

A Framework Convention on Global Health:  
a tool for empowering the HIV/AIDS movements  
in South Africa and Senegal

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## **DEDICATION**

Mark Heywood (mentor and friend)

and

Caroline Southey (mother and editor)

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## LIST OF ACRONYMS

AEC	African Economic Community
ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
African Commission	African Commission on Human and Peoples Rights
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
AU	African Union
CEDAW	Convention on the Elimination of Discrimination against Women
CERD	Convention on the Elimination of Racial Discrimination
Committee on ESCR	Committee on Economic, Social and Cultural Rights
CNLS	Conseil National de Lutte contre le SIDA
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
Global Fund	Global Fund on AIDS, TB and Malaria
HIV	Human immunodeficiency virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MSM	Men who have sex with men
NGO	Non-governmental organisation
OAU	Organisation of African Unity
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
STI	Sexually transmitted disease
TAC	Treatment Action Campaign
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Session on HIV/AIDS

UNICEF

Women's Protocol

WHO

United Nations Children's Fund

Protocol to the African Charter on Human and Peoples'  
Rights on the Rights of Women in Africa

World Health Organisation

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# CHAPTER ONE

## Introduction

Despite the Alma Ata inspired slogan 'health for all by 2000' in the second decade of the twenty first century, the world remains affected and infected with bad health.<sup>1</sup> This situation has generated much debate, and as a result, national and global responses have arguably entered a new era building on the past success and failures of health movements, most notably on the back of the global HIV/AIDS movement.<sup>2</sup> It is acknowledged that the rights instruments that exist relating to the right to health have provided a healthy platform for advocacy and have lead to successes on the ground, but the question is where to go from here.<sup>3</sup>

Within this context, the need for new and innovative solutions to the challenges facing public health has sparked a new conversation around the international right to health framework and has seen the rise of a new vision for the right to health. The concept of a Framework Convention on Global Health (FCGH)<sup>4</sup> has emerged within these debates, though a very young idea it is subject of much discussion in the global health arena.<sup>5</sup>

However, the research on a FCGH is relatively limited, without fully engaging the possible country-specific affects, particularly in the African context. The two case studies chosen for this paper, Senegal and South Africa, aim to look at the current status of the international right to health framework, specifically in the context of the HIV/AIDS epidemic. Through this, this paper explores the possible role of a FCGH in empowering the HIV/AIDS movement in their protection and promotion of the right to health in Africa.

### 1.1 Significance of study

The overall aim of this thesis is to contribute to the existing knowledge around a FCGH. This includes its role for fueling a global movement around health and setting comprehensive standards on the provision of public health, including rights and duties on states and non-state actors. Furthermore, it aims to emphasise that any

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<sup>1</sup> M Heywood & J Shija 'A Global Convention on Health – Would it Help Developing Countries to Fulfill their Duties on the Right to Health? A South African perspective' (2011) 2.

<sup>2</sup> As above.

<sup>3</sup> As above.

<sup>4</sup> Other terms for this concept include Framework Convention on the Right to Health.

<sup>5</sup> Most recently it has been discussed at the Workshop on Democratising Global Health Governance held in Geneva, May 2010; the Regional Dialogue on the Right to Health held in Johannesburg, March 2011, which was attended by Arnand Grover the UN Special Rapporeur on the Right to Health; and the Civil Society Consultation held in New Delhi, May 2011.

international legal framework conceptualisation on the right to health must involve those whose health is at stake. In order to achieve this, analyses of the role played civil society and other actors, who give a voice to those unheard in the halls of state power, are vital for any discussion around new innovations in the international right to health framework and its potential advantages. In this light, this paper hopes to shed some light on the role played by civil society in protecting and promoting the right to health on the ground, and how a FCGH could support and enhance this role.

This research report is structured as follows: Chapter One is a brief introduction, and includes the research questions, methodology and limitations of study. Chapter Two examines the international right to health conceptual framework. It does this by first outlining the current status of the international right to health framework. This leads onto a review of the current discussions around a FCGH, which aims to place this paper into the larger conceptual framework of a FCGH, specifically regarding the role of civil society. Chapter Three contains the first case study, South Africa. It seeks to explore the possible role of a FCGH in empowering the HIV/AIDS movement in their endeavors to protect the right to health. Chapter Four contains the second case study of Senegal. Chapter Five is a summary conclusion that seeks to answer some criticisms of a FCGH in light of what was learnt in the case studies.

## **1.2 Research Questions**

- 1) What is the current status of international law on right to health in the context of HIV and how could this be bolstered by a FCGH?
- 2) What is the potential for a FCGH in empowering the HIV/AIDS movement for the protection of the right to health in South Africa?
- 3) What is the potential for a FCGH in empowering the HIV/AIDS movement for the protection of the right to health in Senegal?

## **1.3 Methodology**

Although the study takes an analytical approach, a descriptive approach is used when appropriate to enhance the analysis. The paper begins by exploring, through a literature review and textual analysis of the current international right to health framework and the emergence of a FCGH. The implications, if any, of a FCGH on the work of HIV/AIDS movements on the ground is examined mainly through critically analysing the corpus of the FCGH, reviewing literature available on the topic and

action by civil society using the current international right to health framework. A comparative approach is also used to bolster the findings of the analysis, by way of examples of similarities and differences in the two case studies.

This research will make use of primarily sources in the form of library-based research including various relevant international and regional instruments making up human rights law, domestic statutes and other right to health measures necessary for the comparative analysis. It will also draw on secondary sources include journal articles, publications and reports on the main thematic issues – health, human rights, civil society movements and international law. A core part of the research is carried out through document analysis, specifically of UN documents. Due to the contemporary nature of the subject the study drew on recent conference articles and unpublished internal materials on the subject of a FCGH. It also makes use of secondary sources from the Internet.

#### **1.4 Limitations of study**

The contemporary nature of the subject meant that there is scant literature available and where it exists it is difficult to access or is unpublished, therefore some of the research is based on internal working papers of research groups on the subject. The specifications required to complete this paper limited the scope of the study. Moreover, the language barrier severely limited the possibility for engaging with French documents needed for the Senegal case study.

In content, the paper has focused on HIV as an example in the context of a FCGH and therefore the conclusions cannot be said to necessarily apply to broader health care systems or other communicable diseases. Furthermore, this paper is based on two case studies and cannot be generalised for the whole of Africa or the rest of the world. However, this research is useful in explaining some of broad conceptual ideas coming out of new discussions around a FCGH. Also, it has expanded on the existing literature on important work being completed by the HIV/AIDS movements in South Africa and Senegal.

## CHAPTER TWO

### The International Right to Health Conceptual Framework

This chapter seeks to examine the concept of a FCGH and how it could be used to bolster the existing international law on the right to health, specifically in the context of HIV. It will begin by outlining the current status of the international right to health framework. This leads onto a review of the current discussions around a FCGH, to place this research into the larger conceptual framework of a FCGH, specifically regarding the role of civil society.

#### 2.1 The current status of the international right to health framework

The current international framework on health (drawn from both binding treaties and non-binding sources such as declarations and UN comments) is commendable in many respects. The majority of international human rights instruments recognise the right to health.<sup>6</sup> The UN Committee on the Economic Social and Cultural Rights (Committee on the ESCR) has written one of the most recognised and expansive documents on the right to health entitled General Comment No 14.<sup>7</sup> It describes the health as

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.<sup>8</sup>

General Comment No 14 went a long way in inserting meaning into the broad declaratory language of the right. It parsed the right to health into norms, obligations, violations, and implementation thereby specifying core obligations for the achievement of this right.<sup>9</sup> In so doing, the Committee on the ESCR specified the famed minimum core obligations including primary healthcare, essential food; basic shelter, sanitation and safe portable water; and essential drugs.<sup>10</sup> Moreover, the Committee on the ESCR specifically recognised the prohibition of discrimination,

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<sup>6</sup> Examples of right to health articles include: art 12.1 of the ICESCR recognises 'the right of everyone to enjoyment of the highest attainable standard of physical and mental health'; art 55 of the UN Charter states to 'promote... solutions of international economic, social, health, and related problems', art 25 of the UDHR recognises 'standard of living adequate for... health', art 24(1) of the CRC recognises 'the enjoyment of the highest attainable standard of health', art 5(e)(iv) of the CERD prohibits racial discriminations in the enjoyment of "the right to public health, medical care, social security and social services", art 12 of the CEDAW ensures that all measures must be taken to prevent discrimination "in the field of health care in order to ensure on a basis of equality of men and women, access to health care services, including those related to family planning", art 25 of the CRPD.

<sup>7</sup> Committee on the ESCR General Comment No 14.

<sup>8</sup> As above.

<sup>9</sup> L Gostin 'Meeting the Survival Needs of the World's Least Healthy People: A Proposed Model for Global Health Governance' *Journal of the American Medical Association* 298 (2007) 381.

<sup>10</sup> General Comment No 14 (n 7 above) para 43.

including on the grounds of health status (encompassing HIV).<sup>11</sup> The Committee even stresses that many measures, including strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information.<sup>12</sup>

This step towards defining the right to health is supported by other concrete steps taken by the Committee on the ESCR to show that socio-economic rights are not vague and imprecise. In recent years, the Committee on the ESCR has begun to issue other General Comments which are meant to help clarify the scope and content of the rights contained in the ICESCR. Aside from delineating the scope and content of the rights, the Committee on the ESCR is of the view that

a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*.<sup>13</sup>

This highlights that there is a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every state party.<sup>14</sup> Seen together, these General Comments provide a base for a comprehensive understanding of the right to health. It indicates that both the UN and its nation-states are looking at health in a manner that seeks to promote and strengthen the provision of public health and its underlying determinants.<sup>15</sup> What the Committee on the ESCR has shown is a notable shift towards the argument that health should be viewed as a substantive good. Farmer acknowledges that it was not until diagnosis and care were made rights (as highlighted in General Comment No 14) rather than commodities, that PLHIV and in poverty had any hope of help.<sup>16</sup>

Moreover, the international community has made attempts to remedy the absence of strong enforcement mechanism for the ICESCR, where previously

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<sup>11</sup> General Comment No 14 (n 7 above) para 18.

<sup>12</sup> As above.

<sup>13</sup> Committee on the ESCR General Comment No 3 para 10.

<sup>14</sup> A Chapman, 'A "Violations Approach" for Monitoring the International Covenant on Economic Social and Cultural Rights' (1996) 18 *Human Rights Quarterly* 409.

<sup>15</sup> Final Report of the Commission on Social Determinants of Health 'Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health' (2008).

<sup>16</sup> P Farmer 'Challenging orthodoxies: The road ahead for health and human rights' (2008) 1 *Heath and Human Rights Journal* 2.

economic and social rights had been marginalised stymieing their full realisation.<sup>17</sup> The Optional Protocol to the ICESCR was a response to this lacuna. In 2008, the UN adopted an individual complaints mechanism for violations of socio-economic rights contained in the ICESCR.<sup>18</sup> This means that any country that signs on to (and is therefore bound by the contents of) the Optional Protocol to the ICESCR,<sup>19</sup> may be forced to answer to an international body for violations of the ICESCR.<sup>20</sup> This provides a positive step for the recognition of the right to health as delimitable and enforceable against states. However, the Optional Protocol has not yet come into force,<sup>21</sup> and it remains to be seen whether the 10 signatures needed for its adoption will be garnered in good time.<sup>22</sup>

The developments in the binding international right to health framework have emphasised the growing recognition of health not only as human right but also as a public good concept able of definition. These binding treaties are supported by a plethora of non-binding declarations and observations starting with the 1978 Alma Ata Declaration<sup>23</sup> and in the twentieth century the Millennium Declaration that encompasses the Millennium Development Goals, which set specific targets for health and HIV as well as other areas.<sup>24</sup> There have also been commitments made specifically in the context of HIV. For example, in June 2001, at the UNGASS, 189 national governments agreed to the Declaration of Commitment on HIV/AIDS.<sup>25</sup> The

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<sup>17</sup> M Dennis and D Stewart, 'Justiciability of Economic, Social and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing and Health?' (2004) 98 *American Journal of International Law* 463.

<sup>18</sup> The General Assembly adopted Resolution A/RES/63/117 on 10 December 2008.

<sup>19</sup> Optional Protocol to the ICESCR available at [http://www2.ohchr.org/english/law/docs/A.RES.63.117\\_en.pdf](http://www2.ohchr.org/english/law/docs/A.RES.63.117_en.pdf).

<sup>20</sup> M Brennan 'To Adjudicate and Enforce Socio-Economic Rights: South Africa Proves That Domestic Courts Are A Viable Option' (2009) 9 *QUT Law and Justice Journal* 64.

<sup>21</sup> For the latest information in the status of ratifications to the Optional Protocol available at [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-3-a&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3-a&chapter=4&lang=en).

<sup>22</sup> M Langford 'Closing the Gap? – An Introduction to the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights' 27 (2009) *Nordisk Tidsskrift For Menneskerettigheter* 3.

<sup>23</sup> The WHO Alma-Ata Declaration defined primary health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible [and affordable] to individuals and families in the community . . . to maintain at every stage of their development in the spirit of self-reliance and self-determination." available at WHO, Declaration of International Conference on Primary Health Care, art. VI, Alma-Ata (1978), available at [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf).

<sup>24</sup> Specifically Goal 4: Reduce child mortality: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate; Goal 5: Improve maternal health: (A) Reduce by three quarters the maternal mortality ratio (B) Achieve universal access to reproductive health; Goal 6: Combat HIV/AIDS, malaria, and other diseases: (A) Have halted by 2015 and begun to reverse the spread of HIV/AIDS (B) Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it (C) Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases; Goal 7: Ensure environmental sustainability: (C) Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation (D) By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers. See generally United Nations Millennium Declaration, United Nations General Assembly (2000).

<sup>25</sup> UNGASS on HIV/AIDS 'Commitment on HIV/AIDS' available at [http://data.unaids.org/publications/irc-pub03/aidsdeclaration\\_en.pdf](http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf).

document commits governments to improve their responses to their domestic AIDS epidemics and sets targets for AIDS-related financing, policy, and programming. Importantly, in recognition of the crucial role civil society plays in the response to HIV/AIDS, the Declaration calls on governments to include civil society, particularly people living with HIV/AIDS, in the review process. All these non-binding declarations and agreements have substantially increased the substantive content of the right to health, however their non-binding and therefore weak status within the international legal framework temper their potential impact.

The African regional human rights system has also been very active in expanding on the substance of the right to health as guaranteed in article 16 of the ACHPR and other regional human rights documents.<sup>26</sup> The African Commission, in a number of cases, has emphasised states obligations in protecting and promoting the right to health.<sup>27</sup> Though most African states may not be able to guarantee the highest attainable standard of physical and mental health to all their nationals, the African Commission recognises that there are certain minimum obligations required of states.<sup>28</sup> Also, the African Commission has emphasised that the right to health must be interpreted in accordance with international standards.<sup>29</sup>

Despite these positive legal developments, in the justiciability and in the enforcement of economic and social rights, regionally and internationally, the international right to health framework faces challenges. It is characterised by vague rights in various conventions, and where it outlines more material public health needs and guidelines, they are non-binding. The question is where to take this framework from here. The arguments for a FCGH are not based on replacing the current existing framework but rather explore how a FCGH could support and develop the existing system. It could cement the shift away from vague human right norms guaranteed in the various binding treaties toward the concretisation of the

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<sup>26</sup> Other references to the right to health in African human rights instruments include: art 14 African CRWC, art 73 of the Protocol on Women; art 14 of the Treaty establishing the AEC and art 2 of the SADC Protocol of Health. Other regional human rights systems like the European and Inter-American systems also have right to health frameworks but those are beyond the scope of this paper.

<sup>27</sup> For example cases include, *Social and Economic Rights Action Center & the Center for Economic and Social Rights v Nigeria* Comm. 155/96, 2001 (SERAC) the Commission found the right to food implicit in the right to life (art 4), right to the best attainable state of physical and mental health (art 16) & the right to economic, social and cultural development (art 22) (paras 64- 67); *Sudan Human Rights Organisation v The Sudan* Comm296/05 – *Centre on Housing Rights and Evictions v The Sudan* Comm 279/03, 2009 (Sudan cases) the Commission found violation of the right to health as state failed to provide services such as safe drinking water (paras 209-212); *Purohit and Moore v The Gambia* Comm. 241/2001, 2003, the Commission found violation of the right to enjoy the best attainable state of physical and mental health (art 16) & right of the disabled to special measures of protection in keeping with their physical & moral needs (art 18(4)) in the African Charter.

<sup>28</sup> SERAC case (as above).

<sup>29</sup> S Kiapi 'Interpreting the Right to Health Under The African Charter' (2005) 11 *East African Journal for Peace and Human Rights*.

substantive content of the right to health, as defined by UN General Comments and other non-binding documents. It is within this context, a FCGH seeks to bolster the current international right to health framework and to accelerate the achievements already made.

This section aimed to outline the current status of the international right to health framework, which leads onto a review of the current discussions around a FCGH. This aims to place this paper into the larger conceptual framework of a FCGH, specifically regarding the role of civil society in the protection and promotion of the right to health.

## 2.2 Introduction to a FCGH

In *A Proposed Model for Global Health Governance*, Gostin provides one of the most thorough typographies on the right to health within the international legal framework.<sup>30</sup> He acknowledges that international institutions and social activists have increasingly turned to the language of human rights to articulate their fondest dreams for global health.<sup>31</sup> However, he argues that

though the international right to health resonates with bold-sounding obligations, these high minded declarations have little normative force as they lack the basic features of a right: What exactly does the right entail and to what obligations do states, and others, have to conform? When is the right violated? And what are the mechanisms to enforce entitlement?<sup>32</sup>

Therefore, setting normative standards and assuring follow-through are particularly problematic in health, even more so than other fields of international law.<sup>33</sup> For Gostin, this requires innovative solutions that outline set targets, dismantle barriers to constructive engagement with the private sector, and actively engages with civil society.<sup>34</sup> It is within this context that Gostin summarised the FCGH as

a global health governance scheme that incorporates a bottom-up strategy that strives to do the following: build capacity, so that all countries have enduring and effective health systems; set priorities, so that international assistance is directed to meeting basic survival needs; engage stakeholders, so that a wide variety of state and non-state participants can contribute their resources and expertise; coordinate activities, so that programs among the

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<sup>30</sup> Gostin (n 9 above) 226.

<sup>31</sup> Gostin (n 9 above) 381.

<sup>32</sup> As above.

<sup>33</sup> As above.

<sup>34</sup> Gostin (n 9 above) 335.



proliferating participants operating worldwide are harmonised; and evaluate and monitor progress, to ensure that goals are met and promises kept.<sup>35</sup>

The exact content of a FCGH is subject to much debate and it is not the aim of this paper to anticipate that debate. However, in broad strokes, it is possible to observe that a global agreement would at least set global norms and standards in the most common areas of health delivery, and perhaps timeframes for the achievement of these standards.<sup>36</sup> The current discussions, which expound on this concept, outline some areas on which these standards could be set. For the purposes of this paper it is important to highlight the following areas: (1) recommended levels of domestic public sector expenditure on health services; (2) a definition of the essential health services that should be available to all the population; (3) priority setting with appropriate targets and benchmarks for progress; and (4) recognition of elements of non-discrimination and protection of vulnerable groups.<sup>37</sup>

This concept calls for the inclusion of concrete public health concepts, which are placed at the service of the poor rather than merely normative ideology.<sup>38</sup> The current international right to health framework (discussed above) is characterised by recognition of vague rights in various conventions, and where it outlines more material public health needs, they are non-binding. This calls into question the current global health architecture. What human beings fundamentally need is secure access to an essential package of elementary basic goods for the personal value of human life including subsistence supplies (of food and drink, clothing, shelter and basic healthcare).<sup>39</sup> Therefore, despite the differences of culture, social position or circumstance, it is imperative to ensure that all human beings receive the minimum necessary means all require to meet their needs and realise their capacities.<sup>40</sup> A FCGH would aim to outline and concretise these minimum necessary means to realise the right to health.

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<sup>35</sup> Gostin (n 9 above) 226.

<sup>36</sup> M Heywood & J Shija (n 1 above) 2.

<sup>37</sup> M Heywood & J Shija (n 1 above) and Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) Internal Working Papers (unpublished); Other areas which a FCGH aims to confront include: duties of states to support each other in order to achieve the right to health, and to manage exceptional health crises; minimum staffing norms for the delivery of effective and quality essential health services; minimum conditions of employment for health care workers; principles of equal access and non-discrimination in access to health care services; rights of migrants to health care services; and measures that states agree not to take that hinder other states' capacity to realize the right to health.

<sup>38</sup> P Farmer 'On Suffering and Structural Violence: Social and Economic Rights in the Global Era' in *Pathologies of Power: Health, Human Rights and the New War on the Poor* (2003) 236.

<sup>39</sup> T Pogge 'World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms' (2008) 55.

<sup>40</sup> Beetham 'Human Rights and Cosmopolitan Democracy' in D Archibugi, D Held and M Kohler *Re-imagining Political Community: Studies in Cosmopolitan Democracy* (1998) 60.

### 2.3 A FCGH as a tool for civil society empowerment

Given these views, other canvasses of a FCGH have identified several arguments that support such a concept.<sup>41</sup> A central assertion is the role that a FCGH would play in empowering civil society.<sup>42</sup> Fidler argues that governance of global health issues has shifted from a Westphalian to a post-Westphalian context in which both state and non-state actors shape responses to transnational and national health threats and opportunities.<sup>43</sup> The proliferation of networks of NGOs, linking local with international levels, is one of the most striking developments of the human rights regimes since 1948.<sup>44</sup> These changes are associated with globalisation, which has resulted in the widening of social inequalities within and between states,<sup>45</sup> where disparities between the global North and South are stark when looking at for example the effects of the recent famine in East Africa. Globalisation has also necessitated the rise of risks that cannot be grappled at national level alone,<sup>46</sup> like for example the cholera outbreak in Southern Africa in 2009. All this has given space for the emergence of civil society actors that try to counter the growing influence of vested state and private interests, and try to ensure that the people on the ground, most affected by these global changes, are protected and provided for.

The existence of a global standard and framework on the right to health, particularly if it has come about as a result of a mobilisation of health movements through health rights education and advocacy from below, intends to empower civil society in this new context.<sup>47</sup> Specifically, it aims to bolster NGOs, health professionals and citizens in their local and national campaigns by providing binding set obligations with a defined package of essential services, which they could demand from governments.<sup>48</sup> As defined above, a FCGH could recommend levels of domestic public sector expenditure on health services and provides a definition of the essential health services that should be available to all the population along with

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<sup>41</sup> For the purposes of this paper not all the arguments will be expanded upon, for more information see 'Realising the Right to Health in Our Lifetimes? Towards a Framework Convention on the Right to Health' Discussion document for SECTION27 Regional Activist Dialogue 25 March 2011.

<sup>42</sup> See generally I Kickbusch 'Wake-Up Call for a Strong Global Health Policy' (2003) *Yale Global Online* available at [http://yaleglobal.yale.edu/display.article?id\\_1476](http://yaleglobal.yale.edu/display.article?id_1476); P Farmer and L Garret 'Marvelous Momentum to Health Care for All' (2007) *Council on Foreign Affairs*.

<sup>43</sup> D Fidler 'Architecture amidst Anarchy: Global Health's Quest for Governance' (2007) 1 *Global Health Governance* available at [http://diplomacy.shu.edu/academics/global\\_health](http://diplomacy.shu.edu/academics/global_health) 2.

<sup>44</sup> Beetham (n 40 above) 63.

<sup>45</sup> L London & H Schneider 'Globalisation and health inequalities: Can a human rights paradigm create space for civil society action' *Social Science & Medicine* (not yet published) 3.

<sup>46</sup> As above.

<sup>47</sup> 'Realising the Right to Health in Our Lifetimes? Towards a Framework Convention on the Right to Health' (n 41 above) 14.

<sup>48</sup> As above.

appropriate targets and benchmarks for progress.<sup>49</sup> Though it does not help resolve the core problem that governments and ministries face with a lack of capacity and funding, especially in Africa, a FCGH aims to support civil society in this context to help governments set priorities within their situational constraints.

Heywood argues that a FCGH 'would assist health activists by setting a standard against which citizens are able to measure their governments.'<sup>50</sup> Therefore, within this environment, civil society seeks to reduce immediate economic and social rights deprivations rather than to topple entire regimes.<sup>51</sup> Instead, civil society needs a comprehensive set of standards against which they can judge their government's performance, and at present, the international human rights mechanisms are vague in their content (or where defined, not binding on states) such that it's not clear when they are violating the "standard" (to the extent there is one) and how they can be held to account. A FCGH aims to bolster the existing framework by, not only outlining these minimum core standards but also, incorporates a bottom-up strategy that strives to build capacity, and engages stakeholders, so that a wide variety of state and non-state participants (as will be discussed below).<sup>52</sup>

Gostin and others further this argument by stating that 'the most transformative changes in global health have come from the 'bottom up' through social movements, such as campaigns to fight HIV/AIDS'.<sup>53</sup> Heyns and Viljoen argue that the international rights framework has been used actively by civil society in countries like South Africa for demanding the right to health in their specific environment, translating law into a language that communities can relate to and interact with, in demanding their rights.<sup>54</sup> Therefore, the international right to health framework has been a productive tool for effecting change on the ground to those who need it. The effective employment of the framework by civil society is explored in the next chapter. But first the section below will explore why the area of HIV/AIDS and specifically the HIV/AIDS movement is the most apt vehicle with which to explore

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<sup>49</sup> M Heywood & J Shija (n 1 above) and JALI Internal Working Papers (n 37 above); Other areas include: duties of states to support each other in order to achieve the right to health, and to manage exceptional health crises; minimum staffing norms for the delivery of effective and quality essential health services; minimum conditions of employment for health care workers; principles of equal access and non-discrimination in access to health care services; rights of migrants to health care services; and measures that states agree not to take that hinder other states' capacity to realize the right to health.

<sup>50</sup> M Heywood & J Shija (n 1 above) 2.

<sup>51</sup> J Perelman and L White 'Stones of Hope: Experience and Theory in African Economic and Social Rights Activism' in L Whik and J Perelman *Stones of Hope: How Africa Activists Reclaim Human Rights to Challenge Global Poverty* (2011) 176.

<sup>52</sup> Gostin (n 9 above) 226.

<sup>53</sup> L Gostin, M Heywood, G Ooms, A Grover, J Rottingen and W Chenguang 'Joint Learning Initiative on National and Global Responsibilities for Health' (2010) *WHO Bulletin*.

<sup>54</sup> See C Heyns & F Viljoen 'The Impact of the United Nations Treaties on the Domestic Level' (2001) 23 *Human Rights Quarterly* 398; And more generally P Hunt *et al* 'Health Systems and the Right to Health: an Assessment of 194 Countries' (2008) 372 *The Lancet* 2047.

the value of a FCGH. For the purposes of this paper the scope is limited to the HIV/AIDS movement, which has been a fundamental force in the development of the right to health.

## 2.4 The HIV/AIDS movement as a prototype for a FCGH

As Farmer states, stories of the rampage of the AIDS epidemic, in the eyes of the epidemiologist as well as the political analyst, has brought together millions of people living in similar circumstances.

‘These victims, past and present, do not share culture or language or a certain race. What they share, rather, is the experience of occupying the bottom rung of the social ladder in inegalitarian societies.’<sup>55</sup>

In this picture, Mann noted that AIDS has helped catalyse the modern health and human rights movement, which leads far beyond AIDS, for it considers that promoting and protecting health and promoting and protecting human rights are inextricably connected.<sup>56</sup> The growth in the importance of health in world politics over the past decade, constitutes an unprecedented transformation, the implications of which experts are trying to understand and, if possible, manipulate.<sup>57</sup> For health activists and academics alike, it is evident that efforts to address HIV/AIDS deepened the human rights content of international right to health framework.<sup>58</sup> Moreover, the framework has evolved from its early extremely limited content to its current more expansive substance.<sup>59</sup>

During the last decade, there was a ‘marvelous momentum for health assistance’<sup>60</sup> built on the back of the AIDS movement that many believed showed ‘no signs of abating.’<sup>61</sup> Over the past few years, this momentum is under huge pressure fueled by the global economic crisis. Initiatives that created the foundation for funding for HIV/AIDS treatment and prevention for much of the developing world, like Global Fund and the PEPFAR, have shown a distinct lack of willingness to continue funding at the same rate.<sup>62</sup> These funding challenges severely obstruct developing states abilities to provide basic essential medicines like ARVs to their population. According

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<sup>55</sup> Farmer (n 38 above) 29.

<sup>56</sup> Farmer (n 38 above) 56.

<sup>57</sup> Fidler (n 43 above) 1.

<sup>58</sup> Fidler (n 43 above) 9.

<sup>59</sup> As above.

<sup>60</sup> Farmer & Garrett (n 42 above).

<sup>61</sup> As above.

<sup>62</sup> See letter written by TAC to US Ambassador of South Africa concerning ‘We call on the US government to provide global leadership to achieve millennium development goal6, including universal access to antiretroviral therapy’ available at <http://www.section27.org.za/2010/06/18/call-on-us-government-to-fund-aids-and-health/>.

to a UNAIDS 2010 report in low-income countries, 88% of spending on AIDS comes from international funding.<sup>63</sup> Therefore, civil society has and will continue to play a strong role in campaigning and advocating for funding for ARVs from developed nations. This is another area – the inequality between North and South - that a FCGH hopes to address but this discussion does not form part of this paper. The point that needs to be emphasised here is that the need for funding for treatment and prevention of HIV has highlighted the weaknesses in the existing international governance framework in sustaining and furthering international assistance for developing nations. Also it has highlighted the need for set priorities, so that international assistance is directed to meeting the most important basic survival health needs.<sup>64</sup>

Moreover, whilst conversations around funding are necessary, they are not sufficient. Lessons from studies of public health programmes, through the lens of HIV/AIDS, suggest that even with funded, functioning health systems, the results can be disappointing mainly because of the lack of engagement with communities.<sup>65</sup> This is especially the case for HIV/AIDS programmes.<sup>66</sup> Research has consistently shown that an effective response to this epidemic goes beyond the provision of essential drugs like ARVs, the supply of condoms, health messages for safe sex and other material elements.<sup>67</sup> It is necessary for the response to extend to issues such as stigma, discrimination, power networks and kinship systems.<sup>68</sup> Therefore, any exchange about HIV/AIDS and the international right to health framework, especially in Africa, is not only a matter of health systems but also about culture and societal leanings.

Despite international efforts to tackle HIV/AIDS, stigma and discrimination remain among the most poorly understood aspects of the epidemic.<sup>69</sup> Stigma refers to overt acts or behaviour manifested by others towards the stigmatized, in this case PLHIV.<sup>70</sup> It is often implicit, living in the minds of each individual, based on existing beliefs and cultures, thus making its presence difficult to establish.<sup>71</sup> In its extreme

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<sup>63</sup>UNAIDS 'Report on the global AIDS epidemic' (2008) available at <http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/Default.asp>.

<sup>64</sup> Gostin '(n 9 above) 226.

<sup>65</sup> M Chopra & N Ford 'Scaling up health promotion interventions in the era of HIV/AIDS – challenges for a rights based approach' 4 (2005) *Health Promotion International* 355.

<sup>66</sup> As above.

<sup>67</sup> As above.

<sup>68</sup> As above.

<sup>69</sup> D Skinner & S Mfecane 'Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa' 1 (2004) *Journal des Aspects Sociaux du VIH/SIDA* 158.

<sup>70</sup> P Eba 'Stigma[ta]' (2007) *AIDS Review* 18.

<sup>71</sup> F Viljoen 'Introduction' in F Viljoen (ed) *Righting Stigma: Exploring a right-based approach to addressing stigma* (2005) 7.

form, it reveals itself as discrimination and even violence.<sup>72</sup> HIV-related stigma has its own unique qualities, and is 'heightened as it is layered upon other stigmas associated with race, gender, homosexuality, drug use, promiscuity etc.'<sup>73</sup> In part, HIV-related stigma developed because of the ways in which the epidemic and patterns of behaviour were oversimplified and reduced to personal sexual behaviour.<sup>74</sup> Due to these demarcations HIV/AIDS-related stigma is always underpinned by a kind of moral fundamentalism resulting in communities not wanting to engage with the subject of HIV/AIDS.<sup>75</sup> Stigma has been identified as one of the major barriers to effective community engagement on HIV/AIDS issues.<sup>76</sup>

Poverty and social attitudes and practices, related to a lack of training and information, as well as cultural beliefs, are undoubtedly the breeding ground for HIV in Africa.<sup>77</sup> These factors pose deep problems for the HIV/AIDS movement, as the fight against HIV is not only in material terms, but also on a social and cultural level. Many of the violations against the right to health for PLHIV in most countries in Africa occur in the form of discrimination and stigmatisation.<sup>78</sup> Even if the epidemic can be fought effectively from a clinical and epidemiological perspective, it is not enough to only provide the basic essential services but also through voluntary testing and monitoring of people who agree to declare their HIV status. The stigma and discrimination against PLHIV mean that they will naturally tend to hide their status.<sup>79</sup> This attitude will result in the inability to identify infected people and threatens the containment of HIV/AIDS through comprehensive treatment, care and support.

African legal academics therefore argue that it is urgent that African countries try to influence these factors through legal measures.<sup>80</sup> The demands for creating a new legal order to face the spread of the epidemic in Africa has grown more evident with the particularity of the disease in the context of stigma and discrimination. A FCGH provides a concrete outline of priorities emphasising the protection and promotion of vulnerable groups (in this case PLHIV). Through this, strategies to combat stigma and discrimination would have to be inherent in any policy or law that

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<sup>72</sup> As above.

<sup>73</sup> R Lee, A Kochman & K Sikkema 'Internalised stigma among people living with HIV-AIDS' (2002) *Aids and Behaviour* 309.

<sup>74</sup> Eba (n 70 above) 18.

<sup>75</sup> As above.

<sup>76</sup> B Kante 'VIH et droits humains' Paper presented at a workshop to exchange experiences on the theme 'Integration of HIV / AIDS in programs or development projects in Africa the West', held in Dakar by the Regional HIV and Development Project in Pretoria (2002) (translated from French) 3.

<sup>77</sup> As above.

<sup>78</sup> As above.

<sup>79</sup> As above.

<sup>80</sup> B Kante 'Droit et VIH en Afrique' Paper written for the New Delhi office of the Regional UNDP HIV and Development (1996) (translated from French) 1.

prioritised PLHIV. Therefore, a FCGH may in fact broaden the perspective of the fight against the epidemic.

This section aimed to explore why the area of HIV/AIDS, and specifically the HIV/AIDS movement, is the most apt vehicle with which to explore the value of a FCGH. In light of the challenges to the right to health within states presented by the need for essential medicines to tackle the HIV/AIDS, the lack of funding and capacity for health systems in general, and the problem of stigma and discrimination in African states, some argue that a FCGH is a moral, legal, political and public health imperative.<sup>81</sup> The next section will give a brief outline of some of the arguments against a FGCH. It is within the lens of the HIV/AIDS movements, in the two case studies, that that this paper aims to tackle some of these criticisms in the forthcoming chapters.

## 2.5 Arguments against a FCGH

There is an expanse of literature which problematises the concept of a FCGH, especially for the tangible realisation of rights for those most in need. Critics have called into question the value of yet another international agreement, when the real obstacles to health care lie at a national level and should be actively negotiated at that level.<sup>82</sup> The progress made on global health governance is questioned when confronted with the challenges that governments face in realising the right to health.<sup>83</sup> This failure is a failure to build and sustain public health capabilities locally and nationally, and interface these activities with global level activities.<sup>84</sup>

This links to the criticism that the right to health already exists in multiple human rights treaties and has further been elucidated upon in many different international documents like General Comment No 14, therefore it is better to strengthen existing systems and employ the current documents. Following this, critics question the litter of unfulfilled international commitments and declarations seeing that current international treaties, particularly current human rights treaties, are often ineffective and poorly implemented.<sup>85</sup> A study done by Palmer *et al* showed that ratification of human rights treaties was not significantly related to a positive change in national health.<sup>86</sup> Moreover, the ratification of treaties has been criticised

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<sup>81</sup> M Heywood & J Shija (n 1 above) 7.

<sup>82</sup> As above.

<sup>83</sup> Fidler (n 43 above) 2.

<sup>84</sup> As above.

<sup>85</sup> JALI Internal working papers (n 37 above).

<sup>86</sup> A. Palmer, J Tomkinson, C Phung, et al. "Does ratification of human-rights treaties have effects on population health?" (2009) *Lancet* 1990.

for reducing the state action as states become complacent once they have made the paper commitment.<sup>87</sup>

These criticisms will be explored within the context of the case studies in the forthcoming chapters to highlight that maybe the critics have been too fast in their complete rejection of this concept. There may be innovative new spaces where such an idea can be capitalised upon to improve the work of civil society and in conjunction the lives of citizens.

## 2.6 Conclusion

The current international right to health framework, as described above, has made great strides in the recognition of the right to health and the substantiation of the content of this right. However, it has not brought about the needed micro changes for people living on the ground or the desired macro shifts in global health.<sup>88</sup> Though the war on HIV/AIDS has propelled the entire global health movement to a grand scale, the HIV/AIDS movement is at an impasse. It faces challenges both globally, with the flatlining of HIV/AIDS funding and other global concerns, and nationally, with social and cultural challenges including HIV-related stigma and discrimination. The question is where does the international right to health framework go from here. A FCGH, as illustrated above, aims to empower civil society movements with binding concrete definitions of the essential health services and priority areas, while incorporating a bottom-up strategy that strives to build capacity and engage stakeholders.

It is from this perspective that the next two chapters will look at the status of international right to health framework within the context of the two case studies of HIV/AIDS movements in South Africa and Senegal. There are innovative new spaces within this context where the idea of an FCGH can be capitalised upon to improve the work of these movements and in conjunction the lives of citizens.

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<sup>87</sup> See generally Fidler (n 45 above); W George *et al* 'The Transformational Model of International Regime Design: Triumph of Hope or Experience?' (2000) 38 *Columbia Journal of Transnational Law* 465.

<sup>88</sup> 'Realising the Right to Health in Our Lifetime? Towards a Framework Convention on the Right to Health' (n 41 above).



## CHAPTER THREE

### The HIV/AIDS movement in South Africa and a Framework Convention on Global Health

This chapter will begin by setting out the current status of the right to health framework in South Africa, specifically in the context of HIV/AIDS. This contextualises an exploration of the protection of the right to health for PLHIV by the HIV/AIDS movement and what the potential role is for a FCGH in empowering this movement?

#### 3.1 Introduction

As a young democracy, with its first democratic elections taking place in 1994, South Africa's legal architecture is based upon the conception of human rights and responsibilities that emerged in the mid-1990s.<sup>89</sup> The new democratic regime brought an end to the racially qualified constitutional order that had accompanied 300 years of colonialism, segregation and apartheid.<sup>90</sup> The background of historical unequal opportunities and disadvantaged conditions presents one of the greatest challenges to the process of democratization in South Africa, impacting all spheres of society. The economic disparities have fundamentally affected the delivery of all economic and social goods to the poorest and most vulnerable within the society. The advent of the AIDS epidemic only compounded these inequalities. Due to the history of the epidemic in South Africa, from the denialism period to current funding challenges and health systems weaknesses, civil society has had to find new and innovative ways to engage and combat government, to ensure the delivery of basic health services to PLHIV. It is within this context that conversations around a FCGH are framed.

#### 3.2 Current right to health framework in South Africa

In the context of the international right to health framework, South Africa was only accepted back into the international community after the 1994 elections and the inauguration of a new democratic government. It was only after this that they started discussing the ratification of international treaties.<sup>91</sup> The new government actively made efforts to sign and ratify all international treaties. However, most notably, South Africa has not yet ratified the ICESCR and therefore the use of the Optional-Protocol

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<sup>89</sup> M Heywood & J Shija (n 1 above) 1.

<sup>90</sup> See generally *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS & the Law* (2007) 215.

<sup>91</sup> CERD came into force 09/01/99; CDESCR was signed 03/10/1994 but not ratified; CCPR came into force 10/03/1999; CEDAW came into force 10/04/1996; CRC signed 29/01/1993; ACHPR ratified on the 09/07/1996; ACRWC ratified on the 1/10/1997; Women's Protocol ratified on the 17/12/2004 and came into force 16/07/1995.

for individuals claiming violations under the ICESCR is not possible. There have not been any public arguments against its ratification but it might be the consequence of nothing more than 'bureaucratic bungling'.<sup>92</sup>

Although dualist, the Constitution of the Republic of South Africa, 1996 (hereafter the SA Constitution),<sup>93</sup> can be described as highly international human rights law friendly.<sup>94</sup> The President of the Republic is empowered to negotiate and sign international agreements.<sup>95</sup> As a general rule these treaties must be ratified by parliament in order to bind the country under international law. An international agreement becomes part of domestic law only once it has been 'enacted into law by national legislation', in other words, once it has been incorporated.<sup>96</sup>

Under the SA Constitution, international human rights treaties – whether ratified or not by South Africa – are a guide to judicial interpretation. Most important in this respect is the interpretation clause of the Bill of Rights, which provides that in the interpretation of the Bill of Rights, international law must be considered.<sup>97</sup> Moreover the SA Constitution provides that every court when interpreting 'must prefer any reasonable interpretation of the legislation that is consistent with international law over any interpretation that is inconsistent with international law.'<sup>98</sup>

Moreover, Chapter Two of the SA Constitution, named the Bill of Rights, guarantees both civil and political rights as well as economic, social and cultural rights and numerous provisions impact directly and indirectly on HIV/AIDS.<sup>99</sup> The drafters of the SA Constitution therefore emphasised and entrenched certain economic and social rights, including the right of access to health care services and other rights which are determinants of health including sufficient food, water and social security.<sup>100</sup> The rights impose duties on the state to ensure that these economic and social rights are 'progressively realised,' 'within available resources' by 'reasonable legislative and other measures.'<sup>101</sup> Moreover, in South Africa these rights enshrined in the Constitution are justiciable and there has been litigation before the

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<sup>92</sup> C Heyns and F Viljoen (n 54 above) 546.

<sup>93</sup> Constitution of Republic of South Africa Act 108 of 1996 (the SA Constitution).

<sup>94</sup> As above.

<sup>95</sup> As above.

<sup>96</sup> art 213 of the SA Constitution.

<sup>97</sup> art 39(1)(b) of the SA Constitution.

<sup>98</sup> art 233 of the SA Constitution.

<sup>99</sup> These include art 9: Equality; art 10: Human dignity; art 11: Life; art 12: Freedom and security of the person; art 14: Privacy; art 23: Labour practices; art 24: Environment; art 25: Property; art 26: Housing; art 27: Health care, food, water and social security; art 28: Children; art 29: Education; art 31: Cultural, religious and linguistic communities; art 33: Just administration; art 35: Arrested, detained and accused persons; and art 36: Limitation of rights. See report 'Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS & the Law' (2007) 215.

<sup>100</sup> art 26 (housing) and art 27 (healthcare, food, water and social security) of the SA Constitution.

<sup>101</sup> art 26 of the SA Constitution.

Constitutional Court on the issue of HIV/AIDS, most notably the *TAC* case, which will be discussed below.<sup>102</sup>

Interestingly, the entire discourse surrounding the debate around economic and social rights was couched in Committee on ESCR terms, in particular regarding implementation.<sup>103</sup> The treaties have had a far-reaching impact on human rights in South Africa, in that the legal system has largely been transformed to reflect the norms expressed in the treaties.<sup>104</sup> This indirect effect of the treaties is particularly visible in the Bill of Rights. Given the close fit between the Bill of Rights of the SA Constitution and the different international treaties creates an optimal environment for studying how a FCGH could be effective with respect to the right to health.

The domestic legislative framework indicates overwhelmingly that in addressing the HIV/AIDS epidemic, and affording protection to the rights of those affected or infected, South Africa (like other states in Africa) elected to respond to the HIV/AIDS epidemic by introducing policies, codes or guidelines, rather than legislation.<sup>105</sup> For example, the most prominent is the HIV/AIDS & STI National Strategic Plan for South Africa 2007-2011; it represents the country's multi-sectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS and sets out strategies for prevention, management, care and human rights protections.<sup>106</sup> Where legislation does address HIV/AIDS issues, it tends to be limited to the areas of criminal law and labour law.<sup>107</sup> The South African legal framework, despite its weaknesses, has provided a sound framework for HIV/AIDS movement to mobilise and make demands on the government for the right to health, as will be explored below.

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<sup>102</sup> *Minister of Health and others v Treatment Action Campaign and others* CCT 9/02; 2002 (5) SA 721 (CC). Other examples include: *Hoffmann v South African Airways* CCT 17/00; 2001 (1) SA 1 (CC); *Van Biljon & Others v Minister of Correctional Services* CPD, 1997; 1997 (4) SA 441 (C); *Jordan and others v Republic of South Africa* CCT31/01.

<sup>103</sup> C Heyns and F Viljoen (n 54 above) 553.

<sup>104</sup> S Liebenburg 'The ICESCR and its implications for South Africa' *South African Journal of Human Rights* 570.

<sup>105</sup> For other policies relating to HIV/AIDS in SA see further *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS & the Law* (2007) 219.

<sup>106</sup> NSP 2007-2011 available at <http://www.info.gov.za/otherdocs/2007/aidsplan2007/index.html>. There are ongoing discussion for the next NSP (see discussion on SECTION27 website available at <http://www.section27.org.za/wp-content/uploads/2011/09/SECTION27-SUBMISSION-What-is-an-NSP-201109071.pdf>).

<sup>107</sup> Example of legislative provisions include: Schedule 6 (a)(iv) of the Criminal Procedure Second Amendment Act 85 of 1997 makes the granting of bail more difficult in instances where the suspected rapist is known to be HIV positive; Sections 34(1) and (2) of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 make direct reference to HIV and AIDS; Sections 6, 7(1) and (2) and 50(4) of the Employment Equity Act 55 of 1998 deal specifically with HIV and AIDS in employment. For other policies relating to HIV/AIDS in SA see further *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS & the Law* (2007) 219.

In conclusion, this section on the current status of the right to health framework in South Africa highlights that the international legal framework on the right to health has been well received and well domesticated into national law and policy (apart from the unratified ICESR). The fact that the international treaties, even if not domesticated, may be used as sources for interpretation provides a strong basis for civil society to use the rights contained in these document in domestic courts. Moreover, the SA Constitution, which was seeped in the rights culture emanating from the ICESCR, is the most important instrument from which the right to health may be protected and promoted in South Africa, as will be seen below. This aimed to give a legal context to the following exploration of the protection of the right to health for PLHIV by the HIV/AIDS movement in South Africa. This will then lead onto what the potential role is for a FCGH in empowering this movement.

### **3.3 History HIV/AIDS epidemic and the birth of the HIV/AIDS movement in South Africa**

South Africa is home to nearly 5.6 million people with HIV.<sup>108</sup> The estimated number of people needing treatment in 2007 was 889,000 of which 488,739 (55%) enrolled and 371,731 (42%) initiated on the ART programme.<sup>109</sup> These numbers would not be so vast had South Africa's new democratic government acted responsibly in the 1990s and early 2000s.<sup>110</sup> The emergence of the denialist outlook in government circles, led by then President Mbeki and his Minister of Health Manto Tshabalala, resulted in delay on the government's part in the delivery of life-saving PMTCT and responses in treatment, care and support for PLHIV.

But the current situation could have been more severe had the government not been challenged and their policies transformed by a remarkable social rights struggle.<sup>111</sup> A struggle, which was largely led by the Treatment Action Campaign (TAC). Launched in 1998, TAC was a response to the HIV/AIDS epidemic whose impact was becoming apparent. TAC aimed to campaign for greater access to treatment for all South Africans, by raising awareness and understanding about issues surrounding availability, affordability and use of HIV treatments.<sup>112</sup> It began as a grassroots organization working to raise public awareness and understanding of

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<sup>108</sup> 'Health in South Africa' 374 (2009) *The Lancet* 759.

<sup>109</sup> Statistics by Actuarial Society of South Africa available at <http://www.health-e.org.za/uploaded/c0b24898135d6363351d590125ba7a6b.pdf>.

<sup>110</sup> W Forbath 'Cultural Transformation, Deep Institutional Reform, and ESR Practice: South Africa's Treatment Action Campaign' in L Whik and J Perelman *Stones of Hope: How Africa Activists Reclaim Human Rights to Challenge Global Poverty* (2011) 51.

<sup>111</sup> S Friedman 'Gaining comprehensive AIDS treatment n South Africa: the extraordinary 'ordinary' in J Gaventa and R McGee *Citizen action and national policy reform: making change happen* (2010) 45.

<sup>112</sup> For more about TAC visit their site available at <http://www.tac.org.za/community/about>.

the issues that surround the availability, affordability, and use of HIV treatments. TAC has become a vocal and visible lobby in the developing world for the rights of people with HIV to treatment, justice and non-discrimination.<sup>113</sup> However, they had not expected to campaign against the government – their intended target was multinational pharmaceutical companies, which were expected to obstruct attempts to secure affordable treatment for people living with the virus.<sup>114</sup>

During the challenging period of denialism, TAC's success in using both the international and domesticated concepts of the right to health, for protecting and promoting the rights of PLHIV, can be seen as a product of circumstance.<sup>115</sup> As stated above, the SA Constitution forthrightly sets out a host of social rights, including the right to healthcare; it declares that the rights entail affirmative governmental duties, and it makes them justiciable. What is more, the SA government had acknowledged, in principle, its obligation to undertake broad provision of social goods.<sup>116</sup>

TAC's 'politics-centered' approach to right to health advocacy included aspects of grassroots empowerment and international collaborations.<sup>117</sup> Its grassroots 'treatment literacy campaign' aimed to empower poor and physically and spiritually debilitated South African's with HIV to participate in and make demands for their own treatment and care – and to remake themselves into rights-bearing members of local communities, activist organisations, and larger publics in schools with a stake in the future of South Africa's healthcare and social policies.<sup>118</sup>

Though the original objective was to make essential medicines accessible to all people with HIV/AIDS, TAC also challenged AIDS-related stigma in communities through engaging with communities, clinics, support groups, nongovernmental organizations, community-based organizations, faith-based organizations, churches and TAC branches. The aim is to emphasize that AIDS is a shared concern, not just the problem of those who are infected.<sup>119</sup>

International collaborations included partnerships with international organisations like Medecins Sans Frontieres (MSF) who provided important science

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<sup>113</sup> UNAIDS Report on HIV-Related Stigma, Discrimination and Human Rights Violations UNAIDS Best Practices Collection (2005) available at [http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf).

<sup>114</sup> Friedman (n 111 above) 45.

<sup>115</sup> Forbath (n 110 above) 56.

<sup>116</sup> Forbath (n 110 above) 56.

<sup>117</sup> Forbath (n 110 above) 51.

<sup>118</sup> Forbath (n 110 above) 53.

<sup>119</sup> UNAIDS Report on HIV-Related Stigma, Discrimination and Human Rights Violations UNAIDS Best Practices Collection (n 113 above).

and medical based support. But hewing local and international action seemed insufficient. Therefore, instead of shunning national political action and large-scale national institutions, TAC's critical engagements with government – sometimes assailing but sometimes cooperating – proved imperative to the struggle.<sup>120</sup> Therefore, while plowing local, grassroots, and international terrains, TAC also built itself into an oppositionist movement in national policy, with strategies directed at protesting, challenging, and changing state policy, and enlisting and collaborating with allies in the state and party apparatus and in the national trade union federations.<sup>121</sup> Even after universal access to antiretroviral treatment was finally adopted in 2004, minimal investment in monitoring systems made attempts at holding government to account for the programme very difficult.<sup>122</sup> As a result, civil society groups including the TAC established their own monitoring network to track equity and coverage of ARV access across South Africa during the rollout, illustrating the role of civil society monitoring as essential to accountability in a human rights framework.

Moreover, TAC used litigation sparingly for the enforcement of the right to health in the service of many-sided strategies to prod government to change state policies, to open up policy-making processes, and to fashion and implement robust and democratic programs of social provision.<sup>123</sup> One of the most famous social and economic rights cases in South Africa is the case of *Treatment Action Campaign v Minister of Health*.<sup>124</sup> This case involved a challenge to the limited nature of the measures introduced by the state to PMTCT. The Constitutional Court (the Court) held that the government's programme to PMTCT did not comply with its obligations in terms of art 27(1) and (2) of the SA Constitution. The Court made both declaratory and mandatory orders against the government to implement a more reasonable policy regarding PMTCT.

However, the outcome of this case disappointed many SA human rights advocates who had hoped for broad judicial declarations of the 'core' substance and programmatic contours of social rights like the right to health.<sup>125</sup> Many have criticised this deferential approach by the Court stating that the Court should offer the government and civil society at least a minimum content and meaning of the right to

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<sup>120</sup> Forbath (n 110 above) 51.

<sup>121</sup> Forbath (n 110 above) 87.

<sup>122</sup> London & Schneider (n 45 above) 5.

<sup>123</sup> Forbath (n 110 above) 52.

<sup>124</sup> *Minister of Health and others v Treatment Action Campaign and others* CCT 9/02; 2002 (5) SA 721 (CC).

<sup>125</sup> Forbath (n 110 above) 6.

health.<sup>126</sup> The question that arises is how can civil society gauge whether the government is making adequate progress towards realising South Africans right to health, without a clear constitutional standard, setting out what the government must achieve. These critics argue that ‘the dispossessed and impoverished citizenry are entitled to have the minimum content of their [economic and social rights] articulated, so they and their political and legal advocates may more readily hold the government to account.’<sup>127</sup> The Committee on ESCR has embraced this notion of a ‘minimum core’ definition of economic and social rights, as highlighted in the previous chapter.

Therefore, even if there is a constitutional right to access to healthcare services it has been limited to a ‘reasonableness standard’. Thus, there is considerable possibility for the development of a blueprint for the government of what the international right to health minimally demands, which could inform national standards and that blueprint could in turn inform and empower advocacy who have been disappointed by the deference of the South Africa Constitutional court.<sup>128</sup> Here it is possible to see a space for conversations around a FCGH setting out this ‘minimum core’, which could aid HIV/AIDS movements in their work to ensure the right to health is respected and protected. These innovative but concrete initiatives become important in the protection and promotion of the right to health in South Africa, particularly when tackling new challenges that face the HIV/AIDS movement. Some of these challenges will be highlighted below.

### **3.4 Challenges facing the protection and promotion of the right to health in South Africa**

As Mary Crewe, Director of the Centre for the Study of AIDS at the University of Pretoria, has stated

HIV and AIDS have brutally exposed the fault lines of our society – poverty, gender equality, violence, lack of access to education, healthcare and social service as well as the importance of employment and social security.<sup>129</sup>

On 29 October 2009, President Jacob Zuma brought a decade of AIDS denialism to an end. In a land- mark speech to the National Council of Provinces (NCOP), Zuma recognised “the devastating impact that HIV and AIDS is having on our nation.”<sup>130</sup> In

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<sup>126</sup> Forbath (n 11 above) 66.

<sup>127</sup> As above.

<sup>128</sup> As above.

<sup>129</sup> quoted in F Viljoen & S Precious (ed) *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* (2007) 4.

<sup>130</sup> Zuma’s address to the NCOP is available at <http://www.pmg.org.za/node/19020>.

the aftermath of the denialism period and this supportive environment from government, TAC and other civil society organisations working around HIV/AIDS in South Africa have begun to address the broader political economy of healthcare in a more systematic fashion.<sup>131</sup> This includes the gross inequalities of resources between the private and public sectors, and the range of institutional reforms needed to make HIV/AIDS treatment effective.<sup>132</sup> Major inequities remain within South Africa – there is huge variation in health status and health service access across the nine Provinces, and even between communities who live next to each other.<sup>133</sup> For example, only 14% of citizens are able to access the private health care sector, and yet they benefit from up to 60% of national health expenditure.<sup>134</sup> Simply put, the new strategic challenge lies in amalgamating the immediate task of pushing for the implementation of the operational plan of government with the longer-terms goal of promoting the strengthening of the broader healthcare system; as well as within the framework of individual rights and the more utilitarian notion of public health.

Any number of examples illustrates the hardware failure problem. Efforts to increase the percentage of HIV-infected people, in sub-Saharan Africa, with access to ARVs mainly suffer from inadequate capabilities to deliver drugs effectively to those in need, not because there is a lack of drugs.<sup>135</sup> This is highlighted by most recent example when in 2009 when the South African government imposed a moratorium on the rollout of antiretroviral drugs for new HIV/AIDS patients in the province of the Free State.<sup>136</sup> This experience paints a picture of poor budgeting and expenditure monitoring, a lack of appropriate Department of Health oversight, and jurisdictional issues between health and finance at the provincial sphere of government.<sup>137</sup> Moreover, these issues are compounded by the diminishing funds available for HIV/AIDS treatment (as highlighted in Chapter Two), which further puts pressure on the system. In a country like South Africa, which has such a heavy HIV/AIDS burden, the smallest cut in funding will have a detrimental effect on the on the delivery of essential medicines to PLHIV and the health system more generally.

Therefore, in the HIV/AIDS context of a country like South Africa, which faces a simultaneous crisis of an extremely high HIV/AIDS rate and a crisis of health

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<sup>131</sup> Forbath (n 110 above) 73.

<sup>132</sup> As above.

<sup>133</sup> *The Lancet* South Africa Series Executive Summary core group. Writers Lawn JE, Kinney MV. The Lancet Health in South Africa: Executive Summary for the Series (August 2009) 2.

<sup>134</sup> As above.

<sup>135</sup> Fidler (n 43 above) 14.

<sup>136</sup> For more information about the financial and health crisis that occurred in the Free State see the AIDS Law Project report available at [http://www.tac.org.za/community/files/ALP\\_Free\\_State\\_Report.pdf](http://www.tac.org.za/community/files/ALP_Free_State_Report.pdf).

<sup>137</sup> E Scheepers 'Government in the cockpit (at last): the new challenges facing HIV prevention and treatment' in *AIDS Law Project Review: January 2009 to March 2010* 53.



systems,<sup>138</sup> In light of these health system challenges, the HIV/AIDS movement will have to build on its previous momentum, which has also been affected by the funding crisis, as have many of organizations working around HIV/AIDS. Therefore, novel methods are needed to tackle these challenges. The section below aims to explore how a FCGH could support the HIV/AIDS movement in facing these new challenges.

### **3.5 The role of a FCGH as a tool for empowering the HIV/AIDS movement in South Africa**

Unfortunately, a FCGH is not a quick fix strategy and cannot solve these internal challenges. The HIV/AIDS movement is confronted with the inherent constraints within governmental and health systems delivery of the right to health. Thus, the problems that face HIV/AIDS face health generally. But, as stated above, A FCGH could provide a comprehensive blueprint, including recommended levels of domestic public sector expenditure on health services, a definition of the essential health services and priority areas. Thus, giving civil society and government a sound working board for combating these challenges.

For example, one of the government's responses to the medicine stock outs in the Free State and the challenges facing the provision of healthcare is a commitment to introduce a system of National Health Insurance (NHI) within the next 5 years. It aims to guarantee an essential package of healthcare services to all people funded by a single health insurance system.<sup>139</sup> It is within initiatives like this that a FCGH may prove instrumental in its ability to provide a comprehensive blueprint for government, as well as for civil society to mobilise around, providing a common vision for what to demand and the priorities for the achievement of the basic needs of those they are representing.

Moreover, the HIV/AIDS movement can use the FCGH to challenge the way in which the state is currently organising around the right to health. Movements such as the TAC and its fellow organisations like AIDS and Rights Alliance of Southern Africa (ARASA) have deepened democracy by demanding accountability from governments who have not been accustomed to such pressure. It is within this context that a FCGH, could be used as an advocacy tool by the HIV/AIDS movement in their ambition to hold government to account.

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<sup>138</sup> "Health in South Africa," *Lancet* 374 (2009) 759-1031.

<sup>139</sup> The National Health Insurance in South Africa Policy Paper available at <http://www.info.gov.za/view/DownloadFileAction?id=148470>.

### 3.6 Conclusion

This chapter highlights the effective use of the current international right to health framework in the protection and promotion of the rights of PLHIV in South Africa. The work of organizations like the TAC sought to use human rights campaigns to open up political debate about where to allocate, when to expand, and how best to renew limited resources in ways that enable all people to live decent lives.<sup>140</sup> However, this chapter also highlights that the current challenges to health presented by government constraints and other limitations marks the need for new innovative ideas that strengthen civil society's work on the ground. In this context, Heywood proposes a more comprehensive single instrument (like a FCGH) which would not only bring together concepts from the existing array of instruments, but also expand and concretise tangible rights and obligations providing a form of 'minimum core' for state and non-state actors, to take forward the current advocacy and activism around health.

The next chapter seeks to explore the same discussion on a FCGH and its role in empowering the HIV/AIDS movement but within the context of Senegal. This aims to show that even where epidemics have distinct gestations, a FCGH may be used as a tool to empower the HIV/AIDS movement.

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<sup>140</sup> J Perelman & L White (n 51 above) 166.

## CHAPTER FOUR

### The HIV/AIDS movement in Senegal & a Framework Convention on Global Health

This chapter will begin by setting out the current status of the right to health framework in South Africa, specifically in the context of HIV/AIDS. This contextualises an exploration of the protection of the right to health for PLHIV by the HIV/AIDS movement and what the potential role is for a FCGH in empowering this movement?

#### 4.1 Introduction

Senegal has historically been described as a healthy democracy, an exception in the region of West Africa, with periodic multiparty elections, an elected national assembly and a strong president.<sup>141</sup> It gained independence from France in 1960 and boasted title as one of Africa's most enduring democracies with President Senghor voluntarily relinquishing power in 1980. In 2000, longtime opposition politician Abdoulaye Wade won an election and overturned 40 years of unbroken rule by the Socialist Party (PS). It was hailed an historic victory for democracy and the new president promised that the country would never again come under de facto one-party rule for decades on end. But only ten years later, Wade's own government is threatening to become that which it fought so hard to reject.<sup>142</sup> This poses threats to the famed democratic state and also to the gains made in the provision of basic essential services to the most vulnerable.<sup>143</sup>

It is within this democratic context that this paper will analyse the response to HIV/AIDS by civil society movements in Senegal and look at possible opportunities presented by a FCGH for enhancing the work of the movement. This chapter will first look at the status of the right to health in the Senegalese legal framework.

#### 4.2 Current right to health framework in Senegal

Senegal became a member of the UN on 28 September 1960, soon after independence. From the start, the first President Leopold Senghor, regarded international relations of great importance and throughout its history Senegal has

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<sup>141</sup> A Patterson 'A reappraisal of democracy in civil society: evidence from rural Senegal' 36 (1998) *The Journal of Modern African Studies* 426.

<sup>142</sup> 'A Niang 'Between centralisation and decadence: Senegalese politics under Wade' (2009) *Pambazuka News* available at <http://pambazuka.org/en/category/features/60920>.

<sup>143</sup> Report by ENDA-Sante Frontières et Vulnérabilités au VIH SIDA en Afrique de l'Ouest: Senegal, Guinee, Guinee Bissau, Cap-Vert (2010) (translated from French) 1.

attached important to the dissemination of the norms in the international treaties it has ratified.<sup>144</sup> However, it must be noted for the purposes of this paper, that the level of awareness of Committee on ESCR is lower than in respect to other treaties and the rights contained are seen as largely aspirational.<sup>145</sup>

International human rights treaties become part of domestic law through adoption.<sup>146</sup> Treaties ‘duly ratified’ have, upon their publication, an authority superior to that of the ‘law’.<sup>147</sup> This means that, in principle, self-executing provisions of international treaties may be invoked before courts directly. However, this is done infrequently, especially in relation to economic and social rights.<sup>148</sup> Generally speaking, francophone African judges consider a treaty to be ‘self executing’ if ‘provisions are sufficiently precise to fit into legal and financial structures of the municipal law.’<sup>149</sup> The courts have not been eager to apply economic and social rights as self-executing but have stated these rights need to be expounded upon before the courts can properly enforce them.<sup>150</sup>

The Constitution of the Republic of Senegal (herein the Senegalese Constitution), as adopted on the 22<sup>nd</sup> of January 2001, addresses the promotion and protection of human rights in both the preamble and the Bill of Rights.<sup>151</sup> The preamble affirms the people’s adherence to “the international instruments adopted by the United Nations and the Organisation of African Unity,” citing among others, the UDHR, the CEDAW, the CRC and the ACHPR.<sup>152</sup> The preamble also proclaims the right of everyone to participate in public affairs and have access to public services.<sup>153</sup> Importantly, the preamble is ‘an integral part’ of the Senegalese Constitution.<sup>154</sup> The Bill of Rights is enshrined in Title II of the Senegalese Constitution, entitled ‘Freedoms and the person’. The Bill of Rights covers all three ‘generations’ of rights and seems to adopt indivisibility and interdependence between categories of

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<sup>144</sup> ICESCR was signed 06/07/1970 and came into force 13/05/1978; CERD was signed 22/07/1968 and entered into force 19/05/1972; CCPR was signed 06/07/1970 and came into force 13/05/1978; CEDAW was signed 29/07/1980 and came into force 07/03/1985; CRC was signed 26/01/1990 and came into force 02/09/1990; ACHPR was ratified in 1982; Women’s Protocol was ratified 27/12/2004; and ACRWC was ratified on 29 September 1998.

<sup>145</sup> Heyns and Viljoen (n 54 above) 537.

<sup>146</sup> As above.

<sup>147</sup> art 79 of the Senegalese Constitution.

<sup>148</sup> Heyns and Viljoen (n 54 above) 537.

<sup>149</sup> H Adjolohoun ‘Visiting the Senegalese Legal System and Legal Research: A Human Rights Perspective’ (2009) *Yale Global Online* available at [http://www.nyulawglobal.org/Globalex/SENEGAL.htm#\\_ednref](http://www.nyulawglobal.org/Globalex/SENEGAL.htm#_ednref).

<sup>150</sup> As above.

<sup>151</sup> The Constitution of the Republic of Senegal, 2001.

<sup>152</sup> para 7 of the Senegalese Constitution.

<sup>153</sup> para 14 & 15 of the Senegalese Constitution.

<sup>154</sup> para 18 of the Senegalese Constitution.

rights.<sup>155</sup> Particularly, article 8 sets out a number of rights that are usually contained in a Bill of Rights and includes the right to health. The Constitution does not provide for the reliance on international law as an interpretive guide.<sup>156</sup>

The highest judicial structure in Senegal is comprised of three separate courts. The first is the Supreme Court (*Cour Supreme*), which is the highest body for hearing appeal matters from the lower courts. It was abolished in 1992 but restored in 2008 amalgamating the existing Court of Cassation and the Council of State. This court can be approached on appeal, from the Appeal Court, by any citizen who felt their rights have been violated. However, this court only verifies if the law was well applied and does not hear a case on its merits. The second court in this structure is the Constitutional Court (*Conseil Constitutionnelle*), which is mandated to ensure compliance with the Senegalese Constitution. This includes the review of the constitutionality of legislation, as well as electoral concerns. The third court is Financial Court (*Cour des Comptes*), which is responsible for regulating of public finances of the state and public enterprises. Unlike in South Africa, even though the right to health is justiciable, the domestic judicial system has not been used to enforce the economic and social rights entrenched in the constitution.<sup>157</sup>

In general, Senegal is said to take the international human rights system seriously.<sup>158</sup> An attitude of almost rampant internationalism has been adopted by Senegal, as exemplified by the consistently high profile of Senegal in the UN and other international institutions with the presence and important role of UNDP, UNAIDS, UNESCO, UNICEF and WHO in Senegal and its acceptance of almost all possible international human rights standards.<sup>159</sup> But the failing is that much is made of the status of human rights norms as part of domestic law, but the international instruments are utilised on very rare occasions, making the guarantee largely rhetorical.<sup>160</sup> In this context the right to health in the context of HIV/AIDS may symbolically recognised but not necessarily used as rights language elsewhere within the legal system.

Moreover, the domestic legislation has only recently begun to recognise the right to health of PLHIV. There has been no specific legislation on prevention, care, protection and promotion of the rights of those infected, affected persons, groups recognised vulnerable and the general population. However, in 2009 a new

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<sup>155</sup> Adjolohoun (n 149 above).

<sup>156</sup> Heyns and Viljoen (n 54 above) 537.

<sup>157</sup> Adjolohoun (n 149 above).

<sup>158</sup> Heyns and Viljoen (n 54 above) 518.

<sup>159</sup> As above.

<sup>160</sup> As above.

HIV/AIDS law was enacted which aims to fill this gap covering issues of vulnerable groups, stigma, funding and other.<sup>161</sup>

More strikingly, there has been a new development with a strong consideration for a 'Health Code' or 'code de la sante'. The philosophy behind this project is to understand the relationships between health, and the law, and take into account the recent emergence of new ethical and health issues. The arguments for the developing a Health Code specifically suggests a process, which takes into account the global context where the process of developing legislation and standards are being universalised.<sup>162</sup> This development could be highly supportive to conversations around a FCGH as a FCGH would provide a blueprint of international standards for the right to health including: (1) recommended levels of domestic public sector expenditure on health services; (2) a definition of the essential health services that should be available to all the population; (3) priority setting with appropriate targets and benchmarks for progress; and (4) recognition of elements of non-discrimination and protection of vulnerable groups.<sup>163</sup>

### **4.3 History HIV/AIDS epidemic and the birth of the HIV/AIDS movement in Senegal**

In contrast with the sub-Saharan African countries, Senegal's successful attempts to check the spread of HIV/AIDS has transformed the country into a model over the last two decades and a source of inspiration in the global fight against the epidemic.<sup>164</sup> Senegal has a very different epidemiology of HIV/AIDS to that of South Africa and the rest of Sub-Saharan Africa. The profile of the HIV/AIDS in Senegal is concentrated, with a country prevalence low of about 0.7%, but higher among vulnerable groups such as sex workers of about 20% and MSM or men who have sex with men of about 21.5%.<sup>165</sup>

Several factors have contributed to Senegal's success in maintaining a low HIV prevalence rate. Firstly, West Africa's epidemic has been a different strain of HIV (HIV2 rather than HIV1 which is common in sub-Saharan Africa), HIV2 seems to be less infectious and has a slower rate of progression.<sup>166</sup> This is a partial explanation of

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<sup>161</sup> Project de Loi No 06/2009 Relatif au VIH et au SIDA available at <http://www.divisionsida-ist.sn/ProjectDeLoi.pdf>.

<sup>162</sup> M Becker 'L'etat de la codification sanitaire au Senegal: vers un Code de la sante?' (2011) available at [rds.refer.sn/IMG/pdf/1BECKERCODESENEGALANIMA.pdf](http://rds.refer.sn/IMG/pdf/1BECKERCODESENEGALANIMA.pdf) (translated from French).

<sup>163</sup> M Heywood & J Shija (n 1 above).

<sup>164</sup> T Matthew 'Senegal Renews its Campaign Against AIDS' (2004) *Contemporary Review* 169.

<sup>165</sup> see UNAIDS report 2008 available at <http://www.unaids.org/en/regionscountries/countries/senegaland>.

<sup>166</sup> G Gottlieb et al 'Emergence of Multiclass Drug-Resistance in HIV-2 in Antiretroviral-Treated

the low prevalence rates. However, since the 1970s, Senegal has also made safe blood supply a priority and has also required sex workers to register and to have quarterly checkups.<sup>167</sup> However, the main reason for Senegal's small epidemic is that soon after the epidemic broke out in 1984, the then government, in partnership with civil society, speedily mounted a public education strategy that massively mobilised the population against the disease.<sup>168</sup> Senegalese society has a tradition of active community involvement in health and development issues.<sup>169</sup> Thus, when it became clear that HIV/AIDS was a potential threat to national well being, community groups were well placed to respond. The effort involved all levels of society, notably women's groups, faith-based organisations, youth groups, government agencies, the private sector and the media.<sup>170</sup> As a result of all these factors, Senegal is seen as an example of a 'best practice' country for the fight against HIV/AIDS.

As a predominantly Muslim country, the HIV/AIDS movement successfully involved religious communities and leaders in the struggle, which was integral to the success of the response.<sup>171</sup> It was clear that religious leaders wanted to be involved when as early as 1989 a conservative Islamic organisation, Jamra, approached the National AID Council to discuss HIV prevention strategies.<sup>172</sup> Although initially rather hostile to condom promotion and some other aspects of AIDS prevention, the group became an important partner in a dialogue between public health officials and religious leaders.<sup>173</sup> Moreover, Christian organisations are important providers of health services in Senegal.<sup>174</sup> In the early period of the epidemic, the churches gradually developed a more supportive outlook towards prevention led by a Catholic NGO SIDA Service. They provided important counselling and psychosocial support, and frequently referred those in need to alternative providers where they could not meet needs, for example for condom provision.<sup>175</sup>

Before 1990 the larger NGO community was not well developed. However, the already existing community organisations working around health provided a sound base for the rise of different civil society organisations working around

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Individuals in Senegal: Implications for HIV-2 Treatment in Resource- Limited West Africa' (2009) 48 *HIV/AIDS Clinical Infectious Diseases*.

<sup>167</sup> 'Acting Early to prevent AIDS: The case of Senegal' UNAIDS Best Practice Collection 1999.

<sup>168</sup> Matthew (n 165 above) 169.

<sup>169</sup> 'Acting Early to prevent AIDS: The case of Senegal' (n 168 above).

<sup>170</sup> Matthew (n 165 above) 169.

<sup>171</sup> As above.

<sup>172</sup> Acting Early to prevent AIDS: The case of Senegal' (n 168 above) 12.

<sup>173</sup> As above.

<sup>174</sup> Acting Early to prevent AIDS: The case of Senegal' (n 168 above) 13.

<sup>175</sup> As above.

HIV/AIDS.<sup>176</sup> Currently, there are more than 3000 civil society organisations involved in the HIV/AIDS response from community-based groups to national level NGOs.<sup>177</sup> Some of the most prominent organisations include l'Agence pour la Promotion des Activités de Population (APAPS),<sup>178</sup> ENDA - Sante,<sup>179</sup> Society for Women and Aids in Africa (SWAA Sénégal),<sup>180</sup> Association Sénégalaise pour le Bien Etre Familiale (ASBEF)<sup>181</sup> and SIDA Service (as mentioned above). Moreover, as part of this dynamic of innovation, these NGOs and other partners have encouraged establishment of organisations aiming to strengthen the social networks of vulnerable groups like MSM and sex workers. There are a handful of MSM associations (organisations of MSM that provide social spaces for individuals and that are centrally involved in HIV/AIDS outreach to MSM populations) in Senegal, mostly in the urban areas.<sup>182</sup>

Furthermore, while politicians in some other African countries ignored the threat of HIV/AIDS for fear of alienating conservative supporters by initiating a discussion about safe sex, politicians in Senegal supported efforts to confront the epidemic.<sup>183</sup> The leadership of the national HIV/AIDS programme has been remarkably consistent over time and this fundamentally contributed to a successful response.<sup>184</sup> The government took direct control of the CNLS, previously run almost exclusively by local medical practitioners, by placing it under the Prime Minister's supervision, to facilitate more direct involvement of civil society NGOs and grassroots communities in the struggle against HIV/AIDS.<sup>185</sup> The CNLS adopted measures to prevent the spread of HIV/AIDS, promoting condom use, instituting a sentinel surveillance system, and increasing the number of voluntary counselling and testing sites.

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<sup>176</sup> Matthew (n 165 above) 169.

<sup>177</sup> D Diouf 'HIV/AIDS Policy in Senegal: A Civil Society Perspective' *Public Health Monitoring Reports* available at [http://www.soros.org/initiatives/health/focus/phw/articles\\_publications/publications/senegal\\_20071015/senegal\\_20071015.pdf](http://www.soros.org/initiatives/health/focus/phw/articles_publications/publications/senegal_20071015/senegal_20071015.pdf) >18.

<sup>178</sup> APAPS was created in 1996 by researchers and development experts eager to help improve efficiency in the design and implementation of national policies and programs on population and sustainable development.

<sup>179</sup> Enda-sante is a unit of the International Organisation Enda Third World and works primarily on health issues supporting community organisation in the aim to community responses on HIV / AIDS.

<sup>180</sup> SWAA - Senegal was founded in 1989 run by women have undertaken to reduce the risk of infection and the impact of HIV/AIDS on women, their families and community. Similar to the 'literacy campaign' by the TAC, they are also involved in the management of issues of reproductive health, sexually transmitted diseases and HIV through training, advocacy, education and research.

<sup>181</sup> ASBEF was founded in 1974 but approaches the HIV/AIDS issue from the paradigm of family planning to the sexual and reproductive health rights.

<sup>182</sup> 'Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal' Human Rights Watch Report (2010) 2.

<sup>183</sup> Acting Early to prevent AIDS: The case of Senegal' (n 168 above).

<sup>184</sup> As above.

<sup>185</sup> Matthew (n 165 above) 169.



As a result of the different epidemiology of the disease and a unique government response, the civil society working around HIV/AIDS has a very different character to that of South Africa. There are noted similarities in the politics-centered approach taken including grassroots empowerment and international collaborations.<sup>186</sup> However, due to the concentrated nature of the epidemic and the progressive steps taken by the Senegalese government, the provision of treatment and care for people living with HIV/AIDS has for the most part been a success.<sup>187</sup> Moreover, unlike in South Africa, these civil society organisations did not have to use economic and social rights language and tools to leverage committed engagement as this engagement was readily given. The use of public spaces, like the CNLS, opened up ‘political debate about where to allocate, when to expand, and how best to renew limited resources in ways that enable all people to live decent lives’.<sup>188</sup>

However, despite these celebrated successes in combating HIV/AIDS by both government and civil society, there are major threats to the strides Senegal has made in the fight against HIV/AIDS. Tidiane Sy of ENDA-Sante, who has been working on AIDS since its inception in Senegal, is cautious about the Senegal success story.<sup>189</sup> The section below will highlight some of the challenges that face the HIV/AIDS movement and the protection and promotion of the right to health in Senegal.

#### **4.4 Challenges facing the protection and promotion of the right to health in Senegal**

One of the biggest challenges for the HIV/AIDS epidemic in Senegal comes in the form of stigma and discrimination. The perception of HIV/AIDS as a “gay disease” has stigmatised MSM and HIV workers who operate in the MSM community and placed them at increased risk of stigma, discrimination and violence.<sup>190</sup> The belief that homosexuals are to blame for the epidemic or that homosexuals are the only group at risk of HIV is still common.<sup>191</sup>

Moreover, as affirmed at the 15th International Conference on AIDS and STIs in Africa (ICASA) in Senegal, December 3-7, 2008, criminalisation of homosexual conduct is a significant hurdle in providing education, testing, and treatment to men

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<sup>186</sup> Forbath (n 110 above) 51.

<sup>187</sup> Matthew (n 165 above) 169.

<sup>188</sup> J Perelman & L White J Perelman and L White (n 51 above) 166.

<sup>189</sup> Matthew (n 165 above) 169.

<sup>190</sup> Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal’ Human Right Watch Report (2010).

<sup>191</sup> R Parker & P Aggleton ‘HIV/AIDS-related stigma and Discrimination: A Conceptual Framework and an Agenda for Action (2002).

who have sex with men (MSM) populations in Africa.<sup>192</sup> It reinforces the stigma against these vulnerable groups and drives MSM populations underground in fear of discrimination, violence, arrest, and other repercussions.<sup>193</sup> Moreover, in recent years, the risk to MSM living with HIV is compounded by a growing backlash against homosexuality and MSM.<sup>194</sup> Violence against people on the grounds of sexual orientation and gender expression escalated in Senegal starting in early 2008.<sup>195</sup> Men who identify as or are perceived to be gay increasingly became targets of popular vengeance and arbitrary arrests.<sup>196</sup>

This trend of stigmatisation can also be seen in the country response where it is argued that despite Senegal's concentrated HIV/AIDS epidemic, the national response has not sufficiently targeted men who have sex with men.<sup>197</sup> Reports speak of Senegal's early response to the epidemic, its concerted efforts to reach (female) sex workers, and the critical role of women's groups and religious organisations in Senegal's "success" but make no mention of men who have sex with men.<sup>198</sup> But, even if the epidemic could be fought effectively from a clinical and epidemiological perspective, it is not enough to only encourage voluntary testing, and monitoring of people who agree to declare their HIV status. The social context of stigma and discrimination against PLHIV naturally leads to them hiding their status.<sup>199</sup>

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<sup>192</sup> Homosexuality, specifically same-sex sexual activity, is outlawed in 38 different African countries. In Senegal, article 319.3 of Senegal's Criminal Code (1965) penalises "unnatural" sexual acts with five years in prison and a fine of CFA 100,000 to 1,500,000 (approx. US\$200 to 3000). While the law ostensibly criminalises conduct, not character (that is, acts, not identities), this report shows that it is being used as a tool for targeting certain "types" of individuals—on the grounds of their real or perceived sexual orientation and/or gender identity and expression—whose engagement in homosexual conduct is inferred from their appearance or upon hearsay even in the absence of any evidence.

<sup>193</sup> A key 2009 UNAIDS (Joint United Nations Programme on HIV/AIDS) publication also states that MSM and transgender populations are among the people at highest risk of HIV infection and makes a public health as well as human rights-based argument for addressing state failure to reach these vulnerable populations. UNAIDS, "UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People" (2009) available at [http://data.unaids.org/pub/Report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf), accessed on November 1, 2009.

<sup>194</sup> Report 'De l'Intervention en Temps De Crise Au Plaidoyer A Long Terme: Promouvoir La Tolérance et Le Respect Des Droits Des Groupes Vulnérables Au Senegal (2011) (translated from French).

<sup>195</sup> Two key incidents have been identified by Human Rights Watch and HIV/AIDS organisation as indicators of an increase in homophobic tendencies in Senegal including the "gay marriage" scandal of February 2008 and the arrest of the "nine homosexuals of Mbao" in December 2008.

<sup>196</sup> Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal' Human Rights Watch Report (2010) 2.

<sup>197</sup> M Lom "Senegal's Recipe for Success: Early Mobilisation and Political Commitment Keep HIV Infections Low" *Africa Recovery* available at <http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/15no1pdf/151aid11.pdf>.

<sup>198</sup> As above.

<sup>199</sup> Kante (n 76 above) 3.

In this context, stigma and discrimination create serious obstacles to implementing programs to control HIV/AIDS.<sup>200</sup> Services can only reach people who are known to be HIV-positive or who seek care. People who are living with HIV/AIDS often take measures to keep their status secret, even to family members, so they often lack basic support and access to treatment and care. They may be reluctant to join associations for people living with HIV/AIDS and may refuse home visits because they fear their neighbors will start asking questions.<sup>201</sup>

The above sections aim to highlight the different context into which the HIV/AIDS movement in Senegal was born. The naissance of this movement is in stark contrast to that of South Africa, both in the nature of the disease and the relationship with government. However, this chapter also highlights that the current challenges to health presented by stigma and discrimination emanating from societal and cultural beliefs marks the need for new innovative ideas that strengthen civil society's work on the ground. The next section seeks to explore the role of a FCGH in this different HIV/AIDS context in Senegal. This aims to show that even where epidemics have distinct gestations, a FCGH may provide a role to HIV/AIDS movements to strengthen their work, even if the environment is different.

#### **4.5 The role of a FCGH as a tool for empowering the HIV/AIDS movement in Senegal**

In this context, the response to the question of whether a FCGH would be helpful to HIV/AIDS movement will have a slightly different tone. This distinctive character is not only affected by the difference in the epidemiology of the disease in the fact that the epidemic is small and concentrated within mainly vulnerable groups but also the strength and of government's commitment to HIV/AIDS.<sup>202</sup> As highlighted above civil society in Senegal is strong and was a robust community involvement from beginning of HIV AIDS response, including important alliances of religious leaders and traditional healers. But the challenge comes from within the society itself. The answer is fundamentally founded in the cultural and social context in which HIV/AIDS manifests in Senegal. Thus, the challenge is not limited to the affordability and availability of treatment and prevention to all those infected, but it goes to the core of facing the stigma and discrimination which isolates the groups affected from society.

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<sup>200</sup> Diouf (n 178 above) 16.

<sup>201</sup> As above.

<sup>202</sup> As above.

In this case, it will be in new conversations around a 'Health Code', which needs concrete concepts to frame health and its various components, that a FCGH may prove helpful. Also, in the strengthening strategic responses to stigma and discrimination, a FCGH will provide a new innovative tool for civil society health movements. It is not the framing of the right to health as a 'right' that is of significance in Senegal, as would be the case in South Africa. In fact, the use of rights language in this context can be problematic as the community does not see those infected with HIV/AIDS as deserving of rights.<sup>203</sup> The use of rights language could lead to further exclusion. PLHIV are viewed as asking for 'special rights' and the community questions why that group has claim to 'more' rights.<sup>204</sup> Therefore, in this context, it is rather the technical substance contained in the FCGH that is of import, including concrete strategies for the protection of vulnerable groups. The movement away from purely human rights language to a more substantiated understanding of public health was explored in the Chapter Two of this paper, the Senegalese case provides strong support for this shift. Thus, an outline of essential ingredients within a FCGH could prove useful to existing channels of civil society in Senegal, to find new ways to explore the right to health within challenging societal contexts.

#### 4.6 Conclusion

This chapter highlights the possible role of a FCGH in context of HIV/AIDS in Senegal. The collaboration between government and civil society in the fight against HIV/AIDS has been a world-renowned success in preventing the spread of the disease. There is space to build on these successes where a FCGH could complement new initiatives like a 'Health Code'. However, this chapter also highlights that the current challenges to the successful protection of the right to health of PLHIV (especially of vulnerable groups like MSM) are based in cultural and societal barriers. A FCGH will play a different role within this context. It may not have a direct role to play in combating stigma and discrimination. However, it does present an innovative idea that could generally strengthen government and civil society's work on the ground, particularly in strategies for the protection of vulnerable groups.

The following chapter will bring together the various aspects discussed throughout this paper, and in light of these discussions, it will attempt to tackle some of the criticisms posed against a FCGH.

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<sup>203</sup> Diouf (n 178 above) 16.

<sup>204</sup> As above.

## CHAPTER FIVE

### Summary and conclusion

#### 5.1 Summary

Drawing from the two case studies it is possible to discern at least four possible roles a FCGH could play in empowering the HIV/AIDS movement in their protection and promotion of the right to health.

The first is could that a FCGH could fill in the ambiguities around the right to health.<sup>205</sup> For example, it could define the contents of the minimum core obligations, how to measure progressive realisation and clarify the meaning of ‘maximum of...available resources’ in the ICESCR. It could also ‘update’ the right to health to take into account constitutional court and other legal developments, like the justiciability of the right, and acknowledge different jurisdictions, like the African Commission.<sup>206</sup> It could similarly turn even existing clarifications of the right to health, such as through General Comment No 14 and concluding comments of the Committee on ESCR into legally binding elements and refinements of the right to health.<sup>207</sup>

Even short of, or before achieving, a legally binding treaty, the movement towards an FCGH could lead to achievements that lead to change on the ground.<sup>208</sup> A draft FCGH that has been developed by civil society and communities could be an important advocacy tool around which social movements can mobilize. For example in South Africa, the HIV/AIDS movement could use it to mobilise around to campaign for better resources from funders. A FCGH could create a unifying vision for civil society advocacy.<sup>209</sup> Moreover, the FCGH could reduce current fragmentation and tensions about different health movements (e.g., AIDS, maternal health, primary health care). Moreover, it could also be a useful guide to governments and other parties as a guide for setting health priorities. The case studies provide good examples: in South Africa it could be helpful for the governments NHI initiative, and in Senegal conversations around the ‘Health Code’.

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<sup>205</sup> JALI Internal Working Papers (n 37 above).

<sup>206</sup> As above.

<sup>207</sup> As above.

<sup>208</sup> As above.

<sup>209</sup> As above.

Secondly, a FCGH could contribute to broader improvements in national governance on health and beyond.<sup>210</sup> The FCGH could contribute to improvements in democratic accountability, transparency, public participation, and other areas that encompass but extend outside health.<sup>211</sup> This possibility is based in the achievements of the HIV/AIDS movement, which made contributions in areas such as these and others that had an impact well beyond the field of HIV/AIDS.<sup>212</sup> This includes identifying through inclusive processes, marginalised and vulnerable populations, and developing strategies for removing obstacles to accessing quality health services and to enabling them to achieve health status comparable with the general population.<sup>213</sup> Examples of this can be found in both case studies, for example, the empowerment of PLHIV in South Africa or the strength of government leadership and intersectoral collaboration in Senegal.

These ideas partly respond to the critique that international treaties, particularly current human rights treaties, are often ineffective and poorly implemented. The FCGH has a potential mobilisation role to play in the current international right to health framework.<sup>214</sup> Thus, engaging social movements in developing and taking ownership of the FCGH, from determining its contents through to securing its adoption and effective implementation, is integral to ensuring an FCGH.<sup>215</sup>

Moreover, if the treaty came into force it could also impact national behavior.<sup>216</sup> It offers countries like Senegal an opportunity to reemphasise the use of international law domestically where previously in international law recognition has been mainly rhetorical. There may be non-judicial channels that civil society can use (e.g., parliamentary hearings) to promote compliance. For example, in South Africa and Senegal the national AIDS councils provide a good non-judicial channel within which to engage government concerning health challenges. Furthermore, the treaty would establish obligations from an international law perspective regardless of whether or not the country has passed implementing legislation, especially in monist states like Senegal. Thus, any regime of international incentives and sanctions that are part of the treaty would apply.

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<sup>210</sup> As above.

<sup>211</sup> As above.

<sup>212</sup> As above.

<sup>213</sup> As above.

<sup>214</sup> As above.

<sup>215</sup> As above.

<sup>216</sup> As above.

And fourthly, the very process of developing an FCGH could ensure that global health remains a global priority for many years to come –building on the advances made in the first decade of the 21<sup>st</sup> century.<sup>217</sup> It could be a process of concerted mobilisation of Southern and Northern civil society and communities for advocacy on health issues requiring global cooperation.<sup>218</sup> HIV/AIDS movements in both South Africa and Senegal, are facing similar global challenges that have an impact on health including trade and intellectual property, health financing, health worker migration, and the environment and health.

## 5.2 Conclusion

This paper has sought to contribute to the existing knowledge around a FCGH. This includes its role for fueling a global movement around health. It has explored the current international right to health conceptual framework, specifically how a FCGH could fit into the existing right to health framework. It then proceeded to examine the possible role for a FCGH in empowering the HIV/AIDS movement in their protection and promotion of the right to health in Africa. The subject is relatively new and this paper aimed to expand on the little research that has been done on the social dynamics of particular domestic contexts especially in the African environment.

Moreover, it sought to emphasise that any international legal framework conceptualisation on the right to health must involve those whose health is at stake and their representatives. In campaigning for this type of global agreement civil society must be the driver of the process, showing both ownership and commitment.<sup>219</sup> A global agreement without the input of civil society will fail because citizen activism, popular mobilisation around health and an acceptance of state's accountability to their populace and to each other is essential to success.<sup>220</sup>

Therefore, it is necessary to engage more around how this type of international legal instrument could be effective for local civil society fights for the right to health. Through the case studies, it is possible to see that different states on the African continent face diverse challenges regarding the realisation of the right to health in the context of HIV/AIDS. The important role played by civil society in the empowerment of citizens, and the establishment of an environment favorable to the right to health, has been highlighted in both the Senegalese and South African case. As showed above, the existence of a global standard and framework on the right to

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<sup>217</sup> As above.

<sup>218</sup> As above.

<sup>219</sup> M Heywood & J Shija (n 1 above) 2.

<sup>220</sup> As above.

health, in the form of a FCGH, particularly if it is as a result of a movement of health rights education and advocacy from below, intends to empower civil society.<sup>221</sup>

It has been highlighted that though human rights can and have been made universal, as can be seen in the context of PLHIV, the risk of having one's rights violated is not universal.<sup>222</sup> The HIV/AIDS movements have shown, through both cooperative means like in Senegal and combative strategies like in South Africa, that they reject low standards of healthcare as official policy.<sup>223</sup> Only a double concerted action at international and national levels will give content to the right to health. This effort is especially necessary in sub-Saharan Africa where the scourge of HIV/AIDS has been so detrimental to the social and economic conditions within the state, as highlighted in the South African case. In this context, the FCGH could be well placed to bring together key players to answer some of the pressing questions that plague health both on an international and national level. It is only a failure of imagination that will limit discussions around what the next step for the international right to health framework may be.

[WORD COUNT: 17 096]

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<sup>221</sup> 'Realising the Right to Health in Our Lifetimes? Towards a Framework Convention on the Right to Health' (n 41 above).

<sup>222</sup> Farmer (n 38 above) 231.

<sup>223</sup> Farmer (n 38 above) 241.



## BIBLIOGRAPHY

### Books

Freeman, M (2011) *Human Rights: The Role of the Social Sciences' in Human Rights: An Interdisciplinary Approach* Polity Press

*Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS & the Law* (2007) Pretoria University Law Press

Hunt, P (1996) *Reclaiming Social Rights: international and comparative perspectives* Dartmouth, England

Langford M (2008) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* Cambridge University Press

Pogge, T (2008) *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms* (2<sup>nd</sup> ed) Cambridge: Polity Press

Precious S & Viljoen F (ed) (2007) *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* Pretoria University Law Press

Viljoen, F (2007) *International human rights law in Africa* Oxford: Oxford University Press

### Chapters in books

Beetham 'Human Rights and Cosmopolitan Democracy' in Archibugi, D, Held, D, and Kohler, M (1998) *Re-imagining Political Community: Studies in Cosmopolitan Democracy* Stanford University

Farmer, P 'On Suffering and Structural Violence: Social and Economic Rights in the Global Era' in Farmer, P *Pathologies of Power: Health, Human Rights and the New War on the Poor* (2003) University of California Press

Forbath W 'Cultural Transformation, Deep Institutional Reform, and ESR Practice: South Africa's Treatment Action Campaign' in Whik, L and Perelman, J (2011) *Stones of Hope: How Africa Activists Reclaim Human Rights to Challenge Global Poverty* Stanford University

Friedman, S 'Gaining comprehensive AIDS treatment in South Africa: the extraordinary 'ordinary'' in Gaventa, J & McGee, R (2010) *Citizen action and national policy reform: making change happen* Zed Books

Perelman J and White L 'Stones of Hope: Experience and Theory in African Economic and Social Rights Activism' in Whik, L and Perelman, J (2011) *Stones of Hope: How Africa Activists Reclaim Human Rights to Challenge Global Poverty*

Susskind, L 'The Weaknesses of the Existing Environmental Treaty-Making System' in Susskind, L (1994) *Environmental Diplomacy: Negotiating More Effective Global Agreements* Oxford University Press

Viljoen, F 'Introduction' in Viljoen, F (2005) *Righting Stigma: Exploring a right-based approach to addressing stigma* AIDS and Human Rights Research Unit, University of Pretoria

### Journals & articles

Adjolohoun, H 'Visiting the Senegalese Legal System and Legal Research: A Human Rights Perspective' (2009)

Sewankambo N & Katamba A 'Health in Africa: learning from South Africa' (2009) 374 *Lancet*

- Becker, M 'L'état de la codification sanitaire au Senegal: vers un Code de la sante?' (2011)
- Brennan, M 'To Adjudicate and Enforce Socio-Economic Rights: South Africa Proves That Domestic Courts Are A Viable Option' (2009) 9 *QUT Law and Justice Journal*
- Chapman, A "Violations Approach" for Monitoring the International Covenant on Economic Social and Cultural Rights' (1996) 18 *Human Rights Quarterly*
- Chopra, M & Ford, N 'Scaling up health promotion interventions in the era of HIV/AIDS – challenges for a rights based approach' (2005) 4 *Health Promotion International*
- Daniels, N *et al* 'Justice Is Good for Our Health' (2000) *Boston Review*
- Dennis, M & Stewart, D 'Justiciability of Economic, Social and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing and Health?' (2004) 98 *American Journal of International Law*
- Eba, P 'Stigma[ta]' (2007) *AIDS Review*
- Fagen A 'Practicing Universality: The Inter-Disciplinary Imperatives of Human Rights' (2003) 3 *Human Rights and Human Welfare*
- Farmer, P 'Challenging orthodoxies: The road ahead for health and human rights' (2008) *Health and Human Rights Journal*
- Farmer, P & Garret, L 'Marvelous Momentum to Health Care for All' (2007) *Council on Foreign Affairs*
- Fidler D 'Architecture amidst Anarchy: Global Health's Quest for Governance' (2007) 1 *Global Health Governance*
- George, W *et al* 'The Transformational Model of International Regime Design: Triumph of Hope or Experience?' (2000) 38 *Columbia Journal of Transnational Law*
- Gostin L 'Meeting the Survival Needs of the World's Least Healthy People: A Proposed Model for Global Health Governance' (2007) 298 *Journal of the American Medical Association*
- Gostin, L., Heywood, L., Ooms, G., Grover, Rottingen, A., and Chenguang, W., 'Joint Learning Initiative on National and Global Responsibilities for Health' (2010) *WHO Bulletin*.
- G Gottlieb *et al* 'Emergence of Multiclass Drug–Resistance in HIV-2 in Antiretroviral-Treated Individuals in Senegal: Implications for HIV-2 Treatment in Resource-Limited West Africa' (2009) 48 *HIV/AIDS Clinical Infectious Diseases*.
- Heywood, M & Shija, J ' A Global Convention on Health – Would it Help Developing Countries to Fulfill their Duties on the Right to Health? A South African perspective' (2011)
- Heyns C & Viljoen F 'The Impact of the United Nations Treaties on the Domestic Level' (2001) 23 *Human Rights Quarterly*
- Hunt, P *et al* 'Health Systems and the Right to Health: an Assessment of 194 Countries' (2008) 372 *The Lancet*; Kante, B., Nsubuga, Y., Mzegwu, F & Odbiambo, D 'Évaluation du réseau africain sur l'éthique, le droit et le VIH' Dakar : [Projet régional VIH et Développement (1999)
- Kante, B 'VIH et droits humains' Paper presented at a workshop to exchange experiences on the theme 'Integration of HIV / AIDS in programs or development projects in Africa the West', held in Dakar by the Regional HIV and Development Project in Pretoria (2002)

Kante, B 'Droit et VIH en Afrique' written for the New Delhi office of the Regional UNDP HIV and Development (1996)

Kiapi, S 'Interpreting the Right to Health Under The African Charter' (2005) 11 *East African Journal for Peace and Human Rights*

Kickbusch, I 'Wake-Up Call for a Strong Global Health Policy' (2003) *Yale Global Online*

Langford, M 'Closing the Gap? – An Introduction to the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights' 27 (2009) *Nordisk Tidsskrift For Menneskerettigheter*

Lee, R, Kochman, A & Sikkema, K 'Internalised stigma among people living with HIV-AIDS' 6 (2001) *Aids and Behaviour*

Liebenburg, S 'The ICESCR and its implications for South Africa' (1995) 11 *South African Journal of Human Rights*

Lom M "Senegal's Recipe for Success: Early Mobilisation and Political Commitment Keep HIV Infections Low" (2001) *Africa Recovery*

London & H Schneider 'Globalisation and health inequalities: Can a human rights paradigm create space for civil society action' *Social Science & Medicine* (not yet published)

Lurie, N and Dubowitz, T 'Health Disparities and Access to Health' (2007) 297 *Journal of the American Medical Association*

Matthew, T 'Senegal Renews its Campaign Against AIDS' (2004) *Contemporary Review*

Palmer, J Tomkinson, C Phung, et al. "Does ratification of human-rights treaties have effects on population health?" (2009) *Lancet*

Patterson, A 'A reappraisal of democracy in civil society: evidence from rural Senegal' 36 (1998) *The Journal of Modern African Studies*

Mukherjee, J 'Basing Treatment on Rights Rather than Ability To Pay: 3 by 5' (2004) 1071 *The Lancet*

Scheepers, E 'Government in the cockpit (at last): the new challenges facing HIV prevention and treatment' *AIDS Law Project Review: January 2009 to March 2010*

Sewankambo, N 'Human systems in Africa: learning from South Africa' 374 (2009) *The Lancet*

Wade, A et al., 'HIV Infection and Sexually Transmitted Infections among Men Who Have Sex with Men in Senegal' (2005) 19 *AIDS*

Skinner, D & Mfecane, S 'Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa' (2004) 1 *Journal des Aspects Sociaux du VIH/SIDA*

## **Papers/Reports**

'Acting Early to prevent AIDS: The case of Senegal' UNAIDS Best Practice Collection (1999) available at <[http://data.unaids.org/publications/irc-pub04/una99-34\\_en.pdf](http://data.unaids.org/publications/irc-pub04/una99-34_en.pdf)>

'Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health' Final Report of the Commission on Social Determinants of Health (2008) available at <[http://www.searo.who.int/LinkFiles/SDH\\_SDH\\_FinalReport.pdf](http://www.searo.who.int/LinkFiles/SDH_SDH_FinalReport.pdf)>

'Fear for Life: Violence against Gay Men and Men Perceived as Gay in Senegal' Report by Human Rights Watch (2010) available at <<http://www.unhcr.org/refworld/docid/4cf629665a4.html> [accessed 29 October 2011]>

'Frontières et Vulnérabilités au VIH SIDA en Afrique de l'Ouest: Senegal, Guinee, Guinee Bissau, Cap-Vert' Report by ENDA-Sante (2010)

'HIV/AIDS Policy in Senegal: A Civil Society Perspective' Public Health Monitoring Reports (2007) available at <[http://www.soros.org/initiatives/health/focus/phw/articles\\_publications/publications/senegal\\_20071015/senegal\\_20071015.pdf](http://www.soros.org/initiatives/health/focus/phw/articles_publications/publications/senegal_20071015/senegal_20071015.pdf)>

Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) Internal Working Papers

'Rapport De l'Intervention en Temps De Crise Au Plaidoyer A Long Terme: Promouvoir La Tolérance et Le Respect Des Droits Des Groupes Vulnérables' (2011) available at <[http://www.google.com/search?client=safari&rls=en&q=Senegal+African+Consultants+International+Report+'Rapport+De+l'Intervention+en+Temps+De+Crise+Au+Plaidoyer+A+Long+Terme:+Promouvoir+La+Tolérance+et+Le+Respect+Des+Droits+De+s+Groupes+Vulnérables'+\(2011\)&ie=UTF-8&oe=UTF-8](http://www.google.com/search?client=safari&rls=en&q=Senegal+African+Consultants+International+Report+'Rapport+De+l'Intervention+en+Temps+De+Crise+Au+Plaidoyer+A+Long+Terme:+Promouvoir+La+Tolérance+et+Le+Respect+Des+Droits+De+s+Groupes+Vulnérables'+(2011)&ie=UTF-8&oe=UTF-8)>

'Realising the Right to Health in Our Lifetimes? Towards a Framework Convention on the Right to Health' Discussion document for SECTION27 Regional Activist Dialogue (2011) available at <<http://www.section27.org.za/wp-content/uploads/2011/04/DiscussionDocument.pdf>>

Report on financial and health crisis that occurred in the Free State available at <[http://www.tac.org.za/community/files/ALP\\_Free\\_State\\_Report.pdf](http://www.tac.org.za/community/files/ALP_Free_State_Report.pdf)>

UNAIDS Report on Universal Access for Men who have Sex with Men and Transgender People" (2009) available at <[http://data.unaids.org/pub/Report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf), accessed on November 1, 2009>

UNAIDS Report on HIV/AIDS-related stigma and Discrimination: A Conceptual Framework and an Agenda for Action (2002) available at <[http://pdf.usaid.gov/pdf\\_docs/Pnacq832.pdf](http://pdf.usaid.gov/pdf_docs/Pnacq832.pdf)>

UNAIDS Report on HIV-Related Stigma, Discrimination and Human Rights Violations (2005) available at <[http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf)>

UNAIDS Report on the global AIDS epidemic (2008) available at <<http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/Default.asp>>

UNAIDS Report on Universal Access for Men who have Sex with Men and Transgender People (2009) available at <[http://data.unaids.org/pub/report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf)>

UN Report 'Senegal's Recipe for Success: Early Mobilization and Political Commitment Keep HIV Infections Low' (2001) available at <<http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/15no1pdf/151aid11.pdf>>

'WHO, 'The Framework Convention/Protocol Approach' in Framework Convention on Tobacco Control Technical Briefing Series (1999) available at <[http://whqlibdoc.who.int/hq/1999/WHO\\_NCD\\_TFI\\_99.1.pdf](http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.1.pdf)>

## **Treaties**

Abuja Treaty Establishing the African Economic Community (1991)

African Charter on Human and Peoples' Rights (1982/1986)  
African Charter on the Rights and Welfare of the Child (1990/1999)  
Convention on the Elimination of Discrimination against Women (1979)  
Convention on the Elimination of Racial Discrimination (1966)  
Convention on the Rights of the Child (1989/1990)  
Convention on the Rights of Persons with Disabilities (2006/2008)  
International Covenant on Civil and Political Rights (1966/1976)  
International Covenant on Economic, Social and Cultural Rights (1966/1976)  
Southern African Development Community Protocol of Health (1999)

### **Resolutions and General Comments**

UN Committee on Economic, Social and Cultural Rights *General Comment No 3: The Nature of States Parties' Obligations* (Art. 2, Para. 1, of the Covenant) (1990)  
UN Committee on Economic, Social and Cultural Rights *General Comment No.14 The right to the highest attainable standard of health* (2000)  
Optional Protocol to the International Covenant on Economic Social and Cultural Rights (2008)  
UNGASS 'Declaration of Commitment on HIV/AIDS' (2001)  
United Nations Millennium Declaration, United National General Assembly Res 55/2 (2000)  
Universal Declaration of Human Rights (1948)  
WHO Alma-Ata Declaration (1978)

### **Internet sources**

Niang, A 'Between centralization and decadence: Senegalese politics under Wade' (2009) *Pambazuka News* available at <<http://pambazuka.org/en/category/features/60920>>  
Sen, A 'Will There Be Any Hope for the Poor?' *Time Newspaper* May 22 (2000) available at <<http://www.time.com/time/magazine/article/0,9171,997021,00.html>>  
Speech by President of the Republic of South Africa to the National Council of Provinces available at <<http://www.pmg.org.za/node/19020>>  
Statistics by Actuarial Society of South Africa available at <<http://www.health-e.org.za/uploaded/c0b24898135d6363351d590125ba7a6b.pdf>>  
TAC letter to US Ambassador of South Africa concerning 'We call on the US government to provide global leadership to achieve millennium development goal 6, including universal access to antiretroviral therapy' available at <<http://www.section27.org.za/2010/06/18/call-on-us-government-to-fund-aids-and-health>>

### **National legislation and legal documents**

#### **Senegal**

Loi No 65-60 Code Pénal du Sénégal (1965)  
Loi No 06/2009 Relatif au VIH et au SIDA (2009)  
The Constitution of the Republic of Senegal (2001)

## **South Africa**

Criminal Procedure Second Amendment Act 85 (1997)

Employment Equity Act 55 (1998)

HIV/AIDS & STI National Strategic Plan for South Africa 2007-2011

Promotion of Equality and Prevention of Unfair Discrimination Act 4 (2000)

The Constitution of the Republic of South Africa Act 108 (1996)

The National Health Insurance in South Africa Policy Paper (2010)

## **Cases**

### **African Regional system**

*Centre on Housing Rights and Evictions v The Sudan* Com. 279/03 & *Sudan Human Rights Organisation v The Sudan* Com. 296/05, 2009

*Purohit and Moore v The Gambia* Com. 241/2001, 2003

*Social and Economic Rights Action Center & the Center for Economic and Social Rights v Nigeria* Com. 155/96, 2001

### **National system**

*Hoffmann v South African Airways* 2001 (1) SA 1 (CC)

*Jordan and others v Republic of South Africa* 2002 (6) SA 642 (CC)

*Minister of Health and others v Treatment Action Campaign and others* 2002 (5) SA 721 (CC)

*Van Biljon & Others v Minister of Correctional Services* 1997 (4) SA 441 (CC)

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**END**