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HUMAN RIGHTS AS A RESPONSE TO HIV/AIDS

BY

ELIJAH CHIMWEMWE SITALI

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HUMAN RIGHTS AS A RESPONSE TO HIV/AIDS

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ELIJAH CHIMWEMWE SITALI,

Being a paper presented in partial fulfilment for the award of the Degree of Bachelor of law of the University of Zambia.

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School of Law
Lusaka

February 2009
I recommend that the directed essay prepared under my supervision by Elijah Chimwemwe Sitali entitled:

**HUMAN RIGHTS AS A RESPONSE TO HIV/AIDS**

Be accepted for examination. I have checked it thoroughly and I am satisfied that it fulfils the requirements related to the format as laid down in the regulations governing directed research.

Signature............................ Date......

Mr. P. Mulonda (Supervisor)
Declaration

I Elijah Chimwenwe Sitali; Computer number 28086627, do hereby declare that the contents of this Directed Research paper are entirely based on my own findings. The work used in here is not mine, I have endeavoured to acknowledge the same.

I therefore bear the responsibility for the contents, errors, defects and omissions there in.

Date: 21/02/09

Signature: 

.................................
Dedication

This obligatory essay is dedicated to my parents Mr Mathews Sitali and Mrs Sinai Kanyimbo Sitali.
Acknowledgements

This study like many others come about with the help and support of many individuals and more especially God who gave me the strength, guidance and much needed wisdom in all my endeavours. I am also greatly indebted to my Supervisor Mr P. Mulonda for his commitment in guidance and analytical insights.

Last but not the least, in addition to their love and counsel, I wish to express my heartfelt appreciation to my family members for investing in me.

To these and to others whose names are not here but are craved on my heart, i give my accolades.
Abstract

HIV/AIDS is as much a disease of society as it is a disease of the body. Not only does invade the body’s immune system, but it feeds off and further exacerbates pre-existing human rights violations in society such as gender inequality and socio-economic exclusion and deprivation.

Chapter one goes on to give an overview of the meaning of human rights and the civil, political, economic, social and cultural rights which are found in international law, through treaties and declaration. Other useful tools which contain useful standards on HIV/AIDS and Human Rights are also discussed.

Chapter two looks at the different vulnerable groups affected by HIV/AIDS. The most vulnerable groups some being women, children, sex workers, injection drug users, refugees and migrants, prisoners. Will also try to examine how the status of women in society has made the so vulnerable to the HIV/AIDS pandemic. We will also try to look at how these groups can be helped to realize their civil and political, and economical, social and cultural rights.

Chapter three discusses the criminalisation of HIV/AIDS, when criminalisation can be warranted; we also look at the alternatives to criminal law, the need to punish harmful conduct and the concerns about miscarriage of justice.

Chapter four discusses the challenges to a Human Rights based approach to HIV/AIDS, which are disclosure and routine testing.

Chapter five is the conclusion and recommendations.
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Convention on the Rights of the Child

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Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and other Related Infectious Diseases
List of Abbreviations

AIDS- Acquired Immune Deficiency Syndrome

CEDAW- Convention on the Elimination of All Forms of Discrimination against Women

CRC- Convention on the Right of the Child

HIV- Human Immune Virus

ICCPR- International Covenant on Civil and Political Rights

ICESCR- International Covenant on Economic, Social and Cultural Rights

STDS- Sexually Transmitted Diseases

VCT- Voluntary counselling and Testing
1.1 INTRODUCTION:

The statistics of 2007, show that of the 35 million and more people worldwide living with HIV/AIDS, a high percentage of these live in sub-Saharan Africa. It is estimated that about 1 million Zambians are living with HIV, most recent HIV survey at antenatal clinics showed HIV infections among pregnant women to be higher in urban than in rural areas. The impact of HIV on men and women across the developing world are devastating and wide-ranging. Girls may have to drop out of school to look after sick relatives, boys to earn money. The death of the working-age adults can mean that the surviving family members struggle to get by, with grandparents shouldering the burden of looking after orphaned grandchildren, often in dire poverty. Young women may have to resort to sex work, and other risky surviving strategies to support themselves and their families. Young men are growing up with ideas about masculinity that include violence and the sexual domination of women, contributing to the spread of HIV. The highest rate of infections in Africa is experienced among the women and girls (15-24). However, in many parts of the developing world the HIV transmission rate for women and especially young women and girls has surpassed, or is about to surpass, that of men. Gender inequality, power dynamics in sexual relationships and women's lack of economic empowerment related directly to patterns of poverty are the key factors as to why the HIV transmission rate among young girls and women is higher than men.

1.2 Problem Statement

HIV/AIDS is as much a disease of society as it is a disease of the body. Not only does it invade the body's immune system, but it feeds off and further exacerbates pre-existing human rights violations in society such as gender and social economic exclusion and deprivation. Devastating
the social fabric through high levels of death and illness, HIV and AIDS have taken hold particularly in Southern and Eastern Africa, which have become the global epicentre of HIV and AIDS.

1.3 Objectives of the Research

To assess how best human rights can be used to protect the most vulnerable groups, and to see if criminalisation as a legal response can help reduce the spread of HIV/AIDS, in order to come up with recommendations for a Human Rights based approach to HIV/AIDS.

1.4 Research Questions

1. How best can a Human rights based approach as a response to HIV and AIDS help in reducing the effects of the epidemic?

2. What can be done to protect those infected from discrimination and stigma?

3. Which groups are most vulnerable to HIV/AIDS?

4. Is criminalisation as a Legal Response the best way to reduce the spread of HIV?

5. Can the application of specific human rights in the context of the HIV epidemic help fight the disease?

1.5 Methodology

The research being proposed intends to use ethnography as an approach in order to analyse the effects of HIV/AIDS and how human rights can be used to help in reducing the spread of the disease.
In this chapter we look at the Human Rights which encompass civil, political, economic, social and cultural rights. These are found in international law, through treaties and declarations such as the Universal Declaration of Human Rights. In addition, there are some other tools which contain useful standards such as the International Guidelines on HIV/AIDS and Human Rights and the Declaration of Commitment on HIV/AIDS, adopted at the UN General Assembly Special Session on HIV/AIDS (2001).

1.6 Human Rights:
The term 'human rights' maybe used either in an abstract and philosophical sense, as denoting a 'special kind of moral claim' that all humans may invoke, or more pragmatically, as the manifestation of these claims in positive law, for example as constitutional guarantees that serve as the basis to hold governments accountable under national legal processes. The first understanding of the term can be understood as 'human rights' and the second as 'human rights law'.

Because the concept 'human rights', presupposes the existence of 'humans', it finds application in human interactions, and is thus relational in nature. Sustained human contact and community requires mutual respect - respect of the other's life, of the child's needs, of the elder's age and wisdom, and so on. In close knit society, such as 'traditional' African communities often lacking a centralised structure, the reciprocity of expectations is taken for granted, and need not be formally determined - members of society are socialized into their roles. In these contexts non compliance carries the risk of social exclusion, and even expulsion - a life outside the group.

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1 F. Viljoen International Human Rights Law in Africa. (Oxford: At the University Press, 2007)
These relationships could have been formally conceptualized as 'rights and duties', but there is no need to do so, as they were already intricately tied to one's very identity and social role. Understood in this way, there is little doubt that 'human rights' (but perhaps not 'human right law') existed in traditional (pre-colonial) Africa. As colonialism, urbanisation, and industrialisation ruptured traditional African societies, the bonds of immediacy and reciprocity grew weaker, people became alienated and isolated, and form new communities. Formalised states structures were instituted to organise social interaction on the basis of pre-determined expectations of roles, referred to as 'rights' and 'duties'.

Although majoritarianism legitimates legislation and the increasingly bureaucratized function of the executive, majority sometimes get it wrong. They may have little regard for 'numerical' minorities such as sentenced criminals, linguistic or religious minorities, non-nationals, 'indigenous peoples', and the socially stigmatised. It therefore becomes necessary to guarantee the existence and rights of numerical minorities, of the vulnerable, and the powerless. This is done by agreeing on the rules governing society in the form of a constitutionally entrenched and justiciable Bill of Rights, containing the basic human rights of everyone. Through a Bill of Rights, human rights become integral to the legal system - become 'human right law', superior to ordinary law and executive action.²

From the discussion above it emerges that human right law is closely linked to the emergence of the nation state. The implication of this state-centredness is that states are the primary duty bearers in respect of these rights. A fundamental paradox is therefore introduced: individuals

depend on the states to guarantee their rights, but they also have to defend their rights against these very states as the principle violators of their rights. In a particular state, human rights law represents the states obligation at a given time, while human rights serve as a yardstick against which the nature and extent of these obligation can be assessed, an ideal toward which to strive and an inspiration for struggle to improve the state of affairs.

1.7 International Legal Framework:

There are no HIV/AIDS-specific treaties within the international legal framework. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) both came into force in 1976, about four years before the first HIV/AIDS case was documented. Nevertheless, specific provisions of these treaties may be applied to various legal situations affecting people living with or affected by HIV/AIDS. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is similar, having been adopted in the early days of the epidemic. The Convention on the Rights of the Child (CRC), however, was adopted in 1989, nearly ten years after the first reported case of HIV/AIDS. The fact that in the CRC no mention is made of HIV/AIDS with respect to children can be viewed as a missed opportunity to develop policy for this vulnerable group.

1.7.1 Universal Declaration of Human Rights (UDHR):

The Universal Declaration of Human Rights was adopted unanimously by the General Assembly on 10th December, 1948 which has since been declared the World Human Rights Day.

\[\text{N. Phiri HIV/AIDS and Human Rights in Zambia. Pretoria: At the University Press, 2007}\]
The UDHR expressed as "a common standard of achievements for all peoples and all nations" sets out a wide span of rights covering all aspects of life. Its first article famously describes the idea of fundamental rights: "All human beings are born free and equal in dignity and rights."

After setting out general prohibitions of discrimination, the declaration enumerates specific groups of rights; civil, cultural, economic, political, and social. Article 3 to 21 describes classic civil and political rights. Article 22-28 guarantees a range of economic, social and cultural rights, with the importance recognition in Article 28 that, "Everyone has the right to a social international order in which the rights and freedoms set fourth in this Declaration can be fully realised."

While the Declaration is, as its name suggests, not a directly legally binding instrument, its importance should not be underestimated. It is of high moral force, representing as it does the first international agreed definition of the rights of all people, adopted in the shadow of a period of massive violations of the rights there described.

The Declaration also laid in a direct fashion the groundwork for the treaty structure to be erected in the decades to come.

### 1.7.2 International Covenant on Civil and Political Rights (ICCPR); 1966

The Civil and Political Rights Covenant elaborates civil and political rights set out in the Declaration, with the exception of the right to property as well as the right to asylum (which was covered in the 1951 Convention on the status of Refugees). It also includes additional rights such as the rights of detainees in Article 10, and protection of minorities in Article 27.
In addition to Article 2(1) and 3 on non-discrimination, Article 26 ensures equality before the law and non-discriminatory protection of the law generally in force in a state. Article 2 provides also for the right to effectively remedy for violation of Covenant rights, including an independent and impartial forum before which allegations of such violation can be advanced.

1.7.3 International Covenant on Economic, Social and Cultural Rights (ICESCR); 1966

The ICESCR develops corresponding rights in the UDHR in considerable details, specifically the steps required for their full realisation. For example, on the right to education, ICESCR mirrors the language in the UDHR but devotes two (2) Articles (Art.13 & 14) to its different dimensions, specifying the obligation to secure compulsory primary education free of charge and to take steps towards achieving free secondary and higher education.

Some of the key economic, social and cultural rights include the right to;

- Non-discrimination
- Work
- Just and favourable conditions of work
- Trade union rights
- Social security
- Protection of the family
- Adequate standard of living
- Health
- Education
- Participate in cultural life.

The covenant recognises the wider role of the international community in Article 2(1), 11(2), 15(4), 22 and 23.

Part IV requires state parties to report to the committee on Economic, Social and Cultural Rights to carry out the function of monitoring implementation of the covenant's provisions. Submission of the initial report is two (2) years after ratification/accession and then periodic reports are at a five (5) year intervals.

1.7.4 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979;

In 1979, the international community adopted a new treaty which addressed a specific phenomenon, discrimination against women on the basis of sex. The CEDAW sets out in more detail what is meant by the prohibition of sex discrimination from the perspective of equality between men and women. It address a range of programmatic and policy aspects of the specific problem.

Article 2 requires States to embody the principle of the equality of men and women in their national constitutions or other appropriate legislations if not yet incorporated therein and to ensure, through law and other appropriate means the practical realisation of this principle.

Article 6 explicitly requires States to suppress all forms of trafficking in women and exploitation of prostitution, even though these phenomena may implicitly fall within the prohibitions of slavery and forced labour contained in other instruments. Article 7 and 8 details obligations to
ensure equal participations of women and men in public and political life. Article 14 addresses the particular problem faced by women in rural areas.

1.7.5 CONVENTION ON THE RIGHTS OF THE CHILD (CRC), 1989;

The first treaty to deal comprehensively with the right of the child, defined as human beings under the age of 18 years. However children still enjoy all human rights provided for in the other treaties. The CRC provided restatements of these rights with additional provisions relevant to children.

The CRC has four general principles for implementing children's rights;

1. Non-discrimination; the obligation of States to respect and ensure the rights set forth in the Convention to each child within their jurisdiction without discrimination of any kind, Article 2.

2. The best Interest of the Child; that the best interest of the child should be a primary consideration in all actions concerning the child, Article 3.

3. The right to Life, Survival and Development; the child's inherent right to life and State parties' obligation to ensure to the maximum extent possible the survival and development of the child, Article 16;

4. The Views of the Child about his or her own Situation; the child's right to express his or her view freely in "all matters affecting the child", those views being given due weight "in accordance with the age and maturity", Article 12.
The problem of involvement of children in armed conflicts, and of the sale of children, child prostitution and child pornography, are covered in more detail in two optional protocols to the Convention, adopted in 2000.

1.8 INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted HIV/AIDS and Human Rights – International 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/AIDS, including building the capacity and responsibility of civil society to respond ethically and effectively.” The Guidelines deal with the following human rights principles:⁴

- Guideline 1: Encourage states to adopt a multi-sectoral approach through an effective national framework.
- Guideline 2: Enable community organisations to carry out activities in the field of ethics, human rights and law. Consult widely with such organisations in drafting all HIV policies.
- Guideline 3: Review and reform public health laws to adequately address HIV/AIDS.

⁴ UNAIDS and OHCHR, HIV/AIDS and Human Rights - International Guidelines, 1996
• Guideline 4: Review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and address HIV/AIDS without targeting vulnerable groups.

• Guideline 5: Enact or strengthen anti-discrimination laws to protect vulnerable groups. Ensure privacy, confidentiality and ethics in research involving human subjects.

• Revised Guideline 6: Enact legislation to provide for the regulation of HIV-related goods, services and information in order to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. Ensure that all persons on a sustained and equal basis have access to quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for the treatment of HIV/AIDS and related opportunistic infections.

• Guideline 7: Implement and support legal support services to educate people affected by HIV/AIDS about their rights, develop expertise on HIV-related legal issues and use means other than courts such as human rights commissions to protect the rights of people affected by HIV/AIDS.

• Guideline 8: States, together with communities, should promote an enabling and prejudice-free environment for women, children and other vulnerable groups. • Guideline 9: Promote the distribution of creative education, training and media programmes designed to change attitudes of discrimination and stigmatisation around HIV/AIDS.

• Guideline 10: Translate human rights principles into codes of conduct with accompanying mechanisms to implement and enforce these codes.
• Guideline 11: States should ensure monitoring and enforcement mechanisms to guarantee and protect HIV-related human rights.

• Guideline 12: States should share experiences concerning HIV-related human rights issues at an international level and through UN agencies such as UNAIDS.

1.9 RELEVANT OAU/AU RESOLUTIONS ON HIV/AIDS

Over the years, the Assembly of Heads of State and Government of the Organisation of African Unity (OAU, now called the African Union or AU) adopted a number of resolutions addressing the HIV/AIDS epidemic. Only those relevant to HIV/AIDS and human rights are discussed here. In June 1994, the Tunis Declaration on AIDS and the Child in Africa was adopted by the OAU at the Assembly of Heads of State and Government in Tunis, Tunisia. The Declaration declares a commitment to: “Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.”

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa was adopted by the Assembly. The Resolution urged African leaders to implement those declarations and resolutions that had been adopted in the past, specifically referring to the Tunis Declaration.

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the Abuja Declaration on HIV/AIDS, Tuberculosis and other
Related Infectious Diseases, and the Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, aimed at implementation of the principles set forth in the Abuja Declaration. In the Abuja Declaration, the Heads of State acknowledged that “stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it.” The Abuja Framework conceptualises the commitments made in the Abuja Declaration into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas, and the following strategies are identified:

- develop a multi-sectoral national programme for awareness of and sensitivity to the negative impact of the pandemic on people, especially vulnerable groups;
- enact relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB;
- strengthen existing legislation to: (a) address human rights violations and gender inequities, and (b) respect and protect the rights of infected and affected people;
- harmonise approaches to human rights between nations for the whole continent; and
- assist women in taking appropriate decisions to protect themselves against HIV infection.

1.10 Conclusion:

Although HIV/AIDS has not been included in any international or regional treaties, relevant resolutions and guidelines do exist, and specific provisions in the major treaties will apply to the situations of people living with or affected by HIV/AIDS. Some states have included the measures that they undertook to address HIV/AIDS in their state reports, and the treaty

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5 Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases
monitoring bodies have often commented on these efforts in Concluding Observations. It is important for countries to stop operate with a policy-based approach to HIV/AIDS, and move to a rights-based approach, the UNAIDS and OHCHR HIV/AIDS and Human Rights – International Guidelines offers guidance to move from policy to rights.
Chapter 2

THE MOST VULNERABLE GROUPS

2.1 INTRODUCTION

People who are already disadvantaged in a society are also those who are most vulnerable to HIV and AIDS. In Africa, as many other societies, cultural traditions and modern law conspire to marginalize women, especially girls and to silence children. Impoverished people, especially in rural areas, live on the margin of social life without access to nutrition, health care, and education. The Latent vilification of sex work which, though formally illegal, is allowed to continue, surfaces when scapegoats are sought. Prisoners are victims of society's unconcern. Feeding off the combination of inequality, social exclusion, and denial and targeting the vulnerability of these groups, the tremor of HIV and AIDS not only runs along existing fault lines, but further deepens them. In this chapter the discussion now turns to four group's namely women, Children, sex workers and prisoners.

2.2 WOMEN

Women's inferior position in tradition has made them more vulnerable to HIV and AIDS. Traditional practices that predispose women to infection include polygamy, the precarious position of widows (through wife inheritance or practices allowing for sex with a widow by the deceased brother) and early marriages. In many African countries violence against women is not only rife but also left unpunished. The legal position in respect of marriage, divorce, property and such matters further exacerbates women's precarious position. Legislation is needed to address these issues, which are linked to one of the major root causes of the spread of HIV in

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Africa-inequality of women. There are various human rights declarations and standards that are commonly accepted across the African continent and are generally considered to be universal in nature, applicable to all individuals. They include the right to the highest attainable standard of health in relation to sexuality; the right to health and family planning; the right to life, freedom, integrity, and security; the right not to be assaulted or exploited sexually; the right not to be tortured or to be the object of cruel, inhuman, degrading punishment or treatment; the right not to be subject to sex-based discrimination; the right to privacy; the right to bodily integrity; and the right to pursue a satisfying and safe sexual life. Several human rights treaties and other documents establish these universally applicable rights. With few exceptions, all of them have been signed by every country in the world. The agreements include the UN’s Universal Declaration of Human rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All Forms of Discrimination against Women.

Article 12 of the International Covenant on Economic, Social, Cultural and Political Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Furthermore, it outlines steps to be taken by member states to achieve the full realization of this right, including the implementation of measures designed to prevent the spread of disease and the elimination of discrimination in access to health care and treatment for all. The covenant includes sexual and reproductive health in this right and encourages gender equity. HIV/AIDS and most other diseases are not mentioned specifically in this covenant, but many analysts and policymakers have suggested that the agreement should be interpreted to include

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7 Ibid, 596
8 International Covenant on Economic, Social, Cultural and Political Rights.
prevention, treatment, and care services for HIV/AIDS as a health right.\textsuperscript{9} As indicated specifically in this agreement and at least tacitly in many other international human rights conventions, reproductive and sexual rights are essential for women and men to exercise their right to health. These rights include freedom of choice on the numbering and spacing of children and the forms of contraception; consistent and unimpeded access to information about reproductive services; the right to be protected from sexual harassment and abuse; the right to have a satisfying sexual life; and the right to be protected from sexual violence. According to the Platform of Action adopted at the UN’s Fourth World Conference on Women, held in Beijing, China, in 1995, “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”\textsuperscript{10} The importance of these rights was bolstered by a landmark decision by the International Criminal Tribunal for the Former Yugoslavia, which ruled that serious sexual assaults and rape were implicitly prohibited by the provisions in international human rights law that safeguard physical integrity.\textsuperscript{11} The International Criminal Court subsequently followed suit, defining sexual slavery, forced prostitution, forced pregnancy, forced sterilization, and other forms of sexual violence as crimes against humanity or war crimes.\textsuperscript{12}

The Constitution of Zambia provides for the equality of women and men. Men and women both enjoy the same basic human rights and freedoms without discrimination\textsuperscript{13}. Zambia, like most African countries, has customary rules and traditions that it adheres to very strongly. HIV/AIDS

\textsuperscript{9} Sex work, HIV/AIDS and Human Rights (Report, 2005).
\textsuperscript{10} UN’s Fourth World Conference on Women, (Beijing, 1995).
\textsuperscript{12} Rome Statute of the International Criminal Court.
has disproportionately affected women in Zambia as a result of certain cultural and traditional practices. These include:

- Polygamy: An accepted practice particularly in the rural areas.

- Ritual sexual cleansing of widows/widowers: The practice of sexual cleansing of the widow or widower increases the risk of HIV infection.

- Dry sex: The use of drying agents by females prior to sexual intercourse can create lesions or sores that increase vulnerability to HIV. A Sexual Behaviour Survey carried out recently found that 4% of men and 18% of women reported engaging in dry sex in their last encounter with a non-regular sexual partner. About 2% of adolescent men and 15% of adolescent women said they engaged in dry sex.

- The subordination of women: This cultural practice prohibits women from insisting on safe sexual practices because they are taught at a very early age and at initiation ceremonies to be submissive to men. It is considered taboo for a woman to demand the use of contraceptives such as condoms for purposes of safe sexual practices. Although there is increased awareness of the danger posed by these cultural and traditional practices, they continue to occur, especially in rural areas. No legislative measures have been undertaken to change the manner in which these are practised.

There is Legislation and policies protecting women and the most vulnerable in society, Section 3.10 of the 2002 National HIV/AIDS/STD/TB Policy states in terms of gender: “Government shall strengthen the enforcement of existing legislation dealing with sexual harassment, abuse and violence.”

13 Constitution of Zambia cap.1, Art. 23.
14 National HIV/AIDS/STD/TB Policy February, 2002 p. 28
enacted a revised National Gender Policy. Section 4(3) of the National Gender Policy deals with education and training, with subsection (k) stating that: "the government will integrate reproductive health education in the curriculum to prevent amongst others early pregnancy as well as HIV/AIDS." The National Gender Policy also addresses gender violence and recommends the following interventions in an attempt to reduce and ultimately eliminate all forms of gender violence:

- promote awareness through campaigns to change harmful and negative cultural practices of society and especially target health and media personnel, the police and other security and defence agencies in terms of gender issues; and
- promote and conduct awareness campaigns targeted at women and men about the existence of legal provisions in the Penal Code, Intestate Succession Act and other laws protecting women and those with disabilities against violence, sexual harassment and abuse. The National Gender Policy further advocates for the strengthening, enforcement or enactment of laws and procedures to make all forms of gender violence such as rape punishable with harsher penalties.

The government is also addressing the education of women on HIV/AIDS and reproductive health. The Guidelines on HIV/AIDS Counseling specifically refers to the counseling of women in Section 3.3.4 and mentions amongst its policy statements: “Persons who have unlawful sexual intercourse with women or men must undergo compulsory testing for HIV infection. In this case a court or other lawful authority may allow the results to be known to the concerned parties ... the traditional practice of cleansing by sexual intercourse must be discouraged and avoided.”

Chapter XV, Section 132 of the Penal Code prohibits rape and also criminalises marital rape.

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15 National Gender Policy March, 2000 p. 86-88
Section 133 states the penalty for rape is imprisonment for life. Section 134 also makes life imprisonment the penalty for attempted rape. Defilement of girls under 16 is illegal in terms of Section 138(1) and Section 159 criminalises incest. In 1997, the police department established a Victim Support Unit (VSU) tasked with providing legal protection for girls, women and the elderly who have been subjected to sexual violence and abuse.

2.3 CHILDREN

With some 44 per cent of the African population under the age of 15, the adage that 'children are the future' rings more true in Africa than anywhere else. The protection of children's right is not only an investment in the future, but also an imperative of the present, which is characterised by children's exploitation as soldiers, labourers and sex workers and in human trafficking, the neglect of orphans, especially due to AIDS deaths, the prevalence of street-children, early marriages and other harmful cultural practices. An authoritarian mindset, justified by cultural traditions, often exacerbates the precarious position of children in Africa.

The United Nations Convention on the Rights of the Child is the first treaty to deal comprehensively with the rights of the child, defined as human beings under 18 years of age. It was unanimously adopted by the UN General Assembly on 20th November 1989 and entered into force on 2nd September 1990, nearly ten years after the first reported case of HIV/AIDS. The fact that in the CRC no mention is made of HIV/AIDS in respect to children can be viewed as a missed opportunity to develop policy for this vulnerable group. Even though the CRC does not include any HIV/AIDS-specific provision a number of articles can be highlighted as they indirectly impact on children living with HIV/AIDS. For instance Article 24(1) of the CRC
affirms that state parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. Also that State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services,\footnote{The United Nationals Convention on the right of the Child (1989)}

(2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(f) To develop preventive health care, guidance for parents and family planning education and services.

(3) States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

This article talks about the health of the child, combating disease which should include HIV/AIDS. It also discusses pre-natal health care for mothers to help with the prevention of mother to child transmission of HIV/AIDS.

The Constitution of Zambia guarantees the enjoyment of basic human rights and freedoms to all, including children. All children under the age of 5 years are entitled to receive free health care at
any public health institution or facility in the country while the Guidelines on HIV/AIDS Counseling recommends that, children with AIDS should be provided with free medical care. At present, children living with HIV/AIDS do not have special access to health care facilities, and are subjected to the same conditions as adults. Both the government and NGOs involved in HIV/AIDS programmes recognise the importance of a continuum of care. This continuum includes efforts to prevent HIV infection in the first instance and to provide counseling, spiritual and emotional support and medical care to persons who are HIV infected. Currently the government through the Ministry of Health and the CBOH has made the following interventions in a bid to reduce mother-to-child transmission (MTCT) of HIV:

• providing VCT and access to family planning services;

• reducing the transmission of HIV during breastfeeding by encouraging the use of alternative feeding; and

• using anti-retroviral therapy. Also HIV-positive pregnant women receive free Nevirapine, to help prevent MTCT. This is through a USAID-funded project, Linkages, which has already trained over 63 healthcare providers in Ndola on how to administer the drug. The CBOH has set up the Prevention of MTCT Project, which promotes the prevention of transmission of HIV from pregnant mothers to their babies at three pilot projects sites in Lusaka, Mbala and Monze. The mother-to-child package is supported by 4 components, which are:

• provision of good quality voluntary and confidential counselling and HIV testing for women and their partners, including counselling on feeding options;

• integration of a minimum package of care, including anti-retroviral drugs (AZT or Nevirapine) into antenatal and delivery services;

18 The Guideline on HIV/AIDS Counselling in Zambia, Ministry of Health, 2000 p.8
19 AIDS and Human Rights Research Unit (Pretoria: At University Law press, 2007)
• formation or strengthening of community support networks for the mothers and children; and
• advocacy and programme communication. One of the specific objectives of the Draft Strategic Plan is the provision of improved care and support services for orphans and vulnerable children through, amongst other strategies, ensuring provision of education, shelter, clothing and other basic needs to orphaned children, particularly girls.20

2.4 SEX WORKERS

Few doubt that human rights laws and agreements are necessary to serve as a framework in which to implement rights provisions. However, the ongoing denial of these rights on the ground clearly indicates that it is equally if not more important for the rights guaranteed therein to be enforced comprehensively and consistently by all—especially governments, law enforcement, and service providers. The most consistent and passionate advocates are usually those affected directly. Therefore, a key strategy for those working with sex workers should focus on creating the conditions for the effective mobilization of sex workers. The quality and scope of service provision for sex workers are also likely to be improved only when they are able and willing—ideally by forming coalitions of like-minded and supportive individuals and organizations—to identify what they need and why reform is necessary not only for them, but for society in general. Ensuring the health and well-being of the population at large is contingent upon improving the health and rights of those most at risk. Although the agreements like the UN’s Universal Declaration of Human rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All Forms of Discrimination against Women, do not specifically address sex work, they theoretically protect sex workers in general because they are universally applicable to

all people. The major international convention that refers directly to sex work is the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, which was promulgated by the United Nations in 1949. The 75 state parties to this convention agree to punish anyone who:

• procures, entices or leads away, for purposes of prostitution, another person, even with the consent of that person;
• exploits the prostitution of another person, even with the consent of that person;
• keeps or manages, or knowingly finances or takes part in the financing of a brothel; and
• knowingly lets or rents a building . . . for the purposes of prostitution. The intentions of this convention’s framers may have been well-meaning, but the agreement has significant limitations. For one thing, although it recognizes the difficulties inherent in regulating consensual adult prostitution, it fails to acknowledge the differences between forced and voluntary prostitution and therefore is rooted in the belief that sex work should end. In this respect it shares a fundamental flaw with some other international, regional, and national agreements designed to protect women; in their zeal to prohibit or limit behavior that may be dangerous to women, many protocols deny women the right to choose how they can and wish to make a living. Many women are not coerced into sex work. Instead, they opt to engage in it for a variety of reasons that may or may not have to do with economic self-sufficiency, independence, or financial desperation. Whether for moral or health reasons, banning sex work is not generally an appropriate strategy and may even be counterproductive. Many women’s rights to employment may be limited, and prohibition often pushes such behavior further underground, thus further jeopardizing sex workers’ health and limiting their ability to advocate for their rights. Acceptance and recognition of prostitution as work of one’s choice is needed to combat crime
and economic disparity and to help ensure successful HIV/AIDS prevention efforts. In 1997, the Asia Pacific Women’s Consultation on Prostitution adopted a statement in which human rights activists, academics, and lawyers urged governments to “recognize and validate the reality of women who are working in prostitution”, and defined all labor performed by women in the sex industry as work. In 2004, members of the European Committee on Women’s Rights and Gender Equality agreed to protect the legal rights of sex workers, and stated that any new legislation on prostitution must include these rights. Unfortunately, such enlightened language is missing from many high-profile international human rights agreements.

Another example of the potentially negative consequences—to women’s rights—of otherwise well-meaning agreements may be found in the United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons. Adopted in 2000, this convention created a clear and distinct global definition of trafficking in human beings. In Article 3, trafficking is defined as “the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation”. The protocol’s condemnation of coerced sex work is laudable. However, it did little to define unforced prostitution or to proclaim the necessity of recognizing and safeguarding sex workers’ human rights. Also of particular relevance to issues discussed in this report is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which is a broad-based non-discrimination treaty, CEDAW requires state parties to take all

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21 Sex work, HIV/AIDS and Human Rights (Report 2005) p. 35
22 Ibid, p. 35
appropriate measures to remove obstacles and to foster the conditions necessary for women to realize their full potential as the equals of men. This convention also pays special attention to the issue of trafficking, with Article 6 mandating that all state parties “take all appropriate measures, including legislation, to suppress all forms of traffic in women”\textsuperscript{24}. Furthermore, General Recommendation 19 in CEDAW calls upon states to take measures to combat gender-based violence, which can impair the ability of women to access their human rights and fundamental freedoms—including the right to life; the right not to be subject to torture or cruel, inhuman, or degrading treatment or punishment; the right to legal protection; the right to liberty and security of person; the right to equal protection under the law; and the right to the highest attainable standard of health. Recommendation 19 recognizes the need for special protection of “prostitutes” because of their particular vulnerability to violence. CEDAW’s General Recommendation 24, meanwhile, emphasizes the importance of states to closely consider the societal determinants of health, paying particular attention to the health needs and rights of women belonging to vulnerable and disadvantaged groups, including migrant women and women engaged in sex work.

Health and human rights have a reciprocal relationship—the right to health can only be achieved when individuals have the ability to obtain consistent and equitable access to health care and as well as to seek redress for human rights violations. This relationship underpins the importance, as stated previously, of removing legal prohibitions against sex work and seeking to reduce stigma and discrimination against those engaged in it. Where sex work is criminalized, sex workers’ concerns about safety, security, and physical and psychological abuse are not integrated

\textsuperscript{24} Convention on the Elimination of all Forms of Discrimination against Women, 1979.
into the public legal and health sectors. When their activity is illegal or not regulated, sex workers often avoid any contact with law enforcement out of fear of persecution or harassment. Decriminalization of sex work is the first key step to effectively and comprehensively applying the international human rights framework to sex workers. One additional international agreement of relevance to sex work is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which was adopted by the UN General Assembly in December 1990 and entered into force upon its 20th ratification in 2003. Although it does not specifically mention sex workers or prostitution, the agreement provides a broad definition of what constitutes a migrant worker and draws a distinction between migrant workers who are lawfully working within the host state and those in “irregular” situations (illegal). The convention obliges the state parties to guarantee all migrant workers, regardless of their legal status, a limited selection of social, economic, and cultural rights. All should have the right to non-discrimination with respect to remuneration and conditions of work, and the right to participate in trade unions. This is not a very widely ratified agreement at this point; as of October 2008, just 39 states worldwide had acceded to it or ratified it. The convention’s ability to help protect the rights of migrant sex workers will be greatly enhanced in countries where sex work itself is legalized. Some observers believe that greater protection of the rights of sex workers would be obtained through a special UN-level international declaration that would contain an overall acceptable definition of sex work and would spell out the international human rights pertaining to sex work—and call upon governments to decriminalize sex work. Others, meanwhile, believe that such a strategy is unnecessary because CEDAW and the International Covenant on Economic, Social, Cultural and Political Rights in particular provide adequate protections for sex workers, assuming their provisions are enforced. They also express concern.

25 Sex work, HIV/AIDS and Human Rights (Report 2005) p. 36
that a special overarching UN declaration might in fact be counterproductive given the current opprobrium-influenced political and social climate regarding sex work. In their opinion, the declaration would likely be much weaker than intended, thus undercutting the rights established by the other two existing conventions.

Prostitution is not illegal under Zambian law; however, it is illegal to solicit customers or to live off the earnings of someone engaged in sex work. Sections 146(1) and 147 of the Penal Code states that: “Every male person who (a) knowingly lives wholly or in part on the earnings of prostitution; or (b) in any public place persistently solicits or importunes for immoral purposes; is guilty of a misdemeanour”. (147) Every woman who knowingly lives wholly or in part on the earnings of the prostitution of another or who is proved to have, for the purpose of gain, exercised control, direction or influence over the movements of a prostitute in such a manner as to show that she is aiding, abetting or compelling her prostitution with any person, or generally, is guilty of a misdemeanour.\(^\text{26}\) Section 3.8.2 of the 2002 National 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 them to take responsibility for their partners’ sexual health.\(^\text{27}\)”

2.5 PRISONERS

HIV/AIDS is a serious health threat for prison populations in many countries, and presents

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\(^{26}\) Zambian Penal Code

significant challenges for prison and public health authorities and national governments. Worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons. This situation is often accompanied and exacerbated by high rates of other infectious diseases such as hepatitis and tuberculosis. The generally accepted principle that prisons and prisoners remain part of the broader community means that the health threat of HIV within prisons, and the health threat outside of prisons, are inextricably linked and therefore demand coordinated action. Internationally, high rates of HIV infection in prisons reflect two main scenarios:\textsuperscript{28}

a. Countries in which there are high rates of HIV infection among injecting drug users, many of whom spend time in prison, and some of whom continue to inject while incarcerated. In these countries, high rates of HIV (and HCV) infection are related primarily to sharing of injecting equipment outside and inside prison.

b. Countries (primarily in Africa) in which there are high rates of HIV infection in the general population, infection rates driven primarily by unsafe heterosexual sex. In these countries, high rates of HIV infection among prisoners are related to high rates of HIV infection in wider population as a whole. The continued spread of HIV within the prisons in these countries is related especially to sexual contact (primarily men having sex with men), as well as unsafe medical practices, rather than to injecting drug use.

Despite this situation, many countries have yet to implement comprehensive HIV prevention programmes in prisons, or achieve a standard of prison health care equivalent to the standard

\textsuperscript{28} United Nation Office on Drugs and Crime (HIV/AIDS Prevention, care, treatment and support in prison settings) A Frame work for an Effective National Response (2006) p.7
outside of prison, thereby jeopardizing the health of prisoners, prison staff, and the wider community.

Like all persons, prisoners are entitled to enjoy the highest attainable standard of health. This right is guaranteed under international law in Article 25 of the United Nations Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social, and Cultural Rights. Furthermore, the international community has generally accepted that prisoners retain all rights that are not taken away as a fact of incarceration, including the right to the highest attainable standard of physical and mental health. Loss of liberty alone is the punishment, not the deprivation of fundamental human rights. States therefore have an obligation to implement legislation, policies, and programmes consistent with international human rights norms, and to ensure that prisoners are provided a standard of health care equivalent to that available in the outside community.

The vast majority of people committed to prison eventually return to the wider community. Therefore, reducing the transmission of HIV in prisons is an integral part of reducing the spread of infection in the broader society, as any diseases contracted in prison, or any medical conditions made worse by poor conditions of confinement, become issues of public health for the wider society when people are released. Its very important that governments promote public heath, and prevent the spread of HIV in prisons and in the wider society.

It has been acknowledged officially that sex between men occurs in African prisons. Sexual acts between men in enclosed environments such as prisons may arise from coercion, but is also a
pragmatic or preferred form of sexual expression. The high incidences of HIV and the high toll due to AIDS in prison are at least to some extent due to the infection of prisoners while they are in prison\textsuperscript{29}.

There are approximately 13 000 men and women in Zambia’s prisons. Prisoners’ vulnerability to HIV/AIDS stems from engaging in unprotected sex, which is usually in the form of rape. There is an extremely high prevalence rate of STDs, and very low and inconsistent use of condoms in prisons. There are no official policies in place to stop the spread of HIV/AIDS in prisons; the distribution of condoms in prisons is prohibited by law and there is no policy on HIV testing and education in prisons. The number of prisoners who are HIV positive is unknown. This is due to the fact that no prison has the testing facilities available to conduct HIV surveillance studies.

An NGO called In But Free seeks to promote HIV/AIDS prevention in prisons using inmates and officers as key players in the intervention measures. These measures include:\textsuperscript{30}

- training inmates as peer educators (PEs);
- training prison officers as counsellors;
- producing and distributing IEC materials;
- HIV/AIDS counselling and testing; and
- providing nutritional support for ill inmates. Despite the efforts of In But Free, prisoners have little or no access to medical care, thus delaying the timely diagnosis and treatment of STDs. HIV-positive prisoners do not have access to ARVs. HIV-positive prisoners are not kept separately from other prisoners.

\textsuperscript{29} F. Viljoen International Human Rights Law in Africa (Oxford: At the University Press, 2007) p. 598.
\textsuperscript{30} AIDS and Human Rights Research Unit (Pretoria: At the University Law press, 2007)
2.6 Conclusion

The government has to diligently adhere to it’s obligation to protect the right of those infected and affected by HIV/AIDS especially those who are already disadvantaged in society as they are the most vulnerable to HIV and AIDS. They also have to implement laws that will address the root cause of the problem.
Chapter 3

Legal response of HIV/AIDS:

3.1 Introduction:

Criminal law is one field in which reactive legislation has been adopted. Criminal measures send the message that HIV is an external danger and source of deviance that threatens an HIV-free society. Upholding the rights of victims of rape, for example, serves the right to bodily integrity and security of the person. Notwithstanding, in many countries laws were adopted to codify or clarify the current statutory or common law position. In addition, criminalization efforts resulted in the creation of new offences, such as HIV exposure or negligent transmission. However, the danger always lurks that these measures may target those already at the greatest risk and blamed for the spread of HIV, such as women and migrants.

3.2 Criminalization of HIV/AIDS:

In a number of African states, sentences for HIV-positive perpetrators of sexual offences (including rape) have increased. Deterring transmission of HIV through rape is aimed at upholding the human right of bodily integrity and security. Nevertheless, these legislative provisions have human rights implications also in their formulation. In Botswana, for example, a minimum sentence of 15 years applies if an accused is convicted for rape and it is shown that he was HIV positive at the time of conviction, even if he had been unaware of this fact when he committed the offence. If by a balance of probability it is shown that he had been aware of his status at the time, the minimum sentence is 20 years. The Court of Appeal held the first of these provisions, article 142(2)(a), to be unconstitutional, as its discriminatory effect could not be

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31 F. Viljoen International Human Rights Law in Africa. (Oxford: At the University Press, 2007)
32 Botswana Penal code(Cap 08.01) art. 142(2)(a)
justified in light of the possibility that the suspect tested positive after the commission of the offence, or that he may have contracted the infection during his commission of the offence.\textsuperscript{34} The constitutionality of the second provision, article 142(2)(b), was upheld on the basis that it constituted a reasonable limitation serving the purpose of deterrence.

The feasibility of imposing criminal sanctions in the real of HIV and their contribution to addressing the root causes of the increases in HIV prevalence is questionable. It appears that legislation is directed at symbolical issues such as public outrage at isolated events rather than at the real factors that drive the HIV epidemic in the region.\textsuperscript{35} In the absence of anything more than a handful of persecutions, these penal measures remain mostly symbolical. Criminal measures are often not used due to the social cost of lodging a compliant, problems of proof, and generally dysfunctional criminal justice systems. However, given that all these inhibiting factors were foreseeable when the relevant laws were adopted, the laws serve only to further demonize and stigmatize HIV and to legitimize social opprobrium and even violence against HIV-positive people. Highly symbolical and largely unenforced, most of the criminal laws adopted in response to HIV may be categorized as highly ineffectual laws.\textsuperscript{36}

Nonetheless, the criminal law may have a positive contribution to make. The Mauritius HIV and AIDS Act provides an example of a right based criminal law provision that addresses stigma.\textsuperscript{37} The Act makes it an offence for any person to treat 'any other person or his relative unfairly,

\textsuperscript{33} Ibid art. 142(2)(b)
\textsuperscript{34} Makuto v. State[2000] 5 LRC 183 (Botswana)
\textsuperscript{35} F. Viljoen International Human Rights Law in Africa. (Oxford: At the University Press, 2007)
\textsuperscript{37} Adopted 22 December 2006, not yet in force
unjustly' or with 'hatred, ridicule or contemp' on account of 'being, or being perceived as being, infected with HIV'.\textsuperscript{38} Other positive roles of criminal law are manifest criminalization of martial rape, as is the case in South Africa,\textsuperscript{39} the criminalization of female circumcision and of sexual harassment.\textsuperscript{40} Although these measures may also be consigned to Highly Ineffectual Laws if they remain unenforced, they are not merely symbolic, but address the root causes of HIV infection.

There are no HIV/AIDS-specific provisions in Zambian criminal law. However various NGOs such as the YWCA have been advocating harsher sentences for rapists and other sex offenders for harmful HIV-related behaviour. Section 3.9.1 (b) of the 2002 National Policy states that mandatory testing should be legalised in the case of persons charged with any sexual offence that could involve risk of HIV transmission. Moreover, Section 3.9.6 of the 2002 National Policy mentions the provision of a framework to deal with the willful transmission of HIV, stating that the government shall legislate against willful transmission of HIV and will put in place support systems for victims and offenders in the form of counselling, education, information, rehabilitation and appropriate therapy.\textsuperscript{41}

3.3 Punishing harmful conduct

If some one knows that he or she is HIV positive, acts with the intent to transmit HIV and does transmit HIV, that person's state of mind, behaviour, and the resulting harm justifies punishment. Such malicious acts in the context of HIV are rare, and the available evidence shows that most

\textsuperscript{38} Mauritius HIV and AIDS Act art. 18(3)
\textsuperscript{39} Domestic Violence Act 113 of 1993, s 5
\textsuperscript{40} Kenyan Sexual Offences Act, ss 23 and 31.
\textsuperscript{41} National HIV/AIDS/STD/TB Policy, February 2002
people living with HIV who know their status take steps to prevent transmitting HIV to others.\textsuperscript{42} In situations apart from intentional transmission, criminal prosecution is not warranted. For example, the criminal law is not appropriately applied where a person has disclosed his or her HIV-positive status to a partner (who is able to consent freely to sex), where that partner is already aware through some other means that the person is HIV-positive, or where the HIV-positive person takes steps to reduce the risk of HIV transmission (e.g. by using condoms or otherwise practising safer sex by avoiding higher risk activities). Such actions indicate that the person did not intend to transmit HIV, and that their conduct should not be considered reckless. To prosecute people in such situations would be directly contradicting efforts to prevent HIV transmission by encouraging safer sexual practices, voluntary HIV testing and voluntary disclosure.

Much onward disclosure takes place soon after a person has acquired HIV, when his/her infectiousness is high and before the person knows or suspects s/he is HIV-positive or s/he may be passing the virus onto others.\textsuperscript{43} After this period, many people still do not learn their status, either because they do not have access to confidential voluntary HIV testing and counselling or because they are afraid to be tested due to negative consequences, such as discrimination or violence, which might arise from a positive diagnosis. In such cases, people are unknowingly transmitting HIV and should not face criminal prosecution.

\textsuperscript{42} Bunnell R 'Changes in sexual risk behaviour and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda' (2006)

\textsuperscript{43} Brenner BG 'High rates of forward transmission events after acute/early HIV-1 infection' Journal of Infectious Diseases (2007)
3.4 Concerns about miscarriage of justice:

Extending criminal liability beyond cases of deliberate or intentional HIV transmission to reckless conduct should be avoided. Such broad application of the criminal law could expose a large number of people to possible prosecution without their being able to foresee their liability for such prosecution. Prosecution and convictions are likely to be disproportionately applied to members of marginalized groups, such as sex workers, men who have sex with men and people who use drugs. These groups are often blamed for transmitting HIV despite insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safer behaviours with their partners due to their marginalized status.\(^\text{44}\) In jurisdictions where HIV transmissions has been criminally prosecuted, the very few cases that are prosecuted out of the many infections that occur yearly often involve people from ethnic minorities, migrants or men who have sex with men.\(^\text{45}\)

The inappropriate or overly-broad application of criminal law to HIV transmission creates also a real risk of increasing stigma and discrimination against people living with HIV, thus driving them further away from HIV prevention, treatment, care and support services. Establishing who transmitted HIV to who is often difficult (particularly where both parties have had more than one sexual partner) and may depend on testimony alone. People charged with HIV transmission may thus be found guilty in error. Phylogenetic testing can only determine the degree of relatedness


\(^{45}\) GNP+ Europe and Terrence Higgins Trust Criminalisation of HIV transmission in Europe (2005)
of two samples of HIV and cannot establish beyond a reasonable doubt the source, route or
timing of infection, it is also not available in many jurisdictions and is very costly.\textsuperscript{46}

There is no data demonstrating that the threat of criminal sanctions significantly changes or
deters the complex sexual and drug using behaviours which may result in HIV transmission. Available data show no difference in behaviour between places where laws criminalizing HIV transmission exist and where they do not.\textsuperscript{47} Further more using criminal law beyond cases of intentional transmission could actually undermine effective HIV prevention efforts in the following ways:

- It could discourage HIV testing, since ignorance of ones status might be perceived as the best defence in a criminal law suit. This would obstruct efforts to increase the number of people accessing testing and being referred to HIV treatment, care and support. HIV testing and treatment are vital for HIV prevention because people who receive a positive diagnosis usually change their behaviour to avoid transmitting HIV and because taking antiretroviral therapy reduces infectiousness and likelihood of onward HIV transmission.

- It places legal responsibility for HIV prevention exclusively on those already living with HIV and dilutes the public health message of shared responsibilities for sexual health between sexual partners. People may (wrongly) assume their partners are HIV negative because they have not disclosed, and thus not use protective measures.

\textsuperscript{46} Bernard E ‘The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission’ (2007)
- It could create distrust in relationships with health service professionals and researchers and impede the provision of quality care and research, as people may fear information regarding their status may be used against them in a criminal case.

Behind some efforts to criminalize HIV transmission is the understandable desire to prevent the transmission of HIV to vulnerable women and girls and to punish men who have infected them. In many societies, women and girls are particularly vulnerable to HIV due to cultural norms which sanction multiple sexual partners for men, sexual coercion and other forms of gender-based violence and discrimination in education and employment which makes it difficult for women to leave relationships which place them at risk of exposure to HIV. Reports indicate many women have acquired HIV in marriages and other intimate relationships, including where rape and sexual coercion has occurred.48

Yet ironically applying criminal law broadly to HIV transmission may result in women being disproportionately prosecuted. Women often learn they are HIV positive before their male partners because they are more likely to access health services and thus, are blamed for bringing HIV in the relationship. For many women it is also difficult or impossible to negotiate safer sex or to disclose to their status to a partner for fear of violence, abandonment or other negative consequences. Women may face prosecution as a result of their failure to disclose for valid reasons.

48 Report on the ARASA/OSISA Civil Society Consultative Meeting on the Criminalisation of the willful transmission of HIV, Johannesburg, South Africa June 2007
In such situations the better way to protect women from exposure to HIV is to enact and enforce laws protecting them from sexual violence, discrimination based on gender and HIV status and inequality in employment, education and domestic relations, including property, inheritance and custody rights.

There is 30% risk of transmission from a HIV-positive mother to her child during pregnancy, delivery or via breastfeeding. This risk is significantly reduced when the mother and child are given antiretroviral treatment, but in 2007 only an estimated 34% of pregnant HIV-positive women in need were receiving such treatment.\(^{49}\)

Some countries have enacted or are considering legislation which criminalize mother to child transmission. This is inappropriate because:

-Everyone has a right to have children,\(^{50}\) including mothers living with HIV'

-When pregnant women are counselled about the benefit of antiretroviral therapy, almost all agree to being tested and receiving treatment.

-In the rare cases where pregnant women may be reluctant to undergo HIV testing or treatment, it is usually because they fear that their HIV-positive status will become known and they will face violence and discrimination or abandonment.

-Forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for mother to child transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent and

\(^{49}\) Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals Report of the Secretary General (2008), UN Document A/RES/60/262

\(^{50}\) Art.16 of the United Nations Declaration of Human Rights
-often, HIV-positive mother have no safer options than to breastfeed, because they lack breast milk substitute or clean water to prepare formula substitute.

Public health measures including counselling and social support are more appropriate to deal with the rare cases of pregnant women or mothers with HIV who refuse treatment. Governments should ensure both parents have information and access to HIV testing and treatment. Women also need effective measures to protect them and their infants from violence and discrimination related to their HIV status.

3.5 Alternatives to criminal law

Instead of applying criminal law to HIV transmission, governments should expand programmes which have been proven to reduce HIV transmission while protecting the human rights both of people living with HIV and those who are negative. Such measures include providing HIV information, support and commodities to people so they so they can avoid exposure to HIV through practicing safer behaviours increasing access to voluntary (as opposed to mandatory) confidential HIV testing and counselling, and addressing HIV-related stigma and discrimination. Prevention programmes should include positive prevention efforts which empower people living with HIV to avoid transmitting HIV to others, to voluntary disclose their positive status in safety, avoid new sexually transmitted infections and delay HIV disease progression.

Government should also strengthen and enforce laws against rape (inside and outside marriage) and other forms of violence against women and children, improve the efficacy of criminal justice systems in investigating and prosecuting sexual offences against women and children, and
support women’s equality and economic independence, including through concrete legislation, programmes and services. These are the most effective means by which to protect women and girls from HIV infections and should be given the highest priority.

Such public health and legislative measures are necessary for states to realize their commitments to achieve universal access to HIV prevention, treatment and support by 2010, and to halt and begin to reverse the spread of HIV by 2015.\textsuperscript{52}

The two main reasons advanced for criminalizing HIV transmission are to:

- Punish harmful conduct by imposing criminal penalties and
- Prevent HIV transmission by deterring or changing risk behaviours.

Except in the rare cases of intentional HIV transmission, applying criminal law to HIV transmission does not serve these goals.

3.6 Conclusion:

Some countries have enacted HIV-specific criminal legislation making it a crime to transmit or expose another person to HIV and there are public calls in other countries where it does not yet exist. On one hand it is obviously reprehensible for a person knowingly to infect another with HIV or any other life-endangering health condition. On the other hand, using criminal sanctions for conduct other than clearly intentional transmission may well infringe upon human rights and undermines important public policy objectives. I do accept that the use of criminal law may be warranted in some circumstances, such as in cases of intentional transmission of HIV or as an aggravating factor in cases of rape and defilement. Before rushing to legislate, however we

\textsuperscript{51} International Guidelines on HIV/AIDS and Human Rights Guideline 3(b)
\textsuperscript{52} Millennium Development Goal 6
should give careful consideration to the fact that passing HIV-specific criminal legislation can further stigmatize persons living with HIV, provide a disincentive to HIV testing, create a false sense of security among people who are HIV-negative and rather than assisting women by protecting them against HIV infections, impose on them an additional burden and risk of violence or discrimination. Finally there is no evidence that criminal laws specific to HIV transmission will make any significant impact on the spread of HIV or on halting the epidemic. Therefore, priority must be given to increasing access to comprehensive and evidence informed prevention methods in the fight against HIV/AIDS.
Chapter 4

Challenges to a Human Rights based approach to HIV and AIDS:

4.1 Introduction:

In the last few years, the human rights-based response to HIV and AIDS has increasingly been questioned, not only from a public health perspective but also from 'within' the human rights movements. Two particular issues, both questioning the traditional wisdom of applying a human rights-based approach, have been raised, namely, shared confidentiality or compulsory disclosure to sexual partners or even to family members, and routine testing. Criticizing the approach followed so far as ‘HIV and AIDS exceptionalism’, which allowed HIV and AIDS to be exempted from traditionally proven public health tenets, it is argued that the disclosure of HIV status and test results should correspond as far as possible to that of other diseases.

4.2 Disclosure:

The scale of the epidemic prompted an erosion of the right to privacy and confidentiality. 'Privacy' may be defined as the state or condition of being free from public attention. The right to privacy, accordingly, is an individualistic right, the ultimate right to be left alone, indicating an individual self separated from collective identity and rooted in personal preferences. The right to privacy is often associated with claims pertaining to 'nobody's business but mine', which may include decisions concerning sexual relationships.

55 Longman Dictionary of Contemporary English
The law in some countries imposes a legal obligation to disclose one’s HIV positive status to sexual partners or others, such as health-care workers. UNAIDS does not support a legal obligation to disclose one’s HIV-positive status. Everyone has the right to privacy about their health and should not be required by law to reveal such information, especially where it might lead to serious stigma, discrimination and possibly violence, as in the case of HIV status. However, all people have the ethical obligation not to harm others. Governments should provide HIV programmes for HIV-positive people that empower them to practice safer sex and/or voluntarily disclose their status in safety. This was agreed in the Political Declaration on HIV (2006) and includes government’s commitments to ensure laws and programmes to protect people against discrimination and other human rights abuses based on HIV status. To protect themselves from exposure to HIV in health-care settings, health-care workers should have access to and training on universal precautions against all blood-borne pathogens, including HIV.

The International Guidelines on HIV/AIDS and Human Rights advises that public health legislation should authorize, but not require, that health professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria.

- The HIV-positive person in question has been thoroughly counselled.
- Counselling of the HIV positive person has failed to achieve appropriate behavioural changes.
- The HIV positive person has refused to notify or consent to the notification of his/her partner(s).
- A real risk of HIV transmission to the partner(s) exists.
- The HIV-positive person is given reasonable advance notice.

- The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice.

- Follow up is provided to ensure support to those involved, as necessary.

Particular consideration and support should be given to HIV-positive women who may not be able to disclose their status for fear of violence or other negative consequences.

In the era of HIV and AIDS, other notions of privacy have been advanced. These depart from a premise of a collective interest or stake in private knowledge, and give rise to the notion of confidentiality. In terms of a World Health Organization Fact Sheet, shared confidentiality is confidentiality that is shared with others such as family members, loved ones, care-givers and trusted friends. According to the Fact Sheets, sharing confidentiality is in the discretion of a person who has tested for HIV. The notion of shared confidentiality is premised on the view that confidentiality, as one-on-one exchange between the healer and the patient, rarely exist in tradition African culture.\textsuperscript{56} However, the effect of this understanding of privacy is that it undermines the right of HIV-positive persons, exposing them to discrimination and even violence in society where stigma is rife.

A practical illustration of shared confidentiality is found in Botswana’s National Policy on HIV. It proposes shared confidentiality as an ideal, but stresses that consent should be obtained from the HIV-positive person before the information is divulged. Ideally those who need to know in order to provide appropriate health and social assistance should be told about a person’s HIV

\textsuperscript{56} EM Ankran and LO Gostin, \textit{Ethical and Legal considerations of the HIV Epidemic in Africa} (New York: Raven Press, 1994)
status. This policy flows from the premise that the individual is inextricably linked to a family and a community. The family is, therefore, encouraged to be involved from the pre-testing phase, as a support structure, and not as a potential threat. According to this vision, HIV and AIDS is regarded not as a matter of placing blame but of drawing together to cure.57

A more extreme form of shared confidentiality has found its way into the Botswana Medical Council (Professional Conduct) Regulations 1988, allowing doctors to share confidential information about the HIV status of patients. The amended regulations provide that a person taking care of, living with or otherwise coming into regular close contact with the patient shall be informed about such patient's consent for such a disclosure, the notion of shared confidentiality has been extended. The broad category of people to whom the information may be disclosed (even including those with whom the patient has 'regular close contact'), and also the fact that non of them is under an obligation to keep the information confidential, led Zuyderduin and Melville to conclude that these regulations are unconstitutional.58

The African Union's major normative framework dealing with the rights of women, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol), also invokes notions of shared confidentiality. Provisions included under the heading 'health and reproductive rights' require that a state party ensures that its legal system provides for the right to be informed on one's health status and on the health status of one's partner,

57 S Bockie, Death and the Invisible Powers (Blooming, Ind: Indiana University Press, 1993)
58 A Zuyderduin and I Melville, 'Shared Confidentiality- An ethical Dilemma in Botswana' paper prepared for XIII AIDS Conference, Durban, 5 July 2005
particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognize standards and best practices.\textsuperscript{59}

Internationally recognized standards protect the confidentiality relationship between doctor and patient as part of the right to privacy.\textsuperscript{60} In general, confidentiality regarding all medical information has to be guaranteed, including HIV status. An exception to the general rule may be invoked only when predetermined guidelines have been followed, allowing as a matter of last resort disclosure to a specific person at immediate and clear demonstrated risk of infection. Such an approach, deprived from the principle that all rights may be limited by the right of others (such as right to life), is more in line with international standard than vague notion of shared confidentiality.

4.3 Routine Testing:

The urgency of placing millions of people on ARV treatment in a short time has led to argue that traditional safeguards such as pre- and post-test counselling, confidentiality and voluntariness should not stand in the way of widespread HIV testing.\textsuperscript{61} Widespread testing, it is argued, will both facilitate increased access to HIV treatment and prevent new infections by bringing more people into the health care system, enabling the provision of information on how to prevent HIV transmission. In addition, widespread testing is thought by many to reduce HIV-related stigma and discrimination by normalizing the disease as more people learn their status, it is argued, AIDS will come to be perceived as yet another chronic, manageable illness such as cancer or heart disease. These arguments are raised particularly with reference to Africa, where the

\textsuperscript{59} Art 14(1)(e) of the protocol
\textsuperscript{60} Universal Declaration of Human Rights, art. 1 and 3

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discrepancy between HIV infection rate and individual knowledge of HIV status is at its starkest.\textsuperscript{62}

Even if routine offer or opt-out testing and not compulsory testing is proposed, there are still human right issues involved.\textsuperscript{63} Although routine testing is advertised as voluntary, because it allows patients to refuse, the routine nature of the offer in the context of an unequal power relationship between unsophisticated patients and health care workers impedes individuals agency. In addition, the proposed guidelines and most proponents accept the inevitability, occasioned by an increase in number, of scaled down pre-test counselling. The form of consent required by UNAIDS/WHO under routine testing is simplified informed consent. In the UNAIDS/WHO 2004 Policy Statement on HIV Testing, informed consent is simplified by being reduced to the following elements: a review of the clinical and prevention benefits of testing, the right to refuse, follow-up services, and the importance of informing someone (a partner) at risk if the test is positive. A full education and counselling session is not required, as voluntary counselling and testing (VCT) services are adapted to simply ensure informed consent, without a full education and counselling session.

International human rights laws recognizes the individual right to withhold consent to medical treatment, including diagnostic test. This right derives from the principle of individual autonomy, which has its roots in the inherent dignity of every individual. Testing for HIV without informed consent represents an involuntary intrusion into bodily integrity, which is protected by the right

\textsuperscript{61} KM De Cock, 'HIV Testing in an Era of treatment scale up' (2005)
\textsuperscript{62} F. Viljoen International Human Rights Law in Africa. (Oxford: At the University Press, 2007)
to liberty and security of the person in article 9 of the International Covenant on Civil and Political Rights (ICCPR).\textsuperscript{64}

Under international law (as well as under some domestic constitutions), rights may only be limited by way of laws of general application that pursue a legitimate aim responding to a pressing social need, and that are proportionate to the aim.\textsuperscript{65} In addition, governments must use the least restrictive means possible to achieve those aims. Under the same legal regime, the onus of showing that an inroad into rights is justified rest with the party introducing the encroachment. To meet this standard of persuasion, proponents of routine testing have argued that some curtailment of the right to informed consent maybe justified to ensure that new medical advances particularly ARV treatment, will reach people living with HIV at a large scale. They all accept, as do the WHO Guidelines that the availability of treatment must serve as a prerequisite for testing. However, in reality in most of Africa there is no guarantee that the tested person will indeed receive ARVs due to the unavailability of these medications in many African settings. Even if ARVs are available, there is no guaranteed benefit to the tested person, due to the general requirement that only HIV-positive people with a CD4 count of less than 200 qualify for ARV treatment. Thus, it cannot be assumed that the trade-off being proposed universal treatment in exchange for a reduction in individual rights even exists.\textsuperscript{66} While appropriate treatment may become increasingly available, the present drive towards routine testing is premature. Less restrictive means such as increasing access to VCT, have to be exhausted before this radical departure from the rights-based approach can be supported.

\textsuperscript{64} ICCPR, arts 9 and 10
\textsuperscript{65} Ibid arts 12(3) and 18(1)
\textsuperscript{66} F. Viljoen International Human Rights Law in Africa. (Oxford: At the University Press, 2007)
Other justifications are premised on similar shaky grounds, some proponents of routine testing argue that an increase in the number of people who are tested for HIV, thus learning their status, will lead to a decrease in stigma and discrimination. In this sense, proponents of routine testing depart from the school AIDS exceptionalism, which argues that AIDS is a uniquely stigmatized disease requiring specific human rights protection.

It is true that access to ARVs could contribute to the de-stigmatization of AIDS by reducing the prevalence of body marks associated with opportunistic infections, such as wasting or Kaposi’s sarcoma. Once HIV is perceived as a chronic but treatable condition, one of the factors that amplifies stigma fear of contagion and inevitable death is lessened. However, stigma is much more than fear of contagion. It is related to the perception that HIV infection results from immoral behaviour such as extra-marital sex, homosexuality, prostitution, or injection drug use. While downgrading HIV to the status of a manageable disease may go some distance towards addressing HIV/AIDS-related stigma, it is unlike on its own to alter deeply rooted perceptions of the moral stature of people living with AIDS. On the contrary, information about a person’s status may be dangerous or even deadly, exposing him or her not only to stigma, but also to its physical manifestation such as violence. Without a greater guarantee that such attitudes will be addressed, individuals should not be expected to trade away their individual rights to inform consent for the merger prospect of a stigma-free world or even treatment. Because treatment does not guarantee that HIV-positive persons become non-infectious, the fear of infection remains as does the need for sex and prevention programmes.
The only justification that does merit serious consideration is that an HIV test empowers a patient to make more rational choices. Far from being a means of empowerment, routine testing and possible disclosure may make the position of women much more precarious. Not only is there a likelihood that the confidentiality of test results could be breached, but as women are more likely than men to come into contact with the health system (largely because of antenatal services), routine test may reinforce stereotype about women being the principle carries of HIV infection. Women may thus suffer very greatly from the consequences of routine testing emotionally, physically, and economically. Unless tests are offered in an environment in which efforts are made to establish what ongoing support the women will need, what kind of support is available to the women, and in the absence of family or community support, who she can turn to and has the basic fundamentals of good pre-test counselling, she should not be offered the test. In addition, for many women the option of opting out of the HIV testing in the face of pressure from a medical professional is not realistic.

In Zambia, HIV/AIDS/STI/TB are notifiable diseases under the Public Health Act (Infectious Diseases Regulations).[^67] A policy on testing for HIV exists and is based on informed consent and pre- and post-test counselling. Section 3.9.2 of the 2002 National Policy states the following in terms of partner notification: “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/spouses.”[^68] The principle of partner notification is also addressed in one of the policy statements in the 2000 Guidelines on HIV/AIDS Counselling in Zambia which states:

[^68]: Ibid page 27
“Promotion of partner notification, social behaviour change and individual responsibility to prevent further HIV infection shall be an integral part of preventive counselling.”69 The Guidelines on HIV/AIDS Counselling further mentions that compulsory and mandatory HIV testing is a violation of human rights and shall only be allowed in exceptional circumstances.70

4.4 Conclusion:

The right to privacy is the right to control information about self. A legal obligation should not be placed on an individual to disclose his or her HIV-positive status. The right to privacy on health should be left to the individual, however as has been stated in this chapter all people have the ethical obligation not to harm others. The notion of shared confidentiality, even if consent is obtained from the HIV-positive person before the information is given out to sexual partners or his family has to be brought up to internationally recognised standards so as to protect the HIV-positive person from serious stigma, discrimination and possibly violence. Routine testing may help to get good number of HIV-positive people on ARV’s and help the government make informed judgments regarding the appropriate public health response to the epidemic, its important that human rights of the HIV-positive person are protected.

Chapter 5

5.5 Conclusion

In most African countries governments have, on the whole, complied with the obligation to promote rights by adopting policy statements and embarking on educational and sensitization campaigns to prevent and curtail the spread of HIV. However, these policies, themselves, have not been disseminated systematically or comprehensively, and their effectiveness has been seriously questioned.

In Zambia there is no specific piece of legislation on HIV/AIDS and Human Rights, however the country has made strides that aid in the fight for respect, protection and fulfillment of various human rights that reflect in the fight against the pandemic. From an international perspective, Zambia has ratified/acceded to various international treaties that make it accountable to the international community when it comes to upholding various human rights.

The human rights response of countries should move beyond mere rhetoric and policy to legislation the basis of human rights-based approach. Such a response could, for example, take the form of a comprehensive statute, a Human Rights and HIV/AIDS Act. This Act might spell out government's duty to promote the rights of all affected, by placing a legal duty on government to widely disseminate its policies and to embark on effective awareness-raising campaigns, the duty to prevent, by addressing the legal rules underlying gender inequality, such as those related to divorce law, the inheritance of property, and the status of women, the duty to fulfill, by converting social security benefits and health care into legal entitlements.
5.2 Recommendations

Since it has been established that there seems to be no specific piece of legislation on HIV/AIDS and Human Rights in Zambia, the following recommendations are given for consideration:

1. Zambia should comply with international and regional treaty obligations and domesticate the provisions of these treaties through national legislation.

2. Zambia should review and revise national legislation on social assistance and security to provide specifically for AIDS orphans, families caring for people with AIDS, and people living with AIDS. This would avoid the difficulties of interpreting claims in terms of disability grants.

3. Zambia should develop a separate national policy on voluntary HIV testing, pre- and post-test counselling and factors affecting confidentiality (such as informing an HIV-positive person's partner of his/her status), and avoid the principle of shared confidentiality.

4. Zambia should develop legislation protecting the rights of volunteers in medical trials testing the effects of new HIV drugs and vaccines. Legislation should also regulate the treatment of HIV-positive patients by private and public health care services, specifically prohibiting discrimination against HIV-positive patients.

5. HIV/AIDS-specific legislation prohibiting discrimination on the grounds of HIV status should be developed for all spheres.

6. The Country has to develop HIV/AIDS-specific legislation for the workplace, this must be made a priority, focusing on issues such as non-discrimination against HIV-positive
employees, prohibition of pre-employment HIV testing, offering medical benefits that cater for the special needs of HIV-positive employees, and ensuring that employees have access to information and educational programmes on HIV/AIDS.

7. Legislation should be promulgated to regulate public and private medical schemes in an effort to ensure that people living with HIV/AIDS are not discriminated against or excluded.

Recommendations to the School of Law:

Currently the School of law at the University of Zambia does not offer AIDS Law as a course, it is recommended that the School introduces the course.


5. GNP+ Europe and Terrence Higgins Trust, ‘Criminalisation of HIV transmission in Europe’ (2005)


11. UN Document A/RES/60/262 Declaration of Commitment on HIV/AIDS and Political

Declaration on HIV/AIDS: midway to the Millennium Development Goals, Report of
the Secretary General (2008)

12. Viljoen, F. International Human Rights Law in Africa. (Oxford: At the University
Press, 2007)