HUMAN RIGHTS PROTECTED? NINE SOUTHERN AFRICAN COUNTRY REPORTS ON HIV, AIDS AND THE LAW

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Human rights protected? Nine Southern African country reports on HIV, AIDS and the law

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Preface

Human rights protected? Nine Southern African country reports on HIV, AIDS and the law builds on *HIV/AIDS and human rights in Southern Africa*, an analysis of the situation of HIV, AIDS and human rights in Southern Africa, undertaken by the Centre for the Study of AIDS (CSA) in 2002.[1] The present publication takes these reports further by expanding the countries examined, updating the reports, and amending them to incorporate country-specific information on the four debates presented in *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa*, an accompanying publication by the AIDS and Human Rights Research Unit (Unit) of the CSA and the Centre for Human Rights (CHR). The four issues of particular concern with respect to the protection of human rights, which were incorporated into these updated reports are: the criminalisation of the wilful transmission of HIV; routine testing; the restriction of prisoners' access to prevention and treatment; and the limitations on access to HIV and AIDS-related medicines.

In order to update the existing reports, researchers were identified from existing networks in each of the nine countries under discussion. A questionnaire was developed by the Unit, which was used by the researchers in order to guide the research and to ensure consistency in the nature of information gathered. The responses were then collated by the Unit and are published here. As far as possible, the updated reports set out the position of HIV, AIDS and the law in the respective countries as of 31 July 2007. This report may be read in conjunction with the AIDS and Rights Alliance of Southern Africa (ARASA) research report *HIV/AIDS and human rights in SADC: An evaluation of the steps taken by countries within the SADC region to implement the International Guidelines on HIV/AIDS and Human Rights*, released at the end of 2006 (see http://www.arasa.info). The ARASA report is broader in its regional scope, as it focuses on all 14 SADC countries, but also narrower in its substantive ambit, as it limits itself to the *International Guidelines*.[2]

South African judge and HIV activist, Edwin Cameron, noted that the role of the law in a public health crisis should be 'to contain the epidemic and to mitigate its impact'.[3] In other words, he states, the law 'should aim to save the uninfected from infection and to protect the infected from the unjust consequences of public panic'.[4] Is the law offering this kind of protection in the face of the HIV epidemic? Acknowledging that the most effective way to ensure the protection of human rights is to enshrine international norms in national constitutions and national legislation, this publication examines this

1 See http://www.csa.za.org

2 See also A Strode and B Grant 'A critical review of the extent to which the HIV/AIDS and Human Riglopment Community' (2007) *Obiter* 70.

3 E Cameron 'Using the law in the HIV pandemic: sword or shield' Lecture at Birkbeck College, London 28 June 2007 http://www.nat.org.uk/document/307 (accessed 30 August 2007).

4 As above.

question with respect to nine Southern African countries: Botswana, Lesotho, Malawi, Namibia, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe. While the findings note that these countries are by no means ignoring the epidemic and the many human rights threats and violations that accompany it, the response tends to be focused at policy rather than legislation.

The information presented in the reports is comprehensive, covering, for example, a general background on each country, international human rights law, case law, HIV and AIDS policy, the rights of vulnerable groups, and criminal law. Common threads emerge with respect to the nine countries in the form of weaknesses or gaps in the response to the epidemic in terms of human rights. As was hypothesised at the conceptualisation of the publication, some of these trends have proven to correspond and support the debates mentioned above and presented in *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa.*

For example, with respect to prisoners' rights and HIV and AIDS, a debate explored in the above-mentioned publication, the reports reveal that only South Africa, Lesotho and Mozambique distribute condoms in prisons – at least in theory or from time to time. In the other countries surveyed, condoms are not made available to prisoners so as not to encourage sexual relations between men, a crime in all the countries but South Africa. In most of the cases, prisoners do not have access to ARVs administered in the prisons at government expense and where such is provided for, there is a conflict between policy and practice. For example, in South Africa, failure to implement legislation related to the provision of ART forced 15 inmates of the Westville prison in Durban and the Treatment Action Campaign to take legal action against the prison and the South African government in order to demand access to ART.

Another common thread uncovered in the reports is inadequate legal protection afforded to women and a subsequent failure to address one of the root causes of the HIV epidemic. While in all of the countries examined equality on the basis of sex is enshrined in the Constitution, customary law exists and, in some cases, takes precedence over the constitutional provision of equality. The reports also refer to the many customary practices that are still respected and which can potentially contribute to the spread of HIV, such as polygamy, wife inheritance, widow cleansing, and child marriage. Reflective of a gross underestimation of the link between domestic violence and HIV transmission, less than half of the countries (Malawi, Zimbabwe, Namibia, and South Africa) have specific legislation prohibiting domestic violence. Enacting domestic violence legislation should be a priority in the response to the pandemic.

A striking feature of the reports is the discordance between policy, legislation, and practice. In all of the countries, AIDS policies exist, alongside policies relating to testing, treatment, and orphans and other vulnerable children, for example. In many cases, these policies have been clearly influenced by the International Guidelines on HIV/AIDS and Human Rights. The policies, while commendable and demonstrative of political recognition of the severity of the epidemic and the threat to human rights that it presents, lack mechanisms for

accountability and as such, in certain respects, rather pay lip service to action. While policy development is a necessary step in addressing the epidemic, it can often give the impression that political will is greater than what the situation on the ground presents. For example, pre- and post-test counselling features in all testing policies and guidelines yet in practice it is rarely carried out effectively, if at all.

On the other hand, the reports show a need for increased legislation specific to HIV and AIDS which would not only complement existing policies but provide for strengthened government accountability whereby victims of human rights violations in the face of the epidemic are empowered to seek legal redress for injustices incurred. Through dissemination to both civil society and policy makers, it is hoped that *Human rights protected? Nine Southern African country reports on HIV, AIDS and the law* will serve as a tool to assist those involved in advocacy as well as government stakeholders to agitate for legislation towards increased human rights protection in the context of the HIV pandemic.

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- Susan Precious, co-author of the South Africa report
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September 2007

List of frequently used acronyms and abbreviations

AIDS	-	Acquired Immunodeficiency Syndrome
ACHPR	-	African Charter on Human and Peoples' Rights
AHRLR	-	African Human Rights Law Reports
ART	-	Anti-retroviral treatment
ARV	-	Anti-retroviral
CD4	-	Cluster of differentiation 4
CEDAW	-	Convention on the Elimination of all forms of Discrimination against Women
CRC	-	Convention on the Rights of the Child
FGM	-	Female genital mutilation
HIV	-	Human Immunodeficiency Virus
HTC	-	HIV testing and counselling
ICCPR	-	International Covenant on Civil and Political Rights
ICESCR	-	International Covenant on Economic, Social and Cultural Rights
IEC	-	Information Education Communication
IGBRIHS	-	International Guidelines for Biomedical Research Involving Human Subjects
MDG	-	Millennium Development Goals
NAC	-	National AIDS Commission
NGO	-	Non-Governmental Organisation
NHRI	-	National Human Rights Institution
NTTC	-	National Teachers Training College
OSISA	-	Open Society Initiative for Southern Africa
PLHA	-	People living with HIV and AIDS
PEP	-	Post-exposure prophylaxis
PMTCT	-	Prevention of Mother-to-Child-Transmission
PSI	-	Population Service International
STD	-	Sexually transmitted disease
STI	-	Sexually transmitted infection
TB	-	Tuberculosis
TRIPS	-	Trade-Related Aspects of Intellectual Property Rights
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNGASS	-	United Nations General Assembly Special Session on HIV/ AIDS
UNICEF	-	United Nations Children's Education Fund
UHT	-	Universal HIV testing
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation
WTO	-	World Trade Organisation

1 HIV, AIDS and the law in Botswana

1. Background to country

1.1 First AIDS case

Doctors at the Princess Marina Hospital in Gaborone documented the first AIDS case in 1985.[1] The patient was infected with HIV through sexual intercourse. The information was treated confidentially without revealing the identity of the person.

1.2 Demography

The total population of Botswana is estimated to be 1 800 000 in 2007.[2] UNAIDS estimates the national HIV prevalence rate among adults aged 15 to 49 at 24.1 per cent.[3] According to the 2005 Botswana HIV/AIDS Sentinel Surveillance Technical Report based on the Botswana AIDS Impact Survey 2004 (BAIS II), the prevalence rate among women aged 15 to 19 is 17.8 per cent and 30.6 per cent for women aged 20 to 24.[4] The national prevalence rate gathered through BAIS II is much lower than the UNAIDS estimate at 17.1 per cent (19.8 per cent females and 13.9 per cent males) of the population aged 18 months to 64 years.[5] The discrepancy may be attributed to the method of data collection; UNAIDS based its findings on sentinel surveillance studies on pregnant women attending antenatal clinics, while the BAIS II is a household survey designed to test a sample of the general population.[6]

There are approximately 270 000 people living with HIV.[7] The rate of infection is higher for females than for males. Among 260 000 adults aged 15 and over living with HIV, 140 000 are women.[8] Among adult females (aged 25 - 29) the prevalence rate is 40.8 per cent whereas adult males of the same age range have a prevalence rate of

1 National Policy on HIV/AIDS (1998) 2; also see PA Watson (ed) *The front line in the war against HIV/AIDS in Botswana: Case studies from the African Comprehensive HIV/AIDS Partnership* http://www.achap.org/downloads/War per cent20Against per cent20HIV_Aids.pdf (accessed 1 August 2006) 6.

2 UNFPA *State of the world population 2007: Unleashing the potential of urban growth* (2007) 90.

3 UNAIDS '2006 Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.

4 T Smart 'Prevalence among young women in Botswana falls to lowest level since early 1990s, but still high' *AIDSmap news* 28 September 2006 http://www.aidsmap.com/en/news/F9AEAA98-D76B-49D0-BCE7-37B081FC2979.asp (accessed 22 January 2007).

5 National AIDS Coordinating Agency (NACA) & Central Statistics Office (CSO) *Botswana AIDS Impact Studies II (BAIS II) 2004* (2005).

6 As above, xviii.

7 As above.

8 As above.

20.9 per cent. The 2005 Sentinel Survey shows HIV prevalence among pregnant women (15 - 49 years) to be 33.4 per cent.[9]

Males and females living in towns constitute the highest proportion of HIV-positive persons. A 2005 sentinel survey indicated a 39.9 per cent prevalence rate among persons cohabiting, 35.7 per cent among single persons and 27.9 per cent among married couples.[10]

In 2004, the percentage of people aged 15 - 24 years who were HIV positive was 16.9 per cent. In the 25 - 49 age group, the prevalence rate was estimated to be 34.4 per cent.[11]

There is no information on the number of sex workers, intravenous drug users or homosexuals who are HIV positive.

Of seven specified known causes of death (tuberculosis (TB) AIDS, heart disease, stroke, accident, violence and malaria), TB and AIDS are the leading reported causes of death in rural areas at 18 per cent and 11.6 per cent, respectively. In urban areas, the leading reported causes of death are tuberculosis and heart disease.[12] The TB prevalence rate in Botswana is 553 persons per 100 000.[13] TB cases combined with HIV-positive status among adults (15 - 49 years) is 77 per cent.[14]

In 2002, it was estimated that 138 000 people had died of AIDS and that by 2010, an additional 263 000 are likely to die if not given anti-retroviral treatment (ART).[15]

In 2005, there were 120 000 children (0-17 years old) who had lost one or both parents to AIDS.[16]

9 Ministry of Health '2005 Second Generation HIV/AIDS Sentinel Surveillance' (2005) 6.
10 NACA *Botswana HIV/AIDS Response Information Management System (BHRIMS)* (2005).
11 NACA & CSO (n 5 above).
12 As above.
13 UNDP 'Human development report 2006: Beyond scarcity: Power, poverty and the global water crisis' (2006) 313.
14 WHO 'Botswana TB Epidemiological Profile 2005' (2005).
15 NACA 'Government of Botswana Country Report: United Nations Special Session on HIV/AIDS (UNGASS)' (2005).
16 UNICEF 'State of the world's children 2007: Women and children, the double dividend of gender equality' (2007) 114.

2. International human rights treaties

2.1 Ratification status of international human rights treaties[17]

Treaty (entered into force)	Ratification/ accession (deposit)
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	08/09/2000
ICCPR Optional Protocol (23/03/1976)	
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	13/08/1996
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	14/03/1995

2.2 State reports[18]

The record of reporting on international treaties is poor. The initial report on CRC was submitted in January 2003.[19] The concluding observations on the report were adopted in November 2003. Under the heading 'HIV/AIDS' the Committee had the following to say:[20]

> (50) While welcoming the establishment of the National AIDS Council, chaired by the president, the National AIDS Coordinating Council, the National Policy on HIV/AIDS, the Prevention of Mother to Child Transmission Programme and the programme for AIDS orphans, the Committee shares the serious concern of the State party at the still exceedingly high prevalence rate of HIV/AIDS, especially among women in their child-bearing years compounded, in part, by inappropriate traditional practices, stigmatisation and lack of knowledge on prevention methods.
>
> (51) In the light of General Comment No 3 on HIV/AIDS and the rights of children (CRC/GC/2003/3), the Committee urges the State party to strengthen its efforts in combating the spread and effects of HIV/AIDS by, *inter alia*, training professionals, conducting education campaigns on

17 For ratification status, see the website of the Office of the UN High Commissioner for Human Rights (OHCHR) 'Botswana Homepage' http://www.ohchr.org/english/countries/bw/index.htm (accessed 20 January 2007).

18 For the state report and concluding observations see above.

19 Government of Botswana 'Republic of Botswana initial report to the Committee on the Rights of the Child' (CRC/C/51/Add.9) (2003).

20 Committee on the Rights of the Child 'Concluding observations of the Committee on the Rights of the Child: Botswana' (CRC/C/15/Add.242) (2003).

prevention, improving the prevention of mother to child transmission programme, by providing free and universal anti-retroviral medication and improving protection and support for AIDS orphans.

On 2 May 2007, Botswana submitted its initial report to the Human Rights Committee.[21] Under article 6 of the CCPR, related to the right to life, the report mentions HIV and AIDS-related measures adopted by the government of Botswana, namely:[22]

- the initiation of Isoniazid Tuberculosis Preventive Therapy (IPT) for HIV-positive patients who are eligible to prevent them from developing active tuberculosis which is the major cause of mortality; and
- the introduction of a Prevention of Mother to Child Transmission (PMTCT) programme which includes an infant feeding scheme.

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[23]

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	17/07/1986
African Charter on the Rights and Welfare of the Child (29/11/1999)	10/07/2001
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (25/11/2005)	
Treaty of the Southern African Development Community (SADC) (30/09/1993)	07/01/1998
SADC Protocol on Health (14/08/2004)	09/02/2000

3.2 State reports

Botswana has not submitted any state report to the African Commission on Human and Peoples' Rights.

21 Human Rights Committee 'Consideration of reports submitted by states parties under article 40 of the covenant: Initial report of state party due in 2001: Botswana' 2007 http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/aa2fd2212ad9c10ac1257306005173f7/$FILE/G0741511.pdf (accessed 8 September 2007).

22 As above.

23 For ratification status see http://www.africa-union.org and http://www.sadc.int (accessed 10 September 2007).

3.3 Status of international and human rights treaties in domestic law

The status of international and human rights treaties is not specifically addressed by the Constitution.[24] However, according to the common law, customary international law automatically forms part of domestic law subject to statutory modification or abrogation. A dualist approach is adopted in the relationship between international and domestic law in that treaties and conventions form part of domestic law only if incorporated through national legislation. The CRC was referred to in *Mauwe v Taolo*.[25] However, international instruments such as the ICCPR cannot be directly invoked or enforced through the courts and the administration. They must be enacted as part of domestic law before the courts or competent authorities can apply them. There has been no specific legislation implementing treaties ratified.

The institutional arrangement for the implementation of international human rights treaties is initiated by the Ministry of Foreign Affairs on the advice of the Attorney-General Chambers.

3.4 International Guidelines

Stakeholders are aware of the International Guidelines on HIV/AIDS and Human Rights by UNAIDS and Office of the UN High Commissioner for Human Rights. These are reflected as far as possible in policy documents on HIV and AIDS.[26] The Guidelines have not been publicly approved through any public institution.

4. National legal system of country

4.1 Form of government

Botswana is a republican liberal constitutional democracy with an executive president who is both head of state and head of government. The Constitution provides for a unicameral legislature comprising the President and the National Assembly, which is elected every five years by universal adult suffrage. There is an independent judiciary, which has the power of judicial review of executive and legislative actions. The Constitution enshrines a justiciable Bill of Rights fashioned on the Universal Declaration of Human Rights and the European Convention of Human Rights.

24 Constitution of Botswana 1966 (as amended).
25 *Mauwe v Taolo* 2000 1 BLR 297.
26 See National Policy on HIV/AIDS (n 1 above).

4.2 Legal system

The domestic legal system is based on English common law and Roman-Dutch law traditions. The hierarchy of courts consists of Customary Courts, Magistrates' Courts, a High Court and the Court of Appeal. There is a specialised Labour Court (the Industrial Court) which settles trade disputes, and secures and maintains good industrial relations.[27]

4.3 Constitution and Bill of Rights

Botswana has a written constitution which came into effect on 30 September 1966. Chapter II (sections 3 to 19) guarantees the promotion and protection of human rights.[28] The human rights norms in the Constitution are justiciable.[29] The right to non-discrimination is protected under section 15 of the Constitution. It prohibits discrimination based on race, tribe, place of origin, political opinions, colour or creed. However, section 15 does not mention health status explicitly.

4.4 National human rights institutions

There is no national human rights institution.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The department primarily responsible for HIV and AIDS policies and programmes is the Ministry of Health, specifically, the AIDS/Sexually Transmitted Disease (STD) Unit within the Ministry of Health and the National AIDS Council (NAC), chaired by the President of Botswana and co-chaired by the Minister of Health. The NAC was established in 1995 as a multisectoral body involving all sectors and ministries. It integrates representatives from 17 sectors, including civil society and the private and public sectors.

27 See generally EK Quansah *Introduction to the Botswana legal system* (2001).
28 See generally DDN Nsereko *Constitutional law of Botswana* (2001).
29 As above.

The National AIDS Co-ordinating Agency (NACA), created in 1999, oversees the implementation and co-ordination of AIDS programmes and acts as the secretariat of the NAC.[30] It is also responsible for monitoring and evaluation as well as resource mobilisation.[31]

At the community level in Botswana, there are also district multi-sectoral AIDS committees set up in villages. In recent years, these have been strengthened and all districts have district AIDS co-ordinators.[32]

5.2 HIV and AIDS plan

After the Short Term Plan for HIV/AIDS (1987-1988), and the First and Second Medium Term Plans (1989-1997 and 1997-2002), the National Strategic Framework for HIV/AIDS currently guides Botswana's response to HIV and AIDS for the period 2003-2009. The National Strategic Framework was the result of significant consultation with the UNDP, civil society, communities and other stakeholders. The revisions move beyond merely a health response and place the HIV epidemic within a broader development context, requiring immediate emergency attention.[33] The five key goals for the period are:

- prevention of HIV infection;
- provision of care and support;
- strengthened management of the national response to HIV/AIDS;
- psycho-social and economic impact mitigation; and
- provision of a 'supportive, ethical, legal and human rights based environment conforming to international standards'.[34]

A mid-term review of the National Strategic Framework for HIV/AIDS was undertaken in 2006. Amongst other things, the review looks at stakeholder satisfaction and monitoring, evaluation and information management.[35]

30 NACA was established in 1999 by a cabinet directive under the Office of the President, charged with co-ordinating and facilitating the country's response to the HIV/AIDS epidemic.

31 n 15 above, 17.

32 C Stegling 'Botswana's HIV/AIDS Programme' in Interfund (ed) 'Development Update: From disaster to development? HIV and AIDS in Southern Africa' (2005) 5 *Development Update* 231.

33 As above, 231-232.

34 National Strategic Framework for HIV/AIDS quoted in Molatlhegi & Associates *Review of Laws and Policies Relating to HIV/AIDS* (2005) A1.

35 Molomo enlists journalists' *Daily New Online* 22 May 2006 http://www.gov.bw/cgi-bin/news.cgi?d=20060522&i=Molomo_enlists_journalists (accessed 21 June 2006).

5.3 Legislation

There is no specific HIV and AIDS legislation. However, the Medical Council (Professional Conduct) Regulations[36] and the Penal Code have been amended to include provisions relating to HIV (see sec 6.3 and sec 13.1 below).

5.4 HIV and AIDS policy

The government established an AIDS/STD Unit in the Ministry of Health to co-ordinate the AIDS Control Programme. A National Policy on HIV/AIDS was prepared and adopted through a Presidential Directive in 1993 and revised in 1998.[37] The Policy provides a guide and framework for a national multi-sectoral response to the HIV epidemic. The overall strategies of the National Policy on HIV/AIDS are:

- prevention of HIV and other sexually transmitted infections (STIs);
- reduction of the personal and psycho-social impact of HIV/AIDS and STIs;
- mobilisation of all sectors, and of communities, for HIV/AIDS prevention and care;
- provision of care for people living with HIV; and
- reduction of the socio-economic consequences of HIV/AIDS and STIs.

The National Policy on HIV/AIDS is used to guide all actors in HIV prevention and care, including government ministries at policy-making and operational levels, non-governmental and community organisations, parastatal and private sector organisations and enterprises, and members of the community. External support organisations providing financial and technical assistance for all AIDS-related activities do so within the framework of the National Policy on HIV/AIDS.

The Prevention of Mother-to-Child-Transmission (PMTCT) Programme was introduced in 1998 and launched in April 1999 in the cities of Gaborone and Francistown and by November 2000, it was extended to the rest of the country. The PMTCT Programme is providing drugs to 73 per cent of pregnant women who are HIV positive.[38] Services under the programme include counselling, testing, taking blood, educating the patient on PMTCT, tracing partners, enrolling pregnant patients and monitoring these patients

36 Medical Council (Professional Conduct) (Amendment) Regulations 77 of 1999.
37 n 1 above.
38 Honourable Baledzi Gaolathe 'Republic of Botswana Budget speech 2006' 6 February 2006 http://www.gov.bw/docs/BudgetSpeech2006.pdf (accessed 23 January 2007).

up until 34 weeks when they are referred to a hospital. At 34 weeks, pregnant women are provided with Anzidothymidine (AZT) until the time of delivery, at which point, they are transferred to the National Anti-retroviral Drug Programme (National ARV Programme) if their viral load is below 200.[39]

At the same time, HIV-positive babies are provided with AZT syrup for four weeks, starting eight to ten hours after birth. Cotrimaxazole is administered to the baby from six weeks of age until at least 12 months. Free infant formula is provided for 12 months. The babies are tested for HIV between 18 and 24 months.[40]

There were 634 PMTCT programme sites countrywide in February 2005. At the end of September 2004, the PMTCT Programme recorded the highest proportion of new antenatal clinic clients (10 598) tested for HIV. Of the new clients, 82.1 per cent tested for HIV, compared to 74.4 per cent and 71.3 per cent in January to March and April to June, respectively.[41]

In 2000, Voluntary Counselling and Testing centres (VCT, called 'Tebelopele') were established through a partnership between the government of Botswana and USA (BOTUSA), including the Botswana collaboration between the Ministry of Health, Population Services International (PSI), the US Embassy Office of Defence Corporation and others. The vision of Tebelopele is 'working towards an HIV/AIDS-free Botswana by empowering individuals and couples to make positive decisions about their future' through its mission 'to provide quality, accessible, confidential and immediate voluntary HIV counselling and testing services throughout Botswana'.[42]

As of 31 December 2004, 16 VCT centres were in place countrywide. They recorded a total of 14 218 first-time testers. Of these, 98.4 per cent received pre-test counselling, and 100 per cent received post-test counselling.[43]

In 2004, Botswana introduced a routine but non-compulsory HIV testing policy. HIV testing is made routine for the general public and pregnant women seeking health services in government health facilities.[44] People are tested routinely but may 'opt-out' by stating that they do not wish to be tested. More than 180 district trainers from 21 of the 24 health districts in the country have received training on performing rapid HIV tests. These trainers are expected to train all

39 'PMTCT' (2004) 1/4 *Newsletter.*
40 As above.
41 See NACA (n 10 above) 7. Of 10 598 new clients, 8 696 were tested and 2 778 were found to be HIV positive.
42 See generally PSI Botswana 'Tebelopele VCT Centres Marketing Plan Outline' (2003).
43 NACA (n 10 above).
44 Government of Botswana 'Guidelines for Routine HIV Testing' (2004).

the health workers in their respective districts. Currently, 280 public facilities are providing routine HIV testing.[45]

The government employment practice requires non-citizens to undergo compulsory HIV testing as a condition for employment. Government-sponsored students who are going to study abroad are required to undergo compulsory HIV tests. A number of private sector employers (for example, Debswana) also require compulsory HIV testing.[46] There is also compulsory testing for all accused persons convicted of rape.[47]

There are no policies denying access to HIV and AIDS-related treatment on the basis of 'immoral' sexual or social behaviour.

5.5 Court decisions

The High Court and the Court of Appeal normally deal with questions relating to HIV and AIDS and human rights (see sec 8, 10.1 and 13.1 below for a discussion of important court decisions relating to HIV and human rights in Botswana).

6. Access to health care

6.1 Government regulation of access to health care

The Constitution does not expressly provide for the right to health. However, section 4 guarantees the right to life, and as the Human Rights Committee has observed in relation to article 6 of the ICCPR, this can be understood in a broad way to include measures that State parties must take to 'increase life expectancy' and 'eliminat[ing] malnutrition and epidemics'.[48]

The Public Health Act[49] (as amended) also does not expressly provide for the right of access to health care. It places, however, an obligation on the Ministry responsible for health to 'carry out activities that could contribute to the realisation of the right to health.'[50] Neither the National Health Policy nor the National Policy on HIV/AIDS expressly recognises the right to health.

Treatment of foreign nationals remains a particular concern, and in this regard Botswana 'fails to comply with its international

45 Botswana - USA Collaboration on AIDS (BOTUSA) 'Annual report 2004' (2004).
46 Molatlhegi & Associates 'Draft final report, consultancy to review laws and policies relating to HIV/AIDS' (2005) 57.
47 As above, para 5.3.
48 Human Rights Committee, quoted in Molathegi & Associates (n 46 above) 9.
49 Public Health Act 44 of 1971.
50 Molathegi & Associates (n 46 above) 9.

obligations assumed through international agreements such as the African Charter on Human and Peoples' Rights'.[51]

The government established an AIDS/STD Unit in the Ministry of Health to co-ordinate the AIDS Control Programme.[52]

The African Comprehensive HIV/AIDS Partnership (ACHAP), which is a joint initiative between the government of Botswana, the Bill & Melinda Gates Foundation and Merck & Co Inc, has been established to prevent and treat HIV in Botswana. The focus of the ACHAP is the support of the goals of the Government of Botswana to prevent HIV infection and to significantly increase the rates of diagnosis and treatment of HIV by rapidly advancing prevention programmes, healthcare access, patient management and treatment of HIV. The Bill & Melinda Gates Foundation and the Merck Company Foundation will each dedicate $50 million over five years towards the project. Merck is also donating ARVs for the appropriate treatment programmes developed by the government of Botswana in accordance with nationally approved guidelines for the duration of the programme.[53]

The NACA has the key responsibility to manage and co-ordinate the implementation of the National Policy on HIV/AIDS and National Strategic Framework for HIV/AIDS. In discharging this responsibility, NACA is enjoined to ensure the concerted multi-sectoral action of all ministries, sectors, districts and civil society organisations, including non-governmental, community and faith-based organisations, associations of people living with HIV and the private sector.

6.2 Ethical guidelines

The Botswana Medical Council (Professional Conduct) Regulations provide general ethical guidelines for medical doctors and dentists. Article 21, for example, guarantees a right to confidentiality to patients and generally prohibits medical practitioners from revealing a patient's medical condition. However, there are three narrow exceptions to this article in which a medical practitioner may furnish such information:

- to a person taking care of, living with or otherwise coming into close contact with such a person, where the person is suffering from a communicable disease or has an infection which may be passed to such person if appropriate precaution is not taken;
- to a court of competent jurisdiction in Botswana where the court has ordered the disclosure of the information; or

51 As above.
52 National Policy on HIV/AIDS (n 1 above).
53 http://www.achap.org (accessed 1 August 2006).

- to another medical doctor or legal representative who requires or is entitled to the information in the course of his professional duties.[54]

The regulations also permit the notion of 'shared confidentiality', that is, a patient's confidentiality is shared with others, including family members, loved ones, caregivers and trusted friends who are involved in the patient's treatment.[55]

The Registered Nurses Disciplinary and Ethical Rules and the Registered Midwives Disciplinary and Ethical Rules on professional secrecy require nurses and midwives to hold in confidence all patients' personal information and prohibit the disclosure of information regarding a patient's condition, treatment and diagnosis unless prior permission from the patient, the medical officer or the hospital authorities is obtained.[56] With regards to disclosure to patients' relatives or friends, nurses and midwives are prohibited from communicating such information unless prior permission or authorisation has been obtained.[57]

6.3 Medicines

There is a policy in place to ensure access to essential medicines for people living with HIV.[58] In 2002, the government launched Masa, an anti-retroviral therapy (ART) programme[59] which provides free ART to eligible citizens living with HIV. To be eligible for the treatment, a patient's CD4 cell count must be lower than 200 and/or the person must be suffering from an AIDS-related illness.[60] Four priority groups are identified for treatment. They are:

- pregnant women and women with CD4 counts less than 200 and/or with AIDS-defining illnesses and qualifying partners who fulfil the same criteria;
- all HIV-infected children older than six months of age who are inpatients;
- all HIV-infected TB patients with CD4 counts less than 200; and
- all adult inpatients with CD4 counts less than 200 and/or with AIDS-defining illnesses.

54 n 36 above, art 12.
55 As above; R Boland *et al HIV testing and confidentiality: A review of policy, in-service training curriculum, and provider knowledge of national HIV/AIDS policy in Botswana* (2006), a working draft document of the POLICY Project, in partnership with BONELA and USAID.
56 Registered Nurses Disciplinary and Ethical Rules (1989) sec 4; Registered Midwives Disciplinary and Ethical Rules (1989) sec 4.
57 As above, sec 4(5).
58 N Zungu-Dirway *et al* (ed) *An audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe* research paper, Human Science Research Council (2004) 45-46.
59 Masa means 'new dawn' in Setswana.
60 G Anabwani & W Jimbo (eds) 'Botswana Guidelines on Anti-retroviral Treatment' (2002).

By July 2005, more than 40 000 people were receiving ART at 32 sites countrywide.[61] This had increased to 61 981 as of February 2006.[62] It is estimated that 85 per cent of people needing ART are receiving such treatment.[63]

There is also access to treatment of opportunistic illnesses such as TB. Such access is not prevented on the basis of one's perceived 'immoral' sexual or social behaviour.

Masa's greatest challenge is the critical shortage of skilled personnel to carry out the ART programme. In this regard, ACHAP, in collaboration with the Harvard AIDS Institute and the Ministry of Health, has developed a curriculum on HIV and AIDS clinical care, the KITSO ('Knowledge') programme, and has trained 3 231 of the country's health care workers. Of these, 256 are doctors, 2 789 nurses, 47 pharmacists and 106 are pharmacy technicians.[64] Another major challenge in the implementation of the ART programme is the poor development of infrastructure needed to ensure appropriate, safe, and effective use of ART.

No policies or laws limit access to medicines. However, there exists discrimination against foreign spouses of Botswana citizens. Whereas Botswana citizens are eligible for free ART, their foreign spouses are not.[65]

Botswana is a party to the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement by virtue of its signing the WTO Treaty in 1995. Botswana has incorporated some of the TRIPS flexibilities in its Industrial Property Amendment Act.[66] Also Section 9(f) of the Act excluded 'diagnostic, therapeutic and surgical methods for the treatment of humans' from patentability, which enables HIV diagnostic kits to be available in Botswana at a low cost.[67] The government has not taken a specific stand on the use of generic substitution or compulsory licensing and parallel import. Botswana is yet to take advantage of the Doha Declaration to develop capacity in the pharmaceutical industry. Botswana currently uses ten brand-

61 G Jacques 'Routine testing for HIV in Botswana: Public health panacea or human rights fiasco? A social work perspective' unpublished paper, 24th Southern African Universities Social Science Conference, 2005 10.

62 This figure is made up of 51 203 from public hospitals, 2 460 outsourced from public sector and 8 318 from private medical aid and organisations. See ACHAP 'The Masa anti-retroviral therapy programme in Botswana update' (2006) 2. Deaths of patients on ART during the same period is estimated at 4 504.

63 UNAIDS Report (n 2 above) 320.

64 ACHAP 'Backgrounder' (2006) http://www.achap.org/document_download.html (accessed 1 August 2006) 3.

65 Molatlhegi & Associates (n 46 above) 98.

66 Industrial Property Act 14 of 1996, sec 30, 31 & 69; 3DThree 'Trade-related intellectual property rights, trade in services and the fulfilment of children's rights-Botswana' (2004) www.3dthree.org (accessed 25 January 2007).

67 Industrial Property Act 14 (as above) 3.

name drugs, which may put the long-term sustainability of its HIV treatment programme in doubt.[68]

6.4 Condoms

Condoms are easily accessible. Apart from free provision of male condoms at all government health facilities, condoms are on sale at any chemist store and prices vary from store to store but seem to be affordable.[69] Condoms are also distributed free of charge at various locations such as public places of convenience and at the work place. For example, condoms are placed in prominently displayed receptacles at the University of Botswana. At the end of December 2004, the government's Central Medical Stores distributed approximately 3 000 000 male and 200 000 female condoms to organisations and government departments for further distribution. The bulk of the male condoms were distributed to hospitals, clinics and schools (59 per cent), whereas most female condoms were distributed to District Health Teams (79 per cent).[70]

There is a ban on the distribution of condoms in prisons.[71]

6.5 Case law

There are no judgments relating to HIV and AIDS and access to health care. The emerging case law on HIV and AIDS relates to the offence of rape or defilement (see sec 13).

7. Privacy

7.1 Notifiable disease

The duty to notify is only applicable in respect of diseases classified as notifiable by the Public Health Act.[72] HIV is not classified as such under the Act; hence, it is not legally a notifiable disease.[73] However, according to practice directives, health care workers at public hospitals and clinics are required to notify new cases to the public health specialist in the District Health Team (DHT). The public health specialist in turn notifies the AIDS/STD Unit of the Ministry of Health. Private health facilities are also expected to report new cases to the

68 Molatlhegi & Associates (n 46 above) 100-101.
69 NACA (n 15 above) 19.
70 NACA (n 10 above); UNAIDS 'Stepping back from the edge: the pursuit of ART in Botswana, South Africa and Uganda' (2004) *UNAIDS Best Practice Collection* 18.
71 See sec 14 of this report below for further information.
72 Public Health Act (n 49 above) sec 5.
73 Molatlhegi & Associates (n 46 above) 97 and Boland (n 56 above) 29.

DHT they fall under.[74] The information is kept by the Unit and used for planning purposes, especially for the procurement of drugs and related equipment for the fight against HIV.

There are nationwide confidential voluntary testing centres jointly sponsored by the BOTUSA. Trained personnel at these centres offer pre- and post-test counselling.[75] The results of such test are kept confidential.

7.2 Medical experimentation

The regulatory framework for the conduct of medical trials in Botswana is rudimentary. The only reference to clinical trials is found in regulation 18 of the Drugs and Related Substances Act.[76] Under the said regulation, the Director of Health Services is empowered to issue permits for the carrying out of clinical trials involving humans. The Director can issue such permits subject to conditions, which he or she may determine. The Director is required, for the protection of the general public against any risk or adverse effects from the clinical trial of any drug, to monitor the trial from the beginning to the end. There is no mention of the rights of those who volunteer as subjects.[77]

Additionally, two documents have been produced by the Ministry of Health: the Health Research Guidelines and the Guide/Consent form. The purpose of the Health Research Guidelines is to guide the Institutional Review Board on how to review and approve research proposals. A special emphasis is placed on scientific and ethical implications for informed consent. The protection of the participants' confidentiality is also given prominence, as is the thorough examination of specimens and future intentions of using the research. There is no mention of HIV and AIDS research in the Health Research Guidelines.

The Guide/Consent form aims to protect research participants by requiring the researcher to explain:

- what the research is about;
- the purpose of the research;
- what is expected from both the researcher and the participants; and
- procedures related to anonymity and confidentiality to be followed.

74 Molatlhegi & Associates (n 46 above) 97.
75 BOTUSA (n 45 above) para 5.4.
76 Drugs and Related Substances Act 18 of 1992.
77 'No legal protection for clinical trials' *Mmegi* 14 January 2004 http://www.mmegi.bw/2004/January/Wednesday14/673419950 719.html (accessed 1 August 2006).

Again, the Guide/Consent form does not mention HIV and AIDS studies or anything on clinical trials for HIV drugs and vaccines.[78]

7.3 Duty to disclose

The Constitution guarantees the right to privacy in section 9. In the context of HIV, this right is best expressed in the respect of confidentiality and the insistence on informed consent in testing. The National Policy on HIV/AIDS provides that the HIV status of individuals (patients, clients, employees, etc) be treated confidentially and not be normally divulged to others without the consent of the person concerned.[79] However, the Policy suggests that the principle of 'shared confidentiality' should be applied, whereby those who need to know in order for appropriate health and social welfare care to be provided, are told.[80]

Ethical rules for the medical (doctors, nurses and midwives) and the dental professions generally prohibit the disclosure of the medical records of patients without their consent.[81]

Currently, implied consent seems to drive the policy of routine testing because patients who visit government hospitals are assumed in most cases to have consented to be tested, although if they object, testing will not be conducted. The rationale is that although voluntary pre-test counselling has benefited many in their decision to test for HIV, it has also set them apart from others and possibly heightened fear and stigma around the disease. It is felt that testing being the norm rather than the exception will reduce stigma.[82]

The National Policy on HIV/AIDS in paragraph 1.7 acknowledges the need to recognise and respect the human rights, privacy and self-determination of persons living with HIV, in line with the country's Constitution. The National Policy, however, balances this concern for privacy with a concern for the general public welfare. It emphasises the responsibility of persons with HIV to protect others from infection, as well as the right of society to that protection.

The Public Service Code of Conduct on HIV/AIDS in the Workplace (Public Service Code) also articulates the rights, responsibilities, and obligations of public sector employers and employees in accordance with the National Policy on HIV/AIDS on confidentiality of HIV status.[83] The Code provides that a public officer shall not be obliged

78 Molatlhegi (n 46 above) 102-106.
79 n 1 above, para 6.3.
80 As above.
81 Registered Nurses Disciplinary and Ethical Rules (n 57 above), Registered Midwives Disciplinary and Ethical Rules (n 56 above); Botswana Medical Council Professional Conduct Regulation (n 37 above).
82 Jacques (n 61 above) 10.
83 Public Service Code on Conduct on HIV/AIDS in the Workplace (2002).

to inform the employer about his or her HIV status. In addition, the Public Service Code advises that disclosure should only occur when it is legally required and when the person concerned voluntarily discloses it for his or her benefit.[84]

Similar provisions with regards to confidentiality are made in the Tebelopele Voluntary Counselling and Testing Policy Guidelines on Confidential HIV Testing (2004).[85] The Tebelopele Programme has a private network of centres that provide free, anonymous voluntary counselling and testing on a walk-in basis with same-day results in approximately 30 sites throughout the country.

7.4 Testing

In 2004, Botswana introduced a routine, opt-out HIV testing policy which makes HIV testing routine for people seeking health services in government health facilities. People are tested routinely but may opt out by stating that they do not wish to be tested. More than 180 district trainers from 21 of the 24 health districts in the country have received training on performing rapid HIV tests. These trainers are expected to train all the health workers in their respective districts. Currently, 280 public facilities are providing routine HIV testing.[86]

Dr Patson Mazonde, the Director of Health Services, observed in a newspaper interview in 2005 that less than five per cent of people involved in routine testing opt out, as compared to previous refusals to test at around 20 per cent.[87] The goal of routine testing is to increase the number of people knowing their status, hence reducing 'HIV exceptionalism'.[88] However, the dramatically lower number of people opting out from routine test begs a question whether 'opting out' is a truly an option for many of the patients. As Christine Stegling, Executive Director of BONELA (a local NGO) points out, the patients may not be able to 'opt out'.[89] The patients may be under undue moral pressure to accept the test from whom they perceive as a figure of authority. Apart from the potentially coercive nature of routine testing, there are concerns that the importance attached to counselling will be reduced; people may avoid visiting health clinics for the fear of being tested, and that the routine testing policy may increase 'testing-related partner violence'.[90]

84 Boland (n 55 above) 31.
85 BOTUSA (n 45 above) 25-26; NACA (n 15 above) 98-99.
86 As above.
87 Jacques (n 61 above) 14.
88 SD Weiser *et al* 'Routine HIV testing in Botswana: a population-based study on attitudes, practices and human rights concerns' (2006) 3 *PLoS Medicine* 7 1014.
89 C Stegling, cited in 'Treatment Era: ART in Africa- Botswana: Model treatment programme has its problems' *IRIN PlusNews Web Special* December 2004 http://www.plusnews.org/webspecials/ARV/botmod.asp (accessed 23 January 2006).
90 Weiser *et al* (n 88 above) 1014.

In Botswana, traditional informed consent for an HIV test is not required.[91] There is an assumption that by presenting at a facility, a patient has thereby consented to testing and unless there is express refusal, the test will be carried out on the strength of this implied consent. Where a person gives their consent for testing, pre- and post-testing counselling is to be offered as part of the routine testing.[92]

The National Strategic Framework for HIV/AIDS identifies VCT as one of the most important priorities in the country's response to the pandemic. There are approximately 280 public facilities providing VCT. These centres were established through BOTUSA. By September 2004, a network comprising 16 stand-alone sites, eight satellite sites, and four mobile units were providing counselling and testing. Of the 157 406 patients who tested at the centres, 119 081 were first-time testers. It is said that 80 per cent of the population live within a 50 km radius of an HIV testing centre. By 2004, more than 180 district trainers from 21 of the 24 health districts had received training on performing rapid HIV tests.

Some of the challenges facing the testing programme are the lack of sufficient trained personnel and storage space for clients' records. Storing clients' details has posed a huge problem.[93]

8. Equality and non-discrimination

Section 15 of the Constitution guarantees protection from discrimination on the grounds of race, tribe, place of origin, political opinions, colour or creed but does not specifically state that HIV status is a ground for discrimination. There is no special legislation at present guaranteeing the right to equality and non-discrimination of people living with HIV.

In *Makuto v The State*,[94] the Court of Appeal set a precedent according to which HIV status could be implicitly understood as being on the list of protected grounds from discrimination, despite no specific mention in the Constitution:[95]

91 CM Fombad 'Children and informed consent to HIV/AIDS testing and treatment in Botswana' (2005) 2 *University of Botswana Law Journal* 33.

92 Jacques (n 61 above); S Rennie & F Behets 'Desperately seeking targets: The ethics of routine testing in low-income countries' January 2006 *World Health Organisation Bulletin* 51-57.

93 Tebelopele aims to change from anonymous voluntary counselling and testing (VCT) to confidential VCT' *Daily News* 27 April 2006 http://www.gov.bw/cgi-bin/news.cgi?d=20060427 (accessed 1 August 2006) 4.

94 *Makuto v The State* 2000 2 BLR 131 (CA).

95 As above. Note that the Court nonetheless considered the section still constitutional in that it was 'reasonably necessary in a democratic society to abridge the freedom from discrimination provision of the Constitution, in order to combat the spread of the HIV/AIDS pandemic which had afflicted the nation.'

> Although the definition of the expression 'discriminatory' in section 15(3) of the Constitution contained no mention of discrimination against a group or class of persons identified on the grounds of health or physical disability, on a broad and generous interpretation of the said section 15(3) of the Constitution, that definition would cover an identifiable group or class of persons who suffered discrimination as such group or class for no other reason than the fact of their membership of the group or class; and such group or class would be entitled to challenge that law in court as invalid under the Constitution. In so far as section 142(4)(a) of the Penal Code as amended by the Penal Code (Amendment) Act, 1998, treated persons with the HIV syndrome differently in punishment from the rest of men without that syndrome who committed the same act of rape, it was discriminatory.

In *Attorney-General Reference: In Re The State v Marapo,*[96] the Court of Appeal held that mandatory denial of bail to persons accused of rape was unconstitutional. The Court rejected the state's argument that the statutory denial of bail was in support of the fight against HIV.

The Botswana National Policy on HIV/AIDS incorporates the right to non-discrimination. It expressly reflects the principles expressed in the 41st World Health Assembly Resolution WHA41.24 (avoidance of discrimination in relation to HIV infected people and people with AIDS).[97]

9. Labour rights

9.1 Legislation

No specific legislation presently exists for the protection of employees with HIV against discriminatory practices or unfair dismissals in the workplace, but a constitutional provision on non-discrimination can be applied.[98] The Employment Act[99] is silent on the rights of employees living with HIV.

Until May 2005, testing of employees was not regulated, and despite provisions of the National Policy on HIV/AIDS, testing of employees was left to common law principles and the contractual terms between employers and employees. There was also evidence that in some cases, fellow employees put pressure on employers to dismiss workers suspected of being HIV positive in the belief that HIV-positive workers pose a risk to others.[100] Although there was no law

96 *Attorney-General Reference: In Re The State v Marapo* (2002) 2 BLR 26 CA; (2002) AHRLR 58 (BwCA 2002).
97 National Policy on HIV/AIDS (n 1 above) para 6.1.
98 *Diau v Botswana Building Society* IC 35/2003 (unreported).
99 Employment Act 29 of 1982, revised in 1992 and 2003.
100 Molatlhegi & Associates (n 46 above) 61.

currently in place to deal with such a situation,[101] in 2003, the Industrial Court held in *Rapula Jimson v Botswana Building Society* that the dismissal of the Applicant based on his HIV-positive status was unfair.[102] However, the Court refused to deal with the issue of pre-employment testing of HIV and held that although the National Policy on HIV/AIDS discourages pre-employment testing, the Policy is not legally binding.[103]

In May 2005, however, Botswana adopted a National Policy on HIV/AIDS and Employment.[104] This policy, meant to 'form the basis for the enactment of and/or amendment of relevant employment legislation to reinforce the constitutionally guaranteed rights and obligations, such as prohibitions of discrimination against people with HIV or AIDS or those perceived to have HIV or AIDS', defines the rights and responsibilities of the government, employers and employees in the following areas:

- promotion of a safe and healthy work environment;
- equal opportunities to employment;
- continuation of employment and reasonable accommodation;
- HIV testing;
- confidentiality and disclosure in the workplace;
- non-discrimination and protection against victimisation;
- employment benefits;
- gender equality and empowerment;
- access to treatment, care and support; and
- research in the workplace.

Among other things, the policy declares that employers 'should provide equal opportunities to jobs to all qualified citizens of Botswana including those with chronic medical conditions such as HIV and AIDS' and 'are required to make "reasonable accommodation" for employees with chronic medical conditions, including those with HIV and AIDS'.[105]

The Public Service Code of Conduct on HIV/AIDS in the Workplace, adopted in 2001, in addition to elaborating HIV and AIDS education programmes and services in the workplace, articulates the Public Service's position and practices as they relate to officers who are infected or affected by HIV and AIDS.

101 As above, 54-65.
102 *Rapula Jimson v Botswana Building Society* IC 35/03 p14.
103 *Rapula Jimson v Botswana Building Society* IC 35/03 p 20.
104 National Policy on HIV/AIDS and Employment (2005).
105 As above sec 7.3.2 and 7.4.3.

The Industrial Court, which deals with labour matters, is the likely avenue by which an HIV- positive employee who has experienced discrimination may seek redress. Appeals from a decision of the Industrial Court may go to the Court of Appeal.

9.2 Testing

The National Policy on HIV/AIDS and Employment, adopted in 2005, forbids pre-employment HIV testing of Botswana citizens,[106] but it is silent regarding non-citizens. In the public service, non-citizens are required to undertake an HIV test as a condition for employment, and non-citizens who are already employed are required to take an HIV test as a condition for contract renewal. Those non-citizens who test HIV positive are not employed or do not have their contract renewed.[107]

All employers are nonetheless expected to provide their employees with information and knowledge on HIV/AIDS testing and the implications of knowing their status in addition to access to pre- and post-test counselling.[108]

9.3 Medical schemes act

No national medical aid scheme exists. The available medical aids schemes are private. Employees may have the option of joining any of the available private schemes but the treatment of employees living with HIV is dependent on the rules of the individual schemes. The Botswana Medical Aid Society (BOMAID), for example, has an HIV programme under a Special Benefit Fund under which members who are living with HIV can enrol. Each individual enrolled in the programme will be assisted with, among other benefits, up to P1 000 per month to cover the cost of ARVs.[109]

Employers do not have input into how a particular medical aid on offer treats employees living with HIV.

9.4 Duty to provide treatment

There is no specific legislation requiring employers to provide ARVs to employees. The National Policy on HIV/AIDS and Employment, however, declares that

106 As above, sec 7.3.3.
107 Molatlhegi & Associates (n 46 above) 57.
108 National Policy on HIV/AIDS and Employment (n 104 above), sec 7.5.2 and 7.5.5.
109 http://www.bomaid.co.bw (accessed 1 August 2006).

- employers should make reasonable provisions for equitable access to comprehensive, cost effective and affordable care for employees and their dependants
- where employees cannot provide in-house care services, referral linkages should be made with public health services for anti-retroviral treatment and psychological support.[110]

10. Women's rights

10.1 Legal status and protection

The Constitution guarantees women equal rights with men. Section 3 of the Constitution, which provides that 'every person in Botswana is entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, place of origin, political opinions, colour, creed or sex' was interpreted in the landmark case of *Attorney General v Dow*[111] as complementing section 15 which guarantees protection from discrimination on the grounds of race, etc, and guaranteeing the right to equal treatment. The enactment of the Abolition of Marital Power Act[112] grants women equal and current powers of administration over joint estates.[113]

However, under customary law, women are discriminated against in terms of inheritance, property rights and access to land. The potentially polygamous nature of customary marriages in Botswana often inflicts economic hardship on women. A wife has little or no input in her husband's decision to marry another woman. Even where a husband does not marry another wife, his infidelity is generally tolerated, whereas a wife's infidelity is grounds for her husband to divorce her.[114]

There is no special legislation or policy in place to protect women who are more vulnerable to HIV infection. However, the Penal Code criminalises rape and sex with girls aged 16 or less (see section 13.1 below).

10.2 Domestic violence law

There is no law specifically prohibiting domestic violence against women, nor is there an expressed appreciation of the link between domestic violence and HIV. The law in Botswana states that a woman

110 As above.
111 *Attorney General v Dow* 1994 6 BCLR 1 (BwCA); (2001) AHRLR 99 (BwCA 1992).
112 Abolition of Marital Power Act 34 of 2004.
113 EK Quansah 'Abolition of marital power in Botswana: A new dimension in marital relationship?' (2005) 1 *University of Botswana Law Journal* 5.
114 U Dow & P Kidd *Women, marriage and inheritance* (1994).

gives her consent to sex upon marriage; therefore marital rape is not prohibited.[115]

Under customary law and in common rural practice, men have the right to 'chastise' their wives. Greater public awareness and improved legal protection have resulted in increased reporting of domestic violence and sexual assault; however, police are rarely called to intervene in such cases. 'Passion killings', in which jealous men kill their girlfriends or wives and often then commit suicide, is a frequent occurrence.[116]

However, a Domestic Violence Bill is scheduled to be presented for November 2007. The brainchild of several women's organisations, the bill is submitted by MP Gladys Kokorwe as a private member's bill, meaning it cannot involve government expense. The bill does not cover marital rape, but an amendment to the bill may be introduced for its explicit prohibition.[117]

10.3 Customary rules and practices

Several written or unwritten customs or customary laws help exacerbate the political and economic subjugation of women and the spread of the HIV epidemic, such as the following:

- polygamy (including the fact that a wife has little or no input in her husband's decision to marry another woman and the fact that polygamous nature of customary marriage often results in economic hardship for women)[118]
- ritual circumcision and skin-piercing procedures
- non-recognition of marital rape
- adultery being considered a female crime only or a crime for which women should pay greater penalties than men
- wife-inheritance by the brother of the husband if the husband dies
- the institution of *bogadi* (bridewealth/lobola) by which the husband or his family gives the family of the wife a present, usually in the form of cattle, as part of the marriage ceremony, confers on the husband more control over the person of his wife. For example, the payment of *bogadi* transfers the woman's reproductive powers to the husband's family and limits the rights

115 See Quansah (n 27 above) 57.

116 US Department of State, Bureau of Democracy, Human Rights and Labour, 'Country Reports on Human Rights Practices: Botswana' (2005) http://www.state.gov/g/drl/rls/hrrpt/2005/61555.htm (accessed 1 August 2006).

117 'MPs differ on proposed Domestic Violence Bill' *Daily News Online* 23 August 2007 http://www.gov.bw/cgi-bin/news.cgi?d=20070823&i=MPs_differ_on_proposed_Domestic_Violence_Bill (accessed 6 September 2007).

118 S Roberts *Tswana family law* (1972). Divorce is granted by the customary courts.

of the wife over their children when the marriage ends by divorce or death[119]
- impediments to exercise rights to ownership of property and use of family property such as fields and household implements
- discrimination in terms of inheritance, property rights and access to land

Customary law is formally recognised by law in section 3 of the Customary Law Act[120] (as amended) and Customary Courts Act[121] (as amended). It is important to note, however, that customary law is 'inferior and subject to other sources of law in the country', such as common law and constitutional law, and that the definition of customary law excludes rules that are 'contrary to morality, humanity and natural justice' and rules that are 'injurious to the welfare of members or repugnant to the constitution and/or any other enactment'.[122]

10.4 Administration of anti-retrovirals to rape survivors

Free ART has been available to citizens since 2002. There is, however, no established procedure in providing post-exposure prophylaxis to rape survivors to minimise their chances of HIV infection.

10.5 Sex workers

Under the Penal Code, sex work is prohibited and is considered an offence against morality.[123] A person who knowingly lives, wholly or in part, on the proceeds of prostitution, or who keeps a brothel or a place used as a brothel, is liable to punishment in terms of the Code.[124] As a result, many sex workers hide for fear of being prosecuted and shy away from protecting themselves.[125] There is no movement towards the decriminalisation of sex work.[126]

119 I Schapera *A handbook of Tswana law and custom* (1995) 139 & 169.
120 Customary Law Act 51 of 1969.
121 Customary Courts Act 57 of 1968.
122 Molathegi & Associates (n 46 above), 15-16.
123 Penal Code, as amended, secs 155-158.
124 Penal Code sec 149. See also M Richter 'The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six southern African countries' (2003) 8 *Canadian HIV/AIDS Policy & Law Review.*
125 Molathlegi & Associates (n 46 above) 67.
126 As above, 169-171.

11. Children's rights

11.1 Access to health care

The National Policy on HIV/AIDS ensures that children living with HIV have access to health care facilities, although the adequacy of the facilities may differ depending on whether a child lives in a rural or urban area. Children have access to ART through the public programme.

11.2 Children orphaned by AIDS

According to the Botswana UNGASS Progress Report, the number of registered children who have been orphaned reached 51 600 in 2005, a sharp increase from 37 850 in 2002.[127] Children who have been orphaned constitute 17.7 per cent of all children aged up to 18 years old.[128] Rural households reported 17.7 per cent of children who have been orphaned compared to 15.8 per cent in urban areas.[129]

There is no indication as to how many of these children have been orphaned due to AIDS-related deaths. The percentage of households with children who have been orphaned receiving care and support nationally in 2004 was 34.3 per cent. Through the National Orphan Care Programme, which was established in 1998, the government runs an Orphan Care Benefit scheme where a household with children who have been orphaned receives a monthly food basket equal to P216.60; a school uniform, transportation fees, sports fees, tour fees, clothing, rental fees where applicable, and other payments as required. The benefits are received by the orphan's caregiver (guardian) or by a child-headed household looking after younger siblings.[130]

11.3 Education

As part of the Ministry of Education's contribution to the National Policy on HIV/AIDS, the Ministry is required to focus on the following:

- integration of AIDS and STI education into all levels and institutions of education, starting at the primary school level and extending to tertiary, teacher training and non-formal institutions;

127 NACA (n 15 above) 22.
128 NACA & CSO (n 5 above) 25.
129 As above, 25.
130 AVERT 'AIDS orphans' http://www.avert.org/aidsorphans.htm (accessed on 23 January 2007); U.S. Social Security Administration 'Social security programmes throughout the world: Botswana 2005' http://www.ssa.gov/policy/docs/progdesc/ssptw/2004-2005/africa/botswana.html (accessed 23 January 2007).

- involvement of parents through parent teacher associations and appropriate mechanisms in discussion of school-based HIV/AIDS education; and
- ensuring that other services related to HIV and sexually transmitted infections (STIs) control and care are accessible to students in need.[131]

The National Policy on HIV/AIDS discourages discrimination on the basis of HIV status across all sectors of society, including the school system.

No special measures are in place for the education of female children. However, the number of female students enrolled at the University of Botswana provides some indication of how far the education of female children in Botswana has come. During the 2004 - 2005 school year, female students formed 52 per cent percent of the student population of 15 725.[132] This figure is an indication that increasingly girls are being enrolled in secondary schools, giving them the opportunity for higher education.

There is an increasing awareness of the necessity to take the special needs of children who are HIV positive into account within the educational system. Teacher training colleges are taking steps to make trainee teachers aware of these special needs. In the post-graduate diploma in education programme at the University of Botswana, for example, teachers have a course entitled 'HIV/AIDS education, prevention and control' which is taught by the nursing department. This course is designed to make students sensitive to the needs of children living with HIV.

In order to increase the awareness of teachers, a partnership between ACHAP, the Ministry of Education, Botswana Television (BTV) and the UNDP has developed a Teacher Capacity Building programme (TCB). The TCB is an interactive education programme, which targets Botswana's teachers with information about HIV in an effort to build their capacity to deal effectively with HIV in the classroom. As part of the project, 572 primary and secondary schools have been equipped with a television, video cassette recorder, satellite dish and decoder. A weekly programme, 'Talkback' has been developed for teachers to watch and discuss. The goal is to enhance teaching on HIV and advance the school system's capacity to reduce the stigma and break the silence around HIV. The Programme has been aired on BTV twice weekly since March 2003.[133]

Some organisations that provide sponsorship for higher education require the prospective student to undergo an HIV test. If the student

[131] National Policy on HIV/AIDS (n 1 above) 7 & National Strategic Framework for HIV/AIDS 2003-2009' (2003) 63.
[132] http://www.ub.bw/about/documents (accessed 1 August 2006).
[133] ACHAP (n 62 above).

tests positive, he or she does not receive the scholarship. The government does not deny students sponsorship to study locally on the basis of their HIV status but they are encouraged to seek VCT. However, students who seek external sponsorship to study outside Botswana are required to undergo HIV testing when the country of their proposed study requires testing as a condition for entry. Sponsorship will not be offered in the event of a positive result.[134]

12. Family law

There are no specific provisions in Botswana's inheritance laws that specifically address HIV or its impact on those living with HIV. There is also no guardianship legislation that deals with the impact of the virus on caregivers.

The Department of Social Welfare provides registered orphaned children with monthly food baskets under the short term plan of action on care of orphans in Botswana. There are initiatives to formulate a long-term plan for the treatment of children orphaned due to AIDS-related deaths but these are yet to be concretised.

13. Criminal law

13.1 Criminal legislation

Under section 209 of the Penal Code, it may be possible to prosecute a person for wilful transmission of HIV. In paragraph (d) of that section, 'causing death' is defined to include 'any act or omission that hastened the death of a person suffering under any disease or injury which apart from such act or omission would have caused death'.

Section 184 of the Penal Code also creates an offence as follows: 'Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, is guilty of an offence'.

Section 11 of the Public Health Act makes provision for dealing with deliberate attempts to infect others with any communicable disease.[135] The provisions, however, are limited to the spreading of communicable diseases in any street, public place, shop or public convenience and therefore it will be difficult to bring HIV transmission (which mostly takes place through private sexual encounters) within the ambit of these provisions. Apart from the provision for harsher punishment for convicted rapists, the Penal Code provisions have not

[134] Molatlhegi & Associates (n 46 above) 126.
[135] Public Health Act (n 49 above).

been used to prosecute persons found to have wilfully or negligently transmitted the virus.

There has been no known public violence against people who have HIV, although it is thought that some deaths have been related to a person's perceived or real HIV status.

The Penal Code as amended by the Penal Code (Amendment) Act 5 of 1998[136] provides for a compulsory HIV test for all accused persons convicted of rape or sex with girls under the age of 16.[137] The Code as amended also makes provision for harsher sentences for accused persons convicted of rape or sex with girls under the age of 16 who are HIV positive (even if they were not aware of being HIV positive at the time of the offence). For instance, section 142 (Punishment of Rape) reads as follows:

> (1) Any person who is charged with the offence of rape shall —
>
> ...
>
> (ii) subject to subsections (2) and (4), upon conviction be sentenced to a minimum term of 10 years' imprisonment or to a maximum term of life imprisonment.
>
> (2) Where an act of rape is attended by violence resulting in injury to the victim, the person convicted of the act of rape shall be sentenced to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with or without corporal punishment.
>
> (3) Any person convicted of the offence of rape shall be required to undergo a Human Immune-system Virus test before he or she is sentenced by the court.
>
> (4) Any person who is convicted under subsection (1) or subsection (2) and whose test for the Human Immune-system Virus under subsection (3) is positive shall be sentenced —
>
> (a) to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being Human Immune-system Virus positive; or
>
> (b) to a minimum term of 20 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being Human Immune-system Virus positive.

The courts declared such provisions discriminatory but still constitutionally valid (see section 8 above), but in the end they decided that an HIV test performed after the offence was not sufficient proof of HIV status at the time of the offence. Sentence times ended up being the same for persons who were convicted of rape or sex with girls under 16 who were HIV negative and those who

136 Penal Code (Amendment) Act 5 of 1998.
137 Penal Code (Amendment) sec 142, 147.

were convicted for the same acts who did not know their HIV status but were later found HIV positive. The first judgment in this type of interpretation was reached by Mosojane J of the High Court in *State v Lejony*,[138] when he offered the following interpretation of the Penal Code (Amendment) Act 5 of 1998:[139]

> It seems to me clear without any room for doubt at all that the legislature intended to punish those people who were HIV positive but were unaware of their status at the time when they committed the offence and not everybody who was found with the disease after conviction regardless of whether or not they carried the disease when they committed the offence. To punish them simply because they were found to be HIV positive after conviction would be absurd and the language of the subsection permits no such construction in my judgment. [...] Finally, I wish to remark that the possibility exists in this case, as always it will, that the accused got his HIV status, if he has it, from his victim. The law does not say that he should be punished for that. He would however be punished if he was HIV positive though unaware of it when he committed the offence. This is what I understand the law to be saying.

This interpretation was upheld in following cases such as *Makuto v The State*,[140] *Lejoni v The State*,[141] *Nqubi v The State*[142] and *Matlapen v The State*.[143]

The Court of Appeal has, on occasion, criticised the manner in which the results of the HIV test is admissible in the trial. The Court criticised the way medical reports indicating that an accused is HIV positive are produced in courts. It has stated that it is not sufficient that a judge should simply tell an accused that the medical record indicates that he is HIV positive. The medical record should be produced and placed on record as an exhibit with the consent of the accused who admits its correctness. Failing such consent and admission, the person responsible for the report must be called as a witness.[144]

13.2 Men having sex with men

Botswana's Penal Code considers any person who has 'carnal knowledge of any person' obtained 'against the order of nature' or any person who engages in 'indecent practices' involving 'gross indecency with another person' as having committed an 'unnatural

138 *State v Lejony* 2000 1 BLR 326 (HC).
139 Mosojane J, quoted in *Lejony v The State* 2000 2 BLR 147 (CA).
140 *Makuto v The State* 2000 2 BLR 130 (CA).
141 *Lejony v The State* 2000 2 BLR 145 (CA).
142 *Nqubi v The State* 2001 1 BLR 154 (CA).
143 *Matlapen v The State* 2001 1 BLR 161 (CA).
144 *Qam Nqubi v The State* (2001) 1 BLR 154; *Shima Matlapeng v The State* (2001) 1 BLR 161 and *Lefang Gare v The State* (2001) 1 BLR 143.

offence' that will be punished with at least 5-7 years imprisonment.[145] This has been interpreted as a criminalisation of homosexuality.

However, the offence is rarely prosecuted.[146] There is no move to decriminalise sodomy in the foreseeable future because the government does not recognise its criminlisation as a problem.[147]

14. Prisoners' rights

The Prisons Act[148] makes no reference specifically to HIV. However, part vii and viii contain provisions relating to the general health care of prisoners.[149]

Under the Botswana Prison Service HIV/AIDS/STD and Health Care Delivery Policy (which deals with inmates, prison staff and their families), HIV awareness and education campaigns are conducted among prisoners with particular emphasis on risky behaviour, use of bleach for infection control, and the establishment of Health Committees, comprised of prison officers and inmates.

The Health Care Delivery Policy prohibits the distribution of condoms to inmates as it is seen as an encouragement of sex among men in prison. HIV testing of prisoners is not mandatory, and therefore there are no reliable statistics on the number of prisoners who are HIV positive. However, the HIV status of prisoners is kept confidential and no attempt is made to keep them separate from other prisoners. Prisoners have the same access to ARVs as the general population.[150] In terms of sec 78 of the Prisons Act, a prisoner may be released early for health reasons.[151]

15. Immigration

The National Policy on HIV/AIDS provides that there will be no restrictions placed on travel by persons known, or suspected to be HIV positive in Botswana. Foreigners entering the country will not be required to provide proof that they are HIV negative. Foreigners known to have HIV will not be restricted from entry into the country

145 Penal Code, as amended, sec 164-167.
146 *Kanane* v *The State* 2003 2 BLR 67; EK Quansah 'Same-sex relationships in Botswana: Current perspectives and future prospects' (2004) 4 *African Human Rights Law Journal* 201.
147 AB Tafa 'Rights to sexual orientation: The line of the Botswana government' (2000) *Conference on Human Rights and Democracy* 127.
148 Prisons Act 28 of 1979.
149 As above sec 56-63.
150 Molatlhegi & Associates (n 46 above) 119-121.
151 As above, 71.

for this reason.[152] However, foreigners who apply for jobs with the government are required to undergo tests as a condition of employment. If they test positive to HIV, they will be denied a work permit.

The government takes the view that its primary responsibility is to its citizens and therefore it is not considered problematic to discriminate against foreign nationals in such areas as the provision of HIV and AIDS care and ARVs. It is further argued that such discrimination may alleviate the burden upon the already limited resources of the country.[153] However, the denial of treatment and care services to non-nationals can jeopardise the effectiveness of the national response to HIV.

16. Social assistance and other government benefits

HIV is not considered a disability under domestic law. No specific legislation exists that provides social security assistance to people living with HIV. However, the government provides monthly cash grants (P61) and monthly food rations (P172) to people who are unable to support themselves due to old age, disability, a chronic health conditions, needy children under 18 with a terminally ill parent.[154] As mentioned in section 11.2, households taking care of orphaned children benefit from the National Orphan Care Programme.

17. Insurance

There seems to be an evolving policy on the part of insurance companies to ask for an HIV test from those wishing to take out life insurance beyond a given threshold (P100 000). The test is not compulsory, but if one should decline to take the test, either a limit is placed on the policy or the premium payable is increased to reflect a higher risk. Insurance companies deny life cover to applicants that test positive for HIV but this is ostensibly done on medical grounds. Positive results are not released to the applicant by the insurance company. Some companies (for example, Metropolitan Botswana) do not reject HIV-positive applicants outright, but instead are attempting to develop specialised products for them.[155]

[152] National Policy on HIV/AIDS (n 1 above) para 6.5.
[153] Molatlhegi & Associates (n 46 above) 57.
[154] US Social Security Administration (n 130 above).
[155] Molatlhegi & Associates (n 46 above) 119-121.

18. Oversight

There is no specific government mechanism to ensure implementation of HIV-related legislation. However, there is an ad hoc body, the Special Select Committee on HIV/AIDS, which deals with issues related to HIV/AIDS.[156] In view of the multisectoral approach to HIV and AIDS policy in Botswana, any proposed HIV-related legislation will involve relevant stakeholders in its formulation. In 2002, the National AIDS Council, chaired by the State President, established a Committee on Ethics, Law and Human Rights with the specific aim of facilitating the integration of an ethical approach into the national response to HIV. This Committee will obviously be involved in the formulation and implementation of HIV and AIDS-related legislation.[157]

19. Stigma

Some of the key determinants of the spread of HIV in Botswana are stigma and denial.[158] In an effort to create an atmosphere of openness and to break the silence about HIV, the State President, Festus Mogae, took an HIV test and publicly announced the results.[159] However, stigma is not specifically addressed in any legislation. Education through the media for people to seek VCT is helping in raising awareness. However, there is no unanimity as to whether public disclosure will help to curb the stigma attached to HIV.[160]

156 M Caesar-Katsenga & M Myburg, 'Parliament, politics and AIDS: a comparative study of five African countries' (2006) 14.
157 Molatlhegi & Associates (n 46 above).
158 National Strategic Framework for HIV/AIDS (n 131 above) 16.
159 Mogae wins admiration of US Senate' *Daily News Online* 14 November 2003 http://www.gov.bw/cgi-bin/news.cgi?d=20031114 (accessed 1 August 2006).
160 Molatlhegi & Associates (n 46 above) 155-156.

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2 HIV, AIDS and the law in Lesotho

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1. Background to country

1.1 First AIDS case

The first AIDS case in Lesotho was reported in 1986.[1] The Ministry of Health and Social Welfare (MoHSW) documented the case. The person was said to be a foreigner living in the district of Mokhotlong. The mode of infection was not reported.[2] The information was not treated confidentially. In fact, there was a public announcement about the HIV status of the person who was later deported from Lesotho.[3]

1.2 Demography

Lesotho has an estimated population of 1.8 million.[4]

The overall adult prevalence rate was estimated to be 23.2 in 2005.[5] This translates into 250 000 adults (more than 15 years old) living with HIV.[6] An estimated 23 000 AIDS-related deaths was registered in 2005.[7] The HIV prevalence rates for the 15 – 25 age group are 5.9 per cent for males and 14.1 per cent for females.[8]

The tuberculosis (TB) prevalence rate in Lesotho is 544 persons per 100 000.[9] The median syphilis prevalence among antenatal women was 2.7 per cent in 2003, [10] while the percentage of pregnant women living with HIV was 23 per cent in 2004.[11]

It is believed that 25 per cent of babies born to HIV-positive mothers are HIV positive.[12]

Estimates show that 25.7 per cent of women aged 15 to 49 years are living with HIV, whereas men in the same age group have a prevalence rate of 20.3 per cent.[13] The 2004 Lesotho Demographics and Health Survey (LDHS) indicated that people within the 30 - 39 age

1 N Moorosi 'Lesotho's First Network of People Living with HIV & AIDS (LENEPWA) launched' (9 May 2005) http://www.sahims.net/batchfiles_web/2005/06_june/LES/LENEPWA_09_06_05.pdf (accessed 1 August 2006).
2 Informal interview with members of staff of the Lesotho Red Cross Society.
3 As above.
4 UNFPA *State of the world population 2007: Unleashing the potential of urban growth* (2007) 90.
5 UNAIDS '2006 Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
6 As above.
7 As above, 508.
8 As above.
9 UNDP 'Human development report 2006: Beyond scarcity: Power, poverty and the global water crisis' (2006) 313.
10 Status of the Lesotho National Response to the UNGASS Declaration of Commitment on HIV/AIDS (2003-2005) Report (2005), 7-8.
11 Lesotho Demographics and Health Survey 2004.
12 Sentinel Surveillance Report 2005'.
13 UNGASS Report (n 10 above) 7-8.

group were most affected, with a prevalence of more than 40 per cent.[14]

In 2005, there were 97 000 children (0-17 years old) who had lost one or both parents to AIDS.[15]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[16]

Treaty (entered into force)	Ratification/ accession (deposit)
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	09/09/1992
ICCPR Optional Protocol (23/03/1976)	06/09/2000
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	09/09/92
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	22/08/95
CEDAW Optional Protocol (22/12/2000)	24/09/04
Convention on the Rights of the Child (CRC) (02/09/1990)	10/03/92

2.2 State reports[17]

Lesotho's initial report on the International Covenant on Civil and Political Rights (ICCPR) was submitted in 1998. It provided information on the HIV epidemic and the measures taken by the government to protect the health of the people. The report noted that HIV is one of the major problems in the country. It subsumed HIV and AIDS under other health issues. The Human Rights Committee (HRC) in its concluding observations expressed its concerns about the practice of female genital mutilation and discrimination against women. The HRC also recommended that Lesotho amends its law criminalising same sex sexual relations between consenting adults.

14 n 11 above.

15 UNICEF 'State of the world's children 2007: Women and children, the double dividend of gender equality' (2007) 115.

16 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'Lesotho Homepage' http://www.ohchr.org/english/countries/bw/index.htm (accessed 20 January 2007).http://www.ohchr.org/english/countries/ls/index.htm.

17 For the state reports and concluding observations discussed below, see OHCHR (as above).

However, the report did not directly address issues related to HIV and AIDS

Equality Now, a human rights NGO based in Lesotho,[18] submitted a shadow report to the HRC.

Lesotho submitted a report on its implementation of the Convention on the Rights of the Child (CRC) in 1998.[19] The concluding observations of the Committee on the Rights of the Child included the following statement on HIV and AIDS:[20]

> (45) Whilst noting the existence of the National AIDS Strategic Plan 2000/2001-2003/2004 and the Policy Framework on HIV/AIDS Prevention, Control and Management, the Committee remains extremely concerned at the alarmingly high incidence and increasing prevalence of HIV/AIDS amongst adults and children, in particular amongst teenage girls, and the high incidence of teenage pregnancy and STDs. The Committee expresses concern, further, at the insufficient availability of adolescent health programmes and services and the lack of adequate data in this area and on the incidence of suicide, violence, sexual exploitation and abortion, alcohol consumption and tobacco and dagger smoking.
>
> (46) The Committee strongly urges the State party to implement fully the National AIDS Strategic Plan 2000/2001-2003/2004 and the Policy Framework on HIV/AIDS Prevention, Control and Management as soon as possible and to devote to them ample resources to ensure their success. The Committee recommends, further, that a comprehensive and multi-disciplinary study be undertaken to understand the scope of adolescent health problems, including the negative impact of early pregnancy, as well as the special situation of children infected with, affected by or vulnerable to HIV/AIDS and STDs. The Committee urges the State party to give particular attention to the secondary consequences of HIV/AIDS, such as an increase in child-headed households following the death of adult family members. Additionally, it is recommended that the State party undertake further measures, including the allocation of adequate human and financial resources, to develop youth-friendly counselling, care and rehabilitation facilities for adolescents, especially girls, which would be accessible by them without parental consent; in this regard, the Committee notes the development of 'Adolescent Health Corners' at the regional level and recommends that the State party pursue its objective of establishing such facilities at the district level. The Committee recommends that the State party increase its efforts to promote adolescent health policies, including mental health,

18 Equality Now "'Equality Now" submission to the UN Human Rights Committee at the 65th session' (1999) available at http://www.equalitynow.org/english/campaigns/un/unhrc_reports/unhrc_lesotho_en.pdf (accessed 1 August 2006).

19 Government of Lesotho, 'Initial Reports of State Parties due in 1994: Lesotho' (CRC/C/11/Add.20) (1998).

20 Committee on the Rights of the Child 'Concluding observations of the Committee on the Rights of the Child: Lesotho 26th Session' (2001) http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/ae3810fc637a1d6ec12569ee0032b0a3?Opendocument (accessed 7 September 2007).

particularly with respect to suicide prevention, and to strengthen reproductive health education and counselling services. In this regard, the Committee particularly recommends that all training programmes on reproductive health address boys as well as girls. The Committee recommends, further, that the State party implement measures to discourage the abuse of alcohol and the smoking of tobacco and dagger by adolescents.

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[21]

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	10/02/1992
African Charter on the Rights and Welfare of the Child (29/11/1999)	27/09/1999
Protocol to the ACHPR on the Rights of Women in Africa (25/11/2005)	26/10/2004
Treaty of the Southern African Development Community (SADC) (30/09/1993)	26/08/1993
SADC Protocol on Health (14/08/2004)	31/07/2001

3.2 State reports

The initial report on the implementation of the African Charter on Human and Peoples' Rights was submitted to the African Commission in August 2000. The report referred to HIV education and awareness in section 1.14.

3.3 Status of international and human rights treaties in domestic law

Although it is not expressly stated in the Constitution, in practice, Lesotho adopts a dualist approach to treaty domestication.

None of the above-mentioned international human rights treaties have been domesticated; in the absence of domestication, the treaties only play a persuasive role in the legal system. While the

[21] Ratification status available at http://www.africa-union.org and http://www.sadc.int (accessed 10 September 2007).

courts are not bound by the standards set out in the international laws, they can and have usually adopted these standards in domestic cases.

However, there has not been any specific implementing legislation relating to treaties ratified in Lesotho. The task of implementing international human rights treaties is undertaken by the ministry sponsoring the domestication or enactment of the treaty. For example, the implementation of the CRC will be the responsibility of the Ministry of Social Welfare, if or when the Ministry decides to sponsor the domestication of the CRC.

3.4 International Guidelines

Unlike the Millennium Development Goals (MDG), the International Guidelines on HIV/AIDS and Human Rights (International Guidelines) were never publicly approved or directly endorsed by the government or its departments in charge of HIV and AIDS related issues.[22] However, it appears the government is aware of the provisions of the International Guidelines and this is reflected in the way Lesotho manages its HIV epidemic.

Some of the recommendations of the Guidelines have been implemented. For instance, Guideline 1, which provides for the establishment of effective national institutions as well as multi-sectoral bodies dealing with HIV and AIDS, such as inter-ministerial, parliamentary committees or AIDS Councils, has been implemented. In late 2003, the government announced the formation of a National AIDS Commission (NAC) to co-ordinate society-wide AIDS control and mitigation activities.[23] The Parliamentary AIDS Committee was also established in late 2004 to oversee the implementation of HIV and AIDS-related activities within government bodies.

In November 2006, the government of Lesotho adopted a National HIV and AIDS Policy which 'reflects the government of Lesotho's commitment to ensuring adequacy of protection, care and support to all vulnerable groups in all interventions on HIV and AIDS'.[24] The National HIV and AIDS Policy states among its key objectives the

22 UNAIDS & OHCHR *International Guidelines on HIV/AIDS and Human Rights*. The International Guidelines on HIV/ AIDS and Human Rights have not been publicly announced or incorporated into any document on the management of HIV and AIDS in Lesotho. However, the MDGs have been publicly announced and the prioritised goals are set out in public documents. In fact, after adopting these MDGs, the government of Lesotho declared combating HIV as the first national goal.

23 UNAIDS 'Country profile: Lesotho' (2004) http://www.unaids.org/bangkok2004/report.html (accessed 1 August 2006).

24 National HIV and AIDS Policy (2006) ix.

promotion of a 'human rights based approach to prevention, treatment, care, support and mitigation services.'[25]

Chapter 9 of the National HIV and AIDS Policy determines that 'coordination, management, monitoring and evaluation of all HIV and AIDS interventions is necessary to ensure harmonisation and effective harnessing of national resources to the fight against the epidemic'.[26]

Guideline 4 encourages states to

> [c]onduct a comprehensive review of legislation, and adopt appropriate amendments and new legislation. In the realm of criminal law, states should ensure that criminal laws are not misused to target vulnerable groups.[27]

States are further encouraged to enact or strengthen anti-discrimination laws and other laws protecting people with HIV and AIDS, and to ensure the widespread availability of preventative measures and medication. Importantly, states need to go beyond legislating for HIV and AIDS specifically, by addressing underlying inequalities and stereotypes especially in so far as they concern women and children.

This has not been implemented fully because Lesotho is still in the process of mainstreaming HIV and AIDS into its legislation. Nevertheless, there is an improvement in the existing laws dealing with HIV and AIDS when compared to the laws that existed some ten years ago. Important legislative reforms include the adoption of the Sexual Offences Act,[28] the Labour Code Amendment Act[29] and the Legal Capacity of Married Persons' Act.[30]

4. National legal system of country

4.1 Form of government

Lesotho is a parliamentary constitutional monarchy. Under this system, the Constitution recognises the existence of a monarch who is the head of state.[31] The role of the King in the government is ceremonial. There is also a parliament which consists of the King, a Senate and a National Assembly.[32] The Prime Minister is the head of the government.

25 As above, xiv.
26 As above, 54.
27 n 24 above, Guideline 4.
28 Sexual Offences Act 3 of 2003.
29 Labour Code Amendment Act 5 of 2006.
30 Legal Capacity of Married Persons Act 9 of 2006.
31 Art 44.
32 Art 54.

4.2 Legal system

The legal system of the Kingdom of Lesotho includes elements of Roman-Dutch law, English common law as well as customary law. Customary law is said to have been born out of the traditions, norms and practices of the Basotho (people of Lesotho) from time immemorial. Roman Dutch law was introduced into the Kingdom in the late nineteenth century via the British Colony of the Cape of Good Hope. The common law was legally and procedurally extended and declared as the Law of Lesotho from the 1870s. Therefore, disputed matters are brought before the courts to be settled either through the application of customary law, or of the common law (inclusive of the statutory law).[33]

Proceedings on a disputed matter are not, however, based only on whether the litigant chooses a forum and a particular legal system as a tool of adjudication; instead, there are other considerations. Firstly, the disputed matter must fall within the jurisdiction of the chosen court. Secondly, it is inquired whether the matter can be initiated in that court and no other court. In addition, customary courts and formal courts differ on the law they have to apply and on the type of cases they may adjudicate upon. For instance, customary courts have unlimited jurisdiction on all matters based on customary law. Matters initiated in the customary courts can be reviewed by the subordinate courts (referred to as magistrates courts) which are formal first level courts. Appeals against the decisions of the customary courts could go through three or four levels.[34]

The common law and statutory law fall under the jurisdiction of the Magistrate Court and the High Court. However, the only court that has unlimited original jurisdiction to hear any matter based on any law is the High Court. In addition, this court is the appellate court for all lower courts, and has review powers over Magistrate Courts and all quasi-judicial bodies.[35]

Despite legal dualism, the courts at different levels all have written court rules spelling out the procedure from initiation of a case up to final decision.[36]

33 Application of advanced technologies in civil litigation and other procedures' http://ruessmann.jura.uni-sb.de/grotius/Reports/lesotho.htm (accessed on 1 August 2006).
34 As above.
35 As above.
36 As above.

4.3 Constitution and Bill of Rights

The Constitution of the Kingdom of Lesotho (the Constitution) was adopted in 1993. It guarantees fundamental human rights in chapter two.

However, not all the rights in the Constitution are justiciable. In fact, human rights norms are divided into two broad categories. On the one hand, chapter 2 of the Constitution refers to 'the protection of fundamental human rights and freedoms', which mainly includes civil and political rights such as the rights to life, freedom of movement, the right to participate in government etc. On the other hand, chapter 3 lists 'the principles of state policy' which encompasses aspects of socio-economic rights such as the protection of health, the provision for education and the opportunity to work. While civil and political rights contained in chapter 2 are justiciable, the Constitution states in article 25 that 'principles of state policy':

> shall not be enforceable by any court but, subject to the limits of the economic capacity and development of Lesotho, shall guide the authorities and agencies of Lesotho, and other public authorities, in the performance of their functions with a view to achieving progressively, by legislation or otherwise, the full realisation of these principles.

Among the justiciable rights guaranteed under the Constitution, some are of particular relevance as they impact directly or indirectly on HIV. These rights include:

- the right to life (article 5);
- freedom from discrimination (article 18); and
- the right to equality before the law and equal protection of the law (article 19).

4.4 National human rights institutions

There is currently no independent national human rights institution (NHRI) in Lesotho. However, there is a Department of Human Rights under the Ministry of Justice, Human Rights, Rehabilitation of Law and Constitutional Affairs. The Department performs a co-ordinating function for the human rights activities of the Ministry of Justice and does not have the mandate to deal directly with HIV-related issues. The Department does not accept complaints directly from the public. It only coordinates human rights activities and programmes within the country.

The annual report of the Ministry of Justice mentions HIV and AIDS not from a human rights perspective but only to state that Lesotho has implemented a multi-sectoral approach to fighting the epidemic.[37]

37 The Ministry of Justice, Human Rights and Constitutional Affairs.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The process towards the development of a National AIDS programme was initiated in 1999 through a core group led by the MoHSW. This programme is still in place and falls under the MoHSW. However, following the creation of the National AIDS Commission (NAC), the formulation of HIV and AIDS policies and strategies is the responsibility of the NAC through the inputs of stakeholders.[38] The NAC was established in 2005 through the NAC Act (article 4).

The NAC Act (article 10) creates the National AIDS Secretariat, which is responsible for the implementation of strategies and policies adopted by the Commission. The National HIV/AIDS Forum (the Forum) was also created by the NAC Act (article 13). The function of the Forum is to bring all stakeholders and representatives of various sectors of society together. The Forum consists of representatives of concerned governmental organisations, NGOs, women's organisations, youth organisations and the Lesotho Network of PLHA.

5.2 HIV and AIDS plan

Following the expiration of the National AIDS Strategic Plan 2000-2005, Lesotho adopted a National HIV and AIDS Strategic Plan (2006-2011) in November 2006. The overreaching goal of the Strategic Plan is to

> [s]cale up universal access to information, knowledge and services to enable individuals to protect themselves from HIV infection and access treatment, care, support and impact mitigation services, and empathise with those affected by HIV and AIDS.[39]

The Strategic plan pledges that as a key guiding principle of the national response to HIV and AIDS 'human rights and dignity will be respected, irrespective of HIV status. Stigma and discrimination against people with HIV and AIDS will be eliminated'.[40]

5.3 Legislation

There is no HIV and AIDS specific legislation but there are other pieces of legislation that were enacted or proposed in response to the issues raised by the HIV epidemic. These laws and bills include:

38 Information obtained from the NAC.
39 National HIV and AIDS Strategic Plan 2006-2011(2006) 17.
40 As above,15.

- the Labour Code Amendment Act (2006);
- the Legal Capacity of Married Persons' Act (2006);
- the Sexual Offences Act (2003); and
- the Child Protection Bill.

These laws recognise the hardship faced by the two main vulnerable groups (women and children) in the epidemic and they aim at mitigating these hardships.

- The Married Person's Equality Bill gives married women the right to make decisions relating to the marriage, and their socio-economic position within the marriage without their husband's prior consent. The Bill allows them to enter into contracts and to institute legal proceedings. It also removes most of the major unfair practices against married women imposed under the customary law.
- The Sexual Offences Act[41] recognises and punishes various offences that were not recognised as sexual offences in earlier laws. It removes gender discrimination in the definition of sexual offences. This is to extend the scope of sexual offenders to include both males and females. It also imposes penalties for the sexual abuse of children and includes a wide range of actions, which can be considered sexual offences in Part III. This includes child prostitution and molestation, persistent child abuse and other forms of commercial sexual exploitation of children. Part V includes sexual offences against disabled people. The legislation in article 32(7) recognises and makes the HIV status of a person accused of rape an aggravating circumstance once the person is convicted. This makes it possible for a HIV-positive person who is convicted of raping another person to be sentenced to death. The law also recognises and punishes marital rape in article 3(3).
- The Child Protection Bill would, for the first time, give comprehensive protection to the rights of children including orphaned and vulnerable children (OVC), but it is yet to be enacted. This law would recognise the rights of all children in Lesotho. It is particularly directed at the protection of the rights of orphaned and vulnerable children. It generally provides for the obligations of the state to provide for amenities such as health care, education and the other basic necessities of life for OVC. The process of enactment has been slow because of the protection it provides children and the corresponding responsibility it places on the government. It is believed that the law will be passed soon.

41 As above.

5.4 HIV and AIDS policy

In 2000, Lesotho adopted a Policy Framework on HIV/AIDS Prevention, Control and Management (Policy Framework). This Policy Framework was the main document guiding the management of the HIV and AIDS epidemic in the country until 2006. In 2006, Lesotho adopted an HIV and AIDS Policy[42] that updates the Policy Framework. In fact, the adoption of the new HIV and AIDS Policy was based on the realisation that the Policy Framework

> does not fully address the legislative and policy requirements for the expanded programmes and planned interventions. In addition, the policy framework does not fully encompass some of the challenges especially those related to gender inequality in the traditional context and some of the issues emerging from the performance of current and planned interventions.[43]

The overall goal of the HIV and AIDS Policy is

> to enable Government to effectively fight the HIV and AIDS epidemic: to prevent the further spread of the epidemic, provide treatment, care and support services, and to mitigate the impact of HIV and AIDS on individuals, families, and communities.[44]

A Policy of Universal Voluntary Counselling and Testing was initiated in March 2004 as the main document that regulates voluntary counselling and testing (VCT). This document provides the necessary guidelines for VCT and incorporates human rights standards. It regulates VCT, sets out the types of tests, reasons for the test and the applicable standards for conducting VCT.

The National Guidelines for HIV Testing and Counselling (HTC Guidelines) of March 2004 is the latest document guiding HIV testing. The purpose of HTC is to provide national standards that must be adhered to in the provision of high quality HTC services through accredited institutions in the public, private and non-governmental spheres.[45]

Other policies include the Education Sector Strategic Plan (2002), the Five-year Strategic Plan for Directly Observed Treatments (DOTs) Expansion in Lesotho (2003), the Gender and Development Policy (2003), Guidelines to Prevent Mother-to-Child-Transmission (PMTCT) of HIV (2004), the Human Resources Development and Strategic Plan (2005-2025), the Know Your Status (KYS) Campaign (2003), the National Policy on OVC and the National Action Plan for OVC as well as the National Youth Policy.

42 n 24 above.
43 As above, xiii-xiv.
44 As above, xiv
45 National Guidelines for HIV Testing and Counselling, 5.

5.5 Court decisions

HIV and human rights issues fall under the jurisdiction of the magistrate's courts and the high courts. Appeals from these courts are directed to the Court of Appeal. Even though courts in Lesotho have tried cases based on human rights, there is no precedent on questions of human rights relating to HIV.

In addition, the Constitution does not provide protection to various human rights that are relevant to HIV. This is because many of these rights such the right to health and the right to work fall under non-justiciable rights spelled out under the principles of state policy. It is therefore difficult to bring actions under the Constitution or any other international human rights law, which has not been domesticated in Lesotho.

The Sexual Offences Act deals specifically with issues related to HIV.[46] The law provides in article 32(7) for a harsher penalty for a person who has been convicted of the offence of rape. If he is found to be HIV positive and was aware of his HIV status or had reasonable suspicion of the infection at the time of the commission of the offence, he will be sentenced to death.

Importantly, article 3 of the Sexual Offences Act in the definition of rape introduces the failure of disclosure by an HIV-positive person who engages in a sexual act with another (HIV-negative) person.

In the case of ***R v Mothibili Mokara,***[47] the accused was found guilty of raping his 11-year-old daughter and infecting her with HIV.[48] The accused person[49] (who had the knowledge of or reasonable suspicion that he is HIV positive) was ordered to undergo an HIV test by the magistrate during the trial (before he was found guilty). He tested positive to HIV. On referral to the High Court, the judge referred to the Sexual Offences Act for the determination of appropriate penalty under article 32(7).[50]

46 Sexual Offences Act (n 28 above).

47 *R v Mothilbili Mokara* Criminal Sentence 9 of 2004 (case number in the Magistrate Court is Cr 382/03).

48 The case is still pending in the High Court although the case has been determined by the Magistrate Court and has been referred to the High Court for sentencing because the Magistrate Court does not have the jurisdiction to handle the case.

49 Sexual Offences Act (n 28 above) art 32(7) provides that, where a person is infected with HIV and at the time of the commission of the offence the person had knowledge or reasonable suspicion of the infection, he shall be given the death penalty.

50 The matter was referred to the High Court for the appropriate sentence because the Magistrate Court does not have the jurisdiction to sentence the accused person in this case.

There are other rape cases which have been decided by the courts under the Sexual Offences Act, but which do not indicate that the rapist went through a mandatory HIV test to determine HIV status.[51]

6. Access to health care

6.1 Government regulation of access to health care

There have been various initiatives by government to respond to the HIV epidemic. For example, the government has recognised the urgent need to scale up ART and has established structures and frameworks including the UN Theme Group on HIV/AIDS in Lesotho, and multi-sectoral agencies such as the National AIDS Commission (NAC), district AIDS task forces and a national multi-sectoral task force.[52] A directorate for HIV and AIDS was also established in the MoHSW to provide technical advice and to advance the health sector's response to the epidemic. A health sector reform launched in 2000 has focused on building capacity both in the public and private health sector.[53]

A national programme for PMTCT has also been developed and implemented, and ART pilot programmes were carried out in all districts.[54] In response to these programmes, 15 PMTCT sites were established countrywide and 22 881 women were counselled on PMTCT in 2005.[55]

In addition, the government scaled up the total number of people receiving ART from the public sector and it was aiming to put half of the 56 000 people requiring ART on treatment by the end of 2005. The lack of human resources and finances in the country still remain the biggest obstacles in reaching these objectives.[56]

51 The fact that the accused persons in these other cases were not asked to undergo HIV tests might be an oversight of the courts. This is because the reason for their exemption from the HIV test was not stated in the case report.

52 WHO 'Summary Country Profile for HIV/AIDS treatment Scale-up in Lesotho' (2005) http://www.who.int/3by5/support/june2005_lso.pdf (accessed 1 August 2006).

53 UNICEF (n 15 above).

54 As above.

55 Minutes of the UN Theme Group Meeting August 2005.

56 WHO 'WHO applauds Lesotho PM for leading Universal Voluntary HIV Testing Drive' (2004) http://www.who.int/disasters/repo/12506.pdf (accessed 1 August 2006).

It is estimated that, despite the reduced costs of drugs, to provide free ART would cost the government USD 14 million annually[57] related partly to ongoing issues of food insecurity and poverty.[58]

The Policy Framework also does not guarantee the right to health care; it only reiterates the government's commitment to the provision of appropriate health facility-based care, including counselling. It also stresses the government's commitment to strengthen the capacity of health care and social workers to provide care and support to people living with HIV.

Health care in public health care centres is greatly subsidised by the government. Patients are only required to pay less than 10 Maloti (about USD 1.60) to access public health care facilities in the country.

The basic document guiding the rights of people living with HIV is the Constitution. However, the HIV and AIDS Policy, the HTC Guidelines and the other guidelines dealing with treatment indicate the acceptable standards for treatment.

Some of the rights of people living with HIV that are provided for in these documents are:

- the right to freedom from discrimination;[59]
- right to confidentiality and non disclosure of HIV status;[60]
- access to voluntary HIV testing (even though not cheap in all cases but there shall be access to the voluntary testing);
- the right to marry and found a family;[61]
- the right to the highest attainable standard of physical and mental health;[62]
- the right to informed consent before a medical procedure is carried out;[63] and
- the right to information for making choices about one's health and well being.[64]

6.2 Ethical guidelines

Ethical guidelines for the medical profession in Lesotho are not set out in any document. Medical practice is guided by guidelines that are

57 'Lesotho HIV/AIDS testing facilities still to be set up' *IRINNews* http://www.irinnews.org/report.asp?ReportID=39941&SelectRegion=Southern_Africa&SelectCountry=LESOTHO (accessed 1 August 2006).

58 View of Dr M Kiasekoka, the WHO representative who chaired the Lesotho-UN Theme Group on HIV/AIDS in 2004.

59 Constitution art 18.

60 HIV and AIDS Policy (n 24 above) xvii.

61 HTC Guidelines (n 46 above) art 9.

62 As above, It should be noted that this right although not protected under the Constitution, it is one of the rights set out in the HTC Guidelines, art 9.

63 As above 9.

64 As above.

similar to those in the United Kingdom and South Africa. The first and most important universal principle — 'do no harm' — should be applied to all patients irrespective of their HIV status.[65]

One of the main reasons for this *lacuna* is related to the fact that medical doctors are trained outside the country, mostly in South Africa,[66] so the doctors that practice in Lesotho follow the ethical guidelines applicable in South Africa.

6.3 Medicines

The objective of the government's treatment, care and support programme is to 'promote and provide universal access to free treatment, care and support services for all without discrimination or barriers'.[67]

In order to achieve this objective, the HIV and AIDS Policy states that government should, among others:

- ensure free and equitable access to quality ART, TB and STI and opportunistic infections treatment;
- provide standards to ensure adherence to ARV treatment to reduce the risk of drug resistance and treatment failure;
- ensure universal access to treatment, care and support for people living with HIV;
- ensure that children infected with HIV have free access to paediatric treatment;
- develop standards for the involvement of private practitioners and home-based carers in the management and referral of patients on ART; and
- ensure the development of minimum standards for food security and nutrition as an integral element in the provision of ART.

Despite these provisions, access to medicine and the provision of medicine for people living with HIV are still problematic. This is because the number of people who access ART is still a minority of those who are in need of treatment.

There is no policy limiting access to medicines in Lesotho. In fact, the Health and Social Welfare Policy, as well as the Policy Framework, are aimed at making medicines available in Lesotho. This can be seen from the government's commitment under the HIV and AIDS Policy.[68]

65 Excerpts from the interview with Dr Moyamane, President of the Lesotho Medical Association on 25 January 2006.
66 There is no medical school in Lesotho.
67 HIV and AIDS Policy (n 24 above) 31.
68 As above.

There are also no policies or laws aimed at withholding medicines or access to HIV-related prevention or treatment from people living with HIV, particularly on the basis of sexual and social behaviour that is deemed to be 'immoral' or questionable by others such as health care practitioners. Instances where treatment was denied on account of the deemed 'immoral' sexual behaviour of the patient[69] were based on the personal attitudes of the people in charge. For instance, prison authorities refuse to distribute condoms in prisons in spite of the clear requirement of the HIV and AIDS Policy which provides that the government should ensure that all prisoners have access to HIV-related prevention information, education, HTC, means of prevention (including condoms), treatment (including ART), care and support.

Lesotho is a member of the World Trade Organisation (WTO) and is also a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) by virtue of the WTO Agreement.[70] However, the government has not yet taken any stance on generic substitution, compulsory licensing and parallel importing. Since it has not taken any steps towards the production of generic ARVs, there is a strong reliance on donations from multilateral and bilateral cooperation for the provision of HIV and AIDS related treatment and services. The drugs used in the treatment of AIDS-related illnesses and STIs are imported from other countries.

There are no patent laws, control of medicines and hazardous substances statutes, or import and export laws in Lesotho and it is not easy for individuals to import drugs into the country. Nevertheless, NGOs and international governments supporting the provision of ARVs are given permits to bring the drugs into the country and this has helped to ease the burden.

Lesotho has benefited from donations of ARVs and related medicines from the pharmaceutical company Bristol-Myers Squibb. The first treatment centre to deliver low-cost drugs as part of a national rollout strategy, launched in Maseru in May 2005, is funded almost entirely by a pharmaceutical giant. The drug company contributed USD 4.5 million to the first three years of the project, on

69 SIPAA Monitoring the political commitment of governments in response to the needs of women living with HIV workshop 'Policy Report of the International Community of Women Living with HIV/AIDS (ICW): Lesotho (6 - 11 February 2005).

70 WTO Agreement arts II & XII (1) state that accession to the WTO agreement also applies to the multilateral trade agreement annexed to it which are binding on all members. The TRIPS Agreement (Annex 1C to the WTO Agreement) is part of the multilateral trade agreement.

condition that the government takes over the bulk of the costs in 2007.[71]

In addition, Lesotho has, so far, received USD 19,273,380 from the Global Fund to Fight AIDS, Tuberculosis and Malaria for prevention and treatment activities as well as the strengthening of the national health capacities and supporting people living with HIV and AIDS.[72]

Most of the NGOs, governments and private entities providing free ART are time-bound; this is a major cause of concern for many people living with HIV because it will be very difficult for them to continue with the drugs when the programmes draw to a close.

Traditional medicines and healers play a significant role in treatment. People have resorted to traditional herbs and medicines, especially in the absence of access to ARVs.[73]

6.4 Condoms

Condoms are easily accessible only in the major cities, especially in the capital (Maseru). The rural areas still face a shortage of condoms. Condoms are provided in all government departments and ministries. Five million condoms were distributed and 400 condom containers were installed around the country in 2005.[74]

Some condoms are distributed free of charge by the government. In 2005, the government contracted an NGO, Population Services International (PSI), to engage in the social marketing of condoms. The social marketing of condoms is to ensure commitment in the use of condoms as the consumer pays for the product rather than getting it for free. This is based on the belief that if people pay for condoms, they will be more inclined to use them correctly.[75] Condoms marketed by PSI are sold for a nominal fee (as little as USD 0.16 for a pack of three), while those sold in shops cost from USD 0.80 for a pack of four, depending on the quality.

71 The treatment era: ART in Africa' http://www.plusnews.org/webspecials/ARV/lesart.asp (accessed 9 October 2005).

72 The Global Fund to fight AIDS, Tuberculosis and Malaria 'Lesotho and the global fund' www.theglobalfund.org/Programs/grantdetails.aspx?compid=246&grantid=197&lang=en&CountryId=LSO (accessed 4 September 2006).

73 UNESCO 'HIV and AIDS treatment education: a critical component of efforts' http://www.unesdoc.unesco.org/images/0014/001461/146114e.pdf (accessed 1 August 2006) 33. See also 1st Southern African Regional Community Home Based Care Conference http://www.hdnet.org/library/ Sharing%20responsibilities %20 for%20quality%20cares.pdf (accessed 1 August 2006).

74 Information received from the officer in charge of condoms at the HIV/AIDS Directorate under the MoHSW on 17 January 2006.

75 As above.

6.5 Case law

There are no judgments on HIV and AIDS and the right to access to health care or any related human rights issue within the country's jurisprudence. This is because the Constitution and the national laws do not guarantee the right of access to health care.

7. Privacy

7.1 Notifiable disease

HIV is not a notifiable condition in Lesotho.[76]

7.2 Medical experimentation

Medical trials for HIV drugs have not been carried out in Lesotho so there is no procedure in place to protect the rights of people in this regard. The right to bodily and psychological integrity is not specifically guaranteed in the Constitution.

The Policy Framework provides that

> HIV/AIDS-related research will require ethical clearance from LAPCA (now NAC), and must conform to International Guidelines for Biomedical Research Involving Human Subjects (IGBRIHS). All research will be co-ordinated by LAPCA and should include religious, socio-economic, behavioural and cultural surveillance.[77]

The National HIV and AIDS Policy reaffirms the importance of research in the response to HIV and AIDS as follows:[78]

> Although the health impact and implications of HIV is well known, there is significant scope and need for research in the non-health fields of HIV research. Further, as long as a cure or vaccine has not been found, there will be an ongoing need for health research.

7.3 Duty to disclose

The main documents that deal with the issue of HIV and privacy are the HIV and AIDS Policy and the HTC Guidelines.[79] Under these policies, the right to privacy and confidentiality are key issues. The

76 Nothing in the laws relating to HIV indicates that HIV status can be communicated either to a partner, spouse of the PLHA or to the government or any party without the prior consent of the PLHA. The law does thus not make HIV a notifiable condition.

77 Policy Framework on HIV/AIDS Prevention, Control and Management (2006) 9.

78 n 24 above, 52-53.

79 As above, 19-21, and National Guidelines for HIV testing and counselling (n 45 above) art 3.6.

HTC Guidelines provide that 'confidentiality is one of the guiding principles of HIV Testing and Counselling services and must be protected'.

The HIV and AIDS Policy also upholds the principle of confidentiality but under its section devoted to 'beneficial disclosure' adds that

> [t]here is a need to provide clear public health-oriented guidelines to ensure that sexual partners who test positive for HIV should disclose this fact to their partners ... However, healthcare providers should have the legal authority to inform the other partner/s if a properly counselled HIV-positive person refuses to disclose ... [80]

On the issue of partner notification or 'beneficial disclosure' as it is referred to in Lesotho, the HTC Guidelines further state that

> [a]ll patients and clients, both HIV positive and HIV negative, should be empowered to inform their sexual partners of their HIV test results. For HIV-positive clients who are reluctant or fearful to disclose their results, the counsellor should offer additional, ongoing counselling to help the client inform the partner. If the client requests, the counsellor may inform the sexual partner of the client about the HIV test results in the presence of the client.

7.4 Testing

There are four main types of testing in Lesotho. These are:

- VCT: provided in 'stand alone sites' or VCT sites established in the country to provide free access to HIV testing and counselling to the public.
- Universal HIV Testing (UHT) also known as 'Know your status campaign': This is the latest type of HIV testing which was introduced late in 2005. It is a provider-initiated type of testing whereby the VCT counsellor goes to the client (the person to be tested). It is believed that this type of testing will generate greater access to testing and thus more people will be tested. UHT is provided in ministries, factories, private sector institutions and villages and it is not meant to be in any way mandatory.
- Routine offer of HIV Testing and Counselling: this type of testing is provided within integrated sites, such as TB clinics, sexually transmitted infections (STIs) clinics, antenatal clinics (PMTCT), outpatients and inpatient departments. A routine offer of an HIV test is made to patients who are receiving care at any of the above listed clinics. It is voluntary and is offered as part of the normal check-up requirement for patients in these sites. The

[80] n 24 above, 23.

process allows an individual who undergoes counseling to be able to make an informed choice about being tested for HIV.

- Routine offer-diagnostic Testing: This type of testing is provided within health facilities to patients during attendance at antenatal clinics or those with suggestive signs and symptoms, such as those attending diagnostic and treatment facilities for TB and STI clinics and inpatient departments. It is part of the normal medical tests or examination carried out on a patient who presents with symptoms that reasonably suggest that the person is suffering from an opportunistic infection. The patient must expressly refuse the test in order for it not to be carried out. This entails moving beyond the traditional model of voluntary counselling and testing [VCT] where concerned individuals present themselves for counselling and HIV testing. The medical practitioner advises a patient to go for HIV testing and counselling if it is suspected that a patient has HIV although the patient is at liberty to refuse the test.

The position in Lesotho regarding HIV testing is unique. This is due to the recent introduction of the UHT 'know your status campaign' in December 2005 by the King of Lesotho. This system allows for a counsellor to take the test to the receiver and offer VCT to people at their doorsteps without the request being initiated by them. This type of testing is not meant to be mandatory and people have a choice to opt-out at any stage. This process is aimed at testing as many people as possible.[81]

The government also prefers the term universal HIV counselling and testing rather than VCT. This is because even though the test is not mandatory, and there is no imminent health reason for everyone to know his or her HIV status, the test ought to be universal as everyone is expected to know his or her status.

Nevertheless, whatever name is given to testing in Lesotho, the Policy still provides that it should be done with the utmost standard of ethics and care. In this regard, the HTC Guidelines provide that

> all health care providers are bound by an ethical principle to do all that is necessary and available to provide the best possible care through the use of diagnostic tools and follow-up treatment. Therefore an HIV test must be provided when requested or indicated, and treatment or follow-up must be provided as necessary and available.[82]

On the issue of mandatory testing, the HTC Guidelines state as follows:[83]

81 MoHSW '"Know Your Status" Policy Handbook'.
82 National Guidelines for HIV testing and counselling (n 45 above) art 9.
83 As above, art 10.

> 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.

According to the HTC Guidelines, the three crucial elements in obtaining truly informed consent in HIV testing are:

- providing pre-test information on the purpose of testing, and on the treatment and support available once the result is known;
- ensuring understanding; and
- respecting the individual's autonomy.

Under the HTC Guidelines, informed consent and pre- and post-test counselling are required. The Guidelines provide that

> HIV Testing and Counselling 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 HIV testing and counselling should be considered the 'standard of care'. Informed consent should be obtained during the normal process of consultation between the health care provider and the patient.[84]

The Guidelines also provide for post-test support group facilities or services to be offered to the patients under the stand-alone HIV testing and counselling services that are provided in sites that are situated outside the health facilities.[85]

8. Equality and non-discrimination

Legislation and policies impacting on discrimination against people living with HIV are:

- the Constitution;
- the HIV and AIDS Policy; and
- the HIV and AIDS Strategic Plan 2006-2011.

The Constitution provides for non-discrimination on several grounds. This is provided for in article 18 which states as follows:

> (1) Subject to the provisions of subsections (4) and (5) no law shall make any provision that is discriminatory either of itself or in its effect.
>
> (2) Subject to the provisions of subsection (6), no person shall be treated in a discriminatory manner by any person acting by virtue of any written

[84] As above, art 6.
[85] As above, art 7.

> law or in the performance of the functions of any public office or any public authority.
>
> (3) In this section, the expression 'discriminatory' means affording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.

HIV status is not expressly included as one of the grounds for non-discrimination. However, HIV status could be included under 'other status' referred to in article 18(3).

Article 19 provides for equality before the law and equal protection of the law. This means that everyone will enjoy all the protections under any law which binds the state (both local and international laws that have been ratified and domesticated).

The HIV and AIDS Policy affirms the importance of the promotion and protection of human rights as part of the response to HIV. Indeed, the HIV and AIDS Policy maintains that

> [i]nternational human rights law and the Constitution of Lesotho guarantee the right to equal protection before the law and freedom from discrimination and provision of protection for vulnerable groups.[86]

The HIV and AIDS Policy further states that

> [d]iscrimination against PLHAs violates their rights and is counterproductive to the scaling up of the HIV and AIDS response in that it threatens voluntary disclosure of HIV sero-status, thus increasing vulnerability to HIV infection.[87]

The goal of the HIV and AIDS Policy is to

> create and promote an environment where all PLHAs and vulnerable populations fully enjoy human rights and fundamental freedoms, in particular have access to education, inheritance, employment and healthcare rights, social and health services, IEC and BCC, prevention, treatment, care and support services and legal protection.[88]

In spite of these policy commitments, the Lesotho Defence Force (LDF) still applies a mandatory HIV test for prospective employees of the LDF. In 2005, people who tested positive for HIV were refused employment into the LDF. Although the matter has not yet been taken to court, it is being handled by NGOs who are still lobbying for support

86 n 24 above, 14.
87 As above, 45.
88 As above.

and gathering information. However, the matter is proving difficult for the NGOs[89] because the people who were discriminated against under the policy are reluctant to identify themselves because this might involve public disclosure of their status.

9. Labour rights

9.1 Legislation

The Constitution does not recognise labour rights as justiciable rights. It includes them in the category of 'principles of state policy'.[90]

The Labour Code Order 1992 (LCO) and the Public Service Act, the two main laws regulating labour relations, were silent on issues related to HIV until the adoption of the Labour Code (Amendment) Act in 2006.[91]

The Labour Code Amendment Act introduces two important changes. Firstly, it provides for information and education of employees and ensures confidentiality, non-discrimination, eligibility for employee benefits, testing, protection against victimisation, care and support for HIV-positive employees.[92] Secondly, the Labour Code Amendment Act transfers the review powers from the Labour Appeal Court to the Labour Court.[93]

9.2 Testing

Section 235(C) of the Labour Code Amendment Act stipulates that 'an employer shall not require a job applicant or an employee to undergo a direct or indirect HIV testing as a condition for employment, access to the employment, application or training'.

Pre-employment HIV testing is mandatory for employment in the LDF. This is articulated in the new Recruitment Policy of the LDF which requires a mandatory pre-recruitment HIV test. If an applicant tests positive, he or she will not be selected for employment.[94]

89 The Development for Peace Education is an NGO in Lesotho that deals with discrimination based on HIV status in conjunction with the Lesotho Council of NGOs.
90 Constitution chap III.
91 Labour Code Amendment Act 5 of 2006.
92 Labour Code Amendment Act 5 of 2006.
93 As above.
94 This has been condemned by NGOs and there are plans to take the matter to court as soon as possible.

9.3 Medical schemes act

There is no medical schemes act in Lesotho.

9.4 Duty to provide treatment

The laws of Lesotho do not provide for the provision of ARVs by any employer. However article 235(J) of the Labour Code Amendment Act states that the

> employer shall allow an employee an opportunity to seek medical attention of HIV and AIDS counselling from a service provider of the employee's choice' and where HIV and AIDS counselling and care services exist at the work place; the employer shall cause such to be provided for the benefit of the employees ...[95]

Moreover, some government departments are providing free ART treatment and care to their employees as a component of their commitment to allocate two per cent of their budget to HIV and AIDS.

10. Women's rights

10.1 Legal status and protection

The Constitution does not expressly recognise a specific status to women. However, it does not challenge the position of inferiority of women enshrined in customary law. Indeed, customary law, which places women in a subordinate position to men, is formally recognised and upheld by the Constitution.[96]

Nevertheless, article 18 of the Constitution outlaws any discrimination based, among others, on sex. This provision protects women against discrimination.

Until recently, the common law which regulates the status of women in the country provided that unless a woman marries under an ante-nuptial contract, which is reportedly very rare, she is deemed married in 'community of property' and is therefore under her husband's marital power and a minor in law.[97] Women married in community of property cannot own property. If they inherit, the property belongs to their husbands. As under customary law, women under common law without ante-nuptial contracts cannot conclude

95 Labour Code (n 91 above).
96 'Legal Systems of Commonwealth Members' http://www.droitcivil.uottawa.ca/world-legal-systems/engcommonwealthmembers.html (accessed 1 August 2006).
97 S Hanes 'Woman quota changes dynamics of Lesotho vote' *USA TODAY* 9 June 2005 http://www.usatoday.com/news/world/2005-06-09-lesotho_x.htm?csp=34 (accessed 1 August 2006).

contracts, open bank accounts, obtain loans, or apply for a passport without the permission of their husbands.[98]

However, this situation changed significantly with the coming into force in December 2006 of the Legal Capacity of Married Person Act.[99] Article 3 of the Act abolishes the restrictions that marital power placed on the legal capacity of women and article 5 recognises full and equal power of spouses.

Measures to protect women who are vulnerable to HIV infection are found in policies and legislation. The Sexual Offences Act of 2003 protects women from rape and other acts of sexual violence, which are deemed to increase their vulnerability to HIV infection. This Act also introduces the recognition of marital rape in the legal system of Lesotho.

10.2 Domestic violence law

Lesotho does not have a domestic violence law. However, the National HIV and AIDS Policy of Lesotho recognises the link between violence and HIV. In its section on women and girls, the National HIV and AIDS policy acknowledges that

> [w]omen and girls are frequently subjected to social, cultural and economic disempowerment that puts them at greater risk of physical and sexual abuse. Women are treated as legal minors and are physiologically more prone to infection by HIV and AIDS.[100]

To address this situation and ensure the protection of women and girls, the policy enjoins the government to

> [e]nsure that women and girls are protected against gender-based violence, including sexual violence; and
>
> develop mechanisms for protecting women who suffer abuse and domestic violence to assert their rights to safer marital sex and other rights.[101]

In addition, the Sexual Offences Act in article 3(3) indirectly addresses issues related to domestic violence by providing that marriage is no longer a defence for rape.

10.3 Customary rules and practices

Customary law is formally recognised as a source of law by the Constitution.[102] Marriage under customary law is potentially poly-

98 As above.
99 Legal Capacity Married Person Act 9 of 2006.
100 n 24 above, 34.
101 As above 35.
102 'Legal Systems of Commonwealth Members' (n 96 above).

gamous and requires the agreement of the parents of the parties. The fact that under this type of marriage there is no fixed minimum age is also a factor that contributes to the increased vulnerability of women to HIV.[103]

Various cultural practices increase the vulnerability of women and girls to HIV. These practices include:

- scarification (this involves the making of marks on the body using sharp instruments usually a blade. These marks are then smeared with some specially prepares 'muti' to serve as a form of protection against 'evil spirits or bad omen e.g. thunder or lightening');
- habitual blade sharing during initiation and funeral ceremonies (to shave the hair of the bereaved members of family);
- polygamy;
- wife inheritance; and
- female genital mutilation (FGM). Although FGM is no longer widespread in the country, it still exists among some clans as a practice to 'help' young girls keep their chastity.

Under customary law, a woman is a perpetual minor, usually under the guardianship of her father or eldest member of her family, her husband upon marriage and her eldest son or male customary heir upon the death of her husband.[104]

Under customary law, a woman has no legal capacity to enter into contracts without male consent and therefore cannot acquire property or obtain credit (except through her own social organisations).[105] These factors affect the socio-economic position of women, making them subject to risky choices of survival such as transactional sex, or an inability to negotiate safe sex.

Some cultural norms for rearing girls and women affect young women's ability to control sexual situations, thus making them vulnerable to gender-based violence and coerced sex. One such cultural belief which tends to increase the rate of sexual violence is the common belief that men are not able to control their sexuality and hence their demand for sex is understandable.[106] Also, as in most societies, condom use is often associated with promiscuity and the belief is that condoms do not have a place in sexual relations within marriage. It is thus difficult for a woman to negotiate condom use in

103 Equality Now (n 18 above).
104 As above.
105 As above.
106 O Shisana 'Gender and HIV/AIDS: Focus on Southern Africa' 7 June 2004 http://www.hsrc.ac.za/Document-50.phtml (accessed 10 September 2007).

a relationship. At the same time, some men who want to use a condom at times have difficulty in getting the women to agree.[107]

Among the people at the root of traditions in Lesotho, it is believed that the payment and acceptance of 'lobola', which is the agreed bride price paid by the groom's family to the family of the bride, is a condition that the man has full control over the woman, including her sexuality. This inhibits women from negotiating or even going against the sexual desires of the man.

The Policy Framework also stressed the fact that

> Basotho cultural of scarification, habitual blade sharing (especially during and funeral and at initiation schools), polygamy and wife inheritance including loss of religious norms have contributed to the escalating rates of HIV infections. This requires intensive Information, Education and Communication (IEC) campaign, training, social openness, while we stay culturally sensitive.[108]

A lot of effort is taken to ensure that there is an increase in campaigns on HIV and modes of transmission. Most people in charge of ceremonies such as ear piercing and scarification have been taught about safe methods. Some of the safe methods now employed are sterilisation and use of individual blades and instruments so that the risk of contracting HIV during these ceremonies is reduced. None of these cultural practices have been challenged in court.

Steps are taken to ensure that women receive information on the transmission of HIV and safe sexual practices. These steps involve the use of the media, widespread distribution of educational materials on modes of HIV transmission and the use of educational materials for campaigns in the hospitals and antenatal clinics.[109] This is provided for under the Policy Framework which highlighted the role of IEC as the main strategy for the control of HIV pending the discovery of a cure. The IEC programme, developed in close collaboration with the media, will ensure that accurate messages appropriate for the general population and specific target groups are provided. These messages will take into account the religious, social and cultural circumstances of the audience.

[107] As above. It should be noted that these facts are based on a study of South Africa, but it has been adapted for this purpose because the facts stated here have been corroborated by interviews. It is also used in particular study because the vast movement of people within Lesotho and South Africa has resulted in a lot of similarities in their culture and the ways of life of the people. It also considers the similarity in the trend of the epidemic in the two countries.

[108] n 78 above, art 4.21.

[109] Many of these educational materials made for the women are available in the hospitals and clinics.

10.4 Administration of anti-retrovirals to rape survivors

The HTC Guidelines[110] and the National HIV and AIDS Policy[111] provide for the administration of post-exposure prophylaxis (PEP) to rape survivors. The HIV and AIDS Policy provides the general conditions and procedures of the administration of PEP and enjoins the government to

- ensure free and timely access to PEP for all people exposed to the risk of HIV infection through occupational exposure and sexual violence;
- ensure availability of PEP at all health facilities;
- ensure proper sensitisation of law enforcement officers in availability and importance of PEP;
- Ensure provision of training of all healthcare providers in the management and timely administration of PEP; and
- Ensure the development and dissemination of guidelines on the availability and application of PEP.[112]

The Sexual Offences Act is silent on access to prophylactic ARVs.

10.5 Sex workers

The laws are silent on the status of sex workers in the county. The profession has not been legalised or criminalised by any law.

Despite the elusiveness of the law, the National HIV and AIDS Policy stresses that sex workers 'are particularly vulnerable to sexual violence and have a higher risk of contracting HIV infection from the increased number of partners and sexual episodes'.[113] Cognisant of this state of fact, the National HIV and AIDS Policy insists on the need to ensure that sex workers are provided with information and condoms. The Policy states that the government should

- provide guidelines for the establishment of special services for sex workers to have access to confidential and user-friendly health services, sexual and reproductive information, free condoms, and free treatment of STIs and the care of those living with HIV and AIDS; and
- provide guidance for the involvement of sex workers in information dissemination on HIV and AIDS prevention.[114]

110 n 46 above, art 12.
111 n 24 above, 30.
112 As above.
113 As above, 39.
114 As above, 40.

11. Children's rights

11.1 Access to health care

The National HIV and AIDS Policy states that the government should 'ensure that children infected with HIV have free access to paediatric treatment'.[115] Children living with HIV are provided with ART under the same criteria as adults living with HIV. Thus, in the event where a health care facility is inadequate for adults, it will similarly be inadequate for children. Children are provided with ARVs free of charge by the government, NGOs, or international organisations assisting the country with the provision of free ARVs.[116]

A national programme for the PMTCT has been developed and implemented. Pregnant women who test positive are given free ART in an attempt to stop vertical transmission of HIV.[117]

In 2005, 15 PMTCT sites were established countrywide and 22 881 women were counselled on PMTCT. In all the sites established, 8164 pregnant women were tested; of these, 1753 women were HIV positive and 1361 women were put on ART.[118]

11.2 Children orphaned by AIDS

The care of children who have been orphaned falls under the mandate of the Department of Social Welfare. The National Policy on Orphans and Vulnerable Children (OVC) provides a comprehensive framework for care and support for OVC in Lesotho. The National Policy on OVC provides for the basic necessities of life for children who have been orphaned and also provides for their education up to the tertiary level. These provisions are also included in the Child Protection Bill, which has not yet been passed.

11.3 Education

There is no reported case of children being refused access to a school on the basis of his or her HIV status. The Education Sector Strategic Plan provides special measures and gives special consideration to the education of the girl child in Lesotho. The Plan seeks to provide universality and equity in access to ten years of basic education, particularly for girls and other disadvantaged groups.[119] This is

115 As above, 31.
116 However, the data on the HIV prevalence among children born to mothers placed on ARV in order to access the effect of PMTCT is currently unavailable.
117 WHO (n 52 above).
118 'Sentinel Surveillance Report 2005' (n 12 above).
119 Education Sector Strategic Plan (2002) 34.

despite the fact that Lesotho has exceeded gender parity in access to primary education (82 per cent for girls and 75 per cent for boys) and that completion rates are higher for girls (80 per cent).[120]

Teachers in training are also given special training to sensitise them towards the needs of HIV-positive children in school. This is done at the National Teachers Training College (NTTC). The training is comprehensive and there is a special department for the training.[121]

In addition, since 2003, the Ministry of Education and Training (MoET) has conducted training workshops for 8000 primary school teachers and 1000 early childhood care and development teachers in life skills education in collaboration with the United Nations Children's Education Fund (UNICEF).

A standardised life skills education and HIV school curriculum that encompass HIV and life skills education as core subjects from standards four to seven of primary school to forms A, B and C of secondary school education are also in the final stage of development by the MoET and are scheduled for implementation in 2006.[122]

12. Family law

The Legal Capacity of Married Persons Act of 2006 constitutes an important milestone in relation to family law issues in Lesotho.[123] This Act provides for equality of rights for spouses and deal with issues related to property and inheritance.

There is no guardianship legislation specifically related to HIV and AIDS. Nevertheless, the Child Protection Bill proposes to provide for the guardianship rights of children including children orphaned by AIDS.

The Department of Social Welfare is the government department responsible for the co-ordination of all programmes dealing with the care of children who have been orphaned. The department determines the appropriate standard of care for children who are orphaned, especially those in orphanages. The department also monitors and evaluates compliance with these standards by the orphanages.

There is a comprehensive National Policy on OVC, which is to be fully implemented. The Child Protection Bill will, when passed,

120 UNICEF '"Girls" Education in Lesotho' (2003) http://www.unicef.org/girlseducation/files/Lesotho_2003.doc (accessed on 1 August 2006).
121 Information received from the NTTC.
122 UNGASS Report (n 10 above) 11.
123 Legal Capacity of Married Persons Act 9 of 2006.

provide comprehensive protection to the rights of all children including OVC. It is particularly directed at the protection of the rights of OVC. It generally provides for the obligations of the state to provide for such amenities as the health care, education and the other basic necessities of life for OVC.

13. Criminal law

13.1 Criminal legislation

The Sexual Offences Act of Lesotho criminalises the wilful exposure to HIV. In fact, the conjunction of article 2 and 3 of the Sexual Offences Act make it an unlawful sexual act when a person

> knowing or having reasonable grounds to believe that he/she is infected with a sexually transmissible disease, the human immuno-deficiency virus or other life-threatening disease does not, before committing the sexual act, disclose to the complainant that he/she is so infected.

It is relevant to note that the Sexual Offences Act does not require actual transmission of HIV for the offence to be committed. When convicted of the offence of an unlawful sexual act on the ground of the failure to disclose his or her actual or perceived HIV positive status, the accused can be sentenced to the death penalty.[124]

In addition, article 30 of the Sexual Offences Act provides for compulsory HIV testing for persons charged with sexual offences. The Act provides the following:

> 1) A person with a sexual act involving the insertion of a sexual organ into another person's sexual organ or anus shall have his blood substance taken by a medical practitioner within a week of the preferment of the charge.
>
> 2) The blood substance referred to in subsection (1) shall be tested for HIV and the results shall be disclosed by the medical practitioner to the accused and the complainant only.
>
> ...
>
> 4) Where the conviction is secured, the results of the test done pursuant to a subsection 3 shall be tendered in evidence for the sentence.

Penalties for the offences in article 30 are provided for in article 32(vi) and (vii) which provides for death penalty when the accused had knowledge or a reasonable suspicion of the infection.

The Sexual Offences Act has been applied in very few rape cases in Lesotho.[125]

[124] Sexual Offences Act art 32(vii).
[125] *R v Mothibili Mokara* (n 47 above).

13.2 Men having sex with men

Sodomy is prohibited as a common-law offence in Lesotho.[126] There are reported cases of sexual relations between men among prisoners.[127] Four sodomy cases were prosecuted in October 2004.[128] Two people were sentenced to a further 10 years (in addition to their earlier sentence for which they were initially imprisoned) and the other two were sentenced to nine years each.[129]

The National HIV and AIDS Policy notes that

> [p]eople who engage in same-sex sexual relations are socially and culturally vulnerable to prevailing attitudes. Homosexual persons are stigmatised and may not be accorded free access to HIV and AIDS prevention education, treatment, care and support due to their sexual orientation and are at risk of HIV infection.[130]

As a result, the National HIV and AIDS Policy recommends that government should

- [p]ut in place mechanisms to ensure that HIV and STI prevention, treatment, care and support services can be accessed by all without discrimination, including people engaged in homosexual relationships;
- [p]rotect the rights of people engaged in same-sex relationships.

However, the Policy fails to clearly recommend that government decriminalise same sex relations.

14. Prisoners' rights

The National HIV and AIDS Policy recognises that prisoners are 'particularly vulnerable to exploitative and abusive sexual relations because of the environment in which they live'.[131]

The National HIV and AIDS Policy makes specific recommendation to government to ensure access to HIV and AIDS prevention, treatment and care services including access to information, condoms, ART and PEP.[132]

126 D Ottosson *Legal survey on the countries in the world having legal prohibitions on sexual activities between consenting adults in private* (2006) http://www.ilga.org/statehomophobia/LGBcriminallaws-Daniel_Ottoson.pdf (accessed 5 September 2007).

127 'Sodomy spreading AIDS in prisons' *News 24* 4 April 2005 http://www.news24.com/News24/Africa/News/0,,2-11-1447_1685077,00.html (accessed 5 September 2005).

128 As above.

129 As above.

130 n 24 above, 41.

131 As above, 40.

132 As above, 41.

Most of these recommendations have been ignored. The only measure that is partially implemented by the Department of Correctional Service to stop the spread of HIV in prisons is the education of prisoners on the modes of transmission, risks and the methods of prevention.[133] However, reports show that HIV education is still lacking in prisons. Many prisoners do not know how HIV is transmitted or have few options in terms of handling the sick or bleeding with their bare hands because of a lack of gloves.[134]

The total number of HIV-positive prisoners is not known. HIV testing is not mandatory for prisoners.[135] In theory, the HIV status of prisoners living with HIV is kept confidential when the prison officials know it. Nevertheless, the status becomes obvious (or a matter of speculation) when the prisoner starts falling ill with AIDS-related illnesses.[136] Prisoners living with HIV are not kept separately from the general prison population.

Prisoners who are infected with HIV do not automatically have access to ARVs free of charge in prisons. They can only be given access to ARVs if they have access to (and are enrolled at) the public health centres where ARVs are available.

Consensual and forced sexual intercourse especially rape are rife in Lesotho's prisons.[137] However, prisoners have for long not had access to condoms. In 2005, the Maseru divisional commander of correctional service argued that condoms cannot be distributed in prisons because that would mean condoning sodomy.[138] The practice of denial of access to condoms for prisoners clearly contradicts the National HIV and AIDS Policy which stipulates that all prisoners should have access to HIV-related prevention information, education, HTC, means of prevention (including condoms).[139] It is to be welcomed, therefore, that the head of the Lesotho correctional services health unit was quoted, in 2007, as stating that a decision was taken 'to make available condoms and gloves in our prisons'.[140]

The National HIV and AIDS Policy further stresses that the government shall 'ensure that prison authorities take all necessary measurers, including adequate staffing, effective surveillance, and

133 Adapted from the report of the visit of the Parliamentary Committee on HIV/AIDS at the Maseru Central Prison.
134 As above.
135 As above.
136 As above.
137 'Sodomy spreading Aids in prison' (n 127 above).
138 As above.
139 n 24 above, 41.
140 HIV one of toughest hurdles for African prisons, *SABC News* 11 August 2007, http://www.sabcnews com/Article/PrintWhileStory/0,2160,153912,00.html (accessed 30 August 2007).

appropriate disciplinary measures to protect prisoners from rape, sexual violence and coercion by fellow prisoners and by warders'.[141]

15. Immigration

The immigration laws do not take into account the HIV status of an immigrant to Lesotho. In fact, the Policy Framework provides that '[t]here will be no restrictions placed on travel by persons known or suspected to have HIV because of their HIV status whether they are Lesotho nationals or foreigners residing in or visiting the kingdom'.[142]

The immigration laws do not require non-nationals to be tested for HIV prior to gaining admission to the country.

16. Social assistance and other government benefits

People living with HIV do not automatically qualify for state social security and assistance. A public assistance allowance is available to destitute persons.[143] The definition of a 'destitute person' is not provided in the National Social Welfare Policy. It only states that 'professionally trained social workers shall assist destitute people in accessing public assistance'.[144] It also provides that those who are too old to work, severely disabled, chronically ill, or members of child-headed households shall be assisted.[145] People living with HIV do not qualify for disability grants automatically as they need to show a special reason to get the disability grant. Such reasons would include whether he or she has been incapacitated because of his or her HIV status.

Nevertheless, people living with HIV have access to a special grant from the Global Fund specifically for them. The grant has been made available for distribution since 2005 through the NAC. The grant is provided as a means of assistance and it is accessed through the Lesotho's Network of People Living with HIV & AIDS (LENEPWA).

The department with the mandate for social assistance is the Department of Social Welfare, a part of the MoHSW. The department also deals with orphans and vulnerable people in the society. It does not have a direct mandate to deal with people living with HIV, as this falls under the mandate of the AIDS Directorate also under the MoHSW. It would need to be illustrated that the HIV status caused the person's social problems, as social issues are the mandate of the

141 n 24 above, 41.
142 n 77 above, art 4.
143 National Social Welfare Policy (2002) art 6.3.7.
144 As above.
145 As above.

Department of Social Welfare, for the Department to get involved. The Department functions on the principles of social justice and non-discrimination based on class, ethnicity, political and religious affiliations, gender, age or sexual orientation.[146]

17. Insurance[147]

The Insurance Act[148] regulates the granting of life insurance in Lesotho. Under this Act, insurance companies are not allowed to refuse life insurance to any person solely on the HIV status of the person.[149] However, there is a cover limit that insurance companies will not exceed if the client is HIV positive.[150]

There is a policy of compulsory testing for HIV for clients who require certain classes of insurance cover. Clients are sent to laboratories and VCT is done with the utmost care and compliance with the requirement of VCT in the country.[151]

Insurance companies rely on private and independent laboratories. In the case of some insurance companies, the results are sent to the head office with the insurance details of the prospective client so that the branch dealing directly with the client does not get to see the result.[152] The granting of insurance and the terms and conditions are finalised at the head office so the direct broker who deals with the client does not get to see the results. The results are given to the applicant during the process of the post-test counselling.[153]

Even though most insurance companies provide cover to HIV-positive people, the disease must be in either stage one or two. Most insurance companies do not provide cover to applicants that are in stages three or four of the disease.[154]

There are HIV specific life insurance policies on offer by most insurance companies in Lesotho. They have higher premiums.[155]

146 As above.
147 All the information on insurance in Lesotho was collected during an interview with Mr Ngaka Sekokotoana, the Marketing Manager of Metropolitan Insurance Company in Maseru (Lesotho).
148 Insurance Act 18 of 1976.
149 As above.
150 As above.
151 As above.
152 As above.
153 As above.
154 As above.
155 As above.

18. Oversight

Since Lesotho has a multi-sectoral approach to dealing with the HIV epidemic, government mechanisms to ensure the implementation of legislation relating to HIV include all inter-departmental HIV and AIDS committees, faith based organisations, multi-national organisations and NGOs.

In order to facilitate the oversight of the implementation of HIV and AIDS legislation and programmes, all inter-departmental HIV and AIDS committees produce regular reports which are submitted to the appropriate body within the various ministries.

Oversight of all the activities of these bodies is undertaken through the Parliamentary HIV/AIDS Committee (PAC), while the overall oversight function of HIV-related activities in Lesotho is the mandate of the National AIDS Commission (NAC). While the NAC performs the task of coordinating and funding all HIV-related activities in the country, it has the mandate to oversee all ministerial HIV-related activities, as well as the process of resource mobilisation and allocation in the public sector. The NAC is also in charge of the disbursement of the funds received from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The configuration of the secretariat of the NAC includes the PAC as one of the relevant bodies for oversight.[156] This implies that there is a unique link between the oversight function of the PAC and the NAC. The PAC also has the power to call for information from other institutions and other ministries, even the NAC, to assist in its oversight role.[157]

As part of the oversight function of the PAC and the NAC, the evaluation of the implementation of legislation and programmes relating to HIV is measured by the output and the progress in the health statistics and demographic surveys carried out in the country.

Implementation is also measured by the progress the government has made on the implementation of previous recommendations made by the PAC and the NAC or the members of staff handling HIV-related issues within the ministries. This takes into account the impact of such legislation and policy on the people whom it is supposed to protect.

[156] Information received from the NAC on 27 February 2006.
[157] As above.

19. Stigma

Although stigma against people living with HIV has not been specifically and substantially addressed in any policy or legislation, public statements have been made that the reduction of stigma is crucial to the control of HIV. This is one of the guiding principles of the 'Know your status' campaign as it is believed that once everyone knows his or her HIV status, stigma would be reduced in society.

In line with this, the HTC Guidelines provide as follows:[158]

> In the context of HIV/AIDS, stigma and discrimination refer to actions taken against individuals solely on the basis of their HIV status. It has been shown that programmes which allow more people to know their HIV status can actually decrease stigma and discrimination, foster 'normalisation of HIV testing', and open the door for more effective HIV prevention and care. Therefore all facilities providing HTC services are encouraged to come up with innovative strategies that will ensure that more people present for testing and counselling.

[158] n 48 above, 'Stigma and Discrimination'.

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Legislation and policy documents

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- Constitution of Lesotho 2003
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- Human Resources Development and Strategic Plan 2005-2025
- Insurance Act 18 of 1976
- Know Your Status Campaign (2003)
- Sexual Offences Act, Act No 3 of 2003
- Labour Code Amendment Act, Act No 5 of 2006
- Legal Capacity of Married Persons' Act, Act No 9 of 2006
- National AIDS Commission Act
- National Guidelines for HIV Testing and Counselling (2004)
- National Policy on OVC and National Action Plan for OVC
- National Social Welfare Policy (2002)
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3 HIV, AIDS and the law in Malawi

1. Background to country

1.1 First AIDS case

The first AIDS case in Malawi was documented in May 1985 by medical personnel at Lilongwe Central Hospital.[1] In that year, a total of 17 cases were reported throughout the country.[2] There is no information available on how the infection was transmitted and whether the case was treated confidentially or not.

1.2 Demography

The estimated total population in 2005 was 13 500 000.[3]

The adult prevalence rate for HIV in 2005 was estimated at 14.1 per cent (between 6.9 per cent and 21.4 per cent).[4] There were approximately 900 000 (700 000 - 1 100 000) people living with HIV in 2003.[5] Of these, approximately 810 000 (650 000 - 1 000 000) were between the ages of 15-49.[6]

Of the age group 15-49, approximately 460 000 (370 000 - 570 000) or 56.8 per cent were women;[7] children between the ages of 0 - 15 accounted for 83 000 (54 000 - 130 000) of people living with HIV.[8]

The HIV prevalence rate among young women (15 - 24 years) in 2005 was 9.6 per cent (3.9 per cent to 16.8 per cent) compared to 3.4 per cent (1.4 per cent to 5.9 per cent) for young men of the same age group.[9]

The tuberculosis (TB) prevalence rate in Malawi was 501 persons per 100 000 in 2004.[10] In that year, 26 136 cases of tuberculosis (TB) were registered. Of these cases, 6 681 were tested for HIV and 4 804

1 See Ministry of Health and Population & National AIDS Commission (NAC) Malawi 'National HIV and AIDS Estimates 2003: Technical Report' foreword.
2 AC Munthali *et al Formative research on prevention of mother-to-child transmission (PMTCT) of HIV/AIDS* (2003) 1.
3 UNFPA *State of the world population 2007: Unleashing the potential of urban growth* (2007) 90.
4 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
5 UNAIDS 'Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections: 2004 update' (2005) 2, available at http://data.unaids.org/Publications/Fact-Sheets01/malawi_EN.pdf (accessed 1 August 2006).
6 As above.
7 As above.
8 As above.
9 UNAIDS (n 4 above) 508.
10 UNDP 'Human development report 2006: Beyond scarcity: Power, poverty and the global water crisis' (2006) 314.

(72 per cent) were HIV positive.[11] Other opportunistic infections registered between April to June 2005 included 309 cases of Kaposi's sarcoma, 615 cases of cryptococcal meningitis and 1 130 cases of oesophageal candidiasis.[12]

In 2003, of 520 000 pregnant women, 80 000 (15.3 per cent) were HIV positive.[13] In 2004, of 6 069 HIV-positive women who were tested and received counselling for prevention of mother-to-child transmission (PMTCT), only 2 719 (44.8 per cent) accessed a short course of anti-retroviral treatment (ART) regimen for PMTCT.[14]

In 1994, 70 per cent of the commercial sex workers in Lilongwe were HIV positive.[15]

The annual number of deaths related to AIDS in 2003 was 87 000; the cumulative number of AIDS-related deaths as of 2003 was estimated at 641 000.[16]

Of all children who have been orphaned in Malawi, more than half of them were orphaned due to AIDS-related deaths. This amounted to 550 000 children who have been orphaned in 2005.[17]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[18]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	22/12/1993
ICCPR Optional Protocol (23/03/1976)	11/06/1996
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	22/12/1993

11 Ministry of Health and Population (National Tuberculosis Control Programme *et al*) 'Report of a countrywide survey of HIV/AIDS services in Malawi for the year 2004' (2005) 13.

12 Ministry of Health and Population 'Anti-retroviral therapy in Malawi up to 30th June 2005' (2005) 3.

13 Ministry of Health and Population & NAC (n 1 above) 16.

14 Ministry of Health and Population (n 12 above) 13.

15 UNAIDS (n 4 above) 4.

16 Ministry of Health and Population & NAC (n 1 above) 3 & 16.

17 UNICEF 'State of the world's children 2007: Women and children, the double dividend of gender equality' (2007) 115.

18 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'Malawi Homepage' http://www.ohchr.org/english/countries/mw/index.htm (accessed 10 September 2007).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	12/03/1987
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	2/01/1991

2.2 State reports[19]

In its report to the Committee on the Rights of the Child submitted in August 2000, the Malawian Government discussed its National AIDS Control Programme, educational efforts and policy guidelines with regard to orphans.[20]

The concluding observations on the report were adopted in February 2002. Under the heading HIV/AIDS, the Committee had the following to say:[21]

> 47. While noting the existence of the National AIDS Control Programme, the National Task Force on Orphans and the Orphan Care Programme, the Committee remains extremely concerned at the high incidence and increasing prevalence of HIV/AIDS amongst adults and children and the resulting high and increasing number of children orphaned by HIV/AIDS. In this regard, the Committee is concerned at the lack of alternative care for these children.
>
> 48. The Committee recommends that the State party:
>
> (a) Increase its efforts to prevent HIV/AIDS and take into consideration the recommendations of the Committee adopted on its day of general discussion on children living in a world with HIV/AIDS (CRC/C/80, para. 243) as well as the Guidelines on HIV/AIDS and Human Rights adopted in 1996;
>
> (b) Urgently consider ways of minimizing the impact upon children of the HIV/AIDS-related deaths of parents, teachers and others, in terms of children's reduced access to a family life, to adoption, to emotional care and to education;
>
> (c) Involve children in formulating and implementing preventive and protective policies and programmes; and
>
> (d) Seek further technical assistance from, among others, UNAIDS.

With the aim to give effect to the recommendations of the Committee on the Rights of the Child, Malawi has taken the following actions:

- It has developed policies and programmes for the care of orphaned and vulnerable children. In 2003, Malawi adopted a 'National Orphan Care Policy'. In 2004, a Rapid Assessment,

19 For the state reports and concluding observations discussed below, see above.
20 Committee on the Rights of the Child 'Initial report of states parties due in 1993: Malawi' (CRC/C/8/Add.43) (2001).
21 Committee on the Rights of the Child 'Concluding observations of Committee on the rights of the Child: Malawi' (CRC/C/15/Add.174) (2002).

Analysis and Action Planning process (RAAAP) was undertaken to develop an understanding of the situation and scale of the orphans and vulnerable children (OVC) challenge and identify intervention and resources to quickly respond to the emergency situation. The RAAAP contributed to the development and adoption in 2005 of the 'National Pan of Action for Orphans and Other Vulnerable Children, 2005 - 2009'.

- The national response has led to an increasing number of people including children accessing ART and treatment for the management of opportunistic infections as well as an increasing number of OVC receiving psycho-social, nutritional and other support.
- Enhancement of collaboration with international organisations and NGOs. The government has improved its relationships with international organisations such as UNAIDS, WHO, UNICEF, WFP and UNFPA. This resulted in increased technical and financial support for HIV and AIDS activities. The government has also developed good collaboration with various NGOs.

Malawi submitted its initial report to the Committee on the Elimination of Discrimination against Women (CEDAW Committee) on 15 July 1988.[22] HIV and AIDS were only briefly mentioned in the concluding observations of the CEDAW Committee. This is probably attributable to the fact that the report was submitted only three years after the first AIDS case was documented in the country and, therefore, HIV did not constitute a big concern. Nonetheless, the members of the Committee raised questions related to the scope and effects of HIV and AIDS on women.[23]

Malawi submitted a combined second, third, fourth and fifth periodic report to the CEDAW Committee in June 2004.[24] In its report, the government noted the heavy burden that the pandemic put on women. Cultural practices were noted as contributing to women's vulnerability to HIV. The report further provided statistical information and provided information on educational measures.

In its concluding observations the CEDAW Committee recommended that

> sex education be widely promoted and targeted at girls and boys, with special attention paid to the prevention of early pregnancy and the control of sexually transmitted diseases and HIV/AIDS. It also calls on the State party to ensure the effective implementation of its HIV/AIDS

22 Government of Malawi 'Initial report to Committee on the Elimination of all Forms of Discrimination against Women (CEDAW Committee)' (CEDAW/C/5/Add and Amend 1) (1988).

23 As above, concluding observation para 146.

24 Government of Malawi 'Combined second, third, fourth and fifth periodic report of states parties to the CEDAW Committee' (CEDAW/C/MWI/2-5) (2004).

law and policies, to seek technical support from the World Health Organization and the Joint United Nations Programme on HIV/AIDS.[25]

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[26]

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	17/11/1989
African Charter on the Rights and Welfare of the Child (29/11/1999)	16/09/1999
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (25/11/2005)	20/05/2005
Treaty of the Southern African Development Community (SADC) (30/09/1993)	30/08/1993
SADC Protocol on Health (14/08/2004)	7/11/2000

3.2 State reports

Malawi has not submitted any state report to the African Commission on Human and Peoples' Rights.

3.3 Status of international law and human rights treaties in domestic law

In terms of section 211(1) of the Constitution '[a]ny international agreement entered into after the commencement of this Constitution shall form part of the law of the Republic if so provided by or under an Act of Parliament'. Thus, conventions can only be fully effective and be invoked in or enforced through courts after they have been domesticated by an Act of Parliament. So far, Malawi has not incorporated any human rights conventions.

However, chapter II of the Constitution, 'Application and Interpretation', states that 'in interpreting the provisions of this Constitution a court of law shall ... where applicable, have regard to

25 CEDAW Committee 'Concluding comments of the CEDAW Committee: Malawi' (CEDAW/C/MWI/CO/5) (2006) para 32.

26 Ratification status available from http://www.africa-union.org and from http://www.sadc.int (accessed 10 September 2007).

current norms of public international law and comparable foreign case law'.[27]

Taking full advantage of this constitutional provision, several court decisions have applied principles and rules drawn from international human rights treaties. For instance, the High Court in the case of *Thandiwe Okeke v The Minister of Home Affairs* stated the following:[28]

> Apart from the general law and constitutional provisions emphasising the rights ... there are international instruments setting standards and aspirations which our legal system must aim to achieve. These obligations require our legal system to adopt systems of laws that accord citizens these rights and reduce the likelihood of undermining these rights. These instruments require authorities of member countries not to undermine these standards and principles in decisions affecting citizens.

3.4 International Guidelines

In its Concluding Observations to the initial report of Malawi, the CRC Committee recommended that Malawi take into consideration the International Guidelines on HIV/AIDS and Human Rights in its efforts to prevent HIV/AIDS.[29] The International Guidelines informed the development of the National HIV/AIDS Policy.[30] The Draft National HIV/AIDS Policy in 2002 stated that Malawi is committed to 'working within a human rights framework, in accordance with the international instruments to which Malawi is signatory, as well as the International Guidelines on HIV/AIDS and Human Rights of 1996 as amended in 2002'.[31] However, there is no explicit mention of the International Guidelines in the final National HIV/AIDS Policy adopted in 2003 or in any other HIV and AIDS-related policy document in Malawi.

4. National legal system of country

4.1 Form of government

Malawi has been a constitutional democracy since 1994. It was previously a one-party dictatorial regime. In 1993, a referendum was held, which changed the form of government from a single-party

27 Constitution (1994) sec 11(2)(c).
28 *Thandiwe Okeke v The Minister of Home Affairs* (Misc civil appl no 73 of 1997) decided on 8 July 2001 in High Court of Malawi.
29 CRC (n 21 above) 12 para 48(a).
30 According to Dr Andrew Agabu, head of Policy Support and Development at the National AIDS Commission.
31 Draft Malawi National HIV/AIDS Policy (2002) 4.

system to a multiparty system. A new constitution was adopted in 1994.

4.2 Legal system

Malawi's legal system is largely based on English common law with some influence of customary law. The Supreme Court is the highest court, followed by the High Court and the Magistrates' Court.

4.3 Constitution and Bill of Rights

The Constitution was published in the Malawi Gazette on 16 May 1994, following the transition from a single-party system of government to a multiparty democracy. The Constitution came into force provisionally on 18 May 1994 and definitive force on 18 May 1995.[32]

The Constitution is the supreme law of the country and any law or government act inconsistent with it is invalid.[33] Chapter IV guarantees a wide range of human rights,[34] including civil and political rights (for example, right to life, right to liberty, right to human dignity, privacy, and freedom of conscience and opinion) as well as economic, social and cultural rights (for example, right to culture and language, the right to development which includes access to basic resources, education, health services, food, shelter, employment and infrastructure).

Section 20(1) proclaims the right to non-discrimination. It further states that 'legislation may be passed addressing inequalities and prohibiting discriminatory practices and the propagation of such practices and may render such practices criminally punishable by the courts.'[35] Although HIV status is not listed as a ground for non-discrimination, it can be considered to be included in the wording 'other status' of section 20(1).

The justiciability of the rights guaranteed by the Constitution is ensured through two avenues. Firstly, the Constitution recognises the right for any individual to make an application to a competent court to obtain redress for the violation of a fundamental right or freedom.[36] Secondly, it allows for any individual to seek assistance or advice related to a violation of a right or fundamental freedom from the Human Rights Commission or the Ombudsman.[37]

32 Constitution (n 27 above) preface (by PH Fachi).
33 As above, sec 5.
34 As above, ch IV.
35 As above, sec 20(2).
36 As above, sec 46(2)(a).
37 As above, sec 46(2)(b).

4.4 National human rights institutions

Established under chapter XI of the Constitution, the Human Rights Commission of Malawi is an independent body 'competent in every respect to protect and promote human rights in Malawi in *the broadest sense possible* and to investigate violations of human rights of its own accord or upon complaints received from any person, class of persons or body'.[38]

The broad mandate of the Human Rights Commission allows it to entertain all human rights matters including those related to HIV. However, it has not yet received any complaints or taken any particular action pertaining to the violation of rights based on the actual or suspected HIV status of a person.

The 2004 Activity Report of the Human Rights Commission refers to the establishment of a HIV/AIDS Steering Committee in charge of the implementation of the sectoral HIV and AIDS policy for employees of the Commission.[39]

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

Established in 2001 under the Office of the President and Cabinet, the Malawi National AIDS Commission (NAC) is the overall co-ordinating authority of the HIV response in Malawi. The NAC is composed of a board of 19 commissioners representing government, traditional leadership, faith based organisations, civil servants, NGOs and people living with HIV, and a secretariat headed by an executive director. The functions of NAC include facilitating policy development; guiding the National HIV/AIDS Strategic Framework; facilitating policy and strategic planning in sectors and locally; mobilising resources; allocation and tracking of effective utilisation; building partnerships among all stakeholders in the country with regional and international links; overall monitoring and evaluation, and the identification of HIV research priorities.

The NAC and other stakeholders have developed several policy documents addressing the HIV epidemic, including:

- A Plan to Scale up the PMTCT in Malawi, 2004 - 2005;
- Code of Conduct on HIV/AIDS and the Workplace;
- Code of Ethics and Professional Conduct, 1990;

38 Human Rights Commission Act 27 of 1998 sec 12 (my emphasis).
39 Malawi Human Rights Commission 'Annual Report for 2004' (2005) 25.

- Education Sector Policy on HIV and AIDS (Draft);
- HIV/AIDS Counselling and Testing: Guidelines for Malawi, second edition, 2004;
- HIV/AIDS Research Strategy for Malawi, 2005 - 2007;
- National HIV/AIDS Strategic Framework, 2000 - 2004;
- National HIV/AIDS Action Framework, 2005 - 2009 (Draft 2005);
- National HIV/AIDS Policy: a call to renewed action (2003);
- National HIVAIDS Monitoring and Evaluation Plan: Conceptual framework;
- National HIVAIDS Monitoring and Evaluation Plan: Operations plans;
- Policy on HIV/AIDS in the Workplace (Draft 2003);
- Prevention of Mother-to-Child Transmission of HIV in Malawi: Guidelines for Implementers (2003);
- Programme and National Plan of Action on Women, Girls and HIV/AIDS, 2005 - 2010;
- Strategic Plan on Combating HIV/AIDS in the Education Sector in Malawi, 2005 - 2008 (2005); and
- Treatment of AIDS: Guidelines for the Use of Anti-retroviral Therapy in Malawi (2003).

5.2 HIV and AIDS plan

In October 1999, the Ministry of Heath and Population published the Malawi National HIV/AIDS Strategic Framework, 2000 - 2004 (NSF). This was an attempt at a multisectoral national response and a move away from the almost exclusively bio-medical focus of the previous medium-term plans.[40] The NSF sets clear goals, objectives and strategies regarding nine broad issue areas.[41] However, it does not include ART in its Strategic Framework. There are ten guiding principles of the NSF. These principles are designed to provide the foundation for policy formulation and programme design. The principles emphasise gender equality, non-discrimination, the importance of legislative review, and urge all stake-holders to collaborate in the fight against the epidemic.

[40] The first Medium Term Plan (MTP) 1989-1993 dealt specifically with blood screening and public education on HIV/AIDS. An MTP II followed for 1993-1998, which incorporated social, psychological and economic dimensions in its approach. National HIV/AIDS Strategic Framework, 2000-2004 sec 1.2.

[41] The National HIV/AIDS Strategic Framework (2000-2004)'s nine broad issue areas are culture; youth; social change; socio-economic status, despair and hopelessness; HIV/AIDS management; children who have been orphaned, widows and widowers; prevention of HIV transmission; HIV/AIDS information, education and communication; and voluntary counselling and testing.

The NSF is to be replaced by the draft National HIV/AIDS Action Framework (NAF),[42] which has not yet been approved by Cabinet.[43] The NAF will cover the period 2005 - 2009 and it is based on the findings of the end of term review of the NSF. The overall goal of the NAF is to prevent the spread of HIV infection among Malawians, to provide access to treatment to people living with HIV, and to mitigate the health, socio-economic and psycho-social impacts of HIV on individuals, families, communities and the nation.[44]

5.3 Legislation

Malawi does not have any specific legislation on HIV and AIDS. However, in the context of the HIV epidemic some legislative reforms have been undertaken. Several laws have been reviewed and amendments have been recommended which are yet to be approved by Parliament. These laws include the Will and Inheritance Act, the Penal Code and the Children and Young Person's Act. Another important legislative milestone was the Prevention of Domestic Violence Act developed by the Ministry of Gender, Child Welfare and Community Services, which has recently been adopted by Parliament.

- Deceased Estates (Will, Inheritance and Protection) Bill 2004. The major development of this bill is the incorporation of criminalisation of property grabbing. Section 17 of the original Act is amended to protect the right to property of immediate family members. Section 17(b) reads 'every spouse of the intestate shall be entitled to retain all the household belongings which belong to his or her households'.[45]
- Penal Code (Amendment) Bill 2000. The Penal Code (Amendment) Bill 2000, among other things, recommends that the section 137(2) on the age of girls to have consensual sex to be raised from 13 to 16.[46] However, the recently revised Constitution allows, the marriage of a girl over 15 years of age.[47] In an attempt to introduce gender neutrality in sexual offences, the Law Commission recommends that section 137(A) criminalise 'indecent practices' between females as well as between males.[48]
- Children and Young Persons Act Cap 26:03. The revised Children and Young Persons Act introduces legal provisions related to child

42 (Draft) National HIV/AIDS Action Framework, 2005-2009.
43 However, according to Mr Eliam Kamanga, Information Officer at the National AIDS Commission, the NAC has already started the implementation of the activities and strategies provided for in the NAF.
44 Draft NAF (n 42 above) ix.
45 Law Commission 'Report on the Review of Wills and Inheritance Act' (2005) 9, & 132 for new provisions relating to intestacy).
46 Law Commission 'Report on Review of the Penal Code' (2000) 36.
47 Constitution (n 27 above) sec 22(8).
48 Draft NAF (n 42 above); also see Penal Code Cap 7:01 sec 156.

care and protection which are located in several laws. The inclusion of provisions related to residential placement and fosterage should provide better protection to OVC.

- Protection against (Prevention of) Domestic Violence Act 5 of 2006. The Act was developed by the Ministry of Gender, Child Welfare and Community Services and was adopted by Parliament on 21 June 2006. The importance of the Domestic Violence Act is its broad applicability. It covers not only spousal relationships but also includes 'relations between family members' or financially dependent relations.[49] Such relations include spousal relations, child-parent relations and long-term (over 12 months) visiting relations.[50] Furthermore, the Act interprets 'domestic violence' to include 'physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household, dependant or parent of a child of that household'.[51]

Several existing laws deal indirectly with HIV. These laws establish rules and principles related among others to non-discrimination and equality, the protection of women and children, the importation, distribution and manufacture of drugs, and the sharing of the deceased's estate, and so on. They are the:

- Children and Young Persons Act 2003;[52]
- Constitution of Malawi of 1994;
- Employment Act;[53]
- Labour Relations Act;[54]
- Penal Code;[55]
- Pharmacy, Medicines and Poisons Act;[56]
- Protection from (Prevention of) Domestic Violence Act;
- Public Health Act;[57]
- Public Service Act;[58]
- Will and Inheritance Act;[59] and
- Workers' Compensation Act of 2000.[60]

49 Protection Against (Prevention of) Domestic Violence Act 5 of 2006, interpretation of terms.
50 Draft NAF (n 42 above) part 1.
51 Domestic Violence Bill part 1.
52 Children and Young Persons Act of 1969 Cap 26:03.
53 Employment Act 2000 Cap 55:02.
54 Labour Relations Act 4C of 1996 Cap 54:0.
55 Penal Code Cap 7:0.
56 Pharmacy, Medicines and Poisons Act 15 of 1988 Cap 35:0.
57 Public Health Act Cap 34:0.
58 Public Service Act Cap 1:03.
59 Will and Inheritance Act Cap 10:02.
60 Workers' Compensation Act of 2000 Cap 36:0.

5.4 HIV and AIDS policy

In 2003, Malawi adopted the National HIV/AIDS Policy: a call for renewed action as a 'source of renewed motivation for a more unified and concerted effort and a basis for diversifying interventions addressing HIV/AIDS'.[61]

The National HIV/AIDS Policy identifies HIV and AIDS as a health, social, economic, and development issue and calls for a holistic and multi-sectoral approach based on principles of human rights. The Policy does not exclude or deny treatment to people or groups on the basis of their sexual or social behaviour. On the contrary, it recognises people who engage in transactional sex, prisoners and people who engage in same-sex relationships as vulnerable groups who need full access to prevention, treatment, care and support.[62]

The Policy is divided into nine chapters.[63] The document provides comprehensive and detailed policy direction on all issue areas. Non-discrimination and empowerment of people living with HIV are two important themes that run through the Policy. Chapter 5 aims to protect and empower vulnerable groups, including women and girls, children who have been orphaned, widows and widowers, children and young people, the poor, people engaged in transactional sex, prisoners, mobile populations and people engaged in same-sex relations. Importantly, the policy gives equal importance to prevention, treatment, and care and directs the government to 'progressively provide access to affordable, high quality ART and prophylaxis to prevent opportunistic infections'.[64] Furthermore, in its appendix (proposals for legislative reform), the policy provides a detailed list of existing legislation that should be reviewed to provide better protection for people living with HIV.

5.5 Court decisions

The High Court examined issues related to HIV in a case of a patient alleging negligent treatment due to her HIV status and stated that

> the inescapable conclusion is that it was the view of Dr Hayton that the patient was an HIV reactive victim and that it would be a waste of medicine and time to give medicine to such patient who is fated to die in

61 National HIV/AIDS Policy (2003) preface (by M Banda).
62 As above, 24-31.
63 As above. The titles of the nine chapters are: Introduction; Strengthening and sustaining a comprehensive multisectoral response to HIV/AIDS; Promotion of HIV/AIDS prevention, treatment, care and support; Protection, participation and empowerment of people living with HIV/AIDS; Protection, participation and empowerment of vulnerable populations; Traditional and religious practices and services; Responding to HIV/AIDS in the workplace; Establishing and sustaining a national HIV/AIDS research agenda; and Monitoring and evaluation.
64 As above, 'Policy Statement' ch 3.3.2.

> any event. The ... letter was intended to give notice to other doctors with similar views not to 'waste' medicines [on] a person who, according to him was already dying. If this was his view then it must be deplored in no uncertain terms as being both unethical and unprofessional. Doctors who take the Hippocratic Oath before being conferred with dignity and title of 'doctor' have a moral duty not only to save but also to prolong life. Even an AIDS victim is owed such duty from his doctors.[65]

6. Access to health care

6.1 Government regulation of access to health care

The right of access to health care is not specifically protected under the Constitution. The only provision referring to health care is section 30(2), which provides that '[t]he state shall take all necessary measures for the realisation of the right to development. Such measures shall include, among other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure'.

The government has adopted several policies and programmes targeting HIV and AIDS and focusing on prevention, treatment and support. The following services are currently provided free of charge at several health facilities:

- education materials, public display and guidelines on HIV and AIDS and related issues;
- counselling and testing;
- distribution of condoms;
- short regimen ART for the PMTCT of HIV and for post-exposure prophylaxis (PEP);
- treatment of opportunistic infection such as TB, kaposis sarcoma, cryptococcal meningitis and oesophageal candidiasis; and
- provision of ART to HIV positive-patients in stage III or IV and those with a CD4 count below 200/mm3.

6.2 Ethical guidelines

The Code of Ethics and Professional Conduct[66] regulates the behaviour of medical practitioners and dentists towards their patients. Although the Code, issued in 1990, does not mention HIV and AIDS, it establishes general rules applying to the relationship between medical practitioners and their patients. These rules, which also

65 *Neffie Mangani v Register Trustees of Malamulo Hospital,* 5. High Court of Malawi, Principal Registry, Civil Cause No 193 of 1991.

66 See Medical Council of Malawi Code of Ethics and Professional Conduct 1990.

apply to HIV-positive patients, emphasise the respect due to human life, confidentiality as well as courtesy.[67]

6.3 Medicines

The National HIV/AIDS Policy states that the government should progressively provide access to affordable, high quality ART and prophylaxis to prevent opportunistic infections.[68]

Implementing this requirement, the Anti-retroviral (ARV) Scale-up Plan has embraced the concept of free ARV drugs to HIV-infected eligible persons.[69] Eligibility for access to ARVs is based on the ART guidelines, which incorporate the World Health Organisation's (WHO) staging and symptoms.[70] ARVs are provided on a 'first-come-first-serve' basis. In addition to the general eligibility criteria, the equity paper,[71] in a bid to promote equity, targets specific populations judged to be most needy or most vulnerable. These groups of people who are considered to be in 'strategic' or in vulnerable situations include TB patients, pregnant mothers and frontline workers such as health care workers and teachers.[72]

The ARV Roll-out Programme in Malawi is implemented with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).[73] The Roll-out Programme only provides first line regimen drugs.[74] Currently, 60 hospitals and health facilities (including all central, district, Malawi Defence Force and police hospitals as well as major hospitals of the Christian Health Association of Malawi) provide free ARVs.[75] In addition, ARVs are available at 23 private sector facilities countrywide at a subsidised rate of 500 Malawi Kwacha (3.50 USD) per patient per month.

67 As above, secs 1 & 42.
68 n 61 above, sec 3.3.2.
69 Ministry of Health and Population 'Treatment of AIDS, the 2 years Plan to Scale up ART in Malawi' (2004) 8.
70 Eligible HIV-positive people are those in WHO stage III or IV and those with a CD4 count below 200/mm3. See above, 21-28.
71 The 'Equity Paper' was developed by NAC to promote equity in access to ART and to serve as a guide for the ARV Roll-out Programme. The 'Equity paper' was the outcome of consultation and collaboration with key stakeholders including PLHA, NGOs, youth groups and public institutions. See Government of Malawi 'Position paper on equity in access to ART in Malawi'.
72 Ministry of Health and Population (n 69 above).
73 As of April 2006, Malawi (both the NAC and the Ministry of Health) has received USD 47 808 430 from the Global Fund to Fight AIDS, Tuberculosis and Malaria. See Global Fund to Fight AIDS, Tuberculosis and Malaria 'Global Fund disbursements by region, country and grant agreement' (2006), www.theglobalfund.org/en/files/disbursementdetails.pdf (accessed 25 April 2006) 50.
74 These first line regimen drugs are Stavudine®, Lamivudine® and Nevirapine®. See Ministry of Health and Population (n 69 above) 12.
75 President's Office (Department of Nutrition, HIV and AIDS) 'Malawi HIV and AIDS Monitoring and Evaluation Report 2005' (2005) 24.

By the end of September 2005, 30 055 patients had started ART, of whom 39 per cent were male and 61 per cent female.[76] 95 per cent of those receiving ARVs were adults (in the context of the ARV roll-out, adults are people aged 13 and above) and five per cent children.[77] However, those receiving ARVs as of September 2005 represented only 17.7 per cent of the 170 000 people in need of ARVs in the country.[78]

The government also provides free drugs for the management of sexually transmitted diseases such as syphilis, gonorrhea and candida, as well as opportunistic infections including tuberculosis, Kaposi's sarcoma and esophageal candidiasis.[79]

Malawi has been a member of the World Trade Organisation (WTO) since 31 March 1995 and is also a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) by virtue of the WTO Agreement.[80] The ARVs used in Malawi are generics purchased from India through UNICEF, which is the procurement agent for the government. Malawi has not taken any steps on compulsory licensing or parallel importation or any flexibility under the TRIPS Agreement. However, the government is currently negotiating with some companies for the installation of generic manufacturers of ARVs in the country.[81]

6.4 Condoms

Condoms are generally easily accessible in Malawi;[82] some are available free of charge while others can be bought at affordable prices (equivalent to USD 0.16 for a pack of three).

A total of 24 991 484 condoms were distributed for free or sold to consumers by public organisations or NGOs from November 2002 to October 2003. Of these, approximately 10 764 316 were socially marketed condoms which were sold for a nominal fee, while the rest

76 Ministry of Health and Population (n 69 above).
77 As above.
78 As above.
79 See Ministry of Health and Population *Management of HIV related diseases* first edition (2004).
80 WTO Agreement arts II & XII (1) state that accession to the WTO agreement also applies to the multilateral trade agreement annexed to it which is binding on all members. The TRIPS agreement (Annex 1C to the WTO agreement) is part of the multilateral trade agreement.
81 According to Mr Simon Makonbe, Care and Support Officer, HIV Unit, Ministry of Health.
82 This assertion only concerns male condoms. Female condoms are not widely accessible and the Malawi Demographic Health Survey 2004 reveals that only 53.6 per cent of women knew about it compared to 89.9 per cent claiming knowledge of male condoms. See National Statistic Office 'Malawi Demographic and Health Survey 2004 'preliminary findings' 10.

were freely distributed at government health facilities throughout the country.[83]

The National HIV/AIDS Policy, in section 3.2.3, deals with the government's commitment to the distribution and promotion of male and female condoms. It urges the government to

- ensure that affordable male and female condoms and other barrier methods of good quality are made available to all those who need them, in particular, to prisoners;
- promote the proper use and disposal of both the male and the female condom and other barrier methods to prevent HIV and STI transmission;
- promote the implementation of programmes aimed at providing women with support to participate fully in decision making regarding the use of condoms; and
- periodically review and revise fiscal and other measures to ensure equitable access to and affordability of socially-marketed condoms.[84]

6.5 Case law

Although the High Court's decision in the *Neffie Mangani* case (see section 5.5 above) does not directly mention the right to health care, it states that people living with HIV are entitled to the same treatment standard as any other patient.[85]

7. Privacy

7.1 Notifiable disease

AIDS is not a notifiable condition under the Public Health Act[86] of 1948 (last amended in 2000). However, section 11 lists certain opportunistic infections such as tuberculosis, meningitis and pneumonia as notifiable diseases. Section 12 of the Act empowers the minister responsible for health to declare that 'any infectious disease other than those specified in section 11 shall be a notifiable disease under this Act'.

7.2 Medical experimentation

The protection of volunteers in medical testing is ensured under section 19 of the Constitution, which protects the dignity of all people

83 NAC 'Annual HIV and AIDS Monitoring and Evaluation Report 2003' (2004) 23.
84 n 61 above, 15-16.
85 *Neffie Mangani* case (n 65 above) 5.
86 n 57 above.

and provides that '[n]o person shall be subjected to medical or scientific experimentation without his or her consent'.

The HIV/AIDS Research Strategy for Malawi 2005 - 2007 further states that

> [t]he dignity and human rights of the research participants shall be promoted, protected and respected irrespective of their HIV/AIDS status. This will be based on internationally recognised ethical principles, the Constitution of the Republic of Malawi and other statutes. Informed consent for [...] research participation and publication of any research data shall be sought. Confidentiality shall be maintained to the full extent of the law.[87]

The strategy also stipulates that research that leads to or of which the results may lead to discrimination against people living with or affected by HIV and AIDS will not be approved by ethical review committees.[88]

7.3 Duty to disclose

The National HIV/AIDS Policy and the Guidelines for Expanded HIV Testing provide for 'beneficial disclosure' which, in exceptional cases, where a properly counselled HIV-positive individual repeatedly refuses to disclose his or her status to sexual partner(s), empowers the medical practitioner or health care worker to notify the partner(s) without the consent of the source client.[89] However, both documents require that the disclosure by health care personnel follows guidelines outlining how, when and to whom it should be made. These guidelines have not yet been adopted. In terms of the National HIV/AIDS Policy, the guidelines on beneficial disclosure should be developed 'in accordance with [the] UNAIDS and the Office of the United Nations High Commissioner for Human Rights'.

7.4 Testing

There are three policy documents regulating HIV testing in Malawi: the National HIV/AIDS Policy, the HIV/AIDS Counselling and Testing Guidelines for Malawi and the Guidelines for Expanded HIV Testing in Malawi.

Altogether, these documents provide for four types of testing and counselling:

87 NAC HIV/AIDS Research Strategy for Malawi 2005-2007 (2005) 6.
88 Public Health Act (n 57 above).
89 Guidelines for Expanded HIV Testing in Malawi vii and National HIV/AIDS Policy (n 61 above) sec 3.2.2.5.

- Voluntary counselling and testing (VCT) initiated by an individual who has a HIV test.[90] Under the HIV/AIDS counselling and testing guidelines, anyone over 16 years of age is considered competent to give full and informed consent, and youth between 12 and 16 who are married, pregnant, or engaged in high-risk behaviour are competent to give consent to counselling and testing.[91]
- Routine testing and diagnostic testing are offered to pregnant women attending antenatal clinics and to patients whose health situation raises the suspicion of an HIV infection respectively. In routine testing and diagnostic testing, the patient has the right to opt out.[92]
- Compulsory HIV testing is prescribed in the pre-recruitment process of the army, police, prison and immigration sectors.[93]

In 2004, Malawi adopted Guidelines on HIV/AIDS Counselling and Testing, which set specific operational procedures for pre-test and post-test counselling; rules applicable to staff in charge of counselling and testing; and procedures and standards for laboratory HIV testing.

The Guidelines for Expanded HIV Testing, adopted in June 2005 by the Ministry of Health, put clear emphasis that routine and diagnostic testing as 'a national HIV testing strategy focused on traditional voluntary counselling and testing alone is deemed to be insufficient'.[94] In terms of the Guidelines on Expanded HIV Testing, '[a]ll HIV testing must be accompanied by a standard and full post-test counselling, except for traditional VCT where a standard pre-test counselling is also required'.[95]

8. Equality and non-discrimination

In section 20(1), the Constitution prohibits discrimination on 'grounds of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status'. It does not list HIV status as a ground for non-discrimination. However, non-discrimination on the ground of HIV status may be considered to be included in the wording 'other status' of section 20(1).

90 HIV/AIDS Counselling and Testing: Guidelines for Malawi ch 1; National HIV/AIDS Policy (n 61 above) sec 3.2.2 & Guidelines for Expanded HIV Testing in Malawi (as above) iii.

91 HIV/AIDS Counselling and Testing: Guidelines for Malawi (as above) sec 2.9.

92 National HIV/AIDS Policy (n 61 above) sec 3.2.2.

93 As above, sec 3.2.2, and Guidelines for Expanded HIV Testing in Malawi (n 89 above) v.

94 Secretary for Health Circular of the Secretary for Health on the Guidelines for Expanded HIV Testing in Malawi SH 1/1 21 June 2005, addressed to all relevant officers involved in counselling and testing activities.

95 Guidelines for Expanded HIV Testing in Malawi (n 89 above) vi.

Malawi does not have any law directly addressing discrimination against people living with HIV. However, at policy level, several documents clearly address discrimination based on HIV status. The National HIV/AIDS Policy recognises HIV status as a ground for non-discrimination.[96] The High Court in the *Neffie Mangani* case (see section 5.5 above) affirms that people living with HIV are entitled to the same treatment standard as any other patient.

The HIV/AIDS Research Strategy further states that any research that leads to or of which the results may lead to discrimination against people living with or affected by HIV and AIDS will not be approved by ethical review committees.[97]

The Draft HIV/AIDS Policy in the Workplace aims at promoting a non-discriminatory workplace in which people are able to be open about their HIV status without fear of stigma or rejection.[98]

9. Labour rights

9.1 Legislation

Labour rights are broadly protected under the Constitution and specifically in the Labour Relations Act and the Employment Act.

Section 31(1) of the Constitution states that '[e]very person shall have the right to fair and safe labour practices and to fair remuneration'. Further, section 31(3) insists that '[e]very person shall be entitled to fair wages and equal remuneration for work of equal value without distinction or discrimination of any kind, in particular on the basis of gender, disability or race'.

The Labour Relations Act and the Employment Act generally protect employees against discriminatory practices, unfair dismissal and contain provisions on settlement of disputes, and such. Although these acts do not mention HIV and AIDS, their provisions can be applied to HIV-related issues in the workplace.

The National HIV/AIDS Policy, in section 7.2 states that 'an employee living with HIV shall not be unfairly discriminated against or in any way prejudiced within his or her employment for reasons of incapacity in accordance with the procedure set out in the law'.

Section 110(2) of the Constitution establishes an Industrial Relations Court which has jurisdiction over labour disputes and such other issues relating to employment. The composition and functions

96 n 61 above, 5.
97 NAC (n 87 above) sec 3.3.
98 Draft Malawi Policy on HIV/AIDS in the Workplace sec 3.

of the Industrial Relations Court are provided for under chapter VII of the Labour Relations Act.

The National HIV/AIDS Policy outlines the following areas for legislative reform in an effort to eliminate HIV-related discrimination in the workplace:[99]

- section 31(c) of the Constitution, dealing with fair labour practices and equal remuneration for work of equal value, shall be amended to include HIV/AIDS;
- section 5(1) of the Employment Act shall be amended to include HIV serostatus as a ground on which discrimination is prohibited;
- sections 57(1) and (3) of the Employment Act shall be amended to include HIV serostatus among the list of reasons that do not constitute valid grounds for dismissal; and
- sections 6(1) and (2) of the Employment Act, which make provision for equal pay for work of equal value without distinction based on the grounds set out therein, shall be amended to include HIV serostatus.

9.2 Testing

The National HIV/AIDS Policy recommends that all public and private sector policies provide that no employer shall require any person, whether directly or indirectly, to undergo testing for HIV as a precondition for employment.[100] However, the National HIV/AIDS Policy allows that for national security reasons, it is important that the army, police, prisons and immigration sectors be permitted to carry out HIV testing as part of their pre-recruitment and periodic general medical assessment of staff for purposes of establishing fitness.[101]

The government of Malawi has adopted a Code of Conduct on HIV/AIDS and the Workplace, which is intended to act as a guide for employers, trade unions and employees. Among the broad goals declared in the Code of Conduct, the following relate to the protection of human rights:

- eliminating unfair discrimination in the workplace based on HIV/AIDS status;
- promoting a non-discriminatory workplace in which people living with HIV are able to be open about their HIV status without fear of stigma or rejection; and
- creating a balance between the rights and responsibilities of all parties.

99 n 61 above, appendix.
100 As above, sec 35.
101 As above, sec 14.

With respect to HIV testing, the Code of Conduct reads 'there should be no compulsory HIV testing for employment purposes as it is unnecessary and imperils the human rights and dignity of workers'.[102] In summary, the Code of Conduct declares that people should have the legal right to confidentiality regarding their HIV status in all aspects of their employment. It also contains provisions addressing workplace safety, education and information dissemination, gender specific programmes, and dismissal and grievance procedures. Specifically, it states that 'standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV-related grievance and that personnel dealing with HIV-related grievances should protect the confidentiality of the employee's medical information'.[103]

The Ministry of Labour and Vocational Training, in partnership with Project HOPE (an NGO), has developed the draft Malawi Policy on HIV/AIDS in the Workplace. The draft Workplace Policy is similar in its provisions to the Code of Conduct and is seen as a first step towards legislation. The draft Workplace Policy includes two appendices: Appendix A is a set of guidelines for enterprises, and Appendix B deals with employment (HIV/AIDS) regulations and determines that compulsory pre-employment or employment testing for HIV is not permitted. Furthermore, no employer may terminate the employment of an employee on the grounds of HIV status or family responsibilities. It also provides as follows:[104]

> Any person guilty of an offence under these regulations shall be liable to a fine of K30 000 and if the offence in respect of which he was convicted continued after the conviction, he shall in addition be liable to a fine of K500 for each day the offence continues.

9.3 Medical schemes act

There is currently no legislation regulating medical schemes in Malawi. The Code of Conduct declares that '[g]overnment, 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'.[105] Some of the principles in relation to employee benefits include:

- medical scheme information on the medical status of an employee should be kept confidential;
- medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms

[102] Code of Conduct on HIV/AIDS and the Workplace sec 10.1.
[103] As above, sec 16.
[104] Draft Malawi Policy on HIV/AIDS in the Workplace (n 98 above) appendix B & sec 13(i).
[105] n 102 above, sec 13(1).

should provide standard benefits to all employees regardless of their status;

- counselling and advisory services should be made available and should inform all employees of their rights and benefits from medical aid life insurance, pension and social security funds;
- employees living with HIV should not be unfairly discriminated against in the allocation of employee benefits; and
- programmes and schemes should provide similar benefits for workers with HIV/AIDS as for workers with other serious illnesses. Benefits should include free access to public health services or the reimbursement of medical care and health-related expenses associated with the management and control of infection.

The Draft Workplace Policy similarly notes that, subject to any other law providing the contrary, the HIV status of an employee shall not affect his or her eligibility for any occupational insurance or other benefit schemes provided for employees by an employer.[106] The National HIV/AIDS Policy reiterates these principles.[107]

9.4 Duty to provide treatment

There is currently no legislation concerning the provision of ARVs by employers. However, the National HIV/AIDS Policy states that

> the HIV serostatus of an employee shall not affect his or her eligibility for any occupational insurance or other benefit schemes provided for employees by an employer. Where in terms of any law the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV test, the conditions attaching to HIV/AIDS shall be the same as those applicable in respect to comparable life-threatening illnesses.[108]

The NAC encourages and supports public and private sector institutions to develop sectoral workplace responses to HIV targeting workers and their families. In 2002, at least 17.5 per cent of public sector institutions had HIV workplace policies and programmes.[109] Several private sector institutions have also initiated workplace HIV programmes. These programmes provide various types of services, including information, education and communication for HIV prevention as well as treatment, care and support.

106 n 98 above, appendix B & sec 7(1) 'Employment (HIV/AIDS Regulations)'.
107 n 61 above, 36.
108 As above.
109 NAC (n 87 above) 34.

10. Women's rights

10.1 Legal status and protection

In addition to sex being listed as a ground for non-discrimination,[110] section 24 of the Constitution deals as follows with women's rights:

> (1) Women have the right to full and equal protection by the law, and have the right not to be discriminated against on the basis of their gender or marital status which includes the right
>
> (a) to be accorded the same rights as men in civil law, including equal capacity
>
> (i) to enter into contract;
>
> (ii) to acquire and maintain rights in property, independently or in association with others, regardless of their marital status;
>
> (iii) to acquire and retain custody, guardianship and care of children and to have an equal right in the making of decisions that affect their upbringing; and
>
> (iv) to acquire and retain citizenship and nationality; ...
>
> (2) Any law that discriminates against women on the basis of gender or marital status shall be invalid and legislation shall be passed to eliminate customs and practices that discriminate against women particularly practices such as
>
> (a) sexual abuse, harassment and violence;
>
> (b) discrimination in work, business and public affairs; and
>
> (c) deprivation of property, including property obtained by inheritance.

The National HIV/AIDS Policy recognises that women and girls are, in general, socially, culturally, economically and legally vulnerable and may be less able to fully access HIV prevention options, and needed treatment, care and support. Therefore, it recommends that the government should, among others:[111]

- ensure that women and girls, regardless of their marital status, have equal access to appropriate, sound HIV-related information and education programmes, means of prevention and health services (such as woman-specific and youth-friendly sexual and reproductive health services for all women of reproductive age, including women living with HIV);
- ensure that women and girls are protected against violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health; and

[110] n 27 above, sec 20.
[111] n 61 above, sec 5.2.2.

- ensure women's legal rights and equality within the family, in matters such as divorce, inheritance, child custody, property and employment rights, recognising in particular the right to equal remuneration of men and women for work of equal value, equal access to responsible positions, measures to reduce conflicts between professional and family responsibilities, and protection against sexual harassment in the workplace.

On 23 August 2004, the Ministry of Gender, Child Welfare and Community Services published the findings of the Country Report on Women, Girls and HIV/AIDS in Malawi.[112] The major recommendations made in the report were as follows:

- protection of girls from the risk of infection by older men;
- taking active measures to keep girls in school;
- protection of women and girls from the risk of exposure to HIV infection as a result of violence;
- protection of the right of women and girls to own and inherit land;
- establishment of a volunteer charter to ensure respect and protection of those who provide care to the sick and children who have been orphaned; and
- removal of barriers that prevent women from gaining access to medical care and treatment.

In response to these recommendations, the Ministry of Gender, Child Welfare and Community Services has developed a Programme and National Plan of Action on Women, Girls and HIV/AIDS, 2005 - 2010. The purpose of this Programme and National Plan of Action is to reduce HIV infection rates among girls and women and mitigate the impacts of the epidemic on them.[113] The Programme and Plan of Action focuses on the following objectives:[114]

- increasing girls' access to and attainment of education;
- modifying harmful cultural practices and unequal gender relations that pre-dispose women and girls to HIV infection;
- improving the access of young people (boys and girls 6 - 25 years) to gender-sensitive information and skills necessary for preventing HIV transmission;
- improving women's access to property, credit, capital, skills and assets necessary to provide sustainable income;

[112] The report was compiled by the Malawi members of the Task Force on Women, Girls, HIV and AIDS in Southern Africa. The Task Force was established by the United Nations Secretary General to 'catalyse and intensify' action by UN agencies, governments and civil society aimed at reducing the impact of HIV/AIDS on women and girls in Southern Africa.

[113] Ministry of Gender, Child Welfare and Community Services Programme and National Plan of Action on Women, Girls and HIV/AIDS 2005-2010 (2005) 2. The Programme and Plan of Action were officially launched on 13 December 2005.

[114] As above, 9-15.

- improving women's access to justice in relation to gender based violence;
- increasing women's access to HIV counselling, testing and treatment services; and
- mitigating the social and economic burden of care and its impacts on women and girls.

Marital rape is not recognised under Malawian law. Neither the Penal Code nor the revised Penal Code recognises marital rape. The Law Commission argued that the recognition of marital rape would 'have the effect of opening up to the general public the private relations of husband and wife which, for valid social and family reasons, need to be strongly protected'.[115] This position was also held during the development of the Prevention of Domestic Violence Act which does not include marital rape.

10.2 Domestic violence law

The National HIV/AIDS Policy affirms the necessity to protect women against violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.[116] Further, the Programme and National Plan of Action on Women, Girls and HIV/AIDS clearly recognises that domestic violence increases women's and girls' susceptibility to HIV infection.[117]

Women are sometimes victimised by judicial procedure during rape and sexual offence cases. For example, a High Court judge acquitted a man who had sexual intercourse with a woman without her consent because in the judge's view, women always say no to sex even when they want it.[118]

The Ministry of Gender, Child Welfare and Community Services has developed a Protection from (Prevention of) Domestic Violence Act which was adopted by Parliament in 2006. The purpose of the Act is 'to eliminate gender-based violence occurring within a domestic relationship, and to provide for effective legal remedies and other social services to persons affected by domestic violence'.[119] The Act defines domestic violence as 'any criminal offence arising out of physical, sexual, emotional or psychological, social, economic or financial abuse committed by a person against another person within a domestic relationship'.[120] The Act regulates the application for, and

115 n 46 above, 35.
116 n 61 above, sec 5.2.2.
117 Ministry of Gender, Child Welfare and Community Services (n 113 above) sec 3.3.
118 *Rashid Hussein James v Republic* Criminal Case No 12 of 1999.
119 Protection from (Prevention of) Domestic Violence Act 5 of 2006 sec 3.
120 As above sec 2.

granting of, protection, occupation, tenancy and interim orders to, or on behalf of any person within a domestic relationship who has been subjected to domestic violence.[121]

10.3 Customary rules and practices

Customary law is formally recognised in Malawi. Marriages celebrated in accordance with customary law are given formal recognition and can be registered at District Assemblies.[122] Customary law is also accredited under the Will and Inheritance Act.[123]

The National HIV/AIDS Policy, however, recognises that some customary practices increase the risk of HIV infection. These practices include the following:[124]

- *'kuchotsa fumbi'* (removing dust): sexual intercourse after initiation;
- *'mitala':* polygyny;
- *'gwamula'* (society-accepted rape): a rite of passage for young boys who are growing into men;
- *'kulowa kufa'* (cleansing death): another male is asked to have sexual intercourse with the widow to cleanse her and the clan of death after the death of her husband;
- '*chokolo'* (wife-inheritance): where a deceased man's relative inherits the widow as his wife;
- *'fisi'* (hyena): a man will secretly have sexual intercourse with a woman during initiation or when a husband fails to procreate;
- '*kusunga mwamuna'* (keeping the husband): happens during the temporary absence of the wife, a woman is selected (usually the wife's younger sister) to live with the husband and take care of him, in order to prevent him from going to other women;
- '*mbulo*': temporary husband replacement;
- '*kuhaha*': betrothal of little girls of poor parents;
- '*kuhahaza*': the tendency of men to have sexual intercourse with women in a manner that demonstrates their dominance and under the pretext of seeking pleasure; and
- '*chimwamaye':* wife or husband exchange.

One of the main objectives of the NSF was to bring about a change in the socio-cultural and economic environment for women and men in order to address gender imbalances and reduce the spread and impact of HIV.[125] Chapter four of the NSF dealt specifically with culture and HIV/AIDS. It aimed to develop the capacity of communities to

121 As above.
122 CEDAW Committee (n 25 above) 79.
123 Will and Inheritance Act (n 59 above) sec 16.
124 CEDAW Committee (n 25 above) 34-35.
125 Draft NAF (n 42 above) sec 19.

eliminate or modify cultural values, beliefs and practices that facilitate the spread of HIV. Furthermore, the NSF identified the orientation of traditional and religious leaders to gender and human rights issues and the principles of choice as 'major actions' to be undertaken.[126]

Building on the activities launched under the NSF, the draft NAF urges the government to 'develop and support targeted communication interventions that address specific cultural and gender challenges'.[127]

To address these practices and improve the protection of women and girls in the context of HIV, the National HIV/AIDS Policy proposes three series of actions. Firstly, it prescribes that all customary laws that spread HIV, or have become obsolete, or that discriminate against women in marriage relationships, be modified or banned after consultation with traditional leaders and the people. It also notes that the Divorce Act should be revised to provide for the irretrievable breakdown of marriage as grounds for divorce and to take into account situations where there exists real risk of infection with HIV.

In addition to the legislative reforms, the National HIV/AIDS Policy provides for education and advocacy efforts targeting civil society, particularly traditional and religious leaders. The National HIV/AIDS Policy acknowledges the pivotal role of these actors in promoting and encouraging monogamous marriages and fidelity within any type of marriage, to prevent HIV and other STIs as well as in sensitising their communities to the dangers of, and discouraging the practice of, customary widow and widower-inheritance practices and other cultural practices that may spread HIV.

Finally, the National HIV/AIDS Policy recommends that traditional leaders stop or modify unsafe customary practices in order to prevent HIV transmission, or promote alternative customary practices which do not place people at risk of HIV infection.

The recommendations of the National HIV/AIDS Policy were integrated into the formulation of the Programme and National Plan of Action on Women, Girls and HIV/AIDS. The specific activities planned to modify harmful cultural practices and unequal gender relations that pre-dispose women and girls to HIV infection are as follows:[128]

- mobilising traditional leaders and the faith community to promote the rights of girls and women;
- empowering women's groups and associations and faith-based organisations at community level to educate their communities to

[126] As above, ch 4.
[127] As above, 18.
[128] Ministry of Gender, Child Welfare and Community Services (n 113 above) 10-11.

monitor and protect the rights of women in relation to traditional practices; and

- transforming gender norms that negatively affect the sexual reproductive health of women and girls.

Malawi dedicated a section of its report to the CEDAW Committee to HIV and AIDS and sexually transmitted diseases. The report highlighted that the HIV prevalence rate of new infections among young women in the 15 to 24 years age group is about four to six times higher than that of young men of the same age group. The report affirms the gender dimensions of HIV in Malawi and also the persistence of cross-generation sexual intercourse whereby older men have sexual intercourse with young girls who generally cannot negotiate for safer sexual intercourse. The high and increasing levels of knowledge about AIDS were noted and attributed to the programmes co-ordinated by the NAC and implemented by government agencies and NGOs to increase knowledge about HIV infections and AIDS among the population.

However, the report noted that these programmes have led to very limited evidence of behaviour change. For example, 47.7 per cent of women and men having sexual intercourse did not protect their partners from HIV infections in the 12 months that preceded the Malawi Demographic and Health Survey 2000; 48.6 per cent did not tell their partners about their HIV status; and only 12.3 per cent used condoms.[129]

The report finally concluded that the emphasis should be on facilitating the behaviour change communication processes that can result in a change of opinions and cultural practices that predispose women and men to HIV, in making assessments, analyses and taking new action.[130]

10.4 Administration of anti-retrovirals to rape survivors

The National HIV/AIDS Policy stresses the need to 'ensure access to affordable short term ARV prophylaxis for people who have experienced occupational exposure to HIV, as well as for victims of rape'.[131] The draft NAF further highlights the commitment of the government to 'support initiatives to improve services for rape survivors including post-exposure prophylaxis (PEP) and emergency contraception'.[132]

[129] These trends remain similar to those registered in the preliminary findings of the '2004 Malawi Demographic and Health Survey'.
[130] Government of Malawi (n 24 above) 57-59.
[131] n 61 above, sec 3.2.9.
[132] n 42 above, 20.

Rape survivors can access free ART as well as treatment and prevention of STDs at public health facilities. To ensure access to PEP for rape survivors, the police has established and trained victim support officers in all police stations throughout the country who should refer rape survivors to health facilities for care, including access to ART for PEP.

In order to implement systematic and coordinated access to psycho-social and medical care and support to rape and sexual assault survivors, the Ministry of Health developed sexual assault and rape guidelines in 1995. These detail the services to be provided to rape survivors, including access to ART and clarify issues related to the relationship with the police.[133]

10.5 Sex workers

The Penal Code does not criminalise prostitution as such, but rather the exploitation of prostitution.[134] Thus, practices such as procurement of children and women, soliciting, living on the earnings of prostitution (pimping) and the running of brothels are criminal offences that rank as misdemeanours.[135]

Interpreting section 146 of the Penal Code, which deals with prostitution, the High Court in the case of *Republic v Kadzakumanja* found that 'in order for an offence under the section to be committed, it is necessary that the prisoner should gain from the earning of one who is a prostitute'.[136] The Court added, 'it is a moot point as to whether it is an offence for a prostitute to live on the earning of her own prostitution'.[137]

Despite the position of the law and the courts, prostitution is generally regarded as a criminal activity. For instance, in its report to the CEDAW Committee, Malawi acknowledged that the police generally treat prostitutes as criminals. Sex workers are usually arrested for being 'rogues and vagabonds' who are picked up while 'wandering aimlessly at night'.[138] The National HIV/AIDS Policy states in its appendix that '[g]overnment shall engage in education and sensitisation campaigns ... with a view to decriminalising prostitution'.

133 Ministry of Health and Population 'Sexual Assault and Rape Guidelines (2005)' (2005).
134 n 55 above, sec 145-147.
135 As above.
136 *Republic v Kadzakumanja* (3 April 1980), *The Malawi Law Report*, Vol. 9, 343-345.
137 As above.
138 n 24 above, 33. The report further notes that in cases where female prostitutes are found with their male partners, only the women are arrested and men are left to go free.

Despite the confusion around the legal status of prostitution, the National HIV/AIDS Policy identifies commercial sex workers as a group that should enjoy the promotion and protection of their human rights.[139] Further, the National HIV/AIDS Policy states that the government should

- ensure that people engaged in transactional sex have access to confidential and respectful health care, particularly sexual and reproductive health services, female and male condoms, and treatment and care if they are living with HIV;
- ensure that people engaged in transactional sex (including commercial sex workers and their clients) are aware of and take responsibility for protecting themselves and their sexual partners; and
- ensure that young women and men who are approaching adulthood, and who are engaged in transactional sex, are supported through multi-disciplinary interventions with life skills and sexuality education, so that they may make informed decisions about their lives, particularly how to prevent HIV infection.[140]

The implementation of these activities targeting sex workers appears difficult to realise as many sex workers move from place to place to avoid the police.[141] The Behavioural Surveillance Survey Report of 2004 reveals that most sex workers (73 per cent) buy condoms from shops and only 47 per cent have been tested for HIV.[142] These figures confirm the shortage of HIV prevention initiatives targeting specifically commercial sex workers.

11. Children's rights

11.1 Access to health care

In principle, access to health care facilities is equally ensured to every Malawian, including children living with HIV. Treatment, care and support programmes developed according to the National HIV/AIDS Policy and the draft NAF are supposed to benefit everybody including children.[143]

139 n 61 above, sec 1.5.
140 n 61 above, sec 5.7.2.
141 According to Dr Andrew Agabu, head of Policy Support and Development at the National AIDS Commission.
142 Government of Malawi 'Behavioural Surveillance Survey (BSS) Report (2004)' (2004) 96-103.
143 See sec 6 of this study 'Access to health care' for the details on government programmes addressing HIV/AIDS.

The Guidelines for the use of ART provide for the administration of ART to children who are defined as 'any person age 12 or below' and define the conditions of eligibility for treatment.[144] However, despite the growing number of children living with HIV (estimated to be 83 000 in 2003), access to ART for children is still limited. As of 31 June 2005, 21 health facilities countrywide were treating children living with HIV and only 1 172 children were on ART.

The government launched its first National PMTCT Programme on 12 June 2003.[145] The Programme has led to the development of several materials, including Guidelines for Implementers[146] and a Handbook for Health Workers.[147] Following this programme, and in an attempt to implement a comprehensive national response to reduce MTCT, the government has developed a Plan for Scaling-up PMTCT of HIV Services in Malawi 2004 - 2005 (Scaling-up Plan). Objectives of the Scaling-up Plan include, among others, providing Counselling and Testing (CT) services to at least 50 per cent of women attending antenatal clinics (ANC) and providing ART for PMTCT to at least 90 per cent of HIV-positive women and their babies, by the end of 2005.[148] Despite this optimistic projection, only 44.8 per cent (2 719 out of 6 069) of HIV-positive mothers received a short course regimen of ART for PMTCT in 2004.[149]

A study undertaken on the PMTCT programme in 2005 reveals that several problems are hindering its scaling-up, namely, the shortage in human resources, the lack of service delivery in rural areas, the low number of women delivering in health facilities, stigma and discrimination, and the socioeconomic position of women.[150]

11.2 Children orphaned by AIDS

The National HIV/AIDS Policy states that children who have been orphaned are generally underprivileged, but children orphaned due to AIDS are particularly vulnerable. Therefore, it recommends that government undertake to do the following:[151]

- ensuring that communities and extended families caring for children who have been orphaned are assisted and empowered with resources, services and skills to help them cope with the extra burden;

144 Guidelines for the use of ART 25-28.
145 Plan for Scaling-Up PMTCT of HIV in Malawi 2004-2005 (2004) 2.
146 PMTCT of HIV in Malawi: Guidelines for Implementers 2003.
147 PMTCT of HIV in Malawi: Handbook for Health Workers 2003.
148 Guidelines for the use of ART (n 144 above) 7.
149 Ministry of Health and Population (n 11 above) 12-13.
150 See PM Eba 'Political will for HIV and AIDS interventions: the potential role of parliamentarians in addressing the shortcomings of the PMTCT scaling up programme in Malawi' (2005) 14th International Conference on AIDS and STIs in Africa.
151 n 61 above, sec 5.3.2.

- ensuring that children who have been orphaned are not denied access to primary education, whether by virtue of their inability to pay, their age or their gender;
- putting in place mechanisms for the registration of births and deaths at a local level, including by chiefs, to facilitate and inform the monitoring of and planning for the orphan situation;
- ensuring that child-headed households are supported, in order to safeguard the best interests of children; and
- putting in place mechanisms to ensure the protection of inherited property of children who have been orphaned until they attain the age of majority.

The National Policy on Orphans and Other Vulnerable Children (OVC), adopted in 2003, is a comprehensive guide for the provision of care to children who have been orphaned and other vulnerable children. The mission of the Policy is to promote an environment in which OVC are adequately cared for, supported and protected physically, psychologically, materially, socially, morally, spiritually and legally to grow and develop to their potential.[152]

The mission statement, goal and ten guiding principles contained in the National OVC Policy are clearly articulated in the National Plan of Action for OVC 2005 - 2009, which forms the basis for concerted interventions and strategies for mitigating the impact of HIV and AIDS on OVC.

The National Plan of Action for OVC is based on the recognition that extended families and community-based initiatives alone are unable to cope with the situation of children affected by HIV and AIDS. Therefore, it aims at supporting and strengthening community-based responses by providing direct assistance to the communities and community based organisations. The services provided include education support, vocational training, livelihood skill building, support to community based childcare centres and community home based care, fulfilment of basic material needs such as clothes, food and shelter, household economic support, succession planning, child protection and psychological support.[153]

11.3 Education

Section 25 of the Constitution guarantees the right to education for all and specifies that primary education should consist of at least five years of education. Moreover, section 13(f) requires that the state provide adequate resources to the education sector and devise

[152] National Policy on Orphans and Other Vulnerable Children (mini-version) 1.
[153] As above, 19-22.

programmes in order to eliminate illiteracy and make primary education compulsory and free to all citizens of Malawi.

In 2005, the Ministry of Education developed a draft Education Sector Policy on HIV and AIDS (Draft Education Policy), which states in the section on prevention that a curriculum that is sensitive to cultural and religious beliefs, is appropriate to age, gender, language, special needs, and that contains HIV education shall form part of the education for all learners at all levels.[154] It also insists that heads of institutions enforce existing codes and/or rules of conduct, institutional rules, professional ethics, regulations and disciplinary measures, with respect to protecting learners and staff from HIV infection and ensuring rights of people living with HIV.[155] It further emphasises that educators, sector managers, employers, learners and parents have a responsibility to ensure that sexual abuse, violence, harassment, discrimination and stigmatisation are not tolerated.[156]

Finally, the Draft Education Policy notes that learners may not refuse to study with fellow learners, or to be taught by an education sector employee, on the grounds that that person is living with, or perceived to be living with, HIV. Similarly, educators, managers, administrators, support staff or other employees may not refuse to teach or interact with learners or colleagues on the grounds that the learners or colleagues are living with, or perceived to be living with HIV.[157] There has been no reported case of a child being refused access to school on the basis of his or her HIV status.[158]

The mission of the Strategic Plan on Combating HIV/AIDS in the Education Sector in Malawi, 2005 - 2008 is to address issues that affect access, equity, quality, relevance, management, planning and financing of the education sector. The Plan of Action, annexed to the Strategic Plan, sets out detailed activities aimed at reinforcing discussion, debates and interactive teaching or learning on issues of sex, sexuality, HIV and AIDS, and other STIs in a culturally and gender sensitive manner in order to bring about behaviour change.[159]

The government, with the assistance of its development partners, has implemented several programmes to promote the enrolment and retention of girls in schools. The Girls Attainment in Basic Literacy and Education programme (GABLE), implemented between 1993 and 1998, provided tuition fees and learning materials for all girls in

154 Draft Education Sector Policy on HIV and AIDS sec 7.1.1.
155 As above, sec 7.4.2.
156 As above, sec 7.4.3.
157 As above, section 9.4.1.
158 According to Mr Oscar Mponda, Principal Planner, HIV and AIDS Programme, Ministry of Education.
159 Combating HIV and AIDS in the Education Sector in Malawi: Strategic Plan 2005-2008 12.

primary school who passed their examinations and entered higher classes. The GABLE benefited approximately half a million girls.[160]

The Ministry of Education has established an HIV/AIDS programme in the education sector at the headquarter level. Similar committees have been set up at division, district, cluster, zone and primary school levels. The Ministry organises training workshops for secondary and primary school teachers on issues of HIV education. HIV education is also integrated in the curriculum of teacher training schools.

In 2005, the Ministry of Education developed life skills education textbooks including HIV education, which were distributed to all secondary schools, including private schools. Life skills education textbooks for primary schools have also been developed and are in final stages of printing.

In 2005, over 3 500 000 pupils and parents participated in the activities of the National Day of Education commemorated throughout the country under the theme 'Education is a social vaccine against HIV/AIDS'.[161]

12. Family law

The Constitution provides that each member of the family should enjoy full and equal respect and be protected by law against all forms of neglect, cruelty or exploitation.[162] The Constitution further states that children are entitled to know and be raised by their parents and to be protected from economic exploitation or any treatment, work or punishment that is or is likely to be hazardous or harmful to their health or to their physical, mental, spiritual or social development.[163]

In addition to the Children and Young Persons Act, provisions relating to child care and protection are scattered in several statutes. The Affiliation Act[164] makes provision for the maintenance of children born out of wedlock. The Married Women (Maintenance) Act[165] makes provision for the maintenance of married women together with their children. However, these laws alone or together do not provide sufficiently for the care and protection of children.

Therefore, the Law Commission has reviewed the Children and Young Persons Act to enhance the protection to be afforded to children taking into account the adverse effect of the HIV epidemic

160 Government of Malawi (n 24 above) 42.
161 Ministry of Education (HIV and AIDS Programme of the Education Sector) HIV and AIDS Implementation Programme in the Education Sector 2005.
162 n 27 above, sec 22(2).
163 As above, sec 23.
164 Affiliation Act Cap 26: 02.
165 Married Women (Maintenance) Act Cap 25:05.

on the Malawian society.[166] The reviewed and revised Children and Young Persons Act, to be renamed the Child (Care, Protection and Justice) Act, is a breakthrough as it covers the following issues:

- care and protection of children by the family;[167]
- children in need of care and protection;[168]
- guardianship;[169]
- fosterage;[170]
- support for children by local authorities;[171] and
- protection of children from undesirable practices (child abduction, child trafficking, sexual abuse, harmful cultural practices, forced marriage or betrothal, pledge of a child as security).[172]

With the increasing number of deaths due to AIDS, inheritance legislation has gained particular relevance in Malawi. The Will and Inheritance Act includes several provisions that need to be reviewed to enhance their efficiency and ensure better distribution and protection of a deceased's estate.[173] The Law Commission has reviewed the Will and Inheritance Act, now entitled Deceased Estate (Wills, Inheritance and Protection) Bill; however, Parliament has not yet adopted the Bill.

The review concerns three main areas. Firstly, the category of persons entitled to a share of the deceased's estate has been restricted. The current law entitles, under the expressions 'dependants' and 'heirs according to customary law', a nebulous network of extended family members to shares of the deceased's estate.[174] The Bill only designates two categories of beneficiaries, they are the spouse and children (immediate family category) and the parents and a minor whose education was being provided for by the deceased, who is not capable of maintaining himself or herself (dependant category).[175]

166 The Law Commission discussed at length on children suffering from HIV and AIDS or orphaned by AIDS. It was observed that HIV places enormous stress on infected individuals and on their families, who are confronted with the demands of caring for the seriously ill and loss of breadwinners. Many children are themselves contracting HIV and although many die within two years of birth, a significant number can survive even into their teenage years before developing AIDS if proper assistance and health care services are provided. See Law Commission Draft 'Report on the review of the Children and Young Persons Act' (2005) 94-95.

167 Draft Child (Care, Protection and Justice) Act secs 94-113. As above, 158-323.

168 Draft Child Act (as above) secs 114-128 and Law Commission (n 166 above) 158-323.

169 Draft Child Act (as above) secs 129-136 and Law Commission (as above).

170 Draft Child Act (as above) secs 137-161 and Law Commission (as above).

171 Draft Child Act (as above) secs 162-169 and Law Commission (as above).

172 Draft Child Act (as above) secs 170-177 and Law Commission (as above).

173 National HIV/AIDS Policy (n 61 above) appendix 'Proposals for legislative reform'.

174 Wills and Inheritance Act (n 59 above) secs 14 & 16.

175 Draft Deceased Estate (Wills, Inheritance and Protection) Bill secs 17(1) & 3 and Law Commission Report (n 45 above) appendix 1.

Secondly, the discriminatory provisions under the Will and Inheritance Act have been reviewed. For example, section 16 of the Will and Inheritance Act discriminates against women married under matrilineal customary laws who get a lesser share of intestate property compared to those married under patrilineal customary law; in addition, it is discriminatory because husbands are not entitled to inherit their wives' property; and finally, section 16(5) discriminates against women on the basis of their marital status in that the wife loses her inheritance upon re-marriage.[176] The Bill addresses these issues through the replacement of the various provisions by a single and uniform set of rules governing intestacy, irrespective of customary practices. Section 17(4) of the Bill also states that widows who re-marry would only lose property on customary land.

Finally, the Bill increases the fine for 'property grabbing' from MK 20 000 (USD 167) to MK 1 000 000 (USD 8 333) and the imprisonment term to 10 years. It further states that any person found guilty of property grabbing shall not qualify as an administrator or guardian in relation to any estate of a deceased person in Malawi.[177]

The Law Commission noted that the provision on property grabbing in the current Will and Inheritance Act has not been enforced.[178] Therefore, it recommended the introduction of the law of succession in the curriculum of police recruits and cadets during their training. It also recommended a massive education campaign targeted at the police on the law of succession.[179]

13. Criminal law

13.1 Criminal legislation

There are no HIV-specific provisions in the criminal law. However, traditional criminal offences such as rape (section 132 of the Penal Code), murder (section 209 of the Penal Code), attempted murder (section 223 of the Penal Code) and assault (section 253 of the Penal Code) could be used to prosecute the transmission of HIV.[180] In addition, section 192, provided under chapter XVII of the Penal Code

176 This is reputed to force some women into wife inheritance (*chokolo*) in order to retain the property. GD Kainja 'The HIV/AIDS legislative review assessment report' (2004) 38.

177 Draft Deceased Estate Bill (n 175 above) sec 84 and Law Commission (n 46 above).

178 This situation was due to the fact that the special public prosecutors provided under the act have not been appointed and that the police generally consider property grabbing a family issue and therefore does not investigate complaints related thereto. n 166 above, 72.

179 n 45 above, 73.

180 See PM Eba 'Pandora's box: The criminalisation of HIV transmission or exposure in SADC countries' in F Viljoen and S Precious (eds) *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* (2007) 13.

related to 'nuisances and offences against health and convenience', punishes any person who knowingly spreads the infection of any disease, which is dangerous to life. Although this provision does not specifically target HIV infection, it has the potential to allow the prosecution of people living with HIV who knowingly transmit the virus. There is no reported case relating to the application of this provision of the Penal Code.

During the review of the Penal Code, the Law Commission felt that the offence should also carry an element of acting recklessly apart from the element of acting unlawfully or negligently. It also felt that the offence of spreading diseases dangerous to life, especially in the light of the prevalence of HIV, should be regarded as a serious offence and not as a mere misdemeanour as the Penal Code currently provides.[181]

Accordingly, the Law Commission recommended that section 192 be amended as follows:[182]

> Any person who unlawfully, negligently or recklessly does any act which is, and which he knows or has reasons to believe to be, likely to spread the infection of any disease dangerous to life, shall be guilty of an offence and shall be liable to imprisonment for fourteen years.

Finally, the Law Commission noted that it is aware of the worldwide efforts aimed at developing specialised legislation to deal with the complex issues related to HIV and AIDS and concluded that Malawi as a country will in time have to develop such specialised legislation.[183]

Although there are currently no guidelines directing judicial officers to impose harsher sentences on HIV-positive rapists, it is the practice in local courts to do so. In the case of *Republic v Cidreck*, the High Court confirmed the position in the following terms:[184]

> The position has been clearly put in several local cases that the sentence should be enhanced if there is proof that the victim has thereby contracted the virus which causes the disease or that the rapist is HIV positive.

The National HIV/AIDS Policy offers proposals to amend various provisions of the Penal Code. However, it does not deal with the issue of wilful transmission of HIV. The National HIV/AIDS Policy, in fact, makes the following recommendations for the review of the Penal Code:[185]

- The Penal Code shall be revised to make marital sexual abuse a criminal offence;

[181] n 45 above, 50. The Parliament has not yet adopted the reviewed Penal Code.
[182] As above.
[183] As above, 50-51.
[184] *Republic v Cidreck* Confirmation case No 1299/1994, *Malawi Law Report*, 1995, 695-696.
[185] National HIV/AIDS Policy (n 61 above) appendix 'Proposals for legislative reform'.

- The Penal Code shall be revised to make the criminal offence of rape gender-neutral, thus covering the situation where a woman or a girl indecently assaults or rapes (seduces) a man or boy;
- The Penal Code shall be revised to provide that:

– sexual intercourse through the anus without consent constitutes the crime of rape;

– penetration of the anus or vagina using instruments, finger, tongue, penis and other objects or limbs without consent constitutes rape;

- The Penal Code shall be revised to criminalise female genital mutilation; and
- The Penal Code shall be revised to make the prescription of sexual intercourse by traditional healers a criminal offence.

13.2 Men having sex with men

Sodomy and consensual sexual relationships between men are criminalised under sections 153 and 156 of the Penal Code, which, respectively, prohibit 'unnatural' offences and indecent practices between males. The crimes of unnatural offences and indecent practices between males were dealt with in the case of *Twaibu v Reginam* of 1963.[186] Since that time, there has not been any other reported case on these issues.

The appendix to the National HIV/AIDS Policy states that the government 'shall engage in education and sensitisation with all stakeholders including traditional leaders and religious groups with the view to decriminalising ... same-sex sexual practices in the long term'. Further, the National HIV/AIDS Policy recognises that people who engage in same-sex sexual relations are socially and culturally vulnerable to prevailing attitudes. It finally urges the government to 'put in place mechanisms to ensure that HIV and STI prevention, treatment, care and support can be accessed by all without discrimination, including people who engage in same-sex sexual relations'.[187]

14. Prisoners' rights

Section 42(1)(b) of the Constitution states that every person who is detained, including every sentenced prisoner, has the right to be detained under conditions consistent with human dignity, including at least the provision of reading and writing materials, adequate nutrition, and adequate treatment at the expense of the state.

[186] *Twaibu v Reginam*, 31 October 1963 (Cr. App. No. 168 of 1963), *African Law Report Malawi Series*, Vol 2, 532-537.

[187] n 61 above, sec 5.10.

The National HIV/AIDS Policy includes prisoners in the category of vulnerable groups and requires the following:

- that prisoners are not subjected to mandatory testing, or quarantined, segregated, or isolated on the basis of HIV status;
- that all prisoners (and prison staff, as appropriate) have access to HIV-related prevention information, education, VCT, means of prevention (including condoms), treatment (including ART), care and support;
- 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 by fellow prisoners and by warders. Juveniles shall be segregated from adult prisoners to protect them from abuse; and
- that prisoners who have been victims of rape, sexual violence or coercion have timely access to PEP, as well as effective complaint mechanisms and procedures and the option to request separation from other prisoners for their own protection.

The HIV and general health situation is appalling in Malawi prisons. In a report on HIV/AIDS in prisons, Penal Reform International revealed the high rate of HIV transmission and the poor treatment and care received by HIV-positive prisoners in Malawi.[188] The report noted that of 167 deaths in prisons during 1997, 40 per cent were attributed to AIDS, 25 per cent to pulmonary TB, and 20 per cent to dysentery and bloody diarrhea.[189] From October 2004 to December 2005, of 437 inmates tested for HIV at Zomba central prison, the largest prison in the country, 193 were positive.

These concerns were highlighted by the Special Rapporteur on Prisons and Conditions of Detention in Africa who visited several prisons in Malawi in June 2001. The Special Rapporteur recommended that

> HIV/AIDS education programmes in prisons should be intensified. Furthermore, voluntary testing for HIV/AIDS in prisons should be encouraged and suitable structure should be put in place for the psychological and medical support of prisoners who decide to take the test, those who are HIV positive and those already suffering from AIDS. To this end, prison medical staff must, at first, be trained on AIDS prevention and in counselling.[190]

The official position is that sex does not occur in prisons. In addition, sodomy and consensual sexual relationships between men are criminalised under sections 153 and 156 of the Penal Code, which

188 D Jolofani & J DeGabrielle 'A study of HIV transmission and the care of prisoners with HIV/AIDS in Zomba, Blantyre and Lilongwe prisons' (1999).

189 As above, 16.

190 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' (2001) 47.

prohibit respectively 'unnatural offences' and 'indecent practices' between males. However, as noted in the report of the Special Rapporteur on Prisons, 'judging from reported cases of prisoners with STDs and peri-anal abscesses, which could only have been contracted within the prison through anal intercourse, and also confessions made during interviews with prisoners themselves about their sexual behaviour, it can be inferred that a certain proportion of these prisoners who are victims of AIDS may well have contracted the disease while in prison.'[191]

Despite these findings, condoms are not available in prisons. Condoms are distributed to prisoners only on release.[192] In addition, the Human Rights Commission points out 'the lack of access to the services of consensual and voluntary HIV testing and in the few cases where this is done, the lack of ARVs by the prisoners whose status is positive and in need of such drugs'.[193]

15. Immigration

The Immigration Act declares unlawful the entry into or presence in Malawi of several categories of persons qualified as 'prohibited immigrants'.[194] Section 4(1)(e) includes in the list of prohibited immigrant any person who is infected, afflicted with or suffering from a prescribed disease. Although the inventory of prescribed diseases provided under section 11 of the Immigration Regulation does not mention HIV and AIDS, it includes tuberculosis, gonorrhoea and syphilis, which are related to HIV and AIDS. Further, prostitutes and homosexuals are also considered prohibited immigrants.[195]

Although prohibited immigrants are barred from entering Malawi, persons targeted in section 4(1)(e) can be issued a permit to enter and remain in Malawi by the Minister, or any person authorised by the Minister. Such permit is granted under strict conditions spelled out under section 20 of the Regulations.

16. Social assistance and other government benefits

There is currently no specific form of social security or assistance system in place in Malawi. There is also no disability grant or pension scheme. Therefore, disability pensions, social grants for needy children and mothers, and unemployment social grants are non-

191 Jolofani & DeGabrielle (n 188 above) 29.
192 Malawi Human Rights Commission 'Situational Analysis on the Rights of Prisoners' (2004) 23.
193 As above, 25.
194 Immigration Act sec 4.
195 Immigration Act sec 4(g).

existent. Furthermore, the Ministry of Social Development and Persons with Disabilities is preparing a draft Disability Bill which does not specifically include people living with HIV as people in need of protection.[196]

Generally, all Malawians can access free medical services and medication, including ART and the treatment of opportunistic infections at government health facilities. Despite the absence of a comprehensive social assistance scheme, several measures are in place to assist people living with or affected by HIV and AIDS. For instance, the National Plan of Action on OVC provides for schools fees/bursaries for OVC, and access to food and nutritional support. In addition, as part of the national HIV response, psycho-social, nutritional and financial support is also provided to households for the care of HIV-positive adults who have been chronically ill for three months or more.[197]

In an attempt to mitigate the impact of HIV and address the needs of the people living with or affected by HIV and AIDS, the draft NAF has set up major objectives during the period 2005 - 2009 to scale up interventions and support coping mechanisms that minimise pain, suffering, anxiety and loss of service delivery at the individual, household, community and national levels. The objectives include:[198]

- promoting sustainable income generating projects (IGPs) for PLHA, OVC, widows, widowers, and the affected elderly;
- enhancing the provision of psycho-social support to PLHA, OVC, widows, widowers and the elderly affected by the epidemic;
- improving access of OVC to essential social services, integrated and comprehensive community-based support services; and
- promoting food security and nutrition measures among HIV and AIDS affected households and communities.

17. Insurance

The Insurance Act is silent on HIV and AIDS. The appendix to the National HIV/AIDS Policy on 'proposals for legislative reform' recommends that

> [t]he Insurance Act [...] be revised to regulate testing with informed consent for insurance purposes and regulations shall be promulgated to provide for and regulate the practice and procedure for such tests to ensure pre- and post-test counselling.

196 Kainja (n 176 above) 46-48.
197 Draft NAF (n 42 above) 31.
198 As above, 28-32.

Section 10.6 of the Code of Conduct on HIV/AIDS and the Workplace recommends the following in terms of life and other insurance:[199]

- HIV testing should not be required as a condition of eligibility for national social security schemes, general insurance policies, occupational schemes and health and life insurance; and
- insurance companies should not require HIV testing before agreeing to provide cover for a given workplace. Costs and revenue estimates and actuarial calculations must be based on available epidemiological data for the general population.

Although there is no general practice of compulsory HIV testing for insurance purposes, insurance companies require HIV testing for life insurance and do not provide life cover for those who test positive. However, HIV-positive clients are offered other insurance policies according to which the insurer refunds the premium plus additional interest in case of death.

HIV testing for insurance purposes is generally conducted by medical personnel designated by the insurer and the result is treated confidentially. Only the person in charge of writing the policy has access to the result of the HIV test. There are no specific guidelines on testing for insurance purposes. Therefore, pre- and post-test counselling is conducted according to the Counselling and Testing Guidelines.

18. Oversight

Recognising the multi-faceted nature of the HIV epidemic, the government has designed a multi-sectoral approach to the implementation of HIV and AIDS-related legislation, policies and programmes. The multi-sectoral approach was first elaborated in the NSF[200] and was confirmed in the National HIV/AIDS Policy[201] and the draft NAF.[202] In terms of the multi-sectoral approach, all 'stakeholders, including government [ministries and departments], NGOs, religious organisations, private institutions, traditional institutions and communities should collaborate in the design, implementation and monitoring of multi-sectoral and multi-disciplinary programmes'.[203]

199 n 102 above, secs 10.6.1-10.6.2.
200 NSF (n 40 above) sec 3.3. The Guiding Principles of the Strategic Framework states that all 'stakeholders, including government, NGOs, religious organisations, private institutions, traditional institutions and communities should collaborate in the design, implementation and monitoring of multisectoral and multi-disciplinary programmes.'
201 n 61 above, ch 2 'Strengthening and sustaining a comprehensive multisectoral response to HIV/AIDS'.
202 Draft NSF (n 42 above) sec 2.3 'Institutional framework'.
203 As above, sec 3.3 'Guiding principles'.

However, some stakeholders play a greater role. For instance, the public health sector occupies a strategic place to provide direction especially in treatment and care for people living with the virus. For example, the National Assembly created the Parliamentary Committee on Health and Population as the parliamentary oversight body for the health sector. Its functions, in terms of section 164(2) of the Standing Orders, include investigating and inquiring into matters related to health; studying programme and policy objectives of the Ministry of Health and other related structures; studying and reviewing relevant legislation and reporting to the National Assembly; examining estimates of expenditure of relevant ministries and other public bodies; assessing achievement and impact of programmes and reporting to the National Assembly on their findings and making recommendations.[204] The Committee has created a sub-committee on HIV/AIDS, which deals specifically will all matters related to HIV and AIDS. In addition, other ministries, such as the Gender, Child Welfare and Community Services, Education, Agriculture as well as Defence are key line ministries in the implementation of the national response to the epidemic.

While 'all stakeholders' are involved in the implementation of HIV and AIDS-related legislation, policy and programmes, the National HIV/AIDS Policy designates the NAC as the body that manages the overall coordination, monitoring and evaluation of the national response to ensure attainment of the goals and objectives for addressing HIV and AIDS.[205]

To inform and improve its monitoring and evaluation role, the National HIV/AIDS Commission has developed a Conceptual Framework[206] and an Operational Plan[207] for monitoring and evaluation based on indicators focusing on key areas such as HIV prevention, treatment, care and support, impact mitigation, and capacity building and partnership.[208]

19. Stigma

Stigmatisation and non-acceptance of people living with HIV and the affected families were identified in the NSF as major problems that negatively affect the management of the epidemic.[209]

[204] Malawi Parliament 'Standing Orders' adopted by the National Assembly on 22 May 2003.
[205] National HIV/AIDS Policy (n 61 above) 8.
[206] NAC National HIV/AIDS Monitoring and Evaluation Plan: Conceptual Framework (2003).
[207] NAC National HIV/AIDS Monitoring and Evaluation Plan: Operations Plans (2003).
[208] NAC (n 83 above) 13-16. To compile its monitoring and evaluation report, the NAC receives information from all the stakeholders implementing HIV and AIDS-related activities.
[209] National HIV/AIDS Policy (n 61 above) sec 8.5.5.

Furthermore, the draft NAF insists, under its guiding principles, that people living with the virus, orphaned children, widows and women have the right to protection against discrimination and stigmatisation with equal access to education and health, including access to treatment, employment and other services.

In an attempt to effectively address HIV-related stigma and discrimination, the National HIV/AIDS Policy urges government to undertake, among others, the following:[210]

- ensuring that the human rights and dignity of those affected and infected by HIV/AIDS are respected, protected and upheld in a conducive legal, political, economic, social and cultural environment;
- ensuring that people living with the virus are not discriminated against in access to health care and related services and that respect for privacy and confidentiality are upheld;
- ensuring that HIV/AIDS, whether suspected or actual, is not used as a reason for denying access to social services, including health care, education, religious services, or employment; and
- ensuring that sector policy-makers, including those in labour, corporate and social service sectors, put in place sectoral policies that effectively address discrimination on the basis of HIV/AIDS and take steps to effectively eliminate stigma and discrimination in their institutions and in the implementation of their sectoral mandates.[211]

These measures are implemented through information, education and communication campaigns on HIV-related stigma and discrimination co-ordinated by the NAC and targeting the general population. Furthermore, most government ministries and departments as well as private companies have developed or are developing sectoral HIV responses targeting HIV-related stigma and discrimination.

In its Monitoring and Evaluation Report 2004, the NAC noted that high percentages of women (93.6 per cent) and men (95.9 per cent) expressed a willingness to care for AIDS-affected relatives. However, lower percentages of women (48.7 per cent) and men (53.1 per cent) believed an HIV-positive co-worker should be allowed to keep working. The latter would reflect the true attitude towards people living with HIV.[212]

[210] As above, 22-23.

[211] This recommendation is further stressed under the draft 'Policy on HIV/AIDS in the Workplace,' which states that 'the competent authorities shall instigate and promote awareness and prevention programmes to counter stigmatisation and reduce the incidence of HIV in the workplace.' See draft Policy on HIV/AIDS in the workplace (n 98 above) sec 8.4.

[212] NAC (n 83 above) 20.

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4 HIV, AIDS and the law in Mozambique

1. Background to country

1.1 First AIDS case

According to the former AIDS National Commission (*Comissão Nacional do SIDA*) under the National Institute of Health (an organ of the Ministry of Health) the first AIDS case in Mozambique was documented in 1986. It is not known how the person was infected.[1] The person was a foreigner from Haiti[2] and the information about the patient was treated confidentially without revealing the person's identity.

1.2 Demography

Mozambique has an estimated population of 20 500 000 people in 2007.[3] Life expectancy at birth (m/f) was estimated at 42.3/41 in 2004.[4] Child mortality (m/f) per 1000 births is 154/150.[5] The total health expenditure per capita, at an international dollar rate in 2003, was 45 and the total health expenditure as a percentage of Mozambique's GDP (2003) was 4.7.[6]

The HIV prevalence rate was estimated in 2005 at 16.1 per cent (15-49 years old).[7] More than 200 000 new HIV cases needing anti-retroviral treatment (ART) developed in 2005.[8] The central region of Mozambique has the highest HIV prevalence rate. The higher prevalence rate in the central region can be attributed to several factors, including the return of refugees from neighbouring countries with high HIV prevalence rates after the 1992 peace agreement.[9]

Approximately 140 000 pregnant women were estimated to be HIV positive in 2005.[10] There is no data on the number of babies who were born HIV positive. However, an estimated 140 000 children (aged 0 to

1 National Strategic Plan to Fight HIV/AIDS *(Plano Estratégico Nacional de Combate ao HIV/SIDA*) (NSP) part I 'Strategic Component – Situation Analysis 2004'.
2 Interview with Dr Catarina Mboa Ferrão, HIV/AIDS specialist at the Maputo main hospital, Hospital Central de Maputo 12 March 2006.
3 UNFPA *State of the world population 2007: Unleashing the potential of urban growth* (2007) 90.
4 UNDP 'Human development report 2006: Beyond scarcity: Power, poverty and the global water crisis' (2006) http://hdr.undp.org/hdr2006/ (accessed 17 January 2007) table 24 'gender related development index'.
5 WHO 'Country Profile: Mozambique' http://www.who.int/countries/moz/en/ (accessed 17 January 2007).
6 WHO 'Core Health Indicators: Mozambique' http://www3.who.int/whosis/core/core_select_process.cfm?country=moz&indicators=nha&language=en (accessed 17 January 2007).
7 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
8 Minister of Health addressing the parliament (March 2006).
9 UN Economic Commission for Africa *Mozambique: The challenge of HIV/AIDS treatment and care* (2003) 3.
10 Minister of Health (n 8 above).

14) were living with HIV in 2005.[11] The Prevention of Mother-to-Child-Transmission (PMTCT) Programme started recently in Mozambique and in 2005, 3.4 per cent of pregnant women received treatment to reduce mother to child transmission.[12] Of the 800 000 pregnant women who gave birth in 2003 in Mozambique, only 15 000 were tested and 19 per cent of those were tested HIV positive.[13] The HIV prevalence rate is higher among women than men. According to the UNAIDS Report, among the estimated 1.8 million people living with HIV, 960 000 of them were women.[14] In the central region of the country the number of infected women is three times the number of infected men.[15]

The age group most affected by the epidemic is the group between 15-29 years.[16] There is no data about the infection rate among the most vulnerable groups in society such as sex workers, intravenous drug users and homosexuals. Also, there is no data regarding the number of people who died from AIDS-related illnesses since the discovery of the disease. However, it is estimated that around 140 000 people died of AIDS in 2005 alone.[17] This data is not exactly due to multiple diagnoses and patients whose deaths are not recorded by the hospital because they return home before their death. Currently the number of children who have been orphaned by AIDS is estimated to be at around 510 000.[18] There are 273 399 children between 0-17 years whose parents died as a result of AIDS-related illnesses.[19] In 2004, it was estimated that 199 000 people were in need of ART and by 2005, 10 657 people were receiving such treatment.

The tuberculosis (TB) prevalence rate in Mozambique was 635 persons per 100 000 in 2004.[20] The number of TB cases in Mozambique is likely to further increase over the next few years due to HIV. The TB and HIV co-infection rate is high, with 47 percent of adult TB patients testing HIV positive.

11 UNAIDS (n 7 above) 412.
12 As above.
13 NSP (n 1 above).
14 UNAIDS (n 7 above) 412.
15 NSP (n 1 above) 18-22.
16 As above.
17 UNAIDS (n 7 above) 412.
18 UNAIDS (n 7 above) annex 1 'Country profile: Mozambique'.
19 Ministry for Women and Social Action Coordination *(Ministério da Mulher e Coordenação da Acção Social*) *Brief evaluation, analysis and process study of the Action Plans for Orphans and Vulnerable Children in Mozambique* (*Avaliação Rápida, Analise e Processo de Planos de Acção para Órfãos e Outras Crianças Vulneráveis em Moçambique*) (2004) 7.
20 UNDP (n 4 above) 314.

2. International human rights treaties

2.1 Ratification status of international human rights treaties

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	21/07/1993
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	16/04/1997
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	26/04/1994

2.2 State reports

Mozambique fails to submit reports to international treaty bodies consistently and on time. Mozambique submitted its first report to the Committee on the Rights of the Child (CRC Committee) in 2000,[21] and also submitted a combined initial and second periodic report to the Committee on the Elimination of Discrimination against Women (CEDAW Committee) in 2005.[22] The report to the CEDAW Committee refers to the impact of the HIV epidemic on women and children and how the government is improving women's knowledge of HIV women through awareness raising.

The report to the CRC Committee mentioned that, although the consequences of the war are still being felt, from the end of the armed conflict in 1991, infant mortality rates, which used to be the highest in the world, had been falling, but recognises that in the context of the HIV epidemic, the concern for child mortality has returned. The report cited epidemiological studies conducted in 1997, which concluded that there was a risk of 40 per cent of children in Mozambique being infected with HIV through mother-to-child transmission (MTCT) during pregnancy, at birth, or through breast milk of HIV-positive mothers. In response to this growing number, the government reported that it decentralised the AIDS/sexually

[21] Summary Record of the 762nd meeting: Mozambique. (28/02/2003) (CRC/C/SR.762) (Summary Record).

[22] Committee on the Elimination of Discrimination against Women (CEDAW) *Combined initial and second periodic report: Mozambique* (CEDAW/C/MOZ/1-2) (14 November 2005).

transmitted infections (STI) Programme and extended it to the most distant peripheral levels. Related to the issue, the government reported that the AIDS/STI Programme had been integrated into the Mother and Child Health and Family Planning Programmes. The approach to the HIV epidemic had become multi-sectoral, involving various ministries and government sectors and supported by a variety of partners.

The examination of the initial report of Mozambique to the CRC Committee led to some concluding observations regarding HIV and AIDS, namely that the government should

- improve alternative care for children, paying particular attention to children orphaned by AIDS, including the provision of medication for treatment;
- develop and implement HIV and AIDS policies and strategies on behalf of children infected with and affected by HIV and AIDS, as well as their families. This would include making use of the International Guidelines on HIV/AIDS and Human Rights, with particular reference to children's rights to non-discrimination, health, education, food and housing, as well as their rights to information and freedom of expression;
- conduct a national study on public attitudes, taboos and bias with regard to HIV and AIDS and infected persons in order to strengthen existing policies and programmes with regard to HIV and AIDS;
- give particular attention to the role of men in the prevention of HIV transmission;
- strengthen efforts to reduce mother-to-child transmission of HIV, including voluntary prenatal HIV testing of mothers and assistance to infected mothers in obtaining breast-milk substitutes for their children;
- include children in devising and implementing strategies for HIV prevention; and
- take note of the recommendations made by the Committee following its 1998 Day of General Discussion on Children Living in a World with AIDS.[23]

23 See Committee on the rights of the Child 'Consideration of report submitted by States parties under article 44 of the Convention: Concluding observations of the Committee on the Rights of the Child' (2002).

In its combined initial and second periodic report to the CEDAW Committee, the government reported that a high number of women had knowledge of the disease and that the media was the main source of information.[24] According to the same report, awareness about the existence of the disease did not correspond to knowledge of the means of infection and prevention. It was stated that only 34 per cent of women and 54 per cent of men knew at least one method of preventing the HIV infection.[25]

The government reported having in place a program to tackle HIV and STIs. At that time, the government reported that there were no legal or other measures to protect HIV-positive women at the work place, but that there were non-governmental organisations (NGOs) working with the government to ensure protection of people living with the virus from discrimination. In the same report, the government stated that the HIV prevalence rate for adults in 1999 was 15.4 per cent and that the availability of male condoms had increased. In 1997, it reported that 15 million condoms were available.

Mozambique also reported that there were 500 000 children who had been orphaned, and roughly two thirds of those were orphaned by AIDS.

In its concluding comments to the reports submitted by Mozambique, the CEDAW Committee recommended:[26]

- measures to improve women's access to health care services, to improve the availability of information and education regarding sexual and reproductive health and to address the identified causes of maternal mortality;
- measures that aim at the prevention of unwanted pregnancies, including teenage pregnancies, be strengthened by increasing knowledge about family planning services;
- continued and sustained efforts to address all relevant aspects of the impact of HIV/AIDS on women, as well as its social and family consequences; and
- measures to increase and strengthen the participation of women in designing and implementing local development plans, and pay special attention to the needs of rural women, particularly women heads of household, ensuring that they participate in decision-making processes and have improved access to health, education, clean water and sanitation services, fertile land and income generation projects.

24 CEDAW 'Consideration of reports submitted by state parties under article 18 of the CEDAW: Combined initial and second periodic report of Mozambique (2005)' para 1.2.2 Fertility, reproduction and mortality, p 8.
25 As above, 9.
26 See CEDAW 'Concluding comments of the Committee on the Elimination of Discrimination against Women: Mozambique' (2007).

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	22/02/89
African Charter on the Rights and Welfare of the Child (29/11/1999)	22/12/98
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (25/11/2005)	30/02/05
Treaty of the Southern African Development Community (SADC) (30/09/1993)	
SADC Protocol on Health (14/08/2004)	

3.2 State reports

To date, Mozambique has only submitted two out of five reports to the African Commission on Human and Peoples' Rights. The first was submitted in 1997 and the second in 2000. On both occasions, when the reports were submitted, the ACHPR could not discuss the report's content with a governmental representative because one did not turn up. A senior staff member at the Ministry of Foreign Affairs and Co-operation said that the most recent report, due in 2003, was almost complete[27] and would shortly be distributed among civil society for consultation. However, as of March 2006, it had not yet been finalised or circulated for debate.[28]

3.3 Status of international and human rights treaties in domestic law

The legal system in Mozambique belongs to the civil law family, whereby once international and human rights treaties or other international instruments are ratified and published in the official Gazette (*Boletim da República*), they automatically enter into force and become the law of the country like any other law passed by

[27] Interview with a senior staff at the Ministry of Foreign Affairs and Co-operation 7 March 2006, Maputo.

[28] The consultant could not get hold of copies of the reports submitted despite effort at the Ministry of Foreign Affairs or the Ministry of Justice, the two institutions responsible to gather information and draft the reports to international treaty bodies. The reports are also not available on the internet.

parliament. Therefore, in most cases, there is no need to domesticate international treaties in order for them to apply.

The Bill of Rights enshrined in the Constitution is inspired partially by international law and in some cases, replicates *ipsis verbis* what is stated in the international instruments.[29] A specific legislation, based on a ratified treaty, is the 2004 Family Law *(Lei da Família)*,[30] which (in line with the constitutional principle of equality between women and men) improves the protection for women in informal unions and the protection of women's rights, including the recognition of customary marriages.[31] Protection for children is also improved with provisions including an increase in the minimum age for marriage.

Regarding the national arrangement for the implementation of international human rights treaties, there is no single government department with this primary responsibility. Ideally, each Ministry should implement the human rights treaties related to its area of competence. However, in terms of reporting to international treaty bodies, the Ministries of Justice, and Foreign Affairs and Cooperation gather, draft and submit reports. However, this has not always been the case. For instance, the Ministry of Women and Social Co-ordination prepared and submitted the reports to the CRC Committee and the CEDAW Committee. For other cases regarding implementation of domestic and international law, Parliament has established a Petition Commission to hear cases about maladministration of justice or the lack of the government's adherence to the law.

3.4 International Guidelines

The government of Mozambique is aware of the International Guidelines on HIV/AIDS and Human Rights that were published by UNAIDS and the Office of the United Nations High Commissioner for Human Rights.[32] For instance, in line with the Guidelines, the laws outlaw compulsory HIV testing for employees or prospective employees. Confidentiality and privacy of people living with HIV must be ensured at the workplace or by medical personnel. The

29 Art 43 of the 2004 Constitution states that the Bill of Rights has to be interpreted in accordance with the Universal Declaration of Human Rights and the African Charter of Human and Peoples' Rights. Constitution of Mozambique (2004).

30 Family Law 10 of 2004.

31 Previously, women married under customary law could not claim property or custody rights because their marriages were not recognised by the formal courts.

32 Law 5/2002 of 5 February. This law envisages the protection against discrimination or stigmatisation of employees or prospective employees with HIV at the workplace.

government also enacted norms that guide assistance to people living with HIV by medical employees.[33]

4. National legal system of country

4.1 Form of government

Mozambique is a multi-party democracy, whereby the President of the Republic and the members of parliament are elected directly by the people. The Constitution separates and differentiates among three branches of the state: the executive, the legislative and the judiciary. The President is the Head of State and the Head of the government. The President of the Republic and the Speaker of Parliament serve for a five-year term.

4.2 Legal system

Mozambique is a civil law country. The Constitution is the supreme law of the country. The judiciary is comprised of four main institutions: (i) the Supreme Court, which is the highest court of appeal for matters of common jurisdiction (civil, criminal, labour, commercial and maritime); (ii) the Administrative Court, which deals with administrative matters and also is the highest court of appeal for custom and tax matters; (iii) the Constitutional Council, which deals with constitutional matters and electoral claims; and (iv) the Attorney-General's Office, which represents the state in the courts, but also oversees the general implementation of laws and legality by the state and private individuals or institutions.

4.3 Constitution and Bill of Rights

The Constitution in force in Mozambique is its second. The first was enacted in 1975 when Mozambique gained independence from Portugal. The 1975 Constitution had a very poor Bill of Rights, containing only 11 articles and focusing on economic, social and cultural rights and no civil and political rights. For instance, it did not contain the right to life.[34]

[33] Ministerial Diploma 183-A/2001 of 18 December approves norms of organisation of the National Health Services for the assistance of PLHA and guideline principles regulating the way medical assistance shall be processed to PLHA including its technical guidelines.

[34] 1975 Constitution, Title II.

The second Constitution was enacted in 1990, before the Peace Agreements between FRELIMO and RENAMO which ended 16 years of civil war.[35] The 1990 Constitution incorporates a broad range of rights, including the right to life. It defines democracy and the separation of powers. It proclaims Mozambique as a democratic country that upheld social justice.[36] The 1990 Constitution states that the 'protection and promotion of human rights and equality of citizens before the law'[37] is one of the main aims of the state. The 1990 Constitution has a broad Bill of Rights, which focuses on political and civil rights.[38]

The 1990 Constitution was amended in 1996, 1998 and 2004.[39] The 2004 Amendment enhances the Bill of Rights of the 1990 Constitution. Some progressive changes were made, including the acknowledgment of legal pluralism *(pluralismo jurídico)* — the recognition of different normative and dispute resolution systems co-existing in Mozambique.[40] The 2004 Amendment sharpened and clarified a number provisions related to human rights protection, and also included some new rights:

- The 2004 Amendment introduced the right of popular action in courts *(direito de acção popular)*.[41] As individuals or as part of a group, citizens are provided with the right to claim compensation and the right to act in defence of public health, consumer rights, environmental conservation, cultural heritage and public property;
- Whilst the 1990 Constitution recognised the right of the accused *(arguido)* to legal assistance and aid (in article100), the 2004 Amendment recognises the right to choose a defence counsel to assist in all parts of the proceedings *(todos actos do processo)*;[42]
- The 1990 Constitution provided for the right of *habeas corpus* (article102). The 2004 Amendment added a time limit of eight days within which courts must respond to writs of *habeas corpus*;[43]
- The 2004 Amendment provided for new protections for lawyers in the exercise of their functions, including the right to confidential

35 The 1990 Constitution was drafted against the backdrop of peace negotiations, and was part of the process that led to the signing of peace in 1992 between FRELIMO and RENAMO under the General Peace Agreements.
36 n 29 above, art 1.
37 As above, art 6(d).
38 The Bill of Rights of the 1990 Constitution has 40 arts against 11 in the 1975 Constitution.
39 EISA 'Mozambique: Constitution' http://www.eisa.org.za/WEP/moz5.htm#fn5 (accessed 7 September 2007).
40 n 29 above, art 4.
41 As above, art 81.
42 As above, art 62.
43 As above, art 66.

communication between a lawyer and client, including when the client is in detention;[44]
- The 2004 Amendment makes the Bill of Rights justiciable and binding on both public and private entities, as well as the state, and hence in effect, it applies to individuals and companies;[45] and
- The 2004 Amendment balances civil and political rights with economic, social and cultural rights, although Mozambique has not yet ratified the International Covenant on Economic, Social and Cultural Rights.

The rights guaranteed in the Constitution, which may impact directly or indirectly on HIV are the rights to equality, non-discrimination, and the right to health and sanitation.

Furthermore, the 2004 Amendment states that citizens are equal before the law regardless of their race, colour, political affiliation, social status, gender, ethnicity, place of birth, religion or occupation.[46] Regarding the right to non-discrimination and the right to health, the Constitution states that citizens ought to respect each other without discrimination of any sort.[47] Specifically, it states that 'all citizens have the right to medical assistance and sanitation under the law, as well as the duty to promote and protect the public health'.[48]

The Constitution also provides that medical assistance and sanitation are provided through a National Health Service and that the State defines the terms and condition of the provision of such services, either by public institutions or private institutions. As well, the state promotes the control and regulation of the sale and purchase of medicines.[49]

4.4 National human rights institutions

Mozambique does not have a national human rights institution to oversee the implementation, promotion and protection of human rights. Human rights are dealt with by individual units at the Ministry of Justice and Ministry of Foreign Affairs and Co-operation. These units have a broad mandate, which includes HIV and AIDS.

44 n 29 above, art 63.
45 As above, art 56.
46 As above, art 35.
47 As above, art 44.
48 As above, art 89.
49 As above, art 116.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The primary department responsible for HIV and AIDS policies and programmes is the National AIDS Council (*Conselho Nacional do Combate ao Sida* or CNCS).[50] The CNCS comprises officials from six ministerial departements and individuals representing civil society. The CNCS is chaired by the Prime Minister. The Ministry of Health is responsible for conducting the National Programme of Control of Sexually Transmitted Disease (STD) and AIDS (*Programa Nacional de Controle de Doenças de Transmissão Sexual e do Sindroma de Imunodeciência Adquirida* or PNC/DTS/SIDA).

5.2 HIV and AIDS plan

The current HIV and AIDS plan in Mozambique is the 2005-2009 National Strategic Plan to Fight HIV/AIDS (Part I Strategic Component – Situation Analysis, Maputo, November 2004).[51] The National Strategic Plan focuses on orientation and transforms the fight against HIV and AIDS into a national emergency. The Plan, contrary to the previous one, decentralises its operations and also emphasises the involvement of the family in the prevention of HIV infections.[52] The main areas of intervention and general goals established by the National Strategic Plan are:

- Prevention: reducing the number of new infections from the level of 500 per day in adults to 350 per day in five years and to 150 in ten years;
- Advocacy: transforming the response to HIV and AIDS into a national emergency;
- Stigmatisation and discrimination: reducing the stigma and discrimination linked to HIV and AIDS;
- Treatment: prolonging and enhancing the quality of life of PLHA;
- Mitigation: Reducing the consequences of HIV at the individual level (families, communities, companies) and at the global level;
- Investigation: Increasing the level of scientific knowledge about HIV, its consequences and the best practices in its fight; and
- Coordination: reinforcing the capacity to plan and co-ordinate the national response and decentralise the decision-making mechanisms and resource management.

50 Created by Council of Ministers 10/2000 of 23 May.
51 n 1 above.
52 As above.

5.3 Legislation

There is legislation which specifically deals with HIV and AIDS. These are Law 5/2002 of 5 February 2002 and the Ministerial Diploma 183-A/2001 of 18 December (Ministerial Diploma 183-A/2001). Law 5/2002 establishes general principles intended to prevent discrimination in the workplace against persons who are, or suspected to be HIV positive. It prohibits HIV testing without the consent of the person concerned and the dismissal of workers on grounds of HIV status. It protects, *inter alia,* the right to confidentiality, the right of equal opportunity in employment, education, and promotion, and the right to compensation, and appropriate medical treatment and medication in the case of persons infected during the course of their work. Under Law 5/2002, employers have the duty to provide professional redeployment in the case of infected workers and to provide information and counselling to prevent HIV infection.[53]

To monitor the implementation of Law 5/2002, the government, through the Ministry of Labour, established a tri-party commission, which comprises representatives from the Ministry of Labour, unions and employers' representatives.[54]

The Ministerial Diploma 183-A/2001 approves organisational norms of the National Health Services for the assistance of people living with HIV and guiding principles regulating the way medical assistance is to be processed, including technical guidelines. Confidentiality and privacy of people living with HIV are guaranteed at the workplace and by medical personnel according to Ministerial Diploma 183-A/2001. The law regulates the way medical employees have to provide medical assistance to people living with HIV and regulates the overall organisation of public health institutions involved with HIV and AIDS.[55]

The Mozambique Network of AIDS Service Organizations (MONASO) reported that it has drafted a bill on the protection of people living with HIV and the criminalisation of wilful transmission. This Bill was submitted to the Parliament on 1 December 2005. Parliament has not discussed the Bill and it is not scheduled for the first semester session of the Parliament.[56]

53 See WHO *International Digest of Health Legislation* http://www3.who.int/idhl-rils/frame.cfm?language=english (accessed 10 January 2007).

54 NSP (n 1 above) 106.

55 Ministerial Diploma 183-A/2001 (n 33 above) approves norms of organisation of the National Health Services for the assistance of PLHA and guideline principles regulating the way medical assistance shall be processed to PLHA including its technical guidelines.

56 Both MONASO and the parliament, for different reasons, could not provide a copy of the Bill.

Examples of legislation that indirectly deal with HIV and AIDS include the Labour Law and the Social Security Law.[57] The Labour Law protects employees in general and outlines the obligation of the employer to provide medical assistance to employees who get sick at the workplace. The Social Security Law provides for the medical assistance and paid sick-leave of employees who are ill, who are registered and contribute to the social security system.

Other legislation and regulations dealing with HIV and AIDS include:

- Decree 14/87 of 20 of May, General Statute of Public Servants (*Estatuto Geral dos Funcionários do Estado* or EGFE);
- Law 4/98 of 14 January, National Medical Drug Book;
- Decree 22/99 of 4 May;
- Decree 42/2000 of 31 October, amending Article 141 of EGFE;
- Resolution 27/2000 of 31 October, ratifying the SADC Protocol on Health;
- Ministerial Order 8/2000 of 9 August;
- Ministerial Dispatch of 22 December 2000; and
- *Politica do Governo Sobre a Organização do Sistema Nacional para o Atendimento a Pessoas Vivendo com HIV/SIDA e Tratamento Anti-retroviral* of December 2001.

5.4 HIV and AIDS policy

The following HIV and AIDS policy documents are in place:

- National Strategic Plan (PEN) to fight HIV and AIDS 2005-2009;
- Guideline Principles for the Treatment of Sick People Infected with HIV/AIDS and the respective Technical Guides approved by Ministerial Diploma 183/A-2001;[58]
- Ministry of Health, Decision that authorises the circulation in the Country of Anti-Retroviral in the therapeutic schemes approved by Ministerial Diploma 183/A-2001;[59]
- Ministry of Health: Guidelines for the Prevention of HIV/AIDS Vertical Transmission, December 2002;
- National Action Plan for Orphans and Vulnerable Children (OVC) 2005; and
- National M&E Framework (revised during 2005).

There is also a draft National Gender Policy and Implementation Strategy.

[57] Labour Law 8/98 of 20 July; Law 5/89 of September and Decree 46/89 of 28 December regulate the social security system.
[58] Official Gazette 50/2001 of 18 December 2001, I Series.
[59] Official Gazette 16/2001 of 17 April 2002, I Series.

There are no policies or practices aimed at withholding or denying access to HIV-related treatment to people living with HIV.

5.5 Court decisions

The Civil Courts, courts of commons jurisdiction, handle labour cases. These are mainly cases related to unfair dismissal based on the employee's HIV status. Few HIV-related cases are brought to courts under Law 5/2002. According to the Network of Organisations of People Living with HIV/AIDS (ENSIDA),[60] people living with HIV are hesitant to take their cases to court because the employee receives no compensation. The law provides that if the defendant is found guilty of breaching confidentiality, discriminating against employees or prospective employees, or forcing employees or prospective employees to undergo testing, it will be fined. Sixty per cent of the fine is given to the state and the remaining 40 per cent is given to government institutions, namely the CNCS, which is mandated to raise awareness and fight HIV.[61]

6. Access to health care

6.1 Government regulation of access to health care

In Mozambique, the Constitution establishes the right to medical and health care, within the terms of the law.[62] Medical and health care for citizens are organised through a national health system, which benefits all Mozambican people.[63] In March 2004, the government enacted Guidelines for the Organisation and Management of Day Hospitals.[64] The Guidelines provide for a single and permanent identification number for a patient.[65]

HIV treatment is part of the public heath program. All medication and medical care related to HIV are free and the heath care system is in the process of being expanded on account of HIV. In terms of regulation, the Constitution provides for the right to health through the National Health Services. Some initiatives established by government to tackle the HIV epidemic include:

60 Interview with Júlio Ramos Mujojo, National Executive Secretary, RENSIDA (02 March 2006).
61 Law 5/2002 (n 32 above) art 17.
62 n 29 above, art 89.
63 As above, art 116.
64 Ministry of Health Day Hospitals and Ambulatory Care for PLHA: Guidelines for Organisation and Management (Draft) (2004) quoted in NSP (n 1 above), 83.
65 As above, 83.

- the establishment in 2003 of a Community Health Unit to deal with PMTCT of HIV. This activity is directly related to the establishment of the Reintegrated Health Network;[66]
- the introduction of Offices for Voluntary Testing and Counselling (GATVs). These units had their inception in 2001 and were established in health clinics, in schools and near to public spaces. In 2003, 84 GATVs were established countrywide and in 2004 the government planned to increase that number to 130;[67] and
- the establishment of Day Hospitals (*Hospital Dia*). These are HIV and AIDS clinics that provide specialised diagnostic, treatment and social services for people living with the virus. The Day Hospital links with other structures, including VCT centres, PMTCT programs, inpatient services, and blood banks, as sites of HIV testing and entry into the network. These clinics provide ambulatory and domiciliary work.[68]

6.2 Ethical guidelines

Ethical guidelines exist within the medical profession to regulate the behaviour of doctors and health care workers towards those patients who test positive for HIV or are affected by HIV. Ministerial Diploma 183/A-2001 approved the norms of the organisation of the National Health System for the Treatment of People Living with HIV/AIDS and the Guiding Principles for the Treatment of Sick People Infected with HIV/AIDS and the respective Technical Guides.[69]

6.3 Medicines

There are policies in place to ensure access to essential medicines for people living with HIV, including treatment for opportunistic infections.[70] There is a program to scale-up HIV treatment nationwide. The limited number of trained medical professionals has impeded a rapid scale-up of HIV services.[71] Of the total estimated 199 000 people in need of ART only nine per cent of them are receiving such treatment.[72] There are geographic and age inequities.[73] A total

66 As above, 66-67.
67 As above, 73.
68 NSP (n 1 above) 78.
69 Official Gazette 50/2001 of 18 December 2001, I Series.
70 M Zung-Dirway *et al An audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe* research paper (2004) 45-46.
71 IDASA 'An examination of the institutional arrangements established in Mozambique to address challenges of HIV/AIDS' (2003) 5; also see WHO 'Summary Country Profile HIV/AIDS Scale-up: Mozambique 2005' (2005) available at https://www.who.int/3by5/support/june2005_moz.pdf (accessed 17 January 2007).
72 See WHO (as above).
73 Government of Mozambique 'United National General Assembly Special Session on AIDS Progress Report on Declaration of Commitment of HIV/AIDS' (2005) 35.

of 60 per cent of people on ART are in Maputo (the capital city), and paediatric treatment is still very low at three per cent.

Because of opportunistic infections associated with HIV, the government has enacted Guidelines for Treatment of Opportunistic Infections and Opportunistic Infections Prophylaxis.[74] These Guidelines extended this service to all the health service units as described in the Health Sector's Strategic Plan to Fight HIV/AIDS.[75]

According to a WHO report, by April 2005, 10 657 people were receiving ART.[76] It is predicted that in 2007, the number will increase to 112 000 patients, representing 47 per cent of the total number of people eligible for this kind of treatment.[77] The Mozambican Red Cross recently announced that it will train hundreds of volunteers to assist in managing ART for people in their care. It is hoped that this will assist in managing treatment, particularly in rural areas.

There are no policies, practices or laws that limit access to medicines. Nor are there any policies, practices or laws aimed at withholding or denying access to HIV-related prevention or treatment from people living with HIV, particularly on the basis of sexual and social behaviour deemed to be 'immoral' or questionable by health care practitioners.

The government is party to the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). However, the full agreement will only come into force in 2013 for Mozambique.[78] Therefore, the government follows the international standards on generic substitution, and parallel importing is subject to compulsory licensing.

The main concern for the government is the treatment of opportunistic infections. The National Health System ensures the free treatment of TB, through the Strategy against TB and Leprosy (ELAT/ ELAL) programme, which covered 100 per cent of the hospital facilities countrywide. For the treatment of other opportunistic infections, the government only managed to create sound conditions in eight day hospitals countrywide. In the remaining health units the

74 Guidelines for the Treatment of Opportunistic Infections on the Adult Infected by HIV and Opportunistic Infections Prophylaxis.
75 NSP (n 1 above) 77.
76 Guidelines for the Treatment of Opportunistic Infections (n 74 above).
77 NSP (n 1 above) 107.
78 Information available at http://www.ipi.gov.mz/article.php3?id_article=88 (accessed 1 August 2006).

treatment of opportunistic infections is provided through the programme of essential medication.[79]

ARVs are examined and authorised by the Ministry of Health before they are made available to the public. Providing generic ARVs at accessible prices is the next priority.[80]

6.4 Condoms

In Mozambique, there are only two mechanisms of condom distribution, namely, free distribution through the National Health Service by the Ministry of Health, and subsidised distribution by Population Services International (PSI). In 2002, the Ministry of Health distributed 28 million condoms and in 2003 it distributed 6 million.[81] PSI in 2003 distributed about 15 million condoms and in 2004 was expecting to distribute 16 million.[82] However, the usage of condoms is still low. It is reported that in 2004, 29 per cent of women and 33 per cent of men used condoms at last high-risk sex.[83]

Apart from those available at health facilities and other public facilities, condoms are easily accessible in pharmacies, markets, hotels and boarding houses. Condoms are sold at an average price of 10 000 Mts (pack of three), the equivalent to USD 0.4 (the current commercial rate is USD 1 to 25 000 Mts). The female condom is more expensive and rarely available in pharmacies.

6.5 Case law

There are few judgments on HIV and AIDS and the right of access to health care or any related human rights issue within the country's jurisprudence. Most judgments deal with unfair dismissal cases related to employees' HIV status.

7. Privacy

7.1 Notifiable disease

HIV is not a notifiable disease. Confidentiality is the cornerstone of HIV treatment, though it is not absolute. For instance, the law may

79 NSP (n 1 above) 108.
80 Ministerial Diploma 183/A-2001 (n 33 above) approves the norms of the Organisation of the National Health System for the Treatment of People Living with HIV/AIDS and the Guideline Principles for the Treatment of Sick People Infected with HIV/AIDS and the respective Technical Guides.
81 NSP (n 1 above) 62.
82 As above, 62.
83 UNDP (n 4 above) table 9 'Leading global health crisis and risk'.

require that doctors notify colleagues who will be treating the same HIV patient or notify the public health authorities of people with specific infections like TB.[84]

There are two ways of reporting the HIV status of patients. One is passive notification, through health clinics, and the other is active notification, through sentinel posts in the case of pregnant women. The results are passed on to the district authorities and from there to the provinces and then to the CNCS. They are used for HIV surveillance, planning and statistics.

7.2 Medical experimentation

There are no procedures in place to protect the rights of volunteers in medical trials for testing the effects of new ARVs. There are no HIV medical trials undertaken in Mozambique. However, article 40 of the Constitution guarantees to everyone the right to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without informed consent.[85]

7.3 Duty to disclose

The existing policy regarding privacy is that HIV status is not to be disclosed to other people. In case of medical procedures, the HIV-positive condition is registered in the patient's individual record and is disclosed only in the treatment interests of the patient.

7.4 Testing

There are national policies on testing for HIV.[86] Testing is a voluntary and informed act.[87] Individuals who intend to take the test should receive pre-test and post-test counselling.

Medical doctors may only recommend testing. Regarding PMTCT, at their first pre-natal consultation, women are briefed about the existence of a counselling unit on MTCT of HIV and are advised to take an HIV test. Those who voluntarily opt to undergo the test are taken to a separate room for counselling and testing. Those who are HIV positive are, in principle, given access to Nevirapine.[88] Of the 800 000 women that gave birth in 2003, only 15 000 (about two per cent) were counselled and tested. Of those, 19 per cent were HIV positive. Out

84 NSP (n 1 above) 84.
85 n 29 above, art 40.
86 Ministry of Health (Controlling Programme of STD/HIV/AIDS) *Counselling and Voluntary Testing - ATV: Counsellor and Supervisor's Manual at ATV* (2002).
87 Law 5/2002 (n 32 above).
88 NSP (n 1 above), 68.

of those who were diagnosed HIV positive, only 28 per cent received Nevirapine. Explanations for the low percentage of HIV-positive women who received Nevirapine are that many of those women tested did not give birth in that year and that others reached the hospital at a late stage of labour.

8. Equality and non-discrimination

Apart from the Constitution, which establishes the principles of equality and of non-discrimination,[89] Law 2/2005 protects employees and prospective employees in the work place. The Constitution does not specifically state that HIV status is a ground for non-discrimination. However, one could argue that people living with HIV may be protected under the right to equality and non-discrimination on the ground of social status. This has, however, not yet been ascertained through an authoritative interpretation of the Constitution.

9. Labour rights

9.1 Legislation

Labour rights are protected in articles 84 and 85(2) of the Constitution. Further, Law 8/98 protects employees against discriminative practices and unfair dismissal in the workplace.[90]

Law 5/2002 protects the rights of employees living with HIV from discrimination at the workplace.[91] It also outlaws compulsory testing and protects the privacy of the employee living with HIV.

Labour courts are legally established but are not yet operational. Labour matters are heard in judicial courts, which are courts of common jurisdiction.

9.2 Testing

Pre-employment HIV-testing for job applications is outlawed by Law 5/2002.[92] Companies or employers may be prosecuted and fined if they do not adhere to the law.

89 n 29 above, art 35.
90 Law 8/98 (n 57 above).
91 Law 5/2002 (n 32 above).
92 Law 5/2002 (n 32 above).

9.3 Medical schemes act

In Mozambique, there is no legislation regulating the functioning of medical schemes. Companies and employers are free to complement the existing scheme, the National Social Security (INSS), with private medical schemes.

9.4 Duty to provide treatment

Employees have the right to medical assistance through their employer.[93] Under Law 5/2005, employers are obliged to provide medical assistance for employees who become infected with HIV at the workplace.

10. Women's rights

10.1 Legal status and protection

The Mozambican Constitution establishes that women have the same rights as men.[94] Rape in marriage is qualified as a crime under the Penal Code as the law does not specify if the rape takes place within or outside of marriage.[95] Although there are no special measures in place to protect women specifically, the Family Law 10/2004 provides protection for property rights of women in customary marriage.[96]

Other violent crimes punishable under the Penal Code are attempted homicide (article 350), physical offence or attacks (articles 359-361), or administration of dangerous or unhealthy substances to someone else (article 364). The Penal Code disregards the HIV status of the offender.

10.2 Domestic violence law

A law against domestic violence has been drafted but has not yet been adopted. There is no official recognition in government policy or law that domestic violence is linked to HIV transmission.

93 Law 8/98 (n 57 above).
94 n 29 above, art 36.
95 Penal Code, art 393.
96 This issue is specifically dealt in a Bill draft by Forum Mulher, the Mozambican confederation of NGOs advocating for the rights of women and the criminalisation domestic violence.

10.3 Customary rules and practices

Customary law is formally recognised under the Constitution.[97] There are customary rules and traditions in place that put women in an unequal and vulnerable position in society and, therefore, increase their risk of HIV infection. Polygamy, early marriages, the sexual purification of widows, and tolerance of men's infidelity are a few examples. In certain rural areas in the South of Mozambique, wife inheritance is also common.

Some measures are being taken to decrease the risk of HIV infections while performing traditional ceremonies and rites.[98] Considering most Mozambicans do not visit public health care services but attend traditional healers, and also considering that only 50 per cent of the Mozambican population has access to public health care facilities,[99] educating traditional leaders and healers is a very important avenue for HIV prevention.

There are no records of case law concerning traditional practices that expose people to HIV infections. The CNCS newsletter reports that HIV in Mozambique is feminised and thus the fight against HIV requires the empowerment of women through knowledge, education, and economic independence.[100] Measures include projects or jobs to provide women with opportunities to earn an income, and the establishment of legal protection against violence. The strategy to stop the feminisation of HIV includes the development of prevention methods controlled by women such as female condoms and vaginal microbicides.[101]

Information on the transmission of HIV and safe sex practices is delivered through specific programmes organised by the Ministry of Women and Welfare and the Ministry of Health. These include Positive Life (*Vida Positiva*) and Stepping Stones through the NGO Agency for Co-operation and Research in Development (ACORD). Stepping Stones is a training package in gender, HIV, communication and relationship skills.[102] Whereas Positive Life aims to improve women's education, address gender-based violence and support the mostly female caregivers of the sick and orphaned, Stepping Stones aims to facilitate a behavioural change in both men and women through effective communication.[103]

97 n 29 above, art 4.
98 NSP (n 1 above) 43.
99 B Chilundo and S Sahay 'HIV/AIDS reporting systems in Mozambique: the theoretical and empirical challenges of representations (2005) *Wiley Periodicals* 261.
100 Ministry of Health *Boletim DAM Mensal de HIV/AIDS, Junho de 2005* (2005).
101 As above
102 More information available at http://www.steppingstonesfeedback.org/index.htm#indexwhat (accessed 20 January 2007).
103 Ministry of Health (n 100 above)

The United Nations reached an agreement with the government of Mozambique to launch a USD 12.8 million project from 2005 to 2009 to fight the feminisation of HIV in Mozambique. The programme will address the weaknesses of current strategies in responding to the needs of women and girl children regarding HIV prevention.[104]

10.4 Administration of anti-retrovirals to rape survivors

There are no general policy measures to provide post-exposure prophylaxis (PEP) to rape survivors. There is a pilot program of administering PEP to rape survivors at the Maputo Central Hospital. The next phase is to expand it to the provinces, and afterwards to the nation.[105]

ART in the public health sector started in 2001. Currently the government's ART response does not cover all the country but only six provinces. Much of ART treatment is provided by NGOs such as Doctors without Borders, the Community of Saint Egideo (Catholic Church), and Health Alliance International (HAI).[106]

10.5 Sex workers

Prostitution is not a crime in Mozambique but, at the same time, it is not a regulated profession. Although sex workers are not in the formal system and do not have professional licenses, they are not outlawed. However, sex workers may be prosecuted for vagrancy (*Vadiagem*) or performance of immoral acts in public (*Ultraje público ao pudor)*.

NGOs and the government distribute condoms free of charge at the usual sites and encourage sex workers to undergo HIV testing. However, it is reported that only about five per cent of sex workers are reached by these prevention programmes.[107]

11. Children's rights

11.1 Access to health care

Children living with HIV lack adequate access to health care facilities. Though programs exist, shortages of human and other resources allow only five per cent of children to benefit from treatment.[108] Currently,

104 As above.
105 Interview with Dr Catarina Mboa Ferrao, HIV/AIDS expert at Maputo Central Hospital.
106 NSP (n 1 above) 81.
107 UNAIDS (n 7 above) annex 1 'County Profiles: Mozambique'.
108 Interview with Dr Catarina Mboa Ferrão, HIV/AIDS specialist at the Maputo main hospital, Hospital Central de Maputo, interviewed on 12 March 2006.

an estimated 140 000 children are living with HIV in Mozambique. However, the government planned to provide treatment to only 18 200 children by 2007.[109]

In order to reduce MTCT of HIV, the Ministry of Health introduced guidelines for PMTCT in 2002. Since then, mainly NGOs have worked on implementing PMTCT Programmes. But only 7297 pregnant women (five per cent of the population of pregnant women living with HIV) received Nevirapine for the PMTCT. In 2003, only six (out of 10) provinces had PMTCT projects. 814 935 pregnant women were assisted with PMTCT and there were 23 health facilities providing this type of service.[110]

In general, only five per cent of the 200 000 people who needed ART received treatment from the state. This figure includes children.[111]

11.2 Children orphaned by AIDS

It was reported that in 2005, 510 000 children had lost their parents to AIDS-related illnesses.[112] In order to provide care for children orphaned by AIDS, the government has established measures to assist OVC. These measures include the provision of free medical assistance and education. Although theoretically these exist, due to the lengthy paper work, many families and children are not benefiting from the free medical assistance and education. There is no specific law dealing with children's rights but children's rights are protected under the Penal Code and the Civil Code. For instance, articles 343 and 348 of the Penal Code oblige the state to provide alternative care to children who are deprived of a family environment.[113] Furthermore, article 47 of the Constitution specifically deals with children's rights.[114] The Ministry of Women and Welfare has planned a multi-sectoral approach to provide for services and care for OVC from 2005 to 2010.

11.3 Education

The right to education for children is protected under the Law 6/92 on the National Education System (NES) which guarantees basic education for all citizens.[115] Children are protected against

[109] UNAIDS (n 7 above) annex 1 'Country Profile: Mozambique.'
[110] NSP (n 1 above) 67.
[111] As above 82.
[112] UNAIDS (n 7 above) annex 2 'HIV and AIDS estimates'.
[113] Government of Mozambique 'Initial Report of States Parties: Mozambique, the Committee on the Rights of the Child' [CRC/C/41/Add.11] (2000) para 228.
[114] n 29 above.
[115] Government of Mozambique (n 113 above) para 76.

discrimination within the education system, and there are policies on HIV education in place.

There are no specific policies to ensure education for girl children.

Teachers receive special training to sensitise them towards the needs of HIV-positive children. Children have access to general sexual education within the educational system, and the focus is on the prevention of HIV and other STIs.

12. Family law

In Mozambique, there is no inheritance legislation that specifically addresses HIV or impacts on those living with HIV. The Family Law, which recognises types of marriages other than civil marriages, protects the rights of women to inherit properties of the deceased spouse. Women who have been widowed or children who have been orphaned are traditionally taken care of by the extended family. For instance, in many rural areas of Mozambique, a widow is supposed to marry the deceased husband's brother, who will take care of her and her children. When it comes to property, women who have been widowed or children who have been orphaned by AIDS are sometimes discriminated against by the extended family, for example, in the case of property grabbing.[116]

In Mozambique, there is no guardianship legislation that specifically addresses HIV or impacts on those living with HIV. Child-related laws are currently being reviewed.

The Ministry for Women and Social action is responsible for implementing the Plan of Action for Orphaned and Vulnerable Children which aims to provide basic social services to children in Mozambique.[117]

13. Criminal law

13.1 Criminal legislation

Law 5/2002 stipulates in article 15 that 'employees infected with HIV/AIDS have to refrain from harmful HIV-related behaviour which may put other people at risk of infection'.[118] Although this clause is not the criminalisation of wilful infection but rather the

[116] NSP (n 1 above) 93.
[117] More information available at http://www.unicef.org/mozambique/hiv_aids_2971.html (accessed 22 January 2007).
[118] Law 5/2000 (n 32 above) art 15.

criminalisation of harmful HIV-related behaviour, it is a closely related law.

In the Mozambican Penal Code, there are no HIV-specific provisions and there are no laws criminalising the wilful transmission of HIV.[119]

While there is no legislation criminalising the wilful transmission of HIV, a Bill has been submitted to parliament for discussion and approval.[120] There are no public reports about people who were assaulted or killed because of their HIV-positive status.

13.2 Men having sex with men

Sodomy or consensual sexual relations between men is a crime. Article 71 of the Penal Code of Mozambique, inherited from the Portuguese colonial era, prohibits the habitual practice of 'acts against the order of nature'.[121]

14. Prisoners' rights

According to a 1992 study, the HIV prevalence among the prison population in Maputo was 0.6 per cent. Another 2002 study indicates that at the Maputo Central Prison (*Cadeia Central da Machava*) and at the Female Detention Centre in N'Dlavela, the HIV prevalence rate was 31.1 per cent for women and 28.78 per cent for men.[122] It is reported that men having sex with men and the use of injected drugs are common in Mozambican prisons.[123] There is no report that HIV-positive inmates are getting ART at prison health clinics.

The government reports that there are measures in place to stop the spread of HIV in prisons, such as raising awareness and distributing

[119] There a draft proposal bill deposited at the parliament on 1 December 2005, drafted by MONASO and RENSIDA related issues, to protect PLHA but also to criminalize the wilful infection.

[120] Interview with Terezinha Silva, of Forum Mulher (Women Fora), the Bill on wilful transmission of HIV was drafted with no broad support by the CSO and the CNCS was not involved in the drafting. It's reported that the parliament returned the draft to build consensus among the stakeholders before it goes to plenary for the discussion.

[121] D Ottosson (2006) *Legal survey on the countries in the world having legal prohibitions on sexual activities between consenting adults in private* http://www.ilga.org/statehomophobia/LGBcriminallaws-Daniel_Ottoson.pdf (accessed on 5 September 2007).

[122] NSP (n 1 above) 106.

[123] As above.

free condoms. Although the authorities distribute free condoms in prisons, undertake advocacy workshops to raise the inmates' consciousness about HIV, and train activists, authorities have classified the situation in prisons as 'alarming'.[124] Other reports show that condoms, however, are not being distributed in prisons. Officials at the Machava Central Prison, Mozambique's largest prison, have been reported to have refused to distribute condoms.[125]

The Ministry of Home Affairs, which manages most of the prisons in Mozambique, enacted an Annual Plan of Activities for Prevention and Fighting HIV/AIDS in the Ministry. This Plan includes prisons. However, generally, there is no policy for HIV education and testing in prisons and there is no report that health centres in prisons test inmates for HIV. Prisoners are not separated according to their HIV status or even according to the crime committed.

The prison regulations prohibit inmates from having sexual intercourse in prisons, as homosexuality is illegal and punishable by imprisonment. However, it is widely known that men engage in sexual intercourse with other men in prison, coercively or voluntarily.[126]

15. Immigration

There are no measures in place that make HIV relevant to immigration, for travel into or out of the country, or to obtain residence permits. Immigration legislation does not require non-nationals to be tested for HIV before entering the country and does not specifically limit cases for refusal of admission to non-nationals testing positive for HIV.

16. Social assistance and other government benefits

HIV or AIDS is not considered a disability under Mozambican law. People living with HIV fall under the general social security and assistance provisions and only qualify for social security and assistance if they are employed and contributed to the social security system (*segurança social*). Therefore, the social security system applies only to people in the formal employment sector and there is no non-contributory system for people who are unemployed. Law 5/89 and Decree 46/89 regulate the social security system.[127]

124 As above.
125 'Mozambique: recognizing the reality of HIV/AIDS in the prisons save lives' *IRINNews* http://www.irinnews.org/report.asp?ReportID=55674&SelectRegion=Southern_Africa&SelectCountry=MOZAMBIQUE (accessed 2 February 2007).
126 As above.
127 Law 5/89 of September & Decree 46/89 of 20 December cited in Government of Mozambique (n 113 above) para 344.

People living with HIV do not receive any government benefits except for food packages. Due to the lack of government resources, support and assistance is provided by civil society organisations. There are special assistance projects by the Ministry of Women and Welfare Co-ordination and World Food Programme to provide nutritional support to victims of chronic diseases.

17. Insurance

Insurance companies do not have a policy of compulsory testing for HIV. Compulsory testing is illegal in Mozambique. There are no HIV or AIDS specific life insurance policies offered in Mozambique.

18. Oversight

There are specific government mechanisms to ensure the implementation of legislation relating to HIV and AIDS. The main parliamentary committee that deals with issues related to HIV and AIDS is the Social Affairs, Gender and Environment Committee.[128] The challenge with this committee is that its mandate is broad. In addition to HIV and AIDS, it is also responsible for parliamentary oversight in the following areas: education, culture, youth, sports, gender, the protection of family, children and women's issues, the environment, cultural patrimony, employment, social security, re-allocation and protection of demobilised soldiers, population, protection of people with disabilities, and religious activities.[129]

Like other Southern African countries, effective parliamentary oversight is hindered by capacity issues, representatives who sit on multiple overlapping committees and irregular and insufficient public participation.[130]

19. Stigma

Stigma attached to HIV is a significant concern in Mozambique. Although Law 5/2002 specifically addresses stigma, it only protects people employed in the formal sector.[131]

[128] M Caesar-Katsenga & M Myburg *Parliament, politics and AIDS: A comparative study of five African countries* (2006) 14.
[129] As above, 15.
[130] As above, 17-21.
[131] 'Mozambique: AIDS activists develop successful strategies against stigma' *IRIN News* (31 October 2005), http://www.plusnews.org/AIDSreport.asp?ReportID=5395&SelectRegion=Southern_Africa&SelectCountry=MOZAMBIQUE (accessed 19 January 2006).

Issues of stigma are addressed through programmes, advocacy, and awareness raising campaigns. The International Centre for Research on Women (ICRW), for example, is assisting to incorporate stigma reduction into a programme involving TB and HIV diagnosis, treatment and care by providing anti-stigma training for health care workers and community volunteers.[132]

[132] 'HIV/AIDS Stigma: finding solutions to strengthen HIV programs' (2006) 10.

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5 HIV, AIDS and the law in Namibia

1. Background to country

1.1 First AIDS case

The first AIDS cases were documented in 1986.[1] There is no documented information on the way these persons were infected and their identities remain confidential.

1.2 Demography

Namibia has an estimated total population of 2 100 000.[2] The latest HIV prevalence rate among people aged 15 to 49 in Namibia is estimated at 19.6 per cent.[3] Approximately 18 per cent of women attending antenatal care were HIV positive.

Random studies suggest that vertical transmission of HIV (from mother to child) is between 25 to 48 per cent.[4] Moreover, about three in ten infected mothers transmit HIV to their newborn child. This is mainly due to the fact that a very high number of women deliver without knowing their HIV status. Therefore, about 4 300 of the estimated 70 000 babies born every year will be HIV positive.[5]

There are more women living with HIV than men. It is estimated that 52 per cent of adults living with HIV are women.[6] The number of reported deaths in the age group 15 to 49 accounted for more than 50 per cent of all deaths in hospitals.[7] Young people (10 to 24) are estimated to account for up 60 per cent of all new HIV infections.[8]

There is no data available on the prevalence rates of particularly vulnerable groups such as sex workers, intravenous drug users or men having sex with men.

AIDS-related illnesses have been the leading cause of death since 1996. In 1999, AIDS was a factor in 26 per cent of all reported deaths,

1 T Guthrie & A Hickey (eds) *Funding the fight, budgeting for HIV/AIDS in developing countries* (2004) 183.
2 UNFPA *State of the world population 2007: Unleashing the potential of urban growth* (2007) 90.
3 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
4 'Will AIDS be our children's heritage?' *The Namibian* 3 December 1998.
5 Ministry of Women Affairs and Child Welfare 'Namibia is losing its children to HIV/AIDS' (2003).
6 http://womenandaids.unaids.org/womenandaidsnovfin.doc (accessed 1 August 2006).
7 Ministry of Women Affairs and Child Welfare 'National Policy on Orphans and Other Vulnerable Children' (2005) 1.
8 Ministry of Health and Social Services (MoHSS) 'Epidemiological Report on HIV/AIDS for 2000' (2001).

and in 46 per cent of deaths in the 15 to 49 year age group. In 2003, 2 804 AIDS-related deaths were reported in state health facilities.[9]

Namibia has been reported to be the country in the world with the highest prevalence of tuberculosis (TB).[10] In 2002, it was estimated that 676 people out of 100 000 had TB.[11] Pneumonia is also of a high prevalence in Namibia, especially for people living with HIV. It was estimated that in 2001, pneumonia represented 11 per cent of all deaths in public hospitals.[12]

The malaria mortality rate varied between 61/100 000 and 96/100 000 during the past five years. A mean incidence of 255/1000 population for the whole country in the years between 1995 and 2001 was recorded.[13]

The estimated number of children (less than 17 years old) who have lost one or both parents to AIDS-related deaths was 85 000 in 2005.[14]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[15]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	28/11/1994
ICCPR Optional Protocol (23/03/1976)	28/11/1994
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	28/11/1994
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	23/11/1992
CEDAW Optional Protocol (22/12/2000)	26/05/2000

9 MoHSS National Strategic Plan on HIV/AIDS: Third Medium-Term Plan (HIV/AIDS-MTP III) 2004-2009 (2004) 4-5.

10 MoHSS National Strategic Plan on Tuberculosis: Medium-Term Plan I (TB-MTP I) 2004-2009 (2004) 21.

11 As above.

12 WHO 'The World Health Report 2001: Mental Health – New Understanding, New Hope' (2001), http://www.who.int (accessed 1 August 2006).

13 WHO 'Roll back Malaria Country Report: Namibia' (2005) http://www.rbm.who.int/wmr2005/profiles/namibia.pdf (accessed 1 August 2006).

14 UNICEF 'State of the world's children 2007: Women and children, the double dividend of gender equality' (2007) 115.

15 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'Namibia Homepage' http://www.ohchr.org/english/countries/na/index.htm (accessed 21 January 2007).

Convention on the Rights of the Child (CRC) (02/09/1990)	30/09/1990

2.2 State reports

Namibia submitted a report to the Committee on the Rights of the Child in 1992. The report recognised the challenge of HIV and set out a number of measures that the government had taken to address the epidemic.[16]

Namibia's 2003 report on the implementation of the International Covenant on Civil and Political Rights (ICCPR) takes note of the 'unprecedented threat' of HIV and AIDS, but does not set out which measures the government as taken to counter the pandemic.[17] In its concluding observations the Human Rights Committee made the following recommendation:[18]

> The State party should pursue its efforts to protect its population from HIV/AIDS. It should adopt comprehensive measures encouraging and facilitating greater number of persons suffering from the disease to obtain adequate anti-retroviral treatment.

Namibia submitted a combined second and third periodic report to the Committee on the Elimination of Discrimination against Women in 2005.[19] HIV/AIDS is included as a sub-heading under the discussion on health care. The report notes that AIDS is the leading cause of death in Namibia. The report provides statistics regarding the HIV infection rate among pregnant women and provides information on a programme instituted in 2001 to prevent mother-to-child transmission of HIV. The report further takes note of the National Policy on HIV/AIDS for the Education Sector.

In its concluding comments on the combined report submitted by Namibia, the CEDAW Committee recommended that

- concrete measures to enhance women's access to health care, in particular to sexual and reproductive health services, in accordance with article 12 of the Convention and the Committee's general recommendation 24 on women and health; and
- sex education be widely promoted and targeted at adolescent girls and boys, with special attention paid to the prevention of early

16 Government of Namibia 'Committee on the Rights of the Child, Initial report: Namibia' (CRC/C/3/Add.12) (1992) http://www.bayefsky.com/reports/namibia_crc_c_3_add.12_1992.php (accessed 21 January 2007).

17 Government of Namibia 'Human Rights Committee, Initial report: Namibia' (CCPR/C/NAM/2003/1) (2003) http://www.bayefsky.com/reports/namibia_ccpr_c_nam_2003_1.pdf (accessed 21 January 2007).

18 Human Rights Committee 'Concluding observations of the Human Rights Committee: Namibia' (CCPR/CO/81/NAM) (2004).

19 Government of Namibia 'Committee on the Elimination of Discrimination against Women: Combined second and third periodic report of states parties: Namibia' (CEDAW/C/NAM/2-3) (2005) http://www.bayefsky.com/reports/namibia_cedaw_c_nam_2_3_2005.pdf (accessed 21 January 2007).

pregnancy and the control of sexually transmitted diseases and HIV/AIDS. The Committee also calls upon the State party to ensure that its National Strategic Plan (MTP III) 2004-2009 is effectively implemented and its results monitored and that the socio-economic factors that contribute to HIV infection among women are properly addressed.[20]

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[21]

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	30/07/1992
African Charter on the Rights and Welfare of the Child (29/11/1999)	23/07/2004
Protocol to the ACHPR on the Rights of Women in Africa (25/11/2005)	11/08/2004
Treaty of the Southern African Development Community (SADC) (30/09/1993)	14/12/1992
SADC Protocol on Health (14/08/2004)	10/07/2000

3.2 State reports

Namibia submitted its initial report to the African Commission in November 1997. The report was considered by the Commission in April 1998.

3.3 Status of international and human rights treaties in domestic law

Article 144 of the Constitution[22] states that, unless otherwise provided by the Constitution or an 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.

20 Committee on the Elimination of Discrimination against Women (CEDAW) 'Concluding comments of the Committee on the Elimination of Discrimination against Women: Namibia' (2007) http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/95ff8e7ce82c5662c12572a400337548/$FILE/N0724338.pdf (accessed 8 September 2007).

21 Ratification status available at http://www.africa-union.org and at http://www.sadc.int (accessed 21 January 2007).

22 Constitution of the Republic of Namibia (1990).

The inter-Ministerial Committee on Human Rights, which falls under the Ministry of Justice, plays a role in: assisting in the compilation of country reports as required by various human rights treaties to which Namibia is a state party; participating in training programmes aimed at training officials in the compilation of the periodic reports; and procuring copies of the various treaties and documents relevant for the compilation of such reports.

There is no government department with primary responsibility for the ratification of treaties, although the Ministry of Foreign Affairs usually plays a role in the deliberations leading to treaty ratification.

3.4 International Guidelines

The government is aware of the International Guidelines on HIV/AIDS and Human Rights. In 2001, the Ministry of Defence organised a conference on HIV/AIDS and human rights where representatives of UNAIDS from Switzerland explained the implementation of the International Guidelines. The Guidelines were subsequently used to draft the Ministry of Defence HIV/AIDS Policy and the National Assembly used the Policy to formulate the National Defence Bill.[23]

4. National legal system of country

4.1 Form of government

Article 1(1) of the Constitution states that the Republic of Namibia is established as a sovereign, secular, democratic and unitary state founded upon the principles of democracy, the rule of law and justice for all.

4.2 Legal system

In terms of chapter 9 of the Constitution, judicial power shall be vested in the Courts of Namibia, which consist of a Supreme Court, a High Court and Lower Courts. Furthermore, the courts shall be independent and subject only to the Constitution and the law.

The Supreme Court consists of a Chief Justice and other judges; the High Court consists of a Judge-president and other judges. All judges of the Supreme Court and the High Court are appointed by the President on the recommendation of the Judicial Service Commission.

[23] Centre for the Study of AIDS (CSA) & Centre for Human Rights (CHR), University of Pretoria (UP) 'HIV/AIDS and human rights in Namibia' (2004) 21.

Lower courts are established by act of Parliament and shall have the jurisdiction and adopt the procedures prescribed by such act.

The Office of the Ombudsman is charged with the duty to investigate complaints concerning alleged or apparent instances of violations of fundamental rights and freedoms. The Office of the Ombudsman also serves as a supervisory body against corruption and injustice in Namibia. The Ombudsperson is appointed by Proclamation by the President on recommendation of the Judicial Service Commission.

The legal system is a mixture of Common Law and Roman Dutch law.

4.3 Constitution and Bill of Rights

The Constitution was adopted in 1990 following independence from South Africa and is the supreme law of the country. Namibia is a multi-party democracy with a constitution and a bill of rights. The fundamental rights and freedoms enshrined in chapter 3 are to be respected and upheld by the executive, legislature and judiciary and all organs of the Government and its agency, and are enforceable by the courts as prescribed by the Constitution.[24]

The Bill of Rights guarantees a wide range of human rights, including civil and political rights (for example, right to life, right to liberty, right to human dignity, freedom from slavery and forced labour, equality and freedom from discrimination, freedom from arbitrary arrest or detention, right to a fair trial and right to privacy) as well as economic, social and cultural rights (for example, right to culture, right to language, tradition or religion, and right to education).

Article 25(2) on Enforcement of Fundamental Rights and Freedoms states that aggrieved persons who claim that a fundamental right or freedom guaranteed by the Constitution has been infringed or threatened are entitled to approach a competent court to enforce or protect such a right or freedom, and may approach the Ombudsman to provide them with such legal assistance or advice as they require, The Ombudsman has the discretion to provide such legal or other assistance as he or she may consider expedient.

The national response to the HIV epidemic has largely been shaped by the provisions of chapter 3, which ensure the protection of the fundamental rights and freedoms of all persons in Namibia, including people living with HIV. In the context of HIV, articles 8, 10 and 13 are of particular relevance. Article 8(1) provides that 'the

[24] n 22 above, art 5.

dignity of all persons shall be inviolable'. Article 10 ensures equality and freedom from discrimination and provides:

> (1) All persons shall be equal before the law.
>
> (2) No persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

Although article 10 does not make specific reference to discrimination on the basis of HIV, the Supreme Court has held that in giving effect to the protection of fundamental rights and freedoms enshrined by chapter 3, a 'right-giving' and 'purposive' approach is to be followed and that the provisions of the Constitution are to be

> broadly, liberally and purposively interpreted so as to avoid the 'austerity of tabulated legalism' and so as to enable it to continue to play a creative and dynamic role in the expression and the achievement of the ideals and aspirations of the values bonding its people and in disciplining its Government.[25]

Thus, it is likely that the courts would have little trouble in finding discrimination on the basis of HIV status alone to be unconstitutional.

Article 13 protects the fundamental right to privacy, which includes, at the very least, the right to be free from intrusion by the state and others in one's personal life. This constitutional right to privacy strengthens the pre-existing common law right to privacy and in addition to constituting an infringement of a constitutional right, unjustified invasions of privacy remain actionable in common law. In the context of HIV, testing for HIV without informed consent and the unauthorised disclosure of a person's HIV status to another both constitute examples of invasions of the right to privacy.

Namibian policies and laws relating to HIV prevention and testing have recognised that people living with HIV have constitutional rights to dignity, equality, privacy and freedom from discrimination that must be upheld and also that the promotion and protection of human rights constitute an essential component in preventing the transmission of HIV and reducing the impact of the virus. They recognise that the protection and promotion of human rights are necessary both to the protection of the inherent dignity of those infected with HIV and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV on those living with HIV and empowering individuals and communities to respond to the epidemic.

[25] *Government of the Republic of Namibia and Another v Cultura 2000 and Another* 1994 1 SA 407 (NmSC) 418 F-J.

4.4 National human rights institutions

The Office of the Ombudsman is established under article 89 of the Constitution. It is an independent body, subject only to the Constitution and the law. The Ombudsman is appointed by proclamation by the President on the recommendation of the Judicial Service Commission. The mandate of the Office of the Ombudsman, in accordance with the Constitution and the Ombudsman Act,[26] is to receive and investigate complaints relating to violations of human rights among other things. The Office will deal with any complaint relating to HIV under its human rights mandate. However, there have been no complaints under the human rights mandate relating to HIV and no mention of HIV was made in the 2004 annual report or in any documentation of the Office.

The Office of the Ombudsman is in the process of establishing a Human Rights Advisory Committee. To ensure pluralism of membership where civil society will have broad representation, NGO representatives and community-based organisations working with vulnerable communities, organisations of women, people with disabilities, prisoners and children will be invited to become members. It is envisaged that this committee will provide an essential form of outreach and another route for complaints to reach the Office of the Ombudsman.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The National AIDS Committee (NAC) is the highest national authority on AIDS in Namibia and is responsible for policy decision making on matters related to HIV and AIDS.[27] The NAC is made up of 12 Cabinet Ministers, all 13 Regional Governors and the Permanent Secretary of the Ministry of Health and Social Services (MoHSS). The MoHSS is the lead ministry in the response to the epidemic and the Minister chairs the NAC. Other officials from that ministry hold key positions in the coordination mechanism. The Ministries of Education, Information and Broadcasting, and Defense also play important roles in the response.[28]

26 Constitution (n 22 above) and the Ombudsman Act 7 of 1990.
27 MoHSS HIV/AIDS-MTP III (n 9 above) 12.
28 http://www.unaids.org/en/Regions_Countries/Countries/namibia.asp (accessed 1 August 2006).

The National Multisectoral AIDS Coordination Committee (NAMACOC) coordinates the national multi-sectoral response. The National AIDS Executive Committee (NAEC) implements decisions of the NAC and NAMACOC. The Namibia Coordination Committee on HIV/AIDS, Tuberculosis and Malaria (NACCATUM) is the local Country Coordination Mechanism for Global Fund Programmes.[29]

The Namibia Network of AIDS Service Organisations (NANASO) was established to provide a network service to NGOs working in the HIV arena and maximise their capacity to address the issues. The Directorate for Special Programmes (TB, Malaria and HIV/AIDS) is responsible for providing guidance in developing sector wide HIV activity plans.[30]

In July 2004, the government also established the Namibia Business Coalition on HIV/AIDS with the goal of enhancing collaboration with the private sector.[31]

The Parliamentary Standing Committee on Human Resources, Social and Community Development is the parliamentary portfolio committee that conducts oversight of government's HIV activities. The Standing Rules from the Namibian Parliament specifically provide that this committee has the duty to facilitate the implementation of recommendations reached at international fora on HIV prevention and care programmes, poverty reduction strategies and social development programmes such as gender equality, children's rights and family values.[32]

5.2 HIV and AIDS plan

The National Strategic Plan on HIV/AIDS: Mid-Term Plan III (HIV/AIDS-MTP III) provides the framework for collaboration and guides the implementation processes for a multi-sectoral HIV/AIDS response in Namibia. The HIV/AIDS-MTP III covers the period 2004 - 2009. The main focus of the Namibian government's HIV/AIDS intervention is 'the reduction in the incidence of HIV infection to below epidemic threshold'. This vision is to be achieved through five components:[33]

- an enabling environment: People infected and affected by HIV/AIDS enjoy equal rights in a culture of acceptance, openness and acceptance;

29 MoHSS HIV/AIDS-MTPIII (n 9 above).
30 MoHSS 'Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report' (2005) 8.
31 http://www.who.int/3by5/support/june2005_nam.pdf (accessed 1 August 2006).
32 Standing Rules and Orders of the Parliament of the Republic of Namibia sec 51(1)(f).
33 n 9 above, 31.

- prevention: reduced new infections of HIV/AIDS and other sexually transmitted infections (STIs);
- access to treatment, care and support services: access to cost effective and high quality treatment, care and support services for all people living with, or affected by HIV/AIDS;
- impact mitigation services: strengthened and expanded capacity for local responses to mitigate the socio-economic impacts of HIV/AIDS; and
- integrated and co-ordinated program management at all levels: effective management structures and systems, optimal capacity and skills, and high quality program implementation at national, sectoral, regional and local levels.

5.3 Legislation

Several pieces of legislation directly or indirectly address issues relating to HIV and AIDS, such as:

- Chapter 3 of the Namibian Constitution ensures the protection of the fundamental rights and freedoms of all persons in Namibia. Articles 8, 10 and 13 of the Constitution are particularly relevant to people living with HIV. Article 8(1) provides that 'the dignity of all persons shall be inviolable.' Article 10 ensures equality and freedom from discrimination. Article 13 protects the fundamental right to privacy, which includes the right to be free from intrusion by the state and others in one's personal life.
- Article 3(1)(a)(ii)(dd) and article 3(b)(iii) of the Combating of Rape Act[34] provide for harsher punishment for convicted sexual offenders with serious sexual transmitted diseases. It further states it is an offence to coerce someone to have sexual intercourse with a third person. Article 2(3) makes marital rape an offence.
- The Combating of Domestic Violence Act[35] lists offences that would constitute domestic violence in its first schedule. These offences include, but are not limited to, rape and contravention of section 14 of the Combating of Immoral Practices Amendment Act.[36] The Act prohibits sexual abuse in domestic relationships which covers unwanted sexual conduct and therefore situations of marital rape, as well as child abuse, incest and foster care arrangements.[37]

34 Combating of Rape Act 8 of 2000.
35 Combating of Domestic Violence Act 4 of 2003.
36 Combating of Immoral Practices Amendment Act 7 of 2000.
37 Combating of Domestic Violence Act 4 of 2003 secs 2(1)(b) & 3(1).

- Article 7(1) of the Defence Act,[38] on qualifications of members of the Defence Force, states that no person may be appointed in the Defence Force, unless such person:

  (c) has, notwithstanding anything to the contrary in any other law contained, undergone the prescribed medical examination and it has on account of such examination been established that such person does not have any physical or mental defect or does not suffer from any disease or ailment which

  (i) will impair such person's ability to undergo any form of training required to be undertaken, or to perform such person's duties, as a member of that Force;

  (ii) is likely to deteriorate to the extent that it will impair such person's ability to undergo any form of training required to be undertaken, or to perform such person's duties, as a member of that Force;

  (iii) is likely to be aggravated by the undergoing by such person of any form of training required to be undertaken, or by the performance of such person's duties, as a member of that Force.

Although the above sections do not specifically mention HIV or AIDS, they have been used to refuse entry in the Defence Force to HIV-positive candidates.[39]

- Article 2(f) of the Labour Act[40] states that a person must not discriminate in any employment practice, directly or indirectly, against any individual based on HIV or AIDS status.
- Article 19(2) of the Children's Act[41] prohibits any person or guardian or any person having the custody of a child from causing or conducing to the seduction, abduction or prostitution of a child or the commission by that child of immoral acts.
- The Married Persons Equality Act[42] abolishes any marital power a husband would have once had over his wife and her property[43] and provides for equal powers of spouses married in community of property.[44]

The Namibian HIV/AIDS Charter of Rights, launched in 2001, 'sets out those basic rights which all people enjoy or should enjoy and which should not be denied to persons affected by HIV or AIDS, as well as certain duties'.[45] It covers the following areas:

- equal protection of the law and equal access to public and private facilities and benefits;
- liberty, autonomy, security of the person and freedom of movement';

38 Defence Act 1 of 2002.
39 See *Haindongo Nghidipohamba Nanditumbe v Minister of Defence* 1998 LC 24/98.
40 Labour Act 15 of 2004.
41 Children's Act 33 of 1960.
42 Married Persons Equality Act 1 of 1996.
43 As above, sec 2(1)(b).
44 As above, sec 5.
45 HIV/AIDS Charter of Rights (2000), Preamble.

- 'privacy and confidentiality;
- counselling and testing;
- partner notification and reporting;
- gender;
- children, adolescents and HIV/AIDS;
- supportive and enabling environment for vulnerable groups infected and affected by HIV/AIDS;
- children orphaned by AIDS;
- prisoners;
- adequate standard of living;
- access to education;
- access to appropriate information and sex education;
- access to health care and appropriate treatment;
- research and clinical trials;
- employment;
- insurance and medical aid;
- media; and
- cultural and traditional practices.

5.4 HIV and AIDS policy

The National HIV/AIDS Policy[46] was adopted in July 2007. It was developed since 2005 to serve as an overall reference framework for all other HIV and AIDS-related policies and to guide of all sectors in society in their response to the epidemic. It aims to guide current and future health and multi-sectoral responses to HIV and AIDS, to encourage all institutions to fulfil their obligations for responding to the epidemic and it will serve as a guiding frame for a coherent and sustained approach enhancing political commitment and participation of civil leadership at all levels.

A multi-sectoral HIV/AIDS Policy Steering Committee was established to guide the process of developing the policy. The methodology began with a literature review of existing policies, laws and strategic plans related to HIV and AIDS in Namibia, all international conventions signed by Namibia related to HIV and national HIV and AIDS policies of other SADC countries. A draft outline for the policy was developed and was discussed by key stakeholders from the public, private, NGO and faith-based sectors at a national

[46] The National HIV/AIDS Policy was compiled by the AIDS Law Unit of the Legal Assistance Centre in 2005. The document has been submitted to the Cabinet for recommendations and approval, and was approved by the President in late July 2007.

consultative meeting. This meeting built consensus on the overall policy document, agreed on a list of policy issues to be included and identified additional challenging issues.

The first comprehensive draft was then compiled, circulated widely and debated at six sector-specific consultative meetings and at one-day regional meetings held in all 13 regions of the country.

Further drafts incorporating national, regional and technical inputs were scrutinised by the National AIDS Executive Committee, the Ministry of Health Steering Committee and Permanent Secretaries before the final draft was submitted to the National Multisectoral AIDS Coordination Committee (NAMACOC) and the NAC, in early 2006 for endorsement. The Draft Policy was thereafter presented to Cabinet and Parliament.

The ministries of Basic Education, Sport and Culture, and Higher Education, Training and Employment Creation have also prepared a Draft National Policy on HIV/AIDS for the Education Sector.

In 2000, a Charter of Rights on HIV/AIDS was launched which outlines guidelines on confidentiality and privacy for people living with HIV.

Policies geared towards specific health interventions have also been developed. These include: Prevention of Mother-to-Child-Transmission, Post-Exposure Prophylaxis, Highly Active Anti-retroviral Therapy (HAART), Home-Based Care, Nutrition, Recruitment of Community Counsellors, Guidelines for Voluntary Counselling and Testing, Rapid HIV Testing, and others on reporting, notification, confidentiality, surveillance and infant feeding, and ethical guidelines on clinical trials on human beings.[47]

Although not making specific reference to HIV or AIDS, the National Policy for Reproductive Rights 2001 recommends that people should not be denied services based on prejudiced or biased tendencies.[48]

5.5 Court decisions

There is one reported case dealing with HIV and the workplace, *Haindongo Nghidipohamba Nanditume v Minister of Defence*.[49] This case was heard by the Labour Court.

This case was brought by the AIDS Law Unit of the LAC on behalf of Haindongo Nanditume, an ex-People's Liberation Army of Namibia (PLAN) combatant who was refused entry into the Namibian Defence

47 MoHSS HIV/AIDS-MTPIII (n 9 above) 9.
48 MoHSS National Policy for Reproductive Health (2001) principle 3.2.e ch 3.
49 *Nanditume* (n 39 above).

Force (NDF) solely on the basis of his HIV status. Mr Nanditume sought an order:

- directing that the respondent (the NDF) discontinue discriminating against the applicant on the grounds of his being HIV positive in respect of his application for enlistment in the NDF; and
- directing the NDF to process his application for enlistment in the NDF, without having regard to the applicant's HIV status;

It was argued before the Labour Court that, in excluding Mr Nanditume from the NDF solely because of his HIV status, the NDF was acting contrary to the provisions of section 106 of the Labour Act by discriminating against Mr Nanditume in an unfair manner.

In its judgment, the Court found that an employer such as the NDF is not permitted to exclude people from employment on the basis of their HIV status, as being HIV positive does not necessarily mean that one is not fit for employment. The Court found further that an HIV test alone will not achieve the purpose of assessing fitness for employment and that pre-employment testing for HIV can thus only be undertaken as part of a broader assessment of physical fitness.

To date, despite the ruling in *Nanditume,* the NDF is still carrying on with testing prospective candidates and section 7(1)(c) of the Defence Act[50] has not been amended.

6. Access to health care

6.1 Government regulation of access to health care

The Constitution refers to public health in terms of state policy and not as a justiciable fundamental right. Chapter 11, article 95 reads as follows:

> The state shall actively promote and maintain the welfare of the people by adopting, among other things, policies aimed at the following: ... (j) Consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health.

People living with the virus, based on the constitutional rights of dignity, equality and freedom from discrimination enjoy the same rights as any other person in Namibia. Specifically, the government has adopted several policies and programmes targeting HIV and AIDS and focusing on prevention, treatment and support. The following services are currently provided at several health facilities free of charge:

50 The Defence Act (n 38 above) sec 7(1)(c)(i)(ii)(iii).

- education materials, public displays and guidelines on HIV and related issues;
- counselling and testing;
- distribution of condoms;
- short regimen ART for the prevention of mother-to-child-transmission (PMTCT) of HIV and for post exposure prophylaxis (PEP);
- treatment of opportunistic infection such as TB and STIs; and
- provision of ARV therapy to HIV-positive patients in stage III or IV and those with a CD4 count below 200/mm^3.

The Namibian HIV/AIDS Charter of Rights is a non-binding document issued by the LAC stating that HIV status should not be considered as a ground for depriving any person of their right to the highest attainable standard of physical and mental health. To this end, PLHA should have access on a non-discriminatory basis to adequate health care and appropriate and affordable treatment and drugs so that they can live as long and as successfully as possible.[51]

6.2 Ethical guidelines

The Namibian HIV/AIDS Charter of Rights recommends ethical guidelines and codes of conduct for health care workers and counsellors that should be implemented and reinforced to guarantee the right to privacy, confidentiality and dignity of people living with HIV. These guidelines and codes of conduct should require health care workers and counsellors to treat any person living with HIV without discrimination.[52]

In 2002, the MoHSS released the Policy on HIV/AIDS: Confidentiality, Notification, Reporting and Surveillance. The Policy is based on universally recognised human rights standards and states that health care workers are ethically and legally required to keep all patient information confidential and may only reveal the information with the consent of the patient.[53]

6.3 Medicines

Since 2002, the government provides ART free of charge for people living with HIV in need of treatment.

The government, through the TB-Mid Term Plan I,[54] has launched a multisectoral coordinating structure for HIV and has added terms of

51 n 45 above, sec 14 on access to health care and appropriate treatment.
52 As above.
53 MoHSS Policy on HIV/AIDS: Confidentiality, Notification, Reporting and Surveillance (2002) sec 3.4.1.
54 n 10 above, 25.

reference for TB. The government has committed itself to control the spread of TB.[55] The government has noted that TB is one of the problems affecting PLHA and disproportionately affects many sectors in the society.[56] Treatment for TB is currently available in most health care institutions free of charge throughout Namibia.

Treatment for STIs is not free in Namibia. The patient, whether HIV positive or not, will have to bear all the costs of STI treatment.

Section 2.2.5 of the Draft National HIV/AIDS Policy states that HIV/AIDS shall not be used as a reason for denying an individual access to social services, including health care, education and employment. Section 2.2.4 states that people living with HIV shall not be discriminated against in access to health care and related services and respect for privacy and confidentiality shall be upheld; section 4.3.17 states that government shall ensure that medicines for the prevention and treatment of opportunistic infections and STIs as well as ART, including generic medicines, are made readily available through registration with the Medicines Control Council; and subsection 19 states that government and partners, including relevant professional regulatory bodies, shall ensure that all medical practitioners, pharmacists and medical aid provisions, including those in the private sector, adhere to national anti-retroviral treatment guidelines, relating to the provision of treatment for HIV and related infections.

Namibia is a member of the World Trade Organisation (WTO) and is also a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) by virtue of the WTO Agreement.[57]

The current registration of patents pertaining to drugs in Namibia is minimal. Specifically, there are very few, if any, ARV medicines that are registered in Namibia at the present moment. As there are very few drugs that are currently registered, the government is not in any way prevented from importing generic medication from countries where local legislation does not accord intellectual property protection to ARV medication.

6.4 Condoms

The Namibian Social Marketing Association (NASOMA) has the mandate from the MoHSS to ensure that condoms are easily accessible,

55 As above.
56 As above, 12.
57 Arts II and XII (1) of the WTO agreement state that accession to the WTO agreement also applies to the multilateral trade agreement annexed to it which are binding on all members. The TRIPS agreement (Annex 1C to the WTO agreement) is part of the multilateral trade agreement.

affordable and available nationally. NASOMA, therefore, introduced Cool Ryder, Sense and Femidom in the country.

Condoms are for sale by NASOMA at a nominal price. For example, the price of Cool Ryder is N$2.00 (six pack) (+/- USD 0.30); Sense N$5 (three pack) (+/- USD 0.80); and the Femidom N$8 (three pack) (+/- USD 1.30).

Early in 2006, Smile condoms (three in one pack) were made available for free through clinics, hospitals, *shebeens* and bottle stores.

6.5 Case law

There are no documented or reported cases in any court on HIV and the right of access to health care.

7. Privacy

7.1 Notifiable disease

HIV or AIDS are not currently notifiable diseases in terms of public health legislation.

However, the MoHSS implements a system of anonymous reporting whereby all facilities within the MoHSS, civil society and the private sector are required to maintain and submit a 'notifiable disease report' on a monthly basis.[58]

7.2 Medical experimentation

The Constitution does not make specific reference to bodily integrity. However, article 8 on respect for human dignity could be interpreted in this instance in a broader manner to include bodily integrity.

The Namibian HIV/AIDS Charter of Rights recommends that clinic trials should only be conducted in terms of acceptable research protocols, which adequately protect the rights of research subjects prior to, during and after the trials. The results should be made available to the community for timely and appropriate action.[59]

[58] CSA & CHR, UP (n 23 above) 22.
[59] MoHSS (n 48 above) sec 15 on research and clinical trials.

7.3 Duty to disclose

Section 2.2.4 of the Draft version of National Policy on HIV/AIDS directed that people living with HIV not be discriminated against in access to health care and related services and that respect for privacy and confidentiality is to be upheld.

The Namibian HIV/AIDS Charter of Rights mentions that health care workers and counsellors are obliged to maintain confidentiality regarding a person's HIV status. Disclosure by a health worker of a person's HIV status without that person's consent should only take place to an identifiable sexual partner at risk in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counselled as to the need for partner notification.
- The HIV-positive person has refused to notify, or consent to notification of his or her partner(s).
- A real risk of transmission to the partner exists.
- The HIV-positive person is given reasonable advance notice of the intention to notify.
- Follow-up is provided to ensure support to those involved, as necessary.

Further, the Charter states that reporting of HIV-positive results to any health information system should take place on an anonymous basis and the reporting of HIV-positive results should be undertaken for the sole purpose of gathering epidemiological data to facilitate the management of the HIV epidemic.[60]

7.4 Testing

In Namibia, three types of HIV testing are available.

- Voluntary counselling and testing routinely offered to each patient diagnosed with TB or an STI and to all patients presenting symptoms that can be attributable to HIV and AIDS as well as to all pregnant women. In practice, patients that are suspected to be HIV positive are tested with an opt-out option.
- Mandatory testing in pre-recruitment in the armed forces, police and prisons sectors.[61] HIV testing is also required by the Ministry of Home Affairs as a requirement for a visa application.[62]
- Voluntary Counselling and Testing (VCT) initiated by an individual who undertakes to have a HIV test.

60 MoHSS (n 48 above) sec 5.
61 The mandatory testing is based the Defence Act 44 of 1957 sec 65(2) which requires recruits to undergo a medical examination.
62 Ministry of Home Affairs Form 3-1/0033 for Visa Application sec 10.

The Namibian HIV/AIDS Charter of Rights asserts that, through pre- and post-test counselling in a supportive environment, a person undergoing voluntary HIV testing can be motivated to change unsafe sexual behaviour and can be referred to available treatment, care and support services. VCT is thus an essential component in the continuum of prevention, treatment, care and support for persons living with or affected by HIV. VCT services should accommodate the special needs of girls and boys and other vulnerable groups and be widely available.

Section 3.3.1 of the Draft National HIV/AIDS Policy on the Provision of VCT states as follows:

- Testing for HIV should always be voluntary.
- Guidelines and standards for the provision of high quality, confidential[63] and accessible VCT services that reach the largest number of people possible shall be developed and regularly updated by government and partners.
- The provision of VCT services that are accessible, attractive and appropriate to young men and women and to other vulnerable groups shall be promoted.
- Given the high rate of co-infection of HIV and TB, post-test counselling for those testing HIV positive should routinely include an offer of screening for TB.
- All patients reporting at hospitals and other health service providers with any HIV-related symptoms, including TB and STIs, as well as pregnant mothers shall routinely be offered VCT services.
- VCT shall be promoted as part of workplace programmes by all public and private sector employers.
- Socially marketed and public sector VCT services shall be made available as widely as possible.

Government shall ensure the following:

- VCT must 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.
- Youth over the age of 16 must be able to access VCT without the consent of a guardian or parent. Children under the age of 16 shall be entitled to access VCT without the consent of a parent or guardian, provided that the child concerned is accompanied by an adult in a position of responsibility such as a religious leader or teacher or relative. Children whose mothers have died of AIDS shall be offered

[63] All information about a person's health, including his or her HIV status is confidential information. This means that this information may not be shared by the health care worker or the counsellor with any other person without the informed consent of the person concerned.

HIV testing. Counsellors shall receive training in order to equip them to render effective counselling to children, with due regard for the potentially traumatic consequences of a positive test result on the child.

- VCT shall be anonymous except where referral to other HIV/AIDS-related services is mutually agreed on between the VCT provider and the person seeking testing.
- VCT shall be confidential and the results of any HIV test shall thus not be disclosed to a third party without the informed consent of the person seeking testing.
- VCT service providers shall provide written positive test results only for the purpose of referral to other HIV/AIDS-related services and only with the consent of the person seeking testing. Negative results shall not be given in writing.
- Government and its partners shall promote and encourage couple counselling and voluntary partner disclosure of HIV test results.
- Pre-employment testing shall not be permitted.
- VCT services must be available countrywide, including in rural areas and that they are staffed by an adequate number of trained counsellors.
- There must be increased access to counselling and testing by employing approved testing methods.
- VCT services shall be free of charge for all vulnerable groups.[64]
- The government must co-ordinate and ensure that referral systems exist between VCT services and other HIV/AIDS-related services, at facility and community level, to provide a continuum of prevention, treatment, care and support and impact mitigation.

VCT services are currently available throughout Namibia. There are nine VCT centres also known as New Start Centres. Moreover, public health services are also equipped with VCT facilities. Rapid testing is also currently being rolled out to health facilities. However, there are some challenges such as the need to enhance access to VCT services and the establishment of more VCT facilities, especially in health centres.[65]

64 Women, children who have been orphaned, widows and widowers, children and young people, the poor, sex workers, prisoners, people awaiting trial, mobile populations, uniformed services, marginalised or minority groups, street children, persons engaged in trans-generational and/or transactional sex or/and same sex relations, people with disabilities, refugees and displaced groups.

65 S Fuller 'Voluntary counselling and testing' unpublished presentation paper, annual review meeting on the management of HIV/AIDS (15-19 August 2005, Okahandja, Namibia).

8. Equality and non-discrimination

Article 10 of the Constitution states on equality and non-discrimination:

> (1) All persons shall be equal before the law; and
>
> (2) No persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

However, the Constitution does not list HIV status as grounds for non-discrimination.

Other significant policies related to equality and discrimination include:

- The HIV/AIDS-MTP III states that the adverse impacts of stigma and discrimination are being increasingly recognised as key barriers to combating the epidemic. Commitment to reducing stigma and discrimination is therefore a central guideline and principle in all strategies contained in the Strategic Framework.[66]
- The National Policy on HIV/AIDS for the Education Sector, section 4(2) states that no learner or student living with HIV may be unfairly discriminated against directly or indirectly only on the basis of his or her HIV status.
- The National Policy on HIV/AIDS refers in various sections of the draft version, to the right to freedom from discrimination on the basis of HIV status.
- The Labour Act, section 5(2) makes it illegal to discriminate on the grounds of a person's HIV status, or to harass a person because he or she is HIV positive.
- The National Policy on OVC notes that discrimination is not only wrong itself but also creates and sustains conditions leading to vulnerability of orphans and other vulnerable children, including to HIV infection and barriers to receiving adequate treatment, care and support.[67]
- The preamble of the Namibian HIV Charter of Rights recognises that a human rights-based approach to HIV/AIDS, which outlaws discrimination on the basis of HIV status, is central to an effective public health response to HIV/AIDS.

[66] MOHSS HIV/AIDS-MTP III (n 9 above) 10.
[67] Ministry of Women Affairs and Child Welfare (n 7 above) Guiding Principle 4.4.

9. Labour rights

9.1 Legislation

The National Code on HIV/AIDS in Employment[68] states:

> 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 their normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When an employee becomes too ill to perform his/her agreed functions, standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

The Constitution states in article 95 that the state shall actively promote and maintain the welfare of the people by adopting the following policies:

> (a) ... the Government shall ensure the implementation of the principle of non-discrimination in remuneration of men and women ...; and
>
> (c) active encouragement of the formation of independent trade unions to protect workers' rights and interests, and to promote sound labour relations and fair employment practices.

When an employee has been unfairly dismissed on grounds including his or her HIV status, or subjected to unfair disciplinary actions, the employee has two avenues:

- The employee may report the matter to the district labour court (DLC). Each magistrate's court has a district labour court. The complainant must file within one year of the incident. The DLC will refer the matter to a labour inspector, who will try to resolve the dispute through negotiations with the parties.
- The labour court can be approached to determine whether practices are discriminatory or not.

9.2 Testing

In 1998, the Minister of Labour issued guidelines for the implementation of the National Code on HIV/AIDS in Employment under the Labour Act. With the Code, the Ministry of Labour hopes to address most of the issues relating to HIV in the workplace. The Code applies to both government and the private sector. It states that there should be no pre-employment HIV testing and that normal medical tests used to determine current fitness for work should not include HIV tests.

[68] The National Code on HIV/AIDS in Employment (1998) Government Notice 78 GG 1835.

9.3 Medical schemes act

The Medical Aid Funds Act[69] was promulgated to provide for the control and promotion of medical aid funds and to establish the Namibian Association of Medical Aid Fund. There is no specific section dealing with HIV and AIDS. A number of medical aid companies offer reasonable access to ARV medication to members, up to the allocated amount for medication. People on ART need to supplement the costs of their medication once the medical aid funds are depleted.

The Namibia National Teachers' Union (NANTU) Policy on HIV/ AIDS of 2000 declares that health insurance coverage should be available for all 'educational based employees' regardless of HIV status and therefore no pre- or post- employment testing should take place. It also states that health insurance premiums for educational employees should not be affected by HIV status.[70]

9.4 Duty to provide treatment

Under the Employees Compensation Amendment Act,[71] employees who earn less than R 72 000 per year have the right to claim compensation from the compensation fund for accidents and industrial illnesses acquired during employment. HIV is not recognised as an occupational disease in this law, meaning that persons who contract HIV through their employment are not entitled to claim employees' compensation under the Act.

10. Women's rights

10.1 Legal status and protection

There are various provisions that impact on women's rights. Article 10 of the Constitution provides for equality and freedom from discrimination including on the grounds of sex. Article 2(3) of the Combating of Rape Act[72] states that 'no marriage or other relationship shall constitute a defence to a charge of rape under this act'.

The following legislation covers issues such as sexual offences including rape, sexual assault, and domestic violence:

- The Combating of Rape Act;
- The Combating of Domestic Violence Act; and

69 Medical Aid Funds Act 23 of 1995.
70 NANTU Policy on HIV/AIDS (2000) sec 5.2.3.4.
71 Employee Compensation Amendment Act 5 of 1995.
72 Combating of Rape Act (n 34 above).

- The Combating of Immoral Practices Amendment Act.

10.2 Domestic violence law

The Combating of Domestic Violence Act 4 of 2003 forbids the following acts or courses of conduct (and the threat of):

- Physical abuse;
- sexual abuse;
- economic abuse;
- intimidation;
- harassment;
- entering property without the person's consent; and
- emotional, verbal or psychological abuse.[73]

The Combating of Rape Act[74] states that 'no marriage or other relationship shall constitute a defence to a charge of rape under this act'.

10.3 Customary rules and practices

Article 66(1) of the Constitution states that both the customary law and the common law of Namibia in force on the date of independence shall remain valid to the extent to which such customary or common law does not conflict with the Constitution or any other statutory law. The Constitution states in articles 10(1) and (2) that '[a]ll persons shall be equal before the law ... No person may be discriminated against on the ground of sex, race, colour, ethnic origin, creed or social or economic status'.

The Namibian HIV/AIDS Charter of Rights recognises that some cultural and traditional practices act against effective prevention and place people, especially women and girls, at risk of HIV infection. These practices and traditions should be identified and steps should be taken to address them by way of formal and non-formal education and/or legislation.[75]

Some traditional and cultural practices that put women in a vulnerable position in society and fuel vulnerability to HIV are:

- early sexual debut (traditionally girls were married off soon after the onset of puberty often to older men as second wives);

73 As above sec 2(1).
74 As above, art 2(3).
75 MoHSS (n 48 above) sec 19 'Cultural and traditional practices'.

- cross-generational sex (fuelled by the 'virgin cure' myth and poverty. Young girls having sex with older men in exchange for money and services);
- rape, including marital rape;
- piercing and tattooing;
- widow and widower inheritance: 'levirate' (in some cultures, a man could inherit his deceased brother's or cousin's wife on the excuse that the widow and children must be cared for) and 'surrogate' (the deceased women's family provides a younger sister/cousin to replace her); and
- wife/husband lending (in some cultures, a man can offer his wife to a friend or someone of higher social status. This is done to cement the male friendship or as a symbol of kindness. Likewise, a woman can offer her husband to a female guest);[76]
- death cleansing;[77] and
- forced sex for girls and boys coming of age.[78]

The Draft version of the National HIV/AIDS Policy stipulates as follows in section 2.4.2 on the issue of customary practices:

- Traditional leaders shall be sensitised on the dangers of customary practices like death cleansing, forced sex for young girls and boys coming of age, and dry sex, which may lead to HIV infection.
- Traditional initiation counsellors shall incorporate sound and appropriate sexual and reproductive health education into traditional and cultural rites of passage/initiation processes.
- Traditional leaders shall stop or modify unsafe customary practices in order to prevent HIV transmission, or shall promote alternative customary practices which do not place people at risk of HIV infection.
- Traditional leaders and religious leaders shall sensitise their communities on the dangers of and discourage harmful traditional practices like death cleansing, forced sex for young girls and boys coming of age, and dry sex, which may lead to HIV infection.
- Customary practices which involve the use of blades, needles or other skin-piercing instruments, such as scarring, tattooing, circumcision, ear piercing shall be done safely using new needles or blades, to prevent HIV infection.

None of the practices that are harmful and increase the risk of HIV infection have been challenged in court.

76 Edwards-Jauch 'Social-cultural aspects of HIV/AIDS' unpublished presentation paper, Parliamentarians for Women's Health Project, 6-7 October 2005, Windhoek.

77 'Death cleansing' refers to when a widow is expected to sleep with a member of her late husband's family.

78 Draft National HIV/AIDS Policy (n 46 above) sec 2.4 'Traditional, customary, cultural and religious practices and services'.

The Draft version of the National HIV/AIDS Policy in section 2.3.1.1 on women and girls, states:

> Women and girls, including women living with HIV/AIDS, and regardless of marital status, shall have equal access to appropriate, sound HIV-related information and education programmes, means of prevention and health services including women and youth friendly sexual and reproductive health services.

Sub-section 3 states:

> All persons, and in particular women and girls, shall be protected against violence, including sexual violence, rape (marital and other) and other forms of coerced sex, as well as against traditional practices that negatively affect their health.

10.4 Administration of anti-retrovirals to rape survivors

In July 2004, the MoHSS issued the national guidelines on PEP at the workplace. PEP is available only to doctors and nurses.

The MoHSS has also drafted a policy to regulate the administering of ARVs to rape survivors but this has not yet been made public. Rape survivors may be provided with PEP at the discretion of the medical professional. Moreover, PEP is available only in district hospitals.

The Namibian HIV/AIDS Charter of Rights recommends that rape survivors should have access to adequate information about HIV and to affordable and timely prophylactic treatment.[79]

10.5 Sex workers

Commercial sex work is illegal in terms of the Combating of Immoral Practices Act. The LAC has proposed that sex work be decriminalised and discouraged. There is a feeling that there is a need for regulation of the sex work industry. The MoHSS and some members of parliament shared the same view.

11. Children's rights

11.1 Access to health care

In principle, access to health care facilities is equally ensured to every Namibian including children living with HIV. Treatment, care and support programmes developed according to the HIV/AIDS-MTP III and

79 MoHSS (n 48 above) sec 14 'Access to health care and appropriate treatment'.

the National Policy on Orphans and Vulnerable Children reaffirms this.[80] Moreover, the Namibian HIV/AIDS Charter of Rights mentions that quality health care, information and education should be made available to all children and adolescents, including those living with HIV.[81]

The MoHSS completed a one-year pilot programme for PMTCT at Oshakati and Katutura hospitals in 2002. It was agreed that PMTCT and ART should be rolled out simultaneously because of obvious programmatic linkages.

The MoHSS introduced the 'Guidelines for PMTCT of HIV' in March 2002. By the end of 2004, PMTCT and ART services were provided in 24 of the 35 hospitals in Namibia. In 2005, the Primary Health Care (PHC) and Special Diseases Directorates (DSP) compiled a rollout plan for PMTCT and ART services as a guide for the national level including all 13 regions of Namibia.

In April 2003, the MoHSS issued the Guidelines for Anti-retroviral Treatment. Part 3 examines the situation of children. ART is to be provided free of charge to all eligible patients including children in some state hospitals and health centres.

11.2 Children orphaned by AIDS

Namibia is committed to minimising the number of children orphaned by AIDS and reducing the vulnerability of those affected by or living with HIV. For this reason, a multi-sectoral Permanent Task Force on Orphans and Vulnerable Children was established and initial funding necessary for emergency assistance to OVC was provided.[82] Moreover, the National Policy on Orphans and Vulnerable Children, among other principles, states that prevention, treatment, care and support, and impact mitigation are mutually reinforcing elements of a continuum of an effective response to HIV and the associated increasing number of children who have been orphaned and other vulnerable children.[83]

There is no specific grant from the government for children orphaned by AIDS. Any children who have been orphaned, including children orphaned by AIDS, will benefit from either the maintenance grant or the foster grant.

The maintenance grant and the foster grant are managed by the Ministry of Gender Equality and Child Welfare and take the form of a

80 See Ministry of Women Affairs and Child Welfare (n 7 above) Guiding Principle 4.7.
81 See MoHSS (n 48 above) sec 7.
82 National Policy on Orphans and Vulnerable Children (2004) preface (by N Nandi-Ndaitwah).
83 Ministry of Women Affairs and Child Welfare (n 7 above) Guiding Principle 4.7.

monthly allowance. A number of NGOs provide shelter and food parcels for OVC through the financial support of international donors.

11.3 Education

Article 20 of the Constitution declares that '[a]ll persons have the right to education'. The article notes further that primary education should be provided free of charge and that children shall not be allowed to leave school until they have either completed primary education or have attained the age of 16, whichever occurs first.

The Ministry of Education has recognised the centrality of the prevention of HIV, the support of people living with HIV and the mitigation of the effects of HIV. Interventions in education should provide knowledge and encourage development of attitudes and skills with which the spread and impact of the epidemic can be alleviated.

The development of this Policy was a collaborative effort. The education sector, through the Policy Working Group of the Joint HIV/AIDS Committee for Education, and under the leadership of the LAC, conducted focus group discussions at all levels of the education sector, regional consultations, forum meetings and a national conference. The National Policy on HIV/AIDS for the Education Sector was approved by Cabinet in 2003. The National HIV/AIDS Policy on Education Sector provides the foundation for the HIV/AIDS-MTP III. The Policy reflects the human rights provisions contained in the Constitution, Namibian HIV/AIDS Charter of Rights and the international conventions ratified by Namibia.

The National HIV/AIDS Policy on Education formalises the rights and responsibilities of every person involved, directly or indirectly, in the education sector with regard to HIV: the learners, their parents and caretakers, teachers, administrators, ancillary staff, planners, and in fact the whole of civil society. It underscores the dignity of all affected by or living with HIV. The Policy provides guidelines to ensure that all in the education sector are fully informed about HIV, the modes of transmission, and how to live positively.

Section 4 deals with non-discrimination and equality with regard to learners and students living with HIV. Section 4.2 states that no learner or student living with HIV may be unfairly discriminated against directly or indirectly only on the basis of his or her status. Section 4.4 states that learners and students living with HIV should be treated in a just, humane and life-affirming way and provided with support and counselling.

Section 5 deals with HIV testing, admission and continued attendance at schools and institutions. Section 5.1 states that there is no medical justification for routine HIV testing of learners or students. The testing of learners or students for HIV as a requirement

for admission to or continued attendance at an educational institution is prohibited. Section 5.2 prescribes that no learner or student may be denied admission to or continued attendance at an educational institution as a result of his or her HIV status or perceived HIV status.

There are no reported cases of children being refused access to school on the basis of their HIV status.

The government has made strong efforts to improve access to education for boys and girls, reaching an overall net enrolment ratio of 84 per cent for boys and 88 per cent for girls aged 7 - 13. However, marked regional and ethnic disparities exist in the enrolment, performance and gender balance; in particular the female participation in some northern regions is of great concern.[84]

The Forum for African Women Educationalists in Namibia (FAWENA) has a programme for San[85] girls' education. FAWENA puts emphasis on San girls because their social conditions are very poor and as a result, children and especially girls leave school or discontinue their education.[86] The Ministry of Education has also tailor-made curricula for learning-impaired girls.[87]

Section 10 of the National HIV/AIDS Policy on Education is on education and information on HIV and AIDS. Section 10.1 states that a continuing life-skills, sexual health and HIV education, prevention and care programme must be implemented at all educational institutions for all learners, students and education sector employees. Such programmes must also be implemented at hostels. Section 10.4 recommends that the ministries shall appoint and train enough education sector employees as are needed to ensure that adequate attention is given to the teaching of life-skills, sexual health and HIV education at each educational institution.

The HIV/AIDS-MTP III recommends the development and distribution to all school libraries information, education and communication materials regarding life-skills, self-esteem, sexuality and sexual health, HIV and AIDS, TB, discrimination, children's rights, gender equality and other relevant social and equity issues. Moreover, it recommends the implementation of life-skills, sexual health, TB, HIV/AIDS education prevention programmes in all primary and secondary schools for all learners/students and staff.[88] The Namibian National Teacher's Union (NANTU) issued their policy on HIV/AIDS in 2000.[89] NANTU deems that the same ethical principals that govern all

84 Ministry of Education 'Education for all: Namibia report of activities for 2003-2004' (2004) 3.
85 San people are a tribal group often marginalised in Namibia. The San fall under the category of 'Educationally Marginalised Children'.
86 Ministry of Education (n 84 above) 10.
87 Government of Namibia (n 16 above) 239-255.
88 n 9 above, 44.
89 NANTU (n 70 above).

health and medical conditions in the employment context apply equally to HIV and AIDS. However, the gravity and impact of the HIV epidemic and the potential for discrimination create the need for specific policy on HIV/AIDS for teachers.[90] This Policy covers four areas:

- information, education, other preventive health measures and counselling;
- VCT and confidentiality;
- terms of appointment and service: (a) pre-recruitment and employment prospects; (b) continuity of employment; (c) health insurance benefits; (d) protection against victimisation; and
- grievance handling and research.

12. Family law

The 2001 National Census revealed that there were 156 165 children who have been orphaned between the age of 0 and 19 in Namibia.[91]

Article 15 of the Constitution lists a number of rights for children. These rights include the right to a name, to acquire a nationality and, subject to legislation enacted in the best interest of children, as far as possible the right to know and be cared for by their parents. Children are also entitled to be protected from economic exploitation and prevented from being employed if they are under the age of 14 unless otherwise regulated by Act of Parliament. Moreover, no law authorising preventive detention shall permit children under the age of 16 to be detained.

The Committee on the Rights of Child requires each country to develop a National Programmes of Action (NPA) for children. In Namibia, the NPA has been incorporated into government planning; the first and second National Development Plans (NDP 1 and 2) reflect the goals and provisions of NPA.[92]

The Namibian NPA strive to halve malnutrition rates among children, provide access to safe drinking water and proper sanitation for all, provide access to basic education and primary education for 80 per cent of primary school age children, and protect children in difficult circumstances. However, no mention of HIV or AIDS has been made in the NPA.

In December 2004, the Ministry of Women Affairs and Child Welfare (now Ministry of Gender and Child Welfare) issued the National Policy on OVC. A multisectoral permanent task force on

90 HIV/AIDS Policy on Education, sec 5.2.1.
91 Ministry of Women Affairs and Child Welfare (n 7 above) 1.
92 Ministry of Women Affairs and Child Welfare (n 7 above) 2.

children who have been orphaned and vulnerable children was established and initial funding necessary for emergency assistance to OVC was provided.

13. Criminal law

13.1 Criminal legislation

There are no specific provisions in the criminal law on HIV and AIDS. Cases of wilful transmission of HIV could be prosecuted under the common law offence of culpable homicide.

Along the same line, article 3(1)(a)(iii)(dd) of the Combating of Rape Act stipulates that a penalty of imprisonment for a period of not less than 15 years will apply to a first time offender where 'the convicted person is infected with any serious STIs and at the time of the commission of the rape knows that he or she is so infected'. Thus, there is harsher sentencing if the offender was aware of his or her HIV-positive status at the time of the offence, whether or not HIV was transmitted.

On 17 March 2003, the first case under the Combating of Rape Act was heard in the High Court. In this case, the perpetrator was allegedly infected with HIV whilst committing the alleged rape.[93] The accused was later acquitted for insufficient evidence on account of rape.

13.2 Men having sex with men

Sodomy is punishable under section 269 of the Criminal Procedure Act.[94] There have been some reported cases related to homosexuality. In 2002, Jason Pohamba, purportedly HIV positive, allegedly raped a 20 year-old male relative. The accused was acquitted on the basis of insufficient evidence.

The legal position and treatment of lesbians affect the situation of men who have sex with men. In *Frank and Khaxas v Chairperson of the Immigration Selection Board*,[95] Elizabeth Khaxas and her German-born partner, Liz Frank, fought for years to have their relationship recognised for immigration purposes. The Ministry of Home Affairs denied Frank a residency permit, threatening her with deportation because of her sexual orientation. In 2001, the Supreme Court found that a same-sex relationship could not be recognised by Namibian

93 'Court hears first HIV rape case' *The Namibian* 18 March 2003 1.
94 Criminal Procedure Act 51 of 1977.
95 *Frank and Khaxas v Chairperson of the Immigration Selection Board,* Case A 56/99, *Chairperson of the Immigration Selection Board v Frank* 2001 NR 107 (NmSC).

law, and could not find in favour of the applicant.[96] The Supreme Court cited then Head of State Sam Nujoma's own remarks as evidence that Namibian norms and values opposed equality protections based on sexual orientation; it concluded that constitutional anti-discrimination provisions did not mandate recognition of same-sex relationships.[97]

However, Frank's petition for residency was finally granted later that year, when the Ministry of Home Affairs relented; the concession came only after the government had won on its point of principle.

The Draft National HIV/AIDS Policy states in section 2.3.12 on persons engaged in same-sex sexual relations that:

> Whether through choice, circumstance or coercion, a significant number of individuals are engaged in same-sex sexual relationships. Prevailing social and cultural attitudes which do not accept such relationships may render these individuals particularly vulnerable to infection, as these attitudes often dissuade persons engaged in such relationships from seeking out and utilising testing, counselling, treatment, care and support services.

It recommended as follows:

- Appropriate HIV/AIDS/STI prevention information, voluntary counselling and testing, means of prevention including male and female condoms, treatment, care and support and impact mitigation services shall be accessible to all without discrimination, including persons engaged in same sex sexual relationships;
- Laws and policies shall not violate the human rights of or have the effect of preventing access by members of this vulnerable group to HIV/AIDS/STI prevention, treatment, care, support and impact mitigation services;
- Law enforcement agencies and health workers shall be sensitised to deal with members of this group in a professional and respectful manner. In particular they shall not be permitted to discriminate against or harass in any way people on the basis of their sexual orientation.

The Constitution does not offer express protection against discrimination based on sexual orientation and laws criminalising 'unnatural sexual offences' remain in force. There is also a pre-independence law, the Combating of Immoral Practices Act, which is mainly aimed at heterosexual conduct and defines sexual intercourse between two people who are not partners in a civil or customary marriage as 'unlawful carnal intercourse'.[98]

96 Human Rights Watch & International Gay and Lesbian Human Rights Commission 'More Than a Name: State-sponsored Homophobia and its Consequences in Southern Africa' (2003) 32.
97 n 96 above, 33.
98 n 16 above, 266.

The Labour Act, however, includes sexual orientation as a ground for non-discrimination in employment.[99]

For its part, the National Policy for Reproductive Rights of July 2001 recommends in chapter 3 that people should not be denied services based on prejudice or biased tendencies.[100]

14. Prisoners' rights

The Draft National HIV/AIDS Policy includes prisoners in the category of vulnerable people and recommends the following in section 2.3.7:

- There shall be no mandatory testing of prisoners and prisoners shall not be quarantined, segregated or isolated solely on the basis of HIV/AIDS status;
- All prisoners, people awaiting trial and prison staff shall have access to the same HIV-related prevention information, education, voluntary counselling and testing, means of prevention including condoms, treatment (including anti-retroviral therapy), care and support as is available in the general population;
- All prisoners, people awaiting trial and prison staff shall have access to TB related prevention and care as TB is particularly prevalent in prisons and poses a serious hazard to persons with HIV/AIDS;
- Prison authorities shall take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion by fellow prisoners and prison staff and juveniles shall be segregated from adult prisoners to protect them from abuse;
- Prisoners and people awaiting trial who have been victims of rape, sexual violence or coercion shall have timely access to effective complaints mechanisms, psychosocial support, the option to request separation from other prisoners for the purposes of their own protection, and timely access to post-exposure prophylaxis and appropriate counselling services; and
- Prison authorities shall ensure that nutrition, treatment, care and support services are provided to prisoners living with HIV or AIDS in a sensitive and confidential manner and shall guard against inadvertently disclosing the HIV status of any prisoner.

The Department of Prisons and Correctional Services under the Ministry of Safety and Security is in charge of developing specific education programmes on HIV for inmates and prison communities. It is also charged with procurement and distribution of condoms to all offices, prisons, cells and duty stations.

[99] Labour Act 6 of 1992, sec 107(1).
[100] MoHSS (n 48 above) principle 3.2.e.

It is reported that 27 to 30 per cent of the prison population is living with HIV.[101] The status of prisoners is kept confidential and prisoners living with HIV have access to ART at the expense of the government.

Since homosexuality and sodomy are illegal, the Department does not distribute condoms to inmates.[102] The Department believes that condom distribution would be tantamount to condoning sodomy. The Draft National HIV/AIDS Policy and the Strategic Framework, however, recommend a comprehensive HIV/AIDS policy, including a condom distribution policy, to create a supportive and human rights-based environment for prisoners and to reduce stigma and discrimination among prisoners and staff of the Department of Prisons and Correctional Services.[103]

The Draft National HIV/AIDS Policy states in section 2.3.7.1 that there shall be no mandatory testing of prisoners and prisoners shall not be quarantined, segregated or isolated solely on the basis of HIV status; and in practice, prisoners living with HIV are not segregated from other inmates.

There have been reported cases of rape and sexual violence among male inmates in prisons.

15. Immigration

Section 10 of Form 3-1/0033 for a Namibian visa lists several diseases that should be reported to the Department of Home Affairs. These diseases are:

> tuberculosis, other contagious lung disease, trachoma or any chronic eye infection, framboesia, yaws, scabies or any other contagious bacterial skin disease, syphilis or any other venereal disease, or leprosy or Acquired Immuno-Deficiency Syndrome virus (AIDS virus) [*sic*] or any mental illness or affliction.

Although the application form in theory requires the results of an HIV test, there has never been an incidence of a person being denied a visa on the basis of his or her HIV status. Moreover the Immigration Control Act[104] does not require non-nationals to be tested for HIV prior to gaining admission to a port of entry in Namibia. However, section 39(2) of the Immigration Control Act states that a person referred to in subsection 1 shall be a prohibited immigrant in respect of Namibia if ... '(e) such a person is infected or afflicted with a

101 http://www.africa.upenn.edu/Urgent_Action/apic-081703.html (accessed 1 August 2006).
102 'Namibia's prisons sit on AIDS "time bomb"' *Mail & Guardian Online* 4 January 2006.
103 MoHSS HIV/AIDS-MTP III (n 9 above) 42.
104 Immigration Control Act 7 of 1993.

contagious disease or is a carrier of such a virus or disease, as may be prescribed'.

16. Social assistance and other government benefits

The administration of social grants is regulated by the Social Security Act.[105] HIV or AIDS is not considered a disability under the law. People living with HIV will qualify for disability grants not based on their HIV status but if certain conditions are met, such as age, degree of disability to be assessed by a medical practitioner or for children with parents who are unemployed or in prison.

The Department of Social Welfare in the Ministry of Labour provides two types of grants:

- the old age grant for Namibian citizens from 60 years which is currently R 300 every month; and
- the disability grant for people aged 16 to 59 years. The amount is also R300 every month and the disability must be at least 50 per cent, determined by a medical doctor and confirmed by the Chief Medical Officer of the MoHSS.

The Ministry of Gender Equality and Child Welfare provides three types of grants to children under the age of 18:

- The disability grant is for children under 18, whose disability is determined by a doctor and a social worker. Upon establishment of disability, the child is given R200 every month.
- The maintenance grant for children whose parents are in jail, or who have lost one parent. The surviving parent must be unemployed or earning less that R500 a month.
- The foster grant is for children whose biological parents are dead.

For the maintenance and foster grant, the first child is entitled to R200 per month and R100 for any subsequent sibling. There is no special grant for children living with HIV. These children will qualify for the above grants if they are eligible on the prescribed conditions but not solely on their HIV status.

The Ministry of Gender Equality and Social Welfare used to provide food parcels and blankets to children who have been orphaned but due to financial constraints, this has been discontinued and NGOs, community-based organisations and faith-based organisations are encouraged to support people living with HIV through home-based care, support groups and income generating activities.

[105] Social Security Act 34 of 1994.

17. Insurance

There is no legislative regulation in the insurance industry concerning HIV/AIDS.

The Namibian HIV/AIDS Charter of Rights recommends, among other things, that people living with HIV and those suspected of being at risk of having HIV or AIDS should be protected from arbitrary discrimination in insurance and medical aid. Insurers and medical aid administrators should explain to the insured or medical aid member what influence HIV or AIDS would have on the validity and effect of the contract of insurance or medical aid.[106] If HIV testing is required for life insurance or medical aid, the insurer or medical aid administrator should provide access to adequate pre- and post-counselling. The insurer or medical aid administrator requiring the test should ensure that the results are treated with confidentiality.[107]

Most companies have tailor-made life insurance policies for people living with HIV. For example, since 1996, Metropolitan Namibia offers life cover to people with HIV called Inclusive Life, which treats AIDS as a 'dreaded disease'. Inclusive Life offers a range of policies including life cover, unit trusts and pure endowment investment plans. The policy can be ceded as collateral on loans, and this makes purchasing of houses and cars more accessible to HIV-positive people. People living with HIV are expected to pay higher premiums depending on the type of health insurance plan they choose. The insurance cover is also reduced by 50 per cent if a person is HIV positive.

Most insurance companies have a policy of compulsory HIV testing for applicants. The client will be referred to a medical doctor for pre- and post-test counselling and testing and the results will be relayed to the insurance company. The prospective applicant can decide whether to allow for the disclosure of the results to the family doctor.

18. Oversight

The HIV/AIDS-MTP III presents an expanded national response to the HIV epidemic in Namibia. Its implementation will involve many implementing agencies. The government and several development partners will commit an increased amount of resources to its operationalisation. It is important that such resources bring about positive returns through achievement of the strategic results and outcomes outlined in the plan. In a critical area of public health and

106 MoHSS (n 48 above) sec 17: Insurance and medical aid 11.
107 MoHSS (n 48 above) sec 17.

national development such as HIV, it is even more imperative to demonstrate the effectiveness of programmes not only at the national level, but also at regional and local levels.

The complexity of the institutional arrangements outlined in the plan requires multi-level approaches to the monitoring and evaluation of programmes and activities. At the same time, the approaches will facilitate inter- and intra-level monitoring and evaluation particularly for cross-cutting issues such as policy, resource mobilisation and utilisation, programme design and implementation.

The government through the NAC will monitor the overall effectiveness of HIV/AIDS-MTP III's strategies. It will monitor processes of resource mobilisation, allocation and utilisation in the public sector. It will further monitor the extent to which its decentralised management and administrative structures facilitate HIV prevention and mitigation efforts and the integration of HIV within the public sector machinery at the national and regional council levels.

NACOP will monitor stakeholder programme design and implementation at all levels through active participation and ongoing coordination of stakeholder activities. It will collaborate with the stakeholders and implementing partners to develop an overall monitoring and evaluation (M & E) coordination plan. This national M & E coordination plan will define each M & E data source for the core indicators of HIV/AIDS-MTP III and specify how and how often data will flow from each component, level and source to a central repository at MoHSS Directorate: Special Programmes. It will include a flow chart depicting data flows. NACOP will develop a number of information products based on data received and disseminate these information products to all relevant stakeholders to keep them appraised of progress with regard to the implementation of the HIV/AIDS-MTP III. A monitoring handbook for HIV/AIDS-MTP III implementing partners and the Global Fund recipients will be produced separately from this plan.

As part of the management process, annual reviews will be scheduled and adjustments to the plan and targets will have to be justified. A mid-term review of the HIV/AIDS-MTP III will take place in 2007. Targets have been set for 2007 and 2009 for each of the core indicators to assist the evaluation process.

19. Stigma

The HIV/AIDS-MTP III recognises that there must be an enabling environment where people living with HIV enjoy equal rights in a culture of acceptance, openness and compassion. Stigma and discrimination are recognised as major obstacles to effective HIV

prevention, care, treatment and support. Namibia's policies concerning human rights for people living with HIV must still be translated into acceptance by all communities, employers and families.

A results-based approach means that achieving results will produce the following:

- leaders and opinion-setters consistently speak out about HIV/AIDS, AIDS prevention programmes, and improved access to treatment, care and support to combat discrimination;
- relevant policies implemented;
- all necessary legal frameworks in place; and
- people express accepting attitudes towards PLHA.

The HIV/AIDS-MTP III suggests that actions to reduce stigma and discrimination should be the concern of all ministries, NGOs, Ombudsman and civil society. According to the HIV/AIDS-MTP III, to reduce stigma and discrimination, counselling and legal assistance need to be provided to all people living with or affected by HIV/AIDS/STIs or TB who have suffered discrimination and stigmatisation and request such assistance. The activities to achieve the outcome are:

- The enactment, implementation and enforcement of laws and policies that address stigma and discrimination in all sectors and institutions;
- Provision of legal advice and assistance to access remedies for discrimination;
- Training of community paralegals to render advice on the rights of PLHAs starting in 2004 and continuing;
- Training of justice officials, social workers and educators concerning the rights of PLHA and people with TB, starting in 2004; and
- Establishing or identifying a body to investigate cases of discrimination and institute corrective measures.

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- HIV/AIDS Charter of Rights
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6 HIV, AIDS and the law in South Africa

1. Background to country

1.1 First AIDS case

The first two cases of AIDS in South Africa were documented in 1982.[1] It is not clear where the first case was documented, how the person became infected or whether or not his or her information was kept confidential.

1.2 Demography

The question of which sampling methodology is most appropriate for establishing the national HIV prevalence rate has been a matter of controversy. Two primary methods have been used to estimate HIV prevalence in South Africa: (i) the sampling of pregnant women at antenatal clinics, and (ii) the administration of household surveys, based upon questionnaires combined with blood sampling of a representative cross-section of the population.

In 2005, the National Department of Health (DoH) published the 2004 National HIV and Syphilis Antenatal Sero-prevalence Survey. Based on a sample of more than 16 000 women at antenatal clinics across the country, the Survey estimated that in 2004, 29.5 per cent of pregnant women in South Africa were HIV positive and that a total of 6.29 million South Africans were living with HIV.[2]

In 2005, the Human Sciences Research Council of South Africa (HSRC) released its South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey (HSRC Survey). Prevalence figures in this study were calculated by conducting a household survey using questionnaires and blood sampling. The study sampled a representative cross-section of society, visiting 12 581 households across South Africa, of which 10 584 (84 per cent) took part in the survey. 23 275 (96 per cent) Of the eligible people in these households agreed to be interviewed and 15 851 (65 per cent) agreed to take a HIV test. Based upon this sample, the HSRC Survey estimated the overall HIV prevalence rate for persons aged two and older to be 10.8 per cent.[3]

UNAIDS estimates that the 2003 adult prevalence rate for HIV was 21.5 per cent.[4]

1 UNAIDS & WHO 'Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: South Africa' (2004) 6.
2 DoH 'National HIV and syphilis antenatal sero-prevalence survey in South Africa' (2004).
3 HSRC 'South African national HIV prevalence, HIV incidence, behaviour and communication survey' (2005) 33.
4 UNAIDS & WHO (n 1 above) 6.

South Africa has an estimated population of 47.7 million.[5] The adult (15-49 years old) prevalence rate was estimated to be 18.8 per cent in 2005.[6] This translates into 5.1 million adults (more than 15 years old) living with HIV.[7] The exact number of the population that has developed AIDS is unknown.

The tuberculosis (TB) prevalence rate in South Africa was 670 persons per 100 000 in 2004.[8]

In its Progress Report on the Implementation of the United Nations General Assembly Special Session on HIV/AIDS Declaration (UNGASS Progress Report), the DoH estimated that there were 332 205 HIV-positive pregnant women in the country at the end of 2004. They estimated the total number of women to have given birth during 2004 to be 1 118 198. The Department estimated the prevalence rate for pregnant mothers in South Africa to be 29.7 per cent at the end of 2004.[9] It is estimated that at the end of 2004, 104 863 babies were born with HIV.[10]

The HIV infection rate is higher for women than for men.[11] The HSRC's 2005 household survey estimates that 13.3 per cent of women are HIV positive, while the figure for men is 8.2 per cent. The age group worst affected by the epidemic is young adults.[12] Indeed, figures show that it peaks for women aged 15 to 29 years of age, while for men the highest infected age category is among those aged 30 to 34.[13]

There is no recent or comprehensive data for HIV infection rates in South Africa among vulnerable groups such as sex workers, intravenous drug users and men having sex with men. HIV prevalence among sex workers tested in KwaZulu-Natal increased from 50 per cent in 1996-1997 to 61 per cent in 1998.[14] By the late 1990s, the prevalence rate of sex workers in two mining areas had reached nearly 70 per cent. In 2000, 50 per cent of sex workers tested were HIV positive. Prevalence rates were also estimated to be well above 50 per cent for truck drivers who were tested at six sites outside of urban

5 UNFPA 'State of the world population 2007: Unleashing the potential of urban growth' (2007) 90.
6 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
7 As above.
8 UNDP 'Human development report 2006: Beyond scarcity: Power, poverty and the global water crisis' (2006) 313.
9 Government of South Africa 'Progress Report on Declaration of Commitment on HIV and AIDS' (2006) http://www.doh.gov.za/docs/reports/2006/ungass/index.html (accessed 1 August 2006) 22.
10 DoH (n 2 above) 10.
11 HSRC (n 3 above) 33-34.
12 DoH (n 2 above) 10.
13 HSRC (n 3 above) 135.
14 UNAIDS & WHO (n 1 above) 2.

centres.[15] There is also a lack of up-to-date statistics for HIV prevalence rates among men having sex with men (MSM). Indeed, the figures cited in UNAIDS and WHO's 2004 Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections are taken from 1986 data which showed a median HIV prevalence of eight per cent for Durban and 11 per cent in Cape Town.[16]

The number of AIDS-related deaths is extremely difficult to calculate as a majority of deaths have been found to have been misclassified. Several researchers have found that deaths in South Africa are frequently misclassified, and in particular a large proportion of AIDS-related deaths are classified as AIDS-related conditions, without any reference to HIV.[17] In its 2005 World Mortality Report, the UN revealed that the total number of annual deaths (from all causes) has risen from 317 000 during 1990-1995 to 754 000 during 2000-2005.[18] One study of nearly 2.9 million death certificates indicated that there was a 62 per cent increase of deaths among people 15 years of age and older during 1997-2002. Deaths among those aged 25 - 44 years more than doubled during the same period. AIDS is believed to be the primary reason for this mortality increase.[19]

UNICEF estimates that there were 1.2 million children orphaned by AIDS, defined as children under age 17 who have lost one or both parents to AIDS, in South Africa at the end of 2005.[20]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[21]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	10/12/1998

15 UNAIDS & WHO (n 1 above) 2.
16 As above.
17 P Groenewald *et al* 'Identifying deaths from AIDS in South Africa' (2005) 19 *AIDS* 193-201.
18 United Nations Department of Economic and Social Affairs (Populations Division) 'World Mortality Report 2005' (2006) http://www.un.org/esa/population/publications/Worldmortality/WMR 2005.pdf (accessed 10 September 2007) 364.
19 UNAIDS & WHO 'AIDS epidemic update' (2005) 22.
20 UNICEF 'State of the world's children 2007: Women and children, the double dividend of gender equality' (2007) 116.
21 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'South Africa Homepage' http://www.ohchr.org/english/countries/za/index.htm (accessed 20 January 2007). The dates between brackets in the first column are the dates of entry into force of the relevant treaties.

ICCPR Optional Protocol (23/03/1976)	28/08/2002
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	15/12/1995
CEDAW Optional Protocol (22/12/2000)	18/10/2005
Convention on the Rights of the Child (CRC) (02/09/1990)	16/06/1995

2.2 State reports[22]

South Africa submitted its initial report to the Committee on the Rights of the Child in December 1997. The report sets out statistics and measures taken by the government to address the HIV epidemic. The Committee on the Rights of the Child considered the report in January 2000. In its concluding observations the Committee made the following statement with respect to HIV and AIDS:[23]

> While the Committee notes that the State party has launched a Partnership Against HIV/AIDS Programme (1998) which aims, *inter alia*, to establish counselling and treatment centres for people living with HIV/AIDS and sexually transmitted diseases (STDs), it remains concerned about the high and increasing incidence of HIV/AIDS and STDs ... The Committee recommends the reinforcement of training programmes for youth on reproductive health, HIV/AIDS and STDs ... The Committee further recommends the full participation of youth in the development of strategies to respond to HIV/AIDS at the national, regional and local levels. Particular emphasis should be placed on changing public attitudes toward HIV/AIDS and identifying strategies to address the continued discrimination experienced by children and adolescents infected with HIV.

In its concluding observations on South Africa's report on the implementation of CEDAW, adopted in 1998, the CEDAW Committee did not discuss HIV or AIDS.[24]

22 For the state reports and concluding observations discussed below, see http://www.ohchr.org/english/countries/za/index.htm (accessed 20 January 2007).

23 CRC 'Concluding observations of the CRC: South Africa' (CRC/C/15/Add/122) (2000) para 31.

24 CEDAW 'Concluding observations of the Committee on the Elimination of Discrimination against Women: South Africa' (A/53/38/Rev 1) (1998) paras 100-137.

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[25]

Treaty (entered into force)	Ratification/ accession (deposit)
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	09/07/1996
African Charter on the Rights and Welfare of the Child (29/11/1999)	07/01/2000
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (25/11/2005)	17/12/2004
Treaty of the Southern African Development Community (SADC) (30/09/1993)	29/08/1994
SADC Protocol on Health (14/08/2004)	04/07/2000

3.2 State reports

South Africa submitted its initial report to the African Commission on Human and Peoples' Rights in 1998. The report details pending legislation, government policy, and partnership initiatives that concern the HIV epidemic. South Africa acknowledged the frightening scope of its HIV epidemic and summarised both the AIDS action plan for South Africa 1998-2000 and the Government plan to prevent HIV/ AIDS in South Africa.[26] The ACHPR considered the report in April 1999.[27] It favourably observed South Africa's commitment to addressing the epidemic and its national action plan for 1998-2000.[28] However, the Commission recommended that South Africa consider the impact of HIV on the economic and social rights of women and other vulnerable groups.[29]

25 Ratification status available at http://www.africa-union.org and at http://www.sadc.int (accessed 20 January 2007).
26 Government of South Africa 'Initial report on the African Charter on Human and People's Rights' http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/d2c94c67c4df8870802567ef0035d7c8?Opendocument 80-81.
27 ACHPR 'Consideration of initial report to the ACHPR' (1999) 2.
28 As above, 4.
29 As above, 5.

The number of references to HIV and AIDS increased with the first periodic state report submitted to the ACHPR in 2005.[30] South Africa committed itself to educating people about HIV,[31] while recognising that HIV is a social burden not easily dealt with.[32] The report briefly described the HIV/AIDS Strategic Plan. It incorporated provisions to reduce the number of new HIV infections (especially among youth) and to reduce the impact of HIV on individuals and families.

In its concluding observations on the report, the African Commission did not list HIV and AIDS under principal areas of concern. Instead it sought further information on law and policy relating to HIV and AIDS.[33]

3.3 Status of international and human rights treaties in domestic law

Section 231 of the Constitution regulates the signing, ratification and the transformation of treaties into domestic law:

> (1) The negotiating and signing of all international agreements is the responsibility of the national executive.
>
> (2) An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in sub-section (3).
>
> (3)An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time.
>
> (4) Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.
>
> (5) The Republic is bound by international agreements which were binding on the Republic when this Constitution took effect.

30 Government of South Africa 'First Periodic Report on the African Charter on Human and Peoples' Rights: 2001' (2001) http://www.chr.up.ac.za/hr_docs/countries/docs/Periodic%20report%20african%20charter%20final%20print.doc Though the report is dated 2001 it was not submitted to the ACHPR until May 2005 (accessed on 20 January 2007).

31 As above, 127.

32 As above, 135.

33 ACHPR 'Concluding observations and recommendations on the First Periodic Report of the Republic of South Africa, 38th ordinary session, 21 November – 5 December 2005' (2005) http://www.chr.up.ac.za/hr_docs/countries/docs/concluding%20observations%20-%20south%20african%20periodic%20report%20-%20update%20and%20%20adopted.doc.(accessed 20 January 2007).

Therefore, an Act of Parliament or other form of national legislation is necessary for a ratified treaty to be incorporated into domestic law, unless the treaty provisions are 'self-executing'. Three principal methods are employed by the legislature to transform treaties into domestic law: the provisions of a treaty may be embodied in the text of an Act of Parliament; the treaty may be included as a schedule to a statute; or an enabling Act of Parliament may give the executive power to bring a treaty into effect by means of proclamation or notice in the Government Gazette.

Each ministry is responsible for the ratification and implementation of international agreements within its sector. South Africa has implemented international agreements, either through dedicated legislation such as the legislation implementing the Hague Convention on Child Abduction, or through various pieces of legislation, which was the means used to implement the provisions of the International Covenant on Civil and Political Rights.[34]

3.4 International Guidelines

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted the International Guidelines on HIV/AIDS and Human Rights (the Guidelines). The Guidelines focus on three crucial areas: (1) improvement of governmental capacity for acknowledging the government's responsibility for multi-sectoral co-ordination and accountability; (2) widespread reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and (3) support for increased private sector and community participation in the response to HIV, including building the capacity and responsibility of civil society to respond ethically and effectively.[35]

In 1997, the South African Human Rights Commission (SAHRC) approved the International Guidelines and called on the government to implement them.

The most recent state report prepared by South Africa dealing with HIV is the 2006 UNGASS Progress Report.[36] The Report provides an overview of the HIV and AIDS situation in South Africa, discusses South Africa's Comprehensive HIV and AIDS Strategy, and discusses the National Commitment and Action Indicators.

The report does not outline any recommendations. It does, however, discuss the challenges that the country is currently facing

34 Interview with S Maqungo, Principal State Law Advisor, 5 September 2002.
35 OHCHR & UNAIDS 'HIV/AIDS and Human Rights International Guidelines' (1996), foreword.
36 Government of South Africa (n 9 above).

and notes that the most pressing challenges, such as the shortage of health personnel in the public health sector, are related to health systems.

The report generated a significant amount of controversy. First, contrary to UNGASS policy, the report is believed to have been submitted without any input from non-governmental organisations. Moreover, some critics claim that the information reported by the DoH leaves one with the false impression that HIV is under control in South Africa.

Accordingly, the Treatment Action Campaign (TAC) decided to submit an earlier report prepared for the African Peer Review Mechanism to UNGASS in order to present a more balanced perspective of the government's response to HIV. Second, in March 2006, the TAC and the AIDS Law Project (ALP) learned that they had been excluded from accreditation by the United Nations General Assembly Special Session on AIDS. UNAIDS had originally placed them on the list but member countries have a chance to review the list of organisations. It has been suggested that South Africa objected to both the TAC and ALP.[37]

4. National legal system of country

4.1 Form of government

South Africa's constitutional order is more than ten years old. The apartheid system officially came to an end on 27 April 1994, the day of the first democratic election in South Africa. The basic principles and features underlying the new constitutional order are constitutionalism, rule of law, democratic accountability, separation of powers with checks and balances, co-operative government and devolution of power.[38]

In terms of the new constitutional order, South Africa has a clear separation of powers between the legislature (Parliament), the judiciary and the executive (Cabinet). The new South African system is comprised of three spheres of government: national, provincial and local. Each sphere has powers and functions as delineated in the Constitution. All spheres are distinct, yet interdependent on the others.

37 See Treatment Action Campaign 'TAC and ALP excluded from UNGASS' *TAC Electronic Newsletter* 30 March 2006 http://www.tac.org.za/newsletter/2006/ns30_03_2006.html#UNGASS (accessed 1 August 2006).

38 I Currie & J De Waal *The bill of rights handbook* (2005) 7.

4.2 Legal system

The South African legal system is a mixture of Roman Dutch Law and English common law with the new constitutional dispensation. The Constitution is the supreme law of South Africa. The Constitutional Court is the court of final instance in all matters relating to the interpretation, protection and enforcement of the provisions of the Constitution. Some matters fall exclusively within the jurisdiction of the Constitutional Court whilst others will normally first be heard by the High Court. The highest court for non-constitutional matters is the Supreme Court of Appeal. The superior courts are called High Courts and lower courts are the Magistrate's Courts. Other courts include the small claims courts and certain specialised courts such as the Labour Courts.[39]

4.3 Constitution and Bill of Rights

The Interim Constitution[40] came into force on 27 April 1994. The Interim Constitution brought about three fundamental changes in South Africa. Firstly, it brought an end to the racially qualified constitutional order that had accompanied 300 years of colonialism, segregation and apartheid. Secondly, the doctrine of parliamentary sovereignty was replaced by the doctrine of constitutional supremacy and a Bill of Rights was incorporated to safeguard human rights. Thirdly, the strong central government of the past was replaced by a system of government with federal elements.[41] One of the Interim Constitution's principal purposes was to set out the procedures for the negotiation and drafting of a 'final' Constitution. The final Constitution of the Republic of South Africa,[42] entered into law on 4 February 1997.

The human rights norms enshrined in the Constitution are justiciable. The Bill of Rights guarantees both civil and political rights as well as economic, social and cultural rights. Numerous provisions in the Bill of Rights impact directly and indirectly on HIV and AIDS. These include:

- section 9: Equality;
- section 10: Human dignity;

39 Labour Relations Act 66 of 1995 ch VII sec 151 establishes a Labour Court with concurrent jurisdiction to the Supreme Court. The jurisdiction and powers of the Labour Court are set out in secs 157 and 158 of the Labour Relations Act. Sec 167 establishes a Labour Appeal Court, which is the final court of appeal for all judgments and orders made by the Labour Court in respect of the matters within its exclusive jurisdiction.

40 Interim Constitution Act 200 of 1993.

41 Currie & De Waal (n 38 above) 2.

42 Constitution of Republic of South Africa Act 108 of 1996.

- section 11: Life;
- section 12: Freedom and security of the person;
- section 14: Privacy;
- section 23: Labour practices;
- section 24: Environment;
- section 25: Property;
- section 26: Housing;
- section 27: Health care, food, water and social security;
- section 28: Children;
- section 29: Education;
- section 31: Cultural, religious and linguistic communities;
- section 33: Just administration action;
- section 35: Arrested, detained and accused persons; and
- section 36: Limitation of rights.[43]

4.4 National human rights institutions

South Africa's national human rights institution is the South African Human Rights Commission (SAHRC). Chapter 9 of the Constitution confirms that SAHRC is established, along with several other organisations, to strengthen constitutional democracy in South Africa.

The SAHRC's mandate is wide and it has taken on numerous HIV-related issues.[44] A 2003 report on hospitals in the Eastern Cape, for example, reported that 'hospital after hospital complained about the lack of anti-retroviral drugs for general use by HIV/AIDS patients'.[45] Its socio-economic rights reports each contain a section dealing with health that addresses HIV.[46] Recently, SAHRC has taken the South African National Blood Service to task with respect to their ban on gay men donating blood. SAHRC insists that restrictions ought to be based upon epidemiological data or research in the topic.[47]

43 As above.

44 Human Rights Watch 'South Africa: Government Human Rights Commissions in Africa' (2001), http://hrw.org/reports/2001/africa/southafrica/southafrica.html (accessed 1 August 2006).

45 SAHRC 'Report – site visits and investigation – Eastern Cape hospitals' (2003), http://www.sahrc.org.za/eastern_cape_hospitals_report.PDF (accessed 1 August 2006) 30.

46 See, eg, SAHRC 'The right to health' *5th economic and social rights report 2002-2003* (2004) http://www.sahrc.org.za/5th_esr_health.pdf (accessed 1 August 2006) 39.

47 See 'SAHRC: Gay men should be allowed to donate blood' *Mail & Guardian* 20 January 2006, http://www.mg.co.za/articlePage.aspx?articleid=261914&area=/breaking_news/breaking_news__national/ (accessed 1 August 2006).

The SAHRC Annual Report also makes note of the SAHRC's interventions, including HIV interventions, as part of the indicators used to review its own annual performance.[48]

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

At the political (cabinet) level, responsibility for dealing with ongoing HIV and AIDS-related matters has been deferred to an Inter-Ministerial Committee on AIDS (IMC) composed of eight Ministries.

The South African National AIDS Council (SANAC) is the highest body that advises government on all matters relating to HIV and AIDS. It was established in 2000 to mainstream a multi-sectoral approach to the HIV epidemic in South Africa.[49] Its major functions include: advising government on HIV/AIDS/STD policy; mobilising resources for the implementation of AIDS programmes; monitoring the implementation of the Strategic Plan in all sectors of society; advocating for the effective involvement of sectors and organisations in implementing programmes and strategies; and recommending appropriate research.[50] SANAC is assisted by Provincial AIDS Councils in the implementation and definition of AIDS programmes at district, municipality and community levels.

The Deputy President chairs the SANAC. The body is essentially composed of an Executive Committee with 9 members[51] mandated to deal with urgent matters and to oversee the implementation of AIDS programmes; a plenary body of 33 members representing different governmental departments and members of civil society; and 5 technical task teams.[52] It was initially envisaged that SANAC meet on

48 SAHRC 'South African Human Rights Commission annual report 2004-2005' (2005) http://www.sahrc.org.za/sahrc_cms/publish/cat_index_47.shtml (accessed 1 August 2006) 13.

49 Government of South Africa 'South African National AIDS Council (SANAC)' (2006) http://www.info.gov.za/issues/hiv/sanac.htm (accessed 1 August 2006).

50 Government of South Africa HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (2000) 12 http://www.info.gov.za/otherdocs/2000/aidsplan2000.pdf (accessed 1 August 2006).

51 Five Cabinet Ministers, a member of NAPWA, a representative from the women's sector of the civil society, a representative from the hospital sector, and a representative from COSATU.

52 The technical tasks teams are composed of experts in prevention; care and support; information, education, communication and social mobilisation; research, monitoring, surveillance and evaluation; and legal issues and human rights.

a monthly basis; however, in 2002, members agreed that meetings will be held quarterly.[53] Since its inception in 2000, the meetings of SANAC have been scarce and highly irregular,[54] thus hindering the effective fulfilment of the body's mandate as issues to be addressed pile up. Furthermore, the members of SANAC are not full-time paid staff; participation in SANAC is on a voluntary basis. This is believed to affect the commitment of members to their obligations with SANAC. Finally, the high number of government representatives and the prominent role of the DoH have interfered with the transparent operation of SANAC. According to Strode and Grant,[55]

> [t]he current structure has allowed the DoH to dominate SANAC. The (SANAC's) Secretariat was placed within the DoH and they effectively set the agenda for all meetings; this meant that other sectors (namely members of the civil society) were not given an equal opportunity to place issues on the SANAC agenda.

Strode and Grant add that 'SANAC is not accountable to anyone; it does not report to any structure and its minutes and proceedings are kept confidential'.[56]

According to the HIV & AIDS & STI Strategic Plan for South Africa 2007-2011, SANAC will be changed. The newly strengthened SANAC will operate at three levels through

- a high level council, meeting twice per annum, chaired by the Deputy President;
- sector level co-ordination — with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring, and reporting to SANAC; and
- programme level organisation — led by the social cluster of government.[57]

In addition, SANAC will be allotted with a Monitoring and Evaluation Unit.[58]

5.2 HIV and AIDS plan

The HIV & AIDS & STI Strategic Plan for South Africa 2007-2011 (NSP) represents the country's multisectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS. It follows the HIV/AIDS/STI Strategic Plan for South Africa 2000-2005 (2000), and is

53 A Strode & K Barrett Grant *Understanding the institutional dynamics of South Africa's response to the HIV/AIDS pandemic* (2004) 14.
54 For instance, Strode & Grant above. Note that in 2002 SANAC met only three times.
55 n 53 above, 23.
56 As above.
57 HIV & AIDS & STI Strategic Plan for South Africa 2007-2011 (2007) 9. The NSP was adopted on 2 May 2007.
58 n 57 above, 132.

inspired by various other documents, such as the National Operational Plan for Comprehensive HIV and AIDS management, treatment, care and support (2003), the 1997 Annual HIV/AIDS/STD Review, the DoH's White Paper for the transformation of the health system and the 1994 National AIDS Plan for South Africa. The Strategic Plan is based on an Integration of STD/HIV/AIDS and TB Care and Responses. It centres the response to the HIV epidemic on strategies of prevention, management and care.

5.3 Legislation

The following pieces of legislation regulate issues related to HIV and AIDS in South Africa:

- Schedule 6 (a)(iv) of the Criminal Procedure Second Amendment Act 85 of 1997 makes the granting of bail more difficult in instances where the suspected rapist is known to be HIV positive.
- The Medicines and Related Substances Control Amendment Act 90 of 1997 addresses the use of generic medicines.
- The Criminal Law Amendment Act 105 of 1997 provides for harsher sentencing of HIV-positive rapists.
- Sections 6, 7(1) and (2) and 50(4) of the Employment Equity Act 55 of 1998 deal specifically with HIV and AIDS in employment.
- Sections 34(1) and (2) of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 make direct reference to HIV and AIDS.

5.4 HIV and AIDS policy

The following policy documents, though not legally binding, have been adopted to regulate different issues related to HIV and AIDS:

- Charter of Rights on AIDS and HIV, 1992 (non-binding);
- Social Welfare action Plan on HIV/AIDS, 1997;
- National Patient's Rights Charter (non-binding), 1999;
- Management of Occupational Exposure to the Human Immuno-deciency Virus (HIV), DoH, 1999;
- National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions, 1999;
- Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research, 2000;
- Guidelines on Voluntary Counselling and Rapid HIV Testing, 2000;
- HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005;
- Life Office's Association Protocol on HIV Testing, 2000;
- Recommendations for Managing HIV Infection in Children, 2000

- Department of Defence Policy, The Management of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), 2001;
- The South African Medical Association Human Rights and Ethical Guidelines on HIV: A Manual for Medical Practitioners, 2001;
- Guidelines for Good Clinical Practice in the Conduct of Trials in Human Participants in South Africa, DoH, 2001;
- Management Strategy: HIV/AIDS in Prisons, 2002;
- National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, 2002;
- Guidelines on the Adequate Treatment of Opportunistic Infections, 2002;
- Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, 2003;
- Guidelines on Ethics for Medical Research: HIV/AIDS Preventive Vaccine Trials drafted by the South African Medical Research Council in May 2002;
- Policy Guidelines for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs) in Sexual Assault, DoH (undated);
- Policy Guidelines and Recommendations for Feeding of Infants of HIV-Positive Mothers, DoH;
- Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive-Pregnant Women, DoH (undated);
- Recommendations for the Prevention and Treatment of Opportunistic Infections and HIV-related Diseases in Adults; and
- HIV & AIDS & STI Strategic Plan for South Africa 2007-2011 (2007).

5.5 Court decisions

The following court decisions related to HIV or AIDS have been handed down in South Africa:

The Constitutional Court of South Africa:

- *S v Jordan and Others*[59]

For a detailed discussion, see part 10.5 below.

- *Hoffmann v South African Airways*[60]

Before the enactment of the Employment Equity Act, the Constitutional Court decided in this case that the denial of employment to a prospective employee for reasons of his HIV status

[59] *S v Jordan and Others* 2001 10 BCLR 1055 (T).
[60] *Hoffmann v South African Airways* 2001 1 SA 1 (CC).

constituted unfair discrimination and violated the right to fair labour practices guaranteed in the Constitution.[61]

- *Minister of Health and others v Treatment Action Campaign and others*[62]

For detailed discussion, see part 6.5 below.

- *Mnguni v Minister of Correctional Services and Others*[63]

A prisoner serving a prison term of 15 years, without the benefit of legal assistance, sought an order for his medical parole to be reconsidered when he had been diagnosed HIV positive in 1998 while in prison. In 2004 he was informed that his CD4 blood count had dropped below a critical level, below which his immune system was severely compromised. The applicant in the case sought direct access to the Constitutional Court after he was refused medical parole. However, the application for direct access was dismissed because the applicant did not demonstrate exceptional circumstances justifying direct access. The Constitutional Court agreed that the case raised important issues and limited the grounds for its dismissal to the applicant's failure properly to demonstrate exceptional circumstances.

- *E N and Others v Government of RSA and Others*[64]

For detailed discussion, see part 14 below.

The Supreme Court of Appeal:

- *C v Minister of Correctional Services*[65] and *W and Others v Minister of Correctional Services and Others*[66]

The Supreme Court ruled in favour of the applicants 'C' and 'W', specifying that pre-test counselling is compulsory in order to obtain informed consent for HIV testing.

- *Chauke v S*[67]

The case involved an individual convicted of culpable homicide, rape and assault with intent to do grievous bodily harm. The Supreme Court considered the extent to which the HIV-positive status of the accused

61 Pre-employment HIV testing is illegal in South Africa according to sec 7(2) of the Employment Equity Act 55 of 1998, unless such testing is justifiable by the Labour Court in terms of sec 50(4) of the Act. The Employment Equity Act, like the Labour Relations Act, covers everyone, including job applicants, except for members of the South African National Defence Force, the National Intelligence Agency, and the Secret Services.

62 *Minister of Health and Others v Treatment Action Campaign and Others* 2002 5 SA 721 (CC).

63 *Mnguni v Minister of Correctional Services and Others* 2005 12 BCLR 1187 (CC).

64 *E N and Others v Government of RSA and Others* 2007 1 BCLR 84 (D).

65 *C v Minister of Correctional Services* 1996 4 SA 292 (T).

66 *W and Others v Minister of Correctional Services and Others* CPD Supreme Court case number 2434/96 unreported.

67 *Chauke v S* 1997 JOL 1270 (T).

should be a factor in sentencing. Considering the general principle that a convicted person's health or life expectancy may, depending on the circumstances, afford a good reason for not sentencing him to imprisonment, although not automatically relieving him from being imprisoned, the Court held that the burdensome conditions to which he is subjected to in prison require some diminution of sentence.

- *Jansen van Vuuren and Another NNO v Kruger*[68]

The applicant's doctor disclosed the applicant's HIV status, without prior authorisation from the applicant, to two other doctors whilst playing a game of golf. The Appellate Division ruled in favour of the applicant's right to confidentiality and stated that the 'public interest' did not warrant the disclosure.

- *Memory Mushando Magida v The State*[69]

The appellant was convicted on 99 counts of fraud and was convicted to a cumulative total sentence of 16 years and three months' imprisonment. The unsuspended term of imprisonment amounted to five years, five months and two days. The Supreme Court found that appellant's HIV status entitled her to a lesser sentence because the treatment her doctor prescribed to her was not available in prison. The court decided that the appellant should be sentenced to imprisonment for a period of two years, three months and 25 days.

The High Court of South Africa:

- *Applicant v Administrator, Transvaal and Others*[70]

In this case, a provincial hospital promised to treat the applicant with expensive medication (Gancyclovir) and even inserted a catheter into the applicant for this purpose. The hospital then rescinded its decision, stating that the drug was too expensive and that it did not want to set a precedent. The Court ordered the administration of the medicine but stressed the need to examine the specifics of each case. This decision did not mean that all AIDS patients were entitled to the medication.

- *Costa Gazidis v The Minister of Public Services and Administration; the Director-General: Provincial Administration, Eastern Cape Province and Magistrate Maqubela*[71]

In April 1999, Dr Gazidis, in his capacity as a medical doctor and secretary for health of the Pan African Congress, made a public statement criticising the Minister of Health for refusing to make antizidovudine (AZT) available to pregnant women living with HIV in South Africa. In December 1999, a disciplinary enquiry was instituted

68 *Jansen van Vuuren and Another NNO v Kruger* 1993 4 SA 842 (A).
69 *Memory Mushando Magida v The State* Supreme Court case number 515/04 unreported.
70 *Applicant v Administrator, Transvaal and Others* 1993 4 SA 733 (T).
71 The decision of the Magistrate Court is referred to as 25510/01.

against the applicant in terms of the Public Service Act (Proclamation 103 of 1993). He was then found guilty of misconduct. On appeal, the Transvaal Provincial Division of the High Court decided that there was no evidence upon which the third respondent could have convicted the appellant of the charge of having caused prejudice to the department. The result of this judgment is that in future it will be much more difficult for the Department of Public Administration to discipline public servants for speaking out and exercising their rights to freedom of speech on controversial government policies.

- *NM and Others v Smith and Others (Freedom of Expression Institute as Amicus Curiae)*[72]

Three women instituted legal action against the defendants after they had published their full names and HIV status without their consent in the biography of De Lille, written by Smith and published by New Books Africa. The High Court found that only the book's publisher had violated the right to privacy of applicants. However, the Constitutional Court held that all respondents had been aware that the applicants had not given consent to the publication of their names. Therefore, the Constitutional Court found that all respondents had violated the rights to privacy and dignity of the applicants and ordered them to pay to each applicant the sum of R35 000 and that the names of the applicants were to be removed from all unsold copies of the book.

- *Perreira v Buccleuch Montessori Nursery*[73]

Karen Perreira applied to enrol her foster daughter, Tholakele, at the Buccleuch Montessori Nursery School in January 2001. At the time she made the application, she informed the principal of Tholakele's HIV-positive status. The school indicated that they wished to defer the enrolment until the child was three years old and 'past the biting stage'. The Court found that the school had not taken a decision to exclude Tholakele, but had simply 'deferred' her enrolment. The Court dismissed the application with costs.

- *S v Cloete*[74]

In this case, a prisoner was granted early release due to his HIV condition. The Judge ruled that 'his condition is such and has changed so that to continue to serve imprisonment would be far harsher a sentence for him than for any other person serving a similar sentence'.[75]

72 *NM and Others v Smith and Others (Freedom of Expression Institute as Amicus Curiae)* 2007 7 BCLR 751 (CC).
73 *Perreira v Buccleuch Montessori Nursery* Johannesburg High Court case number 4377/02 unreported.
74 *S v Cloete* 1995 1 SACR 367 (W).
75 As above, para F.

- *S v Nyalungu*[76]

The accused was convicted of rape and attempted murder. He had raped the complainant while aware that he was HIV positive. This offence attracted the prescribed minimum sentence of life imprisonment. The High Court decided that the nature of the offences was such that there were no substantial and compelling circumstances warranting a sentence less than life imprisonment.

- *Van Biljon & Others v Minister of Correctional Services*[77]

Four HIV-infected prisoners applied for a declaratory order that their right to adequate medical treatment entitled them to anti-retroviral drugs (which they had received initially, but which were discontinued by the Department of Correctional Services). The Minister argued that the state was obliged only to provide the applicants with the same standard of care as was provided in state hospitals, where the use of the drugs was limited; and, the applicants would not have qualified for ARVs under the policy in place. The Court granted the order, that in determining what constitutes 'adequate medical treatment', it is necessary to examine what the state can afford to provide.[78] In this case, the Court found that the applicants should receive the treatment, but this does not entitle all prisoners with HIV to receive ARVs. A prisoner's right to medical treatment requires an examination of the circumstances of the particular case.

- *Venter v Nel*[79]

The Court granted the plaintiff damages on the grounds that the defendant had infected her with HIV during sexual intercourse. Damages awarded took into account both future medical expenses as well as the possibility of a reduction in life expectancy, psychological stress, and pain and suffering.

- *VRM v The Health Professions Council of South Africa and Others*[80]

The applicant alleged that her doctor had conducted a HIV test without her informed consent and without providing pre- and post-test counselling. The applicant further alleged that her doctor did not disclose her HIV status to her and that he did not advise her on measures to take to reduce the risk of MTCT during birth. The Judge dismissed the case with costs upon finding that a proper case was not made out for the relief sought.

The Labour Court of South Africa:

76 *S v Nyalungu* 2005 JOL 13254 (T).
77 *Van Biljon & Others v Minister of Correctional Services* 1997 4 SA 441 (C).
78 For various reasons, only two of the four applicants in this case were considered by the Court. These two applicants were entitled to ARVs at state expense.
79 *Venter v Nel* 1997 4 SA 1014 (D).
80 *VRM v The Health Professions Council of South Africa and Others* 2003 JOL 11944 (T).

- *Joy Mining Machinery Division of Harnischfeger SA Pty Ltd v National Union of Metal Workers of South Africa*[81]

The Labour Court ruled that anonymous voluntary HIV testing of employees in terms of Section 7(2) of the Employment Equity Act 55 of 1998 is legal. The Court enumerated 11 grounds that must be taken into account when performing voluntary HIV tests, such as: (1) that the test to be used is the ELISA Saliva Test; (2) that at no time will the participating employee be asked his/her name, nor will such information be recorded on the sample; (3) that the employer make it clear that it does not intend to discriminate against HIV-positive employees.

- *A v SAA*[82]

The applicant was refused employment with South African Airways after testing HIV positive in a pre-employment test. The Court held that excluding 'A' from the position of cabin attendant on the grounds of his HIV status was unjustified and awarded him compensation.

The CCMA (Commission for Conciliation, Mediation and Arbitration):

- *Nasuwu obo Zulu v Chen*[83]

The applicant, employed by the respondent as a child-minder, was dismissed after she refused to comply with the respondent's demand to undergo an HIV test. The Commissioner held that employees are not obliged to take HIV tests and that the applicant's refusal to do so was lawful. The applicant's dismissal was therefore automatically unfair.

- *Zungu v ET Security Services*[84]

The applicant alleged that his dismissal was unfair and that, even though he had full-blown AIDS, he was still capable of performing his duties as a security guard. The CCMA found to the contrary and stated that the applicant was lawfully dismissed, that the severity of the opportunistic infection he suffered from made it impossible for him to perform his duties, and that the respondent acted in good faith.

Unreported cases:

- *PW v Minister of Correctional Services* (1994)

For a detailed discussion, see part 14 below.

- *Booysen v Correctional Services* (2000)

A prisoner took the Department of Correctional Services (DCS) to Court for not allowing him visitation rights with his gay partner who

81 *Joy Mining Machinery Division of Harnischfeger SA Pty Ltd v National Union of Metal Workers of South Africa* 2002 23 ILJ 391 (LC).
82 *A v SAA* J1916/99.
83 *Nasuwu obo Zulu v Chen* 2002 5 BALR 511 (CCMA).
84 *Zungu v ET Security Services* CCMA case number KN50648 unreported.

was dying of AIDS. The case was eventually settled out of Court and the DCS allowed the visitation.

6. Access to health care

6.1 Government regulation of access to health care

In November 2003, Cabinet approved the DoH's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (Operational Plan)[85] and began implementation in April 2004. The Operational Plan resulted from recommendations of the report of the Joint Health and Treasury Task Team that was mandated by the Cabinet to examine the treatment options to supplement comprehensive care for HIV and AIDS in the public sector. In terms of managing the HIV epidemic in South Africa, the Strategic Priorities for the National Health System 2004-2009 emphasises the implementation of the operational plan, which includes the safe provision of anti-retrovirals to patients who qualify for enrolment in the programme.

The main objectives of the operational plan are to provide comprehensive care and treatment for people living with HIV and to strengthen the national health system in order, among other reasons, to scale up anti-retroviral treatment in South Africa. It focuses on three main objectives: to strengthen prevention strategies to reduce the number of infections; to enhance efforts to prevent and treat opportunistic infections while improving nutrition and lifestyle choices; and to provide appropriate treatment of AIDS-related conditions, including the possibility of using anti-retroviral therapy in patients with low CD4 counts and suitable palliative and terminal care when treatment has run its course.

The Constitution states in section 27(1)(a) that '[e]veryone has the right to have access to health care services, including reproductive health care'. According to section 27(2) '[t]he state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of these rights'. Section 27(3) states that no one can be denied emergency medical treatment. Section 28(1)(c) provides for 'basic health care services' for children, while section 35(2)(e) provides for 'adequate medical treatment' for detainees and prisoners at the state's expense.

85 DoH 'Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa' http://www.info.gov.za/otherdocs/2003/aidsplan.pdf (accessed 1 August 2006).

The National Health Act[86] was enacted in 2004. It seeks to 'protect, respect, promote and fulfil the rights of the people of South Africa to the progressive realisation of the constitutional right to access to health care services, including reproductive health care.' It does so by regulating national health services, private and public, across the country. The Charter of the Public and Private Health Sectors of the Republic of South Africa of 2004[87] is an agreement between the government and private health care providers to ensure that the standards set in the National Health Act and the provisions of the Patients' Rights Charter are adhered to by private care providers.

The National Health Act is intended to create a national health system that is patient-oriented. Chapter II of the Act lists the rights of patients who use health care services. Although not specifically directed at patients living with HIV, chapter II of the National Health Act must be read in line with the protection of equality guaranteed by section 9 of the Constitution. These rights include:

- the right not to be refused emergency medical treatment;
- the right to be informed of one's own health status except in circumstances where there is substantial evidence that the disclosure of the health status would be contrary to one's best interest;
- the right to be informed 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 refuse health services and to be informed of the implications and risks of such refusal;
- the right to participate in any decision affecting the one's own personal health and treatment;
- the right not to be subjected to any health service without informed consent, except in exceptional cases where the patient cannot give consent or where failure to treat the patient might result in a serious risk for public health;
- the right to confidentiality and privacy over medical information;
- the right to be referred to another health care professional or to a health care facility that can provide the required service if a health service is not available; and
- the right to lay a complaint about the manner in which one was treated at a health establishment and to have that complaint investigated.

86 National Health Act 61 of 2003.
87 DoH Charter of the Public and Private Health Sectors of the Republic of South Africa (2004) http://www.doh.gov.za/docs/misc/healthcharter.pdf (accessed 1 August 2006).

The DoH's 1999 National Patients' Rights Charter,[88] although not legally binding, also declares that everyone has the right of access to health care services. The introduction to the Charter proclaims that

> [t]o ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa, the DoH is committed to upholding, promoting and protecting this right and therefore proclaims this Patients' Rights Charter as a common standard for achieving the realisation of this right.

The Charter enumerates rights and responsibilities of patients which should be observed and implemented. The Charter grants patients a right to each of the following:

- timely emergency care at any health care facility that is open regardless of one's ability to pay;
- treatment and rehabilitation that must be explained to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain and persons living with HIV or AIDS;
- counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV and AIDS;
- palliative care that is affordable and effective in cases of incurable or terminal illness;
- a positive disposition displayed by health-care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance; and
- health information that includes the availability of health services and how best to use such services' and that is provided 'in the language understood by the patient.[89]

The Health Professions Act[90] also provides for the right of patients to seek a second opinion from another doctor or to be treated by another doctor.

6.2 Ethical guidelines

The South African Medical and Dental Council (SAMDC) first published Guidelines on the Management of Patients with HIV Infection or AIDS in 1994. The Health Professions Council of South Africa (HPCSA) has since replaced SAMDC, and in 2002 the HPCSA introduced new guidelines.

88 DoH National Patients' Rights Charter (1999).
89 As above.
90 Health Professions Act 56 of 1974.

The Health Professionals Council of South Africa 'Guidelines for the Management of Patients with HIV Infection or AIDS' (HPCSA guidelines)[91] were adopted in 2002 as moral and ethical principles to guide the activities of the medical profession. The HPCSA guidelines declare that no health care worker may ethically refuse to treat a patient solely on the ground that a patient is, or may be, HIV positive. Equally, no doctor may withhold normal standards of treatment from any patient solely on the ground that the patient is HIV positive, unless such variation of treatment is determined to be in the patient's interest.

The HPCSA guidelines are not legally binding. However, the HPCSA is a self-regulating body which has an internal complaint mechanism whereby one can lodge a complaint when the guidelines have been violated by registered health care professionals. A Committee of Preliminary Enquiry is responsible for investigating any complaint that, if founded, may lead to the suspension of the practitioner involved or the payment of a fine. In *VRM v Health Professionals Council of South Africa and Others*,[92] the Pretoria High Court found that the Committee of Preliminary Enquiry of the HPCSA is not entitled to adjudicate on complaints that raise disputes of fact, particularly because of the weight the Committee is likely to place on the version of the doctors in responding to complaints. The Court further found that the complaint under consideration in the case should have received more attention and that an enquiry should have been held. The decision of the Pretoria High Court is of importance for the rights of patients living with HIV, and for patients in general, because it ensures that complaint mechanisms against medical professionals are less biased in favour of health care providers.

The South African Medical Association (SAMA), a voluntary body for doctors and other health care workers, also has its own set of guidelines. The SAMA's Human Rights and Ethical Guidelines on HIV: a Manual for Medical Practitioners of November 2001[93] gives guidance to medical practitioners on the need to harmonise the rights and interests of patients with those of other individuals, but puts emphasis on the principle of confidentiality.

91 HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS (2002).

92 See n 79 above 11944. The case involved a pregnant woman who was tested for HIV without her consent or pre- or post-test counselling. She was informed of her HIV positive status only after the birth of her stillborn baby, and no available medical options were explained to her. She filed a complaint with the HPCSA, but the latter declined to convene a disciplinary hearing and accepted the version of the doctor who said had acted 'out of compassion'.

93 SAMA 'Human Rights and Ethical Guidelines on HIV: a Manual for Medical Practitioners' (2001) http://www.samedical.org/page.asp?pageid=19 (accessed 1 August 2006).

6.3 Medicines

On 17 April 2002, the South African Cabinet issued a statement emphasising government's commitment to treat and manage opportunistic infections and urging the public to help the government monitor availability of drugs dealing with HIV-related infections such as meningitis, oral thrush, tuberculosis and pneumonia.[94]

In the same year, the DoH issued the Guidelines on the Adequate Treatment of Opportunistic Infections[95] and started training health care providers in the implementation of these guidelines. In March 2006, a Member of the Executive Council (MEC) for Health in Gauteng signed an agreement with SAMA to improve the availability of doctors at sites providing the comprehensive HIV and AIDS prevention, care and management programme, including anti-retroviral therapy, in Gauteng. The challenges, according to the DoH, remain the insufficient number of health care providers skilled in early diagnosis and clinical management of HIV-related conditions and in ensuring a sustainable supply of drugs.[96]

According to the government, common opportunistic infections occurring in people who are HIV positive can be managed in public health facilities. The drugs necessary for the treatment of these infections are on the Essential Drugs List and are available in the public sector.[97] According to the WHO, essential drugs are those that satisfy the health needs of the majority of the population and that should therefore be available at all times in adequate amounts and in the appropriate dosage form.[98] The National Drug Policy for South Africa[99] was published in 1996 with the goal of ensuring an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa, and the rational use of drugs by prescribers, dispensers and consumers. The National Drug Policy aims to promote the availability of safe and effective drugs at the lowest possible cost by monitoring and negotiating drug prices, by

94 Government of South Africa 'Cabinet statement on HIV/AIDS' 17 April 2002 http://www.gov.za/speeches/cabinetaids02.htm (accessed 1 August 2006). The Statement was followed on 9 October 2002 by the 'Statement on the fourth anniversary of the partnership against AIDS' http://www.info.gov.za/speeches/2002/02101009461001.htm (accessed 1 August 2006).

95 See DoH 'The South African government's response to the HIV/AIDS epidemic: Controversies and priorities' http://www.doh.gov.za/aids/docs/gov-aids.html (accessed 1 August 2006).

96 DoH (Monitoring and Evaluation Unit) 'Monitoring Review: Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa' issue 1 (2004) http://www.doh.gov.za/docs/hivaids-progressrep.html (accessed 17 April 2006).

97 Government of South Africa (n 94 above).

98 WHO 'Essential Drugs and Medicines Policy' http://www.who.int/countries/eth/areas/medicines/en/index.html (accessed 1 August 2006).

99 DoH National Drug Policy for South Africa (1996) http://www.doh.gov.za/docs/policy/drugsjan1996.pdf (accessed 1 August 2006).

rationalising the drug pricing system in the public and private sectors, and by promoting the use of generic drugs.[100]

The treatment component of the Operational Plan is supplemented by the National Anti-retroviral Treatment Guidelines of 2004 (ART Guidelines),[101] which are used to assess the eligibility of HIV-positive people for ARVs and to manage their treatment if they are found to be eligible.[102] As part of the Operational Plan, ART was made available in accredited public health facilities from the first quarter of 2004.[103] The Operational Plan contains key strategies to improve care and to provide treatment for those infected with and affected by HIV and AIDS. These strategies include:

- expanding the number of home and community based care service points, including hospices;[104]
- training community carers and health providers and providing home-based care kits to community carers;
- improving nutrition and lifestyle choices;
- monitoring and assessing patients on ARVs.
- integrating traditional and complementary medicine into the comprehensive care, management and treatment programme;
- providing a comprehensive continuum of care, support and treatment;
- providing appropriate treatment of AIDS-related conditions to those HIV-infected individuals who have developed opportunistic infections; and
- providing anti-retroviral therapy to patients with low CD4 counts to improve functional health status and to prolong life.

The Operational Plan is founded upon the principle of universal access to care, management and treatment for all, irrespective of race, colour, gender, economic status or sexual and social behaviour deemed 'immoral'. There exists no government policy aimed at withholding or denying access to HIV-related prevention or treatment to people living with HIV. However, the implementation of the

[100] Sec 4(2) of the National Drug Policy refers specifically to the use of generic drugs and states that amongst other goals, the availability of generic, essential drugs will be encouraged through the implementation of incentives that favour the use and production of generic drugs in the country. In October 2003, the Competition Commission found various drug companies that supply ARVs to be in contravention of the Competitions Act.

[101] DoH National Anti-retroviral Treatment Guideline (2004) http://www.doh.gov.za/docs/factsheets/guidelines/artguide04-f.html (accessed 1 August 2006).

[102] The medical criteria are CD4 count <200 cells/mm ^{3} irrespective of WHO stage III or WHO stage IV.

[103] Government of South Africa (n 9 above) 7.

[104] According to the DoH, the number of home and community based care programmes has increased from 466 in 2001-2002 to 892 in 2003-2004 with over 50 000 beneficiaries. See DoH 'Strategic priorities for the national health system 2004-2009' (2004) http://www.doh.gov.za/docs/policy/stratpriorities.pdf (accessed 1 August 2006).

Operational Plan is slow in some provinces, largely because of human resource shortages. In addition, the HIV & AIDS & STI Strategic Plan for South Africa 2007-2011 outlines a multisectoral response to the epidemic.

The government of South Africa is party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement).[105] In 1997, Parliament passed the Medicines and Related Substances Control Amendment Act.[106] The purpose of the legislation was to facilitate access to cheaper medications in both the public and private health sectors of the country. These measures enabled parallel importation of patented medications, drug price control (with a transparent pricing system overseen by a Price Committee), mandatory generic substitution of off-patented medicines, exclusion of pharmaceutical industry employees from the Medicines Control Council, and international tendering for state medicine purchase contracts. Section 10 of the Act allows the Minister of Health legally to use parallel importing in the public interest whilst section 22F lists measures to regulate generic substitution of medicines.

In February 1998, the Pharmaceutical Manufacturer's Association (PMA), the umbrella body in South Africa for the multinational brand-name pharmaceutical industry, attempted to prevent the South African government from implementing these measures, essentially on the basis of the fact that parallel importation is in violation of the TRIPS Agreement.[107] While implementation of the contested 1997 Amendment Act was blocked pending the lawsuit launched by pharmaceutical companies, the Minister of Health introduced the South African Medicines and Medical Devices Regulatory Authority Bill, which became law in April 1999. The new Act retained all the main contested provisions embodied in the 1997 Amendment Act. Its precipitated adoption was challenged in court. The Transvaal High Court declared the promulgation invalid and the Constitutional Court confirmed the decision in February 2000.[108] On 19 April 2001, the PMA withdrew the court application and agreed to pay all the costs of the case. The implementation of the Medicines and Related Substances Control Amendment Act was then resumed. Under the Act, pharmacists will be required to offer consumers a generic substitute, regardless of their prescription by a doctor, on all off-patent products. In terms of the Patents Act 57 of 1978, government

105 The TRIPS Agreement was signed in Marrakech, Morocco on 15 April 1994 by member states of the WTO.

106 Medicines and Related Substances Control Amendment Act 90 of 1997.

107 See *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex parte President of the Republic of South Africa and Others* 1999 4 SA 788 (T).

108 See *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex parte President of the Republic of South Africa and Others* 1999 4 SA 788 (T); *Pharmaceutical Manufacturers of South Africa: In re Ex parte application of President of the Republic of South Africa and Others* 2000 3 BCLR 241 (CC).

ministers can apply for compulsory licences 'for public purposes'.[109] Compulsory licensing has not been utilised by the government to date.

The government further highlighted the following efforts in terms of affordable drugs:

- Multinational companies have granted voluntary licences to South African companies to manufacture several generic anti-retrovirals;[110]
- South Africa is working towards an appropriate World Trade Organisation agreement that will facilitate developing countries' access to essential medicines for major health problems, including HIV and AIDS, TB and Malaria;[111] and
- NEPAD is engaging in a programme for a number of African countries to work with pharmaceutical companies to manufacture affordable drugs for dangerous diseases, including HIV and AIDS and TB, on the African continent.[112]

6.4 Condoms

The National HIV/AIDS Programme, in one of its sub-programmes, focuses on the sensitisation and distribution of male and female condoms. The Programme aims to achieve the following:

- to ensure an uninterrupted supply of good quality condoms to all provinces;
- to expanding condom supply to non-traditional outlets such as hotels, clubs, *spaza* shops and taxi ranks;
- to making the female condom available in areas where there is a demand and to popularise this form of protection;
- to advocate for the provision of condoms in institutions of higher learning; and
- to ensure condom supply in high-transmission areas such as trucking routes, single-sex hostels, and places where commercial sex work is prevalent.[113]

[109] For a detailed discussion, see T Kongolo 'Public Interest *versus* the Pharmaceutical Industry's Monopoly in South Africa' (2001) 4 *Journal of World Intellectual Property* 609.

[110] For instance, GlaxoSmithKline granted a voluntary license to a major South African generics producer (Aspen), allowing it to share the rights to the drugs AZT, 3TC and the combination Combivir without charge. See AVERT 'TRIPS, AIDS and generic drugs' http://www.avert.org/generic.htm (accessed 1 August 2006).

[111] See Government of South Africa 'Update on the national HIV and AIDS programme' (2003), available at http://www.info.gov.za/issues/hiv/update03.htm (accessed 1 August 2006).

[112] See 'Cabinet statement: Fourth anniversary of the Partnership against Aids' 9 October 2002 http://www.gcis.gov.za/media/cabinet/021009aidspart.htm (accessed 1 August 2006).

[113] DoH 'National HIV/AIDS and TB Programme Organisation' http://www.doh.gov.za/search/index.html (accessed 1 August 2006).

Prevention is one of the 4 priority areas identified under the HIV & AIDS & STI Strategic Plan for South Africa 2007-2011. Condom procurement and distribution is an important part of the prevention policy. The government has undertaken the following activities:

- The DoH through the HIV/AIDS/STD Directorate procures and distributes male condoms to all provinces;
- Condoms are supplied freely to the public;
- All condoms supplied by government undergo quality testing by the South African Bureau of Standards (SABS) in accordance with WHO standards; and
- Strategies are being implemented to improve access to condoms through non-traditional outlets such as *spaza* shops, clubs and taxi ranks.[114]

The DoH regularly organises STI/condom weeks during which wide sensitisation is conducted on the use of condoms. The events are also used as opportunities to distribute condoms all over the country. According to the government, distribution of male condoms has increased from 150 million in 1998 to 270 million in 2003[115] and 346 million in 2004,[116] and distribution of female condoms increased from 1.3 million in 2003 to 2.6 million in 2004. Latest distribution data for 2005 indicate that more than 325 million condoms were distributed through various public and private sector outlets.[117] Condoms are sold in pharmacies and shops at a price ranging from USD 50 cents to USD 2.80.

6.5 Case law on the right to access to health care

The right to access to health care contained in the Constitution was given content in three landmark decisions of the Constitutional Court:

- *Government of RSA and Others v Grootboom and Others*[118]

The Constitutional Court noted in its decision that the Constitution obliges the state to act positively to help people living in deplorable conditions. The state has the obligation to provide housing, healthcare, sufficient food and water, and social security to those unable to support themselves and their dependants. The Constitutional Court agreed that socio-economic rights contained in the

114 Government of South Africa (n 9 above).
115 DoH (n 113 above).
116 For 2004 figures see HSRC (n 3 above). Otherwise see Republic of South Africa 'Implementation of the comprehensive plan on prevention treatment and care of HIV and AIDS: Fact sheet' 23 November 2005 http://www.info.gov.za/issues/hiv/implementation2006.htm (accessed 1 August 2006).
117 Available at http://www.doh.gov.za/search/index.html (accessed 17 April 2006).
118 *Government of RSA and others v Grootboom and Others* 2001 1 SA 46 (CC).

Bill of Rights are justiciable;[119] however, they are subject to progressive realisation by reason of the lack or resources. The state should therefore take 'reasonable legislative and other measures ... to achieve the progressive realisation [of the rights contained in section 27 of the Constitution) within available resources'.[120] In other words, the obligation of the state consists in devising and implementing a national plan that is comprehensive, time-framed and reasonably believed to aim at the fulfilment of the state's duties under the Constitution.

- *E N and Others v Government of RSA and Others*[121]

The High Court in this case reaffirmed the obligation of the State to fulfil the rights to access to health care (section 27 of the Constitution) and the right to adequate medical treatment of detained persons (section 35 of the Constitution). See part 14 for further discussion of the case.

- *Minister of Health and Others v Treatment Action Campaign and Others*[122]

As part of the effort aimed at combating HIV, the government devised a programme for the prevention of mother-to-child-transmission of HIV, using Nevirapine. According to the programme, provision of Nevirapine was only permissible at a limited number of pilot sites, two per province. Doctors in the public sector outside the pilot sites were not allowed to prescribe Nevirapine to their patients. The Court conceded that it was legitimate for the government to ascertain the efficacy, safety and possible resistance to Nevirapine before making it widely available in the country. However the Court found that the needs of children are 'most urgent' and 'their inability to have access to Nevirapine profoundly affects their ability to enjoy all rights to which they are entitled.'[123] The Court therefore ordered that restrictions on access to Nevirapine be removed and that the use of Nevirapine be permitted and facilitated where it is medically indicated. Although Nevirapine has become generally accessible across the country since the decision of the Court, implementation of the Court's order is reported to be slow, particularly in Limpopo, Northern Cape and Mpumalanga.[124]

119 For a discussion on the justiciability of socio-economic rights, see F Viljoen 'The justiciability of socio-economic and cultural rights: experience and problems' unpublished.
120 *Grootboom* (n 118 above) para 38.
121 *E N and Others v Government of RSA and Others* 2007 1 BCLR 84 (D).
122 n 62 above, 1033.
123 *Grootboom* (n 118 above) para 78.
124 Joint Civil Society Monitoring Forum 'Report of the 4th meeting of the Joint Civil Society Monitoring Forum'.

- *Soobramoney v Minister of Health, KwaZulu-Natal*[125]

An unemployed man suffering from chronic renal failure sought an on-going renal dialysis free of charge in a public health facility. The Constitutional Court held that the right to life contained in section 11 of the Constitution does not impose an obligation on the state to provide life-saving treatment to a critically ill patient. According to the Court, the right to access health care should be understood in terms of section 27, which is subject to progressive realisation, and not to involve any right to life. The Court refused to order the provision of the treatment and found that scarce resources must be allocated rationally to ensure that a greater number of patients are cured than would be the case if the dialysis machines were used to keep alive persons with chronic renal failure.[126] Like anti-retroviral treatment, renal dialysis constitutes an on-going treatment that patients have to take for the rest of their lives and that therefore requires substantial financial resources. Nevirapine is however a once-off treatment that is administered to pregnant women during labour and to the new-born baby right after birth.

7. Privacy

7.1 Notifiable disease

HIV or AIDS is not a notifiable disease in South Africa. In April 1999, the Minister of Health proposed the draft regulations relating to communicable disease and the notification of notifiable conditions. The draft regulations proposed an amendment to the existing Health Act[127] that would include provisions for the notification of AIDS but would require HIV-positive status to be notified. The draft regulations were not adopted. However, section 93(1) of the National Health Act 61 of 2003,[128] which came into operation on 2 May 2005, repealed the entire Health Act 63 of 1977.

7.2 Medical experimentation

Section 71 of the National Health Act sets standards to protect research participants, including children. Section 71(1) contains general provisions regarding consent of all research participants. Sections 71(2) and (3) contain provisions regulating the participation

125 *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC).
126 Note that in the case *Applicant v Administrator, Transvaal and Others* (n 69 above), the High Court decided in 1993 that according to the specifics of each case, certain individuals are entitled to expensive life-saving medication at the state's expense.
127 Health Act 63 of 1977.
128 n 86 above.

of minors in medical research. However, section 71 has been criticised for, among other reasons, putting too much weight on the importance of informed consent and overlooking other rights of trial participants.[129]

Although not legally binding, the DoH's Guidelines for Good Practice in the Conduct of Clinical Trials in Human Participants in South Africa[130] provide some standards of protection for participants in medical trials. These include the right of research subjects to have their bodily integrity always respected. The Guidelines explicitly require that participants in medical trials be unpaid volunteers and that they consent to participate in such trials. They further recommend that every precaution should be taken to respect the privacy of the subject, the confidentiality of every patient's information and that the impact of the study on the subject's personality and physical and mental integrity be minimised. In scientific research on human beings, each potential subject must be adequately informed of the study's aims, methods, funding sources, potential benefits and risks, and any discomfort that it may entail. Subjects must also be informed of the researchers' institutional affiliations and any possible conflicts of interest, as well as of his or her right to withdraw consent to participate in the study at any time without reprisal. After ensuring that the subject has understood the information, the physician should then obtain the subject's freely-given informed consent, preferably in writing. If the consent cannot be obtained in writing, non-written consent must be formally documented and witnessed.[131]

Section 12 of the South African Constitution guarantees the right of everyone to bodily and psychological integrity, including the right not to be subjected to medical or scientific experiments without informed consent and the right of freedom from cruel, inhumane and degrading treatment. Section 10 of the Constitution also guarantees the right to have one's human dignity respected and protected.

The HIV/AIDS/STD Directorate published the Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research in January 2000. The Ethical Guidelines are intended to supplement the Medical Research Council's Guidelines for Medical Research by addressing several issues raised in HIV-related research.

In May 2002, the South African Medical Research Council released the Draft Guidelines on Ethics for Medical Research: HIV/AIDS

[129] See A Strode *et al* 'How well does South Africa's National Health Act regulate research involving children?' (2005) 95 *South African Medical Journal* 4.

[130] DoH Guidelines for Good Practice in the Conduct of Clinical Trials in Human Participants in South Africa http://www.doh.gov.za/docs/policy/trials/trials_01.html (accessed 1 August 2006).

[131] As above.

Preventive Vaccine Trials for comments by interested parties. The Draft Guidelines make special provision for the protection of vulnerable populations. It provides that:

> Where relevant, the research protocol should describe the social contexts of a proposed research population that create conditions for possible exploitation or increased vulnerability among potential research participants. Steps must be taken to overcome these conditions, and promote and protect the dignity, safety and welfare of the participants.[132]

The Guidelines further aim to define informed consent and recommend that special measures be taken to protect persons who are limited in their ability to provide informed consent due to their social or legal status.[133]

The South African AIDS Vaccine Initiative (SAAVI) has two locally generated 'candidate vaccines' that have initiated Phase II of HIV vaccine trial in South Africa. Candidate vaccines that are proven to be safe in Phase I trials move on to Phase II trials, allowing investigators to test the immune response and to acquire more data on safety.[134] In addition, South Africa is involved in trials of candidate vaccines that have been developed outside the country.

In December 2002, the Ministerial Committee on Health Research Ethics published a booklet entitled 'What you should know when deciding to take part in a clinical trial as a research participant'.[135] The booklet explains the nature of various clinical trials and highlights possible adverse effects. It further outlines volunteers' constitutional rights and what constitutes informed consent, such as what a participant must know and what he or she has a right to be informed about, as well the role of ethics committees in ensuring the protection of volunteers' rights, dignity and well being.

7.3 Duty to disclose

There exists no general legislation, public health law or criminal procedure that allows for disclosure of the HIV status of an accused to victims or alleged victims of a crime.[136] The Compulsory HIV testing

[132] DoH (HIV/AIDS/STD Directorate) HIV/AIDS Policy Guideline: Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research (2000) http://www.mrc.ac.za/ethics/ethics.htm (accessed 1 August 2006) 125.

[133] The Guidelines also describe a separate process to follow when women and children partake in vaccine trials.

[134] International AIDS Vaccine Initiative 'South Africa begins first Phase II preventive HIV vaccine trial', 14 November 2005 http://www.iavi.org/viewfile.cfm?fid=35115 (accessed 1 August 2006).

[135] Ministerial Committee on Health Research Ethics 'What you should know when deciding to take part in a clinical trial as a research participant' (2002) http://www.doh.gov.za/aids/docs/gcp2.html (accessed 1 August 2006).

[136] E Cameron 'Legal and human rights responses to the HIV/AIDS epidemic' (2005) http://law.sun.ac.za/judgecameron.pdf (accessed 1 August 2006).

of Alleged Sexual Offenders Bill, in section 4(2)(c)(iii) states that '[t]he magistrate must order the disclosure of the HIV test result so obtained to the victim or to the interested person, as the case may be, and to the alleged offender'. Section 1 defines 'an interested person' as 'any person who has a material interest in the well-being of a victim, including a spouse, family member, care giver, friend, counsellor, medical practitioner, health service provider, social worker or teacher of such victim'. Section 10 states that '[n]o person may disclose any information which relates to an application or the result of a test contemplated in this Act, except in so far as it may be necessary for the purposes of this Act'. However, the term 'interested person' has been given a wide scope and the Bill does not prescribe pre- and post-test counselling for the accused.

An employee does not have any legal duty to disclose his or her HIV status to anyone, including an employer. Likewise, in the doctor-patient relationship, disclosure of the HIV status of a patient without consent constitutes an unlawful breach of the right to confidentiality so long as the disclosure is not made in the interest of any person.[137] The South African Medical Association's Guidelines on Human Rights and Ethical Guidelines on HIV state that confidentiality may be breached if the patient provides informed consent or if it is absolutely necessary to protect identified third parties at risk. The Guidelines recommend that health care professionals do the following to protect sexual partners of HIV-positive patients:

- counsel the patient on the need to inform third parties at risk;
- attempt to obtain the patient's informed consent and offer to assist in the process of disclosure;
- point to legal and other risks associated with negligent sexual behaviour; and
- if an identified third party is clearly at risk, inform the patient about a planned disclosure.

7.4 Testing

At present, South Africa does not have any policy of routine testing. The National Policy on Testing for HIV[138] provides that 'routine testing of a person for HIV infection for the perceived purpose of protecting a health care worker from infection is impermissible regardless of consent'. It further states that 'in all instances, this policy shall be interpreted to ensure respect for rights to privacy, dignity and autonomy'.

[137] See *Jansen van Vuuren v Kruger* (n 68 above).
[138] DoH National Policy on Testing for HIV (1999) http://www.doh.gov.za/docs/notices/1999/not99-1479.html (accessed 1 August 2006). Note that this Policy is in the process of being revised.

However, pregnant women who come for antenatal consultation in public facilities are systematically tested for HIV.[139] The general principles for conducting HIV testing (the requirements of informed consent, the provision of pre- and post-test counselling) apply. The reason for testing pregnant women for HIV is two-fold: to prevent mother-to-child-transmission of HIV and to collect statistical data on the prevalence of HIV among sexually-active populations, who are represented by pregnant women.

The importance of informed consent of patients emerged from the Cape Court's decision in *Castell v De Greeff*,[140] where the Court gave precedence to the patient's autonomy and self-determination and found that a doctor must obtain a patient's informed consent to medical treatment and warn the patient of any material risk inherent in the proposed treatment. An HIV test has been understood to be 'medical treatment'.[141]

In December 1999, the HIV/AIDS/STD Directorate of the DoH released Recommendations on the Use of Rapid HIV Tests.[142] It was recommended that these rapid tests be conducted in accordance with the same ethical standards as any other HIV test, through adherence to the principles of pre- and post-test counselling, informed consent, privacy and condentiality.[143] The DoH, in August 2000, issued the National Policy on Testing for HIV in terms of Section 2 of the National Policy for Health Act 116 of 1990. The National Policy outlines circumstances under which HIV testing may be conducted and contains regulations regarding informed consent, pre-test and post-test counselling.

8. Equality and non-discrimination

Section 9 of the Constitution deals with equality and the right to non-discrimination. Section 9(3) provides that '[t]he state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability,

139 UNICEF recommends that for PMTCT programmes to be effective, pregnant women be tested for HIV routinely but that they be given the chance to opt out of learning their HIV results or to choose when to learn the results. UNICEF quoted in N Rutenberg *et al* 'Programme recommendations for the prevention of mother-to-child-transmission of HIV – A practical guide for managers' (2003) 11.

140 Cape Court's decision in *Castell v De Greeff* 1994 4 SA 408 (C).

141 *C v Minister of Correctional Services* (n 65 above) 292.

142 DoH 'References and document sources' http://www.doh.gov.za/docs/policy/norms/part2f.html (accessed on 1 August 2006).

143 According to latest survey (2003), South Africa counted 493 registered VCT sites. For the full list with their respective location and the number of counsellors allocated to each province, see AIDS Helpline 'VCT sites list' (2002) http://www.aidshelpline.org.za/vct_sites_list.htm (accessed 1 August 2006).

religion, conscience, belief, culture, language and birth.' Although section 9 does not include HIV or AIDS as an explicit ground, it can be read into 'disability' or can be treated as an 'other ground' under section 9(3). Cases dealing with HIV or AIDS-related discrimination have analysed HIV status as an analogous ground rather than a disability.

Further, section 9(4) of the Constitution states that '[n]o person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.' The Promotion of Equality and Prevention of Unfair Discrimination Act[144] was enacted in 2000. The Act does not specifically prohibit HIV status as a ground for discrimination. However, the Act prohibits any form of discrimination that — '(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' one of the prohibited grounds enumerated in the Act.[145] Section 34 of the Act also grants to the Minister of Health authority to consider HIV status a prohibited ground of discrimination in terms of the Act:

> (1) 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.[146]
>
> (2) Nothing in this section –
>
> (a) affects the ordinary jurisdiction of the courts to determine disputes that may be resolved by the application of law on these grounds;
>
> (b) prevents a complainant from instituting proceedings on any of these grounds in a court of law;
>
> (c) prevents a court from making a determination that any of these grounds are grounds in terms of paragraph (b) of the definition of 'prohibited grounds' or are included within one or more of the grounds listed in paragraph (a) of the definition of 'prohibited grounds'.

There is also an important policy document, the Charter of Rights on AIDS and HIV, embracing human rights principles that are essential to ensure non-discrimination in the public health system in South Africa.

144 Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.
145 As above, sec 1(xii)(b).
146 This provision was not given effect because in the *Hoffmann* case, the Constitutional Court had already clearly identified HIV status as a prohibited ground for discrimination (see n 60 above).

The Charter was drafted in 1992, incorporating principles from international documents such as the Montreal Manifesto of the Universal Rights and Needs of People Living with HIV Disease, and the United Kingdom Declaration of the Rights of People with HIV and AIDS. The Charter was publicly launched on World AIDS Day in 1992 and was endorsed by a wide range of individuals and organisations, both nationally and internationally.

9. Labour rights

9.1 Legislation

Besides the protection of equality in section 9 of the Constitution, section 23(1) states that '[e]veryone has the right to fair labour practices', and section 22 provides that '[e]very citizen has the right to choose their trade, occupation or profession freely.' Section 39 (1) of the Constitution requires a court, tribunal or forum to consider international law in interpreting the Bill of Rights. These organs must therefore take into consideration the Southern African Development Community (SADC) Code on HIV/AIDS and Employment of 1997,[147] the International Labour Organisation (ILO) Code of Practice on HIV/AIDS and the World of Work of 2001[148] and all other relevant international instruments when considering issues related to the occurrence of HIV and AIDS in the workplace.

The Labour Relations Act[149] was enacted in December 1995 to give effect to Section 27 of the Interim Constitution. Chapter VIII of the Labour Relations Act deals with unfair dismissals in sections 185-197. Section 185 reads: 'Every employee has the right not to be unfairly dismissed.' Section 187(e) prohibits dismissals based 'on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility'. Schedule 7, part B, of the Labour Relations Act, outlines residual unfair labour practices, disputes about unfair labour practices, and the powers of the Labour Court and the Commission for Conciliation, Mediation and Arbitration. Schedule 8 contains a code of good practice for dismissals, including dismissals arising from ill health or injury.

147 SADC Code on HIV/AIDS and Employment (1997) http://www.cosatu.org.za/docs/1998/sadc-hiv.htm (accessed 1 August 2006).

148 ILO Code of Practice on HIV/AIDS and the World of Work (2001) http://www.ilo.org/public/english/protection/trav/aids/code/codemain.htm (accessed 1 August 2006).

149 n 39 above.

The Employment Equity Act[150] was enacted to deal with unfair discrimination in employment. According to section 6:

> No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.

The Employment Equity Act further states in section 7(1):

> Medical testing of an employee is prohibited, unless — (a) legislation permits or requires the testing; or (b) it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job. (2) Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of section 50 (4) of the Act.

Section 50(4) provides as follows:

> If the Labour Court declares that the medical testing of an employee as contemplated in section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to –
>
> (a) the provision of counselling;
>
> (b) the maintenance of confidentiality;
>
> (c) the period during which the authorisation for any testing applies; and
>
> (d) the category or categories of jobs or employees in respect of which the authorisation for testing applies.[151]

9.2 Testing in employment

In 2002, the Labour Court found in two cases that anonymous and voluntary HIV testing conducted to determine HIV prevalence for planning purposes is not prohibited by section 7(2) of the Employment Equity Act. The Court found that in such a situation, the testing is not intended to discriminate against employees and is therefore not prohibited. Whether the initiative for testing comes from the employer or the employee has no importance, provided the employee consented to the test.[152] In 2003, the Labour Court clarified its

[150] n 61 above.

[151] Before the enactment of the Employment Equity Act, the Constitutional Court decided in *Hoffmann* (n 60 above, 1) that the denial of employment to a prospective employee for reasons of his HIV status constituted unfair discrimination and violated the right to fair labour practices as guaranteed in the Constitution.

[152] *Joy Mining Machinery, a division of Harnischfeger (SA) (PTY) LTD v National Union of Metalworkers of SA & Others* (n 81 above); *Irvin & Johnson LTD v Trawler & Line Fishing Union & Others* 2003 24 ILJ 565 (LC).

position in the findings of 2002. Accordingly, even if the HIV test is conducted anonymously, a person who has not consented to it cannot be tested, except with the leave of the Labour Court.[153] The Court found that companies do not have to obtain prior permission from the Labour Court to institute voluntary testing programmes. More companies were expected to begin voluntary testing programmes as the Global Reporting Initiative recommended that the extent and costs of HIV and AIDS on companies listed in the Johannesburg Stock Exchange figure in their financial statements. However, the second King Report on Corporate Governance for South Africa (also known as King II) came into effect on 1 September 2003. King II requires listed companies to report only on the HIV and AIDS strategy plan and policies listed companies have in place to address and manage the potential impact of HIV and AIDS.[154]

A Code of Good Practice on Aspects of HIV/AIDS and Employment has been added to both the Employment Equity and the Labour Relations Acts. The Code is issued in terms of section 54(1)(a) of the Employment Equity Act and is based on the principle that no person may be unfairly discriminated against on the basis of HIV status. The Code makes reference to other pieces of legislation in order to assist employers and employees to apply its principles consistently. The other acts referred to are: the Labour Relations Act, the Occupational Health and Safety Act,[155] the Mine Health and Safety Act,[156] the Compensation for Occupational Injuries and Diseases Act,[157] the Basic Conditions of Employment Act,[158] the Medical Schemes Act,[159]and the Promotion of Equality and Prevention of Unfair Discrimination Act.[160] The Code states that employees with HIV/AIDS may not be unfairly discriminated against in the allocation of employee benefits nor be compelled to undergo HIV testing and that employees' medical information is confidential. Further, the code recommends the adoption of workplace HIV and AIDS policies to ensure non-discrimination.

In 1999, the DoH's HIV/AIDS/STD Directorate published Guidelines on the Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV). These guidelines also contain recommendations regarding HIV post-exposure prophylaxis treatment and compensation for occupationally acquired HIV infection,

153 *PFG Building Glass (PTY) LTD v Chemical Engineering Pulp Paper Wood & Allied Workers Union & others* 2003 24 ILJ 974 (LC).
154 C Dekker 'Second King report on corporate governance for South Africa: What it means to you' 2002 http://www.cliffedekker.co.za/files/CD_King2.pdf (accessed 1 August 2006).
155 Occupational Injuries and Diseases Act 85 of 1993.
156 Mine Health and Safety Act 29 of 1996.
157 Compensations for Occupational Injuries and Disease Act 130 of 1993.
158 Basic Conditions of Employment Act 75 of 1997.
159 Medical Schemes Act 131 of 1998.
160 n 144 above.

administered by the Compensation Commission (formerly known as the Workmen's Compensation Commission).

The Employment Equity Act and the Labour Relations Act cover everyone except the South African National Defence Force, the National Intelligence Agency and the Secret Services. The South African National Defence Force formerly had a pre-employment HIV testing policy. On 30 April 2001, the Department of Defence approved a departmental HIV policy called The Management of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). According to the Policy, HIV testing of any Department employee is not compulsory but may be required to accurately determine the health status of employees who participate in operational deployments.[161] The Policy addresses measures for the containment of the epidemic and the care and support of members and their dependants infected and affected by HIV. In addition, it contains specific guidelines to ensure a non-discriminatory work environment.

9.3 Medical schemes act

The Medical Schemes Act[162] came into operation on 1 January 2001. The Act regulates and reforms private health care insurers and providers. According to section 24(2)(e) 'no medical scheme shall be registered under the Act unless the Council is satisfied that the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds, including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.' This means that no insurance company may refuse to cover reasonable care that could improve the health or prolong the life of people living with HIV. Further, section 29 states that:

> The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters: ... (n) The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant of one or more of the applicant's dependants other than for the provisions as prescribed.

[161] Integrated Regional Information Network 'South Africa: HIV-resting row in the military' 29 October 2003 http://www.aegis.com/news/irin/2003/IR031034.html (accessed 1 August 2006).

[162] n 159 above.

The Act, therefore, prohibits health insurers from unfairly excluding HIV positive- people from health insurance schemes.

The Medical Schemes Act regulates the industry by replacing the principles of risk and exclusion or limitation with principles of community rating and social solidarity. In other words, where a person can afford the premiums associated with health insurance, an insurer cannot exclude him or her. In addition, registered members will not be forced to pay higher premiums based on age or health status; member contributions will rather be based on an 'average' and will increase only if the principal member wishes to register additional dependants.[163]

Regulation 1262 of 20 October 1999 under the Medical Schemes Act provides that HIV-associated diseases are categorised under the prescribed minimum benefits that provide for the compulsory cover of medical and clinical management of opportunistic infections or localised malignancies. The Regulations require a review every two years with the specific focus of developing protocols for the medical management of HIV and AIDS. The current prescribed minimum benefits for HIV infections are:

- HIV voluntary counselling and testing;
- anti-retroviral therapy;
- co-trimoxazole as a preventative therapy;
- screening and preventative therapy for tuberculosis;
- diagnostics and treatment of sexually transmitted infections;
- pain management in palliative care;
- treatment of opportunistic infections;
- prevention of mother-to-child-transmission of HIV; and
- post-exposure prophylaxis following occupational exposure or sexual assault.[164]

The Aid for AIDS (AfA) programme is the largest programme providing comprehensive HIV and AIDS management solutions for medium to large businesses as well as medical schemes. It was reported that in January 2006 there were 25 000 private medical aid members who enrolled in the AfA programme and that more than 70

163 DW Webber 'AIDS and the law in South Africa: An overview' www.hri.ca/partners/alp/resource/docs/saview99.doc (accessed 1 August 2006).

164 Government of South Africa (n 9 above).

per cent of these members were currently on anti-retroviral therapy.[165]

The Code of Good Practice on Aspects of HIV/AIDS and Employment refers specifically to employee benefits in section 10. It recommends that employees who have HIV should be treated the same as other employees with comparable life-threatening diseases with respect to access to employee benefits. Where a medical scheme is offered as part of the employee benefit package, care must be taken that the scheme does not discriminate, directly or indirectly, on the basis of HIV status.

9.4 Duty to provide treatment

Under the common law, employers have no obligation to provide medical services or first aid facilities to their employees, unless they have agreed to do so or are required to do so by law.[166] There is no explicit legal obligation on employers to provide anti-retrovirals or other medications to their employees or members of their families. Section 8(2) of the South African Constitution states that 'a provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right'. At present, this section has not been interpreted to entail any obligation on employers to provide ART to their employees. Understandably, if employers were to be held legally responsible of providing treatment to their employees, the presently high cost of anti-retroviral treatment would likely create undue hardship on them.

The Occupational Health and Safety Act[167] imposes a general obligation on employers to provide safe and healthy working conditions and to ensure that workers are protected from any hazards in the workplace. HIV constitutes an occupational disease only for health care workers.[168] In 2001, the Ministry of Labour issued the Regulations of Hazardous Biological Agents under section 43 of the Occupational Health and Safety Act[169] to detail the obligations of employers with regards to workplace health and safety. Section 1 of the regulations lists hazardous biological agents that are covered by the regulations. HIV fits the description of a Group 3 virus, which may cause severe human disease or serious hazard to exposed persons or

[165] For details of the AfA programme, see Aid for AIDS 'Clinical Guidelines: Fourth edition' (2002), available at http://www.weforum.org/pdf/Initiatives/GHI_HIV_DCSA_AppendixJ.pdf (accessed 1 August 2006).

[166] *Fulss v Mollentze* (1896) 13 SC 369, quoted by F Van Jaarsveld and S Van Eck *Principles of labour law* (2005) 96.

[167] Occupational Health and Safety Act 85 of 1993.

[168] An occupational disease is a disease contracted in the course of performing employment duties or caused by exposure to a workplace health hazard.

[169] See *Government Gazette* 22956.

may present a risk of spreading to the community if prophylaxis and treatment are not employed. According to section 4(1) of the regulations, employers must 'ensure that the employee is adequately and comprehensively informed and trained with regard to 'the potential risks to health for exposure' and 'the precautions to be taken by an employee to protect him- or herself against the health risks associated with the exposure, including the wearing and use of protective clothing and respiratory protective equipment'.

The Mine Health and Safety Act[170] regulates working conditions in the mining sector. It creates an obligation on owners to 'provide conditions for safe operation and a healthy working environment'.[171] This Act is particularly important because the rate of prevalence of HIV among miners, and in communities directly surrounding mine exploitations, is very high. To an extent where no undue hardship is put on mine owners, this section may be understood to include an obligation on them to make HIV education and counselling, as well as condoms, available to miners.

In *Media24 Ltd and Another v Grobler*,[172] the Supreme Court of South Africa, referring to the judgement of the Cape High Court in the matter, said the following:[173]

> (...) If the existing rules relating to vicarious liability in our law are not flexible enough or do not make adequate provision for changed circumstances in order to deal with the problem of sexual harassment in the workplace then, he said, the Constitution obliges the courts to develop the common law accordingly ...

The Supreme Court found that

> [a]n employer owes a common law duty to its employees to take reasonable care for their safety. This duty (...) cannot be confined to an obligation to take reasonable steps to protect them from *physical* harm caused by what may be physical hazards. It must also in appropriate circumstances include a duty to protect them from psychological harm caused by, for example, sexual harassment by their co-employees.[174]

One can extrapolate the judge's statement to confirm the existence of a common law obligation on employers to take at least universal precautions and to provide HIV education materials, HIV counselling and testing services, condoms, and prophylaxis treatment to their employees.

Some companies are currently providing their employees with anti-retroviral treatment as an internal policy to address the effects of the HIV epidemic in their workplaces. The following companies

[170] n 156 above.
[171] As above, sec 2(a)(i).
[172] *Media24 Ltd and Another v Grobler* 2005 6 SA 328 (SCA).
[173] As above, para 16.
[174] As above, para 65.

currently provide anti-retroviral therapy to their employees infected with HIV:

- De Beers;
- Daimler Chrysler;
- BMW South Africa;
- Nedcor; and
- Anglo Gold.

10. Women's rights

10.1 Legal status and protection

The Constitution's section 9(3) equality clause states that '[t]he state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.' Women therefore have formal equality. A Commission on Gender Equality (CGE) was established in accordance with Section 187 of the Constitution. The purpose and function of the Commission is set out in the Commission on Gender Equality Act 39 of 1996.

The Promotion of Equality and Prevention of Unfair Discrimination Act 2 of 2000 lists gender, sex, pregnancy and marital status as prohibited grounds for discrimination in an effort to grant full and equal enjoyment of rights and freedoms to women. The Employment Equity Act provides that women, as one of the so-called 'designated groups', should benefit from affirmative action policies aimed at rectifying gender imbalances in employment.

The Prevention of Family Violence Act[175] declares marital rape a crime and empowers a woman who has been assaulted by her husband to lay a criminal charge or to obtain an interdict against him.

The Domestic Violence Act[176] provides for the arrest, without a warrant, of anyone suspected of having committed an act of domestic violence (section 3), for the application of a protection order (section 4), and for the application and issuance of an interim protection order (section 5). Section 7 lists the powers of a court in terms of a protection order. These powers are broad and include powers to prohibit the respondent from committing any act of domestic violence or from entering the complainant's residence or place of employment.

[175] Prevention of Family Violence Act 133 of 1993.
[176] Domestic Violence Act of 116 of 1998.

The Sexual Offences Bill (Bill) is intended to replace the 1957 Sexual Offences Act. The draft Bill covers both the substantive and procedural law relating to sexual offences.

According to the South African Law Commission, the intention behind the Bill is to 'encourage victims of sexual violence to use the criminal justice system, to improve the experiences of those victims who choose to enter the system, and to increase the conviction rate whilst at the same time giving due regard to the rights accorded to alleged perpetrators of sexual offences'.[177]

The Bill expands the existing definition of rape. Section 3(1) reads:

> Any person who unlawfully and intentionally commits any act which causes penetration to any extent whatsoever by the genital organs of that person into or beyond the anus or genital organs of another person, or any act which causes penetration to any extent whatsoever by the genital organs of another person into or beyond the anus or genital organs of the person committing the act, is guilty of the offence of rape.

An act that causes penetration is *prima facie* unlawful if it is committed under false pretences or by fraudulent means (Section 3(2)). Section 3(4)(c) defines false pretences or fraudulent means as circumstances where a person 'intentionally fails to disclose to the person in respect of whom an act which causes penetration is being committed, that he or she is infected by a life-threatening sexually transmittable infection in circumstances in which there is a significant risk of transmission of such infection to that person.' A person could thus be found guilty of rape where he or she knew of his or her own HIV positive status and did not disclose the information to a sexual partner. Section 3(6) declares that a marital or other relationship will not be a defence to a charge of rape.

However, the Bill has encountered significant delays. Though completed, it has circulated between various government departments since 1998 and still remains to be passed into law.[178]

The Criminal Procedure Second Amendment Act[179] and the Compulsory HIV Testing of Alleged Sexual Offenders Bill of 2002 are discussed in detail in part 4.8.

177 South African Law Commission 'Press statement: South African Law Commission's Project 107: Sexual offences' 21 January 2003 http://www.doj.gov.za/2004dojsite/m_statements/2003/2003%2001%2021_salc%20107.htm (accessed 1 August 2006).

178 'Zuma case reveals rape problem' *BBC NEWS* 15 February 2006 http://news.bbc.co.uk/1/hi/world/africa/4713172.stm (accessed 1 August 2006).

179 Criminal Procedure Second Amendment Act 85 of 1997.

10.2 Domestic violence law

Many reports have noted the greater vulnerability of women with respect to HIV. Recently, a link has also been established between domestic violence and the increased risk of HIV for women.[180] While laws have been passed in South Africa with the aim of reducing violence against women, these are often criticised for being under-enforced. Moreover, the Domestic Violence Act[181] makes no explicit mention of the link between domestic violence and HIV. Notwithstanding these problems, South Africa has joined international campaigns, such as the 16 Days of Activism against Gender Violence Campaign, with the goal of drawing greater attention to the link between violence against women and HIV.[182] Indeed, the 2005 Campaign, titled For the Health of Women, for the Health of the World, sought specifically to address the connections between violence against women and the HIV epidemic.[183] In South Africa, women's organisations also hosted cyber dialogues every day during the campaign on the topic.[184]

10.3 Customary rules and practices

Section 39(3) of the Constitution states that '[t]he Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.' This means that all customary laws and legislation must be consistent with the Bill of Rights and may not discriminate against women in a manner contrary to the equality clause and legislation in place.

The Recognition of Customary Marriages Act,[185] as well as the repeal of section 11(a) of the Black Administration Act,[186] has elevated the legal status of women married under customary law.

[180] L Vetten & K Bhana (2001) 'Violence, vengeance and gender: A preliminary investigation into the links between violence against women and HIV/AIDS in South Africa' research report written for the Centre for the Study of Violence and Reconciliation.

[181] Domestic Violence Act (n 176 above).

[182] Oxfam 'Violence against women at root of HIV/AIDS crisis' 23 November 2005 http://www.oxfamamerica.org/whatwedo/where_we_work/southern_africa/news_publications/feature_story.2005-11-23.7883734659 (accessed 1 August 2006).

[183] Centre for Women's Global Leadership '2005 theme announcement: 16 days of activism against gender violence' http://www.cwgl.rutgers.edu/16days/kit05/theme.html (accessed 4 August 2006).

[184] '16 days of activism against gender violence' *UN Chronicle Online Edition* (2005) http://www.un.org/Pubs/chronicle/2005/issue1/0105p57.html (accessed 1 August 2006).

[185] Recognition of Customary Marriage Act 120 of 1998.

[186] Black Administration Act 38 of 1927.

The following are examples of customary practices that contribute to women's vulnerability to HIV in South Africa:

- 'Tight, dry sex', which is practised by men and women in some communities, can lead to vaginal tearing and thereby place women at greater risk of contracting HIV.
- Polygyny, a form of customary marriage, allows for a man to have multiple wives. An infected partner in a polygynous marriage can expose all other members of the union to the virus.
- Certain other customary practices related to marital rites (known as *ukugena*, *ukuvusa* and *seantlo*) often involve unprotected sexual intercourse between the widow of a deceased partner and another man (usually a male relative of the deceased) chosen by the deceased's family. These practices are primarily aimed at procreation with the sole intent being to produce an heir.[187]
- Ritual circumcision for young boys, as part of initiation ceremonies heralding the boys' 'coming of age', often entail use of the same instrument for the circumcision of a number of boys.
- Several other skin-piercing procedures utilised in health, therapeutic, ceremonial and aesthetic practices carry the potential risk of HIV transmission through infected blood if hygienic instruments are not used.[188]

Other customary practices such as virginity testing, mostly conducted in the province of Kwazulu-Natal, also make women vulnerable. The persistence of the myth that having sex with a virgin will cure HIV infection is very problematic. South Africa's initial report to the Committee on the Rights of the Child also mentions the practice of scarification of the skin as a common practice.

These practices affirm the attitude toward women's reproductive ability as a legal object that can be bought and sold and severely limit women's ability to refuse sex or unsafe sex. These factors in turn increase women's risk of contracting HIV.[189]

Calls for transformation of high-risk customary practices have largely taken place in the context of children's rights, with particular emphasis on young girls. The Children's Act of 2005 prohibits or regulates various cultural, religious and social practices that have the potential to harm children. Many of these provisions were hotly debated and underwent numerous revisions during the process of adoption of the Act.[190] Under the Act, forced marriages are considered an offence carrying up to ten years in prison. Forced

187 See M Pieterse 'Beyond the reach of law? HIV, African culture and customary law' (2000) 3 *TSAR* 431-433.

188 M Pieterse 'Traditional African society and HIV/AIDS' (1999), as quoted in ALP 'Regional audit on HIV/AIDS, human rights and other relevant issues' (2000) 12.

189 See M Richter 'Customary law, gender and HIV/AIDS South Africa' AIDS Conference 4 August 2003 ALP, Centre for Applied Legal Studies.

190 See sec 11 below for more information on the Children's Act.

genital mutilation and female circumcision are also prohibited. The compromise position on the virginity testing issue was to introduce an age threshold. Thus, virginity testing is prohibited if the girl is under 16 years of age and can be performed for girls older than 16 only if they consent to the testing and if they have been properly counselled. In addition, the results may not be disclosed and the girl cannot be marked in any way. Finally male circumcision for medical and religious reasons is allowed at any age, but cultural circumcision is prohibited for boys under the age of 16. Again, the procedure can be performed on those over 16 only if the boy has been properly counselled and has given consent.[191]

10.4 Administration of anti-retrovirals to rape survivors

The government has committed to providing a comprehensive package of care for victims of sexual assault, including counselling and testing for HIV, pregnancy and STDs.[192] According to the Cabinet, a standardised national protocol will be finalised as soon as possible to address issues such as the counselling of survivors and the risks of using ARVs as preventative drugs.

The DoH has issued a 'Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault' (2003). The Policy states that all women and men aged 14 years and older presenting to a health facility after being raped should be counselled by the examining health worker about the potential risks of HIV transmission post-rape. If the survivor presents him- or herself within 72 hours of being raped, ART should be offered to prevent HIV transmission.

In April 2002, the government decided to make ART available free of charge to rape survivors. Despite this, the issue of accessing ARVs remains a challenge.[193]

10.5 Sex workers

Commercial sex work is criminalised in South Africa by the Sexual Offences Act.[194] This law was challenged in the Constitutional Court

191 See Children's Act, Act 38 of 2005. L Jamieson & P Proudlock 'Children's Bill progress update: 13 March 2006' http://web.uct.ac.za/depts/ci/plr/pdf/progress/GeneralUpdate13March2006.doc 4 (accessed 1 August 2006).

192 Government of South Africa Cabinet statement (n 94 above).

193 AIDS Foundation South Africa 'HIV/AIDS in South Africa: Current situation'http://www.aids.org.za/hiv.htm (accessed 1 August 2006).

194 Sexual Offences Act 24 of 1957.

in the case of *Jordan and others v Republic of South Africa*.[195] The Constitutional Court ruled unanimously that the law criminalising the keeping of a brothel was constitutional. The Court's 11 judges were, however, divided 6 to 5 in ruling on the constitutionality of the provisions criminalising the sale of sex. The majority ruled that the sections of the Sexual Offences Act criminalising the sale of sex were not discriminatory against women, stating that the provision applied to both men and women and that both the customer and prostitute could be charged under the act.[196]

Nevertheless, the decriminalisation of prostitution is still being discussed in South Africa.[197] This discussion has given attention to the need for providing women with additional protection against HIV. It has been pointed out that sex workers can be particularly vulnerable to HIV for the following reasons:[198]

- They are not always able to insist that their customers use condoms, and sex is often violent.
- Because sex work is still illegal, it is difficult for sex workers to get information about HIV and safer sex practices.
- Sex workers are often too scared to say that they are sex workers and are not able to go to organisations where they could get help and information.
- They are also not able to protect themselves from rape and abuse because they cannot report these crimes to the police.

195 CCT31/01. This case followed as an appeal from a high court judgment which ruled that the provisions of the Sexual Offences Act criminalising prostitution were unconstitutional but dismissed the appeal in respect of the sections of the Act that criminalise keeping or managing a brothel. The appellants challenged the constitutionality of secs 2, 3(b), 3(c) & 20(1)(a) of the Sexual Offences Act. The first appellant, the owner of a brothel, was charged with contravention of sec 2 of the Act. The second appellant, who was a salaried employee of the first appellant, was charged with contravention of sec 2 as read with secs 3(b) & 3(c). The third appellant, being a sex worker who worked at the brothel and who committed an act of indecency with the police agent, was charged with contravention of sec 20(1)(a). The constitutionality of these provisions were challenged with reference to a number of constitutional rights such as the right to equality, the right to privacy, the right to dignity, the right to trade, and the right of access to health care.

196 The Court, therefore, declined to confirm the order of the High Court declaring invalid sec 20(1)(a) of the Sexual Offences Act. The minority judgment, however, ruled that the provision did discriminate against women by making the prostitute the primary offender and by reinforcing sexual double standards, thereby perpetuating gender stereotypes.

197 See for example, South African Law Commission 'South African Law Commission's Project 107: Discussion paper 102', which investigates changes to the Sexual Offences Act. 'Discussion paper 3' in this project specifically deals with prostitution. The closing date for public comments was 28 February 2002 and no further developments have been publicised to date.

198 For further discussion on this point, see ALP 'Commercial sex work' http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=62 (accessed 1 August 2006).

11. Children's rights

11.1 Access to health care

Section 28(1)(c) of the Constitution states that '[e]very child has the right to basic nutrition, shelter, basic health care services and social services.' Government has introduced free health care for children under six and free health care for pregnant women up to six weeks after delivery.

The DoH has issued 'Recommendations for Managing HIV Infection in Children' that are intended to provide a practical approach for managing HIV and related infections within the health care system in South Africa. Section 10 states that '[n]o child should be denied health care simply on the basis of their HIV status.' In 2004, the DoH subsequently issued the National ART Guidelines, which include guidelines on ART in children.[199]

The PMTCT Programme of the South African government has been very controversial. In his State of the Nation address on 8 February 2002, the President emphasised that 'preventing mother-to-child-transmission of HIV forms part of government's programme of HIV prevention. It is also part of a broader strategy to combat HIV that depends critically on building partnerships across society.' As part of its PMTCT Policy, the Government supplied Nevirapine to HIV-positive pregnant women in identified pilot sites.[200] The Treatment Action Campaign (TAC) successfully challenged the government on its PMTCT Programme, first in the High Court and eventually in the Constitutional Court. On 4 April 2002, the Constitutional Court issued an interim order requiring 'that government make Nevirapine available in public health facilities where in the opinion of the attending medical practitioner in consultation with the medical superintendent of a clinic or hospital, it is medically indicated and the preconditions for its prescription already exist.' The interim order was applicable until the case was heard and final judgment issued by

[199] DoH (n 101 above) 'Section 2: Anti-retroviral Treatment (ART) in Children, National Anti-retroviral Treatment Guidelines' 26.

[200] Research was presented on the use of Nevirapine to reduce mother-to-child-transmission of HIV at the AIDS Conference in July 2000. Based on these results, the government developed a more comprehensive programme to reduce HIV transmission to babies and to conduct further research on the subject resulting in the 18 national research sites in May 2001. By the end of 2001, these sites involved 215 clinics and hospitals. Women attending these sites are offered counselling and voluntary testing for HIV. Mothers who are HIV positive are also offered Nevirapine for themselves and their babies, vitamins to improve their health during pregnancy, preventative measures to prompt treatment of infections in mother and baby, and formula feed if they choose not to breastfeed. Government of South Africa 'Key issues: government's programme to reduce HIV infection in babies' 24 February 2002 www.gov.za/issues/hiv/hivbabies.htm (accessed 27 July 2002).

the Court. The case was heard on the merits in May 2002. The judgment, issued in July 2002, read as follows:[201]

> It is declared that:
>
> (a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child-transmission of HIV.
>
> (b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.
>
> (c) The policy for reducing the risk of mother-to-child-transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs (a) and (b) in that:
>
> (i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine to reduce the risk of mother-to-child-transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned.
>
> (ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of Nevirapine as a means of reducing the risk of mother-to-child-transmission of HIV.
>
> Government is ordered without delay to:
>
> (a) Remove the restrictions that prevent Nevirapine from being made available for the purpose of reducing the risk of mother-to-child-transmission of HIV at public hospitals and clinics that are not research and training sites.
>
> (b) Permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child-transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.
>
> (c) Make provision for counsellors based at public hospitals and clinics other than the research and training sites to be trained in the counselling necessary for the use of Nevirapine to reduce the risk of mother-to-child-transmission of HIV.
>
> (d) Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to

[201] n 62 above, 721 para 135.

> facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child-transmission.

The government subsequently issued a statement saying that 'it welcomed the fact that the protracted court case on the provision of Nevirapine to prevent mother-to-child-transmission of HIV had come to a conclusion. We accept the ruling of the court on this matter.'[202]

In its February 2006 UNGASS Progress Report, South Africa notes that the PMTCT Programme has expanded significantly since its inception in 2001. The government reported that 3 064 facilities offered PMTCT services during 2005 and that based upon available data on the NPBI-4 formula an estimated 78.7 per cent of pregnant HIV-positive women received Nevirapine and formula milk in public sector health facilities in South Africa. Though these numbers indicate an improvement, they also mean that 70 684 HIV-positive pregnant women were left without ART.[203]

The DoH has issued a Policy Guideline and Recommendation for Feeding of Infants of HIV-positive Mothers.[204] The Policy Guideline outlines recommendations for the feeding of healthy infants whose mothers are known to be HIV positive; it is not designed for infants who are HIV positive or otherwise ill. The Policy Guideline states that

> [b]reastfeeding is a significant and preventable mode of HIV transmission to infants and there is an urgent need to educate, counsel and support women and families so that they can make decisions about how best to feed infants in the context of HIV.

It does not address the provision of breast milk substitutes by health-care services or the cost of provision of such substitutes. The Policy Guideline does, however, mention that the cost of providing formula should be weighed against the savings of preventing HIV infection in newborn babies.

In 2000, the Inter-Ministerial Committee on HIV/AIDS requested that a national strategy for children infected and affected by HIV/AIDS be developed. The Minister for Welfare, Population and Development is responsible for the development and implementation of the strategy. According to the constitutive document, the 'National Strategic Framework for Children Infected and Affected by HIV/AIDS' (NSF for Children) will ensure that children who are affected by HIV and AIDS have access to integrated services that address their basic needs for food, shelter, education, health care, family or alternative care, and protection from abuse and maltreatment:

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202 Statement by government on the Constitutional Court judgment regarding PMTCT at www.gove.za/search97cgi/s97_cgi?action=View (accessed 28 August 2002).

203 Government of South Africa (n 9 above) 21-22.

204 C Evian (Policy Consultant, HIV/AIDS & STD Directorate, DoH) Policy Guideline and Recommendation for Feeding of Infants of HIV-Positive Mothers prepared for the HIV Transmission and Breast Feeding Task Group (2000).

> The National Strategic Framework will address the immediate and urgent needs of children at the present time and also develop a longer-term strategy that will prepare South Africa adequately for future challenges. The NSF will link with and build upon existing government strategies in order to engender an effective and concerted governmental response to HIV/AIDS.

11.2 Children orphaned by AIDS

UNICEF estimates that in 2005 over one million children in South Africa were orphaned due to AIDS.[205] There are some measures that have been put in place to deal generally with children who have been orphaned and vulnerable children and, in particular, those who have been orphaned or made vulnerable by AIDS.

The NSF for Children states that 'it is clear that orphaned children are particularly vulnerable and particular emphasis will be placed upon meeting their needs'.[206] One of the NSF's objectives is to ensure that the comprehensive childcare legislation being developed by the South African Law Commission deals effectively with the needs of orphaned children and particularly that the legislation protects children's inheritance rights. The NSF for Children sets out a framework for the implementation of a strategy focusing specifically on community based care and support models such as foster care, adoption placements for children, and securing of other placements for children such as cluster caring or placement of children with relatives within the community.

The Department of Social Development's Strategic Plan is informed by the Ten Point Plan, which represents the priorities to be addressed by the social development sector during the period 2000 to 2005. One of the ten points addresses HIV and AIDS and declares that '[o]ur programmes will include a range of services to support the community based care and assistance for the people living with HIV. Particular attention will be given to children who have been orphaned and children infected and affected by HIV/AIDS.' In August 2002, the Department of Social Development issued National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS. The introduction to the National Guidelines states that '[t]he crisis has led to a situation where the protection of the rights of orphaned and

205 UNICEF 'South Africa: Statistics' http://www.unicef.org/infobycountry/southafrica_statistics.html#14 (accessed 1 August 2006).

206 The document also indicates that: 'In most parts of the industrialised world, usually no more than 1% of the child population is orphaned. Before the onset of HIV/AIDS, societies in the developing world absorbed children who have been orphaned into the extended family and communities at a rate of just over 2,5% of the child population. Today, as a consequence of AIDS, 11% of Ugandan children are children who have been orphaned, 9% in Zambia and 7% in Zimbabwe. The scenario is likely to be repeated in South Africa.'

vulnerable children in many communities can no longer take place effectively without outside assistance.'

The Children's Act was adopted in 2005.[207] Repealing former pieces of legislation such as the Child Care Act of 1983[208] it states that:

> All proceedings, actions or decisions in a matter concerning a child must-
>
> (a) respect, protect, promote and fulfill the child's rights set out in the Bill of Rights, the best interests of the child standard set out in section 7 and the rights and principles set out in this Act, subject to any lawful limitation;
>
> (b) respect the child's inherent dignity;
>
> (c) treat the child fairly and equitably;
>
> (d) protect the child from unfair discrimination on any ground, including on the grounds of the health status or disability of the child or a family member of the child;
>
> (e) recognise a child's need for development and to engage in play and other recreational activities appropriate to the child's age; and
>
> (f) recognise a child's disability and create an enabling environment to respond to
>
> the special needs that the child has.[209]

Chapter 8, part 3 of the Act deals with protective measures relating to the health of children, and sections 130-134 specifically address issues of HIV and AIDS. Section 130 outlines the circumstances in which a child may be tested for HIV, and specifies that a child aged 12 or more may undergo an HIV test without the consent of his or her parents. Section 131 requires that the state pay for an HIV test if it is done for the purposes of placing the child in foster care or putting the child up for adoption. Sections 132 and 133 of the Act deal with pre- and post-test counselling and confidentiality. Section 134 states that no person may refuse to sell or to provide free condoms to a child aged 12 or more on his or her request even without the consent of their care-givers.[210] Section 32 of the Act also constitutes a major step forward for the protection of the rights of children infected with HIV. It allows for the following:

> (1) A person who has no parental responsibilities and rights in respect of a child but who voluntarily cares for the child either indefinitely,

[207] Children's Act, Act No 38 of 2005. The Children's Bill was tabled in Parliament 2003. Significant debate resulted in a prolonged process for tabling and signature of the Bill. The Bill was passed in the National Assembly on 14 December 2005 and was signed by the President on 8 June 2006. The Act should come into force in March 2008, but parts of the Act have already been implemented as of 1 July 2007. An Amendment Bill has been introduced in July 2006.

[208] Child Care Act 74 of 1983.

[209] As above, sec 6(2).

[210] Section 129 also provides that a girl aged 12 or more has the right to have a pregnancy terminated without the consent of her care-givers.

> temporarily or partially, including a care-giver who otherwise has no parental responsibilities and rights in respect of a child, (...)
>
> (2) (...) to consent to any medical examination or treatment of the child if such consent cannot reasonably be obtained from the parent or primary care-giver of the child.

Formerly, under the Child Care Act,[211] permission had to be granted by the Minister of Social Development or the High Court before a medical procedure or a medical treatment may be performed on children under the age of 14 when the consent of a parent or guardian cannot be obtained. Human Rights Watch and ALP found that these requirements impeded children's access to proper treatment, including post-rape medical care and anti-retroviral treatment.[212]

According to South Africa's UNGASS Progress Report, 195 556 of the children receiving social grants in South Africa as of January 2006 had been placed in foster care and that at least 90 per cent of these children were assumed to be orphaned children.[213]

The government has initiated an Orphaned and Vulnerable Children's (OVC) Programme, which identifies vulnerable children and provides counselling, HIV awareness programmes, and material support, including basic food provision and home-based care.[214] The programme also provides training for caregivers.[215] In July 2005, the 'National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS in South Africa' was launched.[216] The key strategies of this Action Plan are to strengthen and support the capacity of families to protect and care for OVC; to mobilise and strengthen community-based responses for the care, support and protection of OVC; to ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children; to ensure access of OVC to essential services; to create a supportive environment for OVC; and to engage the business community.[217]

A recent report by the Human Sciences Research Council (HSRC) entitled 'A situational analysis of children who have been orphaned and vulnerable children in four districts of South Africa' found that the main concern expressed by guardians of OVC was a lack of access

211 n 206 above.
212 See Human Rights Watch (2004) 'South Africa: Safeguarding children's rights to medical care' http://hrw.org/english/docs/2004/07/27/safric9150.htm (accessed 1 August 2006). See also L Gerntholtz 'HIV testing and treatment, informed consent and AIDS children who have been orphaned' (2003) 4 *ESR Review* 11-14.
213 Government of South Africa (n 9 above) 31.
214 As above, 21-27.
215 As above.
216 National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS 2006-2008 (15 July 2005).
217 As above, 3-4.

to grants and that the primary complaint of community organisations was a lack of service delivery.[218]

11.3 Education

Section 9 of the Constitution, the equality clause, protects children against discrimination. Additionally, section 29(1)(a) declares that '[e]veryone has the right to a basic education, including adult basic education.' The Preamble to the South African Schools Act[219] seeks to protect children against discrimination by stating that 'this country requires a new national system for schools which will redress past injustices in educational provision ... [and] combat racism and sexism and all other forms of unfair discrimination and intolerance'. Section 3(1) of the Schools Act provides for compulsory school attendance for learners from age 7 'until the last school day of the year in which such learner reaches the age of fifteen years or the ninth grade, whichever occurs first'. Section 5(1) requires that '[a] public school must admit learners and serve their educational requirements without unfairly discriminating in any way.' Section 5(3) declares that '[n]o learner may be refused admission to a public school on the grounds that his or her parent ... is unable to pay or has not paid the school fees determined by the governing body under section 39'. Additionally, girls who become pregnant are legally entitled to remain in school.

On 10 August 1999, the Department of Education published the National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions (National Policy on HIV/AIDS for Learners and Educators). Section 2(6) of the Policy states that

> [l]earners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practised against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned.

Section 3(1) continues by stating that '[n]o learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly'. Section 4(1) of the Policy declares that '[n]o learner or student may be denied admission to or continued attendance at a

[218] HSRC 'A situational analysis of orphans and vulnerable children in four districts of South Africa' (2006) x-xi.

[219] South African Schools Act 84 of 1996.

school or an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status'.[220]

While schools are prohibited from barring children based upon their HIV status, HIV-negative OVC children do not enjoy the same protections, even though they are disproportionately likely to drop out of school or to fall behind their peers.[221] Though children affected by AIDS are not victims of a direct discriminatory bar to education, it is also clear that their access to education is not truly equal.

With respect to teachers, the National Policy on HIV/AIDS for Learners and Educators states in section 2(10) that '[a]ppropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate learners about the epidemic should also be provided.' Section 2(10)(2) further provides that

> [b]ecause of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life skills and HIV/AIDS education in the school and province ... Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of and skill to deal with HIV/AIDS ... All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

With respect to quality promotion and development, the Department of Education has recently produced several publications relating specifically to HIV and AIDS: *Values and human rights in the curriculum* (6 July 2005), the *Integration guide book for principals and teachers* (9 September 2004), *HIV and AIDS in your school - What parents need to know* (6 August 2004), *Develop an HIV and AIDS plan for your school - A guide for school governing bodies and management teams* (6 August 2004), and *Plan and act to protect education against the impact of HIV and AIDS - Manage HIV and AIDS in your province* (6 August 2004).[222]

A teacher-training programme geared to enhance facilitation skills to enable educators to communicate sex education in a relaxed but professional manner has been implemented under the Life Skills and HIV/AIDS Education Programme of the DoH, in conjunction with the Department of Education.[223] The DoH has produced a handbook

220 But see the recent judgment of the High Court of *Perreira v Buccleuch Montessori Nursery School* (n 73 above).

221 Human Rights Watch 'Letting Them Fail: Government Neglect and the Right to Education for Children Affected by AIDS' 17 (2005) 11.

222 Full text versions of all of these publications can be found at http://www.education.gov.za/mainDocument.asp?src=docu&xsrc=publ (accessed 1 August 2006).

223 ALP 'Regional Audit on HIV/AIDS, Human Rights and Other Relevant Issues' 18.

for educators based on the National Policy on HIV/AIDS for Learners and Educators called *The HIV/AIDS Emergency Guidelines for Educators*. The handbook is available in English, Afrikaans, isiZulu, isiXhosa, Sepedi, Sesotho and Xisonga.[224]

The National Policy on HIV/AIDS for Learners and Educators advises that

> [b]esides sexuality education, morality, and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until marriage and faithfulness to their partners.

Furthermore, the Policy recommends that learners receive education about HIV, AIDS and abstinence in the context of life-skills education on an ongoing basis. Life-skills and HIV education should not be presented as an isolated learning concept, but should be integrated in the whole curricula. It should be presented in a scientific but understandable way. Section 9 of the Policy deals with education on HIV and AIDS and sets out detailed guidelines covering life skills and HIV education programmes for all learners, students, educators and other staff members.

According to the Cabinet, promoting public awareness, life skills and HIV education programmes forms part of the core effort to prevent transmission of HIV. HIV education is now a compulsory part of the school curriculum and full implementation is expected by the end of 2003. The Life Skills Education Programme has been strengthened through the Integrated Strategy for Children. This initiative of the Department of Education, in conjunction with the DoH, is aimed at providing information about HIV and focuses on attitudes, skills development, and motivational support. Topics covered in this programme include self-esteem, understanding sexuality, preventing HIV, and the prevention of STIs.[225] The Life Skills Programme is to be expanded to all primary and secondary schools over a three-year period. It has already commenced in primary schools and is now in its fifth year.[226]

In addition, the School Health Service, as part of the primary health care package for South Africa, is expected to provide health-promoting services by acting in a co-ordinating role and by making use of the skills and capacity in different sectors of society, including learners and educators. According to the guidelines of this

[224] DoH 'HIV/AIDS Emergency Guidelines for Educators.' The handbook is available at http://education.pwv.gov.za/HIV/AIDS_Folder/aids%20book.pdf (printed in 2000 and reprinted in 2002, accessed on 31 August 2006).

[225] ALP 'Regional audit on HIV/AIDS, human rights and other relevant issues' 18.

[226] 'The South African Government's response to the HIV/AIDS epidemic: Controversies and priorities' (2000) http://www.doh.gov.za/aids/docs/gov-aids.html (accessed 13 September 2007).

programme, educators are directly involved in activities such as distributing health-promoting educational materials, promoting healthy sexuality, and dealing with the results of unhealthy sexual behaviour.

12. Family law

There exists no inheritance legislation that specifically addresses HIV or impacts those living with HIV. Inheritance in South Africa was regulated by the Intestate Succession Act and the Black Administration Act up until the Constitutional Court's decisions in *Bhe and Others v The Magistrate, Khayelitsha and Others;*[227] *Shibi v Sithole and Others;*[228] and *South African Human Rights Commission and Another v President of the Republic of South Africa.*[229] Of particular importance was section 23 of the Black Administration Act, which instituted the rule of primogeniture in the regulation of inheritance among black South Africans. The section was particularly detrimental to women and children, especially if they were affected by HIV and AIDS, since very often they were stripped of all their belongings by their own relatives upon the death of their husband or father.[230] However, in the *Bhe* case, the Constitutional Court decided that the rule of male primogeniture in South Africa is unconstitutional. The effect of the *Bhe* case is that all deceased estates will be transferred to heirs or beneficiaries in terms of the Intestate Succession Act,[231] under which the estate of a decedent shall benefit a spouse regardless of gender and children regardless of legitimacy.

Further, the Customary Succession Bill proposes that people who marry under customary laws, including members of polygamous marriages, be allowed to have their property divided up under the rules of the Intestate Succession Act in the event of death of one of the spouses.

The Child Care Act regulates the guardianship of minors, while the Adults with Impaired Decision-Making Capacity Bill[232] regulates adult guardianship. Chapter 6 of the Adults with Impaired Decision-Making Capacity Bill introduces the concept of 'enduring power of attorney',

227 *Bhe and Others v The Magistrate, Khayelitsha and Others* 2004 2 SA 544 (C).
228 *Shibi v Sithole and Others* CCT69/03.
229 *South African Human Rights Commission and Another v President of the Republic of South Africa* 2005 1 SA 580 (CC).
230 See Speak Out Legal Services 'News, laws and legislation surrounding rape' http://www.speakout.org.za/legal/laws/laws_law_of_succession.html (accessed 1 August 2006).
231 Intestate Succession Act 81 of 1987.
232 Adults with Impaired Decision-Making Capacity Bill (2004) http://www.doj.gov.za/salrc/dpapers/d105_prj122/dp105_prj122_c08bill_adm_2004.pdf (accessed 1 August 2006).

according to which an agent can make decisions about the principal's property and personal welfare in the event of incapacity of the principal. According to the explanatory note to the Bill, 'personal welfare means any matter relating to the person of an adult with incapacity not relating to 'property' and includes health care'. Although the Bill does not specifically address HIV or AIDS, it is relevant, especially at a later stage of the development of the disease when the patient is in a vegetative state or suffers from AIDS dementia. However, the Bill is not clear on the extent of the power granted to the guardian with regards personal welfare.

13. Criminal law

13.1 Criminal legislation

The Criminal Law Amendment Act[233] provides for life imprisonment for an HIV-positive offenders conviction of rape - including a first offender. A lesser minimum sentence of ten years is provided for a first offender who is not HIV positive. The Act does not stipulate the kind of evidence of HIV transmission required to support the imposition of a higher sentence. In amending the Criminal Procedure Act of 1977, the Criminal Procedure Second Amendment Act 85 of 1997 now makes the eligibility for bail more difficult in rape cases where the accused is known to be HIV positive. The accused is generally denied bail if he or she is HIV positive, although bail may be granted if the accused establishes 'exceptional circumstances'.[234]

In three criminal cases,[235] the HIV-positive status of the accused has been considered as a mitigating factor in sentencing, and in *Stanfield v Minister of Correctional Services*[236] the Court proclaimed itself in favour of granting parole on medical grounds to terminally ill prisoners with HIV, because 'even the worst of convicted criminals should be entitled to a humane and dignified death'.[237]

The South African Law Commission investigated possible changes to the definition of the crime of rape,[238] as well as the possibility of requiring a sexual offender to undergo an HIV test if requested by the

233 Criminal Law Amendment Act 105 of 1997.
234 As above, sec 60(11).
235 See *S v Cloete* (n 73 above); *S v C* 19962 SACR 503 (T); *S v Sibonyane* Pretoria Regional Court case 14/2865/97. See also *S v Belelie* 1997 2 SACR 79 (W) where HIV infection was regarded as a mitigating factor by the Magistrate's Court.
236 *Stanfield v Minister of Correctional Services* 2004 4 SA 43 (C).
237 As above, para 18.
238 Under the common law, a person found guilty of anal rape can only be charged for indecent assault. However, in July 2005, the Lydenberg Magistrate's Court in Mpumalanga redefined the crime of rape to include anal rape. See 'Rape's new face before the law' 11 July 2005 *SABC News* http://www.sabcnews.co.za/south_africa/crime1justice/0,2172,108151,00.html (accessed 1 August 2006).

victim and ordered by a magistrate. These changes have been incorporated into two separate bills that were introduced in Parliament in 2003: the Compulsory HIV Testing of Alleged Sexual Offenders Bill[239] and the Criminal Law (Sexual Offences) Amendment Bill.[240] These bills were later merged into a single document: the Criminal Law (Sexual Offences and Related Matters) Amendment Bill 50B of 2003, which was passed by the National Assembly on 22 May 2007.

The document acknowledges the high incidence of sexual offences in the country and recognises that there are links between the spread of HIV and rape. It makes it compulsory for alleged sexual offenders to be subject to an HIV test and has provisions for disclosure of the latter's serostatus to the victim or other interested persons. It also enlarges the definition of rape to apply irrespective of the gender of the victim or the perpetrator and to include sexual penetration with inanimate objects and animal genitalia.

Further, it is interesting to note that the South African Law Commission investigated the possibility of criminalising harmful HIV-related behaviour but in June 2001 published a report[241] recommending that harmful HIV-related behaviour should not be criminalised. It reasoned that criminalisation may harm rather than help people vulnerable to infection, exacerbate discrimination against people living with HIV, and disturb public health efforts to stop the spread of HIV.[242] An earlier draft of the Sexual Offences Bill intended to criminalise persons who intentionally fail to disclose to individuals with whom they have intercourse that they are infected by a life-threatening sexually transmitted infection. This provision was absent from the last version of the Criminal Law (Sexual Offences and Related Matters) Amendment Bill passed in May 2007. In November 2003, in a case involving a man found guilty of attempted murder for raping a woman while knowing he was HIV positive,[243] the High Court concurred with the South African Law Commission's view that the common law is sufficiently wide enough to cover cases of this nature.

13.2 Men having sex with men

In 1996, South Africa became the first country in the world explicitly to include sexual orientation as a prohibited ground for discrimination

239 Compulsory HIV Testing of Alleged Sexual Offenders Bill 10 of 2003.
240 Criminal Law (Sexual Offences) Amendment Bill 50 of 2003.
241 South African Law Commission 'Aspects of the law relating to HIV/AIDS, Fifth Interim Report, The need for a statutory offence aimed at harmful HIV-related behaviour' (2001).
242 See also F Viljoen 'Stigmatising HIV/AIDS, stigmatising sex? A reply to Professor Van Wyk' 41 (2000) *Codicillus* 11-16.
243 *S v Nyalungu* (n 76 above).

in its Constitution.[244] It was not until 1998, however, that the Constitutional Court confirmed that laws criminalising sex between men were unconstitutional, when it struck down common law crimes of sodomy, unnatural sexual offences and section 20(a) of the Sexual Offences Act.[245] In *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*,[246] the Constitutional Court held that these laws violate the rights to equality, dignity and privacy.

14. Prisoners' rights

The only two measures currently in place to stop the spread of HIV in prisons are condom distribution and HIV prevention programmes.[247] The Department of Correctional Services has an HIV policy for offenders.[248] This policy includes voluntary counselling and testing and also covers the provision of HIV and AIDS awareness sessions and peer education.[249]

There are currently no definitive figures on the number of HIV-positive prisoners in South Africa. The mortality rate in South African prisons has risen from 1.65 deaths per 1 000 prisoners in 1995 to 9.1 deaths per 1 000 prisoners in 2004. This increase has not, however, been directly linked to HIV.[250] In 2006, the Department of Correctional Services stated that it was in the process of conducting an HIV prevalence survey to determine HIV prevalence among both prisoners and personnel.[251]

The Department of Correctional Services claims that a prisoner's health status and medical records remain confidential at all times, unless written consent has been given to release the information. The Department also states that prisoners who participate in voluntary counselling and testing and test positive for HIV are not forced to disclose their status.[252] Nevertheless, it has been pointed out that

244 Constitution (n 42 above), sec 9(3).
245 International Lesbian and Gay Association 'World legal survey: South Africa' http://www.ilga.info/Information/Legal_survey/africa/southafrica.htm (accessed 1 August 2006).
246 *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 12 BCLR 1517 (CC); CCT11/98.
247 L van der Merwe (Co-ordinator of the Penal Reform Project, Lawyers for Human Rights) (27 February 2006).
248 C Gerber (Department of Correctional Services) (4 April 2006).
249 C Gerber Department of Correctional Services (24 March 2006) and http://www.dcs.gov.za (accessed 13 September 2007).
250 W Roelf 'HIV survey on track for SA prisons' *Mail and Guardian* 3 April 2006 http://www.mg.co.za/articlePage.aspx?articleid=268421&area=/insight/insight__national (accessed 1 August 2006).
251 Gerber (n 248 above).
252 As above.

since some HIV-positive prisoners are placed on special diets, their status can easily become known to others.[253]

The issue of HIV-positive prisoners' access to anti-retroviral drugs has received wide attention in the courts and the media. In *Magida v South Africa*,[254] in which the appellant's AIDS status was considered as a factor in deciding an appropriate sentence for fraud, the Court noted that the head of the prison in which the appellant served part of her sentence during 2001-2003 confirmed that Nevirapine was not available in any prison in South Africa at that time.[255]

Officially, the Department of Correctional Services maintains that prisoners now have access to anti-retroviral therapy through the DoH's accredited ARV facilities. However, it has been pointed out that the South African government's response to HIV in prisons cannot solely be evaluated by examining policies and court cases, since the implementation of these policies and acts of Parliament has been a major challenge.[256] Indeed, discord exists between policy and reality in the case of prisoners' access to ARVs.

At the end of March 2006, hundreds of HIV-positive inmates launched a hunger strike at the Westville Correctional Centre (WCC) in Durban. According to the Treatment Action Campaign, over 20 prisoners had already died in prison during the three months leading up to this strike because of HIV and AIDS-related infections.[257] The ALP, which was representing some of the prisoners at the Westville prison, was informed that delay in access of ART was caused by slowness in accrediting prison hospitals, the refusal to admit prisoners into ARV programmes at nearby public health facilities for security reasons, and the requirement that prisoners are in possession of a valid ID document.[258] Reports state that authorities require R35 for inmates to obtain a valid ID.[259]

Following unsuccessful negotiation attempts, the ALP, in April 2006, launched an application before the High Court seeking the removal of the restrictions that prevent eligible prisoners living with HIV at WCC from accessing ART at accredited public health facilities. The ALP also sought that the respondents (the government of South

253 Van der Merwe (n 247 above).
254 *Memory* case (n 69 above).
255 *Memory* case (n 69 above) para 11.
256 KC Goyer 'HIV/AIDS policy in South African prisons' in *HIV/AIDS in prisons: problems, policies and potential* (2003) http://www.iss.co.za/Pubs/Monographs/No79/Chap3.pdf (accessed 13 September 2007) 54.
257 'HIV positive inmates embark on hunger strike' *SABC News* 27 March 2006 http://www.sabcnews.com/south_africa/health/0,2172,124521,00.html (accessed 13 September 2007).
258 'Prisoners continue to be denied access to treatment for HIV/AIDS at Westville Correctional Centre (KwaZulu-Natal)' ALP Press Release 19 January 2006.
259 'HIV positive inmates embark on hunger strike' (n 257 above).

Africa and others) be ordered with immediate effect to provide ART treatment to all eligible HIV-positive prisoners at WCC.

The Court found it 'regrettable that prisoners, being of a class, very vulnerable to infection, were not given special consideration in the Operational Plan and Guidelines'.[260] The Court reaffirmed the obligation of the state to fulfil the rights to access to health care (section 27 of the Constitution) and the right to adequate medical treatment of detained persons (section 35 of the Constitution). The Court found that the 'treatment and medical care afforded [to prisoners at WCC] is neither adequate nor reasonable in the circumstances. The respondents have ... fallen short of their constitutional and legislative obligations to the applicants'.[261] The Court ordered the respondents to remove the restrictions to access to ART for eligible HIV-positive prisoners at WCC and required the respondents to lodge within two weeks after the decision an affidavit setting out the manner in which they would comply with the order to provide ART.

Some have suggested using the medical parole procedures to get around the practical dilemma of prisoners not receiving ARVs onsite and the availability of ARVs offsite. This, however, is fraught with difficulties as the parole provisions are framed with the aim of allowing the terminally ill to die in a 'consolatory and dignified' manner. ART, of course, aims to prevent death altogether. Moreover, the Department of Correctional Services has total responsibility for caring for prisoners and ensuring that their health rights are vindicated and that their human dignity is respected. As one author argues, the medical parole provisions do not exist to alleviate shortcomings in the prison system.[262] At the end of 2006, only one detention centre in South Africa — Grootvlei — has been accredited. Prisoners in non-accredited prisons are entitled to be brought to off-site accredited centres. This is not, however, occurring.[263]

Several civil society organisations have led a lengthy battle to distribute condoms in prisons.[264] The Department of Correctional Services notes that condoms are now placed at accessible places to promote safety and awareness of the HIV/AIDS pandemic.[265]

HIV-positive prisoners are not detained separately from other prisoners; however, when they are very ill, inmates are sometimes placed in prison hospitals.[266]

260 *E N and Others v Government of RSA and Others* 2007 1 BCLR 84 (D) 105.
261 *E N and Others v Government of RSA and Others* 2007 1 BCLR 84 (D) 106.
262 For more on this discussion see L Muntingh 'Medical parole: Prisoners' means to access anti-retroviral treatment?' (March 2006) *ALQ* 8-10.
263 Correspondence with L Muntingh (12 April 2006).
264 Goyer (n 256 above).
265 http://www.dcs.gov.za (accessed 1 August 2006).
266 Van der Merwe (n 247 above).

The Department of Correctional Services' policy on sex between men in prison is that it is not allowed. Any forceful sexual practice, for example sexual assault or sodomy, is officially regarded as criminal, and there are reporting mechanisms in place to address such occurrences.[267]

The HIV and AIDS and STI strategic Plan for South Africa, 2007-2011 contains a paragraph on HIV and incarceration in its section on specific vulnerable groups. Although the Strategic Plan provides for various services to prisoners it fails to mention access to ART.

15. Immigration

HIV or AIDS is not explicitly mentioned in the Immigration Act.[268] Nevertheless, there are two main ways in which someone could be indirectly restricted from entry into South Africa based upon the fact that he or she is HIV positive. If someone is declared either to be (1) a 'prohibited person', or (2) 'an undesirable person', the person will not qualify for a visa, and admission into South Africa and temporary or permanent residence permits will be barred. Individuals 'infected with or carrying infectious, communicable or other diseases or viruses' are considered to be 'prohibited persons'.[269] Someone may be declared to be an 'undesirable person' if he or she is likely to become 'a public charge'. There is little statutory direction on either of these two categories, and no court cases have considered the sections, so it remains to be seen how these sections will be applied towards individuals living with HIV.

Non-nationals are not explicitly asked to be tested for HIV prior to gaining admission to South Africa, but there are broad medical clearance requirements which could be interpreted indirectly to require such tests. Applications for a visa into South Africa and for temporary residence permits ask if the applicant is 'suffering from tuberculosis or any other infectious or contagious disease or any mental or physical deficiency'.[270] Medical and radiological certificates are required for all applications for permanent residence.[271] Medical certificates are also required for temporary residence permits in some cases.[272] Medical certificates require that a medical practitioner certify that the non-national is not 'mentally

267 Gerber (n 248 above).
268 Immigration Act 13 of 2000, as amended by the Immigration Amendment Act 19 of 2004 which brought several important changes when it came into force on 1 July 2005.
269 Sec 29(1)(a) Immigration Act 13 of 2002.
270 Application for Visa or Transit Visa pursuant to Sec 7(1)(g) read with sec 10A and 10B; Reg 8(1) and Application for Temporary Residence permit Form BI-1738.
271 Application for Permanent Residence Permit Form BI-947.
272 Application for Temporary Residence Permit Form BI-1738.

disordered or physically defective in any way; not suffering from leprosy, venereal disease, trachoma, tuberculosis or other infectious or contagious condition; and generally in a good state of health'.[273]

Whether the revelation of a positive HIV test would be used to deny a non-national admission into South Africa is not clear. Since state policy on refusing admission to non-nationals based upon HIV tests is fairly inexplicit, effective decisions on the matter may be made at lower levels in the government hierarchy.

16. Social assistance and other government benefits

Section 27(1)(c) of the Constitution states that '[e]veryone has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance'. Section 27(2) states that '[t]he state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of the rights'.

The Social Assistance Act[274] was enacted to provide for the rendering of social assistance to different categories of persons. The Social Assistance Act does not specifically mention people living with HIV. It does, however, provide for disability grants and foster care grants, amongst others. People living with HIV can qualify for a disability grant if they satisfy the criteria stipulated in the Social Assistance Act. Section 2(a) of the Social Assistance Act states that social grants can be made to the aged, to disabled persons, and to war veterans. A 'disabled person' is defined as 'any person who has attained the prescribed age and is, owing to his physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him to provide for his maintenance'. A means test is also applied; applicants are awarded grants only if their financial resources are below a certain level. Thus, an HIV-positive person will qualify for a disability grant only if his or her illness precludes employment.

The current policy of the Department of Social Development, however, is to provide benefits to a person with HIV only if the person has a CD4 cell count below 50 and suffers from a major opportunistic infection.[275] One systemic problem that has been highlighted is that individuals who receive ART and become well may disqualify themselves from disability grants. In cases where the family breadwinner contracts HIV and becomes sick, a choice must be made

[273] Medical Certificate Form BI-811.
[274] Social Assistance Act 59 of 1992.
[275] ALP 'Disability Grants' http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=77 (accessed 1 August 2006).

between pursuing ART and refusing ARVs in order to remain eligible for disability grants that support the family. [276]

The Social Assistance Act was amended in 1994 to further regulate the grants and financial awards to certain persons and bodies. In 1997, the Welfare Laws Amendment Act came into force in order to provide for the uniformity of equality of access to, and the effective regulation of, social assistance throughout the country.

People living with HIV may also qualify for social relief of distress grants under the Social Assistance Act. This scheme provides for temporary assistance (not more than 3 months) to individuals, most often in the form of coupons. A person qualifies for social distress grants if he or she is medically unfit to work and does not qualify for another grant.

In 2004, the President assented to the new Social Assistance Act.[277] With the exception of chapter 4, which deals with the Inspectorate for Social Assistance, the Act entered into force on 1 April 2006.[278]

The Department of Social Development maintains an annual publication entitled *You and social grants*, which contains step-by-step instructions on how to apply for social grants.[279] The brochure also explains the 'means test', the different social grants available, and the documents required for application. The brochure specifies the amounts that will be granted under the various social grants for the current year (for example, R620 per month was awarded for a disability grant in 2002).

In 1996, policy and programme shifts were initiated to transform welfare services in order to accommodate the needs of the elderly, people living with HIV, people with disabilities, as well as to facilitate the upgrading of secure care facilities and the implementation of the National Plan of Action for Children. In 1997, a Social Welfare Action Plan on HIV/AIDS was developed to focus the role of the welfare sector in addressing HIV and AIDS.

The Department of Social Development organised a conference in June 2002 to co-ordinate action for children affected and infected by HIV and AIDS. The recommendations resulting from this conference included each of the following:

- a co-ordination structure with three levels;

276 S Clark 'ARVs versus social grants: the dilemma of the poor' (March 2006) *ALQ* 28-30.
277 Social Assistance Act 13 of 2004.
278 *Government Gazette* Notice R-15 (2006).
279 'You and Social Grants 2000' www.welfare.gov.za/Documents/2002/ugrant/html (accessed 1 August 2006).

- engaging in a national process for identifying children who have been orphaned, vulnerable children and duty bearers, and the creation of a database;
- fast-tracking the process for accessing social security grants;
- determining how civil society through NGOs, Community Based Organisations (CBOs) and Faith-Based Organisations (FBOs) could assist the Department of Social Development with social grants;
- engaging in a national process for creating awareness about services available to orphaned and vulnerable children; and
- suggestions as to how the Department of Social Development could fast-track the process for the establishment of home/community based care.

The National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS were published in August 2002. These Guidelines originate from the NSF on children. One of the objectives of the Guidelines is to make information available on welfare services and grants.[280]

Whilst there were no special provisions for children infected or affected by HIV and AIDS before the August guidelines, under the Social Assistance Act caregivers of these children could access financial support in the form of child support grants (for children younger than seven years), care dependency grants, or foster grants.

The government update on the National HIV and AIDS Programme for 2003 stated that:

- expanded access to child support grants and successive increases in the amount of the grant has been a major benefit to families affected by HIV/AIDS;[281]
- the grant will be extended over the next three years to reach children up to the age of 14 years; and
- a conditional grant of R66 million has been allocated to the Department of Social Development to focus on home/community-based care and specifically to address the issues of orphaned and vulnerable children, social relief (including food parcels), counselling and child care.[282]

[280] This is especially important since a study released in March 2002 indicated that the vast majority (73%) of public health clinics and hospitals reported that they referred clients elsewhere for advice and assistance with accessing a social security grant. Rapid Appraisal of Primary Level Health Care Services for HIV-positive Children at Public Clinics in South Africa, a project of the Children's Institute, University of Cape Town (UCT) in collaboration with the Child Health Unit, University of Cape Town.

[281] At the end of 2002, a total of 2.5 million child beneficiaries were registered.

[282] Government of South Africa 'Update on the National HIV and AIDS Programme' 19 March 2003, available at: http://www.gov.za/issues/hiv/update19mar03full.htm (accessed 1 August 2006).

South Africa is currently considering introducing a Basic Income Grant (BIG) to address the shortcomings in the social assistance system.[283] Enhancing the fight against HIV and AIDS is identified as a benefit of the proposed grant. It is anticipated that such a grant would reach those most affected by HIV and AIDS, such as young adults who currently have very little access to social grants.

17. Insurance

The Life Office's Association (LOA) is an association of life insurance companies in South Africa. In October 2000, the LOA adopted an 'HIV Testing Protocol'.[284] The Protocol forms part of the LOA's Code of Conduct and is, therefore, binding on all member offices. The purpose of the Protocol is to ensure that the life insurance industry adheres to the highest standards in all aspects of HIV screening of applicants for life insurance. It addresses issues such as identification, confidentiality, informed consent, pre- and post-test counselling, transmission of test results, accreditation of test kits and laboratories, and the use of exclusion clauses. The Protocol also states clearly that the results of tests should be relayed only to the doctor or clinic named by the applicant on his or her consent form and that under no circumstances may any HIV test result be communicated to any sales intermediary or other unauthorised person.[285]

Paragraph G(3) of the LOA protocol provides the following:

> If the HIV test is reported as reactive and in cases where the results are discordant, the result should be seen as reactive and uninsurable. The following procedure will then be followed:
>
> (a) The case is declined.
>
> (b) The necessary entry is made on the LOA Life Register.[286]
>
> (c) The client is informed that the medical evidence has been submitted to his nominated doctor.
>
> (d) A copy of the laboratory report, clearly marked 'Private and Confidential' is sent to the nominated doctor.
>
> (e) The company concerned will pay for one counselling session at the rate agreed with SAMA from time to time.

283 See 'South Africans for a Basic Income Grant' http://www.drc.org.za/docs/Background_Brie.ng.doc (accessed 1 August 2006).

284 LOA 'HIV Testing Protocol' http://www.loa.co.za/modules.php?name=Content&pa=showpage&pid=30 (accessed 1 August 2006).

285 As above.

286 The rejected applicant's name is put in code on the Life Register as someone who has been refused insurance. This means that future applications by the applicant to different insurance companies will also be denied.

(f) Any further tests that may be undertaken will be at the client's own expense.

According to annexure 2 of the Protocol, refusal to take the test will result in denial of the application. Annexure 2 also states that any existing policy will remain valid unless periodic retesting for the HIV is required, though such a policy may have an AIDS exclusion clause, which would mean that the policy holder could not collect for treatment required for any AIDS-related illness. According to the Protocol, some insurance companies offer special policies or alternative products for people with HIV. Most insurers, however, charge higher premiums and often limit the amount of insurance available.

Currently, Old Mutual and Sanlam, South Africa's two largest insurers, offer limited life insurance to people with HIV on condition that the coverage is linked to a savings product.[287] Liberty, the nation's third-largest insurer, has no products catering for those who are HIV positive, while Metropolitan Holdings, the fourth-biggest life company, limits its life insurance policies to R50 000.[288]

AllLife is a life insurance firm specialising in life insurance for HIV-positive people. Its policies are underwritten by Nova Life Partners, a venture between property and casualty insurer Santam and Kagiso Treasury Services and reinsured by General Re, a member of Warren Buffett's Berkshire Hathaway group. It provides for life insurance to HIV-positive clients at a premium ranging from R200 to R700 a month, depending on the extent of the illness, with a life insurance policy of R100 000 and a limit of R1 million. Under AllLife policies, regular blood tests and compliance with anti-retroviral treatment are the only conditions for coverage. However, AllLife does not provide coverage to those who have developed full-blown AIDS.[289]

18. Oversight

There is currently no specific government mechanism to ensure implementation of legislation relating to HIV and AIDS in South Africa. Nevertheless, according to chapter 6 of the South African Constitution, Parliament and the provincial legislatures are mandated

[287] See details about OmuCare at http://www.oldmutual.co.za/ProdForInd/Products.asp?item=Life%20and%20Disability&needid=C4631D8B-3D08-4C1C-8241-21C9517A3E0E (accessed 1 August 2006) and details about Dread Disease Cover at http://www.sanlam.co.za/eng/aboutus/sanlambusinesses/sanlamlife/products/matrixriskcover/dread +disease+cover.htm (accessed 1 August 2006).

[288] See S Bridge 'Affordable insurance for HIV+ people: AllLife says product will revolutionise sector' 1 December 2005 http://www.busrep.co.za/index.php?fSectionId=611&fArticleId=3017698 (accessed 1 August 2006).

[289] As above.

to exercise legislative oversight of the executive.[290] Part of this oversight is the monitoring of the budget and service delivery by government departments. Both parliamentary and legislative oversight in South Africa is largely conducted by portfolio committees who review departmental reports and hold government to account. At present there is no structured HIV and AIDS oversight structure at Parliament or the provincial legislatures. HIV and AIDS oversight is rather conducted tangentially by portfolio committees such as the Portfolio Committees on Health, Social Development and Education.[291]

While HIV is not being monitored comprehensively at the committee level, government departments engage in a certain degree of self review. Coordinating bodies such as the Gauteng Intersectoral AIDS Unit are currently in the process of strengthening monitoring and evaluation systems. In line with UNAIDS 'Three Ones' principles, the Intersectoral AIDS Unit has adopted the UNAIDS Guidelines on Construction of Core Indicators as a monitoring tool.[292]

19. Stigma

Though no South African legislation explicitly addresses stigma, legal interventions have been designed to address the problem.[293] Stigma often manifests itself in the form of discrimination. The Promotion of Equality and Prevention of Unfair Discrimination Act (Equality Act)[294] aims at preventing discrimination. While HIV status is not a specific ground of discrimination under the Equality Act, the directive principles note that the Minister ought to consider the inclusion of HIV status as a prohibited ground.[295] The Equality Act also protects against hate speech. While HIV is, again, not specifically named, some authors feel that prospective cases of HIV hate speech would likely be covered under the hate speech provisions. Discrimination in the workplace is specifically targeted through the Employment Equity

290 Constitution (n 42 above) ch 6.

291 Gauteng Provincial Legislature (AIDS and Human Rights Research Unit) 'HIV/AIDS Mainstreaming in the Gauteng Legislature' (2006).

292 The UNAIDS 'Three Ones' Principles are: '1. One agreed HIV/AIDS Action Framework that provides for coordinating the work of all partners. 2. One National AIDS Coordinating Authority with a broad multisectoral mandate and 3. One agreed country-level Monitoring and Evaluation System'. See UNAIDS 'The Three Ones: principles for the coordination of national AIDS responses' www.unaids.org/en/Coordination/Initiatives/three_ones.asp (accessed 1 August 2006). See also UNAIDS Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators (July 2005).

293 F Viljoen, 'Introduction' in AIDS and Human Rights Research Unit, University of Pretoria *Righting Stigma: Exploring a rights-based approach to addressing stigma* (2005) 8-9.

294 Promotion of Equality and Prevention of Unfair Discrimination Act (n 218 above).

295 Viljoen (n 293 above) 9.

Act,[296] which prohibits discrimination against anyone in the workplace on the basis of HIV status.[297]

[296] Employment Equity Act (n 61 above).
[297] As above, secs 7(1) and 50(4).

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7 HIV, AIDS and the law in Swaziland

1. Background to country

1.1 First AIDS case

Swaziland's first reported AIDS case was documented in 1987.[1] It is not clear where the case was documented, how the person became infected or whether or the person's information was kept confidential.

1.2 Demography

Swaziland has an approximate population of 1 032 000 in 2007.[2] The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the same year Swaziland had 220 000 (150 000 - 290 000) people living with HIV, that the HIV prevalence rate among adults aged 15 to 49 was 33.4 per cent (21.2 - 45.3 per cent) and that a total of 16 000 (10 000 - 23 000) people died as a result of AIDS.[3]

HIV in Swaziland is most common among young adults. UNAIDS and the World Health Organisation (WHO) put the HIV prevalence rate among those aged 20 to 29 at an astonishing 56 per cent.[4] Women have been hit much harder by the epidemic than have men. 2005 HIV-prevalence rates were roughly 22.7 per cent (11.5 - 35.9 per cent) among women aged 15 to 24 and 7.7 per cent (3.9 - 12.1 per cent) among men of the same age group.[5] About 120 000 (65 000 - 170 000) Swazi women over the age 14 were living with HIV in 2005.[6]

Approximately 15 000 (5 500 - 32 000) children aged 0 to 14 were living with HIV in 2005.[7] No statistics are available on the number of babies born HIV-positive each year. In 2004, about 37.3 per cent of young (aged 15 to 24) pregnant women in Mbabane were HIV positive.[8] UNAIDS and the WHO put the national rate of HIV prevalence among

1 UNAIDS & WHO 'Swaziland Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: 2004 Update' (2004) http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS_PDFs/EFS2004_SZ.pdf (accessed 1 August 2006) 6.

2 UNFPA 'State of the world population 2007: Unleashing the potential of urban growth' 90.

3 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 505-508.

4 UNAIDS & WHO 'Summary Country Profile for HIV/AIDS Treatment Scale-up: Swaziland' (2005), http://www.who.int/3by5/support/june2005_swz.pdf (accessed 1 August 2006) 1.

5 UNAIDS (n 3 above) 508.

6 As above, 506.

7 As above, 507.

8 As above, 509.

pregnant women at 43 per cent.[9] Roughly 63 000 (45 000 - 77 000) children have been orphaned due to AIDS in 2005.[10]

The tuberculosis (TB) prevalence rate was about 1.2 per cent (1 119.6 per 100 000) in 2004.[11] In 2003, 75 - 80 per cent of adults (ages 15 to 49) with TB were also infected with HIV.[12]

No statistics are available on infection rates among injecting drug users, sex workers, or men having sex with men.[13]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[14]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	26/03/2004
ICCPR Optional Protocol (23/03/1976)	
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	26/03/2004
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	26/03/2004
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	7/09/1995

2.2 State reports[15]

Swaziland submitted its initial state report to the Committee on the Rights of the Child on 16 February 2006. The report makes reference

9 UNAIDS & WHO (n 4 above) 1.
10 UNAIDS (n 3 above) 509.
11 WHO 'Core heath indicators database' http://www3.who.int/whosis/core/core_select.cfm (accessed 1 August 2006).
12 UNAIDS & WHO (n 4 above) 1.
13 UNAIDS (n 3 above) 510.
14 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'Swaziland Homepage' http://www.ohchr.org/english/countries/sz/index.htm (accessed 13 September 2007).
15 For the state reports and concluding observations discussed below, see above.

to a number of measures the government has taken in its fight against HIV and the epidemic's impact upon children. [16]

The Committee's concluding observations were adopted on 16 October 2006. Under the heading HIV/AIDS the Committee had the following to say: [17]

> 53. The Committee, while acknowledging the various efforts of the State party to prevent and combat HIV/AIDS, *inter alia* through providing free anti-retroviral drugs, free voluntary testing and counselling, and the creation of a centre to support HIV-infected children, is deeply concerned at the high rate of HIV/AIDS infection in the State party and the devastating impact this has on children, with the number of orphaned and vulnerable children currently projected at well over 70,000.
>
> 54. The Committee recommends that the State party, while taking into account the Committee's general comment No 3 (CRC/GC/2003/3) on HIV/AIDS and the rights of the child and the International Guidelines on HIV/AIDS and Human Rights:
>
> (a) Strengthen its efforts to combat HIV/AIDS, including through awareness-raising campaigns, and to prevent discrimination against children infected with and affected by HIV/AIDS;
>
> (b) Ensure the full and effective implementation of a comprehensive policy to prevent HIV/AIDS that includes all preventive measures, and the complementarity of the different approaches for different age groups;
>
> (c) Ensure access to child-sensitive and confidential counselling when such counselling is required by a child;
>
> (d) Continue to strengthen its efforts to prevent mother-to-child transmission of HIV; and
>
> (e) Seek international assistance from, among others, UNAIDS and UNICEF, to that effect.

The Committee made further recommendations concerning children without parental care. These recommendations include the following:[18]

- Develop an effective and comprehensive policy addressing the needs of children without parental care;
- Effectively support programmes for children in vulnerable families, particularly those affected by HIV/AIDS and families suffering from poverty;

16 Government of Swaziland 'Initial report of states parties due in 1997: Swaziland' (CRC/C/SWZ/1) (2006).
17 Committee on the Rights of the Child 'Concluding observations of Committee on the Rights of the Child: Swaziland' (CRC/C/SWZ/CO/1) (2006).
18 As above.

- Provide psychosocial and financial support to extended families that care for children of parents who have died of AIDS and for child-headed households;
- Promote and support family-type forms of alternative care for children deprived of parental care, in order to reduce the resort to residential care;
- Develop clear standards guiding the operation of orphanages and ensure their implementation via an effective inspection system;
- Establish confidential complaints and counselling mechanisms to which children have access.

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[19]

Treaty (entered into force)	Ratification/ accession (deposit)
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	15/09/95
African Charter on the Rights and Welfare of the Child (29/11/1999)	
Protocol to the ACHPR on the Rights of Women in Africa (25/11/2005)	
Treaty of the Southern African Development Community (SADC) (30/09/1993)	16/04/1993
SADC Protocol on Health (14/08/2004)	

3. 2 State reports

Swaziland submitted its initial state report to the African Commission on Human and Peoples' Rights in 2000.[20] However, the report makes no reference to HIV or AIDS.

3.3 Status of international and human rights treaties in domestic law

International and regional instruments cannot be invoked directly in Swazi courts. The Constitution of Swaziland provides that an

19 Ratification status available from http://www.africa-union.org and from http://www.sadc.int.

20 Government of Swaziland 'Initial report of the Kingdom of Swaziland under Article 62 of the African Charter on Human and Peoples' Rights' (2000).

'international agreement executed by or under the authority of the government shall be subject to ratification' and shall 'become binding on the government' only by 'an Act of Parliament' or by 'resolution of at least two-thirds of the members at a joint sitting of the two Chambers of Parliament'.[21] Swaziland has not adopted implementing legislation relating to the treaties it has ratified. In addition, no institutional arrangements have been made specifically for the implementation of human rights treaties.

3.4 International Guidelines

No evidence appears in the public domain of government engagement with the International Guidelines on HIV/AIDS and Human Rights.[22] Presumably the government of Swaziland is at least aware of these guidelines. The UN Resident Co-ordinator sits on the National Emergency Committee on HIV/AIDS (NERCHA), and the UNAIDS Country Coordinator participates in regular meetings with NERCHA.[23] The government has extensive contact with the institutions responsible for promoting attention to international human rights standards in HIV and AIDS policy. However, the government does not seem to have taken steps officially to recognise or to implement the guidelines.

4. National legal system of country

4.1 Form of government

Swaziland is a monarchy. The Constitution vests 'executive authority of Swaziland … in the King as Head of State'.[24] Although Swaziland has a bicameral parliament that shares legislative powers with the King, as well as an 'independent' system of courts that exercises judicial power, the Constitution grants the King nearly complete control over these institutions and other branches of government.[25] The King appoints 20 of the 31 members of the Senate, as well as ten of the 76 members of the House of Assembly, and may prorogue or dissolve

21 Constitution of the Kingdom of Swaziland (2005) sec 238.

22 For the Guidelines, see OHCHR & UNAIDS HIV/AIDS and Human rights International Guidelines (1996) http://data.unaids.org/publications/irc-pub02/jc520-humanrights_en.pdf (accessed 1 August 2006); OHCHR & UNAIDS 'HIV/AIDS and Human rights International Guidelines: Revised Guideline 6' (2002) http://www.ohchr.org/english/about/publications/docs/g6.pdf (accessed 1 August 2006).

23 UNAIDS 'Swaziland: UNAIDS support to the national response' http://www.unaids.org/en/Regions_Countries/Countries/swaziland.asp (accessed 1 August 2006).

24 Constitution of the Kingdom of Swaziland (n 21 above) sec 64(1).

25 n 24 above, secs 106-108 & 138-141.

parliament at any time.[26] He also appoints all justices who sit on the superior courts.[27] Swaziland was one of four Southern African Development Community member states to be classified as 'not free' in the 2006 version of Freedom House's *Freedom in the world*.[28]

4.2 Legal system

The Swaziland national legal system is a mixture of Roman-Dutch law and traditional Swazi law and custom. Roman-Dutch law was imported into Swaziland by the General Administration Proclamation and then confirmed as Swazi common law by the 2005 Constitution.[29] The Constitution also provides that 'the principles of Swazi customary law (Swazi law and custom) ... shall be applied and enforced as part of the law of Swaziland'.[30] In the event of inconsistency, both Roman-Dutch law and Swazi customary law are trumped by statutory law or, of course, by constitutional provisions.[31] The force of Swazi customary law must also yield to 'natural justice or morality' and to 'general principles of humanity'.[32]

The government of Swaziland and the United Nations Development Programme (UNDP) have jointly codified Swazi customary law in a set of 12 manuals and are currently working to integrate the codified law into the Swazi legal system.[33]

4.3 Constitution and Bill of Rights

Chapter IV of the 2005 Constitution of the Kingdom of Swaziland guarantees the 'fundamental human rights and freedoms of the individual'.[34] Some of the constitutional rights that may potentially impact upon HIV are listed below:

- the right to personal liberty: 'A person shall not be deprived of personal liberty save as may be authorised by law' for any one of

26 As above, secs 94(1), 94(3), 95(1) & 134(1).
27 As above, sec 153(1).
28 The other three countries were Angola, Zimbabwe, and the Democratic Republic of Congo. See Freedom House 'Freedom in the world 2006: Selected data from Freedom House's annual global survey of political rights and civil liberties' http://www.freedomhouse.org/uploads/pdf/Charts2006.pdf (accessed 1 August 2006) 7-12.
29 General Administration Proclamation Act 4 of 1907, sec 2; n 27 above, sec 252(1).
30 Constitution of the Kingdom of Swaziland (n 21 above) sec 252(2).
31 As above, sec 252(1) & (3).
32 As above, sec 252(3).
33 For an account of this project, see UNDP Swaziland 'Codification of Swazi Law and Custom' http://www.undp.org.sz/codification.htm (accessed 1 August 2006). For copies of the 12 manuals of codified Swazi customary law, see also http://www.undp.org.sz/codification_downloads.htm (accessed 1 August 2006).
34 Constitution of the Kingdom of Swaziland (n 21 above) sec 14(1).

several enumerated purposes, including 'the purpose of preventing the spread of an infectious or contagious disease';[35]

- the right of detainees to medical treatment: 'Where a person is arrested or detained ... that person shall be allowed reasonable access to medical treatment';[36]
- the right against inhuman or degrading treatment: 'A person shall not be subjected to ... inhuman or degrading treatment or punishment';[37]
- the right to equality before the law: 'All persons are equal before and under the law ... [A] person shall not be discriminated against on the grounds of gender ... or disability';[38]
- the right against arbitrary searches: 'A person shall not be subjected ... to the search of the person' except when 'reasonably required in the interests of' fundamental social objectives such as the promotion of 'public order, public morality [or] public health';[39]
- the rights of mothers and children to special protection: 'Motherhood and childhood are entitled to special care and assistance by society and the State';[40]
- the right of the needy and elderly to special assistance: 'Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of the needy and the elderly';[41] and
- the rights of persons with disabilities: 'Persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realise their full mental and physical potential'.[42] Furthermore, 'Parliament shall enact laws for the protection of persons with disabilities so as to enable those persons to enjoy productive and fulfilling lives'.[43]

The Constitution makes these rights justiciable in Swaziland's High Court:[44]

> Where a person alleges that any of the foregoing provisions of this Chapter has been, is being, or is likely to be, contravened in relation to that person or a group of which that person is a member (or, in the case of a person who is detained, where any other person alleges such a contravention in relation to the detained person) then, without prejudice to any other action with respect to the same matter which is lawfully available, that person (or that other person) may apply to the High Court for redress.

35 As above, secs 16(1) & (1)(g).
36 As above, sec 16(6).
37 As above, sec 18(2).
38 As above, sec 20(1) & (2).
39 As above, secs 22(1)(a) & (2)(a).
40 As above, sec 27(4).
41 As above, sec 27(6).
42 As above, sec 30(1).
43 As above, sec 30(2).
44 As above, sec 35(1).

Whether and how each provision above will ultimately be applied to HIV and AIDS-related issues remains unclear. The right to personal liberty and the right to be protected against arbitrary searches are each explicitly qualified by the state's duty to ensure public health. The right of the needy is likewise qualified by constraints on state resources. Although ostensibly absolute, many of the other rights are vague with respect to HIV. The right against discrimination and the rights of persons with disabilities will not apply to people living with HIV unless HIV is considered a 'disability' for constitutional purposes. The right of detainees to reasonable medical treatment and the prohibition of inhuman or degrading treatment will have uncertain implications until the terms 'reasonable', 'inhuman' and 'degrading' are given judicial constructions. The new Swaziland Constitution has yet to undergo a rigorous process of interpretation.

Section 10.1, 10.3, 11.3 and 15 of this chapter discuss additional rights enshrined in the Constitution.

4.4 National human rights institution

No human rights institution currently exists in Swaziland. The Constitution envisages that a Commission on Human Rights and Public Administration 'shall be established within a year of the first meeting of Parliament after the commencement of the Constitution'. The Constitution entered into force on 8 February 2006.[45] This institution is still to be established.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The National Emergency Response Committee on HIV/AIDS (NERCHA) bears primary responsibility for Swaziland's HIV and AIDS policies and programmes. The government of Swaziland 'established NERCHA through an Act of Parliament to coordinate and facilitate the national multi-sectoral response to HIV and AIDS'.[46] NERCHA's mandate is very broad, including each of the following responsibilities:

45 See The World of Parliaments 'Parliamentary developments' (2006) http://www.ipu.org/news-e/21-9.htm (accessed 1 August 2006); Media Institute of Southern Africa 'MISA-Swaziland country profile' http://www.misa.org/swaziland.html (accessed 1 August 2006); Amnesty International 'Living with HIV/AIDS in Swaziland' (2006) http://web.amnesty.org/wire/July2006/Swaziland (accessed 1 August 2006).

46 Government of Swaziland National Multisectoral HIV and AIDS Policy (2006) 12. See also the NERCHA Act 8 of 2003.

- to develop, implement and periodically to review the National Strategic Plan and National Policy on HIV/AIDS;
- to develop and periodically to review 'sector HIV and AIDS policies, strategies and action plans';
- to 'mobilise, receive, manage and allocate resources, from government and other sources';
- to 'manage the HIV/AIDS Emergency Fund and any other fund that may be established by council';
- to 'monitor and evaluate projects funded by council in the national response to the epidemic';
- to develop 'a national database of HIV and AIDS related policies and [to] facilitate policy dissemination';
- to develop and periodically to review 'a database of responding organisations, institutions, departments and communities in the national response'; and
- to 'facilitate information sharing on local and international best practices among all sectors of society'.[47]

NERCHA is the latest in a string of state institutions designed to spearhead Swaziland's response to HIV. NERCHA superseded the Crisis Management and Technical Committee on HIV/AIDS, which itself was created in 1999 to take over leadership responsibilities from the Ministry of Health and Social Welfare and its National AIDS Prevention and Control Programme.[48]

5.2 HIV and AIDS plan

Swaziland's Second National Multi-sectoral HIV and AIDS Strategic Plan 2006-2008 (the Strategic Plan) was prepared by NERCHA and released in April 2006.[49] The Strategic Plan aims at the realisation of four broad goals: (1) reduction of new HIV infections; (2) reduction of 'morbidity and mortality due to HIV and AIDS'; (3) mitigation of 'the social and economic impact of the epidemic'; and (4) creation of 'an enabling environment for the effective management and co-ordination of the national response'.[50] Each of these four goals is broken down into a number of more concrete objectives, and each objective is in turn linked to both implementation strategies and

47 As above, 12; NERCHA 'Nercha Background', http://www.nercha.org.sz/bg.html?FrameLoad=100 (accessed 1 August 2006).

48 NERCHA '2003-2005 UNGASS Indicators Country Report' (2005) http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf (accessed 1 August 2006) 11 - 12. See also Government of Swaziland 'The Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008' (2006) 12 -15 for a brief history of Swaziland's national response to HIV/AIDS.

49 National Strategic Plan (as above) i iii.

50 As above, 19, 33, 44, 53.

indicators of success. A total of 70 specific objectives are listed in the Strategic Plan.[51]

5.3 Legislation

Swaziland has no HIV and AIDS-specific legislation. The state's guiding HIV and AIDS policy document calls for HIV and AIDS-specific laws addressing discrimination, sex crimes and wilful transmission of HIV.[52] None of this legislation has yet been produced.

5.4 HIV and AIDS policy

Swaziland's HIV and AIDS policy framework is set out in the 'National Multi-sectoral HIV and AIDS Policy' (the National Policy).[53] The National Policy declares itself devoted to the same four goals underpinning the Strategic Plan.[54] Less concrete and practice-oriented than the Strategic Plan, the National Policy aims to 'provide the framework, direction and general principles for interventions' against HIV and AIDS.[55] It provides wide-ranging policy statements that are meant to guide the government as well as 'all other stakeholders and partners involved in ... the national response' to HIV/AIDS.[56]

The Strategic Plan makes reference to a number of additional policies and plans, although some are in preparation, relevant to the government's fight against HIV:

- The government policy outline on economic empowerment and development commonly known as the Smart Program on Economic Empowerment and Development (SPEED);
- Draft National Policy on Children;
- Draft Decentralization Policy;
- National Development Strategy;
- The Poverty Reduction Strategy and Action Plan, Health Sector Response to HIV/AIDS Plan in Swaziland 2003-2005;
- National Population Policy;
- Daft Social Welfare Policy;
- Draft Project Implementation Manual for Social Protection of Vulnerable Children Including Orphans;
- National HIV/AIDS Communication Strategy for Swaziland 2004; and

51 As above, 64.
52 As above, 7-9.
53 As above.
54 As above, 3 4.
55 As above, iii.
56 As above, 4.

- Public Sector HIV/AIDS Strategic Plan, 2006-2008.[57]

5.5 Court decisions

To date, no reported court judgments have dealt with questions of HIV, AIDS and human rights.

6. Access to health care

6.1 Government regulation of access to health care

The Constitution obligates the state to 'take all practical measures to ensure the provision of basic health care services to the population'.[58] However, neither the Constitution nor any statute creates a general right of access to health care or a right of access specific to people living with HIV.

The National Policy adopts the goal of '[u]niversal access to HIV and AIDS related health services' as a '[g]uiding principle' of the national response and further declares that '[a]ll HIV and AIDS-related services shall be made accessible to all vulnerable social groups'.[59] However, these policy statements do not provide individuals with a legal right of access to such services.

6.2 Ethical guidelines

No ethical guidelines within the medical profession specifically regulate the behaviour of health care providers caring for people living with HIV.

6.3 Medicines

Swaziland began offering free ARVs in 2003.[60] The National Policy states that '[a]ll PLHA shall benefit from [an] (accessible, continuous, affordable) ART programme' and that '[t]reatment for opportunistic infections and other HIV-related conditions shall be made available, accessible and affordable.'[61] The ARV programme is still being scaled-up. According to the Strategic Plan, the government hopes that by 2008 it can raise the proportion of people living with the virus

57 National Strategic Plan (n 48 above) 1.
58 Constitution (n 21 above) sec 60(8).
59 Government of Swaziland national policy (n 46 above) 4 10.
60 NERCHA (n 48 above) 20; UNAIDS & WHO (n 4 above) 2.
61 Government of Swaziland national policy (n 46 above) 8.

receiving ART to 75 per cent and can 'increase to an average of seven years' the average survival time after the point of infection.[62]

As a member of the World Trade Organisation (WTO), Swaziland is a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).[63] Both the Strategic Plan and the National Policy are silent on the matters of generic substitution, compulsory licensing and parallel importing.

6.4 Condoms

The National Policy insists that '[h]igh quality male and female condoms shall be made available, accessible and affordable to all'.[64] The Strategic Plan aims by 2008 '[t]o increase the number of available male condoms from 6 286 800 ... to 10 000 000', 'the number of available female condoms from 19 966 ... to 80 000' and 'the number of new condom outlets per region by 200'.[65] '[M]ost condoms are distributed free of charge', but 'some are distributed through commercial outlets with the support of social marketing'.[66]

The Strategic Plan laments that the current 'availability and accessibility of condoms is limited by being mostly available through traditional outlets like health facilities and office toilets', which 'have time restrictions' and are sometimes 'unfriendly to young people'.[67]

6.5 Case law

There is no reported judgment concerning HIV and AIDS and the right of access to health care.

7. Privacy

7.1 Notifiable disease

Neither the National Policy nor the Strategic Plan speaks to the question whether HIV or AIDS is a notifiable disease. AIDS was classified as a notifiable disease in the previous version of the Nation-

62 n 48 above, 35 - 36.
63 WTO 'Swaziland and the WTO' http://www.wto.org/english/thewto_e/countries_e/swaziland_e.htm (accessed 1 August 2006).
64 n 46 above, 6.
65 n 48 above, 27.
66 As above, 26-27.
67 As above, 26.

al Policy.[68] Whether the new version's silence is meant to indicate a change of policy is uncertain.

7.2 Medical experimentation

No policies or procedures exist to protect the rights of volunteers in medical trials. The National Policy says only that '[t]rials, studies and research in HIV prevention shall be monitored and findings appropriately implemented'.[69] The Constitution does not guarantee people a right to bodily and psychological integrity.

7.3 Duty to disclose

The National Policy states that 'partner-disclosure of HIV test results shall be encouraged and promoted'.[70] However, no legal duty to disclose exists. A draft Sexual Offences and Domestic Violence Bill would penalise any person who 'intentionally fails to disclose … that he or she is infected by a life-threatening sexually transmissible infection in circumstances in which there is a significant risk of transmission'.[71]

7.4 Testing

The National Policy calls for universal access to HIV counselling and testing.[72] It also envisions widespread use of opt-out testing, stating that '[h]ealth provider-initiated testing and counselling shall be routinely offered in the context of clinical care'.[73]

The National Policy mandates that HIV testing always be confidential and that it also be consensual except in cases of 'sample screening through anonymous unlinked testing for surveillance' and of the 'testing of blood for transfusion'.[74] However, testing without consent is also permitted when a person is unconscious and HIV testing is considered essential for his or her medical care. The National Policy does not specify that consent must be 'informed' or that counselling must accompany the test. The Strategic Plan identifies the requirement of informed consent as an obstacle to HIV treatment but

68 Government of Swaziland Policy Document on HIV/AIDS and STD Prevention and Control (1998) 8.
69 n 46 above, 7.
70 As above, 6.
71 Amnesty International 'Memorandum to the Government of Swaziland on the Sexual Offences and Domestic Violence Bill' (2006) http://web.amnesty.org/library/Index/ENGAFR550032006?open&of=ENG-347 (accessed 1 August 2006) sec 3.
72 n 46 above, 6.
73 As above.
74 As above.

takes no clear position on whether the requirement is worth its costs.[75]

8. Equality and non-discrimination

The National Policy makes clear that 'the HIV status of a person shall not be used as a reason for denying access to services, including education, health care, or employment' and also that '[l]egislation shall be developed to protect the rights of PLHA including protection against any form of stigma and or discrimination'.[76] No HIV-specific anti-discrimination legislation is currently in place.

Whether the constitutional proscription of discrimination on grounds of disability applies to HIV and AIDS is still uncertain.[77]

9. Labour rights

9.1 Legislation

The Industrial Relations Act prohibits employers from discriminating 'against an employee, directly or indirectly, on any arbitrary ground, including … disability'.[78] Victims of such discrimination may appeal to the Industrial Court for reinstatement or compensation.[79] However, it is unclear whether HIV status or AIDS constitutes a disability under the statute. No legislation specifically attends to employment discrimination on grounds of HIV status. The broad anti-discrimination legislation called for by the National Policy (see section 8 above) presumably should address this issue.

9.2 Testing

No legislation forbids pre-employment HIV testing. However, the National Policy provides that '[a]ll workplace policies, guidelines and programmes shall comply with ILO (International Labour Organisation) Code of Conduct'.[80] In turn, the 'ILO Code of Practice on HIV/AIDS and the World of Work' (the ILO Code) states that employers should 'not require HIV/AIDS screening or testing' except in the case of

75 As above, 39.
76 As above, 9.
77 See sec 4.3 for the detailed discussion.
78 Industrial Relations Act of 2000 http://www.gov.sz/home.asp?pid=2664 (accessed 1 August 2006), sec 2(f).
79 As above, sec 16(1).
80 Government of Swaziland national policy (n 46 above) 10.

'anonymous, unlinked surveillance or epidemiological HIV testing in the workplace'.[81]

9.3 Medical schemes act

Swaziland has no medical schemes act, nor any other statute regulating medical schemes. The ILO Code prohibits HIV testing 'as a condition of eligibility for ... occupational schemes and health insurance' and further forbids insurance companies to 'require HIV testing before agreeing to provide coverage for a given workplace' or employers to 'facilitate any testing for insurance purposes'.[82]

9.4 Duty to provide treatment

Employers have no statutory duty to provide medical care to employees. The ILO code says only that '[w]orkers with HIV/AIDS should be treated no less favourably than workers with other serious illnesses in terms of benefits, workers' compensation and reasonable accommodation'.[83]

10. Women's rights

10.1 Legal status and protection

Section 28 of the Constitution invests women with a right to equality and the state with a special duty to assist women in the realisation of this right:[84]

> (1) Women have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.
>
> (2) Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.

How the government and the High Court will implement these provisions remains to be seen. '[W]omen married in community of property legally hold a minority status' in Swaziland.[85] UNDP Swaziland reported in 2002 that it was planning, in collaboration with

81 ILO 'An ILO Code of Practice on HIV/AIDS and the World of Work' (2001) http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf (accessed 1 August 2006) 13-21.
82 As above, 21.
83 As above, 22.
84 n 21 above, sec 28.
85 For more information on UNDP Gender Mainstreaming Programmes, see http://www.undp.org.sz/gov.htm (accessed 30 January 2007).

the Swaziland Government, to review 'three pieces of legislation: the Marriage Act of 1964', 'the Administration of Estate Act of 1902 and the Deeds Registry Act of 1968 … with a view to reforming the status' of women in Swaziland.[86] However, no amendments to these laws have yet been made. UNDP Swaziland also helped to produce a draft 'National Gender Policy' that addresses, among other topics, 'legal and human rights', 'health, reproductive rights and HIV/AIDS' and 'gender based violence'.[87] The draft policy still awaits government adoption.[88]

The National Policy promises that '[l]egislation that addresses issues of sexual assault, abuse and exploitation shall be reviewed and amended in light of HIV and AIDS' and that '[w]omen and girls … shall be protected against gender based violence, including domestic violence, sexual abuse [and] traditional, cultural and other practices that may negatively affect their health.'[89] The draft Sexual Offences and Domestic Violence Bill, mentioned in section 7.3, aims at least partially to fulfil these promises. If enacted, the draft bill would, among other things, expand Swaziland's legal definition of rape to include rape within marriage and require the Minister of Justice and Constitutional Affairs to issue 'a protocol for the care, treatment and (forensic) medical examination of "sexual offences victims"'.[90]

10.2 Domestic violence law

Women currently have no statutory protection against domestic violence. The draft Sexual Offences and Domestic Violence Bill would create some level of protection by establishing civil legal remedies in cases of domestic violence.[91]

10.3 Customary rules and practices

The Constitution gives customary law a subordinate position within the Swazi legal system.[92] It also proclaims that '[a] woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed'.[93] The draft Sexual Offences and Domestic Violence Bill would add a statutory layer of protection by criminalising

86 As above.
87 More information on National Gender Policy available at http://www.undp.org.sz/gov.htm (accessed 30 January 2007).
88 As above; Strategic Plan (n 45 above) 45.
89 n 46 above, 7- 9.
90 Amnesty International (n 71 above) secs 4 & 11.
91 As above, sec 15.
92 See sec 4.2 above.
93 Constitution of the Kingdom of Swaziland (n 21 above) sec 28(3).

the non-consensual subjection of women (or of any person) to some specific cultural practices.[94]

The Strategic Plan acknowledges that some cultural practices 'are perceived to have a potential for contributing to the spread' of HIV and identifies '*inhalanti* (a younger sister or child of the brother-in-law is given to men as wife)', '*kwendzisa* (girls are given away by parents under arranged marriages) and *kungena* (widow inheritance including those whose husbands died of AIDS)' as particular problems.[95] It notes that 'the abuse of power by men through condoning socio-cultural practices that promote their dominance contributes to [the] vulnerability of women and children' to HIV infection and calls for the government to develop 'public awareness on the relationship of … socio-cultural practices … to HIV and AIDS'.[96] A 2002 UNDP study adds to the list of practices viewed as harmful both polygamy and '*umhlanga* (the reed dance)'.[97] None of these practices has yet been successfully challenged in the Swazi courts.

10.4 Administration of anti-retrovirals to rape survivors

The Strategic Plan makes it an objective '[t]o increase to 100 per cent by 2008 the number of persons reported to have been raped or exposed to incest who receive post-exposure prophylaxis (PEP)'.[98] Currently, 'both [rape and incest] survivors and the police are generally unaware of' PEP.[99]

10.5 Sex workers

Sex work is prohibited by the Crimes Act.[100] The government evinces no interest in decriminalising the practice.

11. Children's rights

11.1 Access to health care

Children living with HIV still do not have adequate access to health care facilities. Although children, like adults, are meant to benefit from the government's free ART programme, the Strategic Plan admits that there is still 'insufficient focus on paediatric anti-

94 Amnesty International (n 71 above) sec 10.
95 n 45 above, 7.
96 As above, 46 & 62.
97 UNDP Swaziland 'Gender focused responses to HIV/AIDS: The needs of women infected and affected by HIV/AIDS' (2002) 1 -2.
98 n 45 above, 30.
99 As above, 30.
100 Crimes Act 6 of 1889, sec 5.

retroviral therapy'.[101] 'There are no national clinical guidelines for managing children who have been diagnosed as HIV positive', despite the fact that 'children living with HIV and AIDS require special care, support and treatment.'[102] Paediatric tuberculosis care also receives insufficient attention even though 'the risk of developing active tuberculosis is … higher in children' than in adults.[103]

Swaziland inaugurated a programme for the PMTCT of HIV in 2003, building PMTCT sites and mounting a PMTCT public awareness campaign.[104] Achievements fell 'far below target' in the programme's first few years of existence.[105] The Strategic Plan announces an aim of reducing 'the proportion of children (0-4 years) who are HIV positive by 30 per cent by 2008' and proposes to meet this goal by creating 'an enabling environment for the up-scaling, provision and support of PMTCT services', including 'HIV testing and counselling by pregnant women and partners, comprehensive reproductive health services, laboratory services and anti-retroviral prophylaxis'.[106]

11.2 Children orphaned by AIDS

The National Policy contains several provisions on OVC:[107]

- Interventions for OVC shall be guided by the four principles enshrined in the CRC.
- Universal [p]rimary [e]ducation shall be implemented to facilitate access to education for all children and in particular OVC in line with the Constitution of Swaziland of 2005.
- Interventions aimed at protecting, improving access to basic needs and improving livelihoods of OVC and other vulnerable populations shall be encouraged, promoted, strengthened and supported.
- OVC shall be cared for first and foremost within the family and community structures and exceptionally in residential care facilities.
- Community based OVC caring shall be supported.

NERCHA delivers services to children orphaned by AIDS through the system of Swazi chiefdoms.[108] The programme already contains food-provision and socialisation components, and NERCHA is preparing to implement psychosocial-support and economic-empowerment com-

101 n 45 above, 33.
102 As above, 34.
103 As above, 37.
104 NERCHA (n 48 above) 8.
105 Strategic Plan (n 45 above), 7.
106 As above, 24 -25.
107 n 46 above, 10.
108 NERCHA 'NERCHA's Intervention on Orphaned and Vulnerable Children' http://www.nercha.org.sz/NERCHA%20Intervention%20on%20OVC.pdf (accessed 1 August 2006) sec 2.

ponents as well.[109] NERCHA also operates a program called Young Heroes, which 'gathers funds from sponsors to distribute to Swazi orphan children'.[110] Swaziland has drafted a National Policy on OVC, but the Policy has not yet been adopted.[111]

11.3 Education

The Constitution provides that '[e]very Swazi child shall within three years of the commencement of this Constitution have the right to free education in public schools at least up to the end of primary school, beginning with the first grade'.[112] The constitutional right to equality before the law makes clear that this guarantee of free education applies equally to boys and girls. It may or may not also bar schools from discriminating against HIV-positive students. (See section 4.3 above for further discussion of the constitutional right to legal equality.) The National Policy states very clearly that 'the HIV status of a person shall not be used as a reason for denying access to services, including education'.[113]

School fees are still charged in Swaziland.[114] The Minister of Education noted in 2004 'that school fees are a deterrent for poor families to send their children to school' and suggested that 'perhaps the country should remove' its declaration regarding the CRC's provision on free primary education.[115] The Ministry of Education operates a 'conditional grant scheme' in order to alleviate problems caused by the fees.[116] The Strategic Plan declares it an objective '[t]o ensure that by 2008 …100 per cent [of] OVC aged 6-14 years' and 'at least 80 per cent [of] OVC and disadvantaged youth' of all ages 'have access to free formal or non-formal education'.[117]

A general program of sexual education is outlined in the National Policy:[118]

- Young people shall be encouraged to abstain from sex or delay sexual debut.
- Faithfulness and consistent condom use shall be encouraged among young people who choose to be sexually active.

[109] As above, secs 2-5.
[110] Young Heroes 'How young heroes works' http://www.youngheroes.org.sz/works.asp (accessed 1 August 2006).
[111] Strategic Plan (n 48 above) 45.
[112] n 21 above, sec 29(6).
[113] n 46 above, 9.
[114] S Lewis 'Report on the mission of Stephen Lewis, UN Secretary-General's Special Envoy on HIV/AIDS, to Swaziland' (2004) http://www.nercha.org.sz/Stephen%20Lewis.pdf (accessed 1 August 2006) 5.
[115] As above, 5.
[116] As above, 5.
[117] n 48 above, 51.
[118] n 46 above, 5.

- Young people shall be provided with evidence-based sex education. Youth-friendly sexual and reproductive health services and school-based Health Clubs shall be promoted.
- HIV and AIDS and life skills shall be promoted in primary and high schools, tertiary and vocational institutions and integrated in the curricula as an examinable subject.

A limited school HIV and AIDS program is already in place and is administered by School HIV and AIDS and Population Education (SHAPE).[119] A draft 'Education sector HIV and AIDS policy' has been devised and awaits state approval.[120] In an attempt to target children who do not attend school, the Swaziland National Youth Council has also established a number of youth centres staffed with trained peer educators.[121]

12. Family law

No inheritance or guardianship legislation addresses or otherwise specifically bears upon HIV and AIDS.

13. Criminal law

13.1 Criminal legislation

Swazi criminal law contains no HIV-specific provisions. The Ministry of Health and Social Welfare, in collaboration with the WHO, prepared a draft Public Health Bill in 1999 that would criminalise the transmission of sexually transmitted diseases.[122] The Public Health Bill, however, was 'referred back for further stakeholder consultations' in 1999 and has yet to be enacted.[123] The draft Sexual Offences and Domestic Violence Bill would not only criminalise intentional failure to disclose HIV status in certain circumstances (see section 7.3 above) but would also provide for the death penalty for the crime of rape 'where HIV/AIDS is an aggravating factor'.[124]

13.2 Men having sex with men

There is no specific legislation prohibiting homosexual relationships in Swaziland. However, the common law criminal offence of sodomy applies to both sexes.

119 Strategic Plan (n 45 above) 20.
120 As above, 45.
121 NERCHA (n 48 above) 23.
122 Committee on the Rights of the Child (n 17 above) secs 312-13.
123 As above, sec 312.
124 Amnesty International (n 71 above) secs 3 & 7.

14. Prisoners' rights

The National Policy and Strategic Plan make scarce reference to prisoners. The National Policy lists inmates among vulnerable populations but otherwise never mentions them. The Strategic Plan does likewise, saying little about inmates except to include them among the 'special groups' that should be targeted by programmes addressing 'HIV vulnerability and risk factors'.[125]

No statistics are available on the number of HIV-positive prisoners.

15. Immigration

Section 26 of the Constitution creates a right to 'freedom of movement', including 'the right to move freely throughout Swaziland ... the right to enter Swaziland, the right to leave Swaziland and immunity from expulsion from Swaziland'.[126] However, this right is qualified by the government's right to impinge upon it when a deprivation is 'reasonably required in the interests of ... public health'.[127]

Non-nationals need not be tested for HIV in order to gain admission to Swaziland.[128]

16. Social assistance and other government benefits

No legislative or policy provisions regulate the provision of social assistance to people living with HIV. Whether HIV or AIDS is considered a disability under Swazi law has not yet been determined. (See sections 4.3 and 9.1 above for discussion of how this question pertains to both constitutional and statutory law.)

17. Insurance

The National Policy addresses workplace health insurance plans, forbidding employers and insurance providers to require that employees submit to HIV tests. HIV testing as a criterion of eligibility for life insurance plans is not addressed in Swazi law.

[125] n 45 above, 22.
[126] n 21 above, sec 26(1).
[127] As above, sec 26(3)(b).
[128] Swaziland Ministry of Tourism 'Passports and Visas' http://www.gov.sz/home.asp?pid=1309 (accessed 1 August 2006).

Insurance companies require HIV testing for some life insurance policies. For example, the Swaziland Royal Insurance Corporation (SRIC) offers fixed-sum life insurance policies worth ZAR 25 000 (USD 3 500) or more only to applicants who test negative for HIV.[129] The tests are administered by SRIC-approved doctors and the results transmitted directly to the corporation.[130] A positive result renders an applicant ineligible for a large, fixed-sum policy; the applicant is instead offered an 'investment' policy that accrues in value over the course of the applicant's life.[131] Surprisingly, SRIC claims that it does not make the test result available to the applicant even when the applicant requests the information.[132]

18. Oversight

NERCHA is responsible for implementation of both the National Policy and the Strategic Plan.[133] It has produced and published a monitoring and evaluation plan and a set of guidelines regarding collection of data on HIV interventions.[134] No department has been made expressly responsible for implementation of HIV and AIDS-related legislation.

19. Stigma

The National Policy asserts that '[l]egislation shall be developed to protect the rights of PLHA including protection against any form of stigma' and more broadly that '[m]easures to address HIV and AIDS related stigma … shall be developed and implemented.'[135] The Strategic Plan also calls for the 'reduction of stigma … in facilities and communities' and the 'expansion of initiatives that minimize stigmatisation and discrimination in the community'.[136] More detailed information on the tactics used to combat stigma — or on the success of those approaches — is not yet available.

129 Telephone communication with a representative of the Swaziland Royal Insurance Corporation, 17 July 2006.
130 As above.
131 As above.
132 As above.
133 Government of Swaziland national policy (n 46 above) 12.
134 NERCHA 'National Multisectoral HIV and AIDS Monitoring and Evaluation System' (2005), http://www.nercha.org.sz/NME%20Plan_small.pdf (accessed 1 August 2006); NERCHA 'Specifications for Participatory Supervision and Data Auditing of Data Received through the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS) Reporting System' (2005), http://www.nercha.org.sz/SHAPMoS%20Participatory%20Supervision%20Guidelines.pdf (accessed 1 August 2005).
135 Government of Swaziland national policy (n 46 above) 5 -9.
136 n 54 above, 32, 40 -49.

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- UNDP Codification of Swazi Law and Custom

8 HIV, AIDS and the law in Zambia

1. Background to country

1.1 First AIDS case

The first case of AIDS in Zambia was reported in 1984 at the University Teaching Hospital (UTH) in Lusaka. The case was documented at the UTH and the mode of transmission was not established. The information was treated confidentially without revealing the person's identity.[1]

1. 2 Demography

The population of Zambia is estimated to be 12.1 million in 2007.[2] Estimates for this country explicitly take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected.[3]

It is estimated that 17 per cent of the adult population was infected with HIV in 2005.[4] This translates into 1.1 million adults and children living with HIV in the country.[5]

About 84 per cent of people living with HIV are between the ages of 20 and 29. Only 9.4 per cent of women and 13.8 per cent of men in Zambia have ever been tested for HIV. Despite limited HIV testing, it is estimated that 17.8 per cent of women and 12.9 per cent of men are currently infected. Infection rates are higher in urban areas than in rural areas of the country. Sexual contact is the primary mode of transmission of HIV in Zambia. Estimated mortality risk from AIDS suggests that for the Zambian population with an HIV prevalence of 16.5 per cent, more than half of all youth now aged 15 will die of AIDS.[6]

In the Global AIDS Epidemic Report 2006, UNAIDS estimated that 1.1 million adults and children were living with HIV and that 98 000 died as a result of AIDS-related illnesses.[7] In Lusaka, the 2004

1 Ministry of Health National HIV/AIDS/STD/TB Policy (2001) 3.
2 UNFPA 'State of the world population 2007: Unleashing the potential of urban growth' (2007) 90.
3 CIA 'World Factbook: Zambia' https://cia.gov/cia/publications/factbook/geos/za.html (accessed 10 November 2006).
4 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 506.
5 As above, 505
6 US Department of Health and Social Services (Centers for Disease Control and Prevention) 'The emergency plan in Zambia' http://www.cdc.gov/nchstp/od/gap/countries/zambia.htm (accessed 10 November 2006).
7 UNAIDS (n 4 above) annex 1 'Country profile: Zambia'.

prevalence rate among pregnant women aged 15-24 was 20.7 per cent.[8] Of the HIV-positive population aged 15-49, 62.2 per cent had contracted tuberculosis (TB).[9] The incidence of HIV related Kaposi's sarcoma has increased 50-fold since it was first recognised in Zambia in 1983.[10]

The number of babies born HIV positive is not known. However, it is estimated that 39 per cent, or 30 000 infants, are born HIV positive.[11]

The proportion of HIV-positive women rises sharply with age. Among women aged 15-19 the prevalence rate is seven per cent; aged 30-34, the prevalence is 29 per cent; and aged 45-49 the prevalence is 14 per cent. The prevalence rate among men under the age of 25 is below five per cent. Men aged 25-29 have the prevalence rate of 15 per cent. The prevalence rate peaks at 22 per cent between the ages of 35-39 and is 20 per cent between the ages of 40-49.[12]

In Zambia, women are the most vulnerable group to HIV infection. According to the Demographic Health Survey of 2001-2002, women account for 54 per cent of all people living with HIV. Women between the ages of 20-29 are particularly vulnerable, as are children who have been orphaned and other vulnerable children (OVC). Other vulnerable groups include military personnel, sex workers, truckers, fisheries workers and fishmongers. UNAIDS studies recorded that 68 per cent of female sex workers were HIV positive.[13] In 2004, Zambia's prison headquarters reported 449 inmate deaths from AIDS-related illnesses.[14] In 1993, the HIV prevalence rate among patients with sexually transmitted infections (STIs) in urban areas was 58 per cent.[15] In 2004, the HIV prevalence rate among adult TB patients was 54 per cent.[16] The risk of HIV transmission from an infected mother to her child in Zambia is around 40 per cent.[17]

Zambia has one of the highest rates of orphanhood in the world. Zambia's orphan crisis has increased drastically since the onset of the epidemic. In 2003, the Zambian Sexual Behaviour Survey reported

8 As above.
9 Sentinel Health Survey 2004.
10 AC Bayley 'Occurrence, clinical behaviour and management of Kaposi's sarcoma in Zambia' http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=1821324&dopt=Abstract (accessed 13 November 2006).
11 Government of Zambia 'Zambia Country Report Follow Up United Nations General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS (UNGASS)' (2005).
12 Ministry of Heath 'Demographic and Health Survey 2003' (2003).
13 UNAIDS (n 4 above) 'At risk and neglected: 4 key populations'.
14 As above.
15 UNAIDS 'Epidemiological Fact Sheet 3 By 5: Update 2004' (2004).
16 WHO 'TB Country Profile for Zambia' (2004).
17 'Risk of mother-to-child transmission in Zambia is around 40 per cent' 5 November 2006 http://english.people.com.cn/200611/05/eng20061105_318453.html (accessed 12 November 2006).

that 17.8 per cent of children under 15 had lost one or both their parents to AIDS.[18] In 2004, it was estimated that 19 per cent of Zambian children under the age of 18 have been orphaned.[19] It is estimated that there are approximately 1.1 million children who have been orphaned in Zambia.[20] In 2005, UNAIDS estimated that 710 000 children were orphaned as a result of an AIDS-related death.[21]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[22]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	10/04/1984
ICCPR Optional Protocol (23/03/1976)	10/04/1984
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	10/04/1984
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	21/06/1985
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	06/12/1991

2.2 State reports

The United Nations Human Rights Committee considered the report submitted by Zambia under the ICCPR on 26 and 27 March 1996. The Concluding Observations did not mention HIV or AIDS, but admitted that women and men were not equal in Zambia. Women suffer discrimination in school and at home which leads to a lower level of education and marketable skills. Women thus have difficulty earning as much as men. In the past they could not own property because they were not allowed to take out loans.

18 Zambian 'Sexual Behaviour Survey' (2003).
19 UNICEF 'OVC Situational Analysis' (2004).
20 Zambian Central Statistics Office (2005).
21 UNAIDS (n 4 above) 6.
22 Office of the High Commissioner on Human Rights *UN Treaties series* (updated) (2006). The dates between brackets in the first column are the dates of entry into force of the relevant treaties.

Few women secure high level political positions. While the 1996 Constitution[23] protects against inhuman treatment, financial limitations often prevent segregation of accused and convicted prisoners and of juvenile and non-juvenile offenders in prisons. The rights of children are protected and abortion is illegal. The report by Zambia admits that the social welfare systems responsible for children are limited in terms of funds, staff, and equipment.[24] The Human Rights Committee expressed concern that the Constitutional right to freedom from discrimination was afforded only to citizens excluding foreign nationals. As well, the Human Rights Committee cited as worrisome the high maternal morality rates due to unsafe illegal abortion and the sentencing of children as adults. The Penal Code fixes the age of criminal responsibility at eight years.[25]

The Committee on Economic, Social, and Cultural Rights considered Zambia's initial report on 26 and 27 April 2005. The report contained many references to HIV and AIDS. To ensure the right to work, Zambia adopted the HIV/AIDS and Labour Market Policy. In recognition of the right to social security and protection from occupational hazards, SADC (including Zambia) is producing a Code of Conduct on HIV/AIDS in the Workplace.

VCT requires scaling-up, as does Prevention of Mother-to-Child Transmission (PMTCT) programmes (provided in three out of 72 districts).

The education system suffers as children are forced to miss school and teachers become scarce. Zambia is party to a number of international instruments aimed at addressing this problem, which include the World Health Organisation (WHO)/International Labour Organisation (ILO) Guidelines on HIV/AIDS.

As a result, the following measures have been taken:

- reproductive health campaigns;
- HIV awareness promoting in schools and workplaces;
- application of guidelines; and
- strengthening of worker education and family welfare programmes.

The Poverty Reduction Strategy also includes provisions on HIV and AIDS which is cited as an explanation of child labour. HIV and AIDS negatively impact the elderly by impairing the system of pensions and

[23] Constitution of Zambia Act 17 of 1996 hereinafter referred to as 1996 Constitution.

[24] Government of Zambia 'Second periodic reports of States parties due in 1990: Zambia' (CCPR/C/63/Add.3) (1995).

[25] Human Rights Committee 'Concluding observations of the Human Rights Committee: Zambia' (CCPR/C/SR.1487-1489) (1996).

by making them caretakers of orphan households. Poor economic performance makes it difficult to implement policies.[26]

The Committee on ESCR considering the report expressed concern that large numbers of widows and girl-children who have been orphaned live under harsh conditions as a result of traditional practices like 'widow-cleansing', early marriages and denial of inheritance. Moreover, there are large numbers of street children in Lusaka who are exposed to abuse, prostitution, and a high risk of HIV infection. While noting activities such as the Programme for the Advancement of Girl-Child Education (PAGE), the Committee was still concerned about discrimination faced by girl-children.[27]

The most recent state report submitted under CEDAW combined the third and fourth reports and was considered on 4 June 2002. This report covered the period from 1964 to December 1997. The report acknowledged the need to strengthen legislation against prostitution, exploitation of prostitutes, and trafficking in women. Some civil society organisations focus on this issue and try to reform prostitutes and protect girl-children who have been orphaned from resorting to prostitution.

Under the Ministry of Education, the PAGE attempts to reduce drop out rates and lower early pregnancy. It also includes HIV education.

The health system is decentralised but continues to be burdened. Furthermore, women are more affected by the distance to health facilities and often require permission from a male family member to visit a health facility. The introduction of user fees in 1993 as part of reform further disadvantaged rural women, who have fewer resources.

In 1996, the health policy took into account safe motherhood, adolescent health, and HIV and AIDS. Ninety per cent of sexually active women reported awareness of one contraceptive method. Ninety-six per cent of pregnant women received antenatal care from a trained provider. Most adolescents prefer condoms, while overall women prefer the pill. However, only 14 per cent of women used a reliable form of contraceptive. Until 1990, women needed a letter of consent from a husband to obtain contraceptives. The policy is no longer active, but in practice many providers still require it, not knowing the policy has changed.[28]

[26] Government of Zambia 'Initial state report submitted under ICESCR' (E/C.12/1/Add.106) (2005).

[27] CESCR 'Concluding observations of the Committee on Economic, Social and Cultural Rights: Zambia' (E/CN.4/2005/SR.27) (2005).

[28] CEDAW 'Consideration of Zambia's 3rd and 4th reports' (CEDAW/C/SR.551 and 552).

In its observations to the report submitted by Zambia, the Committee on Elimination of all forms of Discrimination Against Women (CEDAW Committee) noted the efforts made to strengthen the national machinery on women, the introduction of gender mainstreaming and the adoption of several policies and programmes to eliminate discrimination against women, including the National Gender Policy and the establishment of the Gender in Development Division, under the Office of the President.

In addition, the Committee approved of the adoption of legislation to protect women's inheritance with the enactment of the Marriage Act and the Intestate Succession Act. However, article 23(4) of the Constitution still permits discrimination against women in the area of personal law, namely:

- revenue allocation;
- adoption;
- marriage;
- divorce;
- burial;
- devolution of property on death; and
- other matters of personal law and customary law with respect to any matter.

The CEDAW Committee expressed concern that the provisions in existing laws, including new laws such as the Marriage Act and the Employment Act, discriminate against women directly or indirectly. The Committee expressed concern at the high level of violence against women and girls, including domestic violence and marital rape. It also expressed serious concern about the number of older women who have been murdered for superstitious reasons by family members or by others in recent years.[29]

The Committee on the Rights of the Child considered the initial report from Zambia on 22 May 2003. The Zambia report cites the HIV epidemic as contributing to the break-up of families, the disruption in education, stress on health system, and the general poverty, distress, and neglect of children.

The CRC committee noted that the government passed policies concerning HIV and AIDS and children and is slowly implementing them. Non-governmental Organisations (NGOs) and Community-Based Organisations (CBOs) are overwhelmed by the HIV epidemic but continue to provide services to some. The Public Welfare Assistance Scheme (PWAS) was established to protect disadvantaged groups from the adverse effects of economic policies in the country, and is

[29] Government of Zambia 'Initial reports of States parties due in 1994: Zambia' (CRC/C/11/Add.25) (2002).

administered by the Ministry of Community Development and Social Services. Priority beneficiaries are street children, orphans, children in protective care, old people and young people in rehabilitation or correctional institutions.

The CRC committee also noted that the financial allocations for the PWAS are meagre. The health-care sector has a safety net system for four categories of users. Exemptions from user fees are given to children below age five and to adults aged 65 years and above. All antenatal and post-natal care, as well as treatments for chronic illness such as TB, STDs and HIV, are exempted from user fees.[30]

The report noted that there is no legislation dealing specifically with HIV and AIDS. The issue of a person living with HIV intentionally contaminating another person is being considered for legislative action. AIDS is a significant cause of morbidity. Prenatal transmission accounts for 75 per cent of all paediatric HIV cases.

The Ministry of Education is in the process of strengthening school health services to provide appropriate information and education regarding sexuality. The information provided will include prevention of unwanted pregnancies, STDs and HIV infection.

The report further states that the Constitution of Zambia, the Penal Code and the Juveniles Act prohibit sexual exploitation and sexual abuse. Zambia has faced a number of problems in dealing with this issue. One of the very big problems is the reluctance of families and the general public to acknowledge the existence of the problem. The lack of data and of disaggregated data on child sexual abuse in particular, is also a problem. The dual legal system (statutory/ customary) contributes to child sexual abuse in that children can be married off at an early age as long as parents give consent. These children are usually victims of sexual abuse in their marriages. The high poverty levels and the HIV epidemic have aggravated the problem of child sexual abuse. The Zambian government acknowledged the need to address this area more fully.[31]

In its comments, the CRC Committee expressed concern at the conflicting definitions of children. Under the Penal Code an adult is eight years old, while the Constitution sets the age at 15. Under customary law, puberty decides.

The CRC Committee noted the existence of the Child Care Upgrading Programme but was concerned that a growing number of children are being placed in institutions and that there is a lack of disaggregated data in this regard, which makes it difficult to fully

30 As above.
31 CRC 'Concluding observations: Zambia' (CRC/C/15/Add.206) (2003).

assess the need for institutional care and to develop effective policies.[32]

3. Regional human rights treaties

3.1 Ratification status of AU and SADC treaties[33]

Treaty (entered into force)	Ratification/ accession (deposit)
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	10/01/1984
African Charter on the Rights and Welfare of the Child (29/11/1999)	
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (25/11/2005)	02/05/2006
Treaty of the Southern African Development Community (SADC) (30/09/1993)	16/04/1992
SADC Protocol on Health (14/08/2004)	

3.2 State reports

In its initial report to the African Commission on Human and Peoples' Rights, Zambia provides an account of HIV and AIDS-related measures adopted to implement the right to life and the right to best attainable physical and mental health.[34] The report states that Zambia does not have adequate resources to fully implement the right to an adequate standard of living or health care.[35] It, furthermore, notes the epidemic's effects on the work force, parents, and other resources have seriously reduced Zambia's ability to mount an appropriate response.[36]

3.3 Status of international and human rights treaties in domestic law

Zambia is a dualist state. Under the Zambian legal system, international instruments are not self-executing and require

32 African Union Documents, last updated February 2006.
33 See Government of Zambia 'Initial report to the African Commission on Human and People Rights' (2006) http://www.achpr.org/english/state_reports/40_Zambia%20initial%20report_Eng.pdf (accessed on 9 September 2007).
34 As above, 162.
35 As above.
36 *The People v John Banda* HPA/6/1998.

legislative implementation to be effective as law. Thus an individual cannot complain in a domestic court about a breach of Zambia's international human rights obligations unless the right has been incorporated into domestic law. Nevertheless, courts in Zambia have, in appropriate cases, taken judicial notice of international instruments, which Zambia has not incorporated into domestic legislation.[37]

Some of the international principles apply to national laws, for example, the principle that a pregnant woman or a person under the age of 18 cannot be executed. To date, no law domesticating an international or regional instrument has been passed in Zambia.

The Ministry of Justice is primarily responsible for the implementation of international human rights treaties. The judiciary plays a prominent role in the protection of fundamental freedoms and human rights because a victim of a violation of human rights has the right to institute proceedings and, where appropriate, remedies are granted.[38]

3.4 International Guidelines

Zambia is aware of the International Guidelines on HIV/AIDS and Human Rights developed by the UNAIDS and Office of the United Nations High Commissioner for Human Rights and adheres to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators. The National HIV/AIDS/STI/TB Council (NAC) publicly approved these Guidelines in 2003 and has recently submitted a Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) for the period of January to December 2005.[39]

4. National legal system of country

4.1 Form of government

Zambia is a multi-party constitutional democracy. Zambia has a written Constitution, which is the supreme law of the land. The Constitution was adopted at independence in 1964 and was last amended in 1996. It established a republican form of government with an executive President, the legislature and the judiciary, each forming a separate and distinct organ of government.[40]

37 Government of Zambia 'Core document forming part of the reports of states parties: Zambia' (GENERAL/HRI/CORE/1/Add.22/Rev.1) (1995).
38 Government of Zambia (n 11 above).
39 As above.
40 CIA (n 3 above).

4. 2 Legal system

Zambia has a plural legal system founded upon statutory law, which in turn is based on English common law and customary law. Zambia holds judicial review of legislative acts in an ad hoc constitutional council, and has not accepted compulsory International Court of Justice jurisdiction.[41]

Article 91 of the Constitution establishes the judiciary. It consists of the Supreme Court, the High Court, subordinate courts, local courts and any other courts as may be prescribed by an act of parliament. In the discharge of their judicial functions, judges of courts are independent, impartial and subject only to the Constitution and the law. The judiciary is autonomous and is administered by an Act of Parliament.[42]

4.3 Constitution and Bill of Rights

Zambia has a written Constitution amended by the Constitution Amendment Act 17 in 1996. The Constitution provides for justifiable human rights; article 28 details the process for their enforcement.

The Preamble specifically protects the dignity of the family and the equal worth of men and women in their right to participate in society. Part II of the Constitution of Zambia[43] guarantees the protection of civil and political rights, including, but not limited to, the right to life, personal liberty, expression, conscience, movement, fair protection under law, privacy, freedom from slavery, inhuman treatment, discrimination, and deprivation of property.

Economic, social, and cultural rights are mentioned in the Constitution under article 112 as directives of state policy, but are not justiciable (article 111). These include the directive to provide employment, education, shelter, clean water, medical care, a healthy environment, development of culture, social benefits to the disabled, aged, and disadvantaged, and fair working conditions (article 112).

Article 23 of the Constitution is relevant to HIV as it guarantees freedom from discrimination. However, freedom from discrimination has a limited application as it does not apply to laws with provisions directed at non-citizens;[44] laws with respect to adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law;[45] and a law with reference to particular customary

41 Government of Zambia (n 11 above).
42 Constitution of Zambia (n 23 above) art 11-28.
43 As above, art 23(4)(b).
44 As above, art 23(4)(c).
45 As above, art 23(4)(d).

laws.[46] The right to liberty is protected except in the case of a law passed preventing the spread of an infectious or contagious disease.[47]

4.4 National human rights institutions

A permanent Human Rights Commission (HRC) grew out of a commission of inquiry formed by President Chiluba in May 1993 to investigate human rights violations by past governments.

Article 125 of the 1996 Constitution establishes the provision for an Act of Parliament to specify the functions, powers, composition, funding and administrative procedures of the HRC. The objectives of the HRC include:

- investigating human rights violations;
- investigating any misadministration of justice;
- proposing effective measures to prevent human rights abuse;
- visiting prisons and places of detention or related facilities with a view to assessing and inspecting conditions of the persons held in such places and make recommendations to redress existing problems;
- establishing a continuing programme of research, education, information and rehabilitation of victims of human rights abuse to enhance the respect for and protection of human rights; and
- performing all such duties as are incidental or conducive to the attainment of the functions of the Commission.[48]

The HRC is mandated to target all victims of human rights violations, which include people living with HIV. Unfortunately, to date, the HRC has not taken up HIV and AIDS-related cases. The HRC has expressed a keen interest in taking up such cases and is in the final stages of developing a five-year strategic plan, which will include HIV and AIDS-related activities. HIV and AIDS are not mentioned in any of the annual reports of the HRC.[49]

The success of any organisation to a large extent depends on its resources. The lack of adequate financial support from the government limits the HRC. According to the Commissioners, the HRC has not been funded at a level that would allow it to undertake the expected tasks. As a result, it is unable to attract or retain high calibre and skilled personnel.[50]

46 As above, art 13(g).
47 As above, art 125.
48 See Annual HRC Reports submitted.
49 Human Rights Watch 'Protectors or Pretenders? Government Human Rights Commissions in Africa: Zambia' (2001) http://www.hrw.org/reports/2001/africa/zambia/zambia5.html (accessed 17 January 2007).
50 As above.

Weaknesses in its founding statute also limit the HRC. The lack of enforcement powers is a major impediment that damages its ability to do anything more than to make recommendations with little or no meaningful impact.[51]

In April 2004, the President of the Republic appointed new commissioners to serve on the HRC. The body had been without commissioners for a long time. It is now expected that greater prominence will be given to human rights issues in the country.[52]

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The Zambian government is committed to addressing HIV and declared the epidemic a national emergency in August 2004. Several national support structures have been put in place, including a high level Cabinet Committee on HIV and AIDS, which provides policy direction and regularly reports to the Cabinet on HIV and AIDS-related issues.

The NAC established in December 2002, co-ordinates the national multi-sectoral response. The NAC is primarily responsible for HIV and AIDS policies and programmes.[53] Zambia has also adopted a National HIV/AIDS Strategic Framework 2006-2010 in 2006.

5.2 HIV and AIDS plan

The government of Zambia has implemented a National HIV/AIDS/STI/TB Strategic Plan for 2002-2005. The Strategic Plan established the NAC to provide national leadership for coordinating and supporting planning, monitoring and resource mobilisation. The NAC drafted a National HIV/AIDS/STI/TB Policy (National HIV/AIDS Policy), a National Monitoring and Evaluation Strategy, and a Strategic Framework 2006-2010. Currently, the NAC manages 14 Technical Working Groups and provides support to nine provincial AIDS Task Forces and 72 District AIDS Task Forces.[54]

The National HIV and AIDS Strategic Framework 2006-2010 adopted in May 2006 includes an estimate of the costs of HIV and AIDS-

51 Zambia Semi-Annual Country Report (January-August 2004).
52 NAC 'Joint Review of the HIV/AIDS/STI/TB Intervention Strategic Plan' (2004).
53 US DoHSS (CDC) (n 6 above).
54 Government of Zambia National HIV and AIDS Strategic Framework 2006-2010 (2006).

related interventions focusing on scaling up prevention, treatment, care and support.[55]

The government has been scaling-up the health sector response to HIV through several initiatives, including:

- Poverty Reduction Strategy Programme;
- Highly Indebted Poor Country Initiative;
- Zambia Social Investment Fund; and
- Zambia National Response to HIV/AIDS which is funded through the World Bank Multi-Country HIV/AIDS program for Africa.

The government in its 5th National Development Plan recognised HIV and AIDS as a developmental issue and has dedicated an entire chapter to addressing HIV and AIDS, as well as integrating HIV and AIDS in all the other areas.[56]

5.3 Legislation

There is no HIV and AIDS-specific legislation in the country. The Law Development Commission is in the process of reviewing all relevant national legislation with a view to drafting a comprehensive HIV and AIDS legislation. The following pieces of legislation have either a direct or indirect bearing on HIV and AIDS.[57]

- The Constitution of Zambia Act, Cap 1
- The Constitution of Zambia Bill, 2005
- The Penal Code Act, Cap 87
- The Public Health Act, Cap 295
- The Insurance Act of 1997
- Employment Act, Cap 268
- Employment of Young Person's and Children's Act
- National Pensions Scheme Act
- Worker's Compensation Act
- National Blood Transfusion Services Act
- The Minimum Wages and Conditions of Employment Act, Cap 276
- The Industrial and Labour Relations Act, Cap 269
- The Factories Act, Cap 441
- The Defence Act, Cap 106
- The National Services Act, Cap 121
- The Birth and Deaths Registration Act, Cap 52
- The Prisons Act, Cap 97
- The Medical Examination of Young Person (Underground Work) Act, Cap 216
- The Matrimonial Causes Act of 1973

55 Government of Zambia (n 11 above) 6.
56 Zambian Legal Information Institute to download Zambian Laws.
57 National HIV/AIDS/STI/TB Policy (2005) 2.3.1.

- The Adoption Act, Cap 54
- The Deceased Brother's Widow's Marriage Act, Cap 57
- The National Health Services Act, Cap 315
- The Mental Disorders Act, Cap 305
- The State Proceedings Act, Cap 71
- The Pneumoconiosis Act, Cap 217

The contents of the above pieces of legislation are framed in three broad, but overlapping and inter-connected categories, focusing on:

- anti-discriminatory and protective laws such as laws relating to constitutional guarantees and freedoms, equality of legal status, privacy and confidentiality, codes of practice and ethical research and rights of workers in the workplace;
- regulatory laws and correctional systems: criminal law, public health laws and regulations, prisons, mental asylums and relations laws); and
- institutional administration and legal process laws: laws pertaining to procedural requirements of the process of law review and reform, due process and/or accessibility to legal redress and institutional responsibilities.

5.4 HIV and AIDS policy

Zambia has the following HIV and AIDS policies in place:

- National HIV/AIDS/STI/TB Policy 2002
- Anti-retroviral Therapy Policy
- National HIV/AIDS/STI/TB Strategic Framework 2001-2005
- National HIV/AIDS/STI/TB Strategic Framework 2006-2010

The National HIV/AIDS Policy has ten objectives:[58]

- providing a legal framework for the establishment of a multi-sectoral autonomous institution for technical guidance to implementing agencies and monitor and evaluate the national response to HIV/AIDS/STI/TB;
- providing a framework and facilitating advocacy and social mobilisation in order to promote partnership in the fight against HIV/AIDS/STI/TB;
- intensifying and strengthening preventive intervention programmes by various stakeholders in order to reduce the spread and impact of HIV/AIDS/STIITB;
- reducing morbidity and mortality related to HIV/AIDS/STI/TB;
- eliminating the socio-economic impact of HIV/AIDS/STI/TB;
- upholding and protecting the human rights and dignity of all people with HIV/AIDS/STI/TB;

58 As above.

- ensuring gender mainstreaming in all HIV/AIDS/STI/TB interventions;
- encouraging and supporting research in HIV/AIDS/STI/TB prevention and management;
- ensuring mobilisation of resources by government for the implementation of HIV/AIDS/STI/TB interventions; and
- monitoring and evaluating interventions of the National HIV/AIDS/STI/TB Policy.

The National HIV/AIDS Policy recognises the fact that VCT is the entry point for diagnosis and management of HIV-infected persons, and that VCT has now become part of a wide range of interventions such as PMTCT.

It is government's vision to decentralise counselling and testing facilities in order to make them readily available in public and private institutions and within communities.[59] These policies are not aimed at routinely testing individuals.

The Scaling up of ART for HIV/AIDS in Zambia Implementation Plan 2004-2005 (Scaling-up ART Implementation Plan) has eight service areas:[60]

- developing mechanisms to improve access to ART for various population groups;
- the expansion of ART services in the government health facilities;
- strengthening ART services provided by non-government health facilities;
- developing the national human capacity to deliver ART;
- ensuring continuous availability of drugs and supplies;
- strengthen the role of communities in provision of ART;
- improving monitoring and evaluation of the ART programme in Zambia; and
- strengthening programme management and co-ordination.

The document estimates that 200 000 people living with the virus need immediate ART. To date, 52 centres for ART are operational. The current programme plans to provide ART to about ten per cent of those who need it.[61]

There are no policies or practices aimed at withholding or denying access to HIV-related treatment to people living with HIV on the basis of sexual and social behaviour that is deemed to be 'immoral' or questionable by health care practitioners.

59 Scaling-up ART for HIV/AIDS in Zambia Implementation Plan 2004-2005.
60 VC Mtonga 'Progress report on ART Scale-up in Zambia' (2006).
61 Public Health Act, Cap 295.

5.5 Court decisions

There are no reported court decisions that deal with HIV and AIDS.

6. Access to health care

6.1 Government regulation of access to health care

The right to health care is provided for under the Directive Principles of State Policy contained in Part IX of the 1996 Constitution. The Public Health Act,[62] the National Health Services Act[63] and the Employment Act[64] provide for the right to health.

The government has taken various steps to address the HIV epidemic. The current National Health Strategic Plan (NHSP)[65] is the fourth in a series of strategic plans. The NHSP recognises that all health care interventions are important and should continue to receive the necessary level of support. However, the prioritisation of interventions is of critical importance as the resources and capabilities are strained. The NHSP Plan focuses at achieving national health priorities, including national public health priorities such as HIV and AIDS.

During the duration of the NHSP 2001-2005, the government took major steps towards the strengthening of the policy framework to address the HIV epidemic. These include the following:[66]

- all government line ministries, including the Ministry of Health, developed action plans on the implementation of HIV/AIDS at the workplace;
- in 2002, a National Action Plan for the implementation of AIDS-related activities was adopted;
- the National HIV/AIDS Policy was finalised and adopted by Cabinet; and
- in 2003, the National HIV/AIDS and Infection Prevention Committee was established by Central Board of Health.[67]

Within the National HIV/AIDS Policy and Strategic Framework, the health sector has been implementing several interventions. The Counselling Testing and Care (CTC) Programme was strengthened and

62 National Health Services Act, Cap 315.
63 Employment Act, Cap 268.
64 National Health Strategic Plan (NHSP) 2005-2009.
65 As above.
66 The Central Board of Health was dissolved in February 2006. This will have an impact on the delivery of HIV-related services.
67 PS Jones 'On a never-ending waiting list: towards equitable access to anti-retroviral treatment? Experiences from Zambia' (2005) 8/2 *Health and Human Rights* 82; Ministry of Health NHSP 2005-2009.

expanded to 420 centres countrywide. The PMTCT Programme was strengthened and expanded to 220 centres.

ART roll out was also scaled-up. In this respect, a total of 700 medical personnel were trained in the administration of ART and the management of opportunistic infections. The number of centres providing ART increased from two in 2003 to 84 in 2005. As a result of all these efforts, the level of ART awareness improved significantly, leading to an increase in the number of eligible patients accessing ART from 4 000 patients in 2003 to about 32 144 by August 2005. However, despite the recent dramatic increase in people receiving ART, it is unlikely that the national target of 100 000 eligible HIV patients on ART by end of 2005 (50 per cent of each year's demand) will be accomplished.[68] The general obstacles in scaling up the ART in Zambia are the lack of infrastructure and trained personal. These structural obstacles prevent people living in rural areas to benefit from the free ART policy.[69]

Home-Based Care (HBC) activities were scaled-up in all 72 districts and a total of 305 trainers were trained to establish and strengthen palliative care in communities. The HBC programme has been implemented primarily through NGOs and faith-based organisations. A total of 3 600 health workers were trained in syndrome management of STI. Youth-friendly health services were established in 50 districts. These need to be expanded to cover all the health centres. STI treatment protocols and guidelines were revised and are being used as reference materials by health facilities.[70]

As the safe transfusion of blood is one of the most effective direct methods of preventing the transmission of HIV and other blood-borne infections, it is one of the major strategies in the fight against the spread of HIV. Over the past few years, the operations of the Zambia National Blood Transfusion Service were strengthened through increased financial and technical support. Significant achievements have been recorded. HIV prevalence in donated blood has reduced from over 25 per cent in the late 1980s to around five per cent; all blood collected is being tested for HIV, hepatitis B and C and syphilis in accordance with national and WHO guidelines.[71]

HIV continues to present significant challenges to the health sector. Currently, multi-sectoral co-ordination at provincial and district levels is still limited, and there is a lack of capacity to scale up programmes using best practices. A shortage of HIV test kits and specialised testing equipment remains. Although VCT services have

68 As above, 85.
69 NHSP (n 64 above).
70 As above.
71 As above.

been expanded in most districts, especially those in remote areas, only a few health facilities offer these services.[72]

The following strategies have been adopted to halt and reverse the spread of HIV and STI:[73]

- scaling-up prevention activities through increased promotion and support to ABC programmes and culturally sensitive information, education and communication;
- increasing access to HIV counselling and testing, in health facilities and at community level;
- strengthening PMTCT activities through integration with reproductive and child health and routine HIV testing in antenatal clinics;
- developing and implementing HIV/AIDS workplace policies at the provincial and district levels;
- expanding access to ART for eligible adults and children;
- strengthening and scale up of HBC activities;
- expanding access to STI interventions;
- further strengthening the national blood transfusion services so as to ensure equitable and affordable access to adequate and affordable safe blood and blood products; and
- facilitating the strengthening of the multi-sectoral response to HIV/AIDS.

The right of access to health care is not protected in the Constitution, national legislation, or policy documents. People living with HIV do not have any rights when using public or health care services apart from the 'right to access ART' as provided for in the 2005 ART Policy.

6.2 Ethical guidelines

There are no ethical guidelines that exist within the medical profession to regulate the behaviour of doctors and health care workers towards those patients who test HIV positive or are affected by HIV and AIDS.

The government has developed national guidelines on the management and care of patients with HIV.[74]

72 National HIV/AIDS Council Policy 2005.
73 NAC 'National Guidelines on Management and Care of Patients with HIV/AIDS' (2004).
74 WHO 'HIV/AIDS Treatment Scale-up: Summary Country Profile: Zambia' http://www.who.int/hiv/HIVCP_ZMB.pdf (accessed 20 January 2007).

6.3 Medicines

An estimated 183,000 persons in Zambia need treatment for HIV including ART.[75] In 2005, only about 43 964 infected Zambians are receiving ART.[76] A recent rapid assessment of the Zambian ART Program identified several important constraints including: inadequate human resources for testing, counseling, and treatment-related care; gaps in supply of drugs in the public sector; lack of adequate logistic/supply chain systems; stigma which hinders people from seeking care and treatment; lack of information on the availability of treatment services; a high level of misinformation about ART; need for a continuous funding stream as cumulative patients on therapy result in a growing need for support; high cost of ART to patients, despite being subsidised in the public sector; lack of referral between counseling and testing services and ART; and lack of referral between home-based care services and access to testing and referral to ART. A primary hurdle to scaling-up ART is maintaining a continuous funding stream as cumulative patients on therapy result in a growing need for support.

The ART Policy ensures access to the treatment of opportunistic infections and ARVs for people living with HIV. There are no policies, practices or laws that limit access to medicines if they are available.

Zambia is a member of the World Trade Organisation (WTO) and is also a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) by virtue of the WTO Agreement.[77] Zambia has issued a compulsory licence, in September 2004, to permit the local production of first-line ART.[78]

6.4 Condoms

Promotion of condoms has largely been the responsibility of the Zambia Social Marketing Project (ZSMP), which is run by PSI and the Pharmaceutical Society of Zambia with funding of the United States Agency for International Development (USAID). In 1992, the Project launched a brand of condom, 'Maximum', which rapidly became a market leader due to its affordability, high-profile advertising and availability in a wide range of outlets — including bars and grocery

75 As above.

76 Article II and XII (1) of the WTO Agreement states that accession to the WTO Agreement also applies to the multilateral trade agreement annexed to it which are binding on all members. The TRIPS Agreement (Annex 1C to the WTO agreement) is part of the multilateral trade agreement.

77 WHO 'Access to AIDS medicine stumbles on trade rules' (2006) 84 *WHO Bulletin* 5 337-424 www.who.int/entity/bulletin/volumes/84/5/news10506/en/index.html (accessed 14 November 2006).

78 AVERT 'HIV/AIDS in Zambia: prevention and care' http://www.avert.org/zambia-aids-prevention-care.htm (accessed 12 November 2006).

stores. This was followed by the introduction of Zambia's first female condom, 'Care', in 1997.[79] The government has distributed 16.3 million condoms (2002) while social marketing condoms have sold 12.3 million (2003).[80]

Condoms are the second best known method of fertility-regulation after the pill, but popular attitudes dictate that these are particularly associated with sex workers, teenage sex, extra-marital affairs, and use during menstruation.[81]

In 2004, the government banned the distribution of condoms in schools on the grounds that it promotes immorality and premarital sex.[82]

About three per cent of outlets carry the unbranded male condom donated to the government of Zambia by international donors. These unbranded male condoms are available in 76 per cent of the public clinics, 15 per cent of private clinics and 13 per cent of hotels, but in very few other outlets. The availability of government condoms in groceries, kiosks and bars is negligible.[83]

About two per cent of all outlets stock one or more commercially supplied condom brand. Pharmacies (50 per cent) and drug stores (13 per cent) are the outlets most likely to carry commercial brands. Again, there are virtually no commercially supplied condoms available in grocery stores, kiosks or bars. About 39 per cent of all outlets currently carry the social marketing supplied male condom, 'Maximum'. A substantial proportion of grocery stores (37 per cent), kiosks (30 per cent) and bars (49 per cent) carry the social marketing male condom. 'Maximum' is also available in the majority of pharmacies (89 per cent), drug stores (83 per cent) and supermarkets (63 per cent), in about half of the hotels (52 per cent) and in a substantial proportion of petrol pump stores (44 per cent) and retail stores (41 per cent).[84]

There is much less access in rural areas. For poorer Zambians, kiosks and grocery stores are an important access point, while richer

79 NAC (n 52 above).
80 EK Bauni 'Attitudes to Sexuality and Family Planning' (1998) 48 *Progress in Reproductive Health Research* 8.2 http://www.reproline.jhu.edu/English/6read/6issues/6progress/prog48_e.htm (accessed 13 November 2006).
81 'Zambia bans distribution of condoms in schools to prevent "immorality"' *Agence France-Presse* 15 March 2004 http://www.aegis.com/news/afp/2004/AF040362.html (accessed 12 November 2006).
82 S Agha & T Kusanthan, 'Equity in access to condoms in urban Zambia' (2003) 18 *Health Policy and Planning* 3 301-302.
83 As above, 301-305.
84 As above, 299–305.

Zambians get condoms from pharmacies. There is a need to put condoms in high-risk locations such as bars and night clubs.[85]

The female condom is also available in many locations such as pharmacies, beauty parlours, and grocery stores, but at about ten times the price of a male condom. The price of male condoms on the world market is about USD 0.03 and the price in Zambia is comparable,[86] while the female condom costs around USD 0.58.[87]

6.5 Case law

There are no documented or reported cases in any court on HIV and AIDS and the right of access to health care.[88]

7. Privacy

7.1 Notifiable disease

HIV and AIDS as well as other STI and TB are notifiable diseases[89] under the Public Health Act (Infectious Diseases Regulations).[90] The Public Health Act has a number of provisions, which appear draconian at face value, but which are or may be justifiable by reference to the permitted limitations on the rights contained generally in article 25 of the Zambian Constitution.[91]

For example, a medical or health officer may, under the Public Health Act, enter any building wherein he has reasonable cause to believe that any person suffering from an infectious or notifiable disease may be residing and for this purpose may compel a person to submit to medical examination in respect of any suspected or notified infectious disease. This power may be used to compel HIV-positive patients to submit to medical examination, and all that the medical practitioner has to do is to claim to be examining the patient for TB or some such infectious or communicable disease declared to be a notifiable disease.

85 'The Global coalition on Women and AIDS Backgrounder: Basic facts on the female condom' (2006) http://www.global_campaign.org/clientfiles/gcwa_bg_female_en_pdf.pdf (accessed 3 February 2007).

86 As above.

87 Zambia Legal Information Institute.

88 A notifiable disease is any infectious disease which the Ministry may, by statutory instrument, declare as such. The declaration of any disease as a notifiable gives the health authorities very broad and sweeping power of compulsive medical examination, inspection and quarantine.

89 Public Health Act (Infectious Diseases Regulations) Cap 535 (see n 62 above).

90 The permissible limitations in article 25 authorise the restriction of rights by recourse to laws that are reasonably justifiable in a democratic society in the interests of public health, public morality and public safety.

91 National HIV/AIDS Policy (2002) sec 3.9.2.

Moreover, a policy on testing for HIV exists and is based on informed consent and pre- and post- counselling. The National Policy states that in relation to partner's notification:[92]

> In order to bring about shared confidentiality that is desirable to promote prevention, better care and coping with HIV/AIDS, government shall legislate against individuals who deliberately and knowingly withhold their HIV status from their partners/spouse.

Partner notification is also addressed in the 2000 Guidelines on HIV/AIDS Counselling in Zambia, which states that 'promotion of partner notification, social behaviour change and individual responsibility to prevent further HIV infection shall be an integral part of preventive counselling'.[93]

7.2 Medical experimentation

The Constitution states in article 15 dealing with the protection from inhuman treatment that '[n]o person shall be subjected to torture, or to inhuman or degrading punishment or other like treatment'. This could broadly be interpreted to include bodily and psychological integrity.

In April 2006, The Zambia Emory HIV Research Project, the International AIDS Vaccine Initiative (IAVI) and Targeted Genetics Corporation announced the initiation of a clinical trial in Zambia to test the safety and immunogenicity of tgAAC09, a preventive HIV vaccine. The vaccine candidate, tgAAC09, was developed by Targeted Genetics, based in Seattle. The vaccine is based on HIV subtype C, which is most common in Southern Africa. TgAAC09 is designed as a preventive vaccine, intended to protect people not infected with HIV from contracting the disease. It is designed to elicit two different types of immune responses — an antibody response and a cell-mediated response. The trial should take about 18 months to complete. At the Lusaka clinical trial site, 16 volunteers (men and women) who are in good health will be enrolled. IAVI estimates that there are 30 preventive HIV vaccine candidates in human trials on six continents.[94]

7.3 Duty to disclose

The Guidelines on Employment, HIV/AIDS and Human Rights in Zambia stipulate that a medical doctor, who has knowledge of a person's HIV

92 National Guidelines for HIV Counselling and Testing (2000) sec 4.

93 'Zambia begins first preventive HIV vaccine trial' 26 April 2006 http://www.iavi.org/viewfile.cfm?fid=38470 (accessed 12 November 2006).

94 Policy Project II 'Guidelines on Employment, HIV/AIDS and Human Rights in Zambia' (2001) 6.

status cannot divulge the employees status to his employer without the employees consent. A doctor who has information of an employee's HIV status must treat that information as confidential.[95]

7.4 Testing

The National Guidelines for HIV Counselling and Testing were adopted in 2006. The Guidelines acknowledge that testing policies must adhere to regional and international guidelines and full pre- and post-test counselling is required.[96] Although VTC is used widely by the government as an entry point for HIV services and care,[97] the Scaling-up ART Implementation Plan indicates greater emphasis on the routine testing in clinical settings for more efficient identification of patients in need of ART.[98] It also suggested that the Ministry of Health should consider a new national policy promoting routine counselling and testing of all at risk patients entering a hospital or attending medical or specialised clinics.[99] However, currently, there is no national policy on routine testing.[100] HIV testing is routinely offered to pregnant women and TB patients. There is a mandatory HIV testing for those seeking employment with the military.

There are over 262 public counselling and testing sites in the nine provinces of Zambia. 115 are stand-alone counselling and testing site and 147 offer integrated care, which include ART and PMTCT. In addition, donor organisations fund private counselling and testing services that include the New Start Centre and Kara Counselling, located in Lusaka, Livingstone and the Copper belt.

Counselling and testing is offered in all provincial capitals and in many districts in Zambia. There are still certain rural areas where counselling and testing services are not available. As a result, the donor community is introducing and supporting mobile counselling and testing services. Trained counsellors conduct counselling and testing.[101]

8. Equality and non-discrimination

Article 23(1) of the 1996 Constitution provides protection against discrimination, but HIV is not specifically included. Thus, the right to equality for people living with HIV is not specifically protected. HIV-

95 National Guidelines for HIV Counselling and Testing (n 92 above).
96 National HIV/AIDS Policy (n 91 above) sec 1.8.1.f.
97 Scaling-up ART Implementation Plan (n 59 above) sec 1.0.1.
98 As above.
99 NAC (n 52 above).
100 NAC 'World AIDS Day District Toolkit' (2004).
101 Zambia Legal Information Institute.

related issues were said to have been the subject of dispute in local courts which administer customary law. However, no cases were found.[102]

One of the main objectives of the National HIV/AIDS/STI/TB Policy of 2005 is to ensure that the rights of people living with HIV are protected and stigma and discrimination are eliminated. The measures in place to ensure this include:

- encouraging voluntary counselling and testing for all persons and insisting on the maintenance of confidentiality by health care providers and employers;
- discouraging anonymous HIV testing;
- discouraging mandatory testing for scholarships and employment;
- educating the insurance industry to develop and apply policies which take into account the insurance needs of PLHA;
- integrating HIV and AIDS services required by people with different abilities into existing health and social welfare delivery systems; and
- promoting positive living among PLHA.

The rights of people living with HIV have not been ascertained in court, but the Human Rights Referral Centre (the Referral Centre) has the mandate to assist and make referrals to appropriate services for legal redress or social assistance. The Referral Centre helps to ensure an appropriate service response by screening clients and referring them to organisations that have agreed to handle cases of discrimination.

9. Labour rights

9.1 Legislation

Although no laws have been passed specifically dealing with HIV and AIDS, there has been some debate on the subject.

Mandatory screening of employees for HIV has been condemned by trade unions in Zambia as an unwarranted violation of the right to privacy. There is a fear that employers will discriminate against prospective or current employees who test positive. The right to employment is protected by the Industrial and Labour Relations Act; by the Employment Act, and by Statutory Instrument No 56 of 1989 made under the Employment (Special Provisions) Act (Cap 515).[103]

[102] Labour Relations Act 1993; Employment Act (n 63 above) Cap 512; Statutory Instrument 56 of 1989 under Employment (special provisions) Act Cap 515.

[103] K Sokoni 'Women, Aids and the law in Zambia' (1998) http://www.einaudi.cornell.edu/africa/outreach/pdf/Women_AIDS_and_the_Law_in_Zambia.pdf (accessed 21 January 2007).

Under these laws, an employee's tenure is secured. Under the Industrial and Labour Relations Act, it is prohibited to dismiss or deny an employee or prospective employee employment on the grounds of social status. People living with HIV can, in principle, challenge dismissal from employment or refusal of employment before the Industrial Relations Court if dismissal or refusal is founded on their HIV status. In practice, however, when people have been victimised due to their HIV status, they are sometimes reluctant to take the matter to the Court for fear of publicity and further victimisation.[104]

In September 1993, participants of a Seminar of Permanent Secretaries held in Livingstone recommended mandatory HIV antibody testing for those intending to marry. This was met with great opposition on the ground that such testing violates the right to privacy.

Employees in Zambia are protected against discriminatory practices and unfair dismissal by the Employment Act[105] and the Industrial Relations Act.[106] People living with HIV would need to rely on the provisions in these laws to protect their labour rights. In the event of a dispute, they could present a case before the Industrial Relations Court. The rights of HIV-positive employees are protected through workplace policies, protecting employees against discrimination and providing a supportive environment in which an HIV-positive employee can work.[107] On its part, section 36(2) of the Employment Act Cap 268 of the laws of Zambia is to the effect that the rights of employees living with HIV are protected until they become indisposed and upon certification by a medical practitioner of such indisposition.

The Constitution recognises that state policy principles should include provisions on fair labour practices and safe, healthy working conditions. However, these rights are not justiciable.[108]

Fair labour practices require that all employees be treated equally without discrimination on the grounds of disability. An employee in the public service, para-statals or statutory corporations, who is denied promotion on account of his or her HIV-positive status can complain to the Commission for Investigations created under the Constitution.[109] Moreover, any worker who is treated unfairly by his or her employer can file a complaint with the Industrial Relations Court (section 108 and 85 of the Industrial and Labour Relations Act).

104 Employment Act (n 63 above) Cap 268.
105 Industrial Relations Act Cap 269.
106 M B Chuulu 'Guidelines on employment, HIV/AIDS, and human rights in Zambia' (2001) 5-6.
107 Constitution of Zambia (n 23 above) arts 111-112.
108 As above, art 123.
109 Chuulu (n 106 above).

9.2 Testing

Section 28 of the Employment Act requires that every employee be medically examined by a medical officer before he or she enters into a contract of service of at least six months' duration. The purpose of the examination is to ascertain the fitness of the employee to undertake the work.

The Act does not require that prospective employees be tested for HIV. However, there is no law protecting prospective or current employees from such a test. Section 34(1) of the Employment Act provides for the medical examination of every person who enters into a written contract of service which conceivably may include a test for HIV.

The policy of the Zambia Federation of Employers is that employers should not require prospective job applicants to undergo an HIV test. An HIV test as part of a medical examination should only be done with the full consent of the employee. Also, an employer cannot demand that current employees take an HIV test.

The Zambia Defence Force is the only employer that requires applicants to undergo HIV testing. Those recruits who test HIV positive are not employed.[110]

9.3 Medical schemes act

There is no medical schemes act in place regulating the functioning of medical schemes at a national level, nor are there measures in place to ensure that medical schemes offered by employers do not discriminate against employees living with HIV. Much depends on what the workplace policy provides.

Generally most workplace policies do not discriminate against employees living with HIV. Benefits covered under the Employment Act, Industrial Relations Act and other legislation include medical and health-related benefits, disability relating to spouses or dependants, housing benefits, life insurance, pensions, and bursaries. Companies that provide these benefits must provide them to all employees equally.[111]

[110] As above.

[111] Private companies started providing ART to their employees long before the ART Policy was passed. In addition, the fact that this Policy exists has not translated into ART provisioning to all those in need. Access to ART depends on the availability of human resources, drugs, and laboratory equipment. Many health facilities in the rural areas lack these resources.

9.4 Duty to provide treatment

There is no duty on an employer to provide anti-retroviral therapy and other medication to employees. The Government ART Policy of 2005 provides free ART to all who require it at public health facilities.[112]

There are no laws in place that concern the provision by employers of medical care for those infected with HIV. Workplace policies usually provide benefits to employees who are HIV positive.[113]

10. Women's rights

10.1 Legal status and protection

The findings of the United Nations Secretary General's Taskforce on Women and Girls and HIV/AIDS in Southern Africa show that gender inequality fuels HIV infection because many girls are not in a position to negotiate safe sex or turn down unwanted sex. The findings demonstrate that HIV and AIDS deepens and exacerbates women's poverty and inequality because it requires greater domestic labour as women care for the sick, the dying and the children who have been orphaned.[114]

Article 11 of the Constitution of Zambia guarantees equality to both male and female. Men and women enjoy the same basic human rights and freedoms without any discrimination. The Preamble to the Constitution also refers to men and women's equal right to participate in the determination of, and construction of, their society.

There are no special measures in place to protect women who are more vulnerable to HIV infection. Section 132 of the Penal Code criminalises rape.[115] The defilement of girls aged less than 16 years (section 138) is illegal, as is incest (section 159). An Amendment to the Penal Code, enacted in September 2005, prohibits the sexual harassment of children. However, there are no laws that specifically prohibit the sexual harassment of adults and there is no legal provision prohibiting marital rape.

112 Chuulu (n 106 above).
113 United Nations Secretary General Taskforce on Women, Girls and HIV/AIDS in Southern Africa (2005).
114 Penal Code, Cap 15.
115 World Organisation Against Torture (OMCT) 'Violence against women in Zambia: a report prepared for the Committee on the Elimination of Violence Against women' (2002) http://www.omct.org/pdf/vaw/zambiaeng2002.pdf (accessed 12 November 2006).

At present, the criminal law remedies available to women who are victims of domestic violence are limited to proceedings for assault occasioning actual bodily harm under section 248 of chapter 87 of the Penal Code. Women who have suffered physical injury as a result of domestic violence may also sue their husband or partner for damages in civil courts and physical violence is recognised as providing a motive for divorce under both customary and statutory law. Importantly, however, none of these remedies cover women who are victims of psychological or economical violence.[116]

10.2 Domestic violence law

About 80 per cent of Zambian wives find it acceptable to be beaten by their husbands 'as a form of chastisement', according to the latest Zambia Demographic Health Survey.[117] In spite of this, there is no specific law prohibiting domestic violence. When prosecuting offenders, general assault statutes are used. There is increased awareness by government that domestic violence is linked to HIV transmission. A Draft Gender Violence and Sexual Offences Bill exists but there is no 'clear timeline for when it would be considered by the National Assembly'.[118]

10.3 Customary rules and practices

Customary law is formally recognised in Zambia. Chapter 29 of the Laws of Zambia governs the administration of customary law. The most important role of local courts which administer customary law is the settlement of domestic disputes arising from marriage relations and the realisation of sexual or reproductive rights. The Local Courts mainly deal with non-statutory marriages, divorce, reconciliation, custody of children, and the payment of the bride price (*lobola*), pregnancy suits, compensation for adultery, elopement, and the devolution of the property of persons who die intestate. The local court plays the roles of arbiter, medium of reconciliation to the family and the guardian of custom.[119]

No clear definition of customary law has been developed, nor has there been any systematic development of customary law. It has been argued that customary law cannot be the subject of formal legal

116 'Zambia: culture of silence over gender violence' *IRINNews* 1 December 2003 http://www.irinnews.org/report.asp (accessed 10 November 2006).

117 Human Rights Watch 'SADC Gender and Development Protocol: How it can Save Lives' 16 August 2007 http://hrw.org/english/docs/2007/08/16/zambia16697_txt.htm (accessed 9 September 2007).

118 Inter-African Network for Human Rights and Development (AFRONET) 'Local Courts Study' (1999) http://afronet.org.za/afronet.htm (accessed on 2 February 2007).

119 OMCT (n 115 above).

education.[120] Conflict often arises between the demands of customary law on the one hand, and the imperatives of human rights on the other hand.

Several customary practices put women in an unequal and vulnerable position in society and increase their risk of HIV infection. These include:

- polygamy;
- ritual sexual cleansing;
- dry sex;
- early marriages;
- tattooing;
- wife-inheritance; and
- initiation ceremonies.

Wife inheritance is a practice by which a widow is inherited by a relative of her deceased husband. In some parts of Zambia, this practice is engaged in, with the belief that the deceased man's brother will cleanse his brother's death by engaging in sex with the widow, without necessarily retaining any obligation to marry her.[121]

The lower social and economic status of women in the Zambian society makes it difficult for them to reject cultural practices that increase the possibility of contracting HIV. Awareness campaigns are taking place nationwide and are ongoing. Moreover, it is submitted that campaigns on behaviour change should incorporate the male population. They should be educated about the benefits and protection provided by a monogamous marriage, and the dangers of having a plurality of sexual partners.[122]

With increased awareness on the mode of HIV transmission, certain practices are being discouraged by traditional leaders, such as the reuse of razor blades for tattooing. Similarly, the practice of wife-inheritance is decreasing. However, much depends on the attitude the traditional leader governing a particular area. Some of these practices have been challenged in court but such cases are poorly documented.[123]

The local courts have dealt with questions relating to HIV, AIDS and human rights. However, due to poor record management it is not possible to obtain copies of these cases.[124] The local courts are seeing an increase in the number of cases that deal with reconciliation where one partner is found to be HIV positive. Where the woman is found to

120 Sokoni (n 103 above).
121 As above.
122 It has been reported that in many cases justices ask litigants to pay for exercise books to record their court proceedings.
123 Most of these cases are reported on the radio.
124 *Kapanda v Shanjili* case 96 of 1970 (Shakumbila Local Court) unreported.

be positive the local courts have a tendency to grant a divorce; where the husband is found to be positive a divorce is not granted.

For instance, under customary law, marriage is a union of a man who may or may not be married and a woman who must be unmarried at the time of entering into marriage. Hence, customary marriages permit polygamy which potentially poses a high risk of infection. In this setting, no matter how faithful a wife may be to her husband, if he takes in another wife who is infected with the virus, the first wife is inevitably put at risk. In a polygamous union, women have very little control over matters such as their husbands' sexuality which have a direct impact on their lives and health.

It could be argued that polygamy does not promote promiscuity of men because a man is restricted to having sexual relations only within the polygamous union. This is not always the case, because it is known that customary law is quite indulgent to husbands in this matter. In one local court case, *Kapande v Shanjili*,[125] a local court Justice stated that breach of the husband's right to exclusive sexual relations with his wife gives rise to a customary wrong of adultery, which entitles him to recover damages from the adulterous male. No similar cause of action is afforded to the wives.[126]

10.4 Administration of anti-retrovirals to rape survivors

There is a high incidence of rape in Zambia. It was reported that there are ten rape cases of young girls in Lusaka every week.[127] Needless to say, rape is one of the most serious crimes, and in some cases, it can be deadly because of HIV.[128] However, there are no measures in place to ensure the administration of anti-retroviral drugs to women who are raped in an effort to minimise their chances of HIV infection.

10.5 Sex workers

The Penal Code criminalises certain aspects of sex work. While prostitution is not illegal, it is illegal under sections 146 and 147 of the Penal Code to solicit customers or live off the earnings of someone engaged in sex work.

There is no movement towards the decriminalisation of sex work in an effort to award greater protection to women against HIV infection. Prostitution is highly stigmatised in Zambian society. Unlike

125 Sokoni (n 103 above).
126 'Zambia: 10 girls raped every week' *IRIN Plus News* 29 November 2006 http://www.plusnews.org/AIDSreport.asp?ReportID=6573&SelectRegion=Southern_Africa (accessed 21 January 2007).
127 P Chela 'Who Will Stop the Brutes' *Times of Zambia* 17 April 1999.
128 Government of Zambia (n 26 above).

men, a woman who has sex with any man outside of marriage is considered a prostitute.[129]

Section 3.8.2 of the National HIV/AIDS Policy states the following in terms of commercial sex work: 'Government shall (a) enforce the provision of the existing law and provide facilities for rehabilitation of sex workers; (b) target clients of sex workers with appropriate information and education and encourage then to take responsibility for their partners' sexual health'.[130]

11. Children's rights

11.1 Access to health care

All children under the age of five are entitled to receive free health care at any public health care institution. The Guidelines on HIV/AIDS Counselling recommend that children living with HIV should be provided with free medical care.[131] The recently passed National ART Policy applies to children living with HIV.

The reality is that children living with HIV do not have access to adequate health care facilities and are subjected to the same conditions as adults. For children in the rural area this means having to walk long distances to get to the health care facility which is often understaffed, with drugs in short supply.[132]

Children have access to ART at the government's expense but this is on a very limited scale.[133]

Zambia has a PMTCT Strategic Framework 2003-2005 in place. The objectives of this strategy are:[134]

- to contribute to the improvement in child survival and development through the reduction of HIV-related infant and childhood morbidity and mortality;
- to contribute to the decrease in maternal mortality through the strengthening of antenatal, delivery and postpartum care services; and
- to contribute to the improvement of the length and quality of life of HIV positive women and their families through the provision of care and support services.

129 Centre for Study of AIDS & Centre for Human Rights, University of Pretoria *HIV/AIDS and Human Rights in Zambia* (2004) 25.
130 National Guidelines on HIV/AIDS Counselling (n 92 above).
131 'Zambia: Kids slip though ARV net' *IRIN Plus News* 12 January 2007 http://www.plusnews.org/AIDSreport.asp?ReportID=6639&SelectRegion=Southern_Africa (accessed 21 January 2007).
132 Supported by the Centres for Disease Control.
133 National Protocol Guidelines on the Integrated PMTCT of HIV/AIDS.
134 National HIV/AIDS Policy (n 91 above) sec 1.8.4.

The Zambia National PMTCT programme uses a four-pronged approach to PMTCT it adopted from WHO recommendations. Major components include primary prevention of HIV among young people, women and men, the prevention of unwanted pregnancies among HIV-positive women, the prevention of HIV transmission from infected mothers to their babies, and care and support to families of people living with HIV.

11.2 Children orphaned by AIDS

There are no measures in place by government to provide food for children who have been orphaned. Many donor agencies provide support to children who have been orphaned, including food, education, clothing, health care and very limited shelter.

The Department of Social Welfare in the Ministry of Community Development and Social Services is involved in the provision of grants to child-friendly NGOs and CBOs. In addition, an OVC forum which comprises government, donors and all other stakeholders is in the process of developing a minimum package of care for OVC.[135]

11.3 Education

The Constitution protects everyone, including children, from discrimination. HIV education is ongoing in schools, and the Ministry of Health has an HIV/AIDS in Workplace Policy in place. Children have access to general sexual education through the HIV awareness campaigns that take place. These focus on abstinence. In addition, HIV/AIDS Guidelines for Educators have been developed.[136]

Children are not refused access to schools on the basis of their HIV status, but some HIV-positive children will drop out of school because of the stigma they face.[137]

A 50/50 enrolment policy ensures the education of the girl-child.[138] Teachers do not receive special training to sensitise them towards the needs of HIV-positive children. Most schools have ongoing HIV awareness activities. The Strategic Plan aims to train and sensitise teachers in HIV-related issues so that they can educate students. As well, it is planned to review and expand existing education programs to tackle HIV-related issues more thoroughly.[139]

135 Ministry of Education HIV and AIDS Guidelines for Educators 2003.
136 National HIV/AIDS Education Strategic Plan 2002-2005.
137 Programme for the Advancement of Girl-Child Education.
138 National HIV/AIDS Education Strategic Plan (n 136 above).
139 Intestate Succession Act, Cap 59.

12. Family law

There is no inheritance legislation that specifically addresses HIV and impacts on people living with HIV. Generally, the Intestate Succession Act[140] makes adequate financial and other provisions for the surviving spouse(s), children, dependants and other relatives of the intestate and provides for the administration of the estates of persons who have died before making a will. Section 34 of the Intestate Succession Act protects beneficiaries of an estate. Under section 35 it is an offence for an administrator or guardian to wrongfully deprive a minor of property or a share in property to which the minor is entitled.

Similarly, there is no guardianship legislation that specifically addresses HIV and AIDS or impacts on people living with HIV. Adoption and legal guardianship are regulated by section 4(1) of the Adoption Act.[141] Most Zambians assume guardianship without officially adopting or fostering the child, and there is no monitoring to determine the presence of abuse or neglect.[142]

The position of children who have been orphaned has only recently started to receive the level of attention it deserves. As a result, Cabinet recently approved the Child Policy which recognises OVC as emergency issues. The National Child Policy includes sections on the need to improve the welfare of the child (including OVC) through child protection, basic education, early childhood development with the emphasis on community-based initiatives and the co-ordination of various interventions. In addition, discussions are ongoing regarding the drafting of a comprehensive Child Act.[143]

13. Criminal law

13.1 Criminal legislation

There are no HIV-specific provisions within Zambia's criminal law. With the increased awareness regarding HIV, the Law Development Commission is reviewing all laws with a bearing on people living with HIV in order to determine whether they protect their rights. The Commission plans to draft comprehensive HIV and AIDS legislation if current laws do not suffice.

There is no legislation criminalising the wilful transmission of HIV. However, the Penal Code contains offences that could be used for the prosecution of wilful transmission of HIV. For instance, section 200 of

140 Adoption Act, Cap 54.
141 Government of Zambia (n 11 above).
142 National Child Policy 2003.
143 National HIV/AIDS Policy 2005.

the Penal Code states that 'any person who of malice aforethought causes the death of another person by an unlawful act or omission is guilty of murder'. Section 199 provides that any person, who by an unlawful act or omission causes the death of another, is guilty of manslaughter. An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health whether such omission is or is not accompanied by an intention to cause death or bodily harm. Arguably, as the law on homicide stands in Zambia, there is a basis on which to place charges against someone who deliberately transmits the virus for either death or manslaughter.

The 2005 National HIV/AIDS Policy advocates the legalisation of mandatory testing for persons charged with any sexual offence that could involve the risk of HIV transmission. Also, the Policy advocates developing a framework to deal with the wilful transmission of HIV. The government also mentions putting in place support systems for victims and offenders in the form of counselling, education, information, rehabilitation and appropriate therapy.[144]

Cases of child rape are increasing in number because of the belief that sex with a virgin cures AIDS.[145] This leads to harsher sentences given to people found guilty of child rape or 'defilement'. Under national laws defilement occurs when you have sex with a person under the age of 16.[146]

No one has ever been reported as having been assaulted or killed solely because of their HIV status.

13.2 Men having sex with men

Sodomy or consensual sexual relations between men is a crime in Zambia. Under section 155 of the Penal Code sodomy is regarded as an unnatural act against the order of nature, and under section 158 it is regarded as an indecent practice between men. This offence has seldom been prosecuted as this is only possible if the act is not consensual. If it is consensual there is no evidence to prove the offence. To civil society, homophobic sentiments are regarded as a problem in government policy. For instance, the permanent Human Rights Commission emphasised that they could not intervene on homosexual issues. In 1997, the Chair, Judge Lombe Chibesakunda,

144 Human Rights Watch *Suffering in silence: the link between human rights abuses and HIV transmission to girls in Zambia* (2002) http://hrw.org/reports/2003/zambia/zambia1202.pdf (accessed 21 January 2007) 2 & 31.

145 'Defilement as a threat to HIV/AIDS prevention' 15th International AIDS Conference 2004 in Bangkok, Thailand.

146 Human Rights Watch & International Gay and Lesbian Human Rights Commission 'More than a name: state-sponsored homophobia and its consequences in Southern Africa' (2003) 44.

emphasised that 'homosexuality is not one of our priority areas of concern. We are concerned with pressing issues, including poverty and prisons'.[147] Another example occurred in 1998 when the Norwegian embassy gave a substantial grant to a local organisation and expressly targeted part of it for supporting the organisation's work with lesbians, gays and transgendered persons. A new furore erupted when the donation was reported in the state-sponsored press. This led to a reply from the Norwegian foreign affairs minister to his Zambian counterpart.[148]

14. Prisoners' rights

There are between 13 000 to 15 000 inmates in Zambia's prisons, most of whom are men. Researchers visited three of the country's main jails between November 1998 and June 1999. They found that 27 per cent of inmates tested HIV positive (n=1,566, of whom 43 were women). There was a significant difference in HIV prevalence between male prisoners (26.7 per cent) and female prisoners (32.6 per cent).

Among inmates aged 20 years and below, HIV prevalence was 14.5 per cent, compared with 31.5 per cent among those 30 to 39. HIV prevalence among unmarried prisoners was 23.7 per cent; among those currently married, 27.2 per cent; and among those separated, divorced, or widowed, 36.3 per cent. These findings are much higher than the HIV prevalence rate of 16.1 per cent reported in similar studies conducted in 1988-89. The researchers concluded that the major source of HIV infection among prisoners in Zambia was heterosexual intercourse outside prison. Nevertheless, they believed that the risk of HIV transmission from penetrative anal sex is high in Zambian prisons. They also stressed that the poor socio-economic conditions in most prisons contribute to transmission and lack of care.[149]

There are currently no measures in place to stop the spread of HIV in prisons. At present, Zambian courts do not take HIV status into consideration when sentencing. There are no voluntary counselling and testing facilities in prisons, and HIV tests are only conducted when a convict falls ill repeatedly.[150] HIV-positive prisoners are not separated from other prisoners. Prisoners do not have access to condoms because government believes that this would encourage homosexual practices which are a criminal offence under the Penal Code. Penetrative anal intercourse is common and unprotected. In

147 As above.
148 L Garbus (Aids Policy Research Centre, University of California San Francisco) 'Country Aids policy analysis project: HIV/AIDS in Zambia' (2003).
149 'HIV pandemic in African prisons' (2004) http://realcostofprisons.org/blog/archives/2004/10/hiv_pandemic_af.html accessed 12 November 2006.
150 National HIV/AIDS Policy (n 143 above)

some instances prisoners delay accessing medical services, thus delaying the timely diagnosis and treatment of STIs.[151]

15. Immigration

There are no measures in place making HIV relevant to immigration, travel into or out of Zambia, or to obtain any form of permission to enter and stay in the country.[152]

Refugees are recognised as a vulnerable group in the 2005 National HIV/AIDS Policy. Large numbers of refugees enter Zambia and few are diagnosed HIV positive although scepticism about the extent of the disease persists. The government restricts the use by refugees of public health facilities. Rape crisis centres, reproductive health services, and HIV-related services are minimal at best.[153]

16. Social assistance and other government benefits

HIV or AIDS is not considered a disability under domestic law, and people living with HIV do not qualify for disability grants. They are eligible for general social security and assistance under the National Pension Scheme Act. The Public Welfare Assistance Scheme aids vulnerable groups, including children who orphaned by AIDS through government-funded church and NGO programs.[154]

Various donors offer certain services to support people living with HIV. These services include HBC, palliative care and nutritional support. A few hospices exist in Zambia, run by various church organisations and supported by donors which provide social assistance.[155]

17. Insurance

The Insurance Act[156] does not include a non-discrimination clause based on HIV status.[157] Insurance law in Zambia does not regulate the granting of life insurance to people living with HIV. A standard clause which states, 'no benefits shall be payable under this policy in respect of a claim if the death of the person insured occurs within a period of five years from the date of acceptance where the death is as a result

151 Immigration and Deportation Act cap 123.
152 'HIV pandemic in African prisons' (n 149 above).
153 Zambia Legal Information Institute.
154 Catholic Relief Services RAPIDS Success Program.
155 Insurance Act, Cap 392.
156 Zambia Legal Information Institute.
157 Madison Insurance Company, Professional Insurance.

of AIDS or AIDS-related disease,' is included in all insurance policies if a HIV test is not taken. Insurance companies do not have a policy of compulsory testing. There is no HIV and AIDS-specific life insurance policies offered, but there are a few insurance companies that have started exploring the possibility and viability of offering such policies.

Information pertaining to an individual's HIV status is kept confidential. Information about the HIV status of a client is taken personally from the underwriter to the personal doctor who in turn relays this information to the client.[158] The National HIV/AIDS Policy is aimed at encouraging insurance companies to consider the needs of people living with HIV when developing policy.[159]

18. Oversight

There is no specific government mechanism to ensure the implementation of legislation relating to HIV and AIDS. The implementation of HIV and AIDS legislation would fall under the Ministry of Justice as does the implementation of all other legislation. Policies and practices related to the implementation of the National HIV/AIDS Strategic Plans fall under the NAC.

The NAC has developed a National Monitoring and Evaluation Plan for 2002-2005. The Plan includes monitoring of virus transmission through surveys of pregnant women who visit antenatal clinics and through population surveys. Other surveys include the Demographic Health Survey and the Sexual Behaviour Survey. These surveys are conducted through the Central Statistics Office and the Ministry of Health and measure, among other indicators, condom use, acceptability of people living with HIV and other stigma indicators, the knowledge of family planning methods, HIV-testing experience, maternal mortality, and knowledge of HIV transmission.[160]

19. Stigma

HIV stigma is specifically addressed in the National HIV/AIDS Policy and the documents related to that policy. The section in the National Policy addressing stigma includes calls for public education about people living with HIV and insurance policies that consider their needs.

Other related sections call for partner notification, voluntary counselling and testing, protection for the victims of wilful

[158] National HIV/AIDS Policy (n 143 above).
[159] National Monitoring and Evaluation Plan 2002-2005.
[160] National HIV/AIDS Policy (n 143 above).

transmission, the protection of children's rights, the protection of HIV status confidentiality, and allowances for people with disabilities in government health and social welfare delivery systems.[161]

The 2001-2003 Strategic Framework mentions vulnerable groups such as children and women who often suffer from stigma and discrimination in the form of loss of property and harassment.

Currently there is little legal recourse available, but advocacy groups are working on legislation. The government has employed mass media campaigns focused on young people to educate them about HIV transmission, the ABCs of prevention, and to eliminate stigma and discrimination. In addition, government partnered with NGOs such as the Zambian Network of People Living with AIDS to train peer educators and to start workplace advocacy programs to mitigate stigma.[162] The National HIV/AIDS Education Strategic Plan 2001-2005 seeks to equip teachers and learners with the resources to become better informed about HIV and AIDS and thus combat HIV and AIDS related stigma.

[161] NAC *Overview of Zambia's response to HIV/AIDS* (2004).
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9 HIV, AIDS and the law in Zimbabwe

1. Background to country

1.1 First AIDS case

Zimbabwe's first reported case of AIDS was documented in 1987.[1] It is not clear where the first case was documented, how the person became infected or whether the person's information was kept confidential.

1.2 Demography

In 2007, Zimbabwe's population is estimated to be 13.2 million.[2] The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the same year Zimbabwe had 1 700 000 (1 100 000 - 2 200 000) people living with HIV, the HIV prevalence rate among adults aged 15 to 49 was 20.1 per cent (13.3 - 27.6 per cent), (compared to 24.6 per cent, in 2003) and that a total of 180 000 people died as a result of AIDS.[3]

Women have been hit much harder by the epidemic than men. 2005 HIV prevalence rates were roughly 14.7 per cent (7.7 - 23.2 per cent) among women aged 15 to 24 and 4.4 per cent (2.3 - 6.9 per cent) among men of the same age group.[4] About 890 000 (520 000 - 1 300 000) Zimbabwean women over the age of 14 were living with HIV in 2005.[5]

Approximately 160 000 children aged 0 to 14 were living with HIV in 2005.[6] No statistics are available on the number of babies who are born HIV positive each year. In 2004, about 18.6 per cent of young pregnant women in Harare were HIV positive.[7] Roughly 1 100 000 children have been orphaned due to AIDS in 2005,[8] compared to 1 000 000 in 2003.

1 UNAIDS & WHO 'Zimbabwe Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections' (2004) http://data.unaids.org/Publications/Fact-Sheets01/zimbabwe_EN.pdf (accessed 6 August 2006) 6.
2 UNFPA State of the world population 2007: Unleashing the potential of urban growth (2007) 90.
3 UNAIDS '2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition' (2006) 505-508.
4 As above, 508.
5 As above, 506.
6 As above, 507.
7 As above, 509.
8 As above.

Tuberculosis (TB) prevalence rates were about 0.67 per cent (672.6 per 100 000) in 2004.[9] In 2002, around 75.3 per cent of adults (ages 15 to 49) with TB were also infected with HIV.[10]

No statistics are available on infection rates among injecting drug users, sex workers, or men who have sex with men.[11]

The statistics show a decline in prevalence in HIV and most figures have either remained constant or declined since 2003 (except for the increase in the number of children who are orphaned by AIDS). These figures have been confirmed by research undertaken by the Imperial College in London in early 2006 indicating that there has been a drop in HIV prevalence in the youth. The results indicated a 49 per cent decline in women aged between 15 and 24 and a 23 per cent decline in men aged between 17 and 29.[12] It was also confirmed that the overall HIV prevalence has declined from 23 per cent to 20.5 per cent. In men aged 17 to 54, infections dropped from 19.5 per cent to 18.2 per cent, while in women aged 15 to 54, the number testing positive dropped from 25.9 per cent to 22.3 per cent.[13] The drop in prevalence has been attributed to a reduction in casual sexual relationships, increase in condom use and increased educational awareness on HIV.[14]

2. International human rights treaties

2.1 Ratification status of international human rights treaties[15]

Treaty (entered into force)	**Ratification/ accession (deposit)**
International Covenant on Civil and Political Rights (ICCPR) (23/03/1976)	13/05/1991
ICCPR Optional Protocol (23/03/1976)	
International Covenant on Economic, Social and Cultural Rights (ICESCR) (03/01/1976)	13/05/1991

9 WHO 'Core Heath Indicators' database http://www3.who.int/whosis/core/core_select.cfm (accessed 6 August 2006).
10 UNAIDS & WHO (n 1 above) 1.
11 UNAIDS (n 3 above) 510.
12 For more information, *The Daily Mirror* 7 February 2006 4.
13 As above.
14 As above.
15 For ratification status, see Office of the UN High Commissioner for Human Rights (OHCHR) 'Zimbabwe Homepage' http://www.ohchr.org/english/countries/zw/index.htm (accessed 20 January 2007).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (03/09/1981)	13/05/1991
CEDAW Optional Protocol (22/12/2000)	
Convention on the Rights of the Child (CRC) (02/09/1990)	11/09/1990

2.2 State reports[16]

Zimbabwe submitted its initial report to the Committee on Economic, Social and Cultural Rights in September 1995.[17] The report took note of the AIDS Prevention and Control Programme and a number of education initiatives. The Committee on ESCR did not make any reference to HIV and AIDS in its concluding observations on the report.[18]

In its concluding observations on Zimbabwe's initial report on the ICCPR,[19] the Human Rights Committee commended the provision of statistics in the report and the inclusion of HIV and AIDS awareness in school curricula.[20]

The Committee on the Rights of the Child considered the initial report of Zimbabwe in May 1996.[21] The Committee noted its concern at the number of orphaned and abandoned children as well as at the increase in child-headed families, as a result of the high incidence of AIDS.[22]

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) considered the initial report of Zimbabwe in January 1998[23] and adopted concluding observations in May 1998.[24] The Committee made the following observations with regard to HIV and AIDS:

- The Committee is deeply concerned about the effect of the HIV/AIDS pandemic and the very high rate of infection among young women, who comprise 84 per cent of those infected in the 15 to 19 year age

16 The state reports and concluding observations discussed below are available at OHCHR (see above).
17 Government of Zimbabwe 'Initial Report: Zimbabwe' (E/1990/5/Add.28) (1995).
18 CESCR 'Concluding observations of the Committee on Economic, Social and Cultural Rights: Zimbabwe' (E/C.12/1/Add.12) (1997).
19 Government of Zimbabwe 'Initial reports of States parties due in 1992: Zimbabwe' (CPR/C/74/Add.3) (1997).
20 Human Rights Committee 'Concluding observations of the Human Rights Committee: Zimbabwe' (CCPR/C/79/Add.89) (1998).
21 Government of Zimbabwe 'Initial reports of States parties due in 1992: Zimbabwe' (CRC/C/3/Add.35) (1995).
22 CRC 'Concluding observations of Committee on the rights of the Child: Zimbabwe' (CRC/C/15/Add.55) (1996) para 17.
23 Government of Zimbabwe 'Committee on the Elimination of Discrimination against Women: Zimbabwe state party report (CEDAW/C/ZWE/1) (1998).
24 CEDAW 'Concluding observations of the CEDAW Committee: Zimbabwe' (A/53/38) (1998) paras 120-166.

group and 55 per cent of the 20 to 29 year age group. The Committee notes that this is of particular concern given the risks of transmission to infants through childbirth and breastfeeding.[25]

- The Committee urges the government to increase its efforts to combat the HIV/AIDS pandemic and to ensure that appropriate sexual and reproductive health information, education and services are provided to all women and, in particular, to adolescents.[26]

Zimbabwe did not directly refer to the recommendations of the committees when developing its national HIV and AIDS policies but the issues of concern raised are, to an extent, incorporated in the National HIV/AIDS Policy. Zimbabwe is not up to date in its reporting obligations and has not submitted reports to any of the committees since 2000.

3. AU and SADC treaties

3.1 Ratification status of AU and SADC treaties[27]

Treaty (entered into force)	**Ratification/ accession (deposit)**
African Charter on Human and Peoples' Rights (ACHPR) (21/10/1986)	30/05/1986
African Charter on the Rights and Welfare of the Child (29/11/1999)	19/01/95
Protocol to the ACHPR on the Rights of Women in Africa (25/11/2005)	
Treaty of the Southern African Develop-ment Community (SADC) (30/09/1993)	17/11/1992
SADC Protocol on Health (14/08/2004)	13/05/2004

3.2 State reports

Zimbabwe submitted reports to the African Commission on Human and Peoples' Rights (the Commission) in 1992, 1996 and 2006. Zimbabwe's

25 As above, para 147.
26 As above, para 160.
27 Ratification status available at http://www.africa-union.org and http://www.sadc.int.

seventh and tenth combined periodic report to the Commission is dated October 2006.[28] The report was examined by the Commission at its 41st ordinary session in May 2007. The report includes a section on 'The Fight Against the HIV/AIDS Pandemic' under its discussion of articles 16 and 18 of the African Charter. The report notes that 20 000 persons are on anti-retroviral treatment, but that the number of people in need of such treatment exceeds 300 000.[29] Measures put in place to ensure affordable access to anti-retroviral drugs include compulsory licensing under the Declaration of Period of Emergency on HIV/AIDS Notice 2003, S.I 32 of 2003.[30] A National Aids Council (NAC) has been established to coordinate the national effort to curb the pandemic. The report further notes that the Labour Relations Amendment Act No 17 of 2002 makes discrimination in the workplace on the ground of HIV status prohibited.[31]

3.2 Status of international and human rights treaties in domestic law

The domestication of international and regional law is based on a dualist or transformation approach. The incorporation of international and regional obligations is performed in terms of Section 111B of the Constitution of Zimbabwe. Section 111B reads:

> Except as otherwise provided by this Constitution or by or under an Act of Parliament, any convention, treaty or agreement acceded to, concluded or executed by or under the authority of the President with one or more foreign states or governments or international organisations:
>
> (a) Shall be subject to approval by Parliament; and
>
> (b) Shall not form part of the law of Zimbabwe unless it has been incorporated into the law by or under an Act of Parliament.[32]

This provision allows for a three-pronged approach to the domestication of legislation. The process starts with the executive signing the convention or treaty. Parliament is then mandated with ratification, after which the line ministry prepares the legislative measures to be put in place to give effect to the convention's provisions.

The government has established an Inter-Ministerial Committee on Human Rights and International Humanitarian Law, which

28 Republic of Zimbabwe, 7th, 8th, 9th and 10th combined report under the African Charter on Human and Peoples' Rights 20 October 2006 http://www.achpr.org/english/state_reports/Zimbabwe per cent20State per cent20Report_eng.pdf (accessed on 20 January 2007).
29 As above, lx.
30 As above, lix.
31 As above, xiv.
32 Constitution of Zimbabwe (1979) sec 111B.

comprises 12 government ministries. The Committee is mandated with the coordination of government efforts on the enforcement of human rights issues, advising government on human rights issues and making recommendations to government on which conventions or treaties it should sign. It is also mandated with the compilation of periodic reports in relation to the implementation of various conventions and treaties to which Zimbabwe is party. The Committee has powers of recommendation and not of enforcement. However, most international treaties are not directly incorporated and domesticated and are generally incorporated 'piece-meal'. For example, the CRC was not domesticated by incorporation but the Child Protection and Adoption Act[33] borrowed strongly from the Convention.

3.4 International Guidelines

There seems to be no express mention of the International Guidelines on HIV/AIDS and Human Rights[34] in policies and laws or evidence in the public domain of government engagement with the Guidelines, although a close reading of some policies shows that elements of these have nonetheless been applied.

4. National legal system of country

4.1 Form of government

Zimbabwe is a former British colony that gained independence on 18 April 1980. It has a government that is influenced by both the Westminster system and the American system.

Zimbabwe is a unitary state with the executive, the legislature and the judiciary forming the three tiers of government.[35]

The Cabinet and the President constitute the executive. As head of the executive branch, the President is also the head of state and commander-in-chief of the armed forces. The executive has a duty to uphold the Constitution of Zimbabwe and ensure that the provisions of this Constitution and of all other laws in force are executed. A prominent feature of the government over the past few years has been the excessive centralisation of power as a result of a strong

33 Child Protection and Adoption Act [ch 5:06].

34 For the guidelines, see OHCHR & UNAIDS 'HIV/AIDS and Human Rights International Guidelines' (1996) http://data.unaids.org/publications/irc-pub02/jc520-humanrights_en.pdf (accessed 22 June 2006); OHCHR & UNAIDS 'HIV/AIDS and Human Rights International Guidelines: Revised Guideline 6' (2002) http://www.ohchr.org/english/about/publications/docs/g6.pdf (accessed 22 June 2006).

35 Constitution of Zimbabwe (n 32 above) ch IV, V & VIII.

executive presidency. The balance of power is excessively tilted toward the executive branch, with the president appointing 20 of the 150 members of parliament and all judges sitting on Zimbabwe's Supreme Court and High Court.[36] The bi-cameral parliament is comprised of elected and appointed members with the power to enact laws that govern the country. The judiciary constitutes the Supreme Court (with appellate and Constitutional jurisdiction), High Court (with inherent jurisdiction) and the Magistrates Courts (with statutory jurisdiction).

4.2 Legal system

The Constitution is the supreme law and all laws that are not in conformity with its provisions are void to the extent of their inconsistency.[37] Zimbabwe's prevailing legal system incorporates elements of the Roman-Dutch and English common law. The Constitution also provides for the recognition of customary law when a statute authorises its application.[38]

Authorisation for the application of customary law to a wide, though poorly defined, range of civil cases is provided by the Customary Law and Local Courts Act:

> (1) Subject to this Act and any other enactment, unless the justice of the case otherwise requires—
>
> (a) Customary law shall apply in any civil case where—
>
> (i) The parties have expressly agreed that it should apply; or
>
> (ii) Regard being had to the nature of the case and the surrounding circumstances, it appears that the parties have agreed it should apply; or
>
> (iii) Regard being had to the nature of the case and the surrounding circumstances, it appears just and proper that it should apply;
>
> (b) The general law of Zimbabwe shall apply in all other cases.
>
> (2) For the purposes of paragraph (a) of subsection (1)—
>
> 'Surrounding circumstances', in relation to a case, shall, without limiting the expression, include—
>
> (a) The mode of life of the parties;
>
> (b) The subject matter of the case;
>
> (c) The understanding by the parties of the provisions of customary law or the general law of Zimbabwe, as the case may be, which apply to the case;

36 As above, secs 38(1)(b) & (d) & 84(1).
37 As above, sec 3.
38 As above, sec 89.

> (d) The relative closeness of the case and the parties to the customary law or the general law of Zimbabwe, as the case may be.[39]

4.3 Constitution and Bill of Rights

The Constitution enshrines various civil and political rights in a bill of rights in chapter III. These rights are justiciable and protection of these rights is sought in the highest court, the Supreme Court of Zimbabwe. Section 11, the Preamble to the Bill of Rights, states:

> The provisions of this Chapter shall have effect for the purpose of affording protection to those rights and freedoms subject to such limitations on the protection contained herein, being limitations designed to ensure that the enjoyment of the said rights and freedoms by any person does not prejudice the public interest or rights and freedoms of other persons.

A number of these rights are potentially relevant to HIV and AIDS:

- The right to life: 'No person shall be deprived of his life intentionally save in execution of the sentence of a court in respect of a criminal offence of which he has been convicted.'[40] The right to life impacts on HIV and AIDS in so far as it may be widely interpreted to include the right to adequate basic healthcare which is necessary to better and prolong the lives of those infected and affected by HIV and AIDS. If a rights based approach is to be taken in interpreting the section, then it is possible to argue that denying those living with HIV from the necessary medical care they need shortens their life-span depriving them of their right to life. This approach has not been argued however, likely due to the fact that no litigants are forthcoming given the stigma and discrimination that surrounds one's positive HIV status.
- The right to personal liberty: 'No person shall be deprived of his personal liberty save as may be authorised by law ... for the purpose of preventing the spread of an infectious or contagious disease';[41]
- The protection against inhuman or degrading treatment: 'No person shall be subjected to torture or to inhuman or degrading punishment or other such treatment';[42]
- The protection against arbitrary search or entry: '[No] person shall be subjected to the search of his person or his property' except when the search is made pursuant to a law 'in the

39 Customary Law and Local Courts Act (7:05) sec 3.
40 Constitution of Zimbabwe (n 32 above) sec 12(1).
41 As above, sec 13(1) & (2)(g).
42 As above, sec 15(1).

interests of defence, public safety, public order, public morality, public health or town and country planning';[43]
- The right to freedom of movement: 'No person shall be deprived of his freedom of movement' except when the deprivation is 'required in the interests of defence, public safety, public order, public morality or public health';[44] and
- The protection against legal discrimination: '[N]o law shall make any provision that is discriminatory either of itself or in its effect', and 'no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office of any public authority.' A person is a victim of discrimination when 'subjected to a condition, restriction or disability' based upon the person's 'race, tribe, place or origin, political opinions, colour, creed, sex, gender, marital status or physical disability'.[45]

The rights mentioned above are justiciable in Zimbabwe's Supreme Court.[46] However, the rights come with very serious limitations. The rights to personal liberty and freedom of movement, as well as the right against arbitrary search or entry, are each explicitly qualified by the government's power to take action in the interest of public health. The right against legal discrimination cannot be used to avoid 'the application of African customary law in any case involving Africans'.[47] Finally, it is uncertain whether the term 'physical disability' in section 23 encompasses HIV infection or AIDS.

4.4 National human rights institutions

Zimbabwe does not have a human rights institution. However, it has established an Office of the Ombudsman, which 'may investigate action taken by' certain state actors when such an actor is alleged to have caused an injustice not remediable 'by way of proceedings in a court'.[48] The specific objective of the Office of the Ombudsman is to address complaints from the public arising against government ministries and departments, which in the pursuit of their administrative functions cause prejudice to an individual. The Office of the Ombudsman also entertains complaints relating to violations of the rights enshrined in Zimbabwe's Constitution. In theory, this should include HIV and AIDS-related issues, especially with respect to discrimination.

43 As above, sec 17(1) & 2(a).
44 As above, sec 22(1) & (3)(a).
45 As above, sec 23(1) & (2).
46 As above, sec 24.
47 As above, sec 23(3)(b).
48 As above, sec 108(1)(a).

The Office of the Ombudsman has dealt with a few cases tangentially involving HIV but not cases that are reported directly because of HIV or AIDS. Civil servants, for example, have brought cases relating to late or non-disbursement of their pension benefits by their relevant ministries, which affects their ability to access healthcare as they may be living with HIV. In many cases involving complaints about late pension disbursements, there is some measure of success when the Office of the Ombudsman intervenes and approaches the Pensions Office directly to discover the problem.[49]

After the 2002 fact-finding mission, however, the African Commission for Human and Peoples' Rights found that the Ombudsman had insufficient powers and urged Zimbabwe 'to establish independent and credible national institutions that monitor and prevent human rights violations'.[50] The United Nations Human Rights Committee has also complained that 'the Ombudsman has no power to initiate investigation *suo motu* but only where a complaint has been lodged and that 'the President, the President's Office, the Attorney-General and Secretary for Justice, Legal and Parliamentary Affairs and any member of their staff are specifically excluded from investigation by the Ombudsman'.[51] The government of Zimbabwe claims that it is 'conducting research towards the establishment of a Human Rights Commission' that would 'streamline' the functions of the office of the Ombudsman'.[52] The Human Rights Commission will have a general mandate to address issues of human rights in Zimbabwe. The proposed areas of focus have not been articulated and it is difficult to say whether HIV and AIDS will be part of the mandate of the commission. There is speculation that the Commission will be modelled along the lines of the South African Human Rights Commission.

However, it is unclear whether the proposed Human Rights Commission would meaningfully exceed the Office of the Ombudsman in power. According to the Minister of Justice, the Human Rights Commission is set up in Zimbabwe as a measure to 'counter the large scale orchestration of alleged violations that was witnessed as per submissions made to international and continental bodies'.[53] The minister went on to justify the setting up of the Commission alleging that this arose from the falsification, exaggeration, orchestration and stage-managing of human rights violations in Zimbabwe.

49 As above.
50 ACHPR '17th annual activity report of the African Commission on Human and Peoples' Rights' 'Executive summary of the report of the fact-finding mission to Zimbabwe 24 to 25 June 2002' (2004).
51 Human Rights Committee (n 20 above) sec 10.
52 ACHPR (n 50 above) 'Comments by the government of Zimbabwe on the report of the fact finding mission' sec 10.1.
53 Minister of Justice P Chinamasa quoted in 'We're not human rights violators' *The Saturday Herald* 1 April 2006 9.

The government's commitment to this institution is questionable given that the Minister categorically stated that Zimbabwe had no problem with its human rights record and that Zimbabwe was not a violator of human rights 'by any stretch of the imagination'.[54] The Minister in the same article went on to say, 'In order to counter these [falsifications and exaggerations], we feel that we should set up this Commission so that any complaints, which are raised, can be investigated immediately and we can establish the facts and, where violations have occurred, redress can be made'.[55]

The Office of the Ombudsman is currently supplemented by 'an Inter-Ministerial Committee on Human Rights and International Humanitarian Law and a Human Rights Secretariat housed within the Ministry of Justice'.[56] Like the Office of the Ombudsman, these organs possess very limited powers and their work on HIV and AIDS-related issues, if any, is not known.

5. Government regulation of HIV and AIDS: overall picture

5.1 Responsible department

The Ministry of Health and Child Welfare is the department responsible for issues relating to HIV and AIDS.

5.2 HIV and AIDS plan

In 1986, an AIDS Advisory Committee was established. It was transformed in later years into the Zimbabwe AIDS Health Expert Committee. Between 1987 and 1988, a One-year Emergency Short Term Plan (STP) aimed at creating public awareness about HIV prevention and control was implemented. The STP was followed by a Medium Term Plan (MTP1) from 1988 to 1993, which focused on consolidating the interventions initiated during the STP, motivating appropriate behaviour change among specific population groups, counselling and caring for people living with HIV, and monitoring the epidemic through epidemiological surveillance. The need to mobilise other sectors to actively participate in the fight against HIV contributed to a multi-sectoral approach in the Second Medium Term Plan (MTP 2) from 1994 to 1998. The main objectives of MTP 2 were to reduce:

- the transmission of HIV and other sexually transmitted diseases (STIs);

54 As above.
55 As above.
56 As above.

- the personal and social impact of HIV/AIDS/STIs; and
- the socio-economic consequences of the epidemic.

MTP 2 identified the need for the development of a national HIV and AIDS policy and a unit was established within the National AIDS Co-ordinating Programme (NACP) to facilitate the process.

The National HIV/AIDS Policy was introduced in 1999.[57] It acknowledged that HIV and AIDS should be addressed through a multisectoral approach, which is to be coordinated by the National AIDS Council (NAC).

Zimbabwe enacted the National AIDS Council of Zimbabwe Act,[58] which provides for a broadly representative NAC. The NAC has four strategic areas: care, prevention, mitigation and support.

A National AIDS Strategic Framework (Strategic Framework) was introduced in November 1999 for the period 2000-2004.[59] Among the strategies to promote mitigation by caring and supporting the affected, the Strategic Framework identifies the following key objectives that relate to human rights:

- reducing the stigma associated with HIV and AIDS;
- promoting policies and legislation which safeguard the rights of those affected by HIV. A key area is the assurance of equity in service programming delivery and utilisation; and
- ensuring gender sensitivity in policies and plans and programmes.

The National AIDS Council Strategic Plan 2005-2007 (NAC Strategic Plan) contains sections on fifteen strategic issues:[60]

- prevention of HIV infections;
- comprehensive care and treatment for the infected;
- comprehensive community and home based care for the infected;
- mitigating the impact of HIV/AIDS;
- advocacy enhancement;
- operational research in HIV/AIDS programmes and documentation;
- capacity building of stakeholders and partners;
- effective monitoring and evaluation of HIV/AIDS interventions;
- mobilisation and equitable utilisation of resources;
- operational policies, manuals and standards;
- coordination and working relationships with stakeholders;
- organisational structure efficiency and effectiveness;

57 National HIV/AIDS Policy of the Republic of Zimbabwe.
58 National AIDS Council of Zimbabwe Act 26 of 1999.
59 National AIDS Strategic Framework 2000-2004.
60 NAC 'National AIDS Council Strategic Plan 2005-2007' http://www.nac.org.zw/pdfs/3yr.pdf (accessed 8 August 2006) 2.

- human resources development initiatives;
- communication for effectiveness; and
- development and enhancement of information technology.

5.3 Legislation

At present, HIV and AIDS legislation is limited to criminal and labour law. The following Acts legislate directly and indirectly on HIV and AIDS-related issues:

- National AIDS Council of Zimbabwe Act;
- Sexual Offences Act;[61]
- Criminal Law and Evidence Amendment Act;[62]
- Labour Relations Regulations on HIV/AIDS and Employment Statutory Instrument (Labour Relations Regulation);[63]
- Labour Relations Amendment Act;[64] and
- National Social Security Act.[65]

Chapter 9(21) of the Sexual Offences Act deals directly with HIV and AIDS and, in Part V, looks specifically at the prevention of the spread of HIV. Section 15(1) criminalises the deliberate transmission of HIV by an individual who is fully aware that he or she is infected (see section 13.1 below in this chapter).

Section 16 also states that where a person is convicted of sexual crimes in the criminal category of rape, sodomy or having sex with an intellectually handicapped person and it is proved that at the time of the offence the convicted person was infected with HIV, whether or not he was aware of his infection, he shall be sentenced to imprisonment not exceeding twenty years.

Section 17 provides the court with discretion to order the testing of a sexual offender for HIV. Samples of blood for HIV testing are taken from the accused person and if the accused is found guilty, the court will order testing. If the accused is acquitted, the samples are destroyed without being tested for HIV.[66] The results are used to impose stiffer penalties in a situation where the accused tests positive for HIV. According to section 17(2), the Court may also exercise this discretion in the case of an accused who is merely charged with commission of a sexual offence.

61 Sexual Offences Act 8 of 2001 (ch 9:21).
62 Criminal Law and Evidence Amendment Act 8 of 1997.
63 Labour Relations Regulations on HIV/AIDS and Employment Statutory Instrument 202 of 1998.
64 Labour Relations Amendment Act 2001.
65 National Social Security Act (ch 17:04).
66 Sexual Offences Act (n 61 above) sec 17(4).

The relevant section reads as follows:

> Without any derogation from any other law, where a person is charged with committing a sexual offence, the court may direct that an appropriate sample or samples be taken from the sexual offender, at such place and subject to such conditions as the court may direct, for the purpose of ascertaining whether or not he is infected with HIV.[67]

These samples are stored at an appropriate place until finalisation of the trial. It must be noted that it is only upon conviction of the accused that the sample is then tested for HIV antibodies, where the accused is found not guilty the sample is destroyed without testing for HIV antibodies.[68] If the convicted offender tests positive for HIV antibodies, a stiffer penalty is instituted particularly where the victims are young.

Section 18(1) presumes that if the presence of HIV antibodies or antigens is found in the sample from a person's body, this shall be regarded as *prima facie* proof that he or she is HIV positive. Section 18(2) states that if it is proved that a person was infected with HIV within thirty days after committing an offence referred to in those sections, it shall be presumed unless the contrary is shown, that he was infected with HIV when he committed the offence.

The Labour Act[69] in the Labour Relations Regulations[70] deals with HIV and AIDS in the workplace. The Labour Relations Regulations makes it compulsory for employers to provide education and information on:[71]

- promotion of safe-sex and risk reducing measures in terms of STDs and STIs;
- the acquiring and transmission of HIV;
- the prevention of the spread of HIV; and
- counselling facilities for HIV-infected individuals.

It is not compulsory for an employee to undergo HIV testing; neither is it mandatory for an employee to disclose his or her status to the employer. Paragraph 5(2) reads:

> No employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his employment, his HIV status.

Further in terms of paragraph 4(1), HIV testing cannot be a pre-condition for employment, will not affect an employee's eligibility for benefits or schemes, or alone be the grounds for termination. According to paragraph 6(1), 'No employer shall terminate the

67 As above, sec 17 (3).
68 As above, sec 17(4).
69 Labour Act (ch 28:01).
70 Labour Relations Regulations (n 63 above).
71 As above, para 3 'Education of Employees on HIV/AIDS'.

employment of an employee on the grounds of that employee's HIV status alone.'

It also provides for the equality[72] of those employees who are living with HIV and those who are not. As regards sick leave, an employee living with HIV shall be subject to the same conditions relating to sick leave applicable to any other employee.

Contravention of any of the provisions of the HIV/AIDS Labour Regulations subjects the employer to a penalty of a fine not exceeding five thousand Zimbabwean dollars or a period of imprisonment of not more than six months, or both. Due to the hyperinflationary environment currently prevailing in Zimbabwe, there will be a need for a review of this penalty if it is to be a practical and effective deterrent.

The NAC was created to

> ... provide for measures to combat the spread of the HIV and the AIDS and the promotion, co-ordination and implementation of programmes and measures to limit or prevent their spread and to provide for matters connected with or incidental to the foregoing.[73]

The NAC's functions are detailed in section 4 and include enhancing the capacity of various sectors of the community to respond to HIV/AIDS, to coordinate their responses, and to disseminate information on all aspects of HIV/AIDS.

The Public Health Act[74] makes no mention of HIV or AIDS as an infectious or communicable disease. However, in section 17 the minister is at liberty to declare HIV and AIDS by way of statutory instrument to be a communicable or infectious disease either throughout Zimbabwe or in any part of Zimbabwe.

5.4 HIV and AIDS Policy

The following policies are in place:

- National HIV/AIDS Policy 1999;
- National AIDS Strategic Framework 2000-2004;
- The Orphan Care Policy;
- Community Home Based Care Policy 2001;
- National Gender Policy for the Republic of Zimbabwe 2000;
- The Patient's Charter (non-binding);
- National Guidelines on HIV Testing and Counselling;[75]

72 As above, para 8 'Sick and Compassionate Leave'.
73 National AIDS Council of Zimbabwe Act (n 58 above) sec 4.
74 Public Health Act 19 of 1924 (ch 15: 09).
75 Ministry of Health and Child Welfare & WHO National Guidelines on HIV Testing and Counselling (2005).

- Guidelines for Anti-retroviral Therapy in Zimbabwe;[76] and
- The Zimbabwean HIV/AIDS & Human Rights Charter.

The National HIV/AIDS Policy contains sections on response management, public health, care for people living with HIV, gender, HIV/AIDS education, and HIV/AIDS research, as well as two sections regarding HIV/AIDS and human rights.[77]

There are no provisions for the denial of treatment on moral grounds.

5.5 Court decisions

There have been a few court cases related to HIV or AIDS. Recently, the Magistrates Court in Mbare, Harare, denied bail to a woman alleged to have deliberately transmitted HIV to her husband on the grounds that she would go about infecting people on a whim. The High Court overturned the decision in April 2006 and granted bail to the woman citing the principle of innocence until guilt is proven in her favour. The matter of deliberate transmission under the Sexual Offences Act has yet to be adjudicated.

There is a case relating to HIV and the right to privacy in the High Court in the matter of *Paul Mukarakate v Zimbabwe Newspapers (1980) Ltd*.[78] Mukarakate sued the Sunday Mail for publishing a picture in which he appeared with a caption below with read, 'LIVING POSITIVELY ... a group of men living with HIV/AIDS.'[79] He stated that the author and the photographer did not seek or obtain his permission to publish the photo and he only became aware of its publication when his brother notified him. He argued that he had been subjected to HIV-related discrimination since the publication of the picture, even though he is not HIV positive. He argued that, in any case, his status is a private matter. Mukarakate noted that he was suffering psychological pain and since the article was published, he no longer lived a normal life. A decision is pending from the High Court.

The Mutare Magistrates Court heard a case which involved a disc-jockey who was charged of statutory rape and willful transmission of HIV. He was accused of having had sex with a 15 year-old on several occasions, and consciously infecting her with HIV.[80]

76 Ministry of Health & National Drug and Therapeutics Policy Advisory Committee Guidelines for anti-retroviral therapy in Zimbabwe (2005).
77 National HIV/AIDS Policy (n 57 above) vi-viii.
78 *Paul Mukarakate v Zimbabwe Newspapers Ltd* 1980 HC/6189/05.
79 'World AIDS Day: Time to think about women' *The Sunday Mail* 31 October 2004.
80 W Johwa 'Risky sex and the law: incompatible bedfellows?' www.ipsnews.net/africa/intern a.asp?idnews=26574 (accessed 17 October 2006).

6. Access to health care

6.1 Government regulation of access to health care

The right to access to health is not provided for in the Constitution; however, it may be read into the right to life.[81]

The National HIV/AIDS Policy does not contain a positive right to health for those living with HIV; instead it calls upon them to respect the rights and health of others, and provides that 'whilst the rights of PLHA are upheld, the PLHA have a responsibility to respect the rights and health of others'.[82] This is founded upon guiding principle 2 which reads as follows:[83]

> The human rights and dignity of people living with HIV/AIDS should be promoted and protected. Discrimination and stigmatisation should be avoided as far as is consistent with the rights of society and those who are uninfected.

Section 3 of the National HIV/AIDS Policy also addresses the right to confidentiality of medical information of people living with HIV.[84] It emphasises that, 'privacy over health matters is a basic human right and is a fundamental principle of ethics of the medical practice'.[85]

The Strategic Framework identifies the following responses to the HIV epidemic by the health sector:[86]

- STIs management protocols and flowcharts have been produced and are updated every 2-3 years;
- Improved promotion, distribution and education on condoms has significantly increased condom uptake;
- Activities by the National Blood Transfusion Service have gone a long way to achieving the objective of providing safe blood for transfusion;
- HIV/AIDS activities have been integrated into reproductive health projects; and
- New policies have been developed to give guidance to activities such as guidelines on infant feeding as it relates to HIV/AIDS.

In July 2001, the Ministry of Health and Child Welfare issued the Zimbabwe Community Home Based Care Policy. Guiding Principle 5 recognises that particular attention must be paid to ethical issues, specically, confidentiality and allocation of resources, informed consent and safeguarding of human rights.

81 Constitution of Zimbabwe (n 32 above) sec 12.
82 National HIV/AIDS Policy of the Republic of Zimbabwe (n 57 above) sec 3.
83 As above.
84 As above, sec 5.
85 As above.
86 National Strategic Framework (n 59 above) sec 4.3.

The government has made post exposure prophylaxis (PEP) available to health care workers.[87] There are no guidelines, policy or measures on PEP as the approach is on a small scale basis targeting mainly employees in the healthcare delivery system.

Zimbabwe has declared HIV and AIDS a national disaster through regulations enacted by the President using the power enshrined in the Presidential Powers Temporary Regulations. This declaration was meant to expedite access to HIV and AIDS drugs.

6.2 Ethical guidelines

The Ministry of Health has formulated ethical guidelines for counselling and testing for HIV to be followed by all health care service providers.[88] The Guidelines describe the service delivery model types for voluntary counselling and testing (VCT) in Zimbabwe namely, the integrated services approach, stand alone service, private sector service and the outreach service approach.[89]

The Guidelines also examine in great detail the qualifications of counsellors for VCT centres. They note that counsellors are to be trained on HIV testing and counselling by qualified trainers using the national training manuals approved by the Ministry of Health and Child Welfare.[90] Counsellors can be drawn from the following different backgrounds:

- health professionals, such as doctors and nurses;
- non health professionals such as social workers, teachers and pastors;
- cadres who have 5 passes at Ordinary level (secondary education) including English language; and
- community based service providers such as community based counsellors.

Chapter 5 of the Guidelines examines and describes HIV testing in detail by looking at the laboratory HIV test, testing algorithms, window period and the laboratory standards that examine quality assurance and the handling of contaminated waste such as needles.

Chapter 6 deals with the scaling up of HIV Testing and Counselling Services and particularly addresses the measures to be taken by government to ensure a conducive environment for more citizens to know their status.

87 Interview with an official in the Ministry of Health and Child Welfare.
88 National Guidelines on HIV Testing and Counselling (n 75 above).
89 As above, ch 3.
90 As above, ch 13.

The final chapter of the Guidelines explains the ethical and legal considerations arising out of HIV testing. The chapter looks specifically at the following:

- HIV testing and counselling and human rights;
- stigma and discrimination;
- ethical issues relating to informed consent;
- mandatory testing;
- the minimum age for testing which is 16 years and above and anyone below requires parental consent;
- testing of children and notes that only the primary concern for the welfare of the child should be the main consideration in such cases;
- testing for mentally challenged persons, indicating also that the welfare of this individual should be the primary concern; and
- it also examines confidentiality particularly, confidential record keeping, shared confidentiality, anonymity, written results, issues relating to rape and also disclosure, partner notification.

6.3 Medicines

Zimbabwe launched its anti-retroviral treatment (ART) programme in March 2004.[91] In 2004, UNAIDS and WHO estimated that 295 000 people in Zimbabwe were in need of anti-retroviral treatment.[92] As of May 2005, only 15 000 people were receiving anti-retrovirals (ARVs).[93]

As a member of the World Trade Organisation (WTO), Zimbabwe is a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).[94] In 2002, the Minister of Justice, Legal and Parliamentary Affairs issued a notice declaring a period of emergency on HIV/AIDS for the purpose of enabling

91 Government of Zimbabwe 'Republic of Zimbabwe Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Zimbabwe Country Report' (2006) http://data.unaids.org/pub/Report/2006/2006_country_progress_report_zimbabwe_en.pdf (accessed 8 August 2006) 13.

92 WHO 'HIV/AIDS Treatment Scale-up: Summary Country Profile: Zimbabwe' (2005) http://www.who.int/3by5/support/june2005_zim.pdf (accessed 31 January 2007).

93 As above.

94 WTO 'Zimbabwe and the WTO' http://www.wto.org/english/thewto_e/countries_e/zimbabwe_e.htm (accessed 8 August 2006).

> [t]he State or a person authorised in writing by the Minister to make or use any patented drug, including any anti-retroviral drugs, used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions; and/or to import any generic drug used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions.[95]

Subsequent to this declaration, Zimbabwean companies have been authorised both to manufacture and to import generic ARVs.[96] However, production remains expensive (although markedly cheaper than imports), and the government recently admitted that the state had less than one month's stock of anti-retroviral drugs.[97] CAPS and VARICHEM are the pharmaceutical companies producing ARVs for use in the country.

Medicines are, in theory, provided free or subsidised to those who cannot afford to pay market prices but most government hospitals have a significant shortage of drugs.

The Zimbabwean government has set up Opportunistic Infection Clinics in many of the major hospitals such as Parirenyatwa Hospital, Wilkins Hospital and Beatrice Infectious Diseases Hospital.[98] The Opportunistic Infection Clinics are used as points of accessing ARVs provided by the government of Zimbabwe.

6.4 Condoms

Guiding Principle 9 of the National HIV/AIDS Policy recommends that condoms should be made available, accessible and affordable to all sexually active individuals.

Female and male condoms are distributed by Population Services International (PSI) and the Zimbabwe National Family Planning Council respectively. Condoms are sold at pharmacies, service stations, supermarkets, kiosks and bars. The price of condoms in Zimbabwe ranges from as little as ZW$10 000 for a three pack of *Protector Plus* and to as much as ZW$400 000 for imported brands such as *Avacare* and *Durex*. The government makes provision for free condoms in all its medical centres, hospitals and clinics. These are usually plentiful and available to those accessing the healthcare facilities, whether in the urban or rural context.

95 Declaration of Period of Emergency (HIV/AIDS) General Notice 240 of 2002, quoted in SF Musungu & C Oh 'The use of flexibilities in TRIPS by developing countries: Can they promote access to medicines?' (2005) http://www.who.int/intellectualproperty/studies/TRIPSFLEXI.pdf (accessed 8 August 2006) 22, quoting.

96 Musungu & Oh (as above) 23.

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

98 Interview with an official at the NAC.

6.5 Case law

There are currently no judgements on HIV and AIDS and the right of access to health care.

7. Privacy

7.1 Notifiable disease

HIV or AIDS is not a notifiable disease in terms of the Public Health Act (Chapter 15:09). However Guiding Principle 24 of the National HIV/AIDS Policy states that, 'where HIV or AIDS is deemed to be a public health concern, they shall be separately and confidentially notified by the medical practitioner in terms of the Public Health Act.'[99]

All diseases classified as infectious under the Public Health Act are notifiable.[100] Although the Public Health Act does not include HIV or AIDS in its list of diseases considered to be infectious, it empowers the Minister of Health to declare, by statutory instrument, any sexually-transmitted disease to be an infectious disease for purposes of the Act.[101]

7.2 Medical experimentation

Regarding volunteers participating in HIV and AIDS-related clinical trials, the National HIV/AIDS Policy calls on the government to ensure that all those involved in research strictly observe ethical standards with particular attention to issues of confidentiality, informed consent and the safeguarding of human rights.

The Medical Research Council of Zimbabwe's 'Guidelines for Researchers and Ethics Review of Committees in Zimbabwe' does not specifically address HIV or AIDS but states that for medical research to be ethical any person participating in the research must comprehend and consent to 'the extent to which confidentiality of records identifying the subject will be maintained'.[102]

99 National HIV/AIDS policy (n 57 above) 21.
100 Public Health Act (n 74 above) sec 18.
101 As above, sec 17.
102 Medical Research Council of Zimbabwe 'Guidelines for researchers and ethics review of committees in Zimbabwe' (2004) 9 http://www.afronets.org/guidelines_for_researchers_and_ethics_committees.pdf (accessed 8 August 2006) 9.

7.3 Duty to disclose

The National HIV/AIDS Policy encourages partner notification though it does not place a direct and distinct duty to notify.[103] It instead encourages couples or partners to share information about their HIV status with each other in order to take informed action to prevent HIV transmission. There is, however, the desire to develop legislative provisions to enable health professionals to disclose the HIV status of a patient to his or her partner under certain specific conditions which are not specified, even if consent is denied.[104] In certain cases, possibly where ART will need to be commenced, medical doctors will disclose the HIV status of either a husband or wife to their spouse however no legislation has been generated that gives the directive for disclosure.

It can be argued that by criminalising the deliberate transmission of HIV, the Sexual Offences Act, thereby, creates a legal duty to disclose HIV-positive status to sexual partners.

Labour Relations Regulations prohibits discrimination based on HIV status in the workplace and specifically aims to 'ensure non-discrimination between individuals with HIV infection and those without and between those with HIV/AIDS and other comparable life-threatening medical conditions'. The Labour Relations Regulations were enacted under the Labour Relations Act and, therefore, only cover workers in the private sector and parastatals; groups in other sectors such as civil servants and uniformed forces are not covered by the Labour Relations Regulations. Section 4(1) and (2) of the Regulations state that pre-employment testing should not be undertaken except in circumstances where fitness for work is a precondition to the offer of employment. Section 5 of Labour Relations Regulations, which examines HIV in the workplace, states that

> no employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his employment, his HIV status.

7.4 Testing

Currently, mandatory and routine opt-out HIV testing are not part of routine medical treatment. Routine, opt-out testing is however envisaged to eventually be a part of routine medical treatment.[105]

[103] National HIV/AIDS policy (n 57 above) 20.
[104] As above, 21.
[105] Interview with an official at the Ministry of Health and Child Welfare.

The National HIV/AIDS Policy note, as follows:[106]

> The public health justification for mandatory testing is strictly limited. Mandatory testing, risks, and is often used for discrimination and creates fear and resistance. It is counterproductive to the aims of HIV/AIDS prevention and improved care and does not help control the epidemic.

The National HIV/AIDS Policy notes that certain groups of people, such as pregnant women and engaged couples, may benefit greatly from knowing their HIV status, but at the same time these specific groups highlight the disadvantage of mandatory testing. For example, if a pregnant woman tests positive she may not have many options open to her in terms of accessing treatment, but rather she becomes a victim of fear and anxiety. Similarly, accurate testing of new-born babies is not currently widely available in Zimbabwe, so in such a situation no purpose would be served in mandatory testing.

Legalising mandatory testing is not recommended by the National HIV/AIDS Policy in any situation other than in the case of a person charged with any sexual offence.[107] Prompt testing of such an offender is recommended by the National HIV/AIDS Policy while the victim should be offered voluntary counselling and testing, and where appropriate, treatment at the expense of the state.

The National HIV/AIDS Policy identifies strategies and guidelines for HIV testing. Guiding Principle 3 emphasises that confidentiality regarding a person's HIV status should be respected and that legal provisions should be enacted to enable health professionals to disclose a patient's HIV status if critical reasons for disclosure exist. At the same time, Guiding Principle 23 encourages partner notification of HIV status for both men and women.

Guiding Principle 18 declares 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. The National Guidelines on HIV Testing and Counselling speak of the need to normalise HIV testing and counselling in the community. This is to be done through public HIV testing efforts by influential people and role models in the society which the guidelines note increases normalisation of the importance of knowing one's status.[108]

HIV or AIDS is not a notifiable disease in terms of the Public Health Act.[109] Nevertheless, Guiding Principle 24 of the National HIV/AIDS Policy advises that, where HIV/AIDS is deemed to be a public health

106 National HIV/AIDS policy (n 57 above) 19.
107 As above 'Guiding Principle 21.'
108 Ministry of Health (n 75 above) 27.
109 Public Health Act (n 74 above).

concern, the Ministry of Health should be notified separately and confidentially by the practitioner in terms of the Public Health Act.

The Zimbabwe National Guidelines on HIV Testing and Counselling were developed by the Ministry of Health and Child Welfare and the World Health Organisation. Chapter 4 describes the counselling process and includes pre-test and post-test counselling.[110] There is no specific reference to informed consent; however there is provision for follow-up counselling.[111]

8. Equality and non-discrimination

Section 23 of the Constitution prohibits discrimination but does not specifically prohibit discrimination on the basis of HIV. Discrimination is only prohibited on the grounds of sex, gender, religion and race. The Constitution's ban on legal discrimination based upon 'physical disability' could be construed to apply to HIV status.

Zimbabwe has a Prevention of Discrimination Act which also does not mention prohibition of discrimination on the basis of HIV status.[112] It targets only discrimination on grounds of 'race, tribe, place of origin, national or ethnic origin, political opinions, colour, creed or gender'.[113]

The National HIV/AIDS Policy provides that '[a]ll asymptomatic people with HIV infection should be treated as any healthy individual with respect to education, training, employment, housing, travel, health care and other social amenities and citizenship rights' and that '[p]eople with AIDS should be treated as others who may have chronic of life-threatening conditions'.[114] However, the National HIV/AIDS Policy does not recommend any new anti-discrimination legislation.

9. Labour rights

9.1 Legislation

There are HIV/AIDS Regulations under the Labour Relations Act.[115] The regulations aim to ensure non-discrimination between individuals with HIV and those without; and between HIV and AIDS and other comparable life-threatening medical conditions. In relation to employment, the HIV/AIDS Regulations establish that HIV infection is

110 n 75 above, 14.
111 As above, 15.
112 Prevention of Discrimination Act 19 of 1998.
113 As above, preamble.
114 National HIV/AIDS policy (n 57 above) 34.
115 Labour Relations Regulations (n 63 above).

an infection with a virus that by itself does not affect an employee's ability to perform the functions for which he or she will be or has been assigned in employment.

The Regulations provide the following rights for those living with HIV:

- One has the right to receive education and information relating to HIV/AIDS and STIs and on counselling facilities for those with HIV/AIDS.[116]
- One has the right to enter employment without being subjected to a mandatory HIV test as a precondition for work placement.[117]
- In addition to freedom to choose whether or not to be tested, there is a right to confidentiality as regards an employee's HIV status. The employee is not compelled to reveal his or her status to the employer, and no individual can disclose the HIV status of an employee without his or her written consent.[118]
- The right to work is guaranteed by section 6(1) which reads, 'No employer shall terminate the employment of an employee on the grounds of that employee's HIV status alone'.
- The right to receive equal employment benefits is granted in section 7(1): 'Subject to any other law to the contrary, the HIV status of an employee shall not affect his eligibility for any occupational or other benefit schemes provided for employees.'
- There is also provision for equal treatment in the workplace. Section 8 notes that the same conditions of sick leave shall apply in the same manner to all employees regardless of HIV status.

Labour rights relating to discriminatory practices on the basis of HIV status are not contained in the Constitution, but they are enshrined in the Labour Act in Part II, specifically section 6(1) which states the following:

> No employer shall discriminate against any employee or prospective employee on grounds of race, tribe, place of origin, political opinion, colour, creed, gender, pregnancy, HIV/AIDS status or subject to the Disabled Persons Act (Chapter 17:01), any disability referred to in the definition disabled person in this Act.

Section 6(2) expressly provides for criminal sanctions against an employer who discriminates an employee or prospective employee on the specified grounds.

An aggrieved employee has recourse to the Labour Court established in terms of section 84 of the Labour Act. The Labour Court is tasked with hearing and determining applications and appeals in

[116] As above, sec 3(1).
[117] As above, sec 4(1) – the only exception is that medical testing of persons for fitness fro work can still be a precondition for employment under sec 4(2).
[118] Labour Relations Regulations (n 63 above) sec 5.

terms of the Labour Act or any other enactment, including HIV and work related matters.[119]

The public sector is regulated by the Public Service Regulation.[120] Section 38 relates to sick leave. Subsection 2 of this provision provides that 'during any one year period of service a member may be granted a maximum of ninety days' sick leave on full pay and ninety days' sick leave on half pay.' Sick leave is applicable in any calendar year. This provision is especially significant for employees who are living with HIV, who are usually negatively impacted by stringent leave regulations.

Section 38(5) of the Public Service Regulations continues:

> Sick leave on half pay which extends beyond the period of sick leave on full pay may only be granted by the head of department if recommended by a medical board appointed by the Secretary for Health, if in the opinion of the medical board it is probable that the member concerned will be able to resume duty after such further period of sick leave.

Subsection 6 further states:

> If a medical board has established that a member will be unable to resume duty because of illness or injury, the head of department shall take steps to have the member retired on the grounds of ill health.

Finally, the Strategic Framework identifies the need to introduce a national code of practice on HIV/AIDS and employment at every workplace as one of its key strategies to promote prevention.

9.2 Testing

As stated in the Labour Relations Regulations, HIV testing is not a pre-condition for securing employment, for retaining employment, for benefits or for promotion.[121] Due to the fact that many employees fearing stigma do not reveal their status, there has not been a reported case where one has been denied promotion on the basis of their status. In cases where employees have revealed their status, there has been no reported case of one being fired for being HIV positive.

9.3 Medical schemes act

There is no medical schemes act in place in Zimbabwe. There are no specific measures in place to ensure that employees living with HIV are not discriminated against through existing medical schemes.

[119] n 69 above, sec 89(1)(a).
[120] Public Service Regulations Statutory Instrument 1 of 2000.
[121] n 63 above, sec 4(1).

However, section 7 of the Labour Relations Regulations deals generally with employee benefits and states as follows:

- HIV status will not affect an employee's eligibility for any occupational or other benefit schemes provided for employees; and
- where the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV/AIDS test, the conditions attaching to HIV/AIDS shall be the same as those applicable to comparable life-threatening illnesses. Any such test must be accompanied by pre- and post-test counselling.

The Premier Services Medical Aid, which falls under the National Association of Medical Aid Schemes (NAMAS), covers all civil servants. The government subsidises the premiums, there is no special scheme for those found to be HIV positive. Medical aid in Zimbabwe covers those who are HIV positive and HIV negative in a similar manner, depending on the amount of the individual contributions made.

9.4 Duty to provide treatment

There is currently no legislation in Zimbabwe that places a duty on employers to provide ARVs or other medication to employees. Similarly there is no legislation compelling employers to provide medical care for those infected with HIV.

It appears that the duty to provide medical care for health personnel who contract HIV as a result of occupational hazards is imposed upon the employer in the health sector as there is provision for the administration of PEP following possible and actual exposure to HIV from a patient.[122] It seems there is also possibility of compensation from the employer in the health sector as the Guidelines state that 'If the health worker refuses to be tested, he or she may have no claim for possible future compensation'.[123]

10. Women's rights

10.1 Legal status and protection

Section 23 of the Zimbabwe Constitution provides that there shall be no discrimination on the grounds of sex and thus affords women the same rights as men. The Prevention of Discrimination Act also prohibits discrimination on grounds of gender.[124] The Act contains provisions on discrimination in regard to 'public premises,

[122] Ministry of Health and Child Welfare Advisory Committee Guidelines for Anti-retroviral Therapy in Zimbabwe & National Drug and Therapeutics Policy (2005) 24.
[123] National Drug and Therapeutics Policy (as above) 35.
[124] n 112 above, secs 3(1), 4(1) & 5(1).

commodities, services and facilities'; the 'disposal of immovable property'; and the 'granting of finance'.[125]

The National HIV/AIDS Policy notes that men and women should be accorded equal status with equal opportunity for education and advancement in all spheres of life.[126] The National HIV/AIDS Policy makes special mention of women as a unique group in terms of the HIV pandemic. The National HIV/AIDS Policy acknowledges that gender roles and gender relationships further predispose women to HIV/STIs because of unequal power relations.[127] The strategies to be adopted in view of the unique vulnerability of women is to improve the status of women and girls through measures that enhance access to primary, secondary and tertiary education, credit, skills training and employment. Another strategy is to design participatory programmes to mobilise both men and women in communities to question the norms that shape the unequal power balance in relationships and to encourage wide debate on cultural issues that have a negative effect on the status of women, including the elimination of practices which demean women.[128]

10.2 Domestic violence law

The National HIV/AIDS Policy notes that, some aspects of gender violence are culturally condoned because they are perceived as within the bounds of what is expected of men in their interaction with women in different situations. This violence denotes men's way of asserting and reasserting their control over women and their anger and disapproval of women's real or perceived resistance to this control and these different power relationships have a bearing on the transmission of HIV.[129] The National HIV/AIDS Policy also declares that '[g]ender violence in any form and setting is unacceptable and should be proscribed by law'.[130]

Marital rape is considered a crime under the Sexual Offences Act. Section 8(1) reads:

> Any person who, whether or not married to the other person, without the consent of that other person-
>
> (a) with the male organ, penetrates any part of the other person's body
>
> ... shall be guilty of an offence and liable, subject to section sixteen, to the penalties provided by law for rape.

125 As above, secs 3, 4 & 5.
126 n 57 above, 29.
127 As above.
128 As above.
129 As above, 31.
130 As above, 30.

The Domestic Violence Act of Zimbabwe (Act 14 of 2006) defines domestic violence as including economic abuse as well as emotional, verbal and psychological abuse. Part IV of the Domestic Violence Act creates anti-domestic violence counsellors and an anti-domestic violence council as institutions that will allow a better implementation of the Act.

10.3 Customary rules and practices

Customary law forms part of Zimbabwe's officially recognised legal system (section 89 of the Constitution) and is excluded in certain circumstances (especially regarding family law) from the non-discrimination clause (section 23) of the Constitution.

There is also a Customary Law and Local Courts Act (Chapter 7:05) that regulates the operation of the customary courts.

The traditional practices that put women at risk of contracting HIV are:

- *Ngozi* - the practice of giving young girls as appeasement to avenging spirits that are haunting a family.
- *Kuzvarirwa* - betrothing young children usually females to an older male.
- *Female genital mutilation* - some parts of the country (especially the Ndebele community) still practice FGM, although this is rare. However, no societal discussion of the issue occurs and the potential for HIV transmission is not discussed.
- *Kugara nhaka* - the practice of wife inheritance in situations where a brother will inherit the family of the dead husband usually including the wife.
- *Kumutsa mapfiwa* - where a younger sister will have intercourse with the husband of her older sister, where that older sister is unable to conceive a child.
- *Barika* - the practice of polygamy.
- *Small Houses* - this is a fairly new practice that has emerged among urban Zimbabwean men, who will have one official wife at home, and another mistress who may or may not be recognised officially, but may have the man's children.
- Myths pervade that men who have HIV can be cured by having sex with young virgins who are often very young girls.[131]

Through education and awareness raising campaigns, there has been an attempt to curb most marriage related practices such as *kumutsa mapfiwa* and *barika*.

[131] SAfAIDS, PANOS & UNAIDS *Men and HIV in Zimbabwe* (2001) 25.

The use of condoms can be perceived as a sign of unfaithfulness or insubmissiveness in a woman as culturally, the men control whether or not to practice safe sex.

There have been a few legal judgments that deal with the status of women. In the case of *Magaya v Magaya*,[132] the Court ruled that women are minors and cannot inherit property from their fathers or husbands. This case was decided after Zimbabwe's accession and ratification of CEDAW and the Beijing Platform for Action. In *Rattigan and Others v Chief Immigration Officer*[133] the Supreme Court held that the immigration law discriminated against Zimbabwean women as the law allowed for foreign wives of Zimbabwean men automatic citizenship, but did not allow the same for non-Zimbabwean husbands. Following the *Rattigan* case and the *Ruwodo NO v Ministry of Home Affairs and Others*[134] decision, the government amended the Constitution (14th Amendment), adopting a gender-neutral approach for immigration purposes.

In October 2000, the National Gender Policy (Gender Policy) for the Republic of Zimbabwe was issued with the aim of

> [p]roviding guidelines, institutional framework, and parameters to ensure the availability of resources for the successful and sustainable implementation of the Zimbabwe Constitution and legislative requirements, regional and international conventions, protocols, declarations and agreements on gender equality, equity and non-discrimination.

The Gender Policy recommends the following with respect to gender and HIV:

- sensitising and creating awareness on gender and health issues, including HIV/AIDS;
- developing gender-sensitive multi-sectoral programmes for empowerment of women and girls and to enable men to assume their responsibilities in prevention of HIV/AIDS; and
- introducing measures to counter the exposure of girls to HIV/AIDS through traditional and religious beliefs and practices.[135]

[132] *Magaya v Magaya* 1998 SC 210/98.
[133] *Rattigan and Others v Chief Immigration Officer* 1995 2 SA 182 (ZS).
[134] *Ruwodo NO v Ministry of Home Affairs and Others* 1995 1 ZLR 227 (SC).
[135] National Gender Policy 2004 sec 6.2.3, the Gender Policy recommends the following strategies in an effort to guarantee human rights and democracy: 1) Lobbying for the promotion of equal and equitable participation of women and men in decision-making positions. 2) Legislate and enforce against discriminatory practices, beliefs and traditions that hinder the advancement of women and men, especially the girl child. 3) Incorporate provisions of international human rights instruments into domestic law.

10.4 Administration of anti-retrovirals to rape survivors

PEP is available to rape survivors.[136] The Zimbabwe National Guidelines on HIV Testing and Counselling recommend that in addition to counselling for the rape survivor, PEP must be provided. They also note that it is important to try and establish the HIV status of the alleged perpetrator but if it is not possible, then it must be assumed that the perpetrator is HIV positive and treatment be administered as stated in the guidelines. In most cases the PEP is administered on the basis that rape has been committed and not because of the HIV status of the victim or perpetrator, therefore even if the victim refuses to have a test, PEP can still be administered.

The National Guidelines state: 'All people who have been raped should be offered HIV testing and counselling and post-exposure prophylaxis (PEP) within 36-72 hours.' Though it is not stated clearly whether the receipt of PEP is on condition of undergoing testing, it appears that this is the implication from the general reading of the relevant paragraph.

10.5 Sex workers

The Miscellaneous Offences Act[137] does not make prostitution a criminal act; however, in section 4, it makes loitering for the purposes of prostitution in a public place an offence. The effect of this is to criminalise the sex worker and not the client.[138]

Part IV of the Sexual Offences Act prohibits pimping and the running of brothels and deals with the suppression of prostitution. There is no direct and unequivocal prohibition of those involved in sex work and similarly there is no clear and distinct recognition of the commercial sex worker as a legitimate worker in the laws of Zimbabwe. The Sexual Offences Act, however, criminalises the opening and operation of brothels and the practice of pimping. Section 9(1) states that any person who, *inter alia*,

> (a) the keeper of a brothel; or (b) knowingly lives wholly or in part on the earnings of prostitution shall be guilty of an offence and liable to a fine not exceeding level 7 or to imprisonment for a period not exceeding two years or to both such fine and imprisonment.

The Act also criminalises what can be loosely described as fraternising with sex workers in that a person who is proved to have either consorted, lived with or was habitually in the company of a prostitute and has no visible means of subsistence, shall be deemed, unless the

136 Guidelines for Anti-retroviral Therapy (122).
137 Miscellaneous Offences Act (ch 9:15) sec 4.
138 National HIV/AIDS Policy (n 57 above) 36.

contrary is proved, to have been knowingly living on the earnings of prostitution.[139]

The National HIV/AIDS Policy, which was published two years before the 2001 passing of the Sexual Offences Act and amendment of section four of the Miscellaneous Offences Act, recommends against criminalising sex work and holds that '[i]nformation, education, counselling, male and female condoms and STIs care services must be made accessible and affordable to all sex workers and their clients.'[140] The National HIV/AIDS Policy avers as one of its strategies, strengthening and expanding peer education programmes among sex workers to include income generation and skills training for alternative employment.

There has been no official government policy to decriminalise prostitution, however, there have been various support organisations that exist to assist sex workers to reintegrate themselves into society.

The Gweru Women AIDS Prevention Association (GWAPA) was initially developed by the Department of Health for the Municipality of Gweru and now is a non-governmental organisation (NGO). GWAPA's ideals and mission statement is to cater for those involved in prostitution. The organisation has 339 members, all of whom are former sex workers, and who are trained as peer educators to disseminate information and educate those still involved in prostitution on HIV. The peer educators teach the sex workers how to use condoms, how to negotiate with their customers for safe sex, and they also distribute free condoms. GWAPA also runs a mobile clinic which offers VCT. Members also receive ART, if required. GWAPA also produces pamphlets and posters encouraging women's empowerment and offers loans to sex workers to encourage them to engage in income generating projects and abandon sex work.

Another NGO that works with sex workers is Musasa Project which has offices in Harare and other urban centres. This Organisation runs a programme, Community Action Project on Violence against Women, currently focused in Harare, and educates sex workers on safe sex and negotiation skills. It has trained approximately 90 women as peer educators. The Musasa Project also encourages income generating projects to enable women to leave prostitution.

139 Sexual Offences Act (n 61 above) sec 9(2).
140 National HIV/AIDS Policy (n 57 above) 26.

11. Children's rights

11.1 Access to health care

Access to health care facilities for children in Zimbabwe differs. There are many government clinics in both rural and urban areas that have a specific unit that deals with the welfare and health of children. Children living with HIV also have access to healthcare as they are able to access the Opportunistic Infection Clinics operating at many of the major hospitals nationwide. These facilities are the access point for government funded ART.[141] However, many children living in the rural areas may find it difficult to access facilities that are far away. Although various policies like the National AIDS Plan and National Plan for Action on Orphans and OVC make reference to health care and ART, distance to health care facilities and availability of ART make health care for children insufficient in some cases. UNICEF estimated in 2004 that while there were 20,000 children who required ART, only 2,000 actually received treatment from the government.[142] The Zimbabwe Essential Drugs Action Program (ZEDAP) Survey of 1995, while not focusing on ART but on a wide range of drugs and vaccines, reported that only 46 per cent of surveyed health facilities met the target at 80 per cent availability of drugs. ZEDAP uses WHO indicators in their studies. While not focusing on HIV and AIDS medication the survey provides an indicator of general drug availability.[143]

A nationwide Prevention of Mother-to-Child-Transmission (PMTCT) programme has been implemented in both rural and urban health care facilities. The programme involves the administration of Nevirapine to HIV-positive mothers in the last 28 weeks of their pregnancy and also during labour. A child born to an HIV-positive mother will also be administered Nevirapine syrup from birth to six weeks in an effort to prevent mother-to-child-transmission of HIV.[144] The approach for the PMCT programme is that testing is offered routinely as part of antenatal care and clients have the right to consent or refuse.[145] An office responsible for the PMTCT programme was established in the NACP and a number of clinics have been designated for preventing PMTCT.

141 Interview with a doctor at Parirenyatwa Hospital, Harare.
142 V Nyathi 'Bleak future for children with a double burden' *Health Zimbabwe IPS* (April 2005).
143 I Chinyangara 'Indicators for children's rights: Zimbabwe country case study' (1997) http://www.childwatch.uio.no/cwi/projects/indicators/Zimbabwe/ind_index.html (accessed 13 September 2007).
144 Guidelines for Anti-retroviral Therapy (n 122 above) 15.
145 As above, 16.

Children below five years of age access ART free of charge however, from five years to adolescence, children pay ZW $25 000 every month for ART, which is half the cost that adults pay for the same service. The price is reasonable if the economic situation is taken into consideration and this reflects the fact that the amount is heavily subsidised by government.

11.2 Children orphaned by AIDS

In May 1999, the Department of Social Welfare in the Ministry of Public Service, Labour and Social Welfare launched the National Orphan Care Policy. The National Orphan Care Policy aims to ensure that children who have been orphaned are accorded their rights as prescribed in the CRC and the African Charter on the Rights and Welfare of the Child. It is also anchored on the Zimbabwean cultural adage that a child belongs to the community and not to the parents or guardians only, and provides for the input of children to continuously review the country's responses to children's issues.

Two primary strategies of intervention are identified in the National Orphan Care Policy. The first requires the establishment of a six-tier safety net system involving the biological nuclear family, the extended family, community care, formal foster care, adoption and institutional care. The second advocates the formation of a partnership between the government and the Child Welfare Forum to ensure that the following goals are met:

- medical care for all needy children who have been orphaned;
- facilitation of the provision of education to children who have been orphaned;
- provision of free legal representation and counselling to children who have been orphaned and their guardians in matters pertaining to children who have been orphaned where necessary;
- putting in place clear inheritance laws prioritising the importance of all children benefiting from their deceased parents estate all the time; and
- putting in place a basket fund.

In June 2004, the government introduced the National Plan of Action for Orphans and Other Vulnerable Children. The Plan focuses on the increase in children who have been orphaned and vulnerable children as a result of the HIV epidemic. The Plan lays out the current framework for addressing the needs of children who have been orphaned and other vulnerable children and puts forth plans for the future.

Current programmes include:[146]

- *The Basic Education Assistance Module (BEAM)*, through which tuition fee, levy, and examination-fee assistance is provided to vulnerable children.
- Government assists vulnerable families with basic living costs through programmes such as *Public Works Fund – Cash Transfers to Vulnerable Groups*, *Public Assistance Fund, Drought Relief,* and *Assisted Medical Treatment Order.*
- *A three per cent tax levy supports the National HIV/AIDS Policy.* The NAC administers the National AIDS Trust Fund that supports programmes for PLHA, including OVC.
- *The National Strategy on Children in Difficult Circumstances*, through which the government provides resources to local authorities, which work with all stakeholders to reach out to children in difficult circumstances in the community setting.
- *OVC programmes* are implemented in partnership with community-based organisations (CBOs), faith-based organisations (FBOs), and NGOs. In the past few years many new CBO and FBO initiatives providing care and support to OVC have been started. Many of these initiatives receive support from international NGOs working specifically on OVC in Zimbabwe, mostly in the context of HIV/AIDS.

Although these programmes exist, lack of resources, capacity, and lack of birth certificates prevents some children from accessing these services. For the future, the Plan outlines these objectives:[147]

- strengthen the existing coordination structures for OVC resource mobilisation by December 2005;
- increase child participation as appropriate in all issues from the community to the national level;
- increase the percentage of children with birth certificates December 2005;
- increase new school enrolment of OVC by at least ensuring retention of OVC in primary and secondary schools;
- increase access to food, health services and water by December 2005;
- increase education on nutrition, health, and hygiene; and
- reduce the number of children who live outside by 25 per cent by December 2005 (this includes children living on the streets, and children in institutions).

The following strategy is in place to accomplish the above objectives:[148]

[146] National Plan of Action for Orphans and Other Vulnerable Children (2004) 14.
[147] As above, 17.
[148] As above, 18.

- establishment of a National Secretariat for the National Plan of Action for OVC (the Secretariat) that will work through Provincial and District Secretariats and Child Protection Committees and, together with local authorities, coordinate and monitor implementation of this plan;
- education and advocacy on the implementation of existing legislation and policies in the best interests of the child;
- strengthening community based initiatives and social safety nets;
- strengthening the rights-based approach to programming, where the family, community, local authorities, civil society, and the state are viewed as duty bearers, and must commit to upholding children's rights;
- mobilising domestic and international resources; and
- communicating with local stakeholders and other counterparts, regional and international.

The Children's Protection and Adoption Act established the Child Welfare Council, Children's Courts, and the Child Welfare Fund. The Act contains provisions that protect children against neglect, ill-treatment, and exploitation, which include limitation and rules for medical examination and treatment, custody of a girl child, corruption, and employment. The provisions also govern adoption and the safe houses and institutions for children.

The Guardianship of Minors Act[149] outlines the court procedure for guardianship of a minor. It lists the responsibilities of the different parties and the processes for transferring custody of the child.

11.3 Education

The Education Act[150] lays out a child's fundamental right to education in Zimbabwe. The Act does not mention HIV or AIDS, but states that all children have the right to education, must not be refused admission to any school, and must not be discriminated against. The grounds for non-discrimination in the Act include race, tribe, place of origin, national or ethnic origin, political opinions, colour, creed and gender.[151]

In 1993, the Ministry of Education and Culture (Ministry of Education) introduced HIV education in schools from Grade 4 to A-level through the AIDS Action Programme for Schools. This Programme is supposed to be compulsory and includes training for headmasters and teachers. The Ministry also encourages headmasters to support the establishment of anti-AIDS clubs at schools. The Ministry of

149 Guardianship of Minors Act 14 of 2002.
150 Education Act 22 of 2001.
151 As above, part 11.

Education has a HIV/Life Skills Desk that co-ordinates teaching about HIV in schools. It trains teachers to employ materials and information in the curricula through appropriate methods.[152] The NAC notes however, that despite the 1993 Ministry of Education initiative on HIV education, some school authorities are against it. The general perception apparently being that teaching about HIV encourages children to use condoms and will have a harmful corrupting effect upon their young minds. The NAC and other stakeholders are currently lobbying to ensure that HIV education will be taught by NAC co-ordinators in schools.[153]

Guiding Principle 25 of the National HIV/AIDS Policy states that the rights of children and young people infected or affected by HIV/AIDS must be protected and respected. Other Guiding Principles in the National HIV/AIDS Policy that impact on children are the following:

- Children orphaned by AIDS should not be discriminated against in any way (Principle 26).
- Children have the right to information regarding sex, unwanted pregnancy and HIV/STIs. Girls, in particular, should have access to education, training and employment. (Principle 27).
- Children below 16 have the right to appropriate counselling and care services and advice on means to prevent HIV/STIs.

Zimbabwe has improved in terms of retention figures for girls at all levels of the education system as a result of the affirmative action programs put in place, particularly in tertiary education. The government of Zimbabwe has put in place a gender curriculum, which is in favour of the girl child and includes technical subjects. UNICEF and the Canadian International Development Agency (CIDA) are main sponsors of this project. The long term goal of this project is to create an enabling environment for the girl child's equitable access to participation and achievement in education. The project focuses on changing attitudes, values and perceptions of a variety of stakeholders who play a role in girl child education.[154]

After independence, the government had subsidised education and primary school education was free. However, in the 1990s government stopped subsidising education. With inflation and price hikes for education, many parents choose to send their children to cheaper government schools (with lower pass rates) or withdraw them

[152] The programme was declared through the Chief Education Ofcer's Circular Minute 16 of 1993.
[153] Interview with an official at the NAC.
[154] C Matumbike (Minister of National Affairs) 'Statement at the UN General Assembly Special Session "Women 2000: Gender Equity, Development, and Peace"' 7 June 2000.

from school completely. Many commentators believe that the situation will disproportionately affect the girl child.[155]

12. Family law issues

There is no inheritance legislation that addresses HIV and AIDS or its impacts, neither is there any guardianship legislation that addresses HIV and AIDS or its impacts.

13. Criminal law

13.1 Criminal legislation

Part V of the Sexual Offences Act entitled 'Prevention and Spread of HIV' deals with the deliberate transmission of HIV, sentencing for certain offences where the offender is HIV positive, HIV testing of sexual offenders, and presumptions regarding HIV infection. Section 15 states:

> (1) Any person who, having actual knowledge that he is infected with HIV, intentionally does anything which he knows or ought reasonably to know —
>
> (a) will infect another person with HIV; or
>
> (b) is likely to lead to another person becoming infected with HIV;
>
> shall be guilty of an offence, whether or not he is married to that other person, and shall be liable to imprisonment for a period not exceeding 20 years.

Section 16 provides for a sentence of up to 20 years where an HIV-positive person is convicted of rape or sodomy, regardless of whether he was aware of his status.

Guiding Principle 30 of the National HIV/AIDS Policy recommends that the wilful transmission of HIV in any setting should be considered a crime similar to inflicting other life-threatening injuries.

13.2 Men having sex with men

Consensual sexual relation between men is considered as a common law crime of sodomy. The case of *Canaan Sodindo Banana* who was accused of sodomy was heard in the High Court and the accused was convicted for sodomy under the common law.[156] However, the case

[155] UNICEF Zimbabwe 'School fee hike could impact on education delivery' 13 January 2006 *IRINNews* http://www.irinnews.org/report.asp?ReportID=51099&SelectRegion=Southern_Africa (accessed August 2006).

[156] *S v Banana* 2000 1 ZLR 607.

did not deal with consensual sex between men. Consensual sex between men is rarely prosecuted. There is no formal move towards abolishing the criminal offence of sodomy.

14. Prisoners' rights

Guiding Principle 33 of the National HIV/AIDS Policy recognises that prisoners have basic rights that must be respected and protected including the right to HIV/AIDS/STIs information, counselling and care. Principle 34 states that routine segregation of HIV-positive prisoners is undesirable and impractical.

Some of the recommended strategies in relation to prisoners and HIV are as follows:

- ensuring that all prisoners and detainees have access to voluntary HIV counselling and testing on admission to custodial remand or imprisonment;
- providing information, education and training on HIV/AIDS/STIS prevention to prisoners and staff;
- initiating and promoting peer education;
- promoting the development of and implementation of measures to reduce chances of sexual abuse in prison; and
- applying disciplinary measures to, or solitary confinement of, prisoners who are violent, irrespective of their HIV status.

The current situation for prisoners appears to be as follows:

- Prisoners have the right to information in relation to the epidemic, receive voluntary counselling and have access to voluntary HIV testing.
- There is no policy on mandatory HIV testing upon admission to prison.
- Prisoners do have access to ART at government expense as when they are found to be HIV positive most of them are referred to Opportunistic Infection Clinics that are used by the general public. They can however also have access to ART and other prescribed medication (if it is not available in the prison hospital) if they can afford to pay, or from friends and relatives.
- The number of prisoners that are HIV infected is unknown. The prison capacity in Zimbabwe is 16 000 but currently there are about 23 000 inmates.
- Prisons Services have departments that deal specifically with HIV/AIDS.
- Generally, prisoners that are HIV positive are not kept separately, especially when they do not disclose their status. But if their status is known, those with TB and other infectious conditions are separated from the general population for obvious health reasons,

however there is no separation on the basis of HIV status alone. At prison hospitals, there are separate wards for patients with HIV and related infections. Where prisons do not have hospitals, inmates are referred to general hospitals.
- Condoms are available through prison hospitals.
- Sex between men is discouraged on moral grounds but there is no established policy.

The Prisons Act does not mention HIV or AIDS.[157]

15. Immigration

The National HIV/AIDS Policy states that '[n]o requirement for HIV testing of visitors or immigrants to Zimbabwe will be introduced.'[158]

The Immigration Act makes no reference to HIV or AIDS.[159]

16. Social assistance and other government benefits

Zimbabwe's Social Welfare Assistance Act does not grant a right to social assistance. Instead, the Act states simply that the Director of Social Welfare 'may grant social welfare assistance to a destitute or indigent person where [the Director] is satisfied that such person' meets at least one of several criteria, one of which being that the person 'suffers continuous ill-health'.[160] A person who is both indigent and living with HIV would thus be eligible for a grant of social assistance but would have no right against the Director's decision to withhold assistance.

17. Insurance

The Insurance Act, which pertains mostly to life insurance, makes no reference to HIV or AIDS.[161]

See section 9.3 above for discussion of the Labour Relations (HIV and AIDS) Regulations' provisions on employer-provided insurance and benefits generally.

157 Prisons Act 9 of 1955 (ch 7:11).
158 n 57 above, 20.
159 Immigration Act 18 of 1979 (ch 4:02).
160 Social Welfare Assistance Act 10 of 1988 (ch 17:06) sec 6 & 6(1)(c).
161 Insurance Act 27 of 1987 (ch 24:07).

18. Oversight

The NAC is responsible for the monitoring and evaluation of its own policies and of Zimbabwe's national HIV response generally.[162] The Council has produced a monitoring and evaluation operational plan and began phasing in a data collection system in 2006.[163]

19. Stigma

The National HIV/AIDS Policy equivocates on the topic of stigma, saying that '[d]iscrimination and stigmatisation should be avoided' only 'as far as is consistent with the rights of society and those who are uninfected'.[164] However, the National HIV/AIDS Policy also recognises that 'measures … to eliminate stigma against PLHA' are necessary '[to] achieve full human and constitutional rights for people living with HIV/AIDS'.[165] The strategic plan makes no reference to stigma, and it is unclear what specific measures the government has adopted in order to combat it.

[162] NAC Act (n 58 above) sec 4(1)(e).
[163] Government of Zimbabwe (n 91 above) 18. For more on the Council's M&E activities, see NAC 'Monitoring & Evaluation' http://www.nac.org.zw/html/programs/monitoring.html (accessed 9 August 2006).
[164] n 57 above, 5.
[165] As above, 20.

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- *S v Banana* 2000 (1) ZLR 607

Annexure: NGOs by country

1. NGOs in Botswana

Name	Address	Other Contact
Botswana Networks of AIDS Service Organisations (BONASO)	PO Box 3192 Gaborone	Tel/Fax: 267 317 0582 bonaso@botsnet.bw
Agency for Cooperation and Research in Development (ACORD)		www.bonaso.org.bw
Associations of Medical Missions for Botswana	PO Box 0038 Bontleng Mall, Gaborone	Tel: 267 395 7226
Bobonong Home-Based Care Society		www.bonaso.org.bw
Botswana Network of People Living with HIV/AIDS (BONEPWA)	PO Box 1599 Mogoditshane	Tel/Fax: 267 390 622 /319 0972 /319 0977 bonepwa@botnet.bw
Botswana Network on Ethics, Law and HIV/AIDS (BONELA)	PO Box 402958 Gaborone	Tel/Fax: 267 393 2516 /393 2517
Botswana Christian Council (BCC)	PO Box 355 Gaborone	Tel: 267 3952598
Botswana Christian AIDS Intervention Programme (BOCAIP)	PO Box 601963, Gaborone	Tel/Fax: 267 391 6454 /3971820 BOCAIP@mega.bw
Botswana Council of Women (BCW)	PO Box 339 Gaborone	Tel: 267 395 2109
Botswana Family Welfare Association (BOFWA)	PO Box 00100 Gaborone	Tel/Fax: 267 392 2489 /390 1222 cally@info.bw, bofwa@info.bw
Coping Centre for People living with AIDS (COCEPWA)		www.bonaso.org.bw
Ditshwanelo (Centre for Human Rights)	PO Box 00416 Gaborone	Tel/Fax: 267 390 6998 /3907778 legal.ditshwanelo@info.bw www.ditshwanelo.org.bw
Society for Women Against AIDS in Botswana (SWAABO)	PO Box 70229 Gaborone	Tel/Fax: 267 355 5031 /3185096 nphaladze@yahoo.com.uk
Women's NGO Coalition	PO Box 00342 Gaborone	Tel/Fax: 267 318 5213 /3184685

Tebelopele – Voluntary Counselling and Testing Centre	PO Box 112 Gaborone	Tel/Fax: 267 391 4023 /3170487 Molo1@tebelopele.org

2. NGOs in Lesotho

Name	Contact Number
Anti-drug Abuse Association of Lesotho	+ 266 5885 4048
Basic Law Programme	+ 266 2231 4986
Believers Seed Youth Club	+ 266 6310 0744
Boiteko Women's Association	+ 266 5803 4330
Boseele Association	+ 266 5873 9271
Centre for Empowerment and Social Analysis	+ 266 5800 0748
Hlokomela Bana	+ 266 2231 4281
Khathang Tema Baitsukuli Association	+ 266 5802 3030
Lesotho Durham Link	+ 266 2232 5166
Positive Action Society	+ 266 2232 1671
Red Cross Society Lesotho	+ 266 2231 3911
Sakana la Nkope HIV Support Group	+ 266 2231 0005 /5894 7944
Save the Children Lesotho	+ 266 2232 2559
World Vision International	+ 266 2231 7371

3. NGOs in Malawi

Name	Address and Other Contact
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Adventist Development & Relief Agency ADRA (Main office)	Located at 6 Joachim Chisano Rd Sunnyside PO Box 951, Blantyre Tel: 0-1-620-016, 0-1-622-693, 0-8-833-473 Fax: 0-1-624-980/893 adramalawi@malawi.net
Adventist Health Services - Community Based Family Planning Services & HIV/AIDS, STD Prevention	PO Box 957 or 951, Blantyre Tel: 0-1-621-688, 0-1-620-528 Fax: 0-1-620-528 ahs@malawi.net
African Bible College (ABC) Community Clinic	Located off of Kaunda road, A47 Lilongwe PO Box 1028, Lilongwe Tel: 0-1-761-670 Fax: 0-1-761-743 abcclinic@malawi.net www.partnersinhope.info
Africare	Located on Kenyatta Road PO Box 2346, Lilongwe Manif Tel: 0-1-750-701, 0-1-753-193, 0-1-755-067 Fax: 0-1-753-273 Country Rep direct 0-1-751-502 afrmalawi@sdnp.org.mw
Aged Support Society of Malawi, ASSOM	PO Box 33073, Lilongwe Tel: 0-1-792-541 Fax: 0-1-772-669, 0-1-771402, 0-1-752-973 assom@malawi.net
American Red Cross	PO Box 30096, Presidential Way Lilongwe 3, Malawi Tel: 0-1-775-056, 0-8-844-123
Association for the Empowerment of Women (AFEWO)*	Private Bag 526, Limbe Tel: 0-8-311-722 hmdoka@mail.com
Association of Christian Educators of Malawi, ACEM	PO Box 999, Lilongwe Tel/Fax 0-1-759-775/778 acem@malawi.net

Banja La Mtsogolo	Main office Ginnery Corner, in the old Press Bakeries building PO Box 3008, Blantryre Tel: 0-1-673-240/844, 0-1-677-671/943 Lilongwe PO Box 1854, Lilongwe Falls Clinic Tel: 0-1-724-440, 0-1-725-946 Kawale Clinic Tel: 0-1-790-179 banja@malawi,net
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Concern Universal, CU	Corner of Henderson and Laws avenues PO Box 1535, Blantyre Tel: 0-1-623-761 Fax: 0-1-623-846
Concern Worldwide	Area 9 plot 208 PO Box 1747, Lilongwe Tel: 0-1-754-713/755-217 Fax: 0-1-757-290 malawi.hiv-aids@concern.net
Council for NGOs in Malawi, CONGOMA	PO Box 480, Blantyre Tel/Fax: 0-1-676-459 congoma@malawi.net
Development Aid from People to People (DAPP)	Private Bag 342, Chichiri, Bt3 Tel: 0-1-676-908, 0-1-672-174 Fax: 0-1-678-056 madapp@sdnp.org.mw

Family Health International (FHI)	Arwa House 3rd Floor PO Box 30455, Lilongwe Tel: 0-1-775-106, 0-1-774-378 Fax: 0-1-774-307 mkaseje@FHI.africa-online.net
Family Planning Association	Main office in Area 14 Private Bag B424, Lilongwe Tel: 0-1-773-915 Fax: 0-1-771-032 fpam@malawi.net
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Journalists Association Against AIDS, JAAIDS	PO Box 990, Blantyre Tel: 0-1-642-600, 0-8-317-572 jaaidsmalawi@yahoo.co.uk
Lighthouse Centre	Clinic located behind Lilongwe Central Hospital HBC/VCT in Lilongwe Central Hospital Ward 2B PO Box 106, Lilongwe Tel: 0-1-758-705, 0-8-892-523, 0-8-842-170 0-8-868-087 lighthouse@globemw.net
Lutheran Church of Central Africa	PO Box 30067, Lilongwe Tel: 794-101 mobilemail@africal-online.net

Malawi AIDS Counseling and Resource Organisation (MACRO)	Secretariat located in Area 3 across from post office PO Box 797, Llilongwe Tel: 0-1-759-291/292 macrosec@globemw.net Lilongwe: On Mlangalanga Rd in Falls Estate PO Box 31308, Lilongwe Tel: 0-1-725-027, 0-9-917-184 macroll@malawi.net Blantyre: Pn Kenyatta Drive near Kamba Market PO Box 51917, Limbe Tel: 0-1-677-096 macrobt@malawi.net Mzuzu: Tel: 0-9-950-218 macromz@globemw.net
Malawi AIDS Network, (MANET+)	Kang'ombe House, City Centre, Lilongwe Private Bag B 377 Capital City, Lilongwe 3, Malawi Tel: 01 773 727 Fax: 01 770 194
Malawi Association of Counsellors	PO Box 30368, Lilongwe Tel: 0-1-756-777/908, 0-1-752-028 Fax 0-1-754-425 mchs@malawi.net
Malawi Council of Churches - Lilongwe	Located near UNDP, City Centre Lilongwe PO Box 30068, Lilongwe 3 Tel: 0-1-773-499 Fax: 773-106 mipingo@malawi.net

Malawi Network of AIDS Service Organisations, MANASO Secretariat	1st floor Claim building PO Box 2916, Blantyre Tel: 0-1-635-018/046, 0-8-844-098/099 0-8-871-739, 0-8-898-619 manaso@malawi.net **Southern Region -** PO Box 2916, Blantyre Tel: 0-9- 912-473 **Northern Region -** PO Box 553, Mzuzu Tel: 0-1-334-623 Central Region Located within Action Aid Office, Zimbabwe High Commission Building, City Centre PO Box 30735, Lilongwe Tel: 0-1-774-721
Malawi Red Cross	Located in Area 14 PO Box 30096, Lilongwe Tel: 0-1-775-777 Fax: 0-1-775-590 Director Tel: 0-1-775-505 llredcross@malawi.net
Medecins Sans Frontières - France	Namiwawa, Henderson St. PO Box 2736, Blantyre Tel: 0-1-634-776, 0-1-636-074, 0-8-827-038 msffmalawi@sdnp.org.mw
Medecins Sans Frontières – Greece	A47 Sector 5 Plot 108 PO Box 30549, City Centre, Lilongwe Tel: 0-1-762-711 Fax: 0-1-762-611 msfg-malawi@sdnp.org.mw msfgr@liccom.net
Medecins Sans Frontières - Luxembourg Malawi	Located at ITG opposite Limbe Country Club PO Box 30353, Chichiri, Blantyre 3 Tel: 0-1-644-409, 0-1-645-830 Fax: 0-1-641-468 msfl@globemw.net PO Box 219, Thyolo 0-1-478-219/ 472
Media and AIDS Society in Malawi, MASO	Office at Health Education Unit, Old Town Private Bag 136, Lilongwe Tel: 0-1-725-919, 0-1-744-847/ 637

Muslim Association of Malawi	PO Box 479, Blantyre Tel: 0-1-623-581, 0-8-856-926 Fax 0-1-623-581 mam@globemw.net
National Association for People Living with HIV/AIDS in Malawi, NAPHAM (Secretariat & Lilongwe Branch services)	City Centre Private Bag 355, Lilongwe 3 Tel: 0-1-770-641 Tel/Fax: 0-1-770-803 napham@malawi.net
National Association for the Empowerment of Women, AFEWO*	Located in Waya Building, in Chitawira, behind CONGOMA Private Bag 526, Limbe Tel: 0-1-672-932, 0-8-311-722 hmdoka@mail.com
National Network of Organisations for Vulnerable & Orphaned Children, NOVOC	currently contacted through c/ o SOS Children's Village, PO Box 2359, Lilongwe Tel: 0-1-756-667 sosmalawi@malawi.net
National Smallholder Farmer's Association of Malawi, NASFAM	First floor, St. Martin's House off Independence Dr, City Centre PO Box 30716, Lilongwe 3 Tel: 0-1-772-866 Fax: 0-1-770-858 ppu@nasfam.malawi.net
Orphan Care and Social Rehabilitation, OCSR	Area 12, plot 12/65, off Dunduzu Rd. PO Box 30200, Lilongwe Tel: 0-1-784-050
OXFAM-UK	Plot 147, Laws Rd Private Bag 213, Blantyre Tel: 0-1-622-558, 0-1-636-907 Tel/Fax: 0-1-620-024
Plan International - main office	In City Centre, across from PTC hyperstore PO Box 2053, Lilongwe Tel: 0-1-770-897/946/890/699 Fax: 0-1-774-479 c-malawi@plan.geis.com malawi.co@plan-international.org Lilongwe Programme Unit Located behind Legends Tel: 0-1-759-238

(The) POLICY Project	Amina House Chilambula Road 1st Floor Private Bag B 404, Capital City, Lilongwe Tel: 0-1-754-103, 0-8-828040 Fax: 0-1-754-127
Population Services International, PSI –	Main office Located at 16 Leslie Rd. PO Box 529, Blantyre Tel: 0-1-674-138/139, 0-1-677-295, 0-1-675-986, 0-1-673-138/758 Fax: 0-1-674-138 psi@malawi.net Lilongwe office Off Chilambula Rd, near Securicorps PO Box 30132, Lilongwe Tel: 0-1-752-947
Project HOPE (Health Opportunities for People Everywhere)	Private Bag 588, Limbe Tel: 0-1-644-991/836 Fax: 0-1-643-374 hope@sdnp.org.mw
(The) Salvation Army, TSA	PO Box 51140, Limbe Tel: 0-1-645-613, 0-1-672-105, 0-1-679-031 0-1-830-317 sa-hq@malawi.net
Save the Children UK	PO Box 30335, Lilongwe Tel: 0-1-771-433/414/426 Fax: 0-1-771-443 scfuk@malawi.net hivscfuk@malawi.net
Save the Children US	Area 4, Amina House PO Box 30374, Capital City, Lilongwe Tel: 0-1-755-020, 0-1-753-888/919 Fax: 0-1-756-257 Director Tel: 0-1-756-118 scus@malawi.net
SOS Children's Village	Located off of Blantrye Rd, Office in Area 9 PO Box 2359, Lilongwe Tel: Med office 0-1-724-195, school 0-1-724-745 SOS 0-1-727-105, A9 office 0-1-756-667 Fax: 0-1-751-298 sosmalawi@globemw.net

UMOYO Network	Private Bag 254, Blantyre Tel: 0-1-622-517, 0-1-621-022/ 348 Fax: 0-1-624-680 umoyo@malawi.net Programme Manager : networks@malawi.net
University of North Carolina HIVnet	Amina House, Chilambula Road, Area 4 Private Bag A-104, Lilongwe Tel: PMTCT 0-1-758-274, office 0-1-755-056/954/964 unc_lilongwe@malawi.net unc-hivnet@malawi.net
Voluntary Service Overseas, VSO	1st floor British Council building Private bag B300, Lilongwe Tel: 0-1-772-496/443/445, 0-8-885-114 Fax: 0-1-772-497 vsomalawi@vsoint.org
Women's Voice – Main Office	Private Bag 231, Blantyre Tel/fax: 0-1-622-940 womens-voice@sdnp.org.mw
Women and the Law in Southern Africa Research Trust, WLSA Malawi	Private Bag 534, Limbe, Malawi Tel: 0-1-641-534 www.wlsa.co.zw
Word Alive Ministries	Located behind Blantyre Market along Mandala Rd PO Box 2502, Blantyre Tel: 0-1-674-451, 0-8-838-246 Fax: 0-1-674-372 worldalive@malawi.net
World Vision	PO Box 692, Lilongwe Tel: 0-1-756-484/294, 0-1-754-317 Fax: 0-1-752-580 wvmalawi@malawi.net micah@malawi.net
Youth Ambassadors	Located near Kamba market, at MACRO Chitawira Township PO Box 51917, Limbe Tel:0-1-672-932, 0-9-914-824, 0-1-645-992

4. NGOs in Mozambique

Name	Address	Contact
Action AIDS Mozambique	Av. 24 Julho Maputo	Tel: +258 082 491 488 fermandab@actionaid mozambique.org
Associaçao Homens Contra SIDA		Tel: +258 082 897 526 /082 832 810
Associacao Mulher, Lei e Desenvovimento	Av. Paulo Samuel Kankomba 2150 Maputo	
Business against AIDS	Av. 10 de Novembro Recinto da Facim Maputo	Tel: +258 1 311 734 jstephens@austral .co.mz
Juvenil Contra a Prostituiçao Infantil e SIDA		Tel: +258 082 414 869 /082 818 813
Juvenil de Prevençao e Combate do SIDA a Crinança		Tel: +258 03 301 195 /082 409111 Fax: +258 301 195
Professers do futuro		Tel: +258 23767
Rede Mocambicana de Organzacoes Contra o SIDA (MONASO) (Mozambique Network of AIDS Organisation)	Av. Ahmed Sekou Toure 1425 Maputo	Tel: +258 425 260 Fax: +258 425 256
RENSIDA (Association of People Living with HIV/AIDS)	Av. Vlademir Lenine 1424 1 Andar (lado direito) n 12 Maputo Moçambique	Tel: +258 01 301 014 renside@tvcabo.co.mz
Total Control de Epidemia		Tel: +258 750 384 Fax:+ 258 750 107 adppmz@teledata.mz

5. NGOs in Namibia

Name	Address	Other Contact
AIDS and Rights Alliance of Southern Africa	4 Körner Street Windhoek	Michaela Clayton Tel: + 264 61 223 356 Fax: + 264 61 227 675 mclayton@lac.org.na
AIDS Care Trust of Namibia	1005 Ondoto Street Okuryangava	Penina Ita Tel: +264 61 259590 tuuhulu@yahoo.com
AIDS Law Unit	4 Körner Street Windhoek	Basilia Ngunovandu-Ngairo Tel: +264 61 223 356 Fax: +264 61 234 953 AIDSlaw@lac.org.na
Catholic AIDS Action		Richard Bauer Tel: +264 61 276350 Fax: + 264 61 276364 rick@caa.org.na
Christian AIDS Network		Ken Boltt Tel: +264 61 248 622 Fax: +264 61 258 324 keboltt@mweb.com.na
Family Health International	351 Sam Nujoma Drive	Taimi Amaambo Tel: + 264 61 239 463 Fax: + 264 61 239 461 taimi@fhi.org.na
Family Hope Sanctuary	22 Yohann Albrecht Street Windhoek	Abigall Maphosa Tel: + 264 61 220117 Fax: + 264 61 232293 fhs@iway.na
Khomas Women in Development	1806 Mersey Street Wanaheda	Tel: + 264 61 218723 Fax: + 264 61 265 893 kwid@cyberhost.com.na
Lironga Eparu		Tel: + 264 61 213 638 Fax: + 264 61 213 635 emma@lirongaeparu.org
Mapilelo Project	PO Box 2348 Katima Mulilo	Jejamaije Muyoro Tel: + 264 66 254 300 Cell: + 264 81 124 4462 kaeno@nedico.com.na
Namibia Business Coalition on AIDS	20 Johann Albrecht Street Windhoek	Peter Van Wyk Tel: + 264 61 215 348 Fax: + 264 61 378777 pjvanwyk@africaonline.com.na

Namibia Network of AIDS Service Organisation	PO Box 23281 Unit 9 furniture house Independence Avenue Ausspannplatz Windhoek	Zack Makari Tel: + 264 61 261 122 Fax: + 264 61 261 778 nanaso@nanaso.com
Namibia Red Cross Society	PO Box 346 Windhoek 2128 Independence Avenue Katutura	Razia Essack-Kauaria Tel: + 264 61 235 226 Fax: + 264 61 228 949 secgen@redcross.org.na
Namibia social Marketing Association	PO Box 25156 Windhoek 5 Beethoven Street, Windhoek West	Tel: + 264 61 256 427 Fax: + 264 61 256 424 hosky@nasoma.com
Namibia Women's Network	PO Box 8961 Windhoek 11 Behring street Windhoek west	Marianne Erastus Tel: + 264 61 246 401 Cell: + 264 81 259 5301 nwn@iway.na
New Start VCT (Bernard Nordkamp Katutura)	PO Box 61187 Katutura Windhoek	Tina Rajaal Tel: + 264 61 234 221 Fax: + 264 61 218 665 caaka@mweb.com.na ad.caaka@mweb.com.na
New Start VCT (CCN, Katutura)	PO Box 50282 Bachrecht Windhoek	Tel: + 264 61 220 368 Fax: + 264 61 220 233 vct@iway.na
New Start VCT (ELCAP, Mariental)	PO Box 229 Mariental	Elise Biermann Tel: + 264 63 241 880 Fax: + 264 63 243 390
New Start VCT (Katima Mulilo)	PO Bbx 2289 Ngwezi Katima Mulilo	Kavozu Sandra Tel: + 264 66 252 663 Fax: + 264 66 252 661
New Start VCT (Keetmanshoop)	PO Box 1282 Keetmanshoop	Theresa Cloete Tel: + 264 63 223 436 Fax: + 264 63 223 637 caake@mweb.com.na
New Start VCT (Oshikuku)	PO Box 1263 Oshakati Oshikuku	Anna Shoopara Tel: + 264 65 254 709 Fax: + 264 65 254 738 pmtctosh@iway.na
New Start VCT (Rundu)	PO Box 930 Rundu	Pricilla Mbamba Tel: + 264 66 256 661 Fax: + 264 66 256 661 lifelineru@iway.na

New Start VCT (Tonateni, Oshakati)	PO Box 2 Oshakati	Veronica Tel: + 264 65 220 423 Fax: + 264 65 220 591 ns.caato@mweb.com.na
New Start VCT (Walvis bay)	PO Box 7243 Kuisebmond Walvis Bay	Beverly Figaji Tel: + 264 64 200 219 Fax: + 264 64 200 291 beverly@mpc.org.na
Otjiwarongo HIV/AIDS Support Group	PO Box 1474 Otjiwarongo	Suoma Angala Tel: + 264 67 300 900 Fax: + 264 67 304 724 otjAIDS@iway.na
People in Need	PO Box 273 Keetmanshoop	Katrina Kasova Tel: + 264 63 224 364/67 Fax: +264 63 224 364 pinf.Namibia@centrum.cz
Sister Namibia	PO Box 40092	Liz Franck Tel: + 264 61 230 618 fax: + 264 61 236 371 sister@iafrica.com.na
Social Marketing Association		Christoph Tjirongo Tel: +264 61 244 936 Fax: + 264 61 244 937 christoph.tjirongo@sma.org.na
Take Control		Rianne Selle Tel: + 264 61 283 9111 Fax: + 264 61 224 937 rianne@mweb.com.na
Women and AIDS Support Network		Agnes Tom Tel: +264 61 262 855 wasn@africaonline.com
Young Women Christian Association of Namibia		Lena Kasheeta Tel: +264 61 263 484 Fax: +264 61 263 298 ywcanam@mweb.com.na

6. NGOs in South Africa

Name	Address	Other Contact
Aids Consortium	Auckland House, East Wing, 4th Floor 185 Smit Street Braamfontein Johannesburg	Tel: +27 11 403 0265 Fax: +27 11 403 2106
Aids Foundation South Africa	PO Box 50582 Musgrave Durban 4062	Tel : +27 31 202 9520 Fax : +27 31 202 9522 website@aids.org.za
AIDS and Human Rights Research Unit	Centre for Human Rights & Centre for the Study of AIDS University of Pretoria Pretoria 0002	
Aids Law Project	Centre for Applied Legal Studies University of the Witwatersrand Private Bag 3 Wits 2050	Tel: +27 11 717 8600 Fax: +27 11 403 2341 alpadm@law.wits.ac.za
AIDS Legal Network	Suite 6F Waverley Business Park Mowbray 7700 Cape Town (P.O. Box 13834, Mowbray 7705 Cape Town)	Tel: +27 21 447 8435 Fax: +27 21 447 9946 nacosawc@new.co.za www.aln.org.za
Centre for Study of AIDS	University of Pretoria Pretoria 0002 South Africa	Fax: +27 12 420 4395 csa@up.ac.za
Treatment Action Campaign	National Office 34 Main Road Muizenberg 7945	Tel: +27 (21) 788 3507 Fax: +27 (21) 788 3726 info@tac.org.za

Internet Database	Web Address
Red Ribbon Portal	http://www.redribbon.co.za/home/default.asp
Wits Aids Research Database	http://ward.wits.ac.za/index.php

7. NGOs in Swaziland

Name	Address	Other Contact
Baphalali Swaziland Red Cross Society	PO Box 377 Mbabane	Tel: +268 404 2532 / 404 6106 Fax: +268 404 6108 bsrcs@africaonline.co.sz
Caritas Swaziland	PO Box 19 Manzini	Tel: +268 505 2972 Fax: +268 505 4876
Chesire Homes of Swaziland	PO Box 713 Manzini	Tel: +268 518 4455
Council of Swaziland Churches (CSC)	PO Box 1095 Manzini	Tel: +268 505 3697 Fax: +268 505 5841 c.o.c@africaonline.co.sz
Family Life Association of Swaziland	PO Box 1095 Manzini	Tel: +268 505 3086 Fax: +268 505 3191 flas@africaonline.co.sz http://www.flas.org.sz
Hospice at Home Swaziland	PO Box 23 Matsapha	Tel: +268 518 4485 Fax: +268 518 6405 hospice@realnet.co.sz
IBFAN Africa	PO Box 781 Mbabane	Tel: +268 404 5006 Fax: +268 404 0546 http://www.ibfanafrica.org.sz ibfanswd@realnet.co.sz
Lawyers for Human Rights	c/o 1st Floor Portuguese Club Commercial Road Mbabane	Tel: +268 404 6750 wlsaszd@africaonline.co.sz
Motshane HIV/AIDS Prevention Initiative	PO Box 3127 Mbabane	
National Youth Council	PO Box 22 Mbabane	Tel: +268 505 4347
Red Cross Swaziland	PO Box 377 Mbabane	Tel: +268 404 2532 / 404 0575 Fax: +268 404 6108 thabsile@redcross.org.sz

St John's Ambulance	PO Box 1075 Manzini	Tel: +268 518 6107 Fax: +268 518 4713
Save the Children	PO Box 472 Mbabane	Tel: +268 404 5181 / 404 2562 Fax: +268 404 4719 childsav@realnet.co.sz
School for HIV/AIDS population Education	PO Box 521 Eveni	Tel: +268 404 5066 / 404 5752 Fax: +268 404 5752 shape@realnet.co.sz
SOS Children's village	PO Box 4667 Mbabane	Tel: +268 422 0878 Fax: +268 422 0877 sos-swz@realnet.co.sz
Swaziland Action Group against Abuse	PO Box 560 Matsapha	Tel: +268 505 2899 / 505 7514 Fax: +268 505 2899 www.africaonline.co.sz/org/swagaa swagaa@realnet.co.sz
Swaziland AIDS Support Organisation	SASO Secretariat PO Box 6102 Mbabane	Tel: +268 404 7663 / 422 1640 Fax: +268 422 1640 saso@realnet.co.sz
Swaziland Infant Nutrition Action Network	PO Box 2282 Manzini	Tel: +268 404 8863 / 404 7469 Fax: +268 404 7460
Swaziland Network of AIDS Service Organisations	PO Box 4764 Mbabane	
The AIDS Support Centre	PO Box 1279 Manzini	Tel: +268 404 2573 Fax: +268 404 4719
Traditional Healers Organisation	PO Box 152 Siteki	Tel: +268 505 4790 Fax: +268 505 4752 AIDS Helpline: +268 505 3190
UMTAPO wa Bomake Women's Resource Centre	PO Box 3573 Manzini	Tel: +268 505 5771 / 505 5772 / 505 4762 Fax: +268 505 5771 wrcumtapo@africaonline.co.sz
Women and the Law in Southern Africa	1st Floor Portuguese Club Commercial Road Mbabane	Tel: +268 404 7088 wlsaszd@africaonline.co.sz
Women's Resource Centre	PO Box 3573 Manzini	Tel: +268 505 5771 Fax: +268 505 5771 wrcumtapo@iafrica.sz

World Vision International	PO Box 2870 Mbabane	Tel: +268 422 1665 / 422 1666 / 422 1667 Fax: +268 422 1663 wvswd@realnet.co.sz

8. NGOs in Zambia

Name	Address	Other Contact
AIDS Care and Prevention Programme	St Francis Hospital Post Bag 11 Katete	
Afya Mzuri	33 Joseph Mwilwa Road Northmead Lusaka	enquiries@afyamzuri@org.zm
Association for Restoration of Orphans and Street Children	PO BOX 75507 Compensation House Cnr Broadway/ Moffat Roads Lubuto, Chifubu, Ndola	Tel: 260 02-620048 arosorg@yahoo.co.uk http://www.chin.org.zm
BIZ/AIDS	Standard Chartered Building Showgrounds PO.Box 320144 Lusaka	Nathan@zamnet.zm
Bukwasho Home Based Care	PO BOX 70261 Plot No 2 Luangwa Rd Town Centre, Ndola	Tel: 260 02-620690/097 bukwasho@yahoo.com
Centre for Infectious Disease Control (CIDRZ)	PO Box 346811275 Lubutu Road, Rhodes Park 5977 Benakale Road, Northmead Lusaka	
Chelstone Community HIV/ AIDS Programme Project Centre	PO Box 39156 Plot No 3 Mopani Rd Chelston, Lusaka	Tel: 260 01-281518

Childcare Upgrading Programme	PO Box 130001 Mufumbwe	Tel: 260 08-253103
Chipata Care Prevention and Support Team	PO BOX 512202 Ntilesembe Rd Nabvutwa, Chipata	Tel: 260 06-222551 josiaszulu@counsellor.com
Churches Health Association of Zambia	CHAZ House Ben Bella Road PO Box 34511 Lusaka	cmaz@zamnet.zm
Comprehensive HIV/AIDS Management Programme (CHAMP)	Plot 2339 Kabelenga Road POSTNET 178, Private Bag E835 Lusaka	champ@champ.org.zm
Community Response to HIV/AIDS	PO Box 31559 Lusaka	lusakacf@zamsif.org.zm
Concern Worldwide	Plot 41 Boma Area PO Box K156, Mongu	haconcern@zamnet.zm
Copperbelt Health Education Project	8, Diamond Drive Martindale PO Box 23567, Kitwe	chep@zamnet.zm
Corridors for of Hope	10 Nkachibaya Road PO Box 320303 Lusaka	llong@coh@org.zm
DAPP Hope Humana	PO Box 70505 Ndola PO BOX 511269 Kalongwe, Chipata	hopendl@zamnet.zm Tel: 260 06-222765
EQUIP 2	PO Box 50093 Lusaka	lilion@moe@gov.zm
Facing the Challenge	PO BOX 25 Chongwe Health Centre Great Chongwe	Tel: 260 01-620023/78
Family Health International	Plot 2055 Nasser Road PO Box 320303 Lusaka	cthompson@zpct.org
Health Communication Partnership	PO Box 37230 Lusaka	lynn@hcp.org.zm
HIV/AIDS Prevention and Network Project	PO BOX 40019 Plot No 1080 Malela Market Freedom Rd Mufulira	Tel: 260 02-411328 Hapn-project@zamnet.zm

Households in Distress	PO Box 420079 Tabwa Rd Mbala	Tel: 260 04-450166
HSSP	PO Box 39090 Plot 8327 Nangwenya Road Lusaka	cosmasm@hssp.org.zm
Human Rights Referral Centre	Salvation Army Compound Chishango Road Off Great North Road PO Box 32717 Lusaka	Tel/Fax: 260 237619/ 223191/ 223152 nzprights@zamnet.zm
Integrated AIDS Programme	PO BOX 70244 Broadway Rd Ndola	Tel: 260 02-613146 healdept@zamnet.zm
Isubilo Day Centre Support Group	PO Box 41218 Hospital, Kasama	Tel: 260 04-221096
JSI Deliver(JSI)	No 6 Mwatusanga Road PO Box 320087 Lusaka	wproper@jsi.com
Kara Counselling and Training Trust	174 Luanshya Road Villa Elizabeth Lusaka	trainingcentre@zamnet.zm
Kafue Town Home Based Care	Po Box 360028 Kafue	Tel: 260 312937
Kalomo Mumuni Centre	PO BOX 620070 Plot No 89 Chikanta Rd Town Centre, Palomo	Tel: 260 032-65195
Kaoma Community Home Based Care and Anti AIDS Club	PO BOX 940009 Plot No 103 Kaoma	Tel: 260 07-360041 kaoomahbc@zamnet.zm
Legal Resources Foundation	Woodgate House Cairo Road Lusaka	lrf@zamnet.zm
Luapula Families in Distress (LUFAID)	PO Box 710239 District Communities Development Offices Rm 3 Mansa	Tel: 260 02-821949 deanmulengahamweemba@yahoo.com

Luapula Redemption Coalition for PLHAS and Orphans	PO Box 710010 Luke Mumba Rd Muchika, Mansa	Tel: 260 02-821235
Lumezi People Living with HIV/AIDS	PO BOX 530246 Lumezi Health Centre Lumezi, Lundazi	Tel: 260 06-480023
Mongu Home Based Care	PO BOX 91449 Lusaka Rd, Mongu	Tel: 260 07-221431 hbcdom@zamtel.zm
Mount Carmel Institute for OVC	PO BOX 4 Riverside Stg III Riverside, Kapiri Mposhi	
Murundu Orphanage Foundation	PO BOX 40289 Plot 57 Murundu, Mufilira	Tel: 260 096-921893 roselupiya@yahoo.com
Mthuzi Development Foundation	PO BOX 511008 Pararenyatwa Rd Chipata	Tel: 260 06-222551 www.mdf.semisoft.zm
Mwinilunga HIV/AIDS Epidemic Advocacy Awareness Organisation	PO Box 160121 Mwinilunga	Tel: 260 08-361027
National Legal Aid Clinic for Women	Plot 110A/150 Musonda Ngosa Road Lusaka	naleacw@zamnet.zm
New Start Centre	Cairo Road PO Box 50770 Lusaka	newstart@coppernet.zm
Network of People Living with HIV/AIDS	4th Floor Civic Centre Independence Ave PO Box 32717 Lusaka	napnzp@zamnet.zm
Nyamphande Anti AIDS Club	Po Box 31337 Nyamphande School Rufunsa, Lusaka	
Pact/Zambia AWATCH	331 Independence Ave PO Box 50738 Lusaka	jackm@pactzm.org

PANOS Southern Africa	Plot 32A Leopards Hill Road PO Box 39163 Lusaka	www.panosaids.org
Project Concern International	Kashiba Road PO Box 32320 Lusaka	tom@pcizambia.org.zm
RAPIDS	Sable Road PO Box 32032 Lusaka	bwilkins@worlvision.org
Saviour Faire Project	PO BOX 24100 Rm 215 Dorcus House Buteko Avenue Ndola	Tel: 260 096-929425 saviourfaire@yahoo.com
SHARE	Football House PO Box 51185 Lusaka	mutinta@ziph.org.zm
Society for Family Health	39 Central Street PO Box 50770 Lusaka	cinder@shf.org.zm
Society for Women and AIDS in Zambia	PO Box 12001 Central, Kasempa PO BOX 440030 New Town, Kasama PO Box 740106 Kashikishi, Nchelenge	Tel: 260 08-251125 Tel: 260 02-972078
Thandizani Community Based HIV/AIDS Prevention and Care	PO BOX 530221 Chama Rd, Lundazi	Tel: 260 06-480061 thandizani@zamnet.zm
Tikondane Home Based Care Foundation	PO BOX 510332 76 Hollywood Omel Mumba Rd Chipata	Tel: 260 06-221453
Toyavyana Community Home Based Care	PO BOX 560094 Pocus Premises, Petauke	Tel: 260 06-371156 thocape@yahoo.com
Treatment Advocacy and Literacy Campaign	PO Box 39088 Lusaka	avink@zamnet.zm

Tungati Home Based Care Group	PO BOX 460008 Nsombo Rd Tungati R H Centre, Luwingu	
Twikatane HIV/AIDS Project (THAP)	PO BOX 450160 Musakanya Kombe Dr Boma, Mpika	Contact: Jon Mweshi at thcorg@yahoo.com
Vision on Zambia Shanty Compounds and Sustainable Development Organization	PO BOX 490050 Rm 8, Chilubi Civic Centre Chilubi	Tel: 260 02-830164/35/13 vizashco@yahoo.com zcsta@yahoo.com
VK Home Based Care Organization	Po Box 50878 Plot 12/05 Pendela Rd Garden, Lusaka	Tel: 260 097-851413 /096
Women in Law in Southern Africa	House No 2 Beit Road Rhodes Park PO Box 34777 Lusaka	wlsazam@zamnet.zm
Young Women's Christian Association	Nationalist road PO Box 50115 PO BOX 60763 Musi-o-tunya Rd Town Centre, Livingston	Lusakaywcawr@zamtel.zm Tel: 260 03-022555
Zambia Aids Law Research and Advocacy Network	CUSA House Cairo Road PO Box 39088 Lusaka	zaran@zamnet.zm
Zambia Business Coalition of HIV/AIDS	ZANACO Head Office PO Box 31026 Lusaka	zbca@zamnet.zm
Zambia Interfaith Network Group	Plot 5505 Msanzala Road PO Box 30360 Lusaka	zingo@zamtel.zm
Zambia National AIDS Network	Plot 7450 Katopola Road PO Box 32401 Lusaka	znan@zamnet.zm

9. NGOs in Zimbabwe

Name	Address	Other Contact
Actionaid	PO Box 2451 Causeway Harare	Tel: +263 4 70 3336 Fax: +263 4 788 124
AIDS Counselling Trust	PO Box 7225 Harare	Tel: +263 4 79 2340 Fax: +263 4 797 041 acthelp@mweb.co.zw
Africare		Tel: +263 4 745 859/61 Fax: +263 4 498 108 cchipere@africare.co.zw www.africare.org
The Centre	PO Box A930 Avondale Harare	Tel: +263 4 732 966 Fax: +263 4 732 965 Center2@africaonline.co.zw www.kubatana.net
Family AIDS Caring Trust	PO Box 970 Mutare	Tel: +263 20 63673 /+263 20 66015 Fax: +263 20 65281 director@fact.org.zw
Farm Orphans Support Trust	Agriculture House Marlborough Drive Adylinn Rose	Tel: +263 4 309 800 Fax: +263 4 309 869 fost@cfu.co.zw
Gweru Women's AIDS Prevention Association		Tel: +263 54 20749 Fax: +263 54 23254 gwapa@zarnet.ac.zw
Mashambamsou Care Trust		Tel: +263 4 610 937 /+263 4 610 079 Fax: +263 4 610 079 mashamba@icon.co.zw
Matabeleland AIDS Council		Tel: +263 9 62370 Fax: +263 9 61540 dan.mac@telconet.co.zw linda.mac@telconet.co.zw
Population Service International	30 Chase West Emerald Park Office, Bloc E Emerald Hill Harare	Tel: +263 4 334 631 Fax: +263 4 339 632 khatvold@psi-zim.co.zw www.psi.org
Southern Africa AIDS Information Dissemination Service		Tel: +263 4 307 898 Fax: +263 4 336 195 info@safaids.org.zw www.safaids.org.zw

Zimbabwe National Network for People living with HIV/ AIDS		Tel: +263 4 703 819 / +263 4 700 832 / +263 4 700 924 Fax: +263 4 700 330 zansec@zol.co.zw info@zan.co.zw kmhambi@zan.co.zw www.zan.co.zw
Zimbabwe National Family Planning Council		Tel: +263 4 620 281/5 / +263 4 661 962/4 / +263 4 661 748 / +263 4 668 770 Fax: +263 4 661 748 / +263 4 668 770 znfpc@ecoweb.co.zw
Zimbabwe AIDS Prevention Project		Tel: +263 4 770 610/1 Fax: +263 4 770 170 / +263 4 749 865 ronald@zappuz.co.zw

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 nine country reports contained in this volume, OSISA also financed research towards four papers on contentious aspects related to HIV and human rights, published as Viljoen and Precious (eds) *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa*.