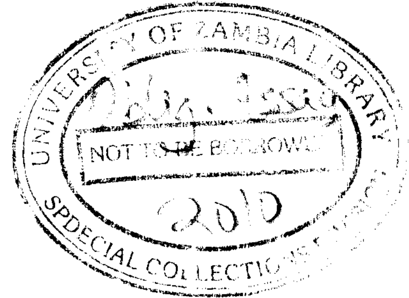
EXTENT OF THE ENJOYMENT OF THE 4 ACCESS ELEMENT OF THE RIGHT TO HEALTH BY PERSONS LIVING WITH HIV/AIDS IN ZAMBIA



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BY

DANIEL SINJWALA LIBATI

A dissertation submitted to the University of Zambia Law Faculty in partial fulfilment of the requirement for the award of the Degree of Bachelor of Laws (L.L.B.)

UNZA APRIL 2010

THE UNIVERSITY OF ZAMBIA

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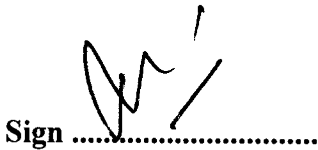

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Abstract

From October 2009 to March 2010 this research was conducted into the legal framework within which the right to health is enjoyed by persons living with HIV in Zambia. Quite particularly, this research was into the extent to which persons living with HIV/AIDS can be said to be enjoying the 'four (4) Access' (4As) element of the right to health. On the one hand it has been a research into the right to health as it exists in Zambia and on the other hand, the extent of the enjoyment of the 4As element of the right to health by persons living with HIV/AIDS in Zambia. A plethora of documents have been referred to. In conducting the research two questions were sought to be asked; (a) to what extent does the right to health exist in Zambia? And two (b) to what extent does a person living with HIV/AIDS enjoy the element of the 4As of the right to health in Zambia? A desk review of documents relevant to the research was conducted and so was a focus group discussion of key informants, PLWHIV. In the end, the research came to the conclusion that international instruments that although ratified and assented to by Zambia cannot be applied unless they are domesticated. The Constitution provides for the right to health, or at least something related to that right as a non justiciable right, otherwise known as a Directive Principle of State Policy. Under International Human Rights Law, the right to health contains the following interrelated and essential elements, the precise application of which depends on the conditions prevailing in a particular State: (a) *Availability,* (b) *Accessibility,* (c) *Acceptability,* and (d) *Quality* otherwise referred to as appropriateness. A feel among Persons living with HIV (PLWHIV) is that human rights are their entitlements although they are not convinced that they have a right to health.

Dedication

I wish to dedicate this work to the memory of all Zambian citizens that have died of HIV related diseases, since its inception, and to all the men and women that have dedicated their lives to fighting this Virus.

Acknowledgements

Special gratitude goes to my supervisor, Mr. Palan Mulonda, for critically analysing every chapter of my work. I will forever be grateful for his good guidance. Thank you, Sir.

I wish to acknowledge the moral, spiritual and financial support rendered by my immediate and extended family, my good friends, my past and present employers, former classmates and residents of Chilenje Township during the period in which I have worked on attaining a degree in law.

I wish to make special acknowledgement of my immediate and extended family: my late parents, Annie and Ronald Libati, my grandfather, Champo Julius Mutati, my uncles, Zachariah Chibemba and Perfector Chituma Chishala, my aunt, Lydia Mwansa, my brothers, Ray, Libati and Mundia, my sisters Akaketwa (the late), Inutu and Chama. My good friends Mazyola, Gilbert, Chitala and Mususa. My present and past employers Setanga Lodge Limited, Abha Patel & Associates and the Zambia AIDSLaw Research & Advocacy Network (ZARAN). My former class mates of 2008 LLB, UNZA graduating intake. All the patrons and residents of Lazymens Clinic and Chilenje Township.

You have all shown me that the knowledge I have earned should and must be shared!

To you all, I say, God richly bless you!

Table of Statutes

Local Legislation

Constitution of Zambia, Chapter 1 of the Laws of Zambia

National Health Services Act, Chapter 315 of the Laws of Zambia (an Act that has since been repealed)

National HIV/AIDS/STI/TB Council Act, No. 10 of 2002

Public Health Act, Chapter 295 of the Laws of Zambia

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Zambia Sugar Plc V. Fellow Nanzaluka Appeal No. 82/2001

Foreign Cases

Mangani V. Register Trustees of Malamulo Hospital, (1991) High Court of Malawi

Minister of Health and Others V. Treatment Action Campaign and Others 2002 (5) SA 717 (South African Constitutional Court) 2002

Table of International Instruments

African (Banjul) Charter on Human and Peoples' Rights, 1981

International Covenant on Economic, Social and Cultural Rights, 1966

List of acronyms

ACHPR	-	African Charter on Human & Peoples' Rights
AIDS	-	Acquired Immunodeficiency Syndrome
ART	-	Anti-retroviral treatment/therapy
CBoH	-	Central Board of Health
FGD	-	Focus Group Discussion
GRZ	-	Government of the Republic of Zambia
HIV	-	Human Immunodeficiency Syndrome
ICESCR	-	International Covenant on Economic Social & Cultural Rights
NHSP	-	National Health Strategic Plan
OHCHR	-	Office of the High Commissioner for Human Rights
PLWHIV	-	Person Living With HIV
PMTCT	-	Prevention of Mother to Child Transmission
STI	-	Sexually Transmitted Infection
TAC	-	Treatment Action Campaign
TALC	-	Treatment Advocacy & Literacy Campaign
TB	-	Tuberculosis

UNAIDS	-	Joint United Nations Programme on HIV/AIDS
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization
ZARAN	-	Zambia AIDSLaw Research & Advocacy Network

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EXTENT OF THE ENJOYMENT OF THE 4AS ELEMENT OF THE RIGHT TO HEALTH BY PERSONS LIVING WITH HIV/AIDS IN ZAMBIA

CHAPTER ONE (1)

1.0 INTRODUCTION

HIV/AIDS has for the past two decades continued to spread across all continents killing millions of adults in their prime, disrupting and impoverishing families and turning millions of children into orphans. Because it affects the most the most productive segments of national populations, the pandemic has tremendously reduced work forces and reversed many years of economic and social progress and has in some cases, posed a serious threat to political stability. [1]

In Zambia, HIV/AIDS has also become increasingly wide spread with an estimated adult HIV prevalence of 16 percent. The peak for HIV among females is 25 to 34 years while that of males is 35 to 39 years. Young women aged 15 to 19 are five times more likely to be infected compared to males in the same group. It is also estimated that 25 per cent of pregnant women are HIV positive and that approximately 40 per cent of babies born to HIV-positive mothers are infected with the HIV virus.[2]

HIV/AIDS negatively touches and impacts fundamental human rights. There have, for instance, been cases involving job redundancies and abrupt loss of income on account of the HIV/AIDS status of an employee. Stigmatization and discrimination have also been rife in homes, communities, schools and workplaces with the result that the infected have found it doubly

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[1] National HIV/AIDSSTI/TB Policy, 2005, at page 1

[2] Ibid, at page 1

difficult to lead normal lives. Indeed, it has now been established that there is a correlation between the HIV/AIDS pandemic and the abuse of human rights.[3]

At the 2006 United Nations High Level Meeting on HIV/AIDS, world leaders, including Zambian leaders, reaffirmed that "the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic". The promotion and protection of human rights is central to the response. As has been said over and over again, this is important in order to reduce vulnerability to infection, empower communities to respond and to mitigate the impact of HIV/AIDS.[4]

One such human right is the right to health, sometimes referred to as the right to the highest attainable standard of health. That right, in relation to persons living with HIV/AIDS is the prime issue upon which this research is based.

The corpus of global human rights instruments consists of four core documents collectively referred to as 'the international bill of human rights', and a host of other major human rights documents.[5] Among the documents that make up the International Bill of Human Rights are the Universal Declaration of Human Rights and the International Covenant on Economic Social and cultural Rights (ICESCR).[6] The ICESCR ensures equal rights for men and women including such rights as the right to health.

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[3] Ibid, at page 12

[4] M, Malila (then Attorney General), 2007, forward to the Zambia AIDS Law Research & Advocacy Network Manual at page VI

[5] C, Anyangwe, 2005, Introduction to Human Rights and International Humanitarian Law, at page 31

[6] Ibid, at page 31

At regional level, on the African continent, five basic instruments form the normative edifice of the African system, one of which is the African Charter on Human and Peoples' Rights (ACHPR).[7] Like the ICESCR, the ACHPR ensures a host of human rights one of which the right to enjoy the best attainable state of physical and mental health.[8]

How well human rights are protected in any particular country depends in the first place on the laws, and the administrative and other practices, of the country concerned and the government that has authority there. Therefore, human rights are, in the first instance, a matter of domestic law and practice. International human rights law sets the global standards with which each state's domestic laws and practice should conform, and against which their conformity can be assessed. It also supplies procedures for making such assessments and also for remedying any established deficiencies.[9]

It is no wonder, that in the Case of Zambia Sugar Plc V. Fellow Nanzaluka[10] the Supreme Court held that international instruments that although ratified and assented to by the state cannot be applied unless they are domesticated. In that case, the respondent had sought to rely on provisions of an International Labour Convention No. 158 of 1982, to which Zambia was a party but had not been domesticated into the national legal system.[11]

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[7] Ibid, at page 114

[8] Ibid, at page 119

[9] Ibid, at page 31

[10] Appeal No. 82/2001

[11] M, Munalula, 2004, Legal Process: Zambian Cases, Legislation and Commentaries at page 89

The Supreme law of the land, the Constitution of the Republic of Zambia, Chapter 1 of the Laws of Zambia, provides for the right to health in Part IX, in what are termed as Directive Principles of state policy. It provides that those principles shall guide the Executive, the Legislature and the Judiciary, as the case may be, in the development of national policies, implementation of national policies, making and enactment of laws and application of the Constitution and any other law. It also provides that their application may be observed only in so far as State resources are able to sustain their application, or if the general welfare of the public so unavoidably demands, as may be determined by Cabinet and that they shall not be justiciable and shall not thereby, by themselves, despite being referred to as rights in certain instances, be legally enforceable in any court, tribunal or administrative institution or entity.[12]

The right to health, or at least something related to that right, therein provides that the State shall endeavour to provide adequate medical and health facilities for all persons and take measures to constantly improve such facilities and amenities.[13]

In 2002 the National HIV/AIDS/STI/TB Council Act of Parliament, No.10 of that year, was enacted. The functions of the Council created by that ACT where to coordinate and support the development, monitoring and evaluation of the multi-sectoral national response for the prevention and combating of the spread of HIV, AIDS, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB.[14]

[12] Constitution of Zambia, Chapter 1 of the Laws of Zambia, Article 111

[13] Constitution of Zambia, Chapter 1 of the Laws of Zambia, Article 112

[14] National HIV/AIDS/STI/TB Council Act, No. 10 of 2002, Section 4

1.01 Rationale

This is a research into the legal framework within which the right to health is enjoyed by persons living with HIV in Zambia. However, and quite particularly, this research is into the extent to which persons living with HIV/AIDS can be said to be enjoying the 'four (4) Access' (4As) element of the right to health. This research has reviewed the various international commitments relevant to the topic that Zambia is a party to and bound to make a reality of by giving effect to the same in her domestic laws. This is in light of the fact that international commitments are not automatically binding unless domesticated.[15] This is also in light of the fact that the highest law of the land, the Republican Constitution, does not guarantee the right to health, per se, but only goes so far as to provide that the State ensures to citizens adequate medical and health facilities for all persons and take measures to constantly improve such facilities and amenities.[16] This will lead to an analysis of the extent to which Zambia could be said to be adhering to her international obligations under such instruments as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples' Rights (ACHPR).

1.02 Objectives

This research has basically had two primary objectives. On the one hand it has been to research into the right to health as it exists in Zambia and on the other hand, the extent to which the enjoyment of the 4As element of the right to health by persons living with HIV/AIDS in Zambia.

1.03 Literature review

[15] M, Munalula, 2004, Legal Process: Zambian Cases, Legislation and Commentaries at page 89

[16] Constitution of Zambia, Chapter 1 of the Laws of Zambia, Article 112

In conducting the research, a plethora of documents have been referred to. These documents being, among others, but not limited to these, as, treaties such as the International Covenant on Economic Social and Cultural Rights (ICESCR) of 1966[17], the African Charter on Human and Peoples Rights (ACHPR) of 1982[18], both of which Zambia is a state party to them, hence acquiring obligations to adhere to and ensure enjoyment of the provisions therein of her citizens.

The research has referred to such interpretations of these treaties as General Comment number 14 of 2000 delivered by the monitoring body of the treaty, the Committee on Economic, Social and Cultural Rights on the Committee's authoritative interpretation of the right to the highest attainable standard of health.[19] The research has gone further to review the country's periodic reporting to monitoring bodies and local legislation and case law relevant to the research.

The research has also referred to a number of International declarations, Guidelines and Resolutions such as the United Nations General Assembly's Special Session on HIV/AIDS and Human Rights, Consolidated Version of 2006 and Resolutions 2002/31 and 2003/28 of the Commission of Human Rights on the right of everyone to the highest attainable standard of physical and mental health.[20]

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[17] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976

[18] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

[19] Committee on Economic, Social and Cultural Rights, General Comment 14, the right to highest attainable standard of health, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003)

[20] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version (Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-26 July 1006. Third International Consultation on HIV/AIDS and Human Rights, Geneva 25-26 July 2002)

In light of a gap in local case law on access to the right to health the research has also referred to foreign Case law relevant and persuasive to the topic at hand such as the South African Treatment Action Campaign (TAC)[21] and Malawian Registered Trustees of Malambo Hospital[22] cases.

The research has referred to the Zambian Constitution[23], being the supreme law of the land, the Public Health Act, being the land's principal legislation on health, the National HIV/AIDS Act[24] and Policy, and other such documents as the current national Health and HIV/AIDS Strategic Plans.

The research also referred to such books as an Introduction to Human Rights and International Humanitarian Law of 2005 by Professor Carlson Anyangwe[25], Legal Process: Zambian Cases, Legislation and Commentaries by Doctor Margret Munalula[26] and the AIDSLaw manual published in 2007 by the Zambia AIDSLaw Research and Advocacy Network (ZARAN)[27].

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[21] Minister of Health and Others v Treatment Action Campaign and Others 2002 (5) SA 717 (South African Constitutional Court) 2002

[22] Mangani v Register Trustees of Malamulo Hospital, (1991) High Court of Malawi

[23] Chapter 1 of the Laws of Zambia

[24] Act No. 10 of 2002

[25] C, Anyangwe, 2005, Introduction to Human Rights and International Humanitarian Law

[26] M, Munalula, 2004, Legal Process: Zambian Cases, Legislation and Commentaries

[27] AIDSLaw Manual, 2007, Zambia AIDSLaw Research & Advocacy Network (ZARAN), Lusaka

1.04 Research questions

In conducting the research, two questions have sought to be answered. These being one (1) to what extent does the right to health exist in Zambia? And two (2) to what extent does a person living with HIV/AIDS enjoy the element of the 4As of the right to health in Zambia?

1.05 Research methodology

This research has employed different tools in its methodology. The first part of it has been to seek an answer to the first research question of '... to what extent does the right to health exist in Zambia?' by conducting a desk review of the various documents highlighted in the literature review referred to above and other relevant documents not specifically highlighted above but pertinent to the issues emanating from the research.

Beyond the desk review, interviews have been conducted with key informants. These interviews sought to address the research question of '...to what extent does a person living with HIV/AIDS enjoy the element of the 4As of the right to health in Zambia?' By so doing, key informants of all four (4) areas of intervention against the HIV/AIDS pandemic being Voluntary Counseling and Testing (VCT), Antiretroviral Therapy (ART), Prevention of Mother to Child Transmission (PMTCT) and the prevention and treatment of Opportunistic Infections such as Tuberculosis (TB) and Sexually Transmitted Infections (STIs).

To that end, the Key informants were drawn from 'service providers', on the one hand, that is such persons as doctors, clinical officers, nurses, lab technicians and pharmacists and 'clients of services', on the other hand, that is the recipients of services provided by the 'service providers' highlighted herein such as persons accessing VCT, persons on ART, pregnant women attending

antenatal services in public health facilities, and persons that present themselves to health facilities with opportunistic infections.

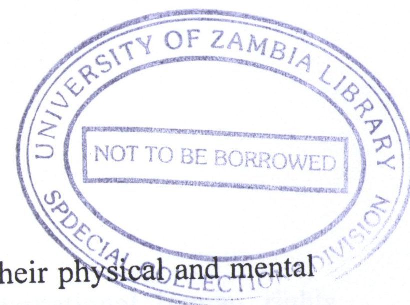
To that end the desk review of relevant documents and interviews of key informants have been the main features of the research's methodology. However, media reports relevant to the topic under research have been referred to as have been various sources of information through the internet on the World Wide Web.

1.06 Time line

The research was conducted in the academic year of 2009 having began early October 2009 to the end of March 2010.

CHAPTER TWO (2)

THE RIGHT TO HEALTH IN ZAMBIA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2.0 INTRODUCTION

Health rights are those claims which a person may make in relation to their physical and mental well being, including access to health care goods, services and facilities. Violations of these rights may enable one to get a legal and/or administrative remedy. Health rights are contained in many codes, like the Constitution[28], The Public Health Act[29], The National Health Services Act[30], among other statutes, and in many policy and ethical documents or guidelines for professional bodies. Generally, every patient is entitled to health rights.[31]

The right to health has many components including (a) the right to medical treatment when sick, without being discriminated against on basis of colour, race, sex and other irrelevant considerations, (b)a right to a healthy and safe environment in which they are placed for treatment, (c) the right to take part in making decisions about their treatment, (d) specific right to primary health care at government clinic or hospital facility only at a reasonable nominal fee as prescribed by law, if a totally free of charge medical service does not exist, (e) right to have information about medical aid schemes, (f) right to give informed consent to medical treatment, (g) right to refuse medical treatment in line with one's social or religious convictions, (h) right to confidentiality and 'privacy' about your medical treatment, (i) right to get second and third

[28] Chapter 1 of the Laws of Zambia

[29] Chapter 295 of the Laws of Zambia

[30] Chapter 315 of the Laws of Zambia (an Act that has since been repealed)

[31] AIDSLaw Manual, 2007, Zambia AIDSLaw Research & Advocacy Network (ZARAN), Lusaka at page 79

medical opinion from other medical practitioners without intimidation and (j) right to complain about poor health services rendered by a health care worker.[32]

2.1 INTERNATIONAL COMMITMENTS

It is interesting to note that Zambia is a party to numerous international human rights instruments. Among which are the International Covenant on Economic, Social and Cultural Rights (ICESCR) that entered into force on the 23rd of March 1976[33], at global level and the African Charter on Human and Peoples Rights (ACHPR) which entered into force on the 21st of October 1986[34], at Regional level. Zambia has long since ratified both documents. It ratified the ICESCR on the 10th of April 1984 and ACHPR 10th of January 1984.[35]

The ICESCR recognizes and guarantees the right to health. Part III and quite particularly Articles 12(1) and (2) provide for the right to health in the following terms:-

Art. 12(1) The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Art. 12(2) The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for

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[32] Ibid at pages 79 to 81

[33] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976.

[34] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

[35] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 313

(a) The provision for the reduction of the still birth-rate and of infant mortality and for the healthy developments of the child

(b) The improvements of all aspects of environmental and industrial hygiene;

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

(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness[36]

The ACHPR, Chapter 1 of Part I, quite specifically Articles 16(1) and (2) provide for the right health therein, in the following manner:-

Art. 16(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.

Art. 16(2) State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[37]

However interesting this might appear, one should be alive to the fact that Zambia is a dualist state. Under the Zambian legal system, international instruments are not self-executing and require legislative implementation to be effective as law.[38]

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[36] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976

[37] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

In dualist states, therefore, a human rights treaty has domestic force only when it has been 'transformed' into municipal law, that is to say, when parliament, by an enabling instrument has adopted it as part of national legislation. The enabling instrument may provide for the partial, wholesale or piecemeal reception of the human rights treaty as forming part of domestic law. When that happens, the treaty metamorphoses, for that state, from an inter-state agreement into a domestic piece of legislation. The act of transformation is an indispensible substantive requirement because that is what validates the extension to individuals of the rules laid down in the treaty. If no such act of transformation is done the human rights treaty is binding upon the dualistic state only internationally. Internally it is not part of the law of the land and is therefore in operative. It cannot be given effect by municipal courts since the requisite enabling legislation for transforming the treaty into municipal law is absent. In order to give domestic effect to any human rights treaty, a dualist state must therefore pass the necessary enabling legislation, or adopt measures, to give effect, domestically, to the rights and freedoms set forth in the treaty.[39]

2.2 CONSTITUTIONAL PROVISIONS

The Constitution is the Supreme (highest) law of Zambia. In this way, all laws and government actions must be in line with the provisions of the Constitution. The Zambian Constitution basically recognizes two (2) categories of rights, that is, civil and political rights and economic social and cultural rights. The former being entrenched in Part III of the Constitution, also known

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[38] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 313

[39] C, Anyangwe, 2005, Introduction to Human Rights and International Humanitarian Law, at page 193

as the Bill of Rights, which are justiciable in the High Court provided that any petition brought to that court rightly falls within the particular articles providing for related civil or political rights.[40]

Zambia has a written Constitution amended by the Constitution Amendment Act 17 in 1996. The Constitution provides for justiciable rights; article 28 details the process for their enforcement. Economic, Social and Cultural rights are mentioned in the Constitution under article 112 as directives of state policy, but are not justiciable (article 111). These include the directive to provide employment, education, shelter, clean water, medical care, a healthy environment, development of culture, social benefits to the disabled, aged and disadvantaged, and fair working conditions (article 112).[41]

Economic, Social and Cultural rights are provided for in Part IX of the Constitution. Unlike the Civil and Political rights found in Part III, the Bill of Rights, that are justiciable, those economic, social and cultural rights found in Part IX are not. The right to health is found in Part IX. This means that any laws or government actions which go against the Constitution can be challenged in the courts of law which may find them null and void. The courts may also follow principles reflected in the Bill of Rights when they are interpreting the law.[42]

The Directive Prinicples of state policy referred to above, and quite specific to the right to health in the Zambian Constitution, provide in the following manner:-

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[40] AIDSLaw Manual, 2007, Zambia AIDSLaw Research & Advocacy Network (ZARAN), Lusaka at pages 21

[41] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 320

[42] AIDSLaw Manual, 2007, Zambia AIDSLaw Research & Advocacy Network (ZARAN), Lusaka at pages 49

Art. 110. (1) The Directive Principles of State Policy set out in this Part shall guide the Executive, the Legislature and the Judiciary, as the case may be, in the-

(a) development of national policies;

(b) implementation of national policies;

(c) making and enactment of laws; and

(d) application of the Constitution and any other law.

(2) The application of the Directive Principles of State Policy may be observed only in so far as State resources are able to sustain their application, or if the general welfare of the public so unavoidably demands, as may be determined by Cabinet.

Art. 111. The Directive Principles of State Policy set out in this Part shall not be justiciable and shall not thereby, by themselves, despite being referred to as rights in certain instances, be legally enforceable in any court, tribunal or administrative institution or entity.

112. The following Directives shall be the Principles of State Policy for the purposes of this Part:

... (d) the State shall endeavour to provide clean and safe water, adequate medical and health facilities and decent shelter for all persons, and take measures to constantly improve such facilities and amenities;...

It therefore becomes clear that Zambia does not have a right to health provision, per se, in its Constitution. In light of that, a question can thus be raised as to whether the right does actually exist in the country.

2.3 DOMESTIC PROVISIONS AND MEASURES

The right to health care is provided for under the directive principles of state policy contained in part IX of the 1996 constitution[43]. The Public Health Act,[44] whose preamble states that it is an

[43] Chapter 1 of the Laws of Zambia

Act to provide for the prevention and suppression of diseases and generally to regulate all matters connected with public health in Zambia and the National Health Services Act[45] (An Act that has since been repealed), provide for the right to health.[46]

The current National Health Strategic Plan (NHSP)[47] is the fourth in a series of strategic plans. The NHSP recognizes that the all health care interventions are important and should continue to receive the necessary level of support. However, the prioritization of interventions is of critical importance as the resources at achieving national health priorities, including national public health priorities such as HIV and AIDS.[48]

Since 1992, the Government of the Republic of Zambia (GRZ) has been implementing Health Sector Reforms aimed at improving health service delivery. The reforms, whose vision is to *"...provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible..."* were articulated in the National Health Policies and Strategies of 1992.[49]

The underlying principle of these reforms is decentralisation of health service delivery through the delegation of key management responsibilities from the centre to the district and hospital levels. Decentralisation also aimed at shifting resources from the centre to operational levels,

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[44] Chapter 295 of the Laws of Zambia

[45] Chapter 315 of the Laws of Zambia

[46] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 326

[47] National Health Strategic Plan (NHSP) 2006-2010

[48] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 326

[49] National Health Strategic Plan 2006 – 2010 at page 7

where healthcare delivery services are conducted. The reforms also emphasized the importance of community participation in the management of health services and the need for a well motivated and remunerated work force.[50]

Implementation of the reforms has been through a series of National Health Strategic Plans (NHSPs), of which this is the fourth, covering the period from 2006 to 2010. The theme of this strategic plan is *"...Towards Attainment of the Millennium Development Goals (MDGs) and National Health Priorities..."* The plan has been developed at a time of considerable policy and legal reforms, including the launching of the National Decentralisation Policy of 2003 and the repeal of the National Health Services Act of 1995, leading to the dissolution of the Central Board of Health (CBoH). These developments have significant implications on both the formulation and implementation of this plan.[51]

The NHSP has been prepared at the time when the country and, in particular, the health sector, is facing significant challenges and changes, including: launching of the National Decentralisation Policy; repeal of the National Health Services Act of 1995, leading to the de-solution of the Central Board of Health (CBoH), together with the hospital and district health boards; critical shortage of health personnel; on-going restructuring of the sector; high disease burden, compounded by high prevalence levels of HIV/AIDS; deterioration in health infrastructure; weak economy and inadequate funding to the health sector. This situation calls for "prioritisation" of intervention strategies, paying particular attention to areas that would make significant impact on

[50] Ibid

[51] Ibid

health delivery and improve the health status of Zambians. This plan therefore places significant emphasis on prioritisation.[52]

[52] Ibid

CHAPTER THREE (3)

THE FOUR (4) ACCESS ELEMENT

3.0 INTERNATIONAL AND REGIONAL PROVISIONS: ICESCR & ACHPR

It is a notorious fact that Zambia is a party to numerous international human rights instruments. Among which are the International Covenant on Economic, Social and Cultural Rights (ICESCR) that entered into force on the 23rd of March 1976[53], at global level and the African Charter on Human and Peoples Rights (ACHPR) which entered into force on the 21st of October 1986[54], at Regional level. Zambia has long since ratified both documents. It ratified the ICESCR on the 10th of April 1984 and ACHPR 10th of January 1984.[55]

The ICESCR recognizes and guarantees the right to health. Part III and quite particularly Articles 12(1) and (2) provide for the right to health in the following terms:-

Art. 12(1) The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Art. 12(2) The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for

[53] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976.

[54] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

[55] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 313

(a) The provision for the reduction of the still birth-rate and of infant mortality and for the healthy developments of the child

(b) The improvements of all aspects of environmental and industrial hygiene;

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

(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness[56]

The ACHPR, Chapter 1 of Part I, quite specifically Articles 16(1) and (2) provide for the right health therein, in the following manner:-

Art. 16(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.

Art. 16(2) State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[57]

3.1 INTERPRETATION THE RIGHT TO HEALTH

Each human rights treaty provides within itself for an expert body denominated 'Committee', to monitor the compliance of states parties with its provisions. Thus, for each human rights treaty,

[56] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976

[57] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

there is a corresponding treaty monitoring committee bearing its name. Thus, for the International Covenant on Economic, Social & Cultural Rights, there is *the Committee on Economic, Social and Cultural Rights*.[58] The work of the committees in authoritatively elaborating well developed bodies of jurisprudence in the course of reviewing country reports, deciding complaints and issuing 'general comments and guidelines' serves to inform domestic legislative processes and law enforcement agencies in their efforts to interpret and implement the rights guaranteed by international instruments.[59]

It is no wonder, therefore, that the Committee on Economic, Social and Cultural Rights at twenty-second (22nd) session in Geneva, Switzerland, held on the 25th of April to the 12th of May 2000 had as its agenda item number three (3) with regards to substantive issues arising in the implementation of the International covenant on Economic Social and Cultural Rights, the issue of the right to the highest attainable standard of health provided for in Article 12 of the Covenant on Economic Social and Cultural Rights. To that effect and to borrow the words of Professor Anyangwe, as quoted above, the Committee in *...authoritatively elaborating well developed bodies of jurisprudence in the course of ... issuing 'general comments and guidelines' ... inform(ed) domestic legislative processes and law enforcement agencies in their efforts to interpret and implement the rights guaranteed by international instruments* when it delivered General Comment Number 14 on the right to the highest attainable standard of health.

Health is a fundamental human right indispensable for the exercise of other human rights.

Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued

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[58] C, Anyangwe, 2005, Introduction to Human Rights and International Humanitarian Law, at page 58

[59] Ibid at page 59

through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.[60]

The human right to health is recognized in numerous international instruments.

Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right".

Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of

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[60] E/C.12/2000/4, 11 August 2000, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS General Comment No. 14 (2000) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) paragraph 1 at page 1

Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.[61]

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.[62]

In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to

[61] Ibid paragraph 2 at page 1 & 2

[62] Ibid paragraph 3at page 2

safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[63]

The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.[64]

With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.[65]

3.2 <u>THE FOUR (4) ACCESS ELEMENT</u>

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

[63] Ibid paragraph 4 at page 2

[64] Ibid paragraph 5 at page 2

[65] Ibid at paragraph 6 page 2 & 3

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.[66]

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:[67]

(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

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[66] Ibid, paragraph 12 at page 4

[67] Ibid, paragraph 12 at page 4

(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas**8** concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.[68]

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[69]

It is this element of the right to health that forms the basis for this research.

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[68] Ibid, paragraph 12 at page 5

[69] Ibid, paragraph 12 at page 5

3.3 STATE PARTIES OBLIGATIONS AS TO THE RIGHT TO HEALTH

The question then arises as to what is the role of the Zambian State with regards to the issues raised thus far in this research. In relating the right to health to issues of HIV/AIDS, The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights (OHCHR) 2006 Consolidated Version of International Guidelines on HIV/AIDS and Human Rights in providing guidance on International Human Rights obligations and HIV provide for the right to the highest attainable standard of physical and mental health. Quite specifically paragraphs 143, 144, 145 and 146 provide for this in the following manner[70]:-

Para. 143 The right to the highest attainable standard of physical and mental health comprises, inter alia, "Prevention, treatment and control of epidemics ... diseases" and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[71]

Para. 144 In order to meet these obligations in the context of HIV, States should assure the provision of appropriate HIV-related information, education and support including access to services for sexually transmitted diseases, to the means of prevention (such as condoms and clean injection equipment) and to voluntary and confidential testing with pre and post-test counseling, in order to enable individuals to protect themselves and others from infection. States should also ensure a safe blood supply and implementation of "universal precautions" to prevent

[70] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version (Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-26 July 1006. Third International Consultation on HIV/AIDS and Human Rights, Geneva 25-26 July 2002) at pages 99 to 100

[71] Ibid at pages 99 to 100

transmission in settings such as hospitals, doctors' offices, dental practices and acupuncture clinics, as well as informal settings, such as during home births.[72]

Para. 145 States should also ensure access to adequate treatment and drugs within the overall context of their public health policies, so that people living with HIV can live as long and as successfully as possible. People living with HIV should also be free to choose amongst all available drugs and therapies. International support is essential from both the public and private sectors, for developing countries for increased access to health care, treatment, drugs and equipment. In this context, States should ensure that neither expired drugs nor other invalid materials are supplied. [73]

Para. 146 States may have to take special measures to ensure that all groups in society, particularly marginalized groups, have access to HIV-related prevention, care and treatment services. The human rights obligations of States to prevent discrimination and to assure medical attention for everyone in the event of sickness require States to ensure that no one is discriminated against in the health-care settings on the basis of their HIV status.[74]

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[72] Ibid at pages 99 to 100

[73] Ibid at pages 99 to 100

[74] Ibid at pages 99 to 100

CHAPTER FOUR (4) – REALITY ON THE GROUND

4.0 TALC - FOCUS GROUP DISCUSSION – With PLWHIV and on ART

Treatment Advocacy & Literacy Campaign (TALC), a non-governmental organization, officially registered on the 5th of August 2005, by the Registrar of Societies, is an HIV and AIDS advocacy and provider of treatment literacy information with more than 100 member organizations. Sixty percent (60%) of which are support groups of people living with HIV and AIDS.[75]

As part of this research, a Focus Group Discussion (FGD) was conducted with members of support groups of people living with HIV. The individuals where drawn from Kabwangwe and Chibusa support groups, both of which are bona fide members of TALC. The Discussion was part of a weekly TALC treatment literacy session. During such sessions, TALC members share information among themselves. Information shared boarders on the various Anti Retroviral Treatment (ARVs) that they are on, the different experiences and reactions of being on such treatment, including the many side effects that that treatment causes. The group that participated in the FGD comprised a total of eleven (11) persons living with HIV that have been and are currently on Anti Retroviral Treatment (ARVs). Within that group, four (4) were male and seven (7) were female.[76]

The discussion was based on paragraph 12 of General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights, on the right to the highest attainable standard of health, as provided for in article 12 of the International Covenant on Economic, Social and Cultural

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[75] C, Mumba, 2008, Issue 1, TALC News – Editorial Comment

[76] Harrison Mwima & Clever Chilende, contact persons, TALC, Lusaka Hub, talcadvocactes@yahoo.com, 0211-233177

Rights (ICESCR).[77] A copy of paragraph 12 of General Comment No. 14 was handed to each of the participants for their perusal before the commencement of the discussion.

Among the questions covered were:

(1) What are human rights?

(2) What examples are there of human rights?

(3) Do you know of the right to health?

(4) Does the right to health relate to you, as a person living with HIV and on ARVs?

(5) What do you understand by access to the right to health?

(6) What, if any, are the elements of access to the right to health?

(7) Whose duty is it to ensure that these elements are accessed?

(8) What, in your opinion, needs to be done to ensure that you, as a person living with HIV and on ARVs, enjoy those elements of access to the right to health?

The group was generally in agreement that human rights were their entitlements as human beings and examples of such entitlements were the right to learn and obtain an education, right to express themselves on such issues as diseases and medicines. In responding to whether they had a right to health, the group formed the view that 'they all wanted life to be good at all times'. In explaining that, the group noted that even though life had its ups and downs, more so with

[77] E/C.12/2000/4, 11 August 2000, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS General Comment No. 14 (2000) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) see annex 1

regards to health, as was especially the case with themselves that had a challenged immune system. In responding to whether they had a right to health or not, the group, although not totally convinced, did believe that they had a right to health. In so saying, the group also noted that though issues of stigma and discrimination did normally face them, with regards to their health, they, as persons living with HIV and on ARV were equally entitled to the right to health.

At this point in the discussion, the group was referred to the piece of paper that had been handed to them.

The group was informed that Zambia is a party to numerous international human rights instruments. Among which are the International Covenant on Economic, Social and Cultural Rights (ICESCR) that entered into force on the 23rd of March 1976. It ratified the ICESCR on the 10th of April 1984.[78]

The group was also informed that each human rights treaty provides within itself for an expert body denominated 'Committee', to monitor the compliance of states parties with its provisions. Thus, for each human rights treaty, there is a corresponding treaty monitoring committee bearing its name. Thus, for the International Covenant on Economic, Social & Cultural Rights, there is *the Committee on Economic, Social and Cultural Rights*.[79]

The group was also informed that the Committee at its twenty-second (22nd) session in Geneva, Switzerland, held on the 25th of April to the 12th of May 2000 had as its agenda item number three (3) with regards to substantive issues arising in the implementation of the International covenant on Economic Social and Cultural Rights, the issue of the right to the highest attainable

[78] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 313

[79] Anyangwe, C, 2005, Introduction to Human Rights and International Humanitarian Law, at page 58

standard of health provided for in Article 12 of the Covenant on Economic Social and Cultural Rights.[80] To that effect and to again borrow the words of Professor Anyangwe[81], the Committee in *authoritatively elaborating well developed bodies of jurisprudence in the course of ... issuing 'general comments and guidelines' ... inform(ed) domestic legislative processes and law enforcement agencies in their efforts to interpret and implement the rights guaranteed by international instruments* when it delivered General Comment Number 14 on the right to the highest attainable standard of health.

Given that background, the group was reminded that the FGD was based on paragraph 12 of the Committee's general comment, a copy of which was what had been handed to each of them at the beginning of the discussion. Hence, and in proceeding with the discussion, the group was asked to explain, in their own understanding of things, what was meant by access to health or the right to health as it were. On that, the group was generally in agreement that access meant being able to utilize the available health facilities. The group was of the view that the elements of the right to health or health as it were, were the elements that made up the health facilities. To that, the group qualified their statement to mean that the elements included such things as doctors and nurses, hospitals and clinics, counseling and medicines among others.

The group was of the view that their being able to utilize these facilities was limited. They cited such reasons as shortage of facilities; doctors, nurses, laboratory testing machines, hospitals, clinics, stock out of drugs. The group noted that in their considered experience, these facilities were either not available or that even when available, these facilities were either at a cost or that

[80] E/C.12/2000/4, 11 August 2000, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS General Comment No. 14 (2000) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) paragraph 1 at page 1
[81] Anyangwe, C, 2005, Introduction to Human Rights and International Humanitarian Law, at page 58

in certain cases doctors and nurses refused to attend to them citing such reasons as being de-motivated by low remuneration packages. One participant noted, to the confirmation of her colleagues, that at one time, when she had gone to collect her anti retroviral drugs, she was handed drugs that completely different from what the doctor had prescribed. She noted that she only discovered this anomally days later when the side effects of the drug where too strong to ignore. She stated, and is hereby quoted '…I almost went mad. Had it not been for my husband, who read out the name of the drugs and informed me that the drugs I had got on my last trip to the clinic were different from the ones that I had getting…I would have been a mad person or even dead, by now…" She attributed this sad experience to a de-motivated pharmacist that did not pay due attention to ensure she was handed the right set of drugs.

The group, in all honesty, did not have a clue as to what needed to be done to remedy their being able to effectively and meaningfully utilize the facilities that ensured them good health, but was of the strong belief that the government was the body that needed to put something in place.

4.1 THE SOUTH AFRICAN SITUATION

Chapter 2 of the Republic of South Africa Consitution covers that Country's Bill of Rights. Section 27 provides for Health Care, Food, Water and Social Security. It provides in the following manner[82]:

"…27. Health care, food, water and social security.-

(1) Everyone has the right to have access to -

(a) health care services, including reproductive health care;

[82] Constitution of the Republic of South Africa

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment…"

In 2002, the Constitutional Court of South Africa, delivered judgment in a matter where a group Known as the Treatment Action Campaign, had taken the South African Government to the High Court for failing to, among other things, provide anti retroviral drugs for women living with HIV that would help prevent their unborn babies from contracting the virus.[83]

The Court in that case made the following orders:

'…We accordingly make the following orders:

1. The orders made by the High Court are set aside and the following orders are substituted.

2. It is declared that:

a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realize progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.

b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.

c) The policy for reducing the risk of mother-to-child transmission of

HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs (a) and (b) in that:

[83] Minister of Health and Others v Treatment Action Campaign and Others 2002 (5) SA 717 (SACC)

i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe nevirapine to reduce the risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned.

ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.

3. Government is ordered without delay to:

a) Remove the restrictions that prevent nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that are not research and training sites.

b) Permit and facilitate the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.

c) Make provision if necessary for counsellors based at public hospitals and clinics other than the research and training sites to be trained for the counselling necessary for the use of nevirapine to reduce the risk of mother-to-child transmission of HIV.

d) Take reasonable measures to extend the testing and counseling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

4. The orders made in paragraph 3 do not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods become available to it for the prevention of mother-to-child transmission of HIV.

5. The government must pay the applicants' costs, including the costs of two counsel.

6. The application by government to adduce further evidence is refused..."

CHAPTER FIVE (5)

CONCLUSIONS AND RECOMMENDATIONS

5.0 CONCLUSIONS

How well human rights are protected in any particular country depends in the first place on the laws, and the administrative and other practices, of the country concerned and the government that has authority there.[84] In Zambia in the case of Zambia Sugar Plc V. Fellow Nanzaluka[85] the Supreme Court held that international instruments that although ratified and assented to by the state cannot be applied unless they are domesticated.[86]

The Supreme law of the land, the Constitution of the Republic of Zambia, Chapter 1 of the Laws of Zambia, provides for the right to health in Part IX, in what are termed as Directive Principles of state policy. It provides that those principles shall guide the Executive, the Legislature and the Judiciary, as the case may be, in the development of national policies, implementation of national policies, making and enactment of laws and application of the Constitution and any other law. It also provides that their application may be observed only in so far as State resources are able to sustain their application, or if the general welfare of the public so unavoidably demands, as may be determined by Cabinet and that they shall not be justiciable and shall not thereby, by themselves, despite being referred to as rights in certain instances, be legally enforceable in any court, tribunal or administrative institution or entity.[87]

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[84] Anyangwe, C, 2005, Introduction to Human Rights and International Humanitarian Law, at page 31

[85] Appeal No. 82/2001

[86] Munalula, M, 2004, Legal Process: Zambian Cases, Legislation and Commentaries at page 89

[87] Constitution of Zambia, Chapter 1 of the Laws of Zambia, Article 111

The right to health, or at least something related to that right, therein provides that the State shall endeavour to provide adequate medical and health facilities for all persons and take measures to constantly improve such facilities and amenities.[88]

In 2002 the National HIV/AIDS/STI/TB Council Act of Parliament, No.10 of that year, was enacted. The functions of the Council created by that ACT where to coordinate and support the development, monitoring and evaluation of the multi-sectoral national response for the prevention and combating of the spread of HIV, AIDS, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB.[89]

Zambia is a party to numerous international human rights instruments. Among which are the International Covenant on Economic, Social and Cultural Rights (ICESCR) that entered into force on the 23rd of March 1976[90], at global level and the African Charter on Human and Peoples Rights (ACHPR) which entered into force on the 21st of October 1986[91], at Regional level. Zambia has long since ratified both documents. It ratified the ICESCR on the 10th of April 1984 and ACHPR 10th of January 1984.[92]

The right to health care is provided for under the directive principles of state policy contained in part IX of the 1996 constitution[93]. The Public Health Act,[94] whose preamble states that it is an

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[88] Constitution of Zambia, Chapter 1 of the Laws of Zambia, Article 112

[89] National HIV/AIDS/STI/TB Council Act, No. 10 of 2002, Section 4

[90] International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution (XXI), 21 U.N.GAOR Supp. (No.16), U.N Doc. A/6316 (1966), 993 Y.N.T.S.3 entered into force January 3rd, 1976.

[91] African (Banjul) Charter on Human and Peoples' Rights (ACHPR) adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force October 21, 1986

[92] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 313

[93] Chapter 1 of the Laws of Zambia

Act to provide for the prevention and suppression of diseases and generally to regulate all matters connected with public health in Zambia and the National Health Services Act[95] (An Act that has since been repealed), provide for the right to health.[96]

The current National Health Strategic Plan (NHSP)[97] is the fourth in a series of strategic plans. The NHSP recognizes that the all health care interventions are important and should continue to receive the necessary level of support. However, the prioritization of interventions is of critical importance as the resources at achieving national health priorities, including national public health priorities such as HIV and AIDS.[98]

Each human rights treaty provides within itself for an expert body denominated 'Committee', to monitor the compliance of states parties with its provisions. Thus, for each human rights treaty, there is a corresponding treaty monitoring committee bearing its name. Thus, for the International Covenant on Economic, Social & Cultural Rights, there is *the Committee on Economic, Social and Cultural Rights.*[99] The work of the committees in authoritatively elaborating well developed bodies of jurisprudence in the course of reviewing country reports, deciding complaints and issuing 'general comments and guidelines' serves to inform domestic

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[94] Chapter 295 of the Laws of Zambia

[95] Chapter 315 of the Laws of Zambia

[96] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 326

[97] National Health Strategic Plan (NHSP) 2006-2010

[98] AIDS and Human Rights Research Unit, 2007, Human Rights Protected? Nine Southern African Country reports on HIV, AIDS and the law, Pretoria University Law Press at page 326

[99] Anyangwe, C, 2005, Introduction to Human Rights and International Humanitarian Law, at page 58

legislative processes and law enforcement agencies in their efforts to interpret and implement the rights guaranteed by international instruments.[100]

The Committee on Economic, Social and Cultural Rights at twenty-second (22nd) session in Geneva, Switzerland, held on the 25th of April to the 12th of May 2000 had as its agenda item number three (3) with regards to substantive issues arising in the implementation of the International covenant on Economic Social and Cultural Rights, the issue of the right to the highest attainable standard of health provided for in Article 12 of the Covenant on Economic Social and Cultural Rights. To that effect and to borrow the words of Professor Anyangwe, as quoted above, the Committee in *authoritatively elaborating well developed bodies of jurisprudence in the course of ... issuing 'general comments and guidelines' ... inform(ed) domestic legislative processes and law enforcement agencies in their efforts to interpret and implement the rights guaranteed by international instruments* when it delivered General Comment Number 14 on the right to the highest attainable standard of health.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.[101]

(b) *Accessibility.* Health facilities, goods and services**6** have to be accessible to everyone without discrimination, within the jurisdiction of the State party.

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[100] Ibid at page 59

[101] Ibid, paragraph 12 at page 4

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.[102]

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.[103]

In relating the right to health to issues of HIV/AIDS, The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights (OHCHR) 2006 Consolidated Version of International Guidelines on HIV/AIDS and Human Rights in providing guidance on International Human Rights obligations and HIV provide for the right to the highest attainable standard of physical and mental health. Quite specifically paragraphs 143, 144, 145 and 146 provide for this in the following manner[104]:-

Para. 143 The right to the highest attainable standard of physical and mental health comprises, inter alia, "Prevention, treatment and control of epidemics … diseases" and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[105]

[102] Ibid, paragraph 12 at page 5

[103] Ibid, paragraph 12 at page 5

[104] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version (Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-26 July 1006. Third International Consultation on HIV/AIDS and Human Rights, Geneva 25-26 July 2002) at pages 99 to 100

[105] Ibid at pages 99 to 100

Para. 144 In order to meet these obligations in the context of HIV, States should assure the provision of appropriate HIV-related information, education and support including access to services for sexually transmitted diseases, to the means of prevention (such as condoms and clean injection equipment) and to voluntary and confidential testing with pre and post-test counseling, in order to enable individuals to protect themselves and others from infection. States should also ensure a safe blood supply and implementation of "universal precautions" to prevent transmission in settings such as hospitals, doctors' offices, dental practices and acupuncture clinics, as well as informal settings, such as during home births.[106]

Para. 145 States should also ensure access to adequate treatment and drugs within the overall context of their public health policies, so that people living with HIV can live as long and as successfully as possible. People living with HIV should also be free to choose amongst all available drugs and therapies. International support is essential from both the public and private sectors, for developing countries for increased access to health care, treatment, drugs and equipment. In this context, States should ensure that neither expired drugs nor other invalid materials are supplied. [107]

Para. 146 States may have to take special measures to ensure that all groups in society, particularly marginalized groups, have access to HIV-related prevention, care and treatment services. The human rights obligations of States to prevent discrimination and to assure medical

[106] Ibid at pages 99 to 100

[107] Ibid at pages 99 to 100

attention for everyone in the event of sickness require States to ensure that no one is discriminated against in the health-care settings on the basis of their HIV status.[108]

A feel among Persons living with HIV (PLWHIV) is that human rights were their entitlements as human beings and examples of such entitlements were the right to learn and obtain an education, right to express themselves on such issues as diseases and medicines. In responding to whether they had a right to health, the group formed the view that 'they all wanted life to be good at all times'.

A focus group discussion of a group of PLWHIV explained that, the group noted that even though life had its ups and downs, more so with regards to health, as was especially the case with themselves that had a challenged immune system.[109] In responding to whether they had a right to health or not, the group, although not totally convinced, did believe that they had a right to health. In so saying, the group also noted that though issues of stigma and discrimination did normally face them, with regards to their health, On that, the group was generally in agreement that access meant being able to utilize the available health facilities. The group was of the view that the elements of the right to health or health as it were, were the elements that made up the health facilities. To that, the group qualified their statement to mean that the elements included such things as doctors and nurses, hospitals and clinics, counseling and medicines among others. they, as persons living with HIV and on ARV were equally entitled to the right to health.

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[108] Ibid at pages 99 to 100

[109] Harrison Mwima & Clever Chilende, contact persons, TALC, Lusaka Hub, talcadvocactes@yahoo.com, 0211-233177

The group was of the view that their being able to utilize these facilities was limited. They cited such reasons as shortage of facilities; doctors, nurses, laboratory testing machines, hospitals, clinics, stock out of drugs. The group noted that in their considered experience, these facilities were either not available or that even when available, these facilities were either at a cost or that in certain cases doctors and nurses refused to attend to them citing such reasons as being de-motivated by low remuneration packages. One participant noted, to the confirmation of her colleagues, that at one time, when she had gone tó collect her anti retroviral drugs, she was handed drugs that completely different from what the doctor had prescribed. She noted that she only discovered this anomally days later when the side effects of the drug where too strong to ignore. She stated, and is hereby quoted '…I almost went mad. Had it not been for my husband, who read out the name of the drugs and informed me that the drugs I had got on my last trip to the clinic were different from the ones that I had getting…I would have been a mad person or even dead, by now…" She attributed this sad experience to a de-motivated pharmacist that did not pay due attention to ensure she was handed the right set of drugs.

The group, in all honesty, did not have a clue as to what needed to be done to remedy their being able to effectively and meaningfully utilize the facilities that ensured them good health, but was of the strong belief that the government was the body that needed to put something in place.

In 2002, the Constitutional Court of South Africa, delivered judgment in a matter where a group Known as the Treatment Action Campaign, had taken the South African Government to the High Court for failing to, among other things, provide anti retroviral drugs for women living with HIV that would help prevent their unborn babies from contracting the virus.

5.1 RECOMMENDATIONS

This research therefore makes a number of recommendations. As a starting point, it is hereby recommended that the State of Zambia enshrines the right to health in the Bill of rights of its Constitution so as to make the right justiciable before its courts of law.

Secondly, and in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights (OHCHR) 2006 Consolidated Version of International Guidelines on HIV/AIDS and Human Rights guidance, the State of Zambia should assure the provision of appropriate HIV-related information, education and support including access to services for sexually transmistted diseases, to the means of prevetion (such as condoms and clean injection equipment) and to voluntary and confidential testing with pre and post-test counseling, in order to enable individuals to protect themselves and others from infection. The State of Zambia should also ensure access to adequate treatment and drugs within the overall context of her public health policies, so that people living with HIV (PLWHIV) can live as long and as successfully as possible. PLWHIV should also be free to choose amongst all available drugs and therapies. The State of Zambia should also take special measures to ensure that all groups in society, particularly marginalized groups, have access to HIV-related prevention, care and treatment services.

All this should be done so that vulnerable persons or groups of such persons as PLWHIV and their affiliate organizations, like TALC, can be able to assert the right to health, most importantly the four access element on their own behalf or that of the communities that they seek to represent. It is the view of this research that, if that could be done, possibly groups such as those

referred to above would be able to challenge the State in Court as did the TAC group against the Minister of Health in South Africa in 2002.

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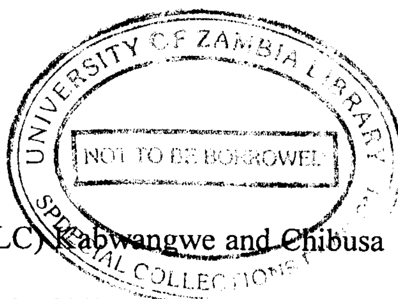

US GROUP DISCUSSION

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