – Botswana, 2004' (n 73 above).

Health in Botswana has considered the fact that a failure to return for results may have indicated that there was some pressure on these women to accept the test when they were not ready for the test results and their implications.⁷⁸ It is possible that the women may have felt intimidated or obliged to comply with the request by healthcare providers to be tested and thus got tested but were not interested to find out the result.

Although the Constitution of Botswana does not provide for a right to autonomy, section 9 does provide for the right to privacy. The National AIDS Policy acknowledges the need to take cognisance of and to show respect for human rights, privacy and self-determination of persons living with HIV/AIDS in line with the country's Constitution.⁷⁹ The Policy, however, balances this concern for privacy with what it calls a concern for the general public welfare. It provides that: 'at the same time, the responsibility of persons with HIV and AIDS to protect others from infection, as well as the right of society to that protection are taken into account'.⁸⁰ Whether this limitation of human rights is justifiable is questionable. The portrayal in many southern African HIV and AIDS policies that people living with HIV are potentially dangerous people from whom the general public needs to be protected, is extremely concerning in countries where stigma and discrimination are rampant.

The lack of clarity about routine testing in Botswana and whether it should be carried out with implied or informed consent may soon be clarified by the Draft National Policy on HIV/AIDS 2005. However, the draft policy is problematic in that it states that a medical doctor or qualified practitioner will not be obliged to comply with the requirements of informed consent in certain circumstances. These circumstances include, but are not limited to: a patient has disclosed engagement in HIV risk behaviour, the patient suffers from sexually transmitted infections, tuberculosis or is pregnant, or the patient specifically asks for a comprehensive medical examination which implies being submitted to all tests including HIV.⁸¹ The draft policy, if adopted, will be a step backward in the protection of the human rights of all individuals attending public health facilities.

5.2 Lesotho

In Lesotho, the position in healthcare facilities is that medical practitioners can only advise a patient to test for HIV if it is suspected that the patient has HIV: The patient is at liberty to refuse the test

⁷⁸ Rennie & Behets (n 14 above).

⁷⁹ Ministry of Health, Botswana National AIDS Policy on HIV/AIDS (1998) para 17.

⁸⁰ As above.

⁸¹ Sec 5(3) of the Draft Botswana National Policy on HIV/AIDS (2005) version 6.

after the counselling has been provided. The Policy Framework provides that the HIV test shall be voluntary, linked and confidential. Pre-test counselling and informed consent will be required and test results will be given after post-test counselling.⁸²

However, even in Lesotho where the policy insists on the voluntary nature of the HIV test, the use of the term ‘HIV testing and counselling’ (HTC) rather than VCT is preferred. The view is that the use of the word ‘voluntary’ makes people believe the test is not wholly necessary.⁸³ Nevertheless, the National Guidelines on HTC are clear that informed consent and education are essential:

Mandatory HIV testing is neither effective for public health purposes nor ethical, because it denies individuals choice, and violates principles such as the right to health, including the right to privacy and the ethical duties to obtain informed consent and maintain confidentiality. *Although the process of obtaining informed consent will vary according to different settings, all those offered the test should receive sufficient information and should be helped to reach an adequate understanding of what is involved.*⁸⁴

The Guidelines further elaborate that;

In Lesotho, HTC must be offered whenever a patient shows signs and symptoms of HIV infection or AIDS; this will aid clinical diagnosis and management. Under these conditions, the offer of HTC should be considered the ‘standard of care’. Informed consent should be obtained during the normal process of consultation between the healthcare provider and the patient.⁸⁵

It is unclear whether healthcare providers are required to provide full pre-test counselling in order to satisfy this requirement of informed consent or whether counselling could be in the form of group information rather than individual counselling.

5.3 Malawi

Malawi’s national policy is crafted in good human rights language and recognises the 3 C’s (counselling, consent and confidentiality) as being the ‘cornerstone’ of all testing.⁸⁶ However, with regard to counselling, the guidelines on expanded HIV testing repeatedly refer to the shortening of time spent in pre-test counselling. Under routine testing, the guidelines provide:

⁸² Art 3(5) of the Lesotho policy framework on HIV/AIDS prevention, control and management.

⁸³ The universal testing campaign will also attempt to educate individuals about the necessity of knowing their HIV status.

⁸⁴ Ministry of Health and Social Welfare ‘The National Guidelines for HIV Testing and Counselling of Lesotho’ (2004) (emphasis added).

⁸⁵ As above.

⁸⁶ Ministry of Health ‘Guidelines for expanded HIV testing in Malawi’ (2005) vi.

Key steps: (a) HIV testing is routinely offered to all clients with minimum amount of health information given individually or as a group to ensure informed consent; (b) then HIV testing is either conducted or not conducted in the case of those patients who choose to opt-out; and (c) standard and full post-test counselling is provided individually, with emphasis on prevention information and linkage to services for clients found to be HIV-positive, including emphasis on the importance of partner notification.⁸⁷

As with Botswana, the justification for shortening pre-test counselling is that, according to a 2000 Demographic Health Survey, most Malawians already know a lot about HIV and AIDS.⁸⁸

Although other countries may not currently be offering routine testing to all individuals attending healthcare facilities, current policies on pre-test counselling and informed consent and their human rights implications still need to be examined, particularly as it looks like these countries are on their way to introducing routine testing policies and programmes, and indeed many already have in STI and antenatal clinics.

5.4 Namibia

Namibia's Draft National HIV/AIDS Policy provides as follows:

Government shall ensure that, VCT shall be carried out only with the informed consent of the person seeking testing. The person shall be provided with adequate information about the nature of an HIV test, including the potential implications of a positive and negative result, in order to allow the person to make an informed decision as to whether or not to undergo the test.⁸⁹

The Ministry of Health and Social Services' Guidelines for the Prevention of Mother to Child Transmission of HIV provide that pre-test counselling for pregnant women may be carried out in a group and testing must be carried out after the signing of a consent form.⁹⁰ It is obvious, though, that where counselling is carried out in a group, consent may be obtained in a very artificial manner bearing in mind the power relations that exist between healthcare providers and the often uneducated women who are most often faced with the offer of testing in the public health facility.⁹¹

⁸⁷ Ministry of Health (n 86 above) iv.

⁸⁸ Ministry of Health (n 86 above) vi.

⁸⁹ Draft National HIV/AIDS Policy Namibia sec 3(3)(1), January 2006.

⁹⁰ The Ministry of Health and Social Services, 'Guidelines for the Prevention of Mother to Child Transmission of HIV Namibia'.

⁹¹ Rennie & Behets (n 14 above).

5.5 South Africa

South Africa has the clearest guidelines on counselling and informed consent in the region. In South Africa, testing for HIV has long been established as a medical procedure⁹² requiring informed consent. The importance of informed consent of the patient emerged from the decision of the Cape Provincial Division Court in the *Castell v De Greeff* case.⁹³ In that case, the Court gave precedence to the patient's autonomy and self determination and found that a doctor must obtain the patient's informed consent to medical treatment and warn the patient of any material risk inherent in the proposed treatment. An HIV test was confirmed to constitute medical treatment in *C v Minister of Correctional Services*.⁹⁴ In this case it was decided that pre-test counselling is required as part of informed consent.

The National Policy Guideline on HIV Testing explicitly states that one must be given both pre- and post-test counselling to ensure that there is informed consent.⁹⁵ Chapter II of the National Health Act, read in line with the protection of equality granted by section 9 of the Constitution, includes the right to full information of the range of diagnostic procedures and treatment options available, with the benefits, risks, costs and consequences generally associated with each option, the right to give informed consent and the right to refuse health services.

The Health Professionals Council of South Africa Guidelines for the Management of Patients with HIV Infection or AIDS (HPCSA Guidelines)⁹⁶ clearly state that HIV testing can only be done with the informed consent of the patient with pre- and post-test counselling. Failure to do so can result in discipline from the professional governing body.

In December 1999, the HIV/AIDS and STD Directorate of the Department of Health released recommendations on the use of rapid HIV tests.⁹⁷ It was recommended that these rapid tests be used according to the same ethical standards as any other HIV test, that is, with the requirements of pre- and post-test counselling, informed consent, privacy and confidentiality.

⁹² *Stoffberg v Elliot* 1923 CPD 148.

⁹³ 1994 (4) SA 408 (C).

⁹⁴ 1996 (4) SA 292 (T).

⁹⁵ South Africa, 'National Policy Guideline on HIV Testing' (2004) 5 - 6.

⁹⁶ The Health Professionals Council of South Africa Guidelines for the Management of Patients with HIV Infection or AIDS <http://www.hpcsa.co.za/hpcsa> (accessed 22 May 2006).

⁹⁷ Centre for the Study of AIDS & Centre for Human Rights University of Pretoria *HIV/AIDS and Human Rights in South Africa* (2004) 26, <http://www.csa.za.org/filemanager/download/89/South%20Africa> (accessed 31 January 2007).

5.6 Zambia

In Zambia, most pregnant women attending their first antenatal clinic receive group counselling on HIV and PMTCT. All pregnant women who attend the group counselling during antenatal care are offered individual pre-test counselling, although the method for doing this varies by site. For example, some of the clinics ask women whether they want individual counselling; at others, all women are given individual counselling. The manner in which women are asked whether they wish to have individual counselling also varies. In some clinics, women are asked in public whether they want individual counselling. This particular method contributes to a high rejection rate due to fear of stigma as well as other reasons, including the need to obtain their partner's consent to be tested.⁹⁸

5.7 Zimbabwe

Guiding principle 18 of the National Policy on HIV/AIDS for Zimbabwe states that: 'access to information and counselling is necessary for informed consent to HIV testing and is ensured as a fundamental human right'. It further states that pre- and post-test counselling should be provided by people with the appropriate technical and professional ability. In addition, the Ministry of Health and Child Welfare has formulated ethical guidelines for counselling and testing for HIV to be followed by all healthcare service providers.⁹⁹ These guidelines provide that both pre and post-test counselling is required for an HIV test and, like the Lesotho guidelines, they differentiate group information from counselling.¹⁰⁰

6 Implications of introduction of routine testing policies in Southern Africa

The UNAIDS/WHO guidelines take cognisance of the fact that to ensure a rights based approach to scaling up treatment a certain 'right' environment must exist, which requires the reduction of HIV stigma, a supportive legal and policy framework and adequate healthcare infrastructure.¹⁰¹ This study shows that unfortunately many of these factors are currently not yet in place in the region

⁹⁸ J Huddart *et al* 'The Zambia HIV/AIDS Workforce Study: Preparing for scale-up' Operations Research Results' (2004).

⁹⁹ Ministry of Health & Child Welfare/World Health Organisation 'Zimbabwe national guidelines on HIV testing and counselling' (2005).

¹⁰⁰ n 99 above 15 - 16.

¹⁰¹ See table in 'Introduction' above, showing the specific dates when each of the SADC countries ratified the major human rights treaties.

although much activity is taking place with respect to scaling up testing by introducing routine HIV testing in healthcare facilities.

Some proponents of routine testing argue that it will result in decreased stigma and increased treatment. It is argued in this study, that the case is not nearly so simplistic. Indeed, to the contrary, there is an argument to be made that the push for routine testing, along with the concomitant loosening or altogether abandonment of informed consent and counselling, actually risk increasing stigma and, therefore, decreasing treatment. It must be acknowledged that stigma and discrimination towards people living with HIV is deeply rooted in Southern Africa, which together with an awareness of how routine testing will affect certain groups of people, most particularly women, have not been properly recognised to date.

6.1 Stigma and discrimination in Southern Africa

HIV-related discrimination and stigma is still rife in all SADC countries. It is discouraging to note, however, that after almost 20 years of speaking about human rights and protecting people living with HIV from discrimination, most SADC countries have no legislation specifically outlawing discrimination on the basis of one's HIV status. In most Southern African constitutions, the right to non-discrimination is often provided, but HIV sero-status is not expressly listed as a ground for non-discrimination. It is possible that it could fall within the ambit of 'health', where this is a protected ground of non-discrimination. Alternatively, it could potentially be added as an analogous ground where constitutions have an 'open list' of protected grounds of non-discrimination.¹⁰² Where the list is closed, the inclusion of HIV status for protection is unlikely.¹⁰³

Although the more specific rights to non-discrimination on the basis of HIV are provided in some policy documents, these rights are not protected legally. Policies are statements of the good intentions of the executive but they offer no real protection to individuals as they are not enforceable legally.

Recognising this lack of solid legal protection, Guideline 4 of the International Guidelines on HIV/AIDS and Human Rights provides that states must

conduct a comprehensive review of legislation, and adopt appropriate amendments and new legislation ... States are further encouraged to

¹⁰² This is generally evidenced by the enumerated list of protected grounds of non-discrimination being followed by 'or other status' or similar such wording.

¹⁰³ For a more detailed country-by-country analysis of these provisions, see AIDS and Human Rights Research Unit *A review of regional and national human rights based HIV and AIDS policies and frameworks in Eastern and Southern Africa* Report for UNDP-OHCHR Joint Initiative for Eastern and Southern Africa (September 2006).

enact or strengthen anti-discrimination laws and other laws protecting people with HIV and AIDS.

The national policies themselves often recognise the need to legislate rights. In Swaziland, for example, the Policy Document on HIV/AIDS and STD Prevention Control provides that

the existing laws will be reviewed to ensure that they adequately address the public health and human rights issues of HIV/AIDS where necessary, appropriate laws passed and regulations made that will facilitate and enforce the implementation of HIV/AIDS-related policies. These include issues related to sexual violence and rape.¹⁰⁴

The Policy Document provides that the government will spearhead a broad multisectoral response to promote the human rights of people living with HIV and avoid discrimination against them. Information and education programmes aimed at removing unfounded fears and myths about HIV and AIDS will be implemented. People living with HIV will have the same rights as any other individual, especially the right to non-discrimination. Persons who suffer from discrimination will be supported to seek legal recourse through the appropriate channels.¹⁰⁵

In terms of Swaziland's Strategic Plan, one of the strategies spelt out therein is to 'enact legislation that ensures eradication of stigmatisation and discrimination'.¹⁰⁶ There is, however, no legislation that has been enacted specifically to address the HIV or AIDS discrimination. It is also not clear how this support to seek legal recourse is provided. Swaziland is not alone in SADC in having good intentions articulated in policy but not actually implemented on the ground.

A Knowledge, Attitudes and Practices (KAP) study carried out in 2003 reported that, in Angola, 'if a local shopkeeper were known to be HIV positive, nearly half of all young people (and more than two-thirds of those with no education) said they would refuse to buy food from him. Similarly, more than one-third (and nearly two-thirds of those with no education) would refuse to share a meal with an HIV-positive person'.¹⁰⁷

In Botswana, studies as recent as 2004 have shown that stigma and discrimination were still very rife.¹⁰⁸ Section 15 of the Constitution guarantees protection from discrimination but does not specifically include HIV status among the listed grounds of non-discrimination. Moreover, there is no specific legislation guaranteeing the right to

¹⁰⁴ The Policy Document on HIV/AIDS and STD Prevention and Control of Swaziland (1998) 11.

¹⁰⁵ n 104 above 7.

¹⁰⁶ National Strategic Plan for HIV/AIDS of Swaziland (2000-2005) 30.

¹⁰⁷ USAID Health Profile: Angola http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/AngolaProfileDec2004.pdf (accessed 4 June 2006).

¹⁰⁸ C Stegling 'Botswana's HIV/AIDS Programme: A Model for SADC? (2004) 5 *Development Update* 241.

equality and non-discrimination of people living with HIV. The Botswana National Policy on HIV/AIDS and the Botswana HIV/AIDS and Human Rights Charter incorporate the right to non-discrimination. The policy states that the principles it contains reflect the principles expressed in the Forty-First World Health Assembly Resolution WHA 42.24 ('Avoidance of discrimination in relation to HIV-infected people and people with AIDS').

Botswana policy currently permits compulsory testing, leaving people living with HIV open to both discrimination and stigma. The Botswana government employment practice requires non-citizens to undergo a compulsory HIV test as a condition for employment. Government-sponsored students who are studying abroad are required to undergo compulsory HIV testing. A number of private sector employers (such as Debswana) also require compulsory HIV testing. There is also compulsory testing for all accused persons convicted of rape. There is no legislation protecting people living with HIV against discrimination in the workplace and this has been a concern for labour organisations in the country who accuse government of not being serious about the rights of people living with the virus.¹⁰⁹

It is important that Botswana scales up testing and treatment. It must also scale-up the process of ensuring the protection of human rights by domesticating international treaties that it is a signatory to as well as providing for non-discrimination laws as required by the UN guidelines on HIV/AIDS¹¹⁰ and UNGASS.¹¹¹ The current Botswana National Strategic Framework for HIV/AIDS 2003-2009 places a strong emphasis on tackling stigma and discrimination through the creation of an enabling environment by developing and adopting protective legislation.¹¹² There is currently a draft Final Report on Review of Laws and Policies relating to HIV/AIDS 2005 which deals with issues of discrimination that have been raised above. As the review involved input from civil society, it is hoped that Botswana will have better legal protection for people living with HIV in the near future.

In Mozambique, there is currently no law providing general protection against discrimination on the basis of HIV status. Some organisations working in HIV and human rights have submitted a broader protection law to the national assembly.¹¹³ Although the promotion and protection of human rights in the context of HIV and

¹⁰⁹ 'Botswana unions to protest over alleged rights abuses' IRIN Plus News 20 May 2005 www.IRINnews.org (accessed 4 April 2006).

¹¹⁰ Guideline 4.

¹¹¹ Para 58 of the UNGASS Declaration (2001).

¹¹² 'The Botswana National Strategic Framework for HIV/AIDS 2003-2009' 10.

¹¹³ Government of Mozambique UNGASS Progress Report, Reporting Period 2003-2005, Draft version 4.1-25/01/2006, 15, http://data.unaids.org/pub/Report/2006/2006_country_progress_report_mozambique_en.pdf (accessed 8 January 2007).

AIDS are clearly addressed in the National Strategic Plan, the translation of these principles into legislation and action still remains.¹¹⁴

In South Africa, a 2002 study revealed that only one third of respondents who had revealed their HIV-positive status were met with a positive response in their communities. One in ten said that they had been met with outright hostility and rejection.¹¹⁵ The Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 of 2000 was enacted in 2001,¹¹⁶ but does not include HIV status as an explicit ground for non-discrimination. However, it defines prohibited grounds as: 'any other ground where discrimination on that other ground (i) causes or perpetuates systemic disadvantage; (ii) undermines human dignity; or (iii) adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on a ground listed in paragraph (a)'. Arguably, HIV would easily fall into this definition.

Section 34(1) of the Act also states that:

In view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status:

- (a) special consideration must be given to the inclusion of these grounds in paragraph (a) of the definition of 'prohibited grounds' by the Minister;
- (b) the Equality Review committee must, within one year, investigate and make the necessary recommendations to the Minister.

Although the Promotion of Equality and Prevention of Unfair Discrimination Act, certainly offers more protection to people living with HIV than in most other SADC countries, it is rather unfortunate that HIV has still not yet been included as a specific ground for non-discrimination.

Although Lesotho does not have a policy of routine testing in public health institutions, similar concerns arise in respect of their universal testing policy, which is a programme of routinely offering the HIV test to all individuals in their home through a door-to-door campaign. It certainly raises the question of how realistic it is to think that a few months of community education will be enough to erode the stigma and discrimination associated with being HIV positive. In theory, treatment will be available everywhere before people are tested, but the slow pace of treatment roll-out – just 6 000 people were put on the drugs in the past 18 months – raises serious questions about how well a decentralised treatment programme will run, and

¹¹⁴ As above.

¹¹⁵ M Steinberg *et al* 'Hitting home: how households cope with the HIV/AIDS epidemic' (October 2002) *Henry J Kaiser Foundation & Health Systems Trust*.

¹¹⁶ Act 4 of 2000.

suggests that testing will either proceed equally slowly or that HIV-positive people will not have easy access to the drugs.¹¹⁷

Activists in Lesotho have raised concerns about support systems, practicality and sustainability of this door-to-door programme:

You will agree to test and they will tell you the result and they will leave you with no psycho-social support, they will just leave you ... then you have people in the mountains with no access to ARVs; they are hours from a clinic or they have no money for transport.¹¹⁸

There is this kind of pie-in-the-sky notion that in the name of public health, you can test everyone door-to-door without serious consequences, even violent ones, for the individual ... But what worries me about so-called universal testing is, what will be the long-term effects on people who get tested and aren't really prepared for their results because they won't get adequate counselling? What will be the consequences for women who test positive and are blamed by their husbands and families, something we hear about on a regular basis here? And what will be the penalties for those that are offered an HIV test and say no for whatever reason?¹¹⁹

6.2 Protection of women

In all SADC countries, women are disproportionately affected by HIV.¹²⁰ Routine testing policies tend to target women mostly, as they are the most likely to come in contact with public healthcare facilities when they are pregnant. However, if pregnant women are singled out for routine testing, the already existing negative image of women as the primary vectors of infection or as the party 'guilty' of infection, may be reinforced. Where pregnant women are targeted for routine testing the legislative environment should ensure that they are protected from the impact of stigma, discrimination and violence.

Most SADC countries, with the exception of South Africa and Namibia, have no laws on domestic violence.¹²¹ Nor do policy documents identify the link between HIV disclosure and violence against women. This is despite the fact that most of the countries in the region ratified the Convention on the Elimination of Discrimination

¹¹⁷ 'Lesotho takes HIV on the road' *The Globe and Mail* 3 May 2006 <http://www.theglobeandmail.com/servlet/story/LAC.20060503.LESOTHOAIN03/TPStory/?query=lesotho> (accessed 10 May 2006)

¹¹⁸ As above, quoting Makokoli Nthinya, programme officer for an AIDS support organisation called Positive Action.

¹¹⁹ As above, quoting Rachel Cohen, field co-ordinator for a *Médecins sans frontières* (Doctors without Borders) AIDS-treatment programme in Lesotho.

¹²⁰ UNAIDS 2006 Report on the Global AIDS Epidemic 'Overview of the Global AIDS Epidemic' 15.

¹²¹ Malawi and Zimbabwe currently have Domestic Violence Bills.

Against Women (CEDAW) in the 1990s.¹²² Studies in sub-Saharan Africa have shown that in the context of VCT, the lowest rates of HIV sero-status disclosure are reported to be among pregnant women.¹²³ The reasons for low rates of disclosure often have to do with fear of violent responses and rejection.¹²⁴

In their Concluding Observations on Angola's Report to the Committee on the Elimination of Discrimination against Women,¹²⁵ the Committee noted that it was concerned about the lack of specific legislation on violence against women, including on domestic violence, as well as the lack of adequate policies, programmes and services and their effective implementation and enforcement. The Committee was also concerned about the attitude of law enforcement officers towards women who report cases of violence, which results in women victims' reluctance to report such cases of abuse. Angola was urged to place high priority on putting comprehensive measures in place to address all forms of violence against women and girls. The Committee has issued remarks similar to these to almost all of the countries in the region that have had a report considered.

In the combined second, third, fourth and fifth periodic report submitted to the CEDAW Committee on 11 June 2004, the Malawian government recognised that there is still a higher level of stigmatisation of women who are HIV positive compared to men.¹²⁶ The HIV/AIDS quarterly report from January to March 2005 shows that more males than females accessed VCT services¹²⁷ although more females tested positive. Women had low levels of VCT uptake, which is probably related to fear of negative repercussions (abandonment, divorce) following disclosure of an HIV-positive status.¹²⁸

The South African Domestic Violence Act¹²⁹ provides for arrest without a warrant of anyone suspected of having committed an act of

¹²² See Table B, ch 1 above, for a table showing the specific dates when each of the SADC countries ratified the major human rights treaties.

¹²³ S Maman *et al* 'High rates and positive outcomes of HIV-sero-status disclosure to sexual partners: Reasons for cautious optimism from a voluntary counselling and testing clinic in Dar es Salaam, Tanzania' (2003) 7 *AIDS and Behavior* 373-374.

¹²⁴ As above.

¹²⁵ Report of the Committee on the Elimination of Discrimination against Women: 30th and 31st Sessions Combined initial, second and third periodic report and combined fourth and fifth periodic report of Angola General Assembly Official Records, Fifty-ninth Session, Supplement No. 38 (A/59/38).

¹²⁶ Committee on the elimination of discrimination against women combined 2nd, 3rd, 4th & 5th periodic report of States parties, Malawi, CEDAW/C/MW/2-5.

¹²⁷ National AIDS Commission (2005/05) 3 (January to March) HIV/AIDS quarterly service coverage report.

¹²⁸ L Nyirenda *et al* 'A gender perspective on HIV treatment in Malawi: A multi-method approach' (2006) 14 *Gender and Development* 96, 79.

¹²⁹ Act 116 of 1998.

domestic violence and for the application of a protection order.¹³⁰ While laws have been passed in South Africa that aim to reduce violence against women, these laws are seemingly under-enforced. The Act, however, makes no explicit mention of the link between domestic violence and HIV/AIDS. The 2006 UNGASS Report also highlights that from the latest statistics, women are still disproportionately carrying the burden of disease in South Africa, and although the National Strategic Plan acknowledges that the 'low status of women' is one of the factors underlying the HIV and AIDS pandemic, when it comes to actual substance addressing women's realities, very little is done.

In Botswana, the Draft National Policy on HIV/AIDS states that 'women shall have recourse to appropriate legal channels for redress of grievances arising out of discrimination, partner notification and enrolment in PMTCT and ARV programmes.'¹³¹ It is not clear how this is to be done as, presently, Botswana's government-funded legal aid system is limited to accused persons with the possibility of getting the death sentence.¹³²

Stigma and discrimination are the major challenges to the scaling up of PMTCT in Southern Africa. The fear of stigma, discrimination and violence are real to women and a protective environment must be created to encourage uptake. It may appear that these fears do not really affect the enrolment of women on PMTCT programmes, as it appears from the high level of acceptability of routine HIV testing in Botswana for example, but the point about cohesive paternalistic health systems should not be ignored, especially in cultural settings where the medical profession has an unequal power relationship with most patients,¹³³ and where the authority of professionals is not easily questioned.¹³³

Stigma, discrimination and the fear of violence shape women's choices about disclosure, breastfeeding and their decision to remain in the PMTCT programmes. The level of disclosure of HIV status by women in the PMTCT programmes is generally low.¹³⁴ Many reasons

¹³⁰ The court has various other powers under the Act which include amongst others: prohibiting the respondent from committing any act of domestic violence; prohibiting the respondent from entering the complainant's residence; and/or prohibiting the respondent from entering the complainant's workplace.

¹³¹ Sec 8(3)(2) of the Draft Botswana National Policy on HIV/AIDS (2005).

¹³² 'Legal Aid System and Poverty' DITSHWANELO – The Botswana Centre for Human Rights available at http://www.ditshwanelo.org.bw/index/Current_Issues/Legal_Aid.htm (accessed 1 February 2001).

¹³³ See comment of Christine Stegling on the Botswana Network of Law and Ethics (BONELA) in 'Botswana: Routine HIV testing not as straightforward as it sounds' IRIN news (n 32 above).

¹³⁴ A Medley *et al* 'Rates, barriers and outcomes of HIV sero-status disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes' (2004) 82 *Bulletin of the World Health Organisation* 300.

such as the fear of stigmatisation and violence justify this situation.¹³⁵ Disclosure actually plays an important role in women's uptake of PMTCT programmes and in their participation in treatment, care and support programmes.¹³⁶ Fear of stigma and discrimination shape women's choices about breastfeeding¹³⁷ and some women might decide not to go for the follow-up visits as the recurrent attendance at health facilities by women in the PMTCT programme could fuel the suspicion about their HIV status.

Thus, advancing stigma and discrimination reduction and access to treatment as justifications for routine testing should be approached with caution. Testing and treatment alone should not be expected to end stigma, which is deeply located in social structures, and in the history of the response to the HIV pandemic. It is also embedded in the ways in which health systems are structured and in the ways in which healthcare workers often behave towards people living with HIV. Indeed, these have in some cases resulted in increased stigma. Regular attendance at clinics, collecting prescriptions and starting to put on weight are all factors likely to identify a person as someone with HIV and subject them to greater stigma.¹³⁸ While access to treatment is clearly a public health and human rights imperative and a desirable outcome generally, policymakers need to exercise caution in the manner in which testing takes place and ARVs are accessed and distributed. Far greater attention needs to be paid to the social, political, economic and personal environment in which medicines are made available. The status of women, the effects of poverty and the level of development in countries where treatment roll-outs occur, all need to be considered.¹³⁹

7 Conclusions and recommendations

7.1 Conclusions

It is generally accepted that focusing prevention strategies on HIV-infected individuals and implementing routine HIV testing, partner notification, and other traditional public health approaches should have a beneficial effect in lowering incidence rates. Health and human rights advocates in other parts of the world are advocating for

¹³⁵ As above.

¹³⁶ Medley (n 134 above) 304.

¹³⁷ See UNAIDS 2006 Report on the Global AIDS Epidemic, 'The Impact of AIDS on People and Societies' 88.

¹³⁸ The International HIV/AIDS Alliance 'Antiretroviral treatment in Zambia: A study of the experiences of treatment users and healthcare workers' (March 2004) 31.

¹³⁹ See also Zuberi in Viljoen (n 15 above).
Crewe & Viljoen (n 34 above) 5.

routine testing. Why then should anyone insist on making a special case for the Southern African region?

The medical advancements that have taken place to engender routine provision of HIV testing are undeniable. Some years after the development of ART, we must not lose sight of the fact that an HIV diagnosis once meant nothing to the diagnosed but a painful death. However, the discussion on access to treatment shows that to most of the SADC region, access to universal treatment is still a long way coming. When there is no access to effective treatment, and with significant psychosocial drawbacks to a positive diagnosis, routine testing or screening is far more an imposition on the individual, regardless of any gains to the community at large. It is a step that should be taken more carefully and one that will be made less effective through resistance from individuals and affected groups.¹⁴⁰

It is clear that compromising individual rights in order to benefit public health will have a negative effect on efforts to curb the spread of the HIV epidemic. It is important to ensure that rights of people attending public health institutions are protected, if scaling up of testing and treatment is going to be a success. Although rights are mentioned in policy documents, these have not been translated into legislation and it seems that human rights are often being overlooked in practice. A rights-based approach does not privilege the protection of individual rights over the public good. In Botswana, the government has complained about criticism of the programme saying it undermines their efforts. However, it should not be forgotten that the gradual process of making HIV testing a more routine part of clinical practice in industrialised countries took place against a backdrop of strong civil institutions and legal protections.¹⁴¹ Governments should ensure that they 'scale-up' efforts to ensure the protection of human rights in conjunction with the scaling-up of testing. Policy makers are urged to reflect on the ethical significance of routine testing for people where such protection does not exist, otherwise claims that these testing practices have a human rights basis become questionable indeed.

There is no doubt that there is a need to increase the availability of testing in the SADC region, and the routine offer of testing may be a way of addressing this need. Research shows that policies of routine offer of testing in public healthcare facilities may have both negative and positive effects.¹⁴² State action in the form of policies that infringe on human rights must be adequately justified and should adopt the least intrusive measures possible to achieve the demonstrably justified objective of reducing the impact of HIV. At the

¹⁴⁰ Wagner (n 6 above).

¹⁴¹ Rennie & Behets (n 14 above).

¹⁴² Weiser *et al* (n 75 above).

moment, no evidence justifies the encroachment of human rights through testing policies that do not respect the right to give informed consent. Even where treatment is available, further research that goes beyond the theory of testing policies needs to be conducted on how exactly routine testing policies are operating in practice and whether human rights *are* being protected on the ground.¹⁴³

Indeed, Botswana must be commended for its success in offering free ART to all of its citizens in need. Treatment roll-out programmes in Botswana are believed to be fairly equitably distributed. Clearly the policy in Botswana has resulted in some positive results. Testing rates have risen from 36 in every 1 000 people being tested in 2004 to 137 in every 1 000 in April 2006.¹⁴⁴ However, it is difficult to learn from Botswana because of the lack of a clearly defined procedure and guidelines, as well as the lack of proper evaluation of the programme in terms of its impact on human rights.

This research shows that throughout the region, the introduction of routine testing in public health services is being done in a haphazard manner. There are no clear guidelines as to how exactly the policies should operate. The inadequate legislative environment as well as prevailing stigma and discrimination, coupled with a disproportionate effect on women, make it questionable whether SADC is in fact ready for the challenges presented by routine testing.

7.2 Recommendations

As testing, counselling, and treatment benefits increase, there is an onus on national governments to provide good quality testing and counselling services. Good quality services will ensure that the rights of people coming to be tested are not violated and that a failure to protect human rights will not become a disincentive to get tested.¹⁴⁵

Based on the findings of this research, this study therefore recommends the following: The protection of human rights in general and particularly those of people living with HIV/AIDS must be a priority where legislation or policies relating to HIV/AIDS is considered. State action that infringes human rights must be adequately justified and should adopt the least intrusive measures possible to achieve the demonstrably justified objective of reducing the impact of HIV.

¹⁴³ Weiser *et al* (n 75 above).

¹⁴⁴ Dr T W Steen (Ministry of Health Botswana Department of HIV Testing) Presentation at the WHO, PITC consultative meeting 3-4 July 2006.

¹⁴⁵ 'Increasing access to HIV testing and counselling: A report of a WHO consultation' Geneva Switzerland (19-20 November 2002) 3.

Routine testing policies must be drafted in clear language and followed up by detailed guidelines on how this HIV testing is to be carried out.

A policy of routinely offering the test with the patient expressly agreeing to the test (closer to the 'opt-in' model) is recommended to ensure the protection of the rights of people living with HIV.

HIV testing policies must follow international human rights standards of pre-test counselling, informed consent and confidentiality.

There must be constant and independent evaluation of the practice of routine offer of testing, which should be carried out in each country. Evaluation of the human rights implications of PMTCT, including routine testing that is currently in place, would be a good place to start. These evaluations must endeavour to answer some of the following questions honestly:

- What is the public health workers' understanding of the routine offer of testing policy?
- How is the policy operating in practice?
- Where guidelines are available such as the UN guidelines for partner notification, how are healthcare practitioners using their discretion and arriving at decisions?
- What is the impact of the different models of testing on how a person is subsequently treated in society, how they adhere to treatment and engage in effective behaviour change?
- Have routine testing policies had any impact on stigma and discrimination in SADC countries and if so what kind of impact have these policies had?

Greater and meaningful involvement of people living with the virus is fundamental to the process of coming up with effective policies on HIV and AIDS.

At SADC level, a properly coordinated response with information exchange and dissemination of best practices will help better the response. The SADC HIV/AIDS framework affirms that harmonisation and co-ordination of policies in the region is required to counter the spread of the virus.

4 The human rights and public health implications of restricting prisoners' access to HIV prevention and treatment in SADC countries

*Babafemi Odunsi**

- 1 Introduction
- 2 HIV/AIDS, prisoners and society
- 3 Public health and human rights in the HIV and AIDS crisis: towards a rights-based approach
- 4 Policies and practices pertaining to prisoners' access to AIDS treatment and to condoms (and other prevention services) in Southern African countries
- 5 Obstacles to prisoners' access to treatment in Southern Africa
- 6 Prisoners' access to condoms in Southern Africa
- 7 Confronting the barriers to prisoners' right to access condoms
- 8 Conclusions and recommendations

1 Introduction

1.1 Background

This paper argues that restricting prisoners' access to condoms and HIV treatment both offends human rights norms and constitutes a threat to public health in Southern Africa. The paper recommends that prisoners in Southern Africa should have unhindered access to HIV treatment and means of prevention, specifically condoms, and that all existing barriers to prisoners' access to HIV treatment and condoms should be removed.

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Having wronged society, prisoners are perceived as deviants and social outcasts who deserve punishment in prison. This view is reflected by the neglect of prisoners' welfare and deplorable conditions of prisons in general.¹ Compounding the public's attitude towards prisoners is society's homophobia with respect to non-traditional sexual behaviour that takes place among some prisoners, taking the form of men who have sex with men (MSM). The criminalisation of such sexual behaviour in many Southern African countries provides evidence of general societal opprobrium attached to MSM.² Against this backdrop, and coupled with the fear that provision of condoms would endorse and encourage MSM, it is not surprising that Southern African prisoners currently have very restricted access to condoms, if at all.

This paper interrogates the access of prisoners to HIV treatment and condoms vis-à-vis prevailing laws, policies and practices. Relevant legal, human rights and sociological principles are examined. The paper aims to contribute to the search for 'best practice' in confronting HIV among vulnerable groups in Southern Africa.

The extent of the HIV epidemic in Southern Africa is elaborated in greater detail in the 'Introduction' of this collection; suffice it to say at this juncture that the region remains the area the hardest hit globally.³ Within this crisis, the prison population deserves special attention. With an estimated cumulative figure of about 316,447,⁴ Southern African prisoners constitute an important part of the regional community. As UNAIDS put it, '[p]risoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities'.⁵

Owing to their already marginalised position, prisoners are a vulnerable group with a higher risk of HIV transmission. The generally unhealthy prison environment combines with high risk behaviour to

¹ G Betteridge 'Prisoners' health and human rights in the HIV/AIDS epidemic' (2004) 9(3) *HIV/AIDS Policy and Law Review* 98; see also O Simooya & N Sanjoko 'Responding to the challenge of HIV/AIDS behind bars - The in but free project in Zambia' *KIT Information and Library Services* http://www.kit.nl/ILS/exchange_content/html/2005-1_responding_to_the_chall.asp?ILS/ex (accessed 6 May 2006) 1.

² See Simooya & Sanjoko (n 1 above). See also *Kanane v The State* [2003] (2) BLR 67 (HC).

³ UNAIDS 'Uniting the World against HIV/AIDS, Sub-Saharan Africa' http://www.unaids.org/en/Regions_Countries/Regions/SubSaharanAfrica.asp (accessed 26 June 2006).

⁴ R Walmsley 'World prison population list' 6th ed. www.prisonstudies.org (accessed 18 August 2006).

⁵ Statement by UNAIDS to the UN Commission of Human Rights, April 1996 - adapted from Joint United Nations Programme on HIV/AIDS (UNAIDS) and Inter-Parliamentary Union (IPU), *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) 61.

increase the risk of prisoners to HIV infection.⁶ High-risk behaviour of prisoners includes consensual or coerced unsafe sexual activities, tattooing, and sharing of needles and syringes.⁷ Therefore, in terms of HIV prevention and HIV treatment, it is important that prisoners enjoy unhindered access equal to that of members of the general public. Inequality in any respect can vitiate the efforts to control HIV, with serious consequences on public health as a whole. Lack of prevention would make prisoners the sources of HIV transmission, while lack of treatment could make prisoners more susceptible to opportunistic infections that could be spread within and outside prisons.

It should be noted that this paper discusses access to condoms for prisoners in the context of consensual sex between prisoners. There is, of course, a separate problem of coerced sex and prison rape that is beyond the scope of this paper. Evidently, prison measures protecting inmates from prison rape must also be stepped up seriously. The OHCHR and UNAIDS 2006 Consolidated International Guidelines on HIV/AIDS and Human Rights address both of these areas head-on by providing for the provision of condoms for consensual sex in prisons, and requiring that prison authorities take 'all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion.'⁸

In Southern African countries, just like in other parts of the world, the use of condoms has been recognised and encouraged as a means of prevention.⁹ However, in most countries, due to government policies and practices, prisoners are denied access to condoms.¹⁰ The principal ground for restriction is that same-sex sexual intercourse is

⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS) and Inter-Parliamentary Union (IPU) (n 5 above) at 61 and H Reyes 'Health and human rights in prisons' (2005) 2 <http://www.icrc.org/Web/Eng/siteeng0.nsf/iwpList302/AAC9DBC FB9954AEAC1256B> (accessed 24 October 2006).

⁷ Reyes (n 6 above).

⁸ OHCHR and UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version Guideline 4, 21(e)'.

⁹ Ministry of Health, AIDS/STD Unit, *Botswana National Policy on HIV/AIDS* (Revised Version), Approved and Adopted by Government through Presidential Directive CAB:33/98, dated 23 September 1998 (Botswana HIV/AIDS Policy) clause 4(4).

¹⁰ See eg 'Condoms shall not be issued to inmates whilst in prison'. Clause 6.1, part 2- 'Policy on HIV/AIDS/STD for Inmates', Botswana Prison Service, *HIV/AIDS and Health Care Delivery Policies* (undated) copy accessed at the library of Botswana Network on Ethics, Law and HIV/AIDS (BONELA) also available at www.bonela.botsnet.co.bw (Botswana Prison HIV Policies).

unlawful in these countries. The criminal law barrier appears to be further reinforced by social attitudes that disapprove of same-sex sexual intercourse.¹¹ Concerning HIV treatment, many policies across Southern Africa provide for prisoners' access to medication; however, it remains debatable whether prisoners enjoy unrestricted access to medication in reality.

1.2 Overview

The paper consists of eight parts. After the introduction, the position of prisoners in society is sketched (in part 2), followed by a brief exposition of the rights-based approach in the context of public health (in part 3). Part 4 provides a survey of the policies and practices in Southern African countries in respect of access both to HIV treatment and to condoms. These two issues are then dealt with separately in the next two parts of the paper. In part 6, the relatively uncontroversial aspect of access to AIDS medication is dealt with. Although the policies of states generally provide for access to AIDS medication, in reality few prisoners have received treatment. In part 7, the more controversial issue of access to condoms for prisoners is discussed, followed by an analysis of the factors preventing such access and ways of overcoming them (in parts 7 and 8).

2 HIV/AIDS, prisoners and society

2.1 HIV/AIDS and stigmatisation

The Centers for Disease Control and Prevention (CDC) in the United States of America identified what came to be known as AIDS on 5 June 1981,¹² when it reported that five previously healthy homosexual young men developed pneumocystis carinii pneumonia (PCP). About two months later, the CDC reported additional cases of twenty-six other homosexual young men diagnosed with Kaposi's sarcoma (KS), a cancer of the blood vessels; PCP also affected some of these men.¹³

Emergence of new diseases usually engenders different reactions, with social attitudes and beliefs, in many cases, influencing the

¹¹ See eg J Berger 'Re-sexualizing the epidemic – desire, risk and HIV prevention' in M Heywood (ed) *From disaster to development, HIV and AIDS in Southern Africa*, (2004) 5(3) *INTERFUND Development Update* 52-54. See also Integrated Regional Information Network (IRIN) Plus news from the HIV/AIDS news service 'Southern Africa: The challenge of HIV in prisons' <http://www.irinnews.org/webspecials/hiv-in-prisons> (accessed 26 June 2006). Homosexual activity is illegal in every southern African country with the exception of South Africa.

¹² T Ducharme 'Preparing for a legal epidemic: An AIDS primer for lawyers and policy makers' (1987-88) 26 *Alberta Law Review* 471, 474; see also LO Gostin *The AIDS pandemic* (2004) xix.

¹³ Ducharme (n 12 above).

reactions instead of a scientific understanding of the disease. Disease outbreak has been equated with supernatural disapproval of some conduct, or punishment for wrongdoing.¹⁴ These social perceptions and reactions may trigger arbitrary public health measures,¹⁵ which add to the burdens of the sick, without any significant effect on disease control.

After its emergence, the social reactions to HIV and AIDS varied between panic, fear, hatred, sympathy and other human emotions for those infected with the disease.¹⁶ These manifested in moral judgments and condemnations at various levels. Due to its initial association with homosexuals, homophobia propelled a feeling of 'they asked for it'.¹⁷ There were unfriendly reactions by many groups. Apparently attributing HIV and AIDS to divine nemesis, some groups held protests with placards reading, 'Thank God for AIDS'.¹⁸

Emerging knowledge that HIV and AIDS was not the 'disease of gays' did not terminate the moral colouring of the disease: it only transformed the assignment of people living with HIV into classes of the 'innocent' and the 'guilty'.¹⁹

Persons who contracted HIV perinatally or through blood transfusion were thought to be blameless and deserving sympathy. But those who contracted HIV/AIDS through sex or sharing drug-injection equipment were reviled and censured for their illness. Many were excluded from jobs, denied insurance and shunned.²⁰

Social attitudes influenced the kind of measures and policies advocated by different groups to confront HIV/AIDS.²¹ Some governments adopted extremely stiff measures. In Cuba, for example, infected persons were isolated and kept in detention.²²

¹⁴ JS Mbiti 'African Religions and Philosophy' (1989) 43-45, 77; see also Ducharme (n 12 above) 471.

¹⁵ 'Public health [measure] is what we, as a society, do collectively to assure the conditions for people to be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered. These threats include crises, such as the AIDS epidemic ...' Institute of Medicine of the National Academies, Washington DC, USA; <http://www.nap.edu/books/0309038308/html/19.html> (accessed 17 July 2005).

¹⁶ Gostin (n 12 above) 7-11; T Olori, 'Health-Nigeria: Stigmatisation, the bane of HIV/AIDS' *ipsnews* 1-3', <http://www.ipsnews.asp?idnews=14221> (accessed 12 August 2005).

¹⁷ See Gostin (n 12 above) xi & xxi.

¹⁸ Gostin (n 12 above) 110.

¹⁹ Gostin (n 12 above) xxv.

²⁰ As above.

²¹ As above. See also S Spencer 'AIDS: Some civil liberty implications' in P Byrne (ed) *Ethics and law in health care and research* (1990) 105. The rights of the individual, we are told, must be sacrificed to protect the rest of the community.

²² ML Cloosen, E Mark & WE Wojcik 'Living with HIV and without discrimination' in Lawrence Gostin & Lane Porter (eds) *International law and AIDS, International response, current issues, and future directions* (1992) 152-153; see J K Mason, RA McCall Smith & GT Laurie *Law and medical ethics* (1999) 22.

In the reaction to HIV, there is real possibility of the denial of human rights. Some cases have shown that people living with HIV are prone to discrimination in employment and other harsh consequences across Southern Africa.²³ Homophobia is prevalent in Southern Africa.²⁴ With same-sex practices perceived as even barbaric or satanic,²⁵ gays and lesbians face harsh social consequences in terms of unpopularity, stigmatisation and discrimination; same-sex practices equally attract stiff legal penalties and other consequences in most Southern African countries.²⁶

2.2 Social perception of prisoners

According to a commentator,

[a] prisoner is potentially in worse condition than the slave, because the slave is the property of someone whose interest is to keep his property in serviceable condition, whereas the prisoner is owned by nobody, unless it be the State which is ultimately responsible for his imprisonment.²⁷

The above statement reflects the situation for prisoners in many parts of the world. Prisoners are viewed as social outcasts with few or no rights. There is a perception that it is legitimate to curtail the rights of inmates as, having committed crimes, they have voluntarily surrendered their rights.²⁸ Prisons represent places of punishment, where prisoners, perhaps, ought to experience the agonies they inflicted on their victims and the society.²⁹ It thus may appear justifiable to some that prisoners should suffer deprivations. Deplorable conditions of prisons across the world seem to illustrate this sentiment.³⁰ The inferior perception and position of prisoners has

²³ See eg *Nanditume v Minister of Defence* (2002) AHRLR 119 (NaLC) (Case LC 24/98, Labour Court of Namibia, 2000); *Hoffmann v South African Airways* 2000 (11) BCLR 1235 (CC) and *Diau v Botswana Building Society* (BBS) Case No. IC 50/2003 Industrial Court of Botswana.

²⁴ See generally, Human Rights Watch and The International Gay and Lesbian Human Rights Commission *More than a name: State-sponsored homophobia and its Consequences in Southern Africa* (2003). See also the case of *Kanane v The State* (n 2 above) together with *Banana v The State* [2000] (4) LRC 621- also reported in [2000] (8) BHRC 345.

²⁵ R Morgan & S Wieringa *Tommy boys, lesbian men and ancestral wives, female same-sex practices in Africa* (2005) 17.

²⁶ See Human Rights Watch and The International Gay and Lesbian Human Rights Commission (n 24 above) 2-3; see also Morgan & Wieringa (n 25 above) 53, 79.

²⁷ K Ruch 'Introduction' to the 1929 Everyman edition of John Howard's *The state of the prisons in England and Wales*, adapted from British Medical Association, *Medicine Betrayed, the participation of doctors in human rights abuses* (2nd edition, 1998) 119 (emphasis added).

²⁸ J Norberry 'HIV/AIDS, Prisons and the Law' (1991) 31 *Trends & Issues in Crime and Criminal Justice* 2.

²⁹ See generally eg Reyes (n 6 above).

³⁰ As above.

a long history. In the United States, for example, prisoners were legally considered to be ‘slaves of the state’ until the 1970s.³¹

Judicial attitudes and public indifference or hostility to prisoners’ welfare seem to collaborate in the marginalisation of prisoners. Under that canopy, prison administrators tend to assume unfettered latitude to administer prisons as they deem fit. Moreover, the courts have generally not been eager to confront issues relating to the policies and administration of prisons.³² Because the administration of prisons is the function of the executive arm of government vis-à-vis the legislature which enacted the enabling laws, the judicial arm is discouraged from meddling in their affairs.³³ In *Prisoners A-XX v State of New South Wales*,³⁴ for example, an Australian court was unwilling to overturn a policy restricting condoms in prisons, noting that a judicial review of an issue involving ‘political considerations’ would lead to passing of ‘political power from the parliament and the electorate to the courts.’³⁵

Courts have also expressed the view that their power does not extend to the supervision of how the executive arm of government treat convicted offenders in prisons and that a lack of practical experience would make it difficult for them to adjudge the administrative decisions of prison administrators.³⁶ Furthermore, courts have also been concerned that granting enforceable rights to prisoners would open up the floodgates to further litigation and that prisoners’ access to judicial review of the action of prison administrators could ultimately undermine prison discipline and security.³⁷

2.3 Dual stigmatisation: living with HIV and being a prisoner

Sex in the context of prison confinement essentially amounts to man-to-man sex, which is unlawful and mostly frowned upon in most Southern African countries. The disapproval of same-sex sexual intercourse is steeped in cultural and religious attitudes.³⁸ The following view of a Namibian commentator offers an illustration of this religious dimension: ‘Biblically, Sodom and Gomorrah were destroyed because of homosexuality. Similarly, the country would be

³¹ See *Ruffin v Commonwealth* (1871) 62 Va 790). See also Norberry (n 28 above).

³² Norberry (n 28 above).

³³ As above. Judicial intervention in prisons has been regarded as interference with the executive arm of government.

³⁴ (1995) 38 NSWLR 622.

³⁵ As above.

³⁶ Norberry (n 28 above).

³⁷ As above.

³⁸ See generally, ‘PRISONACT, IRIN Focus on safe-sex in prisons’ <http://www.prisonactivist.org/pipermail/prisonact-list/2001-January/003490.html> (accessed 21 June 2006).

destroyed if we distributed condoms in prisons because this would promote the practice of homosexuality.³⁹ Thus law, culture and religion collide and act together in restricting condom access in prisons.

What is more, the interplay of homophobia and social attitude towards HIV produces two levels of stigmatisation for prisoners. The first level is based on HIV infection and the second level is based on homosexuality. Due to stigmatisation, prisoners infected with HIV, on one front, are likely to experience social recrimination and other disadvantages. Prisoners requiring condoms for same-sex sexual intercourse, on another front, face the additional challenge of social disapproval. In this light, the issue of prisoners' access to treatment and prevention is enmeshed in the storm of two levels of stigmatisation.

Furthermore, due to low esteem, prisoners in many societies constitute marginalised and unpopular groups whose interests and welfare do not usually attract positive attention. This low esteem of prisoners, generally, tends to complicate the levels of stigmatisation faced by prisoners who are HIV positive and who engage in man-to-man sex.

3 Public health and human rights in the HIV and AIDS crisis: towards a rights-based approach

In the public health drive to control HIV, there is often likelihood that human rights will be infringed. Human rights and public health are all too often placed at two extremes and viewed as separate irreconcilable approaches with measures that either inherently safeguard human rights or measures that trample on human rights.

Every government has a duty to act appropriately in safeguarding public health.⁴⁰ Article 12 of International Covenant on Economic, Social and Cultural Rights provides as follows:⁴¹

³⁹ As above.

⁴⁰ 'Public health [measure] is what we, as a society, do collectively to assure the conditions for people to be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered. These threats include crises, such as the AIDS epidemic...These and many other problems raise in common the need to protect the nation's health through effective, organised, and sustained efforts led by the public sector.' See also Institute of Medicine of the National Academies, Washington DC, USA (n 15 above).

⁴¹ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with art 27 of the ICESCR.

(1) The states parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the states parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: ...

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases ...

The above provision contains obligations to both the individual (the highest attainable standard of physical and mental health) and to society at large (the prevention, treatment and control of epidemics and other diseases). Reconciling these two sets of obligations often places public health and the human rights of individuals head to head.

One aspect of this tension is rooted in the fair allocation of limited resources. The complexity of HIV control as a public health issue, for example, manifests in the need to achieve fair allocation of limited resources to different competing units of the health care system and society. The growing number of people living with HIV requires that more resources be allocated to research and development, counselling, education, treatment, provision of prophylaxis or other services related to HIV and AIDS.⁴² This may warrant depriving other equally important areas of the health care system, or other socio-economic units, which pertain to people uninfected with HIV, of necessary funds.

In addition to increased health care costs, HIV also has a heavy burden on the economy in general terms. Persons who fall ill due to infection sometimes cannot work and, by the same token, cannot contribute to economic growth. Especially in developing countries, family members may also have to leave their jobs in order to take care of the sick and the dying. Industries lose workers and skilled personnel in their productive years of life.⁴³ When having to make hard choices in light of limited resources, the interests of marginalised groups such as prisoners and homosexuals are more likely to be sacrificed to meet the needs of those who are viewed as 'good and decent' members of the society.

Another aspect of tension in public health and human rights relates to the methodology of controlling HIV. Mainly, there are two sides to the discourse; one is that the protection of the human rights

⁴² Gostin (n 12 above) xxiv.

⁴³ As above.

of citizens⁴⁴ is preferable, while the other is that a coercive or rights-restricting approach is desirable.⁴⁵ In the *best approach* debates, public health and human rights may appear to be incompatible elements in the HIV control scenario, whereas this is not necessarily the case.

Admittedly, no right is absolute, and human rights can legitimately be restricted on public health grounds in some circumstances.⁴⁶ As an example, the need to control a contagious disease may warrant restricting the freedom of movement of citizens through quarantine or similar measures. Similarly, the right to privacy in some cases may be restricted for the purpose of epidemiological surveys. In the control of HIV, where and when the attainment of legitimate public health goals *inevitably* demands encroaching on the human rights of citizens there must be a legitimate objective for the encroachment, that is the encroachment must be rationally connected to that objective, it should impair the right in question as minimally as possible, and finally, it must be carried out in good faith. Essentially, the determinant of good faith would be whether the encroachment can be effective in curtailing or reducing the impact of HIV and AIDS.⁴⁷ If not, then the right-restricting measure is not a desirable measure.

HIV control measures that violate human rights are likely to aggravate the HIV pandemic.⁴⁸ For example, discrimination compounds the impact of HIV on infected persons and those related to them. To illustrate, a person living with HIV who loses their job, based on employment discrimination, is prone to financial hardship.⁴⁹ Consequently, their ability to take care of their health, their dependants and meet other financial obligations would be hampered.⁵⁰ Furthermore, the violation of the right to privacy and stigmatisation of people living with HIV may discourage some persons from determining their HIV status. In such a situation, those who are

⁴⁴ 'Right-based approach'. Globally, the prevalent view is that any HIV/AIDS control measure that fails to protect human rights would aggravate the HIV/AIDS pandemic. See eg Joint United Nations Programme on HIV/AIDS (UNAIDS) and Inter-Parliamentary Union (IPU) 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) 24.

⁴⁵ Spencer (n 21 above) 105.

⁴⁶ See Joint United Nations Programme on HIV/AIDS (UNAIDS) and Inter-Parliamentary Union (IPU) (n 6 above) 27.

⁴⁷ LO Gostin & Z Lazzarini *Human rights and public health in the AIDS pandemic* (1997) 69.

⁴⁸ Joint United Nations Programme on HIV/AIDS (UNAIDS) and Inter-Parliamentary Union (IPU) (n 6 above) 24.

⁴⁹ See the case of *Bombay Indian Inhabitants v M/S ZY and Another* AIR [1997] [Bombay] 406 at 431 per Tipnis J.

⁵⁰ In sub-Saharan African societies where the extended family system operates, the consequence of employment discrimination as illustrated above can have spiral effects at other levels as many persons may depend, in one form or another, on the infected person for support. See also p 24.

infected may unknowingly be spreading the infection, thereby hampering efforts to control the spread of the disease.⁵¹

It is thus important that Southern African countries, in conformity with various international guidelines and recommendations, should avoid *unwarranted* restriction of human rights in any form. It is in this context that the policies in Southern African countries relating to prisoners' access to treatment and condoms will be examined.

4 Policies and practices pertaining to prisoners' access to AIDS treatment and to condoms (and other prevention services) in Southern African countries

The policies and practices of a representative sample of states in Southern Africa are now surveyed with respect to prisoners' access to both medication and prevention – in particular to condoms.

It is a general trend among Southern African countries to adopt, explicitly or implicitly, rights-based approaches to HIV control in their respective policies, and to incorporate international recommendations and standards.⁵² Generally, the various policies or national strategic plans of these countries address various issues that include human rights, care for people living with HIV, and, more infrequently, the situation of MSM in prisons.

Protecting, promoting and fulfilling the human rights of people living with the virus, those affected by HIV and AIDS, and those vulnerable to HIV are crucial issues in the global response to the pandemic. Consequently, indications of the use of a 'rights-based approach', which in most cases amount to empty promises, have become routine features in HIV/AIDS policies across the world.⁵³ Hence, where 'rights-based' policies have been adopted, these have to be carefully examined in light of prevailing laws and practices in those countries.⁵⁴

Concerning prisoners' access to HIV treatment and condoms in Southern Africa, the main issue to determine is whether prisoners

⁵¹ UNAIDS & IPU (n 6 above) 25.

⁵² Southern African Development Community (SADC) 'National and Sector HIV/AIDS Policies in the member states of the Southern Africa Development Community' (Document 'Prepared for SADC/HSU by the POLICY Project, 2002) (hereinafter 'SADC Policy Project') 1.

⁵³ Canadian HIV/AIDS Legal Network *Courting rights: Case studies in litigating the human rights of people living with HIV* (2006) 6.

⁵⁴ It is important here to draw the distinction between laws, which are legally enforceable, and policies, which are not legally enforceable. The reference to 'empty promises' refers to rights-based language that is contained in policies that are not legally enforceable.

have equivalent access as do members of the outside community.⁵⁵ Relevant provisions in the HIV and AIDS and prison policies of ten of the 14 SADC countries are discussed below.⁵⁶

4.1 Botswana

Botswana's Prisons Act,⁵⁷ the main legislation regulating the conditions of prisoners, does not have provisions expressly relating to HIV treatment or prevention for prisoners. However, provisions relating to the general health care of prisoners are contained in parts vii and viii of the Act.⁵⁸ The essence of the provisions is to ensure that prisoners receive prompt and appropriate medical treatment at all times.

The Botswana Prison HIV Policy guarantees access to HIV treatment for prisoners. Nothing in the provisions of the Prisons Act or the Prison HIV Policy suggests that prisoners would not have access to ARVs or other forms of HIV treatment simply because they engage in MSM practices. Furthermore, in terms of prevention, the Botswana Prison HIV Policy makes provision that prisoners be targeted with HIV awareness and education campaigns, with particular emphasis on risk behaviour.

However, with the following wording the Botswana Prison HIV Policy explicitly provides that prisoners do not have access to condoms:⁵⁹ '[c]ondoms shall not be issued to inmates whilst in pri-

⁵⁵ A question that may arise in the discussion of access is whether prisoners *actually* receive treatment or condoms, particularly in a country like South Africa where there is provision of condoms in prisons. In addressing that question the approach of this paper is to discuss the prevailing situations in terms of policies, existing laws and social attitudes as reflected in comments or arguments in Southern African countries. From the discussion, inferences can be made as to the natural or probable consequences of the prevailing situations, in terms of access to treatment or condoms. The paper refrains from giving direct answers because doing so could be speculative. It was not possible to conduct interviews or engage in any other sort of physical investigation or interrogation in all the countries covered in the study. In addition, quite unfortunately, efforts to get on the ground information through correspondence were frustrated by lack of responses. Hence, substantial reliance has to be made on relevant literature, the scope of which could not be expanded beyond the postulations of the authors. However, there was an exception in the case of Botswana; there were opportunities of speaking and interacting with organisations and individual activists engaged in HIV/AIDS and human rights, as well as visits to prisons.

⁵⁶ Difficulty was had in obtaining the relevant documents for all 14 SADC countries.

⁵⁷ Cap 21:03, The Laws of Botswana, Revised Edition of 2002.

⁵⁸ See generally, sections 56-63 together with section 76 of the Prisons Act.

⁵⁹ See JDM Orebotse 'HIV/AIDS Pandemic in African prisons: A case of Botswana prisons' Paper Presentation at the 5th CESCA Conference (4-7 September 2001) 7. See also 'Sodomy spreading AIDS in prison' www.news24.com/News24/Africa/News/0,2-11-1447_1685077,00.html (accessed 12 January 2006).

son.⁶⁰ The main rationale for the policy is that giving prisoners access to condoms would amount to encouraging sodomy, which is a crime in Botswana.⁶¹ Apart from criminalisation, it is perceived that same-sex sexual intercourse is a socially reprehensible and unacceptable act in Botswana.⁶² Inferably, provision of condoms in prison would translate into the government encouraging criminal, immoral and socially reprehensible acts.⁶³

Unlike prison inmates, members of the general society have relatively unhindered access to condoms in Botswana. These are distributed free in some cases,⁶⁴ or are available for sale at relatively low prices at various places.

4.2 Lesotho

Lesotho's Policy Framework on HIV/AIDS Prevention, Control and Management⁶⁵ (Policy Framework) enjoins prison authorities to 'provide inmates, staff and their families with HIV-related prevention information, education, voluntary testing and counselling, *means of prevention*, treatment and care'.⁶⁶ Because 'means of prevention' in the widest sense may include condoms, it would appear that, in theory at least, Lesotho's Policy Framework gives prisoners access to condoms. One could argue that the provision that homosexuals should be educated and encouraged on the use of condoms supports the reasoning that condoms would be available for prisoners' uses in man-to-man sex. However, notwithstanding the wide scope of 'means of prevention', the reality is that prisoners in Lesotho do not have access to condoms. The rationale for the prohibition is that providing condoms to inmates would amount to condoning or encouraging sodomy in the prisons.⁶⁷

⁶⁰ Clause 6.1, Part 2 'Policy on HIV/AIDS/STD for Inmates', Botswana Prison HIV Policy at p 21 (n 10 above).

⁶¹ *Penal Code* Cap. 08:01, The Laws of Botswana, Revised Edition of 2002, section 164 (a) and (c).

⁶² See Orebotse (n 59 above) 4. According to the 1991 study, Botswana people generally hate the type of sexual intercourse whereby a penis is introduced into the anus. The association with dirt and faecal matter within the anus disgust them.

⁶³ As above, 4, 7.

⁶⁴ For example, it is usual to have free condoms in receptacles at different places.

⁶⁵ Government of Lesotho 'Policy Framework on HIV/AIDS Prevention, Control and Management' (September 2000).

⁶⁶ As above. Clause 4(12) (emphasis added).

⁶⁷ As above. 'Sodomy spreading Aids in prison' (n 59 above). However, subsequent to the completion of this article, in August 2007, the head of the health unit of Lesotho's department of Correctional Services indicated that condoms were being made available in prisons ('HIV one of toughest hurdles for African prisons' www.sabcnews.com/Article/PrintWholeStory/0,2160,153912,00.html (11 August 2007) - eds.

4.3 Malawi

Malawi has national policies and sector-specific policies on HIV/AIDS.⁶⁸ There is no sector-specific policy for prisons; provisions relating to prisons are contained in the national policies.⁶⁹ In addition to prescribing awareness and training campaigns for citizens, section 2.2.2 of the National HIV/AIDS Policy arranges for access to ARV therapy and treatment by eligible persons at subsidised prices. However, AIDS treatment is not free and is only accessible to those who can afford them at the subsidised prices.⁷⁰ The same arrangement applies to prison inmates.⁷¹

Condoms are quite easily accessible in Malawi for non-prisoners, in some cases free of charge.⁷² With respect to prisoners, section 2(1)(3)(c) of the National HIV/AIDS Policy provides that '[g]overnment shall ensure that all men, women, young people *including people in prisons ... have access to condoms any time they need one*'.⁷³ For prisoners, the policy further prescribes measures which include 'anonymous access to condoms and dental dams (oral sex barriers); access to treatment and care'.⁷⁴

No doubt, on paper Malawi has a favourable regime regarding prisoners' access to prevention, care and treatment. However, the reality is different. The condition that prisoners are required to pay for HIV treatment just like non-prisoners is a formidable obstacle to prisoners' access to treatment in Malawi. Being dependent upon the government, one wonders how prisoners would have the means of paying for treatment. Moreover, in a society with large-scale poverty, many prisoners may not have relatives who can procure the medications for them.

Moreover, under sections 153, 154 and 156 of the Penal Code of Malawi, same-sex sexual intercourse is criminal. In that legal framework, provision of condoms in prison for man-to-man sexual intercourse may be compromised. Ostensibly, this accounts for why in

⁶⁸ See SADC Policy Project (n 52 above) 51. See also, Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, HIV/AIDS and Human Right in Malawi (Pretoria: Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, 2004) (HIV/AIDS and Human Rights in Malawi) 51.

⁶⁹ Ministry of Health and Population 'Malawi National HIV/AIDS Strategic Framework 2000-2004' (October 1999) (hereinafter 'Strategic Framework'); Malawi National AIDS Commission, Malawi National Policy on HIV/AIDS (November 2002) (hereinafter 'Malawi National Policy'). Though the Strategy Framework is not expressly titled 'policy', arguably it qualifies as a policy as the first national prescription of control of HIV/AIDS in Malawi. The provisions of these policies are adapted from HIV/AIDS and Human Rights in Malawi, as above.

⁷⁰ HIV/AIDS and Human Rights in Malawi (n 68 above) 22.

⁷¹ HIV/AIDS and Human Rights in Malawi (n 68 above) 30.

⁷² HIV/AIDS and Human Rights in Malawi (n 68 above) 23.

⁷³ HIV/AIDS and Human Rights in Malawi (n 68 above) 30 (emphasis added).

⁷⁴ As above. See also sec 42(1)(b) of the Constitution of Malawi 1994.

practice condoms are not distributed to serving inmates; they are only distributed to prisoners at the point of release.⁷⁵

4.4 Mozambique

The National Strategic Plan to Combat STI/HIV/AIDS (National Strategic Plan)⁷⁶ is the pivot of Mozambique's drive to control HIV. Generally, Mozambique's National Strategic Plan proclaims the care for people living with HIV in all segments of the population, presumably including prisoners, as a crucial national, regional and communal priority.⁷⁷ Regarding means of prevention, the National Strategic Plan appreciates the importance of condoms. Moreover, Mozambique for many years has supported social marketing of condoms as a government policy.⁷⁸

With specific reference to prisons, the National Strategic Plan classifies prisoners as a vulnerable group and notes the need for condoms in prisons. However, there is no evidence that prisoners in Mozambique have access to condoms.

4.5 Namibia

Namibia's Draft National Policy on HIV/AIDS (Draft Policy) categorises prisoners as a vulnerable group and, along with HIV awareness and training programmes, the policy provides that prisoners shall enjoy access to treatment, care and means of prevention, including condoms, on the same basis as the general population.⁷⁹

In terms of its provisions, the Draft Policy is quite attractive with respect to the access of prisoners to HIV treatment, care and prevention, including condoms. However, under the label of 'unnatural sex crime', same-sex sexual intercourse remains a common law offence in Namibia; therefore, providing condoms in prisons in the shadow of this legal structure is doubtful.

Apart from the criminalisation of sodomy, there is strong opposition from different segments of the Namibian society to the provision of condoms in prison. According to one report, a member of the parliament once 'condemned the provision of condoms to prison inmates, charging that such practice would boost sodomy'.⁸⁰

⁷⁵ Malawi Human Rights Commission *Situational analysis on the rights of prisoners* (2004) 23.

⁷⁶ National Strategic Plan to Combat STI/HIV/AIDS, Maputo February 2000 adapted from SADC Policy Project (n 52 above).

⁷⁷ See SADC Policy Project (n 52 above) 22.

⁷⁸ As above, 19.

⁷⁹ See Namibia, Draft National Policy on HIV/AIDS, section 2.3.7

⁸⁰ A Shigwedha 'Prisoners told "go play with yourselves"' <http://www.namibian.com.na/2001/May/news/01EDF003F6.html> (accessed 22 June 2006).

Generally, the access of prisoners to condoms in Namibian prisons appears to exist more in words than in reality. Continuous existence of 'unnatural sex crime' in the Namibian criminal law book is a formidable impediment to the supply of condoms to prisoners.

4.6 Swaziland

In Swaziland, the Policy Document on HIV/AIDS and STD Prevention and Control recommends the provision of HIV-related prevention information, education, voluntary testing together with counselling, *means of prevention* and care to prisoners.⁸¹ Whatever the scope may be of 'means of prevention', condoms are not supplied to prison inmates in Swazi prisons. The illegality of man-to-man sex in the country appears to be the underlying factor for this.⁸² As one commentator explains:

In Swaziland, the government acknowledged the fact that homosexuality in prisons enhances the spread of HIV/AIDS, but has not provided condoms to inmates, concentrating instead on efforts to curb prison sex.⁸³

4.7 South Africa

South Africa has a series of national and sector-specific HIV and AIDS policies.⁸⁴ The sector-specific Management Strategy, AIDS in Prisons 2000⁸⁵ (Management Strategy), of the Department of Correctional Services contains provisions relating to prisoners. There is provision for HIV treatment and care for prisoners, along with awareness and educational programmes. The Management Strategy⁸⁶ also makes provision for the supply of condoms to prison inmates.

In the case of *National Coalition for Gay and Lesbian and Another v Minister of Justice and Others*,⁸⁷ the South African Constitutional Court struck down the South African anti-homosexuality law as unconstitutional. Therefore, unlike other Southern African countries,

⁸¹ Policy Document on HIV/AIDS and STD Prevention and Control (August 1998) 10-11.

⁸² Sodomy, consensual or otherwise, is a punishable common law offence in Swaziland.

⁸³ Mask Admin 'No Condoms in Prisons' <http://www.mask.org.za/article.php?cat=&id=580> (accessed 31 January 2007).

⁸⁴ See SADC Policy Project (n 52 above) 53-54.

⁸⁵ Department of Correctional Services 'Management Strategy, AIDS in Prisons' 2000.

⁸⁶ See AIDS Law Project 'Policies on HIV/AIDS in Prisons' <http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=109> (accessed 22 June 2006).

⁸⁷ *National Coalition for Gay and Lesbian and Another v Minister of Justice and Others* 1991 (1) SA 6 (CC) can be described as the judicial nail in the coffin of criminalisation of homosexual practices in South Africa.

there is no criminal law barrier against the provision of condoms in South African prisons.

Generally, in terms of policy wording, the South African policy on prisoners' access to treatment and prevention is attractive. However, a recent storm over access to anti-retroviral medication at Westville prison in Durban suggests that prisoners' access to medication in South Africa may also exist more in theory than reality.⁸⁸ In *EN and Others v The Government of the Republic of South Africa and Others (Westville case)*,⁸⁹ the standing arrangement was that prisoners would receive HIV treatment at public health facilities outside the prisons. However, the arrangement faced some difficulties. The prisoners were required to pay R35 each to obtain identification papers, there were delays in the accreditation of hospitals where the prisoners were to receive medication, and there was the non-admission of prisoners into ARV programmes at nearby public health facilities for security reasons.⁹⁰ Consequently, a number of prisoners were unable to receive HIV treatment.

To underscore the depth of the problem, in March 2006, hundreds of HIV-positive inmates embarked on a hunger strike at the Westville prison in protest over the problem. Reportedly, over 20 prisoners had died in the prison during the three months prior to the strike due to lack of HIV treatment.⁹¹ The crisis ultimately snowballed into a court action,⁹² in which the Treatment Action Campaign (TAC) played a critical role, whereby some inmates brought a representative action seeking orders compelling the respondents to make ARV treatment accessible to the applicants by removing obstacles hindering access. The court ruled in favour of the applicants, with the respondents expressing an intention or claiming to have appealed against the judgment.⁹³ After notable delay, the South African Department of Correctional Services now appears willing to comply with the court order.⁹⁴

⁸⁸ 'Prisoners continue to be denied access to treatment for HIV/AIDS at Westville Correctional Centre (KwaZulu-Natal): AIDS Law Project Press Release' (19 January 2006).

⁸⁹ 2007 (1) BCLR 84 (D) (High Court of South Africa: Durban and Coast Local Division).

⁹⁰ As above. 'HIV-positive inmates embark on hunger strike' SABC News (27 March 2006).

⁹¹ 'HIV-positive inmates embark on hunger strike' SABC News (27 March 2006), see also BBC News in video and audio 'HIV Prisoners stage hunger strike' <http://news.bbc.co.uk/2/hi/africa/4850392.stm> (accessed 6 August 2006).

⁹² n 89 above.

⁹³ See <http://mail.law.wits.ac.za/cgi-bin/openwebmail/openwebmail-read.pl?sessionid=richte> (accessed 28 June 2006). There is further comment on the Westville case in the segment on overview of Access to HIV/AIDS Treatment in Southern Africa.

⁹⁴ See G Staley 'Prisons' Department complies with Judges' http://www.iol.co.za/index.php?set_id=1&click_id=125&art_id=qw11577297609255263 (accessed 11 September 2006).

4.8 Tanzania

The National Policy on HIV/AIDS⁹⁵ prescribes the approach for HIV and AIDS in Tanzania. For the general populace, the policy provides for the care, treatment and support for people living with the virus and their families.⁹⁶ With regard to prisoners, the policy states that they have ‘the right to basic HIV/AIDS information, voluntary counselling and testing, and care, including treatment for STIs’.⁹⁷ However, just like non-prisoners, prisoners may have to bear the cost of ARV treatment.⁹⁸ The policy also provides that affordable good quality condoms should be made available,⁹⁹ but is silent on whether prisoners have access to condoms just as non-prisoners do.

The policy emphasises the right to equality. Seemingly, one can build on this equality principle to argue that prisoners are entitled to all of the measures available to the non-prison population in terms of care and treatment and means of prevention, including condoms. However, this position is prone to some challenges, particularly, in light of the anti-sodomy criminal law that exists in Tanzania.¹⁰⁰ Thus, like many other Southern African countries, the illegality of man-to-man sexual intercourse constitutes a formidable impediment to prisoners’ access to condoms in Tanzania.

4.9 Zambia

Zambia’s National HIV/AIDS/STI/TB Policy¹⁰¹ (National Policy) contains express provisions relating to prisoners’ access to HIV/AIDS treatment and means of prevention. The National Policy highlights the vulnerability of prisoners to HIV infection in Zambian prisons. According to the National Policy, prisoners’ vulnerability stems from, ‘unprotected sex frequently in the form of rape, high prevalence of STD, and very low and inconsistent use of condoms ... Penetrative anal intercourse is common and they too are unprotected.’¹⁰² The National Policy provides for detection of HIV and treatment of AIDS among prisoners. With respect to prevention, the National Policy, together with other measures and complementary to education and

⁹⁵ The United Republic of Tanzania, Prime Minister’s Office, *National Policy on HIV/AIDS* (November 2001).

⁹⁶ The United Republic of Tanzania (n 94 above) 26-29.

⁹⁷ The United Republic of Tanzania (n 94 above) 14.

⁹⁸ The United Republic of Tanzania (n 94 above) 5.

⁹⁹ The United Republic of Tanzania (n 94 above) 17.

¹⁰⁰ See ‘Sodomy laws around the World’ <http://www.actwin.com/eatonohio/gay/world.htm> (accessed 24 July 2006). See also R Morgan and S Wieringa (25 above) 53.

¹⁰¹ Republic of Zambia, Ministry of Health, *National HIV/AIDS/STI/TB Policy* February 2002.

¹⁰² Republic of Zambia (n 100 above) clause 1(4)(b).

awareness programmes, provides that the government shall 'encourage and provide condoms' to prisoners.¹⁰³

The National Policy provisions on condoms are commendable; however, once again, the effect in reality is questionable. For example, the National Policy is not definite as to whether prisoners would receive condoms while in confinement or at the point of release from prisons, as is the case in some other Southern African countries. More importantly, as the National Policy notes, '[Zambian] law currently prohibits condom distribution in prisons.'¹⁰⁴ Though the National Policy recommends legislative reforms to facilitate realisation of the HIV/AIDS control programme,¹⁰⁵ it is uncertain when and if that will occur or how far-reaching it will be in respect of provision of condoms in prisons.

4.10 Zimbabwe

The National Policy on HIV/AIDS for the Republic of Zimbabwe¹⁰⁶ (National Policy) prescribes various measures including education and training for prevention of HIV/AIDS among prisoners;¹⁰⁷ however, the supply of condoms in prisons is not included amongst these prescribed measures.¹⁰⁸

Under the segment relating to prisoners in the National Policy, there are no express provisions concerning access of prisoners to HIV treatment, although the National Policy does provide that prisoners have basic rights, which must be protected. Ostensibly, this connotes that prisoners would enjoy similar access to available HIV treatment along with non-prisoners.¹⁰⁹

With regard to same-sex sexual intercourse, the National Policy in a seemingly wide-looping manner, notes that 'homosexuality and sodomy are known to occur in prisons worldwide.'¹¹⁰ Based on the high level of intolerance to homosexuality, especially among political leaders in Zimbabwe,¹¹¹ it seems unlikely the government would support the supply of condoms to prisoners for same-sex sexual intercourse.

¹⁰³ Republic of Zambia (n 101 above) 34, clause 3(8)(3)(a), (c), (d), (e).

¹⁰⁴ As above.

¹⁰⁵ Republic of Zambia (n 101 above) clause 4.2.1.b.

¹⁰⁶ *National Policy on HIV/AIDS for the Republic of Zimbabwe* December 1999.

¹⁰⁷ *National Policy on HIV/AIDS for the Republic of Zimbabwe* (n 105 above) clause 6.8.

¹⁰⁸ *National Policy on HIV/AIDS for the Republic of Zimbabwe* (n 105 above) 9-10.

¹⁰⁹ See *National Policy on HIV/AIDS for the Republic of Zimbabwe* for treatment and care measures prescribed for PLWHA (12-19).

¹¹⁰ *Policy on HIV/AIDS for the Republic of Zimbabwe* for treatment and care measures prescribed for PLWHA (n 109 above) 6.8.

¹¹¹ Human Rights Watch and the International Gay and Lesbian Human Rights Commission (n 24 above) 1.

5 Obstacles to prisoners' access to treatment in Southern Africa

As noted above, HIV/AIDS policies in Southern African countries generally provide for prisoners' access to HIV treatment. While the policy provisions are largely impressive in phraseology, the extent to which prisoners enjoy access to treatment in reality is open to debate. Indeed, several real impediments exist for prisoners in accessing HIV treatment.

Prisoners mostly have to obtain ARVs at public health facilities outside the prisons.¹¹² Because prisoners are escorted by wardens when presenting for treatment, the possibility of stigmatisation exists and may discourage prisoners from revealing their HIV status. Where treatment is provided inside prisons, prisoners also face similar challenges. In Botswana, for example, there have been reports that ARVs are administered in a manner that enables other prisoners to know the HIV status of those infected.¹¹³

The requirement that prisoners pay for their HIV medications, either in full or in part, represents another obstacle. It would be difficult for prisoners who are dependent on the state for their 'livelihood' to raise the necessary money to finance their treatment. The South African *Westville* case¹¹⁴ illustrates how the imposition of financial obligation for treatment, and prisoners having to receive medications outside the prisons, can affect their access to treatment.¹¹⁵

In some countries, where policies explicitly provide for HIV treatment to prisoners, access is often still restricted. The *Westville* case, and another South African case, *Van Biljon and Others v Minister of Correctional Services and Others (Van Biljon case)*,¹¹⁶ are evidence of this. The *Westville* case indicates the broader problem of a fundamental divergence between the content of HIV and AIDS policies and the reality of what is playing out on the ground. As the Treatment Action Campaign (TAC) sums it up, 'a beautiful policy on paper and not properly implemented will be unconstitutional'.¹¹⁷ The

¹¹² See 'ZAMBIA: Agencies step in to address HIV/AIDS in prisons' <http://www.irinnews.org/report.asp?ReportID=48909> (accessed 21 June 2006).

¹¹³ As an example, in one of the prisons visited in Botswana ARVs are reportedly handed over to 'prison-prefects' (also a prisoner) who subsequently supply the medications to the inmates who need the drugs.

¹¹⁴ n 89 above; the background to the case has been discussed above.

¹¹⁵ See background to case above.

¹¹⁶ 1997 (4) SA 441 (C); see also *B and Others v Minister of Correctional Services and Others* 1997 (4) BCLR 789 (C).

¹¹⁷ Treatment Action Campaign (TAC) 'What the Court and TAC expects in the HIV/AIDS plan for Westville Correctional Centre' TAC News Service, 7 September 2006, news@tac.org.za (accessed 8 August 2006).

case also illustrates the importance of litigation, supported by social mobilisation.

Ironically, the *Westville* case was not the first judicial intervention on the issue of prisoners' lack of access to HIV treatment in South Africa. In the *Van Biljon* case,¹¹⁸ a South African High Court had upheld prisoners' rights to HIV treatment at government expense, highlighting that this right was a component of the inherent constitutional right to an adequate standard of medical treatment. While the *Van Biljon* case was perceived as a groundbreaking decision in respect of prisoners' access to HIV treatment, its practical effect in securing neither the access of prisoners to medication nor their right to health as a whole has been limited. Reportedly, the litigants themselves did not even receive HIV treatment despite the court order.¹¹⁹

6 Prisoners' access to condoms in Southern Africa

The rights of prisoners to have condoms for prevention can be set within the normative context of international and regional human rights law and international guidelines relating to prisoners' rights.

6.1 Rights of prisoners to condoms under international and regional human rights law

The United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners (1955) prohibits discrimination.¹²⁰ In respect of medical treatment, article 22(2) provides as follows:¹²¹

Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

In addition, a variety of international human rights instruments and guidelines exist that provide an additional package of rights, including in particular the right to equality and the right to the enjoyment of the highest attainable standard of health, which would apply to prisoners. These include the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955), the Universal Declaration of

¹¹⁸ n 89 above.

¹¹⁹ Canadian HIV/AIDS Legal Network (n 53 above) 115.

¹²⁰ Art 6(1), United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners (1955)

¹²¹ Art 22(1), United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners (1955).

Human Rights (1948), the International Convention on the Elimination of All Forms of Racial Discrimination (1965), the International Covenant on Economic, Social and Cultural Rights (1966), the International Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Convention Concerning Indigenous and Tribal Peoples in Independent Countries (1989), the Convention on the Rights of the Child (1989) and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990). Arguably, the effect of the right to the highest attainable standard of health coupled with the right to equality is that prisoners are entitled to HIV prevention and treatment equal to that which the non-prison population is entitled to.

This entitlement must, however, be considered in relation to prison environments. Due to their confinement, prisoners are dependent on governments, and their custodians, for sustenance. Furthermore, hazardous prison conditions make health conditions worse than in the outside community, making prisoners more vulnerable to infections. The needs of HIV preventative and treatment measures are thus greater in prisons than in the outside community. Attaining *equal access* to health care for prisoners may thus call for some special measures over and above those that are provided to non-prisoners. As the court in *Van Biljon and Others v Minister of Correctional Services and Others* noted:¹²²

Even if it is ... accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the state for patients outside, this principle can ... not apply to HIV infected prisoners. Since the state is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the state must provide them must be treatment which is better able to improve their immune systems than that which the state provides for HIV patients outside.

Indeed, the World Health Organization notes that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'¹²³ Based upon the international human rights to equality, health and HIV prevention, prisoners have the right to have condoms for the prevention of HIV infections. Though the provisions of these treaties are general in phraseology, the relevant provisions indisputably support the rights of prisoners to be protected against disease, and therefore access to condoms.

¹²² n 116 above, para 51.

¹²³ Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation (no. 2) 100 and entered into force on 7 April 1948.

At the regional level, the African Charter on Human and Peoples' Rights also contains some important provisions relating to the right of prisoners to access condoms. These include the rights to equality, health, privacy and life. Article 16 of the African Charter on Human and Peoples' Rights, which deals with the right to health, states that:

- (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
- (2) State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.¹²⁴

The positive obligation on state parties specifically to take measures to protect the health of their people connotes that prisoners should enjoy all facilities and means of ensuring their physical and mental well-being, which includes protection against contracting HIV infection through sexual intercourse in prison confinements.

Many prisoners and non-prisoners in Southern Africa do not have access to ARVs that can prolong their lives in cases of HIV infection.¹²⁵ Consequently, HIV infection in the overcrowded and deplorable prison conditions under which many prisoners live, literally translates to a slow and traumatising death.¹²⁶ In that context, depriving prisoners of a means of preventing HIV infection in prison, arguably indirectly amounts to violating their rights to life and health, guaranteed under articles 4 and 16 of the African Charter.

6.3 International guidelines relating to prisoners' rights

In addition to international and regional human rights law, various standards and guidelines have evolved to guide countries in addressing issues such as HIV and AIDS, conditions of prisons, treatment of prisoners and other human rights related matters.

Among the international guidelines relevant to the conditions of prisoners are Basic Principles for the Treatment of Prisoners,¹²⁷ Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment¹²⁸ and Standard Minimum Rules for the Treatment of Prisoners. Others are Recommendation No R (98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison, World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons

¹²⁴ Art 16, African Charter on Human and Peoples' Rights.

¹²⁵ See generally A Hassim 'Overview of treatment access in the SADC region' in Heywood (n 11 above) 209-224.

¹²⁶ See the *Westville* case, n 89 above, 99A-B. See also 'Zambia: Agencies step in to address HIV/AIDS in prisons' (n 112 above), concerning deaths in Zambian prisons. Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990.

¹²⁸ Adopted by General Assembly resolution 43/173 of 9 December 1988.

(1993) ('WHO Guidelines')¹²⁹ and the International Guidelines on HIV/AIDS and Human Rights ('International Guidelines on HIV/AIDS').¹³⁰

The International Guidelines on HIV/AIDS were first released in 1998. In 2002, they were updated with an expanded section dealing with Guideline 6 on treatment, care and support. Very recently, these were consolidated in the OHCHR and UNAIDS International Guidelines on HIV/AIDS and Human Rights: Consolidated Version 2006 ('Consolidated International Guidelines on HIV/AIDS'), which makes several references to the right of prisoners to access condoms.¹³¹ Guideline 4 of the 'Consolidated International Guidelines on HIV/AIDS' deals with 'Criminal Laws and Correctional Systems' and notes that states should 'review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups.'¹³² The Guidelines for state action, which form part of the 2006 version, state that

[p]rison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.¹³³

A powerful addition to the Consolidated International Guidelines on HIV/AIDS is the statement that a failure by states to provide prevention information and access to condoms in prisons could constitute cruel, inhuman or degrading treatment or punishment.¹³⁴

The International Guidelines on HIV/AIDS do not have the legal effect of treaties, and thus are not *legally* binding on Southern African countries. Nonetheless, as members of a global community, the guidelines are *morally* binding on the countries. As a matter of honour and principle, they ought to respect and uphold the prescriptions of international bodies with which they voluntarily associate. Moreover,

¹²⁹ WHO/GPA/.DIR/93.3.

¹³⁰ International Guidelines on HIV/AIDS and Human Rights. UNCHR res 1997/33, UN Doc E/CN.4/1997/150 (1997).

¹³¹ See the OHCHR and UNAIDS International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version.

¹³² As above.

¹³³ See Guideline 4, 21(e) of the OHCHR and UNAIDS International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version.

¹³⁴ OHCHR and UNAIDS International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version 103.

the guidelines are consonant with the aspirations and efforts of the countries to control HIV.

6.4 Restriction of condoms for prisoners: a public health perspective

It is now indisputable that same-sex sexual intercourse occurs and is contributory to HIV transmission in Southern African prisons.¹³⁵ This raises a public health concern. Prisoners are highly prone to HIV infection because of the harsh and largely unhealthy prison conditions in which they live. They are also potential vectors of transmission, within and outside prison confinements. Inferably, leaving a vulnerable prison population unprotected translates to leaving a source of spread unplugged. This is capable of undermining efforts to curtail spread of HIV in the Southern African region.

As in other parts of the world, there is constant interaction between prisoners and non-prisoners both within the prison community and outside the prison community.¹³⁶ As depicted by a Botswana Prisons Service Commissioner, 'Prisoners and prison officers move in and out of prison everyday. Most prisoners are in for only short sentences, some spend several periods there, returning to the outside world each time after release'.¹³⁷

Thus, apart from the expectations of human rights law and international guidelines, public health requirements demand that prisoners are afforded access to condoms as a means of averting HIV transmission through same-sex sexual intercourse. Protecting prisoners against HIV translates to protecting the whole society of which the prison population constitutes an inextricable component.

7 Confronting the barriers to prisoners' right to access condoms

Having identified criminalisation of man-to-man sexual intercourse as a major obstacle to the provision of condoms to prisoners in Southern Africa, it is recommended that an appropriate solution would be to repeal these restrictive laws. Indeed, Guideline 6 of the Consolidated International Guidelines on HIV/AIDS, which deals with universal access to prevention, treatment and care, specifically notes that 'restrictions on the availability of preventive measures, such as

¹³⁵ See 'PRISONACT: IRIN Focus on safe-sex in prisons' (n 38 above); see also, K Masthe *HIV/AIDS prevention in Botswana prisons: What could be done? The prisoners' perspectives and policy recommendations* (2002) 15-16, 17.

¹³⁶ See Reyes (n 6 above).

¹³⁷ Orebotse (n 62 above), see also Reyes (n 6 above).

condoms, bleach, clean needles and syringes', should be repealed.¹³⁸ The attainment of this goal is however beset with difficulties.

7.1 Anti-homosexuality sentiments of heads of governments and reluctance of legislators

The strong anti-homosexuality sentiment of some powerful heads of government in Southern Africa presents a challenge to redressing access barriers.¹³⁹ Similarly, no noticeable willingness is apparent on the part of law-making bodies in the region to break down the criminal law barriers that presently exist. Judging by the amendment of section 164(c) of Botswana's Penal Code, it seems that legislators may be more disposed to strengthening the laws rather than repealing them.¹⁴⁰

Prior to its amendment in 1998, section 164 of the Penal Code, which came into effect in 1964, provided as follows:

Any person who-

- (a) has carnal knowledge of any person against the order of nature;
- (b) has carnal knowledge of an animal; or
- (c) permits a *male person*¹⁴¹ to have carnal knowledge of him or her against the order of nature,

is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.

Following the 1998 amendment, the section now reads:

Any person who-

- (a) has carnal knowledge of any person against the order of nature;
- (b) has carnal knowledge of an animal; or
- (c) permits any other person¹⁴² to have carnal knowledge of him or her against the order of nature,

is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.

The central point of the Penal Code amendment in Botswana is that 'male person' was replaced with 'any other person'. Obviously, in broadening the scope, the legislature tangentially defused any

¹³⁸ See Guideline 6, 39 of the OHCHR and UNAIDS International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version.

¹³⁹ Human Rights Watch & The International Gay and Lesbian Human Rights Commission (n 26 above) 1-2.

¹⁴⁰ See generally *Kanane* case (n 2 above).

¹⁴¹ Emphasis added.

¹⁴² Emphasis added.

probable challenge of gender discrimination against the Penal Code provisions.¹⁴³

This is further reinforced by the views publicly expressed by some regional political representatives and leaders. A member of the Namibian Parliament, for example, is reported to have said that people in the Oshana region, which he represents, condemned the provision of condoms to prison inmates, charging that such practice would boost sodomy. Instead, he said, prisoners should practice 'self-masturbation'.¹⁴⁴

7.2 Judicial unwillingness or reluctance

In view of the inclination of the executive and legislative arms of government in Southern African countries to sustain the criminalisation of homosexuality, the court ostensibly is a viable option in the drive to remove the criminal law barriers to prisoners' access to HIV prevention. Accordingly, in some cases across Southern Africa the courts have been asked to strike down anti-sodomy laws.

In the case of *National Coalition for Gay and Lesbian and Another v Minister of Justice and Others*,¹⁴⁵ the South African Constitutional Court declared the common law offence of sodomy to be unconstitutional in South Africa. The ground for invalidating the law was that it violated section 9(3) of the South African Constitution that deals with discrimination. The law was also found to have violated the constitutional right to human dignity.

In the Zimbabwean case of *Banana v State*,¹⁴⁶ it had also been argued that criminalisation of sodomy was unconstitutional on the ground of violating the right to equality guaranteed under section 23 of the Zimbabwean Constitution. However, unlike the scenario in South Africa, the Zimbabwean Supreme Court, by majority decision held that the criminalisation of sodomy was *not* unconstitutional. While noting that the common law offence of sodomy differentiates between gay and heterosexual men based on sexual orientation, the court maintained that this did not amount to the constitutionally

¹⁴³ A constitutional challenge of gender discrimination was actually raised against sec 164(c) of the *Penal Code* in the case of *Kanane v The State* (n 2 above). Implicitly, the court agreed that the challenge of discrimination would have succeeded under provision of the Penal Code as it stood prior to the 1998 amendment. However, the present provision as it stands has rendered such challenge nugatory. See generally (*Kanane v The State*) 72- 73, particularly 72 B-C: 'As stated above, the appellant's contention is that secs 164 and 167 violate the Constitution as they hinder his right of association with other males or are *discriminatory against males, including him, on the basis of their gender*' (emphasis added)

¹⁴⁴ See Shigwedha (n 80 above).

¹⁴⁵ n 87 above.

¹⁴⁶ n 24 above.

prohibited act of gender discrimination. Moreover, the offence was legally defensible in view of the prevailing conservative social norms and values against homosexual behaviour in Zimbabwe. As Justice McNally explained,

[f]rom the point of view of law reform, it cannot be said that public opinion has so changed and developed in Zimbabwe that the courts must yield to that new perception and declare the old law obsolete. In the particular circumstances of this case, I do not believe that the 'social norms and values' of Zimbabwe are pushing us to decriminalise consensual sodomy. Zimbabwe is, broadly speaking, a conservative society in matters of sexual behaviour.¹⁴⁷

Similarly, in the Botswana case of *Kanane v The State*¹⁴⁸ (*Kanane case*), section 164 (c) of Botswana's Penal Code relating to sodomy was challenged against the constitutionally guaranteed right to equality. However, after reflecting on the South African and Zimbabwean cases described above, Botswana's Court of Appeal, the country's highest court, held that the Penal Code provisions were constitutional and were not in violation of the right to equality. Along similar lines to the Zimbabwean Supreme Court, the Botswana Court of Appeal embraced the prevailing social norms on sodomy in Botswana to justify maintaining the *status quo* on criminalisation of sodomy. According to Justice Tebutt who delivered the lead judgment,

[a]s I have stated, there is no evidence that the approach and attitude of society in Botswana to the question of homosexuality and to homosexual practices by gay men and women requires a decriminalisation of those practices, even to the extent of consensual acts by adult males in private ... the time has not yet arrived to decriminalise homosexual practices even between consenting adult males in private.¹⁴⁹

In striking down anti-homosexuality laws in South Africa, the case of *National Coalition for Gay and Lesbian and Another v Minister of Justice and Others* was quite remarkable. Arguably, if the two latter cases, and other jurisdictions, had followed in its steps, there could have been a good chance of eradicating anti-sodomy laws, formidable barriers to provision of condoms to prisoners, across Southern Africa. With the subsequent Zimbabwean and Botswana cases taking a contrary stand, it appears that the case has not had any motivational impact on other jurisdictions with regard to the constitutionality of sodomy.

The *Kanane* case can be regarded as a forum to examine the spectrum of views held on sodomy in Southern Africa. From the perspective of case law, *Kanane* represented a watershed on judicial position on the constitutionality of anti-sodomy laws in Southern

¹⁴⁷ n 24 above, 933.

¹⁴⁸ n 2 above.

¹⁴⁹ As above.

Africa. The case offered an opportunity to formulate the dominant or 'majority' Southern African jurisprudence on the constitutionality of anti-sodomy laws. By aligning itself with the Zimbabwean court in the *Banana case*, it can now be said that the prevailing jurisprudence in Southern Africa is that anti-sodomy laws are constitutional.

Considering that the three cases involved substantially similar issues relating to homosexuality and human rights, it may seem strange that the latter two cases departed from the South African decision. One explanation for this appears to be that the cases were decided in line with the respective constitutional provisions of the individual countries; or, put differently, that the first case was decided on the peculiar provisions of the South African constitution that are not the same in the other countries.

Though basically sound, such reasoning is not infallible. While there could be differences in the phrasing or wording of human rights provisions, it is unlikely that this can create a scenario where basic human rights principles such as non-discrimination, would be so altered to the extent of attracting radically diverse meanings in different countries. Moreover, the Botswana court which analysed the two earlier cases did not seem to focus on the question of peculiarity of constitutional provisions in reaching its decision.

Rather, the basis of the dissimilar positions seems to be the emphasis in the latter two cases on prevalent social norms or *public attitude* towards sodomy or homosexuality in the countries.¹⁵⁰ This position raises some important questions, such as whether the 'public opinion' relied on by the courts to justify maintaining the status quo is indeed the *real* opinion of the people. True, the position of the democratically elected Botswana legislature in reinvigorating an anti-sodomy law may be an indication of the anti-sodomy inclination of the citizens, conveyed through their law-making representatives. However, one wonders whether the acts of elected legislators in *all* cases are attributable to the views of the electorate.

Another question to pose is whether the criminalisation of sodomy propels and sustains the public attitude, or is the reverse true? Put simply, is it laws that influence social attitudes or social attitudes that influence laws? Arguably, the existence of criminal sanctions may have fettered an open embrace or support of homosexual practices among the citizens. Perhaps, in the absence of a criminal law barrier, public attitude to homosexuality in Botswana and Zimbabwe would be different than it was perceived to be by the court. Thus, the *real* public attitude towards homosexuality in Botswana and Zimbabwe calls for more interrogation.

¹⁵⁰ See notes 153 and 155 and accompanying texts.

Finally, that public attitude can ever trump constitutionally-protected human rights is incredibly worrisome. Indeed, it is for this reason that one entrenches human rights in a Constitution to begin with, in order to accord them a greater protection above and beyond the whims of society.

Whatever the case may be, the prevailing scenario in Botswana, Zimbabwe and other Southern African countries is that criminalisation and public disapproval of sodomy are major obstacles to the provision of condoms to prisoners, particularly from the perspective of governments implementing HIV control and other state policies. There is a need to overcome these obstacles in order to enable prisoners to have access to condoms for the prevention of HIV infection.

8 Conclusions and recommendations

8.1 An appeal to civil society for action

Since the Botswana case of *Kanane* was decided in 2003, there appears to have been no invitation to the judiciary, at the highest level, in any other Southern African country to decide on the constitutionality of sodomy. Thus, from a sub-regional perspective, based on the majority jurisprudence discussed earlier, this implies that sodomy remains unlawful and a major, if not the primary, barrier to the provision of condoms for HIV prevention in prisons.

Notwithstanding existing international guidelines, treaties and the like, governments¹⁵¹ in Southern Africa largely remain *incapacitated* in providing condoms in prisons. I use ‘incapacitated’ instead of ‘unwilling’ because there are signs that not all Southern African political leaders have an unsympathetic attitude to homosexuality; at least judging by their words.¹⁵² Perhaps, if MSM sexual conduct were lawful in their countries such leaders might be inclined to make condoms accessible to prison inmates.

As noted earlier, the restriction of prisoners’ access to HIV treatment and means of prevention amounts to a human rights violation and a threat to public health in Southern Africa. It is crucial that efforts be intensified to make condoms accessible to prisoners

¹⁵¹ ‘Governments’, in this context, is used in a restricted sense to refer to the executive arms of government which have the primary duty of implementing HIV/AIDS control programmes, managing the prisons as well as executing other state programmes.

¹⁵² See eg M Admin ‘Botswana President: Don’t be judgmental on homosexuals’ <http://www.mask.org.za/article.php?cat=&id=105> (accessed 9 June 2006). Governments in this context, is used in a restricted to refer to the Executive arms of government which have that have the responsibility for implementing HIV/AIDS control policies and measures.

for prevention and there is an urgent need to address the underlying factors responsible for the restriction.

The restriction of prisoners' access to condoms touches on breaches of international human rights treaty obligations.¹⁵³ The international pressure of other state parties to the relevant treaties may thus appear to be an attractive and potent means to make non-complying Southern African countries make condoms accessible to prisoners, in line with their obligations. The issue then becomes: Who is best placed to mobilise and achieve these changes?

While international intervention could assist, this is unlikely to occur. Courts have held that anti-sodomy laws are not unconstitutional or contrary to human rights; accordingly, there appears to be no ground for international pressure to argue for the repeal of such laws. Any pressure in that context would seem to be unwarranted interference in the sovereign affairs of these countries.

Second, the selective attitude of the international community on treaty enforcement also seems to make international intervention uncertain. One commentator notes as follows:¹⁵⁴

Unlike commercial and other treaties where the states parties would usually have the motivation and resources to raise and pursue the failure to comply in appropriate fora, *states' self-interest is normally lacking in relation to human rights treaties.*

Civil society thus seems best placed to handle the task of tackling the barriers to provision of condoms in prisons. Ostensibly, appreciating that the mantle falls on them, civil society organisations in Southern Africa have been making cogent efforts in this area. The efforts range from influencing the inclusion of 'condoms in prison' clauses in national policies,¹⁵⁵ to campaigning against homophobia in various ways,¹⁵⁶ and even to distributing condoms in prisons.¹⁵⁷

While civil society has been persistent and assiduous, the challenges, especially with respect to social attitudes, are equally formidable. As the cases of *Banana* and *Kanane* illustrate, social

¹⁵³ Parties to international treaties are obliged to obey and discharge their duties under such treaties. The duty to fulfill human rights, for example under the African Charter, requires Southern African governments to remove impediments to the enjoyment of human rights. In the case of the condoms-in-prison discourse, this necessarily encompasses repealing anti-sodomy laws and eradication of anti-homosexuality social attitude that militate against the access of prisoners to condoms.

¹⁵⁴ AA An-Na'im 'State responsibility under international human rights law to change religious and customary laws' in RJ Cook (ed) *Human rights of women, national and international perspectives* (1994) 168 (emphasis added).

¹⁵⁵ See Botswana Draft National Policy 2005.

¹⁵⁶ See F Vilakazi 'Protect SA from sexual apartheid: Behind the Mask' <http://www.mask.org.za/article.php?cat=Opinion&id=1319> (accessed 14 September 2006).

¹⁵⁷ See 'PRISONACT, IRIN Focus on safe-sex in prisons' (n 38 above).

attitudes to homosexuality are a major support for anti sodomy laws in Southern Africa. Conceivably, an important step towards breaking down the criminal law barriers is to overcome the negative social attitudes towards MSM. Generally, governments do not want to appear to defy public opinion, particularly when these are deeply rooted in cultural and religious values.¹⁵⁸

Thus, mindful of the obstacles involved in de-criminalising same-sex relations in Southern Africa, it is therefore suggested that civil society should also work towards changing the underlying discriminatory and stigmatising attitudes towards men having sex with men and prisoners. This should be carried out in parallel with a drive for improved prison conditions and welfare of prisoners.

The suggested approach promises some possibilities. Firstly, conducive social attitudes would enable civil society to proceed in an atmosphere devoid of antagonism to its cause, even if there were no significant support for it. Attainment of the set goal would be easier in such a situation rather than in one where civil society appears to be pursuing an unpopular cause, which may attract censure or recrimination, not only from the public, but also from the specific groups whose interests civil society purports to protect.

Secondly, the push for legal reform, vis-à-vis removal of criminal law barriers, obtained with the understanding or support of the society, is more likely to have sustained practical effects. On the other hand, a legal reform achieved without the corresponding social support may not have the desired practical effect. Implementation of such reform may even be frustrated by resentment of the public or disinterestedness of the implementing officers or organs.

8.2 Suggested methodologies for addressing change in social attitudes

In the drive to attain change in social attitudes to homosexuality and public perceptions of prisoners, it is crucial that feasible strategies are adopted. In the specific context of making HIV treatment and condoms accessible to prisoners, it may be helpful to intensify education and awareness activities, particularly at the grassroots level, to stimulate acceptance of the rights of some members of society to engage in man-to-man sex, or other forms of sexual intercourse which may be considered unconventional. Copious references to the supportive comments of prominent members in the society¹⁵⁹ should give some push to this effort.

¹⁵⁸ An-Na'im (n 152 above) 169.

¹⁵⁹ Eg the comments of Botswana's President Mogae concerning homosexuals.

Furthermore, campaigns for the provision of condoms in prison, particularly at the grassroots level, should be re-branded and 'marketed' more as a public health issue, which indeed it is, that affects or benefits the population at large. Arguably, it would be easier to sell this approach.

Generally, civil society groups can harness the improvement of relationships with governments across the Southern African sub-region to nudge decision-makers in governments in the desired direction. Legitimate lobbying and persuasive arguments, delivered in non-confrontational styles can persuade some influential persons to take the campaign to the point of change.

As a pro-active measure, civil society should explore legitimate alternative routes of circumventing the criminal law barriers in the drive to make condoms accessible by prisoners. This would be especially useful in countries where governments cite criminalisation as their fundamental handicap. In this regard, it would be useful to refer to the distribution of needles in prison in some countries without necessarily legalising the indiscriminate use of illegal drugs.¹⁶⁰

Confrontational methodologies, such as court actions, may not be effective weapons in the immediate term to make condoms accessible to prisoners. Based on the prevailing 'Southern African jurisprudence' as portrayed by *Banana* and *Kanane*, the probability of legal success seems low. It is uncertain whether another judicial intervention would strengthen or weaken the existing jurisprudence. Thus, it is recommended that alternative routes to litigation are first explored in order to make some solid advances.

It is important that civil society groups ensure credibility and unity, to enable them to pursue the goal as a cohesive and unified front. While civil society organisations seem in the main, to have overcome past criticisms of insincerity and opportunism, the problem persists of ideological differences, especially between religious or church-linked NGOs and non-religious NGOs in Southern Africa. The promotion of condoms in HIV prevention campaigns is one point of difference:¹⁶¹ With promotions of condoms now transported to the realm of man-to-man sexual intercourse, inherently unacceptable to many religious adherents, the intensity of the differences may be higher.

Ideological differences between civil society organisations should not be to the detriment of mutual respect and understanding of individual objectives. Differences should not propel scenarios where

¹⁶⁰ See eg in the case of Switzerland 'The Hindelbank experiment: Access to sterile injection equipment' in UNAIDS, *Prison and AIDS, UNAIDS technical update*, April 1997, 4.

¹⁶¹ See generally Berger (n 11 above).

one group would undermine the efforts of another, directly or indirectly, in the task to make condoms accessible in Southern African prisons. Hopefully, the growing congregation of civil society organisations under umbrella groups should assist in effecting the desired understanding.

5 The realisation of access to HIV and AIDS-related medicines in Southern African countries: Possibilities and actual realisation of international law obligations

*Dorothy Mushayavanhu**

1	Introduction
2	Human rights as a means to improve access to ART
3	'Flexibilities' under TRIPS as a means to improving access to ART
4	Options outside TRIPS: Accessing funding, drug donations, price reductions and public-private partnerships to improve access to ART
5	Conclusions and recommendations

1 Introduction

1.1 Background

Millions of people have already died and are still dying as a result of AIDS in Southern Africa. Despite high prevalence rates in the region, a large percentage of people living with HIV in Southern Africa remains without access to HIV and AIDS-related medicines. The economic and social impact of the HIV pandemic has been far-reaching, and is further compounded by the high rates of tuberculosis (TB) and malaria. In this contribution, the focus falls on HIV and AIDS. Most of the region's countries have been classified as 'Least Developing Countries' (LDCs), where relatively low life expectancy has decreased dramatically due to the HIV pandemic.¹ These countries are also classified by the World Health Organisation (WHO)

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¹ These countries have experienced a reversal of the human development index (HDI), see UNDP Human Development Report (2005).

as high-burden countries because of the high HIV, TB and malaria prevalence rates.²

It is generally accepted that Highly Active Anti-Retroviral Therapy (HAART) provides an effective baseline of anti-retroviral treatment (ART). The first-line HAART regimen is made up of Stavudine (d4T); Zidovudine (AZT); Lamivudine (3TC); Nevirapine (NVP) and Efavirenz (EFV).³ The second-line regimen, which is mainly introduced to overcome treatment failure and resistance to first-line medications, consists of Didanosine (ddl); Abacavir (ABC); Nelfinavir (NFV), Indinavir (IDV), Saquinavir (SQV), Ritonavir (RTV) and Lopinavir/Ritonavir (LPV/RTV, or Kaletra). Second-line medications are generally much more expensive than first-line drugs.

In most of Southern Africa, the price of HAART places it beyond the reach of countries and individuals.⁴ Hefty prices are partly attributed to the laws that promote intellectual property rights of patent holders and those that regulate drug development. Drug pricing has resulted in non-availability, non-affordability and inaccessibility of HIV and AIDS-related medicines. Prohibitive costs are also related to customs duties and tariffs. Some of the drugs expire before use as a result of protracted and cumbersome customs clearance and due to the very short shelf-life of HIV and AIDS-related medicines. Consequently, there is a huge treatment gap in developing countries generally, and in the SADC region specifically, as illustrated in Table A below:⁵

² UNAIDS/WHO 'Progress on global access to HIV antiretroviral therapy: An update on "3 by 5"' June 2005, www.who.int/3by5/fullreportJune2005.pdf (accessed 30 November 2006).

³ WHO, 'Global Price Reporting Mechanism for ARVs in Developing Countries: 1st quarterly summary report', September 2005.

⁴ Due to limited foreign exchange reserves, a country like Zimbabwe for example relies mainly on domestic resources for financing and for scaling up of treatment. At an individual level, drugs are bought by using household incomes and out-of-pocket expenses.

⁵ A Hassim 'An overview of treatment access in the SADC region' (2004) 5 *Development Update* 209, 212.

Table A: Treatment gap in the SADC region as at June 2004⁶

Country	Population (millions)	Estimated no of PLWHA (0 - 49 years)	Estimated ART need in 2005	Reported no receiving ART June 2004 (15 - 49 years)	ART coverage (%)
Angola	14.1	240 000	32 000	700	2.2
Botswana	1.8	330 000 - 380 000	60 000	18 000	30.0
Dem Rep of Congo	51.2	1 100 000	160 000	2 500	1.6
Lesotho	1.8	290 000 - 360 000	54 000	1 000	1.9
Madagascar	18,6	49 000	unknown	unknown	-
Malawi	12.8	900 000	130 000	3 760	2.9
Mauritius	1.2	unknown	unknown	unknown	-
Mozambique	19.2	980 000 - 1 700 000	190 000	2 840	1.5
Namibia	1.8	210 000	29 000	400	1.4
South Africa	44.4	5 300 000	750 000	59 000	2.7
Swaziland	1.1	210 000 - 230 000	32 000	3 200	10.0
Tanzania	37.7	1 200 000 - 2 300 000	260 000	1 650	0.6
Zambia	10.9	730 000 - 1 100 000	140 000	8 500	6.1
Zimbabwe	12.9	1 500 000 - 2 000 000	290 000	6 000	2.1

This table illustrates the huge treatment gap that is experienced in all countries of Southern Africa, with the exception of Botswana. In 2005, the World Health Organization (WHO) estimated that ARV therapy coverage in sub-Saharan Africa stood at 11 per cent, with an estimated 500 000 people out of a total of some 4.7 million receiving ARV treatment.⁷ Despite the different profiles of the countries in the SADC region, with some recovering from civil war (Angola and the Democratic Republic of Congo), and others (Zambia and Zimbabwe) experiencing political and economic problems or high poverty levels, with the exception of Botswana, they all share a considerable 'treatment gap'.

The debate on access to medicines demonstrates the indivisibility and interdependent nature of human rights. It raises issues of inequality of access to medicines for the world's poorest, and

⁶ See data for Madagascar and Mauritius, which were not considered to be 'high burden countries', were not included.

⁷ UNAIDS/WHO (n 2 above) Table 1, 13.

questions the private property rights of pharmaceutical companies. Additionally, it shows that the poor in developing countries are at the mercy of those who own intellectual property rights. So far, drugs such as anti-retrovirals (ARVs) that have been developed for infectious diseases are very expensive and beyond the reach of the world's poorest, whilst the manufacturing of larger quantities of these drugs is curtailed by laws on intellectual property rights.

Some of the barriers that limit access to medicines include poverty, budgetary constraints, breakdown of healthcare delivery systems, 'bad' governance and inappropriate political programmes, as well as the impact of the World Trade Organisation's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). In addition, factors exist that affect the adoption of TRIPS flexibilities, such as domestic laws and the medicine's patent status in both the importing and exporting country.⁸ Constraints are experienced at two levels in relation to the domestication of the TRIPS Agreement: Firstly, there may be difficulties in providing the legal framework for the implementation of TRIPS at the domestic level; and secondly, there may be pragmatic or practical obstacles relating to local production, such as the lack of technological capacity.

The legal and policy frameworks that govern access to medicines are evolving in response to the high incidence of HIV and are influenced by processes such as international minimum standards arising from international agreements such as the TRIPS. Some of the main policy issues under discussion concern the ways in which intellectual property regimes allow for compulsory licensing, interpretation and enforcement of patent laws, amendments of laws and drug regulation. Laws exist that deal with the regulation of drug development, import and exportation of medicines, compulsory licensing, competition and patents.

The study will focus mainly on compulsory licensing as a policy tool that could be used to address the high prices of medicines, anti-competitive practices, and the need for pharmaceutical industries.⁹ Access to medicines can either be ensured through local manufacturing of generic drugs or drug imports or both; it can also be ensured through resolving the conflict between the right to health and intellectual property rights by the adoption of a rights-based approach to treatment.

⁸ BK Baker *Processes and issues for improving access to medicines: Willingness and ability to utilise TRIPS flexibilities in non-producing countries* (2004) www.iprsonline.org/resources/docs/Baker_TRIPS_Flex.pdf (accessed 31 January 2007).

⁹ See also F Musungu, S Villanueva & R Blasetti *Utilising TRIPS flexibilities for public health protection through sub-Saharan regional frameworks* (2004) 36.

The states under review here are all members of both the African Union (AU) and SADC. As members of the AU, they have responded positively towards the promotion of access to medicines by adopting the 2001 Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Malaria and other infectious diseases, which calls for universal access to HIV/AIDS, tuberculosis and malaria services in Africa by 2010. This was reaffirmed by the Brazzaville Commitment on scaling-up access to HIV/AIDS prevention, treatment, care and support. SADC as an institution has taken some steps, such as the adoption of the Maseru Declaration on HIV/AIDS (reprinted in Annexure D below), the SADC Protocol on Health (1999) and the Revision of the Multi-sectoral HIV/AIDS Strategic Framework and Programme of Action 2003-2007: HIV/AIDS Pandemic in SADC. However, the focus here falls on the actions of the individual 14 states at the national level.

1.2 Study questions

Against the above background, this paper investigates the steps taken by SADC states to bridge the treatment gap for people living with HIV. At least three means or mechanisms of securing improved access to ART are available to states and individuals within states: human rights; the 'flexibilities' under TRIPS; and using fund-raising and exploiting funding frameworks. In the first instance, this contribution inquires which human rights provisions in international and national law are of relevance to the issue of accessing ART. The extent to which SADC countries are required to observe these obligations and the steps they have taken to realise these rights are then reviewed. Secondly, a background is given to TRIPS and the 'flexibilities' that states may adopt. The law and practice in SADC countries are reviewed to ascertain to what extent they have made use of these possibilities. Thirdly, as access to ART depends on available funding, the extent to which governments in SADC have made use of existing funding opportunities is assessed. The first two aspects deal with binding obligations of states, while the third relates to the moral obligation of states to secure life-saving treatment for their nationals.

1.3 Study overview

Part 2 below outlines the legal obligations that arise from the international and regional human rights instruments, and assesses the compliance by SADC states with their obligation to realise the rights of their nationals, especially the right to health. Part 3 outlines the international intellectual property regime, and inquires to what extent SADC states have made use of the available 'flexibilities' to ensure greater access to ART. Part 4 looks at possibilities outside

TRIPS, such as accessing funding frameworks. Concluding findings, with corresponding recommendations, are offered in part 5.

2 Human rights as a means to improve access to ART

2.1 The legal framework of human rights protection

The treatment gap clearly constitutes a violation of human rights, in particular the right to health or to healthcare, and the right to life. In this part, the following questions are posed: What are the sources of these rights, what are the human rights obligations of the states in this regard, and how have the SADC states under review met those obligations to ensure improved access to ART?

2.1.1 *The right to health*

The right to health is provided for principally in two binding human rights instruments: the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples' Rights (African Charter), as well as in the non-binding International Guidelines on HIV/AIDS and Human Rights, adopted in 1996 by a meeting bringing together governmental and non-governmental experts from all around the world. Under national law, the right to health may be guaranteed in binding form under the Constitution or in terms of ordinary legislation, and in non-binding form through policies and programmes.

At the international level, the right to health is recognised in article 12(1) of the ICESCR, which provides that state parties must recognise 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', and article 12(2), which requires of states to realise progressively the right to health. Basic requirements of the right to healthcare are set in General Comment 14, adopted by the Committee on Economic, Social and Cultural Rights (CESCR): All healthcare services and medications should be available in sufficient quantity, accessible to everyone without discrimination, and should also be physically and economically accessible.¹⁰ General Comment 14 further notes that 'health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds'.¹¹ In

¹⁰ General Comment 14: The Right to the Highest Attainable Standard of Health UN Doc E/C.12/2000/4 (2000) para 12.

¹¹ As above.

other words, the content of the right to health contains interrelated and essential elements. These are availability, accessibility (including physical and economic accessibility or affordability, and accessibility of information), acceptability and quality. Principles of human rights and fairness further demand that people living with HIV should play a significant role in the improvement of programmes.

General Comment 14 further provides that one of the minimum core obligations is the provision of essential medicines.¹² The 'essential medicines' concept prioritises a limited list of vital and essential drugs that are supposed to be effective, safe, good quality and affordable for treating 'the priority health care needs of the population'.¹³ 'The core is the minimum essential level of health that states have priority obligations to provide'.¹⁴ The WHO published an updated Model List in 2002, which includes ARVs and other anti-infective medicines.¹⁵ The implication of listing ARVs as essential medicines is that they are supposed to be affordable and accessible by the worlds' poorest. Although these 'General Comments' do not have binding legal authority, they have considerable persuasive force as authoritative interpretations of government obligations under the ICESCR.

Resource implications are associated with the progressive realisation of the right to health, which requires that policies and strategies should be adopted regardless of whether ART is administered in resource-limited settings. For example, there should be access to information on appropriate health services such as VCT and ART. In addition, monitoring of ART requires minimum treatment guidelines and uniformity in approach. Policy frameworks should spell out national responses to HIV, care, treatment and support.

At the regional level, article 16 of the African Charter provides for the right of every individual to enjoy the 'best attainable state of

¹² Para 43: '(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups, (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs ... (e) To ensure equitable distribution of all health facilities, goods and services, (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population, the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process, they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored, the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalised groups.'

¹³ WHO 'Essential medicines' http://www.who.int/essentail_medicines/en/ (accessed 30 November 2006).

¹⁴ L Forman 'The imperative to treat: The South African state's constitutional obligations to provide antiretroviral medicines' <http://www.law.ualberta.ca> (accessed 10 August 2006).

¹⁵ See SF Sacco 'A comparative study of the implementation in Zimbabwe and South Africa of the international law rules that allow compulsory licensing for HIV/AIDS drugs' (2005) 5 *African Human Rights Law Journal* 105, 111.

physical and mental health' and in addition calls upon state parties to take 'the necessary measures to protect the health of their people.'

Although not formally binding on states, the International Guidelines on HIV/AIDS and Human Rights have become a persuasive source of guidance to states on the most appropriate approach to HIV and AIDS. The relationship between human rights and public health in the context of the discourse on HIV and AIDS has been recognised in the Guidelines. Revised Guideline 6 on prevention, treatment, care and support recognises the human rights to health and access to treatment.¹⁶ The original Guideline 6 provided for, 'regulation of goods, services and information'. It called upon states to enact laws that provided for the regulation of HIV-related goods, services and information. The revision of this guideline has been necessitated by the pharmaceutical breakthrough in the introduction of ARVs, the remarkable success of Nevirapine in prevention of mother-to-child transmission (PMTCT) programmes, widespread availability of ARVs in developed countries and the ART treatment gap in developing countries. The UN Millennium Development Goals of 2000 and the World Trade Organisation (WTO) Doha Declaration on Public Health of 2001 were also 'push factors' in the revision of this guideline. This revision also coincided with the WHO and UNAIDS '3-by-5' initiative. The more recently released International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version consolidates the original 1998 Guidelines with the 2002 revised Guideline 6, together with its related commentary and recommendations for implementation.¹⁷

Studies have noted that the issue of access to HIV treatment as a human right under international law is sidelined in the discourse on pharmaceutical policy, trade and intellectual property issues.¹⁸ 'Human rights law not only offers an alternative paradigm for understanding the issues relating to the availability and distribution of medicines, it also provides a workable framework for influencing

¹⁶ The summary of the guideline is as follows: (1) States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. (2) States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions. (3) States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

¹⁷ UNAIDS and OHCHR 'International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version'.

¹⁸ AE Yamin 'Not just a tragedy: Access to medications as a right under international law' (2003) 21 *Boston University Law Journal* 325.

the way in which adjudicative and legislative bodies, as well as other actors, make decisions that affect access to medications.’¹⁹

Access to medicine is a human right which entails moral or humanitarian responsibilities and legal obligations.²⁰ The implication is that failure by governments to discharge their tripartite obligations to respect, protect and fulfil human rights, makes them accountable. The realisation of the right to health requires that governments should adopt steps by ‘all appropriate means’. This means the domestication and adoption of laws and policies, the effective implementation of programmes that promote access to medicines and the strengthening of national health care systems.

With respect to access to medicines, Yasmin noted as follows:²¹

However treaties and statutes relating to trade, competition, intellectual property, or other factors bearing on access to medications can often be ambiguous, in such cases, a human rights framework imposes an obligation to interpret such treaties and legislation in the manner that most fully advances the public health interests.

2.1.2 Progressive and broadened interpretations of the right to life and the guarantee of non-discrimination

Studies have noted that the fact that there is ‘lack of national law directly related to economic, social and cultural rights has itself perpetuated the idea that those rights are not capable of judicial enforcement’.²² The issue of access to treatment clearly demonstrates the need to view human rights as indivisible and inter-dependent. Despite the fact that the right to life has traditionally been classified as a civil and political right,²³ it has increasingly been interpreted broadly, and has even been applied in cases involving access to medication. The Human Rights Committee²⁴ has for example clarified that ‘the expression “inherent right to life” requires an expansive interpretation. The obligations of the state have been defined in protecting human life to ‘include obligations to reduce infant mortality, to increase life expectancy, and to eliminate malnutrition and epidemics’.²⁵ In Latin America, the Inter-American

¹⁹ As above.

²⁰ Yamin (n 18 above).

²¹ Yamin (n 18 above) 104.

²² MC Craven *The International Covenant on Economic, Social and Cultural Rights: A perspective on its development* (1995) 9.

²³ For example, art 6(1) of the International Covenant on Civil and Political Rights (ICCPR) provides that ‘this right shall be protected by law. No one shall be arbitrarily deprived of his life.’

²⁴ Monitors implementation and enforcement of the ICCPR.

²⁵ Yamin (n 18 above).

Commission in *Odir Miranda v El Salvador*²⁶ held that El Salvador's refusal to purchase triple therapy HIV medication amounted to a violation of the rights to life and health, as provided for in the American Convention.

The national courts in a number of Latin American countries have used the right to life to include a right to minimum standards of healthcare. In *Glenda Lopez v Instituto Venezolano de Seguros Sociales*,²⁷ the Supreme Court of Venezuela held that the denial of access to certain medicines such as ARVs constituted a violation of the right to life. In a similar vein, the Constitutional Court of Colombia expanded the meaning of the right to life by stating that it goes beyond 'mere existence, but rather as dignified existence with the conditions necessary to develop, to the extent possible, all the faculties that a human being can enjoy.'²⁸

In developing a national jurisprudence on the right to health, the Constitutional Court of Colombia in *Alejandro Moreno Alvarez v Estado Colombiano*,²⁹ developed criteria that should be satisfied in order for the right to health to become justiciable. First, there should be implications of the health issue on other fundamental rights such as the right to life. Secondly, failure by the state to discharge its obligations has resulted in a grave and imminent threat to human life or health. Third, the plaintiff must experience an extreme need of services, such as financial need and the possibility of providing services in the specific instance must be within the state's resources.³⁰ The Court confirmed that justiciability is a fluid notion that is applicable to dimensions of different rights rather than to certain categories of rights.³¹

The overarching principle that informs a human rights framework is non-discrimination, which is an enforceable right that ensures 'access to medications for marginalised populations or when discrimination on the basis of prohibited grounds is evident'.³² The international legal principle of non-discrimination includes discrimi-

²⁶ Case 12.249, Report No. 29/01, Inter-Am. CHR, Annual Report 2000, OEA/Ser./L/V/II.111, Doc. 20 Rev. (2001) www.cidh.oas.org/annualrep/2000eng/ChapterIII/Admissible/ElSalvador12.249.htm (accessed 30 November 2005).

²⁷ Supreme Court of Venezuela, Constitutional Chamber 1997, <http://www.tsj.gov.ve/decisiones/scon/Abril/487-060401-001343.htm> (accessed 30 November 2006).

²⁸ Yamin (n 18 above) 117.

²⁹ SU.819/99 (Corte Constitucional de Colombia 1999) <http://bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1999/Tutela/su819-99.htm> (judgment to unify jurisprudence on right to health and social security services) (accessed 30 November 2006).

³⁰ *Alejandro Moreno Alvarez v Estado Colombiano*, SU.819/99 (Corte Constitucional de Colombia 1999) <http://bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1999/Tutela/su819-99.htm> (judgment to unify jurisprudence on right to health and social security services) (accessed 30 November 2006).

³¹ Yamin (n 18 above) 118.

³² Yamin (n 18 above) 125.

nation against people living with HIV. The Resolution of the UN Commission on Human Rights provides that discrimination based on 'AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term 'or other status' in non-discrimination provisions international human rights texts can be interpreted to cover health status, including HIV/AIDS.'³³

2.2 Realisation of the human rights framework in SADC countries

2.2.1 *Ratification and domestication of international human rights instruments*

Efforts to promote human rights in many Southern African states are influenced by international treaties to which these states are parties. To secure this influence, the first – rather obvious – step is that the states should formally ratify the relevant instruments. States in Southern Africa have ratified numerous international and regional human rights treaties. One of the most significant treaties pertaining to the right to socio-economic rights, including the right to health, is the ICESCR, which has been ratified by 11 out of the 14 SADC countries. The African Charter, which contains the right to health as a justiciable right, has been ratified by all the SADC states.

Ratification is not enough. In addition, there should be a continuous thread of human rights practice in national laws, policies and services as a result of domestication of international obligations. Domestication of international and regional treaties principally requires that constitutional and other legal provisions be enacted at the national level to give effect to the ratified treaties. This process may be guided either by the 'dualist' theory, which requires states to domesticate transformation of international treaties through legislation, or by the 'monist' theory, which makes international law automatically part of domestic law upon ratification. In most SADC countries that follow the common law legal tradition, the dualist system prevails, while the 'monist' system predominates in countries with a civil law legal background. However, there are some exceptions, for example South Africa's introduction of the concept of 'self-executing' treaty provisions within a predominantly dualism system, thereby allowing for a hybrid position. Once the state has ratified an international treaty, its provisions automatically become part of national laws if the treaty's provisions are self-executing. Namibia, which is a 'common law' country, seems to follow a 'monist'

³³ UN Commission on Human Rights, Resolution on HIV/AIDS, Res. 1995/44, March 1995.

approach, in that its Constitution provides that international agreements 'shall form part of the law of Namibia'.³⁴

The fact that the right to health is not explicitly incorporated in several African countries does not necessarily mean that states should not promote its progressive realisation. Article 27 of the Vienna Convention on the Law of Treaties (VCLT) provides that a state party 'may not invoke the provisions of its internal law as justification for its failure to perform a treaty'. Despite the fact that article 2(1) allows states parties to give effect to ICESCR rights in accordance with domestic constitutional processes, states are therefore prevented from justifying failure to discharge their obligations on the basis that provisions imposing an immediate obligation on states are not self-executing.³⁵

2.2.2 Constitutional protection of the right to health at the national level

The enforcement of the ICESCR is, amongst other legal measures, dependent on constitutional provisions. The right to health has been constitutionalised in the Constitutions of SADC countries in two main forms: enshrined as a justiciable right, or as 'Directive Principles of State Policy'. However, the Constitutions of a number of countries in the region do not contain any provision on the right to health.

The right to health has been constitutionally guaranteed as a justiciable right in the Constitutions of five out of fourteen Southern African countries: These are the Constitutions of Angola,³⁶ the DRC,³⁷ Madagascar,³⁸ Mozambique,³⁹ and South Africa. The South African Constitution is unique to the extent that it guarantees not only civil and political rights, but also economic, social and cultural rights - including the right to health. South Africa's constitutional provisions on the right to health provide that '[e]veryone has the right to have access to health care services, including reproductive health care.'⁴⁰ Section 27(2) further stipulates that '[t]he state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of these rights.' This provision limits the extent to which the right to health can be fulfilled by the

³⁴ Art 144 of the Constitution of Namibia provides that unless otherwise provided by the Constitution or Act of Parliament, the general rules of public international law and international agreements binding upon Namibia under the Constitution shall form part of the law of Namibia.

³⁵ General Comment 3, Nature of the General Legal Obligation Imposed on States Parties to the Covenant: 14 December 1990, para 5.

³⁶ Art 23.

³⁷ Art 47.

³⁸ Art 19 of the 1992 Constitution: 'The state recognises to each individual the right to the protection of his or her health, starting from conception'.

³⁹ Art 89.

⁴⁰ Sec 27(1)(a).

government within ‘available resources’. As time is of the essence in responding to HIV, ‘progressive realisation’ should be interpreted accordingly.

The South African Constitutional Court has developed case-law in relation to the legal obligation of the state on the right to health through provision of medicines to its people. This means that the legal basis for recognising the right to treatment as a human right has been expanded in national jurisprudence. In *Treatment Action Campaign and Others v Minister of Health and Others*,⁴¹ the High Court found that the government’s reluctance to extend the administration of Nevirapine for PMTCT beyond 18 pilot sites was unconstitutional. On appeal, it was argued that the failure by government to provide Nevirapine in the public health sector constituted a violation of human rights enshrined, *inter alia*, in section 27 of the Constitution of South Africa.

Although the right to health is to be progressively realised, there are minimum core obligations that have to be satisfied. These minimum core obligations arguably include the provision of ‘essential drugs’.⁴² Thus, state compliance can be measured by the various initiatives a state has adopted in respect to ‘essential drugs’. A violation of the obligation to fulfil may arise when a state does not include ARVs on the essential drugs list. However, the WHO criteria could be used to develop a flexible standard for a right, which will be determined on a drug-by-drug basis.⁴³

Like any other human right, the right to health requires advocacy in the context of extending the scope of treatment, eligibility criteria, participation of people living with HIV and promotion of a rights-based approach. Advocacy is also important, as it may assist in promoting the importance of the right to health as it co-exists with the right to private property. The *Treatment Action Campaign* case exemplifies the importance of advocacy and its centrality in the progressive realisation of the right to health. The case addresses equity issues, which should inform policy formulation, and underscores the fact that prevention is better than cure by promoting the rights of the unborn child. It also reinforces the obligation of the government to mitigate the impact of HIV and AIDS and reduce child mortality.

⁴¹ 2002 (4) BCLR 356 (T) (*Treatment Action Campaign* case).

⁴² Yamin (n 18 above) 133.

⁴³ M McClellan *The TRIPS agreement and the human right to medicines* http://shepherdapps.wlu.edu/pdf/mcclellan425_04.pdf (accessed 30 November 2006) 13.

The Constitutional Court also considered the effects of child-related policies in *Minister of Health and Others v Treatment Action Campaign and Others (2)*.⁴⁴ It held that '[t]he children's needs are most urgent and their inability to have access to Nevirapine profoundly affects their ability to enjoy all rights to which they are entitled. Their rights are most in peril as a result of a policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to Nevirapine. The Court noted that time is of the essence when dealing with HIV-related rights. In addition, it recognised programmatic vulnerability which takes place when expectant mothers are excluded from the PMTCT programmes.

In the other four countries where the Constitutions guarantee a justiciable right to health, no case-laws exist to demonstrate the application of these provisions in practice.

The Constitutions of four of the 14 SADC countries (Lesotho,⁴⁵ Malawi,⁴⁶ Namibia⁴⁷ and Swaziland⁴⁸) incorporate the right to health as part of the Principles of State Policy: this means that the right is not justiciable in a court of law. As experience in other jurisdictions shows, these Principles may be used as forceful tools to steer the constitution towards an interpretation favourable to socio-economic rights. Such an outcome depends on an activist judiciary. The enshrinement of the right to health as part of Principles of State Policy is therefore disadvantageous, because there is very little judicial activism in the region. A further constraining factor is the lack of direct reference in these constitutions to international human rights instruments to which these countries are parties, even as sources of interpretation.

The Constitutions of five countries (Botswana, Mauritius, Tanzania, Zambia and Zimbabwe) are silent on the right to health. In these countries, as well as in the countries where the right is only included as a 'Principle of State Policy', the right to health is not justiciable. In these circumstances, HIV activists and progressive lawyers should explore, as a basis for extending ART, the possibility of invoking rights that are unequivocally accepted under the national law of all countries, such as the right to life, and the right to non-discrimination.

All SADC Constitutions guarantee the right to life, allowing for the possibility that an economic, social and cultural right, such as the right to health, may be read into an existing fundamental right. Such

⁴⁴ *Minister of Health and Others v Treatment Action Campaign and Others (2)* 2002 (5) SA 721 (CC).

⁴⁵ Sec 27.

⁴⁶ Sec 13(c).

⁴⁷ Art 95(b).

⁴⁸ Sec 60(8).

an approach will be in line with the expanded meaning of the right to life advanced in the cases decided in Latin American states, discussed above, and in the jurisprudence of the Indian Supreme Court.

The principle of non-discrimination as a justiciable right has also been incorporated in the national constitutions of Southern African countries: this is provided for in the 'equality' clauses. This provision applies both to civil and political rights and economic, social and cultural rights such as the right to health. It has also been affirmed by the Human Rights Committee, that the ICCPR's non-discrimination clause applies to legislation on social issues.⁴⁹ 'With respect to access to medications, proscriptions on discrimination demand both that certain marginalised individuals and populations are not treated differently or prevented from acceding to necessary medications, and that people are not discriminated against by health systems because of HIV-positive or other health status.'⁵⁰

2.2.3 Practical realisation of human rights

It is not enough to enshrine the right to health in the national constitution. A commitment to respect this right can only be measured through strategies and concrete measures that are adopted at the domestic level to realise progressively the human right to treatment.

(a) Tripartite obligations

The human right to treatment entails moral and humanitarian responsibilities, as well as legal obligations. Based on the nature of obligations imposed on states, rights in international and national law impose three levels of obligations: to respect, protect, and fulfil. The implication is that failure by governments to discharge their tripartite obligations, as demonstrated partly by the statistics on people living with HIV and AIDS-related deaths, makes them accountable.

The obligation to respect includes the provision of equal access to treatment and quality of medical care, goods and services. For example, the HIV and AIDS statistics outlined earlier in the study are illustrative of the fact that there is a lack of fulfillment of human rights particularly for marginalised and vulnerable groups. This exemplifies the impact of HIV as a result of gender discrimination and increased gender vulnerabilities to the pandemic. Additionally, the HIV and AIDS statistics are an indicator of whether a country is acting

⁴⁹ See eg Communication 182/1984, *Zwaan de Vries v The Netherlands* (9 April 1987), UN Doc A/42/40 (1987) 160.

⁵⁰ Yamin (n 18 above) 124.

reasonably in promoting public health through invoking compulsory licensing and adopting a parallel imports policy.⁵¹

The obligation to protect includes the adoption of minimum treatment guidelines.

The obligation to fulfil requires countries to take steps such as the domestication of international human rights obligations into national laws and the mobilisation of financial resources. The obligation to fulfil the right to health is progressively realised through enacting and adopting legislation, policies and programmes that allocate resources and effect a sustained and equitable distribution.⁵² In addition, it includes the adoption of national pharmaceutical policies, national policies on AIDS, budget allocations to ministries related to health, essential medicines lists, compulsory licensing policies and laws, social schemes to promote equal access to medicines and bulk procurement policy.

The progressive realisation of the right to health also requires that Southern African countries assess the impacts of intellectual property rights on human rights. 'Developing countries are obliged to implement TRIPS taking into account the existence of the CESC and other relevant international treaties'.⁵³ Thus, the adoption of TRIPS flexibilities and minimum obligations arising from the ICESCR and the progressive realisation of the right to health are some of the ways to promote access to medicines.

(b) Availability, accessibility, affordability and acceptability

The framework for analysis, contained in General Comment 14 to the ICESCR, is applied here to SADC countries.

In relation to ARVs, availability entails life-saving drugs, procurement strategies of ARVs and financing the extending initiatives. Thus, failure to produce, procure and import drugs are some of the barriers that are linked to availability of medicines. Central to this component of the right to health is innovation. Some Southern African countries have insufficient manufacturing capacity. Failure to innovate and transfer technology is a barrier to accessing medicines.⁵⁴ In countries

⁵¹ WP Nagan 'International intellectual property, access to health care and human rights: South Africa v United States' (2002) 14 *Florida Journal of International Law* 155, 175.

⁵² Committee on Economic, Social and Cultural Rights, General Comment 14.

⁵³ P Cullet 'Patents and medicines: The relationship between TRIPS and the human right to health' (2003) 79(1) *International Affairs* 153.

⁵⁴ South Africa and Zimbabwe, which have the manufacturing capacity to produce ARVs, are regional exceptions. Mozambique, Zambia and South Africa have compulsory licensing laws in place as a step towards making ARVs and other HIV medicines available.

like Angola, which has experienced a civil war lasting 27 years, the unavailability of health care facilities and ARVs is a serious challenge.

Accessibility is related to financing, cost, affordability of medicines and physical access to healthcare services. It also requires governments to adopt essential drug lists and standard treatment guidelines. These guidelines meet the needs of the people in resource-limited health facilities and are used as a framework for selecting affordable and effective ARVs, such as first-line regimens in health care settings with insufficient skilled manpower and monitoring facilities.

Affordability is seriously challenged by the unavailability of foreign exchange reserves, a decrease in national health budget allocations and world market prices for drugs. The issue of affordability is therefore supposed to be addressed at two levels, that is, national and individual.

The issue of acceptability is related to the safety and efficacy of ARVs. In addition, acceptability entails the development of user-friendly triple-dose combination of the ARVs, diagnostic tests and monitoring tools. There is inadequate information about benefits of ART, such as safety and efficacy issues, which underscores the need for information on accessibility and acceptability. For example, access to information and treatment as a result of routine testing has changed people's attitude and behaviour with regard to stigma and discrimination in Botswana. Drugs could also be available but might be inappropriately used. In addition, barriers exist regarding the appropriateness of ARVs and other medicines; this is because inappropriate use of drugs leads to waste and increased drug resistance. For example, 'in Tanzania, 75 per cent of health workers were found to be dispensing sub-therapeutic doses to stretch inadequate state funding'.⁵⁵

Despite the adoption and update of essential medicines lists by the Southern African countries, the issue of affordability, availability and accessibility of these drugs remains a major challenge.⁵⁶

⁵⁵ P Munderi & G Dukes 'Interim Report of Task Force 5 Working Group on Access to Essential Medicines, The Millennium project commissioned by the UN Secretary-General and Supported by the UN Development Group' (2004) 36, quoted from KS Mnyika *Irrational drug use in Tanzania. Health policy planning* (1991) 180-184.

⁵⁶ N Zungu-Dirwayi *et al* (eds) 'An audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa and Zimbabwe. Social aspects of HIV/AIDS and health research programme' (2004) 45 <http://www.hrscpress.ac.za> (accessed 22 June 2006).

(c) Factors affecting accessibility

The ART currently being delivered in Southern Africa is made up of first-line and second-line drugs.⁵⁷ Access to these drugs is restricted by the limited number of drugs, limited health service infrastructure, the need to deliver drugs to rural areas the triple burden as a result of high incidences of HIV/AIDS, TB and malaria. Some of the problems that are attributed to small ART programmes include: pressure for people to be selected, significant stress on health staff, potential of sharing medication and a thriving black market.⁵⁸ Thus, scaling-up should be done through accredited health facilities so that drug resistance could be reduced. This also underlines why it is so important to integrate any ARV scale-up programme into the context of a larger health care system.

In addition, other challenges that have been identified with regard to scaling-up include education and awareness of treatment, systematic and predictable supply of drugs, VCT sites that are physically accessible and resources in terms of laboratory facilities.⁵⁹ Other obstacles faced in accessing treatment include transport costs to get to the nearest health care service provider and the cost of required laboratory tests. There further is a tendency to start initial treatment programmes in urban areas where the patients are knowledgeable about HIV and AIDS and their treatment, income levels are better than those of the rural populace, and health care is physically accessible.

There are certain policy proposals that exclude rural patients from accessing health care services.⁶⁰ For example, the proposal by Malawi and Zambia to introduce a policy of 'first come first served' has the negative effect of excluding the less-educated, the rural population and women from accessing treatment. In order to improve and promote equity in accessing healthcare services, Malawi has adopted an Essential Health Package. This package is recognised as 'the cornerstone of the National Poverty Reduction Strategy for health ... based on the principle of promoting equity in health and access to health services'.⁶¹ The package incorporates 'redistributive mechanisms for the allocation of resources, to ensure that quality services are provided at peripheral health facilities and for under-served geographical areas'.⁶²

⁵⁷ This is a medication that is given to a patient who has developed resistance to first-line regimen.

⁵⁸ Zungu-Dirwayi *et al* (n 56 above) 98.

⁵⁹ As above.

⁶⁰ R Loewenson & C Thompson (eds) *Equity in health sector responses to HIV/AIDS in Malawi. 'Equity in ART? But the whole health system is inequitable.'* (2003) 5 Equinet Discussion Paper 17.

⁶¹ Loewenson & Thompson (n 60 above) 28.

⁶² As above.

Despite Zambia having declared an HIV/AIDS public health emergency, the majority of patients at the main hospital in Mongu, Western Zambia, and at a cluster of health centres in the District around the hospital, cannot access ARV drugs because there is only one CD4 count machine in Western Zambia. Thus, while NGOs and government may be focusing their efforts on the response to HIV and AIDS on the macro level, fundamental concerns such as the number of testing machines at clinics and transportation and road access to treatment sites are critical to stepping-up treatment.

3 'Flexibilities' under TRIPS as a means to improving access to ART

3.1 The legal framework of intellectual property

3.1.1 *The WTO Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement*

The TRIPS Agreement prescribes minimum standards that relate to the protection and enforcement of intellectual property rights, including patents, trademarks, copyright, and industrial designs. These minimum standards are legally binding on all WTO members. Members are supposed to domesticate these standards within time-frames stipulated in the TRIPS Agreement.⁶³ Failure to domesticate and implement these provisions may attract trade sanctions. In addition, complaints against a recalcitrant member can also be taken to the WTO Dispute Settlement body.

Before TRIPS came into force, most national patent laws were modelled along the Paris Convention for the Protection of Industrial Property (1883). Unlike the TRIPS Agreement, the Paris Convention excludes patenting of pharmaceutical products. The TRIPS Agreement protects 'process patents', which relate to the protection afforded to methods of manufacturing, and 'product patents', which protect pharmaceutical products owned by innovating firms. Mandatory protection of pharmaceutical products was justified by the developed countries as necessary incentives for drug innovation, research and technological development. Two contending arguments were put forward: On the one hand, patents are required to promote access to medicines through the development of new drugs; on the other hand, patents increase prices and limit access to medicines by placing them beyond the reach of impoverished people in developing countries. In an effort to balance these countervailing concerns, the TRIPS

⁶³ It has been criticised as one of the most controversial trade agreements for its one-size-fits-all approach.

Agreement allows for the domestication of a number of the TRIPS 'flexibilities'.

The two key flexibilities provided by the TRIPS Agreement, parallel importation and compulsory licensing, are discussed here. However, it should be noted that some states are provided some additional leeway from adhering to TRIPS in that they are exempted from complying with minimum periods for certain transitional periods. Most importantly, LDC countries are exempted from providing protection for pharmaceutical patents until at least 2016⁶⁴ (although this period may be extended beyond 2016). This transitional period applies to the following eight SADC countries: Angola, the DRC, Lesotho, Madagascar, Malawi, Mozambique, Tanzania, and Zambia. (These states still have to meet the remainder of their obligations under TRIPS.)

Compulsory licensing: Compulsory licensing (or 'non-voluntary' licensing) promotes access to generic medicines through local production by allowing a governmental agency or a private company to manufacture pharmaceutical products in the public interest without the patent holder's consent. Compulsory licensing – or the threat of compulsory licensing – may also serve as a bargaining tool in negotiating for cheaper prices of drugs with pharmaceutical companies, as evidenced by the reduction of the price of drugs in Brazil and South Africa.⁶⁵ It also promotes competition policies to remedy anti-competitive practices and patent abuse, thereby lowering the prices of medicines. Additionally, compulsory licensing is a policy tool that can be adopted to address situations where the price of drugs is beyond the reach of poor people, or where there is a need to promote technology transfer and establish a technological base, especially by countries that have insufficient or inadequate manufacturing capacity. Article 31(f) of TRIPS makes compulsory licensing subject to a number of conditions, including the following: attempts to obtain a voluntary license from the patent holder on 'reasonable commercial terms' must have been unsuccessful; it must be used 'predominantly for domestic supply'; and 'adequate remuneration' must be paid to the patent holder.

'Government use' orders may be regarded as variants of compulsory licenses. A government use order is permission that is granted to enable a government or third parties to make use of a patent without the consent of the patent-holder for non-commercial purposes and the benefit of the public.⁶⁶ The distinction between compulsory licensing and government use is the difference in nature

⁶⁴ Decision of the TRIPS Council on 27 June 2002, taken under art 66(1) of TRIPS (WTO Doc IP/C/W/25).

⁶⁵ SK Sell 'Trade Issues and HIV/AIDS' (2001-2002) 20 *Wisconsin International Law Journal* 481, 513.

⁶⁶ TRIPS, art 31.

and purpose for which the patent is used.⁶⁷ Government use is restricted to public non-commercial purposes.

Compulsory licenses may be granted on a number of possible grounds, including a refusal by the patent holder to grant a voluntary license, public interest, public health, or national emergencies or situations of extreme urgency. It is important to understand that TRIPS does not require that states declare a state of emergency.⁶⁸ If an emergency is not declared, TRIPS requires that a third party has to negotiate for a voluntary license first. However, as will be seen below, SADC states that made use of compulsory licensing did this in the context of a declared state of emergency.

As these actions are taken without prior authorisation of the patent-holder, the interests of patent holders – mostly in developed countries – are allowed to be over-ridden in order to address public health emergencies. Most pertinently, article 31 of TRIPS can be waived by a WTO member in the case of ‘a national emergency or other circumstances of extreme urgency or in cases of non-commercial use.’⁶⁹ As noted earlier, countries have the discretion to determine what constitutes a national emergency. ‘In such a situation they do not need to follow any official procedures, it is not for example obligatory to declare formally that a state of emergency exists.’⁷⁰ Countries are also free to define what constitutes ‘public non-commercial use’. This relates to the procurement or manufacturing of pharmaceutical products that will be for public consumption. This also relates to the purchase of

generic versions of needed medicines without prior negotiations with the patent holder. The patent holder will be informed of the decision to make government use of the patent and the government will have to offer to the patent holder adequate compensation, the level of which is however to be decided by the government itself.⁷¹

Parallel importation: Parallel importation happens when prices of medicines are compared, and medicines are bought cheaply on the world market, and imported to a country in need. The imported products are those that would have been produced pursuant to a compulsory license or government use order issued in the exporting country. Parallel imports promote access to medicines by providing drugs that are cheaper. Musungu and Oh noted that developing countries ‘should avail themselves of the widest scope in terms of parallel importation and incorporate explicit provisions to put into

⁶⁷ SF Musungu & C Oh *The use of flexibilities in TRIPS by developing countries: Can they promote access to medicines?* (2005) 20.

⁶⁸ T Avafia & SM Narasimhan *The TRIPS agreement and access to ARVs* (2001) 13.

⁶⁹ Munderi & Dukes (n 55 above) 51.

⁷⁰ Munderi & Dukes (n 55 above) 51.

⁷¹ As above.

effect an international exhaustion regime in their national patent laws'.⁷²

3.1.2 The Doha Declaration

The TRIPS Agreement was challenged by the developing countries, especially those from sub-Saharan Africa that have been afflicted by HIV, with regard to its scope, interpretation and the application of its flexibilities. As one commentator explains that 'developing countries sought official confirmation that measures to protect public health would not make them subject to dispute settlement procedures in the WTO'.⁷³ The Doha Declaration on Public Health,⁷⁴ which affirms the right of members to invoke compulsory licensing in the context of public health emergencies, was aimed at resolving this challenge.

The Doha Declaration is a political document which assures developing countries adopting TRIPS flexibilities that they will not be subjected to the WTO Dispute Settlement body. The Declaration is also a legal document in that '[i]t states the purpose of the TRIPS Agreement in the area of public health, interprets the TRIPS Agreement with regard to some important aspects, instructs the Council for TRIPS to take action, and decides on the implementation of the transitional provisions for LDCs'.⁷⁵ The Doha Declaration reinstated that the TRIPS flexibilities promote access to medicines.⁷⁶ The position of developing countries that wanted to take advantage of the TRIPS flexibilities was also strengthened because 'it constitutes a confirmation of the position of countries like South Africa and Brazil, which sought to go beyond a narrow interpretation of TRIPS in their search for ways to tackle health crises'.⁷⁷

The Doha Declaration reiterates the right of WTO members to determine what constitutes a national emergency or other circumstance of extreme urgency. Paragraph 2 recognises that TRIPS should be viewed as part of the wider national and international action to address public health problems. In addition, it affirms that there are no provisions that prevent members from taking measures aimed at promoting public health goals. Furthermore, the Doha Declaration gives LDCs until 2016 to provide for patent protection for their pharmaceutical products. Developed countries committed themselves to promote technology transfer to LDCs. Under the Doha

⁷² Musungu and Oh (n 67 above) vi.

⁷³ Sell (n 65 above) 513.

⁷⁴ WTO Doha Ministerial Declaration, Declaration on the TRIPS Agreement and public health, WTO/MIN(01)/DEC/2, adopted on 14 November 2001.

⁷⁵ CM Correa 'Implications of the Doha Declaration on the TRIPS Agreement and Public Health' (2002) 24 ([http://www.gefoodarlert.org/library/admin/uploaded files/Implications_of_the_Doha_Declar](http://www.gefoodarlert.org/library/admin/uploaded/files/Implications_of_the_Doha_Declar)) (accessed 19 June 2006).

⁷⁶ Para 4 of the Doha Declaration.

⁷⁷ Cullet (n 53 above) 154.

Declaration, developed countries affirmed their commitment to developed countries to provide incentives to their enterprises and institutions to transfer technology.⁷⁸

The Declaration gives an unquestionable right to member states to determine what constitutes ‘a national emergency or other circumstances of extreme urgency’.⁷⁹ ‘Public health crises’ is clarified to mean ‘a national emergency or other circumstances of extreme urgency’ and emergency may be either a short-term problem, or a long-lasting solution.⁸⁰ Studies have proposed that the minimum standards that could be used as lobbying strategies for the clarification of the constitutive elements of

national emergency could include the expected decimation in total population attributable to the disease, the estimated drop in life expectancy due to the disease, the amount of people in the country affected by the disease, the impact of the disease on the country’s economy, the number of people who can currently afford treatment, the estimated number of people who will receive treatment, and the adequacy of treatment facilities or, the feasibility of compulsory licensing given the infrastructure of the country.⁸¹

3.1.3 WTO Decision under Paragraph 6 of the Doha Declaration (Decision of 30 August 2003)

Although developing countries are theoretically allowed to grant compulsory licenses, many of these states lack sufficient manufacturing capacity to make use of these possibilities in practice. As was stated above, one of the requirements of compulsory licensing is that it should be used ‘predominantly for domestic supply.’ The WTO Decision of 30 August 2003 allows non-producing countries to invoke compulsory licensing laws in order to import generic medicines, provided it is consistent with a special compulsory license that would have been issued for export by the exporting country.⁸² The lack of

⁷⁸ Para 7 of the Doha Declaration reaffirmed that effective incentives should be granted in developed countries in order to foster specifically the transfer to LDCs of health-related technologies, including pharmaceutical technologies

⁷⁹ n 74 above 10.

⁸⁰ Para 7 of the Doha Declaration.

⁸¹ MM Nerozzi ‘Notes on the battle over life-saving pharmaceuticals: Are developing countries being “TRIPped” by developed countries?’ (2002) 47 *Villanova Law Review* 635.

⁸² WTO, Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health, Decision of the General Council of 30 August 2003, WT/L/540, 1 September 2003, para 2.

sufficient manufacturing capacity underscores the need for technology transfer so that developing countries can manufacture generic drugs locally.⁸³ Article 66 of the TRIPS Agreement expressly provides for technology transfer.⁸⁴

3.2 Adopting (domesticating) and applying (making use of) TRIPS flexibilities in SADC countries

3.2.1 Domesticating TRIP flexibilities

In order for developing countries to take advantage of the TRIPS flexibilities, the first step is that they should adopt a legal and policy framework that allows for compulsory licensing and limited exceptions. As these flexibilities, together with the provisions of the Doha Declaration, are not self-executing, they need to be domesticated. They also 'do not protect governments (or private parties) from legal actions based on national laws and regulations that fail to make use of the TRIPS Agreement flexibilities'.⁸⁵

Most laws that regulate patents in Southern African countries are modelled on former colonial laws. Research⁸⁶ has noted that at the time of the entry into force of the TRIPS Agreement,⁸⁷ Angola and Malawi were among the three countries in sub-Saharan Africa that excluded the patentability of pharmaceutical products. This exclusion was based on the fact that the 'health sector met a basic need and thus should be protected from full commercialisation'.⁸⁸

At present, most SADC countries have intellectual property laws that do not comply with or make use of the possibilities under TRIPS.

⁸³ Research has noted that the adoption of an effective transfer technology and capability approach by India has been the push factor for India's pharmaceutical industry. For example, the drug policy of 1978 and the Patent Act of 1970 also played a pivotal role in the development of India's technological capacity.

⁸⁴ Art 66(1) In view of the special needs and requirements of least-developed country members, their economic, financial and administrative constraints, and their need for flexibility to create a viable technological base, such members shall not be required to apply the provisions of this Agreement, other than arts 3, 4 and 5, for a period of 10 years from date of application as defined under para 1 of art 65. The Council for TRIPS shall, upon duly motivated request by a least-developed country member, accord extensions of this period. (2) Developed country members shall provide incentives to enterprises and institutions in their territories for the purpose of promoting and encouraging technology transfer to least-developed country members in order to enable them to create a sound and viable technological base.

⁸⁵ Correa (n 74 above) 11.

⁸⁶ The Intellectual Property Institute 'Patent Protection and Access to HIV/AIDS Pharmaceuticals in sub-Saharan Africa. A Report Prepared for the World Intellectual Property Organization (WIPO) (2000) 36. See WIPO Document HL/CM/INF/1 Rev. 2 (July 1992).

⁸⁷ Entered into force on 1 January 1995.

⁸⁸ Cullet (n 53 above) 141 quoted from World Health Organisation 'Globalisation, TRIPS and Access Pharmaceuticals: WHO Policy Perspectives on Medicines (2001) (WHO Policy Perspectives).

Angola excludes the patentability of pharmaceutical products.⁸⁹ It allows for compulsory licensing by government in the public interest, national security, public health or the economy. The Industrial Property Act of Botswana provides for compulsory licensing in terms of the Paris Convention. The Democratic Republic of the Congo regulates patents⁹⁰ and compulsory licensing is allowed. A successful application for a compulsory license is dependent on evidence that attempts to obtain a voluntary license from the patentee have been made. Malawi allows for compulsory licenses for 'government use' in cases of emergency for the maintenance of supplies and services essential to the life of the community.⁹¹ Namibia has legislation that governs patents;⁹² for example, section 12 of the Namibian Industrial Property Act allows for the exploitation of a patented invention without the agreement of the owner of the patent if it is in the public's interest. Swaziland has an outdated Patent and Utility Models and Industrial Designs Act that does not allow for compulsory licensing.

The South African patents legal framework is informed by the Patents Act,⁹³ the Intellectual Property Laws Rationalisation Act of 1996, and the Medicines and Related Substances Control Act of 1997. Compulsory licensing is provided for in section 55 of the Patents Act where a voluntary agreement is not reached. The Commissioner of Patents may issue a compulsory license where there is an abuse of patent rights.⁹⁴

Perhaps due to the fact that it has increasingly become ostracised from the West (where the main holders of patents are located), Zimbabwe amended its Patents Act in order to invoke compulsory licensing in case of abuse or insufficient use of patent rights,⁹⁵ inventions relating to food or certain other commodities,⁹⁶ and use of patented inventions for the service of the state.⁹⁷ This amendment seems to be consistent with the TRIPS provisions.⁹⁸

⁸⁹ Industrial Property Law 3/92 of 28 February 1992.

⁹⁰ Law No. 82-01 of 1982 and Ordinance No. 89-173 of August 1989.

⁹¹ Sec 38 and 41 of the Patent Law.

⁹² Act 9 of 1916, Proclamation No 17 of 1923 and Patent Rules of 1917, last amended in 1942, and South West African Affairs Act 25 of 1969.

⁹³ Act 57 of 1978, as last amended by Intellectual Property Laws Amendment Acts prior to 1998.

⁹⁴ Sec 57 of the Patents Act (South Africa).

⁹⁵ Sec 31 of the Patents Act (Zimbabwe).

⁹⁶ Sec 32 of the Patents Act (Zimbabwe).

⁹⁷ Sec 34 of the Patents Act (Zimbabwe).

⁹⁸ For example, sec 35(1)(e) allows the Minister to foster and direct exports and reducing imports and imports of any classes, from all or any countries and redressing the balance of trade or ...'. This means Zimbabwe could be a regional producer for generic ARVs and HIV/AIDS related medicines. However, the new provisions do not have anti-diversion measures that would prevent re-exportation of generic drugs that would have been made available to Zimbabwe through invocation of parallel import procedures.

There are two possible reasons for the lack of domestication – especially allowing for compulsory licensing and parallel importation of pharmaceutical products. Firstly, the delay in incorporating TRIPS could be because the state concerned is a least developed country and has until the 2016 deadline to domesticate TRIPS. Secondly, the reason could be the lack of human resource capacity to deal with the revision of the patent law. Most Southern African countries lack technical capacity to address issues of patents such as the domestication of TRIPS and revision of national laws. As one group of authors explains, there is a knowledge gap with respect to how other countries in the region are responding and what best practices exist:

Another problem that exacerbates the lack of technical expertise to implement TRIPS flexibilities in national laws is the inability to access information on best practices. Developing countries are generally not aware of the measures undertaken by their counterparts around the world. As a result, even countries within a region with similar or the same access problems adopt different strategies, with varying degrees of success.⁹⁹

This shows that there is no policy coordination and coherence from country to country. In addition, there is little to no institutional collaboration between the various government ministries and agencies that deal with patents, medicines, law, trade and health issues.

Having said this, states should not be judged prematurely. As mentioned previously, the Doha Declaration provides LDCs with a grace period to postpone TRIPS compliance for patent and data protections for medicines until 2016. On the one hand, these countries may not yet have amended their national laws so that: (i) the grace period of the Doha Declaration is effected, (ii) generic importation is in accordance with the 30 August Decision, or (iii) they are TRIPS compliant. On the other hand, as Msungu and Oh show, a surprising number of LDCs have adopted intellectual property regimes ahead of the 2016 deadline.¹⁰⁰

3.2.2 Steps taken under TRIPS to make use of flexibilities

Even when TRIPS flexibilities have been adopted, the potential of the domesticated possibilities still has to be unlocked.

⁹⁹ Musungu, Villanueva & Blasetti (n 9 above) 24 - 25.

¹⁰⁰ Musungu, Villanueva & Blasetti (n 9 above) 8.

Only three SADC member states have actually made use of compulsory licensing pursuant to a declaration of a state of emergency, the first country to do so being Zimbabwe.¹⁰¹ The declaration of public health emergency in Zimbabwe coincided with the presidential elections of 2002 and was heavily criticised by both the international community and pharmaceutical companies. However, *Médecins sans frontières* (MSF) welcomed this declaration by saying,

Zimbabwe's announcement marks the first time that a government has gone beyond using the threat of compulsory licensing as a negotiating tool, and actually declared that it will override patents to increase access to needed medicines when the prices are too high as a result of patent protection.¹⁰²

Studies have noted that countries such as Argentina, Brazil and Zimbabwe, which have invoked compulsory licensing, have been classified as egregious violators of property rights protection.¹⁰³

In Zimbabwe, a public health emergency was declared for an initial period of six months,¹⁰⁴ but was further extended to 2007. The main reasons for the extension were the unrealistic brevity of the initial six month term, given the magnitude of the HIV pandemic and its consequences, and the fact that patent and medicines laws could not be amended and access to medicines could not be secured within such a short period of time. Zimbabwe's declaration allowed for the 'making' or 'importation' of any patented HIV medication. A compulsory license was issued to Varichem Private Limited to import and produce HIV and AIDS-related drugs. In the declaration, Zimbabwe did not expressly commit itself to the payment of royalties.

The Zimbabwe declaration differs from those later decreed by Zambia and Mozambique, in that it did not specify that the drugs to be manufactured or imported will comprise a triple-dose combination. Additionally, the declaration provides for parallel imports of generic HIV-related drugs.¹⁰⁵

¹⁰¹ Declaration of HIV/AIDS as a public emergency issued in terms of Statutory Instrument (S.I) No 240 of 2002, Patents Act (Ch 26:03): 'It is hereby notified that the Minister of Justice, Legal and Parliamentary Affairs has, in terms of sec 34 as read with sec 35 of the Patent Act (Ch 26:03) made following notice:1. This notice may be cited as the Declaration of Period of Emergency (HIV/AIDS) General Notice, 2002; 2. In view of the rapid spread of HIV/AIDS among population of Zimbabwe, the Minister hereby declares an emergency for a period of six months, with effect from date of promulgation of this notice, for the purpose of enabling the State or a person authorised by the Minister under sec 34 of the Act. (a) to make or use any patented drug, including any antiretroviral drug, used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions, (b) to import any generic drug used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions.' See also Sacco (n 15 above).

¹⁰² MSF, 'Zimbabwe government takes emergency acts against HIV/AIDS' (2002) <http://www.accessmed-msf.org/prod/publications.asp> (accessed 8 August 2006). Sell (n 65 above) 495.

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¹⁰⁴ Statutory Notice No 240 of 2002 Patents Act (Ch 26:03).

¹⁰⁵ In terms of sec 2(b) of the Statutory Notice No 240 of 2002 Patents Act (Ch 26:03).

In 2004, Mozambique and Zambia also made emergency declarations. In an explanatory preamble,¹⁰⁶ Mozambique declared a national health emergency in relation to HIV/AIDS,¹⁰⁷ and issued a manufacturing license to Pharco Moçambique Lda for the production of generic ARVs.¹⁰⁸ However, as far as could be ascertained, production has not yet started.¹⁰⁹ The Zambian declaration justifies

¹⁰⁶ Mozambican compulsory licensing No 01/M10/04 (www.cptech.org/ip/health/) (accessed 30 November 2006): 'The Government of Mozambique, conscious that the HIV/AIDS pandemic constituted a serious handicap in the national struggle against hunger, illness, under-development and misery and, taking into consideration that high rates of morbidity and mortality have put Mozambique among the ten countries in Africa worst hit by this disease. Current estimates are that at the end of 2002 over 1,5 million Mozambicans were infected by HIV, of whom more than 100.000 are suffering from full-blown AIDS. The AIDS death toll is so far well over 200.000 and about 360.000 children have been orphaned by the pandemic, and that, in spite of multiplication and diversification of vigorous prevention campaigns the spread of the virus is still on a climbing trend as shown by the high number of infections, considering further that, anti-retroviral drugs are already available, which prolong lives of those infected with HIV/AIDS, and that until now, at this day, the international patent owners have failed to make such drugs accessible at affordable prices to most of the Mozambican people, and for such reason on 14 November 2001 the World Trade Organization declared the right of each member state to protect public health and in particular to promote access for medicines for all, by granting compulsory licenses in cases which constitute a national emergency or other circumstances of extreme urgency and of public health crisis, including those relating to HIV/AIDS, tuberculosis, malaria or other epidemics can represent a national emergency or other circumstances of extreme urgency. Considering further that a triple compound of Lamivudine, Stavudine and Nevirapine has proved, in the last few years, to be one of the most effective and economical anti-retroviral treatment, but the three different international owners of such single drugs failed to reach an agreement to produce this combination ...'.

¹⁰⁷ The operative part reads as follows: 'The Ministry of Commerce and Industry of the Republic of Mozambique, making use of the provision of art 70 no.1 point b), of Decree no. 18/99 of 4 May, has decided to grant the compulsory license no. 1/ MIC/04 to the company Pharco Moçambique Lda, which has already presented a project for local manufacture of the mentioned triple compound under the names of Pharcovir 30 and Pharcovir 40. Communication of this decision will be given to the applicant and to the patent owners. In consideration that the mentioned product, a triple combination of drugs, is not marketed in Mozambique by the international patent owners and that it is in the national interest to keep the final price as lowest as possible, the total amount of royalties due to the patent owners shall not exceed 2% of the total turnover of the mentioned products, at the end of each financial year of Pharco Moçambique Lda. This Ministry of Industry and Commerce, in accordance to provisions of Art. 70 point 6 of Decree no. 18/99 will notify the concerned parties of the expiration of the present compulsory license as soon as conditions of national emergency and extreme urgency created by the HIV/AIDS pandemic will come to an end. The Government of the Republic of Mozambique reserves the right to review this compulsory license, in case the conditions in which it was issued are changed.'

¹⁰⁸ Pharco will produce ARVs with generic names Pharcovir 30 and 40.

¹⁰⁹ In order to make the declaration, Mozambique has amended art 70 of the Industrial Property Code (Decree No, 18/99 of 4 May).

the invocation of compulsory licensing laws with reference to the Doha Declaration.¹¹⁰ In its declaration, Zambia indicated that it will start producing ARVs and HIV-related drugs locally and solely for the domestic market.¹¹¹ Zambia has licensed Pharco Pvt Ltd to

¹¹⁰ The Zambian Declaration of Emergency is in terms of Statutory Instrument No 83 of 2004 titled The Patents (Manufacture of Patented Antiretroviral Drugs) (Authorisation) Regulations, 2004 Regulation 3, dated 21 September 2004 (www.cptech.org/ip/health/c/zambia/zcl/html) (accessed 30 November 2006). The Preamble reads as follows: 'The Government of Zambia, conscious that the HIV/AIDS pandemic constituted a serious handicap in the national struggle against hunger, illness, under development and misery; and taking into consideration that high rates of morbidity and mortality have put Zambia among the ten countries in Africa most hit by this disease. Current estimates are that, at the end of 2003, over 917,718 Zambians were infected by HIV, of whom an unestimated number are suffering from full-blown AIDS. The AIDS death toll is so far in excess of 835,904 and about 750,504 children have been orphaned by this pandemic, creating a situation where 75% of households in Zambia are caring for at least one orphan, and that children aged below 14 years headed more than 130,000 poverty stricken households out of a total of 1,905,000, and that; in spite of the multiplicity and diversity of vigorous prevention campaigns, the spread of the virus is still on an upward trend as shown by the high number of infections; taking into account the gravity of the situation being faced by most African Countries, including Zambia, the need to ensure access to drugs at affordable prices, while respecting the protection of intellectual property, is well recognized. For this reason; on 14 November, 2001 the World Trade Organization, while recognizing members commitment to the TRIPS Agreement, declared the right of each member state to take measures aimed at protecting public health and in particular to promote access to medicines for all, by utilising to the full, the flexibilities in the TRIPS Agreement relating to among others, the granting of compulsory licenses, in cases which constitute a national emergency or other circumstances of extreme urgency and of public health crises including those relating to HIV/AIDS, Tuberculosis, malaria, or other epidemics which can represent a national emergency or other circumstances of extreme urgency. Considering further that a triple compound of Lamivudine, Stavudine and Nevirapine has proved, in the last few years, to be one of the most effective and economical anti-retroviral treatments, but that the three different international owners of such single drugs failed to reach an agreement to produce this combination ...'.

¹¹¹ The operative part of the Zambian Declaration reads as follows: 'The Ministry of Commerce, Trade and Industry of the Republic of Zambia, making use of the provisions of sec forty of the Patent Act, Chapter 400 of the Laws of Zambia, and Statutory Instrument No 83 of 2004 titled The Patents (Manufacture of Patented Antiretroviral Drugs) (Authorization) Regulations, 2004 Regulation 3, has decided to grant a Compulsory License No. DC 01/2004 to PHARCO, LTD, a company incorporated in Zambia, which has already presented a project proposal for the local manufacture of the mentioned triple compound under the names of *Normavir 30* and *Normavir 40*. It is further understood that the use or vending of the above mentioned drugs is subject to Regulation 4 of Statutory Instrument No 83 of 2004, titled The Patents (Manufacture of Patented Antiretroviral Drugs)(Authorization) Regulations, 2004, and therefore cannot be exported to any place outside Zambia. Communication of this decision will be given to the applicant and to the patent right holders. In consideration that the mentioned product, a triple combination of drugs, is not marketed in Zambia by the international Patent owners and that it is in the national interest to keep the final price as low as possible, the total amount of royalties due to the patent owner shall not exceed 2.5% of the total turnover of the mentioned products at the end of each financial year of PHARCO LTD. The Ministry of Commerce, Trade and Industry, shall in accordance with sec forty one of the Patent Act notify the concerned parties of the expiration of the present Compulsory License as soon as conditions of national emergency and extreme urgency created by the HIV/AIDS pandemic will come to an end, or upon the expiry of the period of national emergency stipulated in Statutory Instrument No 38 of 2004 titled The Patents

produce ARVs,¹¹² although, as far as could be ascertained, local production of these generic drugs has not yet started due to manufacturing capacity issues.

The SADC state with the greatest treatment need, South Africa, has quite noticeably not made use of TRIPS flexibilities allowed for under domestic legislation. As a result of the socio-economic impact of HIV and AIDS on South Africa, some civil society voices urged for the declaration of a public health emergency. However, President Mbeki refused, referring to the declaration of the state of emergency¹¹³ as a mechanism to ‘restore peace and order and no such threats to the country existed’.¹¹⁴ In his view, a declaration would have given the impression to other nations that South Africa was unstable, thereby deterring foreign investment.¹¹⁵ According to studies, ‘[t]he South African economy will continue to shrink by one percent each year due to disintegrating workforce. The life expectancy will drop from what would have been 70 years to 50 years by 2010. These threats to the economy and population growth arguably satisfy the threat to ‘peace and order’ requirements for the purposes of South Africa’s law’.¹¹⁶

(Manufacture of Patented Antiretroviral Drugs) (Authorization) Regulations, 2004, and therefore cannot be exported to any place outside Zambia. Communication of this decision will be given to the applicant and to the patent right holders. In consideration that the mentioned product, a triple combination of drugs, is not marketed in Zambia by the international Patent owners and that it is in the national interest to keep the final price as low as possible, the total amount of royalties due to the patent owner shall not exceed 2.5% of the total turnover of the mentioned products at the end of each financial year of PHARCO LTD. The Ministry of Commerce, Trade and Industry, shall in accordance with sec forty one of the Patent Act notify the concerned parties of the expiration of the present Compulsory License as soon as conditions of national emergency and extreme urgency created by the HIV/AIDS pandemic will come to an end, or upon the expiry of the period of national emergency stipulated in Statutory Instrument No 38 of 2004 titled The Patents (Manufacture of Patented Antiretroviral Drugs) (Authorization) Regulations, 2004. The Government of the Republic of Zambia reserves the right to review this Compulsory License should the conditions and circumstances under which it is granted should change.’

¹¹² This will be done under the generic names Normavir 30 and 40.

¹¹³ It is only effective for 21 days and only extended with the approval of the Parliament.

¹¹⁴ KM Bombach ‘Can South Africa fight AIDS? Reconciling the South Africa’s Medicines and Related Substances Act with the TRIPS Agreement’ (2001) 19 *Boston University International Law Journal* 289, quoted from J Jeter ‘South Africa resists calls for AIDS “emergency”’, *The Washington Post*, 15 March 2001, A1.

¹¹⁵ Bombach (n 113 above).

¹¹⁶ Bombach (n 113 above) 290.

This underscores the fact that political barriers are some of the strongest barriers that limit access to medicines.

SADC states are also making use of parallel importation. India has been manufacturing generic medicines since the 1970s. Southern African countries are importing generic drugs from India and China where quality-assured drugs have been produced in high volumes at affordable prices. After being threatened with trade sanctions by the United States Trade Representative, India revised its patent laws to be TRIPS compliant by 1 January 2005. Studies have noted that '[r]estricting India's ability to manufacture the newest generations of low-cost essential medicines leaves poor consumers in India and elsewhere in a procedural labyrinth and with long delays in access'.¹¹⁷ Thus, India's compliance with the TRIPS Agreement has direct implications on access to medicines by Southern African countries.

The 30 August Decision, intended as a 'pathway for countries without manufacturing capacity to import generic drugs produced under compulsory license' has not been used to any significant extent.¹¹⁸

A variety of factors accounts for the failure of Southern African countries taking advantage of TRIPS flexibilities. Even if the adoption of flexibilities provided by the TRIPS Agreement 'was intended as a lifeline', in practice 'any country reaching for this lifeline has been handcuffed by US trade negotiators'.¹¹⁹ This is because well-established legal norms of property rights exist and these are an integral part of the United States' identity in the global political economy.¹²⁰ Studies have noted that

a large number of laws currently allow compulsory licensing and still it never happens because of diplomatic, political and attitudinal barriers – law has nothing to do with it. Simply put, it is now a custom for countries aspiring to the polite society of globalisation to never compulsorily license medicines.¹²¹

¹¹⁷ As above.

¹¹⁸ Avafia & Narasimhan (n 68 above) 19.

¹¹⁹ Sell (n 65 above) 500 - 501.

¹²⁰ n 118 above 482.

¹²¹ A Attaran 'Assessing and answering paragraph 6 of the Doha Declaration on the TRIPS agreement and the public health: The case for greater flexibility and non-justiciability solution' (2003) 17 *Emory International Law Review* 750. Illustrative of this is the fact that Zimbabwe has declared a national public health emergency, invoked compulsory licensing and manufacturing ARVs locally. This approach has promoted access to medicines to the poor by ensuring their availability and affordability in public health institutions. Zimbabwe has been labelled a pariah state. See MSF (n 101 above).

Illustrative of the practical impediments faced in invoking compulsory licensing is the lawsuit where the legality of South Africa's Amendment to Medicines and Related Substances Control Act (Medicines Act)¹²² was challenged by the Pharmaceutical Manufacturers' Association of America (PhRMA) in South Africa.¹²³ South Africa had amended its patent laws to make them TRIPS compliant. The amendment sought to implement some of the key components of the national drug policies and would have allowed for parallel imports and compulsory licensing of HIV-related drugs. This led to the lawsuit by the pharmaceutical companies against the South African government, in which the Constitution, intellectual property laws, international law and the TRIPS Agreement were invoked. Immediately after the amendment, South Africa was threatened with trade sanctions by the United States Trade Representative.¹²⁴ Despite the fact that the provision of the amendment was TRIPS compliant, the Medicines Act was eventually repealed on the basis that it was 'unworkable'.¹²⁵ The lawsuit was withdrawn by the pharmaceutical companies.

3.2.3 *The use of national competition law to ensure compulsory licenses are issued to generic competitors*

Under TRIPS, when the patent holder refuses a request for voluntary licenses, generic producers may apply for compulsory licenses.¹²⁶ The TRIPS Agreement also allows that such a refusal may be based on arguments that the patent holder engages in anti-competitive practices.¹²⁷ This is because competition laws remedy patent abuse and anti-competitive practices which keep the prices of medicines beyond the reach of the poorest in the world.¹²⁸ In some SADC coun-

¹²² Act 90 of 1997.

¹²³ *Pharmaceutical Manufacturers' Association and 41 Others v President of South Africa and 9 Others*, High Court of South Africa, Transvaal Provincial Division, case No 4183/98 (2001). See also M Heywood 'Debunking "Conglomo-Talk": A case study of the *amicus curiae* as instrument for advocacy, investigation and mobilization' (2002) 2 *Law, Democracy and Development* 133.

¹²⁴ According to William Clinton, Executive Order on Access to HIV/AIDS Pharmaceuticals in Pharm Policy 26 June 2000 at 3, the US 'should not interfere in legitimate efforts to expand access to essential medicines in developing countries in health crises.'

¹²⁵ Bombach (n 113 above) 279.

¹²⁶ Msungu & Oh (n 67 above) 16.

¹²⁷ Msungu & Oh (n 67 above) 17.

¹²⁸ Art 31(k) allows countries to adopt anti-competitive procedures to remedy patent abuse.

tries there is either non-existence of competition laws or non-enforcement where such laws exist. Case law on company patent policies has been developed in South Africa.¹²⁹ The complaint by Hazel Tau and others to the Competition Commission against two pharmaceutical companies demonstrates the inherent tension between policies that promote pharmaceutical growth and those that promote public health goals.¹³⁰ The TAC complaint, for example, is reflective of the way competition policies could be adopted in an aggressive manner, thereby hindering access to essential medicines. The South African Competition Act 89 of 1998 permits the issuance of compulsory licenses for in response to anti-competitive pricing practices by the pharmaceutical industry. Section 8 of the Act prohibits dominant firms from engaging in excessive pricing and refusing access to an essential facility.¹³¹ In the *Tau* complaint, GlaxoSmithKline and Boehringer Ingelheim agreed to grant voluntary licenses to a South African generic company, Aspen Pharmacare, after a (non-binding) decision of the Competition Commission. The patent holders agreed to this action in a settlement, thus avoiding a binding decision of the Competition Tribunal.

¹²⁹ On October 16, 2003, the South African Competition Commission announced a finding upholding a complaint by the Treatment Action Campaign and others against two pharmaceutical giants, GlaxoSmithKline South Africa and Boehringer Ingelheim, and holding that both companies had charged excessive prices for their patent-protected antiretroviral medicines. The ruling further held that they had unlawfully refused to issue voluntary licenses to generic competitors and that they had thereby unreasonably restricted access to an essential facility preventing production of fixed-dose combination medicines. Under sec 8 of the South African Competition Act '[i]t is prohibited for a dominant firm to – refuse to give a competitor access to an essential facility when it is economically feasible to do so.' Under the Act, an 'essential facility' means an infrastructure or resources that cannot reasonably be duplicated, and without access to which competitors cannot reasonably provide goods or services to their customers.' One possible interpretation of the essential facility doctrine, read against the background of the constitutional duty to interpret legislation to 'promote the spirit, purport and objects of the Bill of Rights' (sec 39), including the right of everyone to access to health services (sec 27), is that the Competition Act imposes an obligation on the respondents to license their patented products on reasonable terms when to do so serves public health priorities.

¹³⁰ *Hazel Tau and Others v GlaxoSmithKline and Boehringer Ingelheim*, Competition Commission of South Africa (2003), summarised and discussed in UNAIDS and Canadian HIV/AIDS Legal Network, *Courting rights: Case studies in litigating the human rights of people living with HIV*, March 2006, 86 - 91.

¹³¹ The South African Competition Commission supports three theories in the issuance of compulsory licenses. These are (i) the access gap theory that relates to the medicine and its accessibility due to excessive pricing, (ii) essential facility doctrine that requires that a compulsory license should be issued whenever voluntary licenses are not granted by a patent holder and the consumer is denied access to the competitor's product, and (iii) a price discrimination theory that could be adopted in order to promote cheaper medicines. These competition-based theories remedy anti-competitive practices and promote fixed dose ARV combinations and access to medicines.

4 Options outside TRIPS: Accessing funding, drug donations, price reductions and public-private partnerships to improve access to ART

Domestic and international funding sources are needed to ensure the realisation of the right to health, not only with respect to the provision of medicines, but also for the expansion of voluntary counselling and testing services, the strengthening of healthcare facilities, technology transfer and improved education and awareness. So far, funding has been through out-of-pocket payment by patients, an AIDS levy, as in Zimbabwe, work-based medical insurance schemes, debt relief and bilateral and multilateral aid such as the Global Fund for HIV/AIDS, TB and Malaria (Global Fund), the US Emergency Plan for AIDS Relief (PEPFAR), the World Bank-Multi-Country HIV/AIDS Program for Africa (MAP), and the WHO '3-by-5' initiative. Because ART requires predictable and sustainable financing, the question must be posed whether external funders will remain committed to ensure financial sustainability in the long term. The dependence on foreign funding to extend provision of ART arguably increases the vulnerability of health programmes. For example, lack of certainty in funding is exemplified by the length of time taken to approve proposals by the Global Fund, and other international donor agencies.

4.1 The Global Fund for HIV/AIDS, TB and Malaria

The core objective of the Global Fund is greater accessibility to quality-assured drugs bought at the lowest price. The Global Fund has at least partly promoted the scaling-up of treatment and has ensured greater geographic equality in the financing of HIV/AIDS, TB and Malaria. All SADC countries are beneficiaries of the Global Fund. The first round of Global Fund allocations benefited countries such as Malawi, South Africa, Tanzania, Zambia and Zimbabwe.¹³² Evaluation of the first round of Global Fund proposals indicates that they are limited in both scope and long-term vision.¹³³ Other than Tanzania's proposal to implement a new treatment policy on malaria, none of the proposals addresses the issue of strengthening laws and policies that promote access to medicines in the context of HIV/AIDS and TB.

¹³² Adapted from Thutula Balfour, TB and malaria in SADC countries. SADC Health Sector Coordinating Unit, Pretoria at 323.

¹³³ Baker (n 8 above) 52.

4.2 The US Emergency Plan for AIDS Relief (PEPFAR)

The objectives of PEPFAR are to provide anti-retrovirals to 2 million people by 2008, to prevent 7 million new infections and to provide care and support to 10 million HIV-infected individuals and AIDS orphans.¹³⁴ PEPFAR supports 15 'focus countries', of which the following are located in Southern Africa: Botswana, Mozambique, Namibia, South Africa, Tanzania and Zambia. The areas funded by PEPFAR include prevention of mother-to-child transmission, abstinence/be faithful, education, other prevention activities, palliative care, tuberculosis treatment, care for orphans and vulnerable children, HIV counselling and testing, antiretroviral drugs, treatment services and laboratory infrastructure, strategic information, policy analysis, system strengthening, management and staffing.

4.3 Negotiations with pharmaceutical firms and public-private partnerships

Southern African countries currently rely heavily on drug imports. Following the threat of compulsory licensing, pharmaceutical companies responded by reducing the price of medicines and donating some of their products. The Accelerating Access Initiative (AAI) was founded in 2000 by UN special agencies and pharmaceutical companies,¹³⁵ who undertook to promote treatment and implement this programme, 'in ways that respond to specific needs and requests of individual countries, with respect for human rights, equity, transparency and accountability.'¹³⁶ As part of this programme, Boehringer-Ingelheim provided Viramune to 300 000 mother-child pairs in countries including South Africa and Zambia,¹³⁷ and granted voluntary licenses for the production of Nevirapine to generic manufacturers Aspen Pharmacare and Thembalami Pharmaceuticals (Pty) Ltd of South Africa¹³⁸ in 2003 and 2004 respectively. One of the terms of the voluntary license was that the manufactured generics were for local and export markets within the SADC countries. The implication is that Boehringer-Ingelheim still has monopoly over generic Nevirapine. In addition, Botswana, Lesotho, Namibia, South Africa and Swaziland have benefited from grants provided by Bristol-

¹³⁴ M Isbell 'The Money Trail: Financing the Global AIDS Response' www.pbs.org/wgbh/pages/frontline/aids/past/financing.html (accessed 10 August 2006).

¹³⁵ Abbot Laboratories, Gilead Sciences, GlaxoSmithKline, Merck & Co Inc, F Hoffmann-La Roche, Boehringer-Ingelheim, Bristol-Myers Squibb.

¹³⁶ JL Sturchio, Partnership for action: The experience of the accelerating access initiative 2000-2004 and lessons learned: A joint venture of Ranbaxy and Adcock Ingram Pharmaceuticals in South Africa, 118.

¹³⁷ n 141 above 127.

¹³⁸ As above.

Myers Squibb. GlaxoSmithKline has concluded deals with Anglo-American and De Beers in Southern Africa to discount the cost of ARVs.

Whilst drug donations improve access to medicines, the benefits are limited because a constant or sustainable supply is not guaranteed. Studies have shown that donations and price reduction by pharmaceutical firms do not promote access and affordability in the long term.¹³⁹ Donations have been criticised as being used to divert 'governments from more effective and sustainable solutions, such as bulk procurement, compulsory licensing, parallel importing and enhancing incentives for local drug manufacturers to produce essential drugs.'¹⁴⁰ Accordingly, governments should not abrogate their legal, political and moral duty of generating domestic revenue to expand treatment at the expense of drug donations, pledges and foreign assistance. From the funders' side, there is a need for 'collateral' domestic resources to be directed towards skilled labour, infrastructure and political will to scale-up treatment and mitigate productivity losses related to HIV and AIDS.

Scaling-up and equity in financing for HIV/AIDS, TB and malaria has been promoted by the Global Fund. It is also dependent on private, public and civil society partnerships. For example, Lighthouse Trust has pilot programmes in Malawi, Mozambique and South Africa. The Merck/Gates/Botswana Partnership (the African Comprehensive HIV/AIDS Partnerships or ACHAP), which was founded in 2000, has made donations in cash and kind. ACHAP supports the Botswana National AIDS Coordinating Agency. Additionally, it funds the strengthening of healthcare infrastructure, the de-stigmatisation of HIV/AIDS and gives grants to community and faith-based organisations. Merck donates ARVs to the Botswana Masa programme ('masa' is the Setswana word for 'new dawn'), the largest national HIV/AIDS treatment programme in Africa.¹⁴¹ The AAI has supported the construction of 32 regional treatment centres, 16 of which are operational. All of these examples underscore the value of private-public partnerships.

Tanzania Care, a partnership with the Abbot Laboratories Fund, is sponsoring the modernisation of public healthcare facilities such as training medical workers and laboratory personnel and expanding VCT. For example, Muhimbili National Hospital in Dar es Salaam,

¹³⁹ KE Maskus 'Ensuring access to essential medicines: Some economic considerations' (2003) 291 *Spec Law Dig Health Care Law* 9-25.

¹⁴⁰ Health Action International 'Increasing and sustaining access to essential medicines: Drug policy at the 54th World Health Assembly' 8 www.haiweb.org/campaign/access/wha54/briefingen/html (accessed on 19 July 2006).

¹⁴¹ According to Access to Treatment Initiative, as of September 2004, nearly 27 000 patients were enrolled, more than 21 000 patients were on ART, more women were receiving treatment (ration of 3:2) and approximately 1 000 new HIV-positive patients each month are being enrolled on the programme.

Tanzania is the largest public health institution that has been renovated and its role enhanced as the country's primary research, referral and teaching facility.¹⁴² The implication is that scaling-up treatment also requires promotion of infrastructure development so that people can have physical access to health care facilities.

Vertical programmes or the so-called 'islands of excellence'¹⁴³ or 'flags in the sand' can, however, affect the government's ability to develop an efficient health care delivery system¹⁴⁴ as they are short-term initiatives.¹⁴⁵ Researchers have noted that 'to enjoy something only at the discretion of someone else ... is precisely not to enjoy a right to health'.¹⁴⁶

5 Conclusions and recommendations

5.1 Inadequate legal framework adopted

Access to medicines is a human right. The study has interrogated the legal and policy frameworks in order to promote access to medicines and correct an 'horrific injustice'.¹⁴⁷ It has revealed that the domestic legal and policy frameworks for public health, patents and medicines are not responsive to the human rights instruments, the TRIPS Agreement and related trade instruments. The study has established that SADC countries have not taken advantages of the hard-won gains of the Doha Declaration. Laws and policies continue to impede access to the human right to treatment. Studies¹⁴⁸ have also identified these impediments as preconditions for the promotion of access. The barriers are manifold and include legal, political, technical, and institutional barriers; additionally, barriers related to health care systems and financial and information barriers exist.

¹⁴² n 141 above 126.

¹⁴³ Loewenson & Thompson (n 60 above) 31.

¹⁴⁴ M Lewis 'Addressing the Challenge of the HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues, Centre for Global Development Working Paper 58' (April 2005) 17 www.cgdev.org (accessed on 18 August 2006).

¹⁴⁵ A trend analysis of donor funding patterns, donor fatigue and the various pledges has exposed governments and people living with HIV/AIDS to serious setbacks. See n 149 above 13.

¹⁴⁶ Y Tayler (ed) *Battling HIV/AIDS - A Decision Maker's Guide to the Procurement of Medicines and Related Supplies* (2004) 25, footnote 103.

¹⁴⁷ Yamin (n 18 above) 144.

¹⁴⁸ Munderi in Mnyika (n 55 above) 43 - 46.

5.2 Legal and policy barriers

5.2.1 No or selective domestication of the TRIPS Agreement

Several Southern African countries have not taken advantage of TRIPS flexibilities. Mostly, their laws contain provisions on compulsory licensing that pre-date the TRIPS Agreement. Governments need to domesticate TRIPS flexibilities into national laws.

5.2.2 No or selective domestication of the international and regional human rights instruments

The right to health is not justiciable in most Southern African countries. There is a need to domesticate minimum obligations arising from international and regional human rights instruments such as incorporating the right to health as a justiciable right. In the absence of a justiciable right to health, reliance should be placed on existing justiciable rights, such as the right to life and the right to non-discrimination. However, such an approach depends on judicial activism, which is largely absent in the region.

5.2.3 No meaningful competition policies and laws

There are no meaningful competition policies and laws. TRIPS flexibilities need to be adopted that will promote meaningful competition legal and policy frameworks.

5.2.4 Tariffs and taxes are barriers in accessing medicines

With no generic competition in Southern Africa, drug prices vary from one country to another. Inevitably, the cost of drugs is passed on to consumers. This cost is associated with import duties, tariffs and taxes all of which limit access to medicines. There is a need to promote equity-pricing mechanisms for 'mission hospitals, company health schemes, and insurance schemes in addition to public sector health services'.¹⁴⁹

5.3 Technical barriers

5.3.1 Lack of technological capacity

Southern African countries demonstrate different levels of development of the pharmaceutical industry. There is a need for the

¹⁴⁹ n 146 above 3.

adoption and promotion of technology transfer policies. Further, the need for technology transfer could be in terms of collaboration and partnerships between national governments, private sector companies, multilateral financial organisations and NGOs. Technology transfer is dependent on domestic economies-of-scale, gross domestic product, the domestic market for the drugs and the removal of trade barriers such as tariffs.

Developing countries with insufficient manufacturing capacity are also allowed to invoke the TRIPS flexibilities to ensure 'technology transfer'.¹⁵⁰ The non-production of HIV-related medicines in Mozambique and Zambia could be attributed to the issue of lack of technological capacity. Central to the debate on international transfer of technology are the protection of intellectual property rights and foreign investment.¹⁵¹

Studies have classified Southern African countries in accordance with the levels of development of pharmaceutical industry.¹⁵² Countries that have manufacturing capabilities that are able to develop a finished product from imported ingredients include Angola, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, United Republic of Tanzania, Zambia and Zimbabwe. Botswana, DRC, and Swaziland are examples of countries that do not have a pharmaceutical industry.

Technology transfer can focus on the regional markets due to weak manufacturing capacity and lack of technical expertise. 'South-South' generic company partnerships exist that include capacity building as a component of their work programme. Their success is dependent on drug regulation.¹⁵³ A number of voluntary licenses for technology transfers are granted by South-South co-operation, research and development companies. Transfer of technology is important in that it promotes local manufacturing of generic medicines, capabilities and skilled human resources. Those countries with reproductive capabilities to work on finished products require foreign exchange reserves to import the active ingredients. Local production is central to making drugs available, accessible and affordable to the poorest people in society.

¹⁵⁰ Art 40 of TRIPS and para 7 of the Doha Declaration.

¹⁵¹ Technology transfer is further supported by arts 1, 8(j), 15 and 16 of the Convention on Biodiversity in the context of indigenous knowledge systems, access to plant genetic resources and access and benefit sharing schemes.

¹⁵² n 74 above 27 - 28.

¹⁵³ <http://www.aids.ca/maincontent/otherdocs/newsletter/vol7no2-32003/treatment.htm> (accessed 30 November 2006).

5.4 Institutional barriers

5.4.1 *No political will and governance*

National political will and governance are central to the success of the ARV roll-out programme. Research has noted that, '[e]ven with a conducive legal environment and good economic conditions poor leadership can derail treatment efforts.'¹⁵⁴ Illustrative of this is the fact that despite the adoption of progressive constitutional provisions that inform the South African human rights framework, 'its health indicators are comparable to some of the least-developed countries.'¹⁵⁵ This is also depicted in the SADC treatment gap table above. There is a need for political will from national governments. Political will is not just expressed in declaring national emergencies and licensing local manufacturers, but also in procuring the necessary products.

5.4.2 *No policy coherency and coordination on intellectual property rights*

Inter-ministerial collaboration in relation to drug procurement and intellectual property rights issues is lacking. The enforcement of drug import regulations is discharged by ministries that are responsible for customs, tariffs and trade, whilst the procurement of drugs is by Medicines Central Stores. Legal expertise is necessary in each of these different agencies. There is a need to understand legal and policy frameworks that regulate the procurement and supply of drugs and to understand the fact that drug procurement is affected by the products' patent status. There is a need to build capacity within ministries dealing with trade, justice, finance and health in drug procurement and intellectual property rights issues.

5.5 Barriers related to health care systems

5.5.1 *Lack of integration of HIV-treatment with the entire healthcare systems*

The treatment of HIV and TB are considered as two vertical programmes that are not interactive and coordinated. In Malawi, this has been improved by incorporating HIV and TB care systems in the National Antiretroviral Treatment Scale-up Plan. There is a need for the improvement of healthcare infrastructure in order to integrate HIV and AIDS into the entire national health care system.

¹⁵⁴ MSF (n 101 above).

¹⁵⁵ MSF (n 101 above).

5.5.2 Introduction of hefty health user fees

Socio-economic inequities and social biases affect access to medicines. Countries like Botswana, Tanzania and Zambia have eliminated fees at the point of delivery.¹⁵⁶ Despite the fact that ART is subsidised in Zimbabwe's public health care facilities, the prohibitive costs associated with CD4 and viral load tests limit access to medicines. Additionally, hefty health user-fees or co-payments have in some instances been introduced, which discriminate against and exclude the poorest in society from accessing medicine. Health-user fees should be scrapped or subsidised, particularly for minimum and absolutely necessary tests such as those for viral loads and CD4 counts.

5.5.3 Stigma and discrimination

It is important to note that

stigma and discrimination permeate the entire prevention-treatment-care continuum of controlling HIV ... The fear of openly taking ARVs affect adherence to the treatment regimen, and disclosure of status to family members has important factors in increasing adherence.¹⁵⁷

There is a need for promotion of rights-based approach advocacy strategies to fight against stigma and discrimination.

5.5.4 ARVs are limited to newborn children under the PMTCT programme

Under PMTCT programmes, ARVs are limited to the newborn children, neglecting the fact that their mothers still require ART, in addition to reproductive health such as post-natal treatment and contraception advice. There is a need to expand treatment and its administration to everyone. Treatment should go beyond PMTCT and ante-natal care.

5.5.5 Treatment is limited to first-line ARVs

In situations where treatment is limited to first-line ARVs, for example in resource-limited settings, there are no second-line or third-line drugs in the event of drug resistance. There is a need to introduce second-line and third-line drugs for those who may develop resistance to first-line drugs.

¹⁵⁶ WHO and UNAIDS, 'Guidance on Ethics and Equitable access to HIV Treatment and Care' (2004).

¹⁵⁷ MSF (n 120 above) 220.

5.5.6 Limited administration of paediatric ARV formula

Studies have noted that only Botswana is administering paediatric ARV formula. Paediatric formula should be produced in large quantities in order to reduce infant mortality rates.

5.5.7 No systematic provision of ARVs

So far ARVs are administered free of charge to pregnant women and survivors of sexual assault or rape. There is limited access to treatment for those who do not fall into the two categories. There are predictable estimates of resource requirements in relation to drug procurement and those eligible for treatment, but these should be further elaborated to include epidemic estimates, estimates on drug quantities,¹⁵⁸ financial needs, healthcare facilities and essential drug procurement and supply. An eligibility criterion for treatment should be developed. ARV provision programmes have to go beyond the PMTCT and prophylaxis for rape survivors.

5.5.8 Erratic procurement and supply of ARVs

Countries like Zimbabwe experience delays in procurement and disbursement of ARVs and HIV-related medicines. This is attributed to unavailability of foreign currency to procure the active ingredients for local manufacturing of ARVs and also for importing generic drugs from India and elsewhere. Studies have also noted that some countries are unable to predict future demand for ARVs. There is a need for constant supply and effective drug management systems in relation to ARVs given that they are life-saving drugs. Foreign currency has to be put aside particularly for their procurement.

5.5.9 Non-integration of the treatment of HIV and TB by the Global Fund proposals

The study has noted that proposals submitted to the Global Fund are mainly concerned with scaling-up of treatment for HIV, AIDS and TB. They do not focus on strengthening institutions and the legal and policy frameworks that provide an enabling environment for accessing medicines. Capacity-building is needed by those drafting the Global Fund proposals to integrate these elements into fundraising proposals.

¹⁵⁸ There should not be underestimates of people who will interrupt drug adherence. Overestimates should also be discouraged because they lead to waste because the shelf-life of ARVs is very short.

5.6 Financial barriers: Operational challenges

Operational challenges faced in expanding treatment relate to funding mechanisms. A trend analysis of donor funding patterns shows donor or compassionate fatigue and the various pledges by pharmaceutical companies have exposed governments and people living with HIV to serious setbacks.¹⁵⁹ There is a need to mobilise financial resources at the domestic level to promote collective responsibility towards HIV and AIDS, such as setting up schemes akin to the AIDS Levy in Zimbabwe.¹⁶⁰

5.7 Information barriers

Studies reveal that there are no realistic assessments of demand for treatment, the ability of governments to have foreign exchange reserves to procure drugs and the economic impact of subsidising HIV/AIDS related medicines. Additionally, there is no information readily available in Southern African states on the pricing of essential drugs as well as the specific drugs that are affordable. Drugs have different prices in different countries. This could be attributed to maximisation of profits, taxes, tariffs, wholesale costs and mark-ups.¹⁶¹ In addition, in most states in the region there is little knowledge and information on how to enter into negotiations with pharmaceutical companies. There is no information on patent status of certain essential medicines. This is because a drug can be patented in one country while in the other it is not. There is a need to develop databases on drug pricing information in Southern African countries and those that export generic drugs, and a need to develop databases on patents and their status in Southern Africa.

¹⁵⁹ Lewis (n 149 above) 58.

¹⁶⁰ 3% of gross income of all formally employed people is levied.

¹⁶¹ Health Action International (n 145 above) 2.

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Annexure A: SADC Treaty (1992, as amended in 2001)

Excerpts

CHAPTER THREE: PRINCIPLES, OBJECTIVES AND GENERAL UNDERTAKINGS

Article 4: Principles

SADC and its member states shall act in accordance with the following principles:

- (a) sovereign equality of all member states;
- (b) solidarity, peace and security;
- (c) human rights, democracy, and the rule of law;
- (d) equity, balance and mutual benefit; and
- (e) peaceful settlement of disputes.

Article 5: Objectives

1. The objectives of SADC shall be to:

- (a) promote sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation with the ultimate objective of its eradication, enhance the standard and quality of life of the people of Southern Africa and support the socially disadvantaged through regional integration;
- (b) promote common political values, systems and other shared values which are transmitted through institutions which are democratic, legitimate, and effective;
- (c) consolidate, defend and maintain democracy, peace, security and stability;
- (d) promote self-sustaining development on the basis of collective self-reliance, and the interdependence of member states;
- (e) achieve complementarity between national and regional strategies and programmes;
- (f) promote and maximise productive employment and utilisation of resources of the region;
- (g) achieve sustainable utilisation of natural resources and effective protection of the environment;
- (h) strengthen and consolidate the long-standing historical, social and cultural affinities and links among the peoples of the region;
- (i) combat HIV/AIDS and other deadly or communicable diseases;
- (j) ensure that poverty eradication is addressed in all SADC activities and programmes;
- (k) mainstream gender in the process of community building.

2. In order to achieve the objectives set out in paragraph 1 of this article, SADC shall:

- (a) harmonise political and socio-economic policies and plans of member states;

- (b) encourage the peoples of the region and their institutions to take initiatives to develop economic, social and cultural ties across the region, and to participate fully in the implementation of the programmes and projects of SADC;
- (c) create appropriate institutions and mechanisms for the mobilisation of requisite resources for the implementation of programmes and operations of SADC and its institutions;
- (d) develop policies aimed at the progressive elimination of obstacles to the free movement of capital and labour, goods and services, and of the peoples of the region generally, among member states;
- (e) promote the development of human resources;
- (f) promote the development, transfer and mastery of technology;
- (g) improve economic management and performance through regional co-operation;
- (h) promote the coordination and harmonisation of the international relations of member states;
- (i) secure international understanding, co-operation and support, and mobilise the inflow of public and private resources into the region;
- (j) develop such other activities as member states may decide in furtherance of the objectives of this Treaty.

Article 5A: SADC Common Agenda

1. The SADC Common Agenda shall be as reflected in article 5 of this Treaty.
2. Without prejudice to paragraph 1 of this article, the Council shall develop and implement the SADC Common Agenda.

Article 6: General Undertakings

1. Member states undertake to adopt adequate measures to promote the achievement of the objectives of SADC, and shall refrain from taking any measure likely to jeopardise the sustenance of its principles, the achievement of its objectives and the implementation of the provisions of this Treaty.
2. SADC and member states shall not discriminate against any person on grounds of gender, religion, political views, race, ethnic origin, culture, ill-health, disability or such other ground as may be determined by the Summit.
3. SADC shall not discriminate against any member state.
4. Member states shall take all steps necessary to ensure the uniform application of this Treaty.
5. Member states shall take all necessary steps to accord this Treaty the force of national law.
6. Member states shall co-operate with and assist institutions of SADC in the performance of their duties.

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Annexure B: Southern African Development Community Protocol on Health (1999)

Excerpts

Article 2: Principles

States Parties shall act in common in pursuit of the objectives of this Protocol, which shall

be implemented in accordance with the following principles:

- (a) Striving for the formulation of regional health policies and strategies consistent with the principles contained in Article 4 of the Treaty;
- (b) promoting, co-ordinating and supporting individual and collective efforts of Member States to attain an acceptable standard of health for all their people;
- (c) a commitment to the Primary Health Care approach;
- (d) promoting health care for all through better access to health services; and
- (e) ensuring equitable and broad participation for mutual benefit in regional co-operation in health.

Article 3: Objectives

States Parties shall co-operate in addressing health problems and challenges facing them through effective regional collaboration and mutual support under this Protocol for the purposes of achieving the following objectives:

- (a) to identify, promote, co-ordinate and support those activities that have the potential to improve the health of the population within the Region;
- (b) to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases;
- (c) to promote and co-ordinate the development, education, training and effective utilisation of health personnel and facilities;
- (d) to facilitate the establishment of a mechanism for the referral of patients for tertiary care;
- (e) to foster co-operation and co-ordination in the area of health with international organisations and co-operating partners;
- (f) to promote and co-ordinate laboratory services in the area of health;
- (g) to develop common strategies to address the health needs of women, children and other vulnerable groups;
- (h) to progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the Region; and
- (i) to collaborate and co-operate with other relevant SADC Sectors.

Article 9: Communicable Disease Control

1. States Parties shall co-operate to harmonise, and where appropriate, standardise policies in the areas of -

- (a) case definitions for diseases;
- (b) notification systems; and
- (c) treatment and management of major communicable diseases.

2. States Parties shall co-operate in the establishment of regional reference laboratories and in sharing technical expertise in order to ensure high immunisation rates to reduce, eliminate, and where possible eradicate communicable diseases.

3. States Parties shall share information related to outbreaks and epidemics of communicable diseases within the Region and work together in epidemic control and management.

Article 10: HIV/AIDS and Sexually Transmitted Diseases

1. In order to deal effectively with the HIV/AIDS/STDs epidemic in the Region and the interaction of HIV/AIDS/STDs with other diseases, States Parties shall -

- (a) harmonise policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of STDs and HIV infection;
- (b) develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonised and standardised manner;
- (c) develop regional policies and plans that recognise the intersectoral impact of HIV/AIDS/STDs and the need for an intersectoral approach to these diseases; and
- (d) co-operate in the areas of -
 - (i) standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information which has a regional impact;
 - (ii) regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and
 - (iii) sharing of information.

2. States Parties shall endeavour to provide high-risk and transborder populations with preventative and basic curative services for HIV/AIDS/STDs.

Annexure C: Code on HIV/AIDS and Employment in the Southern African Development Community (SADC) (1997)

1. General Statement

Human Immuno-deficiency Virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS) in the countries of the Southern African Development Community (SADC) (and globally) is a major health problem with employment, economic and human rights implications. As one response to this problem the SADC Employment and Labour Sector has established this code on the industrial relations standards on HIV/AIDS, the 'Code on AIDS and Employment' (termed after this 'the code'). It should be noted that the provisions of this code applies only to workplaces and cannot and should not be construed as applying to other areas of law such as national immigration laws, policies and related administrative procedures.

2. Policy Principles

The same ethical principles that govern all health/medical conditions in the employment context apply equally to HIV/AIDS. However, the gravity and impact of the HIV/AIDS epidemic and the potential for discrimination create the need for a specific code on HIV/AIDS and employment. At the same time, given the increased risk of spread of the disease under conditions of economic insecurity, non-discriminatory approaches enable economic and public health management. The code will aim to ensure non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health-medical conditions.

The regional nature and implications of the epidemic and the desire to harmonise national standards in dealing with HIV/AIDS motivate this regional code. This code aims to ensure that SADC member states develop tripartite national codes on AIDS and Employment that shall be reflected in law. It presents guiding principles for and components of these national codes.

The code on AIDS and Employment is based on the fundamental principles of human rights and patients rights, WHO/ILO and regional standards and guidelines, medical and occupational health ethical principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals. The approach aims to achieve a balance in protecting the rights of all parties, including those with and without HIV, employers, employees, state and others. This will include obtaining a balance between rights and responsibilities, and between individual protection and co-operation between parties. Employees with HIV should be treated the same as

any other employee. Employees with HIV-related illness, including AIDS, should be treated the same as any other employee with a life-threatening illness.

In its scope, the code should:

1. cover all employees and prospective employees;
2. cover all workplaces and contracts of employment;
3. cover the specific policy components detailed below, viz: job access, workplace testing, confidentiality, job placement, job status, job security, occupational benefits, training, risk reduction, first aid, workers' compensation, education and awareness, prevention programmes, managing illness, protection against victimisation, grievance handling, information, monitoring and review.

SADC member states should ensure that interactions between them are consistent with the principles and policy components of this code and that they share and disseminate information to enable an effective and planned response to the epidemic.

Policy development and implementation is a dynamic process so that the code on AIDS and employment should be:

1. communicated to all concerned;
2. routinely reviewed in the light of epidemiological and scientific information;
3. monitored for its successful implementation and evaluated for its effectiveness.

3. Policy Components

1. Education, awareness and prevention programmes

1. Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should where possible incorporate employee families.

2. Essential components of prevention programmes are information provision, education, prevention and management of STDs, condom promotion and distribution and counselling on high risk behaviour. Workplace AIDS programmes should co-operate with and have access to resources of National AIDS Programmes.

2. Job access

There should be no direct or indirect pre-employment test for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV. Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions related to the assessment of risk behaviour should not be permitted.

3. Workplace testing and confidentiality

1. There should be no compulsory workplace testing for HIV. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with informed consent of the employee in accordance with normal medical ethical rules and with pre- and post-test counselling.
2. Persons with HIV or AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of her/his HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's written consent.
3. Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by the law, ethics, the code or from the employee concerned.

4. Job status

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

5. HIV testing and training

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical conditions.

6. Managing illness and job security

1. No employee should be dismissed merely on the basis of HIV status, nor should HIV status influence retrenchment procedures.
2. Employees with HIV-related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions.
3. HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When the employee becomes too ill to perform their agreed functions the standard benefits and conditions and standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

7. Occupational benefits

1. Government, employers and employee representatives should ensure that occupational benefits are non-discriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefit schemes should make efforts to protect the rights and benefits of the dependents of deceased and retired employees.
2. Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.
3. Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.
4. Counselling and advisory services should be made available to inform all employees on their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums to these funds.

8. Risk management, first aid and compensation

1. Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work.
2. Employees who contract HIV infection during the course of their employment should follow standard compensation procedures and receive standard compensation benefits.
3. Under conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependents.
4. People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

9. Protection and against victimisation

1. Persons affected by or believed to be affected by HIV or AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.
2. Where employers and employees agree that there has been adequate information and education and provisions for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

10. Grievance handling

Standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV-related grievances. Personnel dealing with HIV-related grievances should protect the confidentiality of the employee's medical information.

11. Information

Government should collect, compile and analyse data on HIV/AIDS, sexually transmitted diseases and tuberculosis and make it available in the public domain. SADC member states should co-operate in making available national data for monitoring and planning an affective response to the regional health, human resource, economic and social impact of the AIDS epidemic.

12. Monitoring and review

Responsibility for monitoring and review of the code and its implementation should lie with the parties to the tripartite at national and regional level and with the SADC Employment and Labour Sector.

Annexure D: Maseru Declaration on HIV/AIDS (2003)

Preamble

WE, the Heads of State or Government of:

The Republic of Angola
The Republic of Botswana
The Democratic Republic of Congo
The Kingdom of Lesotho
The Republic of Malawi
The Republic of Mauritius
The Republic of Mozambique
The Republic of Namibia
The Republic of Seychelles
The Republic of South Africa
The Kingdom of Swaziland
The United Republic of Tanzania
The Republic of Zambia
The Republic of Zimbabwe

RECOGNISING that the objectives of the Southern African Development Community are inter alia, to:

- (a) Promote sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation with ultimate objective of its eradication;
- (b) Combat HIV/AIDS and other deadly and communicable diseases;
- (c) Mainstream gender in the process of community and nation building;

RECOGNISING the commitments made by SADC Member States in the Abuja and UNGASS Declarations on the need to fight HIV/AIDS and other communicable diseases such as Malaria and Tuberculosis;

CONFIRMING that the SADC HIV/AIDS Strategic Framework (2000-2004) approved by the SADC Council of Ministers in 2000 showed that State parties are committed to combating the HIV/AIDS pandemic through effective regional collaboration, mutual support and the participation of all key stakeholders;

CONVINCED that halting and rolling back HIV infection constitutes a top priority in the SADC Agenda and is an integral part of the regional programme for eradicating poverty;

FURTHER CONVINCED that our regional efforts in combating HIV/AIDS constitute an essential part of the continental response to the HIV/AIDS pandemic as contained in the Abuja Declaration (2001) on HIV/

AIDS, Tuberculosis and other Related Infectious Diseases and in the New Partnership for Africa's Development (NEPAD - 2001);

WELCOMING AND REAFFIRMING the commitments on HIV/AIDS contained in the United Nations Millennium Declaration (September 2000) and United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration (June 2001), and the United Nations General Assembly Declaration on Children.

DEEPLY CONCERNED THAT Sub-Saharan Africa, in particular the SADC Region, is currently the worst affected in the world by the HIV/AIDS pandemic as demonstrated by the rapid spread of the HIV infection, the heavy burden of illness and millions of deaths caused by HIV/AIDS, and that in Southern Africa in particular, the recent adverse humanitarian crisis resulting from the adverse climatic conditions, was exacerbated by the severe HIV/AIDS pandemic;

NOTING WITH PROFOUND CONCERN THAT the HIV/AIDS pandemic is reversing the developmental gains made in the past decades and is posing the greatest threat to sustainable development of the region due to loss of the most productive individuals in all sectors of our economies, decline in productivity, diversion of scarce resources from production to the care and support of the HIV/AIDS infected and affected persons, as well as mitigating the effects on various sectors, and resulting in an increase in the number of orphans and the disruption of family structures;

RECOGNISING THAT the principal contributory factors to the spread of HIV/AIDS are extreme poverty, ignorance, negative attitudes and practices, and that the general underdevelopment and unfavourable international economic environment reflected in high indebtedness of some of the SADC Member States, limited access to international markets and declining official development assistance, further aggravate the pandemic;

FURTHER RECOGNISING THAT inadequate food security, poor nutrition, inadequate essential public services, limited reproductive health services, gender imbalances and high levels of illiteracy impact negatively on the quality of life of people living with HIV/AIDS;

RECOGNISING THAT:

- (a) The HIV/AIDS pandemic can be curbed, and that within the SADC region there have been some successes and best practices in changing behaviour, reducing new HIV infections and mitigating the impact of the HIV/AIDS pandemic, and that these successes need to be rapidly scaled up and emulated across the region;
- (b) HIV/AIDS is best tackled through multi-sectoral interventions aimed at poverty eradication, which include the promotion of socio-

economic development, fostering positive cultural attitudes and practices, gender equity, and undertaking specific health and nutritional interventions as well as programmes to combat the abuse of alcohol and illicit drugs;

(c) The upholding of human rights and fundamental freedoms for all including prevention of stigma and discrimination of People Living With HIV/AIDS (PLWHA) is a necessary element in our regional response to the HIV/AIDS pandemic, which would encompass access, inter alia, to education, inheritance, employment, health care, social and health services, prevention, support, treatment, legal protection, while respect for privacy and confidentiality will be upheld, and strategies would be developed to combat stigma and social exclusion connected with the pandemic;

(d) Partnerships with all stakeholders including civil society, cultural and faith-based organisations, tripartite social partners, Non-Governmental Organisations, traditional health practitioners, the private sector, international institutions, cooperating partners and the media are vital if, WE, are to succeed in our key intervention areas such as HIV surveillance, prevention, treatment, care, support, monitoring, research, nutrition, poverty eradication and adequate resource mobilisation for combating the HIV/AIDS pandemic.

THEREFORE:

REAFFIRM our commitment, to the combating of the AIDS pandemic in all its manifestations, as a matter of urgency through multisectoral strategic interventions as contained in the new SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007; and DECLARE the following as the priority areas requiring our urgent attention and action:

1. Prevention and Social Mobilisation by:

(a) Reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values, positive behavioural change and promoting responsible sexual behaviour;

(b) Intensifying the provision of comprehensive, affordable and user-friendly reproductive health services to youth, men and women and ensuring that essential commodities such as male and female condoms are made available;

(c) Strengthening initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

(d) Promoting and strengthening programmes for the youth aimed at creating opportunities for their education, employment and self-

expression, and reinforcing programmes to reduce their vulnerability to alcohol and drug abuse;

(e) Rapidly scaling up the programmes for the Prevention of Mother-to-Child Transmission of HIV, and ensuring that levels of uptake are sufficient to achieve the desired public health impact;

(f) Scaling up the role of education and information in partnership with all key stakeholders including the youth, women, parents, the community, health care providers, traditional health practitioners, nutritionists and educators as well as integrating HIV/AIDS education in both the ordinary and extra curricula at all levels of education, including primary and secondary education;

(g) Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed forces, and consider ways of using personnel from these services to strengthen awareness and prevention initiatives.

2. Improving Care, Access to Counselling and Testing Services, Treatment and Support by:

(a) Strengthening health care systems, especially public health;

(b) Strengthening family and community based care as well as support to orphans and other vulnerable children;

(c) Facilitating the expansion of workplace programmes on HIV/AIDS prevention and management among all levels of the workforce, supported by appropriate policy and legal frameworks;

(d) Development of service and caring capacity among all people caring for the HIV/AIDS infected persons, including the home based care providers, as well as upgrading of diagnostic and related technologies;

(e) Expanding access to voluntary counselling and testing;

(f) Preventing and removing stigma silence, discrimination, and denial which continue to hamper and undermine HIV control efforts, particularly, towards the people living with HIV and AIDS;

(g) Putting in place national legislation and regional legal regimes to ensure the availability of technologies and drugs at affordable prices for treatment, including bulk purchasing of drugs and manufacturing of generic medicines in the region;

(h) Increasing access to affordable essential medicines, including ARVs and related technologies, through regional initiatives for joint purchasing of drugs, with the view of ensuring the availability of drugs through sustainable mechanisms, using funds from national budgets;

(i) Investing in nutrition programmes and promoting the use of nutritional supplements, production and consumption of locally available foods;

(j) Developing a regulatory framework and institutional capacity for the testing and utilisation of traditional medicines.

3. Accelerating Development and mitigating the impact of HIV/AIDS by:

- (a) Creating and sustaining an enabling environment conducive to gender-balance, rapid and broad-based socio-economic development of the Region and addressing major underlying factors that lead to the spread of the HIV infection;
- (b) Harmonising policies and strategies and undertaking joint programmes in the priority intervention areas including prevention, treatment, care, support, nutrition and food security;
- (c) Enhancing the regional initiatives to facilitate access to HIV/AIDS prevention, treatment, care and support for people living along our national borders, including sharing of best practices;
- (d) Mainstreaming and factoring HIV/AIDS in our regional integration process and focal intervention areas, particularly in the areas of trade liberalisation, infrastructure development, food security, social and human development;
- (e) Evaluating the economic and social impact of the HIV/AIDS epidemic and developing multi-sectoral strategies to address the impact at individual, family, community, national and regional levels;
- (f) Establishing mechanisms for mitigating the impact of the HIV/AIDS pandemic, including the provision of support to families, orphans and other vulnerable children, and strategies to ensure a sustained labour supply.

4. Intensifying Resource Mobilisation by:

- (a) Establishing a Regional Fund for the implementation of the SADC HIV/AIDS Strategic Framework (2003-2007);
- (b) Reaffirming our commitment to implementing the Abuja Declaration on allocating at least 15% of our annual budgets for the improvement of the health sector;
- (c) Urging the International Cooperating Partners, on humanitarian grounds, to assist our region by substantially increasing the provision of financial and technical support at country and regional levels through various initiatives and commitments such as the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), Official Development Assistance, the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative; and the Multicountry AIDS Programme (MAP);
- (d) Developing and strengthening mechanisms to involve all stakeholders, such as civil society organisations, the private sector, organised labour and business to contribute towards financing HIV/AIDS programmes;
- (e) Establishing simplified mechanisms for the timely disbursement of funds to the operational level, ensuring that all communities have adequate access to these funds.

5. Strengthening Institutional, Monitoring and Evaluation Mechanisms by:

- (a) Developing and strengthening institutional mechanisms for HIV surveillance, sharing of experiences and exchange of information on key areas of interventions such as prevention, provision of care to, and support of, HIV/AIDS infected and affected persons and treatment of HIV/AIDS-related conditions;
- (b) Intensifying training and research initiatives or programmes to strengthen Member States' capacities to manage the epidemic;
- (c) Developing and strengthening appropriate mechanisms for monitoring and evaluating the implementation of this Declaration, and other continental and global commitments, and establishing targets and time-frames which will be included in the SADC HIV/AIDS Strategic Framework and Programme of Action (2003 - 2007).

Background on authors

Patrick M Eba holds a *Maîtrise de Droit Public* from the University of Abidjan-Cocody (Côte d'Ivoire), and the degree LLM (Human Rights and Democratisation in Africa) from the Centre for Human Rights, Faculty of Law, University of Pretoria (2004). In 2006, he worked as a researcher for the Health and Population Committee of the Parliament of Malawi and was involved in research on HIV/AIDS and human rights in Malawi. After completing the research for this publication, he embarked on further studies.

Nyasha C Chingore is a professional assistant for Chingore and Garabga Legal Practitioners, a firm in Harare. She graduated with the degree LLM (Human Rights and Democratisation in Africa) at the Centre for Human Rights, Faculty of Law, University of Pretoria (2005), and holds a Bachelor of Laws (Honours) degree from the University of Zimbabwe (2004). As part of her studies, Nyasha was part of a clinical group that assisted in drafting HIV/AIDS legislation for Southern African countries, wrote the first draft of a policy document on confidentiality and privacy in healthcare in Egypt, and prepared legal drafts on testing and access to treatment for HIV/AIDS and hepatitis C in the Middle East for the Egyptian Initiative for Personal Rights.

Babafemi Odunsi holds a Bachelor of Laws Degree (LLB (Hons) Ife) and Master of Laws Degree (LLM) both from the Obafemi Awolowo University, Ile-Ife Nigeria. He also holds a Barrister at Law (BL) professional qualification of the Nigerian Law School, Lagos, Nigeria as well as a Master of Laws (LLM) Degree of the University of Toronto, majoring in Reproductive and Sexual Health Law as a MacArthur Fellow. He is Barrister and Solicitor of the Supreme Court of Nigeria. He teaches at the Faculty of Law, Obafemi Awolowo University, Ile-Ife, Nigeria, from where he has taken time off to participate as a Research Associate in the AIDS, the Law and Human Rights in Southern Africa: Defining New Debates and Strategies research project for the Centre for Human Rights and Centre for the Study of AIDS, University of Pretoria, South Africa. As an academic and a researcher he has engaged in several research works on HIV/AIDS and human rights.

Dorothy Mushayavanhu holds a Master's Degree in Law and Development (LLM) (University of London at the School of Oriental Studies) specialised in International Environmental Law, Law and Development and Human Rights in the Developing World. She is a former lecturer in International Environmental Law and Public International Law, Department of Public Law in the Faculty of Law, University of Zimbabwe (UZ). She has done extensive research (desk reviews and field work) areas that include in international environmental issues; land reform, gender, human rights, HIV/AIDS and the Law; Law and Development. She has drafted the Draft Environmental Policy (Zimbabwe), the Draft national Biotechnology Bill (Zimbabwe) and draft *sui generis* legislation of protecting indigenous knowledge systems, plant breeders' rights and farmer's rights. She has worked with various government departments, NGOs, International Organisations and local communities in the last 16 years; and was the former Senior Programme Officer with the Commonwealth Secretariat in London on the Democratisation of South Africa.

Information on the AIDS and Human Rights Research Unit

The AIDS and Human Rights Research Unit (AIDS Research Unit or Unit) was founded as a collaboration between the Centre for the Study of AIDS (CSA) and the Centre for Human Rights (CHR), both based at the University of Pretoria. Launched in 2005, the AIDS Research Unit promotes research that situates HIV and AIDS within a rights-based framework, adopting a rights-based approach. Through this research new questions are asked, new explanations and knowledge are sought, new understandings of the epidemic and effective responses generated and new formulation of international trade regimes, policy and programmes developed.

The Unit has been involved in numerous projects.

As consultant to the Gauteng Provincial Legislature (GPL), the Unit prepared a study on 'mainstreaming' HIV and AIDS into the GPL's oversight function. In 2007, the AIDS Research Unit became the first 'consultant group' to address a meeting of members of the GPL on our research findings. Efforts to establish effective oversight by the GPL on HIV and AIDS are ongoing.

The Unit was also involved in the preparation of a research paper on the rights of vulnerable children in the context of HIV and AIDS in Southern Africa. The research was undertaken by research associates in eight Southern African countries, and written up by the Unit. The report has been published as *Legal and policy frameworks to protect the rights of vulnerable children in Southern Africa* (2006). The project was sponsored by Save the Children UK.

Based on field research about HIV stigma in the Hammanskraal community, north of Tshwane, the Unit commissioned a number of papers that were collected in the publication F Viljoen (ed) *Righting stigma: Exploring a rights-based approach to addressing stigma* (2005, Centre for the Study of AIDS, UP). This research formed part of a continuing project of the CSA, and was accomplished with funding from the Norwegian government. This project, focusing on stigma, also led to the training and deployment of para-legals in the Hammanskraal community, in which the Unit participates.

The Unit also conducted research on the issue of 'routine testing', organising a one-day conference on the campus, and presenting a paper at an international consultation on the topic in Montreal, Canada.

With the co-operation of country-based researchers, the Unit prepared a desk study on the legal responses to HIV and AIDS in 22 countries in Southern and East Africa, and assisted in conducting a

workshop for 'change agents' from these countries. This project was sponsored and initiated by the UNDP, in collaboration with the OHCHR.

In addition to the four research papers contained in this volume, OSISA also financed comprehensive reports about HIV, AIDS and the law in nine Southern African countries. A publication containing these country reports (AIDS and Human Rights Research Unit, *Human rights protected? Nine Southern African country reports on HIV and the law*) emanated in tandem with the publication *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa*.