

**HIV TESTING FROM AN AFRICAN HUMAN RIGHTS SYSTEM PERSPECTIVE:
AN ANALYSIS OF THE LEGAL AND POLICY FRAMEWORK OF BOTSWANA,
ETHIOPIA AND UGANDA**

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of the requirements for the degree of LLM (Human Rights and Democratisation in Africa)**

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29 October 2007

DECLARATION

I, **Mizanie Abate Tadesse**, hereby declare that this dissertation is original and has never been presented in any other institution. I also declare that any secondary information used has been duly acknowledged in this dissertation.

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LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
AU	African Union
CEDAW	Convention on the Elimination of Discrimination Against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CRC	Convention on the Rights of the Child
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
NGO	Non-Governmental Organisation
OAU	Organisation of African Unity
OHCHR	Office of the High Commissioner for Human Rights
PITC	Provider-Initiated Testing and Counselling
PLWHA	People Living With HIV/AIDS

PMTCT Prevention of Mother-to-Child Transmission

UDHR Universal Declaration of Human Rights

UNAIDS Joint United Nations Program on HIV/AIDS

UN United Nations

WHO World Health Organisation

VCT Voluntary Counselling and Testing

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CHAPTER ONE: INTRODUCTION

1.1 Rationale

The HIV/AIDS pandemic poses the greatest threat to Africa's efforts to achieve its full potential in the social, economical and political spheres.¹ Cognizant of its devastating consequences, various mechanisms have been designed to address the issue of HIV/AIDS in Africa. Of these mechanisms, HIV testing has long been a focal point for those committed to the struggle against AIDS.² This is because the information that is provided by an HIV-test is crucial if an individual is: to protect himself or herself from exposure to situations that create risk because her or his immune system is compromised; to protect others by avoiding the types of contact implicated in transmission of the virus; to notify others with whom he or she has had contact of their exposure; to make informed reproductive decisions including whether to continue or terminate the pregnancy; to decide whether or not to breast-feed; and to avail himself or herself of early treatment, including monitoring of immune system function.³

Testing for HIV has, however, become one of the thorniest aspects of a health debate that is fraught with human rights implications.⁴ In the early years of the epidemic, most debates seemed to suggest that the choice was between VCT⁵ on the one hand, and some form of compulsory⁶ or mandatory testing,⁷ on the other.

AIDS and human rights activists argued that VCT was the most effective and rights-based method of encouraging HIV testing.⁸ Furthermore, they took a position that infringing on the right to privacy - by, for example, making HIV testing mandatory - effectively drives the AIDS epidemic further

¹ S Gumedze 'HIV/AIDS and human rights: The role of the African Commission on Human and Peoples' Rights' (2004) 4 *African Human Rights Law Journal* 181.

² Canadian HIV/AIDS Legal Framework *Outcomes of the symposium on HIV testing and human rights* (2005) http://www.genderhealth.org/pubs/testing_symposium.pdf (accessed 4 July 2007). See also K Cock *et al* 'A serostatus-based approach to HIV/AIDS prevention and care in Africa' (2003) 362 (9398) *The Lancet* <http://www.thelancet.com/journals/lancet/article/PIIS0140673603149069/fulltext> (accessed 1 July 2007).

³ Voluntary Counselling and Testing, UNAIDS Technical Update, May 2000, *Best practice collection*, 6. See also T Stein *The social welfare of women and children with HIV and AIDS: Legal protections, policy and programs* (1998) 90.

⁴ The South African Institute of International Affairs *Special Feature: States, AIDS experts tests boundaries of HIV testing* <http://www.saiia.org.za/modules.php?op=modload&name=News&file=article&sid=403> (accessed 4 July 2007).

⁵ VCT involves the following elements (often referred to as the 3 C principles): both pre- and post-test counselling, informed consent, and confidentiality of test results. VCT also meant that testing is done on an 'opt-in' basis — i.e., that testing would happen upon following the person's deliberate decision to seek out HIV testing. See Canadian HIV/AIDS Legal Framework (n 2 above) and UNAIDS/WHO *Policy Statement on HIV Testing* (2004) <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf> (accessed 25 May 2007).

⁶ 'Compulsory testing' also known as 'involuntary testing' is defined as testing without a voluntary element — i.e., without informed consent, at the behest of someone or some institution other than the person tested and, sometimes, with neither the fact of having been tested nor the result communicated to the person tested. See R.Jurgens *HIV Testing and Confidentiality* (2000)11; J Mann 'AIDS and human rights: The future of the pandemic' in J Mann *et al* (eds) *Health and human rights* (1999) 44; and Canadian HIV/AIDS Legal Framework (n 2 above).

⁷ 'Mandatory testing' is defined as testing that would occur as a condition for some other benefit, such as donating blood, immigration to certain countries, getting married, joining the military or as a precondition for other kinds of employment. See Jurgens (n 6 above).

⁸ Canadian HIV/AIDS Legal Framework (n 2 above).

underground, particularly where being infected is followed by persecution, ostracism, violence and destitution. International organisations such as UNAIDS and the WHO, following the same line of argument, advanced the view that VCT, in which the patient elects to find out his or her status, was the only appropriate approach.⁹ Save in the cases of blood and body organ donations, they argued that compulsory or mandatory testing represents a violation of human rights and an ineffectual response in terms of public health.¹⁰ Despite these concerns, in some countries, compulsory testing still occurs, and mandatory testing continues to be applied to certain groups of people in certain circumstances, such as immigrants, prisoners, sex workers, and the military.¹¹

States applying mandatory or compulsory HIV testing justify their actions with a public health rationale, which they claim, is strong enough to restrict human rights in the context of HIV testing.¹² Considering its devastating effect, stemming the spread of HIV/AIDS, they argue, is in the public interest.¹³ Since there is neither a vaccine, nor a cure for HIV/AIDS, public interest is best served when people who are HIV-positive abstain from engaging in those behaviours most likely to transmit the virus.¹⁴ As learning about one's HIV status through HIV testing is a crucial step in modifying behaviour,¹⁵ and since VCT is too slow or inefficient to help prevent the persistent spread of HIV, they argue, a call for more widespread and aggressive HIV testing is of paramount importance.¹⁶

Despite the aforementioned arguments raised against it, VCT, as a rights-based approach to HIV testing, gathered pace and supporters until recent years.¹⁷ The other modalities of testing were generally regarded as an invasion to human rights and thus treated as exceptions to the rule.

Although VCT has been recognised as a rights-based approach to HIV testing, there has been increasingly a call to move away from a sole reliance on the VCT model in recent years, particularly in high-prevalence countries.¹⁸ The move towards a more aggressive type of testing is justified, among other things, by the wide availability of ART.¹⁹ Activists and policy-makers have been seeking an efficient way to get ART to those infected with HIV, with routine testing (PITC)²⁰

⁹ The South African Institute of International Affairs (n 4 above). See also UNAIDS/WHO Policy (n 5 above).

¹⁰ Canadian HIV/AIDS Legal Framework (n 2 above).

¹¹ As above.

¹² Report of the Secretary General *Second International Consultation on HIV/AIDS and Human Rights* (1996) [http://www.unhcr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.1997.37.En?Open+document](http://www.unhcr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.1997.37.En?Open+document) (accessed 4 May 2007).

¹³ Stein (n 3 above) 90.

¹⁴ As above.

¹⁵ As above.

¹⁶ Canadian HIV/AIDS Legal Framework (n 2 above).

¹⁷ M Heywood 'The routine offer of HIV counselling and testing: A Human Right' (2005) 8 (2) *Health and Human Rights: An International Journal* 13.

¹⁸ T Metz 'The ethics of routine HIV testing: A right-based approach analysis' (2005) 21(3) *South African Journal on Human Rights* 371.

¹⁹ Metz (n 18 above).

²⁰ 'Routine testing' also called 'opt out testing' or PITC is undertaken upon the initiation of the health care provider, unlike VCT where the person is tested only upon his initiation. PITC is, however, different from mandatory and compulsory

being one strategy considered.²¹ Botswana has been the first country to adopt a policy that has departed from the pure version of client-initiated VCT. According to Botswana's new policy of routine HIV testing, all people in Botswana would automatically be offered HIV testing when they utilised health services. An individual's right to refuse for testing is, however, respected. Although the offer of an HIV test does not in and of itself violate the established principles of informed consent, it does shift the onus of requesting the test from the patient to the provider.²²

Despite the fact that the move towards routine testing attracts some supporters, it has become equally the concern of others. In countries where there is a power imbalance between test provider and client, for example, the voluntary nature of HIV testing may be compromised, as the client may feel compelled to 'consent' to the provider's 'suggestion' or 'recommendation.'²³ Even if one agrees that the 'routine-offer' approaches may cause an increase in the number of tests given, the increase may not necessarily be the most important outcome.²⁴ People who have not prepared themselves for testing and do not have the necessary support to deal with the consequences of disclosure of their HIV status may suffer depression, abandonment, violence and other severe outcomes which would have either been avoided or at least their effect mitigated by VCT approaches.²⁵

The guidelines adopted by the WHO and UNAIDS on HIV testing, on the other hand, emphasised a move from the current VCT model to PITC model.²⁶ The guidelines advise health care workers in countries with HIV prevalence greater than 1% to routinely offer confidential, voluntary HIV tests to all patients seeking treatment at clinics or hospitals. This is a departure from earlier WHO and UNAIDS guidelines that advised health workers to offer HIV tests only if treatment was available.²⁷

Many activists have mocked against this new testing strategy, chiefly on considerations that they may lead to new abuses of power by health care providers and the possible violations of human rights that may follow.²⁸ Others have praised the new testing guidelines as a timely change from

testing in that it is done only where the individual consents to the HIV testing initiated by the health care provider. For a detailed discussion of PITC, see sub-section 4.2.2 of Chapter four.

²¹ Metz (n 18 above).

²² Heywood (n 17 above) 13.

²³ Canadian HIV/AIDS Legal Framework (n 2 above). See also Heywood (n 17 above) 13.

²⁴ Canadian HIV/AIDS Legal Framework (n 2 above).

²⁵ As above.

²⁶ WHO/UNAIDS *Guidance on Provider –Initiated HIV testing and counselling in the Health Facilities* (2007) http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf (accessed 15 June 2007). Even before the introduction of the new guidelines, provider-initiated HIV testing and counselling has already been implemented in a range of clinical settings in several low- and middle-income countries, including Botswana, Kenya, Malawi, Uganda and Zambia, as well as in pre-natal settings in parts of Canada, Thailand, the United Kingdom, and the United States. See *WHO and UNAIDS issue new guidance on HIV testing and counselling in health facilities* <http://www.who.int/media/centre/news/releases/2007/pr24/en/index.html> (accessed 30 June 2007).

²⁷ UNAIDS/WHO Policy Statement on HIV Testing (2004) (n 5 above).

²⁸ See for example M Russo *Opt out testing: Moving forward* <http://www.rhrealitycheck.org/blog/2007/06/28/opt-out-hiv-testing-moving-forward> (Accessed 6 July 2007).

the old scheme, based not only on more availability of antiretroviral drugs but also on a better understanding of protecting human rights and the role of health care providers in this endeavour.²⁹

The debate between proponents of routine, mandatory and compulsory HIV testing on public health grounds and those that oppose such types of testing from a human rights perspective has not been resolved. This study seeks to explore the laws and policies of Botswana, Ethiopia and Uganda in respect of HIV testing and to analyse whether they are in compliance with state obligations stipulated under African human rights instruments.

1. 2 Research Problem

The main question that will be addressed in this dissertation is: Are the legislation and policies of Ethiopia, Botswana and Uganda providing for various modalities of HIV testing consistent with human rights as enshrined under African Human Rights system? The thesis addresses this question in a broader context that requires dealing with the following issues: what are the international human rights standards that govern HIV testing? Which specific rights in the African human rights system are relevant in the context of HIV testing? What are the specific types of testing applied in Uganda, Botswana and Ethiopia? Are the different types of testing applicable in these states consistent with the rights in the African human rights system related to HIV testing? If not, are the inconsistencies justifiable?

1. 3 Methodology

The author of this dissertation will critically analyze the African human rights instruments and the relevant domestic legislation and policies of the three countries. A reference shall also be made to international human rights standards, relevant cases, national legislation and other literature.

1.4 Limitations of the Study

This study is undertaken in South Africa. Due to constraint of first hand information from the countries under study, the author is forced to heavily rely on second hand information and exchange of emails with concerned government institutions and NGOs.

The thesis is limited to a case study of the laws and policies of the three countries. It is believed that the selected states reflect the successes, problems and controversies surrounding HIV testing in Africa. Uganda is chosen because of its success in curbing the spread of HIV/AIDS. On the other hand, Botswana and Ethiopia are selected to show the controversies surrounding PITC, mandatory and compulsory models HIV testing.

²⁹ M Russo (n 28 above).

Exploring whether a country is living up to its human rights obligations requires one to go beyond the laws and policies of a state and examine the prevailing practices of the country in question. Due to the constraints of time, space and resources, however, the study is mainly confined to legislation and policies.

1.5 Literature Review

Several studies have been undertaken on HIV/AIDS and human rights. To take two recent examples, Kirby, in his article,³⁰ argues for a need to look into whether past strategies of testing and counseling should be amended to 'scale up' testing and, consequently, access to antiretroviral treatment as an effective mechanism to control the disease. Gumedze³¹ in a study that focused on the African human rights system pointed out, *inter alia*, that the substantive provisions of the African Charter are to some extent flexible enough to address denial of human rights in relation to HIV/AIDS. There are also a number of studies addressing HIV testing and its impact on human rights. For instance, Metz, in his article,³² proposes a thorough justification for routine testing. A study by the South African Law Commission has also explored the issue of compulsory HIV testing of sexual offenders and the disclosure of HIV-related information to victims of crime in light of the South African constitutional and legal framework.³³

There are also a number of articles on the issue of HIV testing and human rights³⁴ arguing for and against the compatibility of particular models of HIV testing with international human rights norms and public health rationale. Moreover, there are also a number of UNAIDS/WHO and national guidelines on HIV/AIDS and human rights. This dissertation makes use of these and other similar sources as a point of departure to address the problem.

1.6 Overview of the chapters

This dissertation is comprised of five chapters. Chapter one has set out the rationale of the research, identified the problem, reviewed the available literature, discussed the limitations of the study and outlined the methodology. Chapter two provides an overview of the international human rights standards that govern HIV testing. It also highlights the circumstances under which such rights may be restricted. Chapter three focuses on the African regional human rights and discusses

³⁰ M Kirby 'The never – ending paradoxes of HIV/AIDS and human rights' (2004) 4 *African Human Rights Law Journal* 163-180.

³¹ Gumedze (n 1 above) 181-200.

³² Metz (n 18 above) 370-405.

³³ South African Law Commission *Fourth Interim Report on Aspects of the Law Relating to AIDS: Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases* (2000).

³⁴ See for example, A Stanley 'May I ask you a personal question: The right to privacy and HIV testing in the European Community and the United States' (1997) 65 *Fordham Law Review*; M Heywood 'Human rights and HIV/AIDS in the context of 3 by 5: Time for new directions' (2004) 9 *Canadian HIV/AIDS Policy and Law Review*; R Doughty 'The confidentiality of HIV related information: Responding to the resurgence of aggressive public health interventions in the AIDS epidemic' (1994) 82 *California Law Review*; and Heywood (n 17 above).

the African regional human rights instruments pertinent to HIV testing. Chapter four then determines the compatibility of the types of HIV testing available in Botswana, Ethiopia and Uganda with human rights standards that govern HIV testing as envisaged in the African human rights system. Chapter five provides a conclusion and a few recommendations.

CHAPTER TWO: A BRIEF OVERVIEW OF THE INTERNATIONAL HUMAN RIGHTS STANDARDS GOVERNING HIV TESTING

2.1 Introduction

African human rights norms that govern HIV testing are not self-standing norms. As it shall be discussed in chapter three, provisions of various African human rights treaties make cross-reference to principles of international law for the interpretations of the provisions in the African human rights instruments. Thus, with a view to make use of international principles to interpret the African human rights norms, this chapter primarily intends to lay down international human rights norms that are applicable in relation to HIV testing. As a background to this discussion, this chapter commences by discussing briefly the emergence, nature and the significance of the rights-based approach to HIV testing.

2.2 A rights-based approach to HIV/AIDS

2.2.1 Emergence and Nature

In the earliest stages where the virus was described and tests were developed, demands were made for compulsory testing and for the introduction of laws that would punish people who were thought responsible for spreading the virus.³⁵ The difficulty with this approach was that even if everyone in the community could be tested, it was realised that it was almost impossible to isolate those who became positive from the rest of the population.³⁶ A related difficulty was that HIV prevention and care programmes with coercive or punitive features resulted in reduced participation and increased alienation of those at risk of infection.³⁷ As a result, the strategy of the Global Programme on AIDS and WHO Global Commission on AIDS shifted to behavioural modification.³⁸ It was believed that:

*The best way to promote behavioural modification, essential to prevent the spread of HIV, was to ensure that knowledge about the existence, modes of transmission and means of prevention of infection was given to all those at risk of acquiring it in circumstances that they would trust, believe and follow it.*³⁹

³⁵ Kirby (n 30 above) 167. See also Doughty (n 34 above) 122.

³⁶ Echoing the stipulations of relevant human rights instruments (art.9 of the ICCPR), the HIV/AIDS and Human Rights International Guidelines of 1996 provides that subjecting people to coercive measures such as isolation, detention or quarantine solely on the basis of their HIV status is prohibited. Where the liberty of people living with HIV is restricted, all due process guarantees shall be respected. See OHCHR/UNAIDS *HIV/AIDS and Human Rights International Guidelines: Second International Consultation on HIV/AIDS and Human Rights* (1996) <http://whqlibdoc.who.int/publications> (accessed 5 August 2007) para 28 (d). See also UNAIDS/IPU *Handbook for legislatures on HIV/AIDS, law and human rights: Action to combat HIV/AIDS in view of its devastating human, economic and social impact* (1999) http://data.unaids.org/Publications/IRC-pub01/JC259-IPU_en.pdf (accessed 2 August 2007).

³⁷ Report of the Secretary General (n 12 above).

³⁸ Kirby (n 30 above) 168.

³⁹ As above

This was the hallmark of the rights-based approach in the struggle against HIV/AIDS.⁴⁰

A rights-based approach to HIV/AIDS refers to the processes of using human rights as a framework for addressing the HIV/AIDS pandemic.⁴¹ To put this in different words, a human rights-based approach to HIV/AIDS is one that protects, respects and fulfils – rather than restricts – human rights.⁴² The consolidated version of the International Guidelines on HIV/AIDS and Human Rights⁴³ provide a framework for a human rights-based approach to the HIV/AIDS pandemic by outlining how human rights standards apply in the context of HIV/AIDS in concrete and practical terms.⁴⁴

2.2.2 The role of a rights-based approach to HIV/AIDS in combating the spread of HIV/AIDS

Numerous studies reveal that any preventive measure of the virus that undermines human rights has the effect of increasing vulnerability to the virus. Thus, the protection and promotion of human rights are necessary not only for the protection of the inherent dignity of persons affected by HIV but also for the achievement of the public health goal of reducing vulnerability to HIV infection, lessening the adverse impact of HIV and AIDS on those affected, and empowering individuals and communities to respond to HIV.⁴⁵

Realizing that human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS, Heads of State and Government and Representatives of States and Governments, assembled at the UN General Assembly Special Session on HIV/AIDS (2001), declared their commitment to:

enact, strengthen or enforce [by 2003] as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment,

⁴⁰ As above.

⁴¹ Gumedze (n 1 above) 189-190.

⁴² UN Office of the High Commissioner for Human Rights *A Human Rights-Based Approach to HIV/AIDS: UN General Assembly Special Session on HIV/AIDS* (2001) para 4.

⁴³ UNAIDS/OHCHR *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version* (2006) http://www.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf (accessed 26 July 2007) (herein after referred to as the Consolidated Guidelines). The Consolidated Guidelines were developed a decade after the adoption of the 1996 Guidelines to accommodate developments that have taken place with regard to the right to health and access to HIV-related prevention, treatment, care and support since then. In May 2007, WHO/UNAIDS have also issued Guidance on provider-initiated HIV testing and counselling in health facilities. These Guidelines recommend an expanded model of HIV testing yet insist that testing shall be carried out in an enabling environment (in a manner consistent with human rights norms as set out in the 1996 Guidelines on HIV/AIDS and human rights and the consolidated Guidelines). See n 26 above.

⁴⁴ Although such guidelines and other international resolutions and recommendations developed to address the issue of HIV/AIDS are not legally binding, they represent international consensus about the optimal protection and promotion of human rights in the context of HIV/AIDS.

⁴⁵ Consolidated Guidelines (n 43 above) para 94. See also Mann (n 6 above) 223.

*information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.*⁴⁶

As noted by the Special Rapporteur to the Sub-Commission on Prevention of Discrimination and Protection of Minorities of the UN Commission on Human Rights, Economic and Social Council, the importance of a human rights-based approach to HIV/AIDS lies not just in its public health merit but in the fact that it is morally right. Any abuse of human rights impugns human dignity and thus affects us all.⁴⁷

Emphasising that an effective response to the pandemic must be grounded in respect for all human rights, UNAIDS,⁴⁸ WHO⁴⁹ and ILO⁵⁰ have similarly issued strong calls for a human rights-based approach to HIV/AIDS.

2.3 A specific application of a rights-based approach to HIV testing

As pointed out in chapter one, HIV testing has been the focal point for behavioural change which is deemed necessary to curb the spread of the pandemic. For testing to bring the desired outcome, nonetheless, it must be undertaken in an enabling environment that respects rights of individuals.⁵¹ The question that deserves answer at this juncture is: What is a rights-based approach with specific reference to HIV testing?

A rights-based approach to HIV testing not only imposes obligation on states to ensure access to HIV testing as a corollary to their obligation to promote and protect the right to health, but also requires the embodiment of human rights principles and protections at the heart of all policy decisions related to HIV testing.⁵² More concisely, as envisaged in various guidelines and policies issued by UNAIDS, WHO and other UN pertinent organs,⁵³ it means that HIV testing should, in principle, be undertaken in conformity with three inter-woven principles which are often referred to

⁴⁶ n 42 above.

⁴⁷ Sub-Commission on Human Rights, Economic and Social Council, *Discrimination against HIV infected people or people with AIDS: Progress Report by Mr. Luis Varela Quiros, Special Rapporteur*, E/CN. 4/Sub. 2/1991/10 24 July 1991 paras 164, 165, 170 and 173.

⁴⁸ UNAIDS/WHO (n 5 above).

⁴⁹ As above.

⁵⁰ As cited in WHO Report of an International Consultation on AIDS and Human Rights (1989) 50. The International Labour Organisation guidelines, devised in conjunction with the WHO, advise against pre-employment testing. The guidelines state: 'Pre-employment HIV/AIDS testing as part of the assessment of fitness to work is unnecessary and should not be required. People with the HIV virus or suffering from AIDS pose no danger to their colleagues at work. There are hence no grounds for testing potential recruits for HIV'.

⁵¹ Canadian HIV/AIDS Legal Network *HIV testing* (2007)<http://www.aidslaw.ca/publications/interfaces/> (accessed 29 July 2007).

⁵² Canadian HIV/AIDS Legal Network (n 51 above).

⁵³ OHCHR/UNAIDS (n 36 above) para 28 and 31 (b); and UNAIDS/WHO (n 5 above). Such principles are also reaffirmed by the May 2007 provider-initiated guideline for HIV testing. See WHO/UNAIDS (n 26 above).

as the 3C principles: both pre-test and post-test counselling, informed consent and confidentiality of test results.⁵⁴ What follows is a separate treatment of each of these three principles.

2.3.1 Informed consent

The international guidelines on HIV testing stipulate that HIV testing should be made only with a specific consent of the individual.⁵⁵ Informed consent should always be given individually, in private, in the presence of a health care provider.⁵⁶ Verbal communication is normally deemed adequate for the purpose of obtaining informed consent.⁵⁷

Quite in line with the existing international guidelines on HIV testing, the Counselling Guidelines for HIV Testing published by the Canadian Medical Association in 1995⁵⁸ lists express consent (as opposed to implied or presumed one), adequate disclosure of information,⁵⁹ capacity to understand the information and make an informed choice⁶⁰ and voluntary choice free of coercion as essential elements of informed consent.

The principle that consent for testing should be given by the individual concerned has, however, two exceptions. Firstly, critically ill or unconscious patients may not be able to provide informed consent to HIV testing and counselling.⁶¹ In such circumstances, consent should be sought from persons competent to do so under the specific law of a given state.⁶² Secondly, children, in principle, cannot provide legally binding informed consent. As a result, informed consent from the child's parent, guardian or an individual who has authority under the law to make a decision based on the best interests of the child must be obtained.⁶³ However, children have the right to be involved in all decisions affecting their lives and to make their views known according to their evolving capacity. This means, every attempt should be made to explain to the child what is happening and to obtain her or his assent.⁶⁴ As we shall see in the HIV testing policies and

⁵⁴ As above.

⁵⁵ OHCHR/UNAIDS (n 36 above) para 28 (b). Here, it should be borne in mind that since the earliest days of the epidemic, HIV/AIDS has been treated differently from other sexually transmitted or lethal infectious diseases, a trend which is termed as 'HIV exceptionalism'. Specific areas of public health in which approaches have differed include HIV testing, surveillance, and contact investigation. HIV testing, available since 1985, has been restricted for medical as well as prevention purposes because of a strong emphasis on informed consent and counselling. Unlike other infectious diseases (eg, syphilis), for which consent for testing is implicitly assumed by virtue of medical consultation, and diagnosis is encouraged, the diagnosis of HIV infection has often been avoided.

⁵⁶ WHO/UNAIDS (n 26 above).

⁵⁷ As above.

⁵⁸ Canadian HIV/AIDS Legal Network (n 51 above).

⁵⁹ For detailed discussion of this element, see D Dickson *HIV, AIDS and the law: Legal issues for social work practice and the law* (2001) 14.

⁶⁰ In general, an adult client or patient is presumed to have the capacity to give consent for the tests unless a court has adjudicated an individual incompetent (Dickson (n 59 above) 16).

⁶¹ WHO/UNAIDS (n 26 above).

⁶² As above.

⁶³ As above.

⁶⁴ This is a reflection of the right of the child explicitly provided under art. 12 of the Convention on the Rights of the Child, adopted and open for signature, ratification, and accession by General Assembly resolution 44/25 of 20 November 1989, entered into force on 2 September 1990.

legislation of the countries reviewed in this study, children above a certain age limit and/or children who are regarded mature enough to make decisions have been given the capacity to give consent for HIV testing without the involvement of their parents and guardians.

2.3.2 Counselling

Aside from informed consent, pre- and post-test counselling are considered to be essential components of HIV testing. Counselling is indispensable for those whose tests may be either negative or positive. For HIV negative individuals, it helps them not to engage in those activities that may cause vulnerability to the virus.⁶⁵ From the view point of HIV positive individuals, counselling is important to help mitigate the most negative consequences of disclosing HIV status.⁶⁶

The WHO/UNAIDS guidelines provide for the specific information that must be supplied to the client in pre-test and post-test counselling. According to these guidelines⁶⁷, depending on local conditions, pre-test information can be provided in the form of individual information sessions or in group health information talks. In any case, the health care provider should at a minimum inform the client of the benefits of HIV testing and the potential risks; the services that are available in the case of either an HIV-negative or an HIV-positive test; confidentiality of the testing results; in the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV; and an opportunity to ask the health care provider questions. Additional information beyond the minimum requirements is necessary for specific groups.

The guidelines also recommend that all individuals undergoing HIV testing must be counselled when their test results are given, regardless of the test result. Counselling for those whose test result is HIV negative should at a minimum include: an explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure; basic advice on methods to prevent HIV transmission; and provision of male and female condoms and guidance on their use.

The focus of post-test counselling for people with HIV-positive test results is psychosocial support to cope with the emotional impact of the test result, facilitate access to treatment, care and prevention services, prevention of transmission and disclosure to sexual and injecting partners.⁶⁸

⁶⁵ Canadian HIV/AIDS Legal Network and Canadian AIDS Society *HIV testing and confidentiality Final report* (2006) <http://www.aidslaw.ca/vs4.korax.net/publications/interfaces/downloadFile.php?ref=282> (accessed 9 August 2007).

⁶⁶ Canadian HIV/AIDS Legal Network (n 51 above).

⁶⁷ WHO/UNAIDS (n 26 above).

⁶⁸ As above.

2.3.3 Confidentiality

Confidentiality is of particular significance with respect to HIV because of the stigma and discrimination experienced by PLWHA.⁶⁹ Besides, the community has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV/AIDS prevention and care services.⁷⁰ Accordingly, the guidelines provide for the need to respect confidentiality of all information relating to a person's HIV status.⁷¹

As an exception to confidentiality requirement, however, the guidelines support voluntary partner notification. They recommend that public health legislation should authorize, but not require, health-care professionals to notify sexual partners of their patient's HIV status in carefully defined situations.⁷²

2.4 Human rights basis of principles of HIV testing

In the previous section, an endeavour has been made to show the three principles underlying HIV testing within the framework of international guidelines governing HIV testing. This section explores the human rights basis of the 3C principles.

There are no HIV/AIDS-specific treaties within the international legal framework. Nor are there specific provisions dealing with HIV/AIDS in the international human rights conventions. The obvious reason for such silence is that the treaties were negotiated and adopted before the devastating effect of HIV/AIDS had been felt. Despite the fact that these treaties are silent in areas relating to HIV/AIDS, specific provisions thereof have been interpreted by treaty bodies and other UN organs to be applied to various legal situations pertaining to HIV/AIDS. The following subsections discuss those rights upon which the 3C principles are based.⁷³

⁶⁹ OHCHR/UNAIDS (n 36 above) para 98.

⁷⁰ As above.

⁷¹ OHCHR/UNAIDS (n 36 above) para 97. See also Canadian HIV/AIDS Legal Network (n 51 above). For ethical and pragmatic justifications of confidentiality, see M Siegler 'Confidentiality in Medicine – A Decrepit Concept' (1982) 24 *The New England Journal of Medicine* 307, as quoted in Canadian HIV/AIDS Legal Network (n 65 above).

⁷² UNAIDS/IPU (n 36 above). See also Consolidated Guidelines (n 43 above) para 20 (g).

⁷³ It is difficult to safely conclude that the rights that are discussed in this section are the only rights relevant to HIV testing. In view of the principle of indivisibility and interdependence of rights, other rights may in way or another be related to testing. The discussion, however, is confined to those rights that have a direct and practical relevance to HIV testing.

2.4.1 The right to the highest attainable standard health and the right to freedom of expression

The right to health is recognised in numerous international instruments, such as article 25 (1) of the UDHR, article 12 of the ICESCR,⁷⁴ article 5 (e) (iv) of the CERD⁷⁵, article 24 of the CRC⁷⁶ and article 11 (1) (f) and 12 of the CEDAW.⁷⁷

Under article 12 of the ICESCR, states parties recognise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ and further commit themselves to take the necessary steps to achieve the full realization of this right. The authoritative comment on this right, from the UN committee that monitors governments’ progress toward its realization, suggests that the right to health includes basic services, including HIV/AIDS-related health services, that are ‘scientifically and medically appropriate and of good quality,’ as well as respectful of culture and medical ethics.⁷⁸ It is submitted that this includes good quality HIV testing that adheres to the 3C principles.

Moreover, the obligation of states parties to take steps to prevent, treat and control of epidemic diseases under article 12 (2) (c) of the ICESCR requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS.⁷⁹ Since voluntary testing and counselling is central to bring the behavioural change that is instrumental in preventing the transmission of HIV/AIDS, the obligation of the states includes provision of VCT services.

Furthermore, the committee noted that accessibility, as an essential element of the right to health, includes the right to seek, receive and impart information and ideas concerning health issues. The right to seek, receive and impart information and ideas, although an element of the right to health, is also a separate right guaranteed under article 19 (2) of the ICCPR within the ambit of freedom of expression.⁸⁰ Whether the right to seek receive and impart information is a separate right or an essential component of the right to health, it includes the right to seek and receive HIV-related

⁷⁴ International Covenant on Economic, Social and Cultural Rights, adopted and open for signature, ratification, and accession by General Assembly resolution 2200 A (XXI) of 16 December 1966, entered into force on 23 March 1976.

⁷⁵ International Convention on the Elimination of All Forms Racial Discrimination, adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965 enter into force on 4 January 1969.

⁷⁶ n 64 above.

⁷⁷ Convention on the Elimination of All Forms of Discrimination against Women, adopted and open for signature, ratification, and accession by General Assembly resolution 34/180 of 18 December 1979, entered into force on 3 September 1981.

⁷⁸ Committee on Economic, Social and Cultural Rights *General Comment No. 14, The right to highest attainable standard of health* (2000) paras 12(c) and 12(d).

⁷⁹ n 78 above, para 16.

⁸⁰ It is also recognised under art 19 of the UDHR (adopted in 1948), art 13 of the CRC, n 64 above.

prevention information.⁸¹ The Committee, however, pointed out that accessibility of information should not impair the right to have personal health data treated with confidentiality.⁸²

In elaborating the obligation of States Parties to eliminate discrimination in order to realize the right of women to the highest attainable standard of health under article 12 (1) of CEDAW, the CEDAW Committee⁸³ provides that the obligation of State Parties to ensure access to quality health-care services includes acceptable services to women. According to the Committee, acceptable services are those services that are delivered in a way that ensures informed consent, respects dignity, guarantees confidentiality and is sensitive to the needs and perspectives of the women.⁸⁴ It recommended States Parties not to permit various forms of coercion that violate women's rights to informed consent and dignity, such as mandatory testing for sexually transmitted disease as a condition of employment.⁸⁵

The Committee on the CRC, in its General Comment No. 3 that addresses HIV/AIDS and the rights of the child, stated that the right to health (article 24 of the Convention) is central to the issue of children and HIV/AIDS.⁸⁶ Elaborating the obligation of States Parties to ensure that no child is deprived of his or her right of access to necessary health services, the Committee stated that states parties should ensure access to voluntary, confidential HIV counselling⁸⁷ and testing for all children.⁸⁸ The Committee also stressed that States Parties must refrain from imposing mandatory HIV/AIDS testing of children in all circumstances and provide protection against it.⁸⁹

2.4.2 The right to privacy

Article 12 of the UDHR provides a model for other human rights treaties for the protection of the right to privacy.⁹⁰ Drawing on and developing article 12 of the UDHR, article 17 of the ICCPR has several noteworthy elements which are of interest for further analysis of the right to privacy protected in various instruments.⁹¹ It provides that '[n]o one shall be subjected to arbitrary or unlawful interference with his privacy...' 'Everyone has the right to the protection of the law against

⁸¹ Consolidated Guidelines (n 43 above) Para 138. See also Canadian HIV/AIDS Legal Network *Prevention and protection: Enhancing both HIV testing and human rights in Canada* (2007) <http://www.aidslaw.ca/publications/interfaces/> (accessed 30 July 2007).

⁸² n 78 above, para 12(b).

⁸³ Committee on the Elimination of Discrimination against Women *General Comment No. 24, Women and health* (1990) para 22.

⁸⁴ As above.

⁸⁵ As above.

⁸⁶ Committee on the Rights of the Child, *General Comment No. 3, HIV/AIDS and the rights of the child* (2003) para 5.

⁸⁷ Counselling also gives effect to the child's right to receive information under articles 13 and 17 of the Convention.

⁸⁸ n 86 above, para 22.

⁸⁹ n 86 above, para 23.

⁹⁰ It states that no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

⁹¹ The right to privacy is also protected in other international human rights instruments such as art 16 of the CRC (n 64 above).

such interference or attacks.⁹² The right to privacy, therefore, encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, and the need to respect confidentiality of all information relating to a person's HIV status.⁹² From the perspective of children, the Committee on the Rights of the Child urges states parties to protect the confidentiality of HIV test results, consistent with the obligation to protect the right to privacy of children as envisaged under article 16 of the CRC.⁹³

2.4.3 The right to (principle of) non-discrimination, equal protection and equality before the law

Non-discrimination, together with equality before the law and equal protection of the law without any discrimination, constitute a basic and general principle relating to the protection of human rights.⁹⁴ The principle of non-discrimination is recognised in various international instruments, *inter alia*, in article 2 (1) of the ICCPR and article 2 (2) of the ICESCR.⁹⁵ The same principles are protected under article 7 of the UDHR and article 26 of the ICCPR.

While article 2 (1) of the ICCPR and article 2 (2) of the ICESCR limit the scope of the rights to non-discrimination to those provided for in the respective Covenants, no such limitation is provided in article 26 of the ICCPR.⁹⁶ This in effect means that article 26 does not merely duplicate the guarantee already provided for in article 2 of both Covenants but provides in itself an autonomous right.⁹⁷ It prohibits discrimination in law or in fact in any field regulated and protected by public authorities.⁹⁸

The above international instruments prohibiting discrimination enumerate the grounds against which discrimination is prohibited, namely race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. In 1996, the UN Commission on Human Rights resolved that the term 'other status' which is used in several human rights instruments 'should be interpreted to include health status, including HIV/AIDS' and that discrimination on the basis of actual or presumed HIV/AIDS status is prohibited.⁹⁹ The Committee on the Rights of the Child, in similar fashion, has pointed out that the grounds of discrimination under article 2 of the CRC include discrimination on the basis of HIV/AIDS.¹⁰⁰

⁹² Consolidated Guidelines (n 43 above) para 119.

⁹³ n 86 above, para 24.

⁹⁴ Human Rights Committee *General Comment No. 18, Non-discrimination* para 1.

⁹⁵ Other international instruments include art 12 of the CRC (n 64 above), provisions of CERD (n 75 above) and CEDAW (n 77 above).

⁹⁶ n 94 above, para 12.

⁹⁷ As above.

⁹⁸ As above.

⁹⁹ UN Commission on Human Rights Resolution 1996/44 and also Resolution 1995/21 of the Sub-Commission on the Prevention of Discrimination and Protection of Minorities.

¹⁰⁰ Committee on the Rights of the Child *General Comment No. 4, Adolescent health and development in the context of the rights of the child* (2003) para 6.

Beyond the components of the testing process itself, the right to be free of discrimination, in view of the writer, also requires that governments, when setting HIV testing policy and overseeing its practice, take into account the outcomes of HIV testing for people — including stigma, discrimination, violence and other abuse — and do all that they can to prevent other human rights violations.¹⁰¹ Therefore, any HIV testing legislation, policy and practice that puts HIV testing as a condition for enjoyment of rights or results in differential treatment solely in the basis of this status is discriminatory. Thus, for instance, any legislation or policy that provides for HIV screening of international travellers,¹⁰² mandatory pre-marital testing,¹⁰³ and pre-employment mandatory testing¹⁰⁴ infringes the right to freedom of movement, the right to marry and to found a family and the right to work respectively on a discriminatory ground.¹⁰⁵

2.5 Limitations of rights

Since an individual lives in a society with other individuals, the exercise by him of his rights must necessarily be regulated, and restricted to the extent necessary, to enable others to exercise their rights.¹⁰⁶ In order for restrictions on human rights to be justifiable, however, the state has to show that the restriction is:¹⁰⁷ provided for and carried out in accordance with the law,¹⁰⁸ i.e. according to specific legislation which is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly; based on a legitimate interest, as defined in the provisions guaranteeing the rights; proportional to that interest and constituting the least intrusive and least restrictive measure available and actually achieving that interest in a democratic society, i.e. established in a decision-making process consistent with the rule of law.

Thus, states may validly restrict human rights that are applicable in the context of HIV testing in so far as the restriction is compatible with the aforementioned standards.¹⁰⁹

¹⁰¹ Canadian HIV/AIDS Legal Network (n 81 above).

¹⁰² Consolidated Guidelines (n 43 above) para 127.

¹⁰³ Consolidated Guidelines (n 43 above) para 118.

¹⁰⁴ Consolidated Guidelines (n 43 above) para 149.

¹⁰⁵ This violation can be inferred from art 2 (1) read together with 12 of the ICCPR for violation of the right to freedom of movement; art 2 (1) and read cumulatively with 23 of the ICCPR for the infringement of the right to marry and found a family; and art 2 (1) and 6 of the ICESCR (n 74 above) for the violation of the right to work.

¹⁰⁶ N Jayawickrama *The judicial application of human rights: National, regional and international jurisprudence* (2005)182.

¹⁰⁷ Consolidated Guidelines (n 43 above) para 104.

¹⁰⁸ 'Law' does not refer to any arbitrary legislation. The Human Rights Committee in its General Comment No. 16 para 3 pointed out that limitation imposed by any arbitrary law against the right to privacy is not acceptable. It further provided that the law that limits rights shall itself comply with the provisions, aims and objectives of the Covenant.

¹⁰⁹ This is without prejudice to certain non-derogable rights that can not be restricted under any circumstances. Of these rights relevant to HIV testing, these rights include: the right to marry and to found a family and the right to equality before the law, the equal protection of the law and to freedom from discrimination.

2.6 Conclusion

Studies have shown that one of the best ways to combat the HIV/AIDS epidemic is ensuring a rights-based approach to HIV testing. As has been articulated in various guidelines and policies issued by UNAIDS, WHO and other UN pertinent organs, a rights-based approach to HIV testing requires conformity with the 3 C principles, viz., informed consent, pre- and post test counselling, and confidentiality of test outcomes. The three 3C principles have a clear human rights foundation. The right to highest attainable standard of health, the right to freedom of information and the right to privacy, the right to equality and freedom from discrimination are the core rights that the 3C principles aim to safeguard. These rights may, however, be subject to limitation by laws that aim at protecting and promoting legitimate societal interest.

CHAPTER THREE: AFRICAN REGIONAL HUMAN RIGHTS APPLICABLE IN THE CONTEXT OF HIV TESTING

3.1 Introduction

As the UNAIDS/WHO 2006 report on the global epidemic disclosed, an estimated 39.5 million people were living with HIV.¹¹⁰ Sub-Saharan Africa remains the hardest-hit region with 24.7 million people living with the disease.¹¹¹ There are a number of inter-woven factors that contribute to the high HIV/AIDS crisis in sub-Sahara Africa. At the 2006 Abuja Special Summit, the Heads of State of Member States of the AU identified the challenges that hamper efforts to combat HIV/AIDS.¹¹² The main challenges include: the chronic shortage of health care workers; the feminization of HIV/AIDS in Africa due to gender inequality, low socio-economic status of women and gender-based violence; poor access to medicines and commodities;¹¹³ the susceptibility of vulnerable groups such as women and children to the spread of HIV/AIDS; extreme poverty and low levels of education; and an increasing number of orphans and children affected by HIV/AIDS who are often deprived of their rights to education and are vulnerable to exploitation and abuse. Reluctance of people to be tested¹¹⁴ and stigmatisation of PLWHA are other additional factors that contribute to high HIV/AIDS prevalence in Sub-Sahara Africa.¹¹⁵

Despite these grim challenges, the trend of the pandemic in most sub-Sahara African states appears to be stable.¹¹⁶ Declines in national HIV prevalence have also been observed in some sub-Saharan African countries.¹¹⁷ This progress is an outcome of considerable efforts by national governments supported by partners including civil society. Behind the efforts made at the national level, the AU (and its predecessor, the OAU) has played a crucial role in moulding the strategies for the prevention of the epidemic at the regional level.¹¹⁸ To that effect, it has adopted a number of resolutions and declarations.

¹¹⁰UNAIDS/WHO AIDS *epidemic update* (2006) http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf (accessed 27 August 2007).

¹¹¹ As above. As the Epidemic Update shows, Sub-Saharan Africa has just over 10% of the world's population, but is home to almost two thirds (63%) of all persons infected with HIV. Across this region, the prevalence of the epidemic is not uniform. Women bear a disproportionate part of the AIDS burden.

¹¹² Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria, Abuja, Nigeria, (2006) SP/Assembly/ATM/3(1) Rev 2.

¹¹³ Provision of antiretroviral therapy has expanded dramatically in sub-Saharan Africa: more than one million people were receiving antiretroviral treatment by June 2006, a tenfold increase since December 2003. However, the sheer scale of need in this region means that a little less than one quarter (23%) of the estimated 4.6 million people in need of antiretroviral therapy in this region are receiving it. See UNAIDS/WHO (n 110 above).

¹¹⁴WHO/UNAIDS (n 26 above).

¹¹⁵ B Prince *et al Exploring Challenges of HIV/AIDS: Seminar proceedings from the SAHARA sessions at the international AIDS conference* (2006)<http://www.hsrbpress.ac.za/product.php?cat=19&freedownload=1&productid=2204> (accessed 10 July 2007).

¹¹⁶UNAIDS/WHO (n 110 above).

¹¹⁷ As above.

¹¹⁸ At sub-regional level, sub-regional economic communities have a vital role in this regard. The strongest of these communities is the Southern African Development Community (SADC) that laid down various normative frameworks specifically addressing HIV/AIDS. See F Viljoen 'The obligation of governments in a time of HIV/AIDS' (2005) 15 *Interights Bulletin* 50.

Some of these resolutions and declarations are: the Tunis Declaration on AIDS and the Child in Africa of June 1994;¹¹⁹ Resolution on Regular Reporting of the Implementation status of OAU Declarations on HIV/AIDS in Africa;¹²⁰ Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases,¹²¹ and the Abuja Framework for Action;¹²² the 2006 Brazzaville Commitment on scaling up towards universal access to HIV/AIDS prevention, treatment care and support in Africa;¹²³ and the 2006 Abuja Special Summit on Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010.¹²⁴ As it shall be briefly discussed in the next sub-section, these resolutions and declarations, *inter alia*, reiterate the appropriateness of a rights-based approach to prevent the spread of HIV/AIDS.

Against this background, this chapter seeks to discuss the place of a rights-based approach in an endeavour to fight HIV/AIDS in Africa. More importantly, it intends to examine the relevant African human rights standards against which the compatibility of HIV testing policies and legislation of Botswana, Ethiopia and Uganda can be evaluated.

3.2 The place of a rights-based approach in an effort to combat HIV/AIDS in Africa

Consistent with policies of WHO, UNAIDS and other pertinent UN organs, the African regional response to HIV/AIDS also focuses on the right-based approach. This can be discerned from resolutions and declarations that have been adopted under the auspices of the AU which make explicit reference to human rights protection and promotion as one of the strategies designed to combat HIV/AIDS.

In the Tunis declaration, States Parties, as part of their commitment, proclaimed to elaborate a 'national policy framework' to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, and medical and *human rights issues*.¹²⁵ (Emphasis added) The protection of human rights was also recognised as one of the priority areas in the 2001 Abuja Framework,¹²⁶ which identified the following strategies: enacting relevant legislation to protect the rights of people infected and affected by HIV/AIDS; strengthening existing legislation to (a) address human rights violations and gender inequities, and (b) respect and protect the rights of infected

¹¹⁹ Tunis Declaration on AIDS and the Child in Africa *AHG/Decl. 1 (XXX) 1994*.

¹²⁰ Resolution on the Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa *AHG/Res 247 (XXXII) 1996*.

¹²¹ Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases *OAS/SPS/ABUJA/3 (2001)*.

¹²² Framework Plan of Action for the Implementation of the Abuja Declaration on the Control of AIDS, Tuberculosis and Other Related Infectious Diseases in Africa *AHG/228 (XXXVII) Annex III (2001)*.

¹²³ Brazzaville Commitment on scaling up towards universal access to HIV/AIDS prevention, treatment care and support in Africa by 2010, Brazzaville, Republic of Congo 2006.

¹²⁴ n 112 above.

¹²⁵ n 119 above, para II (1).

¹²⁶ n 122 above.

and affected people; and harmonise approaches to human rights between nations for the whole continent.

The African Commission on Human and Peoples' Rights (the African Commission), on its part, declared that 'HIV/AIDS pandemic is a human rights issue which is a threat against humanity'.¹²⁷ Consequently, it called upon State Parties, among others, to ensure human rights protection of those living with HIV/AIDS against discrimination and devise public health programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions.

Furthermore, the Brazzaville Commitment proposes the strengthening of the relevant laws, jurisdictions and policies of AU States Parties, in line with the AU framework on human rights and HIV/AIDS, to address HIV/AIDS.¹²⁸ At the 2006 Abuja Special Summit, too, the Head of States reaffirmed their commitment to respect human rights and consider access to essential medicines and other basic commodities as a human right.¹²⁹

3.3 Applicable African human rights norms to HIV testing

Those resolutions and declarations that have been highlighted in the foregoing section, although indicative of the commitments of African leaders to fight HIV/AIDS in a human rights-friendly way, are not binding by themselves. Thus, in order to comprehend the extent of the legally binding obligations of states to respect, protect, fulfil and promote human rights in the context of HIV testing, it is imperative to discuss the human rights treaties adopted and ratified at the regional level.

On the African continent, the ACHPR,¹³⁰ adopted in 1981, is the principal instrument for the promotion and protection of human and peoples' rights. It does not, however, make specific reference to HIV/AIDS.¹³¹ Surprisingly, the ACRWC,¹³² adopted nearly ten years later, in 1990, still does not also make any reference to HIV/AIDS.¹³³ It is the Protocol to the African Charter on

¹²⁷ See Resolution on HIV/AIDS pandemic –Threat against human rights and humanity, Tripoli, 7 May 2001.

¹²⁸ n 123 above, para 5 (g).

¹²⁹ n 112 above.

¹³⁰ African Charter on Human and Peoples' Rights adopted in June 1981 and came into force in October 1986. All AU members, including the three countries in this case study, are State Parties thereto.

¹³¹ The Commission's amended guidelines on reporting, however, require states to report on issues concerning HIV and AIDS and Commissioners consistently highlight this aspect as part of their questions to state delegates. See F Viljoen (n 118 above) 49.

¹³² African Charter on the Rights and Welfare of the Child adopted in July 1990 and came into force in November 1999.

¹³³ It is only within the Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child (2003) that mention is made of HIV/AIDS. See para 21 (g) of the Guidelines which provides 'States Parties are requested to provide relevant information ...in respect of children who need special protection on account of being in risky or vulnerable conditions and situations such as street children or HIV/AIDS orphans'.

Human and Peoples' Rights on the Rights of Women in Africa (the Women's Protocol)¹³⁴ that mentions, albeit in superficial way, HIV/AIDS.¹³⁵ Given the fact that women in Africa are disproportionately affected by the epidemic, the Women's Protocol should have included detailed provisions to sufficiently address the problem.

The fact that these regional human rights instruments do not make reference to HIV/AIDS does not mean that their provisions are not applicable in the context of HIV testing. In fact, their substantive provisions are flexible and relevant enough to address human rights in the context of HIV testing. The following sub-sections discuss these relevant human rights.¹³⁶

3.3.1 The principles of (right to) non-discrimination and equality

'The principles of non-discrimination and equality are very closely linked, so much so in fact the latter may be said to be a positive expression of the former.'¹³⁷ Article 2 of the ACHPR prohibits discrimination in respect of enjoyment of rights and freedoms guaranteed in the Charter. Thus, article 2 can only be invoked in relation to the implementation of a right protected in the Charter. The scope of application of article 3 (the right to equality), however, extends beyond the rights guaranteed by the Charter.¹³⁸ Accordingly, it requires all State Parties to the Charter to ensure that the application of all national laws is not discriminatory.¹³⁹

Article 3 of ACRWC, broadening the grounds of discrimination, also entrenches the principle of non-discrimination with respect to the enjoyment of rights and freedoms of the child guaranteed in the Charter. Unlike the ICCPR and ACHPR, the ACRWC does not, however, incorporate the right to equality before the law and equal protection of the law which could have protected the child against discrimination in respect of rights that are not specifically covered in the ACRWC. Nevertheless, this is not a major problem since children are also beneficiaries of article 3 of the ACHPR.

The grounds of discrimination enumerated either in the ACHPR or ACRWC do not expressly outlaw discrimination in the context of HIV testing or on the grounds of HIV status. But it can safely be argued that the term 'other status' in both documents can be construed to include prohibition of discrimination on this ground. This argument is supported by article 60 of the ACHPR which allows the African Commission or any other organ that will be involved in the implementation of the

¹³⁴ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in July 2003 and entered into force in November 2005.

¹³⁵ n 134 above, art 14.

¹³⁶ The writer does not believe that the rights that are discussed in this section are the only rights relevant to HIV testing. In view of the principle of indivisibility and interdependence of rights, other rights may in way or another be related to testing. The discussion, however, is confined to those rights that have a direct and practical relevance to testing.

¹³⁷ F Ouguergouz *The African Charter on Human Peoples' Rights: A comprehensive Agenda For Human Dignity and Sustainable Democracy in Africa* (2003) 77.

¹³⁸ Ouguergouz (n 137 above) 80.

¹³⁹ As above.

Charter to look beyond the Charter in interpreting the norms laid down by the Charter. To this effect, the norms developed by various treaty monitoring bodies and special organs of the UN are relevant.¹⁴⁰ As has been discussed in chapter two, sub-section 2.4.3, the UN Commission on Human Rights declared that the term 'other status' used in several human rights instruments 'should be interpreted to include health status, including HIV/AIDS' and that discrimination on the basis of actual or presumed HIV/AIDS status is prohibited.¹⁴¹ In the same manner, the Committee on the Rights of the Child pointed out that the grounds of discrimination under article 2 of CRC include discrimination on the basis of HIV/AIDS.¹⁴² On the basis of this interpretation, the term 'other status' as used under article 2 of the ACHPR and article 3 of the ACRWC prohibits discrimination on the basis of one's HIV status.

3.3.2 The right to work; freedom of movement; the right to marry; and the right to found a family and protection of the family

These four rights should be seen in connection with the principle of non-discrimination discussed above. This is because their actual and potential violation springs from prohibiting of the enjoyment of the rights purely on the basis of HIV status or by putting HIV testing as prerequisite to the enjoyment of these rights to certain groups of persons. Below is a separate discussion of how these rights are subject to invasion in the context of HIV testing.

The ACHPR recognises the right to work stipulating that 'every individual shall have the right to work under equitable and satisfactory conditions'.¹⁴³ Thus, the prohibition against discrimination in respect of employment and occupation on the basis of HIV status could be deduced from the cumulative reading of article 15 and 2 of the ACHPR. Even if there are no cases that have been decided by the African Commission in this respect, there are groundbreaking domestic court decisions.¹⁴⁴ Two of these cases are briefly discussed below.

¹⁴⁰ The phrase 'provisions of various instruments adopted within the Specialized Agencies of the United Nations of which the parties to the present Charter are members', in article 60 of the ACHPR, can be interpreted to mean general comments of treaty monitoring organs and resolutions of specialised organs of the UN, such as the UN Commission on Human Rights (now the Human Rights Council). The same result could be reached by interpreting article 46 of the ACRWC. Currently, CRC is ratified by all African states except Somalia. ICCPR and ICESCR are also ratified by most African states including the countries in this case study with the exception of Botswana which is not a party to ICESCR. See <http://www.ohchr.org/english/countries/ratification/index.htm> (accessed 1 September 2007).

¹⁴¹ n 99 above.

¹⁴² n 100 above.

¹⁴³ n 130 above, art 15.

¹⁴⁴ *Hoffmann v. South African Airways*, Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC); *N v Ministry of Defence* (2000) ILJ 1999 (Labour Court of Namibia, Case No.: LC 24/98); *MX v. ZY*, AIR 1997 Bom 406 (High Court of Judicature, 1997); and *JRB et al. v. Ministry of Defence*, Case No. 14000, Supreme Court of Justice of Venezuela (Political-Administrative Bench)(1998).

In Hoffman v South Africa,¹⁴⁵ the appellant applied for employment as a cabin attendant with South African Airways. Although he qualified for the said job as per the other criteria of selection, the pre-employment blood test showed that he was HIV positive. As a result, he was informed that he could not be employed for the job he was seeking. The appellant challenged the constitutionality of the decision of South African Airways not to employ him. The Constitutional Court, on the basis of the right to equality and non-discrimination of article 9 of the South African Constitution, decided that 'there can be no doubt that SAA [South African Airways] discriminated against the appellant because of his HIV status'.¹⁴⁶

In another case decided in the Labour court of Namibia,¹⁴⁷ the applicant N was a former member of the national liberation struggle in the South-West Africa People's Organization who had received military training while in exile. In September 1996, he sought to enlist. As part of that process, he was tested for HIV. Two weeks later, he was informed by a Namibian Defence Force medical officer that he had tested positive and, as a result, would not be accepted by the Force. The applicant argued that the Namibian Defence Force had breached the 1992 *Labour Act* (section 107) which prohibited discrimination in employment 'in an unfair manner'. Being convinced by the argument of the applicant, the Court held that 'the applicant's exclusion from the Namibian Defence Force solely because of his HIV status amounted to 'discrimination in an unfair manner', contrary to the *Labour Act*'.

These decisions have shown unequivocally that exclusion of job seekers from employment solely on the basis of their HIV status amounts to unfair discrimination.

The various aspects of freedom of movement are provided in article 12 of the ACHPR. Freedom of movement within and freedom to return to an individual's country of origin or residence guaranteed under article 12 applies to 'every person' which includes aliens and stateless persons. This freedom, as it applies to aliens, may, however, be exercised provided that an individual abides 'by the law'.¹⁴⁸ The Commission is yet to establish the contents of these rights, and to interpret the circumstances under which the rights could be limited. On the basis of WHO and UNAIDS Guidelines, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns.¹⁴⁹

¹⁴⁵ n 144 above. The African Commission has the possibility of interpreting the reference to 'African practices' and 'legal precedents' in article 61 as allowing it to rely on the decisions of domestic African courts.

¹⁴⁶ n 144, para 29.

¹⁴⁷ n 144 above.

¹⁴⁸ V Nmehielle *The African Human Rights System: Its Laws, Practice, and Institutions* (2001) 114.

¹⁴⁹ UNAIDS/OHCHR (n 43 above) para 127. For the applications of restrictions to rights, see a detailed discussion under the sub-section 'limitations of rights in this chapter.'

The right to seek and obtain asylum in other countries, as laid down in 12 (3) of the ACHPR, may be enjoyed in accordance with laws of those countries and international conventions. No international instrument prescribes HIV testing as a precondition to seek and obtain asylum. With respect to the limitations that may be provided by national laws, it would be appropriate to have a look at of the jurisprudence of the African Commission. In the only case that the Commission had the opportunity to decide on this matter,¹⁵⁰ it held that article 12(3) 'should be read as including a *general protection of all those who are subject to persecution*, that may seek refuge in another state'.¹⁵¹ (Emphasis added) Hence, it is submitted that refusal to grant asylum solely on one's HIV status or putting HIV testing as a condition to grant asylum is discriminatory and a flagrant violation of article 12.

Article 18 (1) of the ACHPR stipulates that the family shall be protected by the state which shall take care of its physical health and morals. It does not, however, tell us what the duty to take care of the physical and morals of the family consists of. It may be claimed, however, that the general obligation to protect the family within the meaning of this article is a general obligation which may in turn gives rise to different specific obligations. Of these obligations, one can cite the obligation of the state to regulate the institution of marriage, which is the basis of the family. In doing so, states must recognise the right of men and women of marriageable age to marry and to found a family without any unjustifiable limitation.¹⁵² From this, it is clear that "the right of people living with HIV is infringed by mandatory pre-marital testing and/or the requirement of 'AIDS-free certificates' as a precondition for the grant of marriage licences under State laws".¹⁵³ Thus, the obligation of State Parties to extend protection to the family under article 18 (1) of the ACHPR includes the duty to make sure that the right to marry and found a family is not restricted by pre-marital HIV mandatory testing.

3.3.3 The right to physical integrity, respect for dignity and privacy

The right of every individual to respect for his/her physical integrity is recognised under article 4 of the ACHPR and article 4 (1) of the Women's Protocol. The recognition of this right is of crucial importance from the perspective of HIV testing. This is because it is generally interpreted as a right to the protection of the body from any violation not freely consented to, such as the removal of an organ from a living person.¹⁵⁴ From the view point of this interpretation, the relevant prohibitions ensuring protection of the right to physical integrity can be construed as prohibiting HIV testing without the informed consent of the individual.

¹⁵⁰ *Organisation Mondiale Contre la Torture and others v Rwanda* (2000) AHRLR (ACHPR 1996).

¹⁵¹ n 150 above, para 30.

¹⁵² Unlike art 18 of the ACHPR, this right is expressly recognised in article 23 (2) of the ICCPR.

¹⁵³ Consolidated Guidelines (n 43 above) para 118.

¹⁵⁴ Ouguergouz (n 137 above) 102.

The right to respect for one's dignity inherent to a human being is protected both in article 5 of the ACHPR and article 3 of the Women's Protocol. At this juncture, it must be borne in mind that 'there is some sort of convergence between the objects of the right to physical integrity and dignity'.¹⁵⁵ In both instruments, the individual's (women's right in the case of the Women's Protocol) right to respect of the physical integrity of his/her person, although explicitly recognised, can in fact also be inferred from dignity.¹⁵⁶ 'Human dignity is the source of the person's innate rights to freedom and to physical integrity'.¹⁵⁷ Thus, the right to respect for the dignity of the person, one aspect of which is the right to physical integrity, also protects a person against non-consensual HIV testing.

The right to privacy is another right relevant to HIV testing. While the ACRWC explicitly recognises the right to privacy under article 10, the ACHPR and the Women's Protocol do not. The precise content of the right to privacy within the ACRWC has not, however, yet been dealt with. Utilising article 46 of the ACRWC as steppingstone, it is, nonetheless, possible to give content to it. Both UNAIDS/WHO Consolidated Guidelines on HIV/AIDS and Human Rights¹⁵⁸ and the General Comment of the Committee on the Rights of the Child¹⁵⁹ confirmed that the right to privacy encompasses the obligation to seek informed consent to HIV testing and ensure confidentiality of HIV test results.

Although the right to privacy is not explicitly guaranteed in the latter two regional documents, it may be implied from other rights expressly recognised therein. In this respect, it is appropriate to see the decision of the African Commission in *Social and Economic Rights Action Centre and Another v Nigeria*.¹⁶⁰ In this case, the African Commission held that the rights to housing and the right to food (although not expressly guaranteed in the Charter) are implicit in the Charter.¹⁶¹ It went on and held that the combined effect of three corollary rights, namely, the right to property, to health and to protection of the family is to constitute the right to housing.¹⁶² In the same way, it is submitted that even if the right to privacy is not explicitly recognised in the ACHPR and the Women's Protocol, it can be implied from other rights recognised therein. Both the ACHPR and the Women's Protocol recognise the right to physical integrity and the right to respect for one's dignity. As has been shown above, these rights protect the individual from coercive HIV testing. The analysis of the right to privacy in chapter two also shows that the right to privacy requires HIV testing to be carried out only with the informed consent of the individual concerned. It is argued, therefore, that as long as the right to body integrity and respect for one's dignity are incorporated, the right to privacy is implicitly protected in these rights.

¹⁵⁵ Ouguergouz (n 137 above) 90.

¹⁵⁶ As above.

¹⁵⁷ I Currie *et al The Bill of Rights Handbook* (2005)273.

¹⁵⁸ Consolidated Guidelines (n 43 above) para 119.

¹⁵⁹ n 86 above, para 24.

¹⁶⁰ *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

¹⁶¹ n 160 above, para 63.

¹⁶² n 160 above, para 60.

3.3.4 The right to enjoy the best attainable state of health and information

Article 16 of the ACHPR is less elaborative than article 12 of the ICESCR in terms of acknowledging the right to best attainable state of health. Although it, in general terms, requires States Parties to take the necessary measures to protect the health of the people, it does not spell out the specific measures that states are expected to take. Unlike the ACHPR, the ACRWC has articulated the right to health in a more clear way, putting the specific obligations of States Parties in detail.¹⁶³ The Women's Protocol is relatively the best regional instrument in addressing the right to health in the context of HIV/AIDS. It, *inter alia*, expressly requires State Parties to protect and promote the right of women to self protection and to be protected against sexually transmitted infections, including HIV/AIDS.¹⁶⁴

While the right to highest attainable standard of health is recognised in all the three regional treaties, there is yet no clear jurisprudence from their monitoring organs that specifically links them to HIV testing. In such a scenario, it is appropriate to resort to ICESCR, CRC and CEDAW and general comments of their monitoring organs. As has been discussed in sub-section 2.4.1 of chapter two, the Committee on Economic, Social and Cultural Rights interprets the right to health, as contained in article 12 of the ICESCR, so as to include the entitlement of HIV/AIDS-related health services, that are 'scientifically and medically appropriate and of good quality,' as well as respectful of culture and medical ethics.¹⁶⁵ It is submitted that this includes good quality HIV testing that adheres to the 3C principles. It is also argued that accessibility, as an essential element of the right to health, includes the right to seek and receive HIV-related prevention information.¹⁶⁶ The Committee, however, noted that accessibility of information should not impair the confidentiality of health data.¹⁶⁷

The Committee on CEDAW, on its part, noted that the obligation of State Parties under article 12 of the CEDAW (the right to health) includes the duty to ensure access to acceptable services that are rendered in a way that ensures informed consent, respects dignity, guarantees confidentiality.¹⁶⁸ The Committee on the CRC, likewise, stated that the right to health (article 24 of the CRC) imposes a duty on States Parties to ensure access to voluntary, confidential HIV counselling and testing for all children.¹⁶⁹

On the basis of the above interpretations, the right to health, as recognised in the ACHPR, ACRWC and the Women's Protocol, requires consensual HIV testing and confidentiality of test

¹⁶³ n 132 above, art 14.

¹⁶⁴ n 134 above, art 14 (1) (d).

¹⁶⁵ n 78 above, paras 12(c) and 12(d).

¹⁶⁶ Consolidated Guidelines (n 43 above) para 138. See also Canadian HIV/AIDS Legal Network (n 81 above).

¹⁶⁷ n 78 above, para 12(b).

¹⁶⁸ n 83 above.

¹⁶⁹ n 86 above, para 22.

results. Along with freedom of information,¹⁷⁰ it also requires testing to be accompanied by pre- and post-counselling.

In relation to confidentiality of HIV testing results, it is appropriate to read article 16 of the ACHPR and article 14 of the ACRWC together with article 14(1) (e) of the Women's Protocol. The latter inculcates 'the right to be informed...on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices'. This provision, in effect, infuses a limitation against the confidentiality of test result of the sero-positive partner by entitling the other partner to know his HIV status.¹⁷¹ The justification for such limitation is pretty clear; it is to protect the other partner from HIV infection. The right to be informed of the HIV status of one's partner, as stated in article 14 (1) (e) of the Women's Protocol, should, nevertheless, be done in harmony with internationally recognised standards and best practices. In this respect, the WHO Fact Sheet 1 is pertinent.¹⁷² This Fact Sheet incorporates the concept of shared confidentiality, which means confidentiality that is to be shared with others.¹⁷³ Pursuant to the Fact Sheet, sharing confidentiality is in the discretion of a person who has undergone HIV testing.¹⁷⁴ The idea of partner notification is also provided in the 2006 Consolidated Guidelines. In support of partner notification, the Guidelines give health care professionals the discretion to inform their patients' sexual partners of the HIV status of their patient but this discretion is subject to strict criteria.¹⁷⁵ Unlike the Fact Sheet, the Guidelines authorise the health care providers to notify the HIV status of one partner to the other whether the former likes or not once the conditions are met. As will be discussed in sub-section 4.4.1 of chapter four, this is a limitation against confidentiality of test result (thereby the right to privacy) of one of the partner to protect the right (such as the right to life and health) of the other.

3.4 Limitations of rights

With few exceptions,¹⁷⁶ the exercise of most of the rights of the ACHPR and ACRWC is subject to specific article-based limitations. Moreover, all rights of the individual recognised in the ACHPR are subject to the general limitation clause under article 27 (2). Although it is not as explicit as the

¹⁷⁰ Freedom of information is recognised in article 9 (1) of the ACHPR and article 7 of the ACRWC.

¹⁷¹ Such limitation is included in the Women's Protocol taking into consideration the existing reality that women are more vulnerable to HIV/AIDS than men. It is argued, however, that the limitation should be applicable to men as well in view of the principle of equality and non-discrimination provisions of the ACHPR and article 60 of the same.

¹⁷² See http://www.who.int/health-services-delivery/hiv_aids/English/fact-sheet-1/ (accessed on 15 September 2007).

¹⁷³ As above.

¹⁷⁴ As above.

¹⁷⁵ Consolidated Guidelines (n 43 above) para 20 (g). The criteria include the following. (i) The HIV-positive person in question has been thoroughly counselled; (ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes; (iii) The HIV-positive person has refused to notify, or consent to the notification of, his/her partner(s); (iv) A real risk of HIV transmission to the partner(s) exists; (v) The HIV-positive person is given reasonable advance notice; (vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and (vii) Follow-up is provided to ensure support to those involved, as necessary.

¹⁷⁶ In addition to the economic, social and cultural rights, these exceptions include art 5 and 7 of the ACHPR.

ACHPR, article 31 of the ACRWC imposes a similar general limitation. The inclusion of duties on the child in article 31 of the ACRWC is not to enforce them against the child (as no complaint mechanism allows complaints against individuals) rather to show that the right of the child may be restricted in discharging his or her duties.

The general limitation clauses and article-based limitations that specify the grounds of limitations have a relatively less restrictive effect in that once the content of the restricting clause is ascertained, states cannot go beyond that and encroach the right. The real danger comes from claw-back clauses¹⁷⁷ that do not clearly specify the grounds of restrictions. A typical example of such limitation can be seen in article 12 (1) of the ACHPR which states that 'every individual shall have the right to freedom of movement and residence within the borders of a State provided *he abides by the law*'. (Emphasis mine) From this, it is clear that freedom of movement can be limited by the law. In absence of any reference to certain interests which the law is supposed to protect, such kinds of limitations may open the door to unwarranted limitations. States are the lawmakers and the most frequent violators of human rights. In view of this fact, attaching these limitations amounts to putting human rights under the mercy of the very institution which attacks them.¹⁷⁸ What worsens the situation is that such clauses even go further than derogation clauses in the sense that 'they permit a state, in its almost unbounded discretion, to restrict its treaty obligations and endanger the rights' therein.¹⁷⁹

Cognizant of the adverse effect of such open-ended limitation clauses, the African Commission has developed a strict interpretation of these clauses. In doing so, the Commission invoked article 27 of the ACHPR in support of its argument. In its view 'the only legitimate reasons for limitations to the rights and freedoms of the Charter are found in article 27(2)',¹⁸⁰ which stipulates that the right of the Charter 'shall be exercised with due regard to the right of others, collective security, morality and common interest'.¹⁸¹ It went on and held that 'the reasons for possible limitations must be founded in a legitimate state interest and the evils of limitations must be strictly proportionate with and absolutely necessary for the advantages which are to be obtained'.¹⁸² In another communication, the Commission remarked that article 27 (2) is the only legitimate reason for limitations to the rights and freedoms of the Charter,¹⁸³ which in effect amounts to including other article-specific limitation clauses with the ambit of article 27(2).

¹⁷⁷ In the context of ACHPR, the phrase 'claw-back clauses' has been used to generally refer to those provisions of the Charter that tend to limit some of the rights guaranteed under the Charter. See Nmehielle (n 148 above) 165.

¹⁷⁸ As above.

¹⁷⁹ As above.

¹⁸⁰ *Media Rights Agenda and others v Nigeria* (2000) AHRLR (2000) (ACHPR 1998) para 68.

¹⁸¹ As above.

¹⁸² n 180 above, para 69.

¹⁸³ *Prince v South Africa* (2004) AHRLR 105(2000) (ACHPR 2004) para 43.

3.5 Conclusion

Fully understanding the devastating effects of HIV/AIDS in Africa, considerable efforts have been exerted at regional level, under the auspices of the AU (and its predecessor OAU), to restrain the spread of HIV/AIDS. As it can be gathered from the resolutions and declarations that have been adopted at this level, protection and promotion of human rights has been one of the strategies to prevent the transmission of the disease. Although the existing regional human rights instruments, with the exception of the Women's Protocol, do not make explicit reference to HIV/AIDS in general and HIV testing in particular, their provisions are flexible enough to address issues of human rights in the context of HIV testing.

As envisaged in the ACHPR, ACRWC and the Women's Protocol, the core rights that may be applicable in the context of HIV testing include: the right to highest attainable standard of health, the right to freedom of information, the right to privacy, the right to physical integrity, the right to respect for one's dignity, the right to work, freedom of movement, the right to marry, the right to found a family and protection of the family, the right to equality and freedom from discrimination. These rights, however, are not absolute rights and thus may be subject to limitation to protect and promote the rights of others, collective security, morality and common interest.

CHAPTER FOUR: HIV TESTING LEGISLATION AND POLICIES OF BOTSWANA, ETHIOPIA AND UGANDA: A HUMAN RIGHTS ANALYSIS IN THE LIGHT OF AFRICAN HUMAN RIGHTS INSTRUMENTS

4.1 Introduction

The discussion in chapter two has identified principles underlying HIV testing as envisaged in international guidelines that govern HIV testing. It also explored the international human rights basis of these principles. Chapter three contextualised the basis of these principles in the African human rights system.

Although the obligation of states to promote and protect human rights in the context of HIV testing may be derived from the international and regional human rights regimes, international law commitments must ultimately be concretised at the national level, in the domestic legal system.¹⁸⁴ It is domestic legislation and policies that give real life to obligations that emanate from international and regional human rights instruments in their application at domestic level. With this in mind, this chapter discusses the relevant legislation and policies of Botswana, Ethiopia and Uganda regulating HIV testing and examines whether these legislation and policies are compatible with their regional human rights commitments. As a background to this discussion, however, a prior general discussion on types and definitions of HIV testing is made.

4.2 Types of HIV testing

The most general manner in which it can currently be determined whether a person is infected with HIV is through blood tests for the presence of antibodies to HIV.¹⁸⁵ As it can be gathered from the practice in various countries, there are four types of blood testing. These are: client-initiated HIV testing and counselling (VCT); routine testing (PITC); mandatory HIV testing (screening); and compulsory HIV testing. Each of them is discussed below.

4.2.1 VCT

In the early years of the HIV/AIDS epidemic, aggressive calls for punitive, forcible testing sparked widespread concern about the effects of such strategies on individual rights and the spread of the epidemic.¹⁸⁶ Eventually, members of affected communities, human rights activists and public health professionals recognized that HIV testing must be voluntary and that informed choice was central

¹⁸⁴ F Viljoen (n 118 above) 50.

¹⁸⁵ South African Law Commission (n 33 above) para 3 (26).

¹⁸⁶ Kirby (n 30 above).

to creating a climate of confidence and trust between the person being tested and service providers.¹⁸⁷ This gave rise to the emergence of VCT.

As it has been briefly discussed in chapter one, VCT involves individuals actively seeking HIV testing and counselling services that involve the following three elements (often referred to as the 3C principles): pre-and post-test counselling, informed consent, and confidentiality of test results. VCT has been the dominant and recommended model for HIV counselling and testing. One of the basic features of the traditional VCT approach is that it is the individual, not the health system that initiates action; she or he receives counselling and testing services only after having made an active decision to seek out a VCT service and be tested.¹⁸⁸ The other distinctive feature of the VCT model is that it requires extensive pre- and post-test counselling.

In recent years, because of the availability of ART, an international consensus has emerged that access to HIV testing must be scaled up urgently, and that in addition to the traditional model of VCT, new approaches to HIV testing and counselling must be implemented in more settings, and on a much larger scale than has so far been the case.¹⁸⁹ Consensus has also been reached that VCT is not reached by the people¹⁹⁰ although there has been disagreement as to the reason for the low uptake of VCT.¹⁹¹

4.2.2 PITC

The recent striking increase in new financial commitments to battle HIV/AIDS—by governments in acutely affected countries, donor governments, UN organizations, the new Global Fund to Fight

¹⁸⁷ Open Society Institute *Routinising HIV testing in low- and middle-class countries: Background paper* (2007) http://www.soros.org/initiatives/health/articles_publications/publications/routinizing_20061213/routinizing_20070601.pdf (accessed 24 September 2007).

¹⁸⁸ WHO/UNAIDS (n 26 above).

¹⁸⁹ Open Society Institute (n 187 above). See also Aids Law Project *Different models of HIV testing: What are the considerations in South Africa?* (2006) <http://alp.org.za/dedi20a.your-server.co.za/images/upload/HIVTestingPaperFinal.pdf> (accessed 24 September 2007).

¹⁹⁰ Despite decades of AIDS education campaigns, the vast majority (<90%) of HIV-positive people in low -income countries do not know they are infected. See S Rennie *et al* 'Desperately seeking targets: the ethics of routine HIV testing in low-income countries' (2006) 84 *Bulletin of the World Health Organization* January 52. See also Russo (n 28 above).

¹⁹¹ Proponents of scaling up HIV testing attribute the problem to the stringent requirements of VCT itself. The main arguments raised against VCT are summarised as follows: VCT, especially with counselling and informed consent, is too slow and costly to be a useful tool for a public health emergency on the scale of HIV/AIDS, especially in high-prevalence countries; pre-test counselling has dissuaded physicians from offering the test because of the amount of time it takes and because it forces them to raise issues they may not feel comfortable discussing with their patients; pre-test counselling has dissuaded clients from taking an HIV test or created a barrier or impediment to testing when it provides an overload of information; HIV/AIDS awareness is already very high in most high-prevalence countries, and therefore there is less need for counselling; the exceptional human rights protections related to HIV testing compared to those of other infectious diseases only add to stigma; normalizing HIV testing and less insistence on confidentiality or anonymity of testing will reduce stigma; and VCT actually may undermine social justice in that it restricts people's access to testing, which is essential to treatment and care. Others argue that the problem has nothing to do with the requirements of VCT, but is due, rather, the pervasive stigma and discrimination that still attaches to the epidemic. For detailed discussion of these controversies, see Open Society Institute (n 187 above); Canadian HIV/AIDS Legal Framework (n 2 above); Aids Law Project (n 189 above); and S Iwuagwa 'Challenges of stigma and discrimination to voluntary counselling and testing (VCT): Communication implication experiences from Nigeria' in E Biakolo *et al* (eds) *The Discourse of HIV/AIDS in Africa* (2003) 268.

AIDS, TB, and Malaria, and others—provides an unparalleled opportunity to bring HIV care, treatment, and prevention to many people in developing countries.¹⁹² Without knowing who is infected, however, programs are unable to provide individuals or families with appropriate care, treatment, counselling, and support. As a result, rapid expansion of effective HIV testing and counselling capacity is now becoming a pressing issue in many programs and countries.¹⁹³ In response, UNAIDS/WHO have recommended a PITC approach. In fact, even before UNAIDS/WHO recommendation, PITC has been implemented by some countries and currently the number of countries implementing PITC is increasing.¹⁹⁴

According to PITC approach, as recommended by UNAIDS/WHO¹⁹⁵, HIV testing is recommended by health care providers to persons attending health care facilities as a standard component of medical care. People are tested unless they clearly opt out and refuse to be tested. It is emphasized that, like VCT, PITC is voluntary and the 3 C principles – informed consent, counseling and confidentiality – must be observed. Unlike VCT, however, in the case of PITC, clients or patients receive only essential pre-test information about HIV, and there is greater emphasis on post-test, rather than pre-test counselling.¹⁹⁶

This swiftly unfolding and historic development towards expanded testing has raised concerns. First, it is contended that in view of the discrimination and stigma against PLWHA, a shift towards more coercive measures can hinder, rather than assist, efforts to curb the spread of HIV.¹⁹⁷ As a response to this concern, it is argued that if more people get tested and know their HIV status (as a result of PITC), it will decrease the levels of stigma in a society, particularly if it is accompanied by widespread access to HIV treatment.¹⁹⁸ The essence of this counter argument is that as long as more people are tested and treated, one of the sources of stigma and discrimination, i.e. the perception of HIV/AIDS as a contagion and deadly death, will decrease.

Second, concerns have mounted that PITC could in practice amount to mandatory testing, particularly in view of the skewed power relationship between health care worker and patient which

¹⁹² P Nieburg *Expanded HIV testing: Critical gateway to HIV treatment and prevention requires major resources, effective preventions* (2005) [http://usinfo.state.gov/gi/img/assets/5096/expandedhivtesting .pdf](http://usinfo.state.gov/gi/img/assets/5096/expandedhivtesting.pdf) (accessed 17 August 2007). See also AIDS Law Project (n 189 above).

¹⁹³ As above.

¹⁹⁴ African countries, such Botswana, Uganda, Ethiopia, Kenya, Zambia, Lesotho and Malawi, have implemented, or are moving toward implementing the PITC model. See WHO/UNAIDS (n 26 above). Outside Africa, VCT is implemented in several low-prevalence and high-income countries. In the United States of America, for example, the Centers for Disease Control, in September 2006, released new recommendations calling for routine testing. In Canada, several provinces and territories — Alberta, Manitoba, New Brunswick, Newfoundland and Labrador, the Northwest Territories, and Nunavut — have adopted 'opt-out' (HIV testing (PITC)) for pregnant women. See Canadian HIV/AIDS Legal Network (n 81 above).

¹⁹⁵ WHO/UNAIDS (n 26 above).

¹⁹⁶ In some countries, the pre-test counselling is totally excluded. For example, the United States of America Centers for Disease Control, in September 2006, released new recommendations calling for routine testing; the right to decline testing is supposed to remain, but CDC now recommends eliminating pre-test counselling. See Canadian HIV/AIDS Legal Network (n 81 above).

¹⁹⁷ Aids Law Project (n 189 above).

¹⁹⁸ Open Society Institute (n 187 above).

could cause the patient to be intimidated into testing.¹⁹⁹ As will be discussed in the next subsection, the countries in this case study have included, in their policies and strategies, detailed guidelines that the health care service providers need to strictly comply with in rendering PITC services. The guidelines also provide training programmes to build the capacity of health care providers. If these guidelines are effectively implemented, this concern will be alleviated.

Third, and arguably most importantly, a formidable challenge of expanded testing is the need to bolster the capacities of already beleaguered health care infrastructures in the most acutely affected countries in a way that will make PITC a realistic option.²⁰⁰ The mere adoption of an expanded HIV testing policy, without having the required testing and counselling facilities, adequate human power, and affordable and accessible treatment, is not sufficient. Therefore, there is a pressing need to build the capacity of the health infrastructure along with expanding testing policy. Developing countries, like Ethiopia and Uganda, may not have the capacity to do this in a speedy manner. As will be discussed in the next section, these countries, realising the resource limitations, nevertheless, have set priorities to certain categories of people (example, pregnant women, clients presenting with symptoms or signs of illness) in rendering PITC services.

4.2.3 Mandatory HIV Screening

Mandatory testing is defined as testing that would occur as a condition for acquiring a particular status, receive service or other benefit, such as donating blood, immigrating to certain countries, getting married, joining the military or as a precondition of other kinds of employment.²⁰¹ International agencies working on HIV and public health authorities continue to reject mandatory testing as unethical and a violation of human rights and ineffectual in public health terms.²⁰² Moreover, the International Guidelines on HIV/AIDS and Human Rights state that ‘public health does not justify mandatory HIV testing or registration, except in cases of blood/organ/tissue donations where the human product, rather than the person, is tested before use on another person’.²⁰³ As the Guidelines explain,²⁰⁴ mandatory HIV testing is, however, permitted or required in many countries to screen people, such as in areas of access to adoption and foster care

¹⁹⁹ Nieburg (n 192 above). See also Aids Law Project (n 6 above). Particularly, there is a fear that women’s subordinate status in many places can interfere with the exercise of their right to refuse testing. For example, as cited in Nieburg (n 192 above), a 2004 study in India found that at one site, virtually all women agreed to be tested, but few stayed to receive their results. This illustrates how girls and women may feel intimidated or obliged to comply with the health care providers’ request to be tested, but at the same time perceive too many risks in actually learning their status and in acting upon that knowledge.

²⁰⁰ Open Society Institute (n 187 above).

²⁰¹ Canadian HIV/AIDS Legal Framework (n 2 above).

²⁰² UNAIDS/WHO (n 26 above).

²⁰³ OHCHR/UNAIDS *HIV/AIDS* (n 36 above) para 98.

²⁰⁴ OHCHR/UNAIDS (n 36 above) paras 83 and 113.

services,²⁰⁵ education, employment,²⁰⁶ health care, travel, social security, housing, insurance,²⁰⁷ asylum, and military services.²⁰⁸

4.2.4 Compulsory HIV testing

'Compulsory testing,' also known as 'involuntary testing,' is defined as testing without a voluntary element — i.e., without informed consent, at the behest of someone or some institution other than the person tested and, in some cases, with neither the fact of having been tested nor the result communicated to the person tested.²⁰⁹

Early in the epidemic, some recommended that the entire population be forcibly tested for antibodies to HIV.²¹⁰ A popular misconception was that widespread or even universal HIV testing could identify 'all who carry the virus so that they could be isolated and the uninfected majority could be secure from any risk of transmission.'²¹¹ However, wide consensus emerged that it would be a mistake to enact laws requiring the entire population to submit to testing: concerns for protecting public health support this conclusion, just as concerns for protecting civil liberties do; each goal independently militates against compulsory testing.²¹²

Realising the problems inherent in the call for universal testing of the entire population, some have recommended that compulsory testing be limited to members of the so-called 'high-risk groups,' in particular gay men, injection drug users, and haemophiliacs.²¹³ However, such proposals were rejected on the basis that HIV is an indiscriminate virus that does not infect people along group

²⁰⁵ 'Access to adoption (including inter-country adoption) and foster care services frequently *depend* the receiving substitute parents having been furnished with adequate knowledge of a child's HIV status, and HIV testing of available infants is reportedly quite routine in these situations in practice.' (Emphasis added). See J Sloth-Nielsen 'Of newborns and nubile: Some critical challenges to children's rights in Africa in the era of HIV/AIDS' (2005) 13 *The International Journal of Children's Rights* 81.

²⁰⁶ In Uganda, for example, although not allowed as a state policy, some organisations subject prospective employees to a mandatory test before recruitment, and the infected ones are denied job opportunities. Those who get infected during employment are often discriminated against and their job contracts terminated on the basis of their sero-status. See paragraph 2(3) (7) of The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/01-2005/06 (2000).

²⁰⁷ For example, even if there is no any policy or legislation authorising it, insurance companies in Botswana require an HIV test for those wanting coverage. If the results of the test reveal that the applicant is HIV positive, the application for life insurance is either rejected or a higher premium is imposed. See Centre for the Study of AIDS and, Centre for Human Rights, University of Pretoria *HIV/AIDS and Human Rights in Botswana* (2004) <http://www.csa.za.org/filemanager/fileview/90/> (accessed 23 September 2007). In Ethiopia too, insurance applicants are tested for the HIV virus on certain conditions. Interview with Ato A Getachew, deputy head of Life section at the Ethiopian Insurance Corporation, on April 20, 2004, cited in S Tesfaye *The Legality of Mandatory and Compulsory HIV Testing under the Ethiopian Legal System* (2004) 64 .

²⁰⁸ For example, on 26 October 2006, the Indian armed forces announced that HIV testing would become mandatory for those entering the armed forces. See 2006 Human Rights Watch Report as cited in Open Society Institute (n 187 above).

²⁰⁹ Canadian HIV/AIDS Legal Framework (n 2 above).

²¹⁰ Doughty (n 34 above) 122.

²¹¹ UNAIDS/IPU (n 36 above).

²¹² Canadian HIV/AIDS Legal Network (n 65 above). Compulsory HIV testing of the entire population cannot be justified on basis of public health ground. Testing is not an end by itself unless it is accompanied by the required behavioural change. Even if it is possible to forcibly test the entire population, it is difficult to isolate the entire HIV positive people. If this is the case, the HIV people may contribute to the underground transmission of the disease given the fact that they are coerced to be tested and are not duly counselled.

²¹³ As above.

lines. In addition, it was recognized that a compulsory testing program aimed at the so-called 'high-risk groups' would face obvious problems in identifying members of the targeted groups. Furthermore, testing would be associated with stigma and members of high-risk groups would be encouraged to go underground.²¹⁴

As with mandatory testing, the UNAIDS and WHO have entirely rejected compulsory testing on the ground that it is unethical, violates human rights and ineffectual in public health terms.²¹⁵ It is, however, maintained in some countries mainly in two areas, namely in cases of occupational exposure and accused or convicted sexual offenders.

In case of occupational exposure,²¹⁶ the purpose of compulsory testing after exposure is to minimize the risk of HIV transmission through *post-exposure prophylaxis* (PEP). Emergency medical workers, fire-fighters and police officers may face exposure to bodily fluids of people with unknown HIV status in the course of their work. In these cases, it might be possible to minimize the risk of HIV transmission through PEP. PEP involves taking antiretroviral drugs for 28 days and is most effective if it is begun within 72 hours of exposure. In order to apply PEP, the 'source person'— the person to whose bodily fluids someone has been exposed — must be tested,²¹⁷ which in some jurisdictions is compulsory.²¹⁸

The purpose of compulsory testing of accused or convicted sexual offenders is, however, two-fold. Firstly, it helps to ascertain the sero-status of the victim and to apply PEP to minimize the risk of HIV transmission.²¹⁹ Secondly, it assists to gather evidence for the purpose of either prosecuting²²⁰ or sentencing²²¹ the sexual offender.

4.3 HIV testing legislative and policy framework of Botswana, Ethiopia and Uganda

The previous section highlighted the definition and specific features of different models of HIV testing. Against this background, the present section summarises the nature of these models of testing as included in domestic legislation and policies of Botswana, Ethiopia and Uganda.

²¹⁴ As above.

²¹⁵ UNAIDS/WHO (n 5 above).

²¹⁶ Canadian HIV/AIDS Legal Network (n 51 above).

²¹⁷ It must be noted that within 72 hours as of exposure, the testing of the exposed person is not helpful to indicate his or her HIV status as he or she is in the window period.

²¹⁸ Legislation authorizing forced HIV testing in case of occupational exposure has now been enacted in a number of provinces in Canada: Ontario (2001, amended in 2006); Alberta (May 2004); Nova Scotia (October 2004); and Saskatchewan (October 2005). See Canadian HIV/AIDS Legal Network (n 51 above).

²¹⁹ A good example of this is South African Criminal Law (Sexual Offences and Related Matters) Amendment Bill (B50B-2003). This Bill is expected to come into force in the near future. Moreover, some of the provincial laws of Canada on forced testing do permit a person who has been exposed to bodily fluids through a sexual offence to seek an order for compulsory testing. See Canadian HIV/AIDS Legal Network (n 51 above).

²²⁰ As we shall see in coming section, this is applicable in Ethiopia.

²²¹ As we shall discuss in the next section, compulsory testing of sexual offenders for this purpose is applied in Botswana.

4.3.1 Legislative and policy framework in Botswana

HIV prevalence in Botswana has remained one of the highest in both sub-Saharan Africa and the world.²²² To address this problem, the country adopted a National HIV/AIDS Strategic Framework 2003-2009 in 2003.²²³ The strategic framework clearly affirms that so much of the overall national response is dependent on the public being tested.²²⁴ It does not, however, indicate the guidelines that have to be adhered in the implementation of the HIV testing strategy. The following sub-sections summarise the policies, strategies and legislation relevant to HIV testing.

4.3.1.1 The National Policy on HIV/AIDS, and the Botswana Medical Council Regulations

The 2002 Revised National Policy on HIV/AIDS²²⁵ sets forth certain principles that should be applicable to all types of HIV testing. These principles include: the prohibition against carrying out routine testing for HIV/AIDS with the exception of the screening of donated blood and patients presenting with HIV suggestive symptoms; prohibition of HIV testing against the will of an individual; pre- and post-test counselling that must accompany all testing; non-acceptability of pre-employment testing as part of assessment of fitness to work; proscription of HIV testing as part of periodic medical examinations of employees; and provision of, and encouragement for, voluntary counselling and testing.²²⁶

Some measures on confidentiality are also included.²²⁷ It states that consent to disseminate information about the HIV status of individuals should be obtained from the person concerned (i.e. the patient, employee, etc.) before divulging it to others; the principle of 'shared confidentiality' should be followed. According to this principle, 'those who need to know' in order to provide appropriate health and social welfare should be told.²²⁸ Families should be encouraged to be involved from the pre-test phase. There should be no obligation to inform an employer about an employee's HIV status. However, where the employee feels that sharing such information with a supervisor or employer would be helpful, health and social service providers should assist the employee.

²²² UNAIDS *Implementing the UN learning strategy on HIV/AIDS: Sixteen case studies* (2007) http://data.unaids.org/pub/Report/2007/jc1311-un-learning-strat07_en.pdf (accessed 19 October 2007).

²²³ National AIDS Co-ordinating Agency *National HIV/AIDS Strategic Framework 2003-2009* (2003).

²²⁴ n 223 above, para 4 (1).

²²⁵ The 2002 Revised National Policy on HIV/AIDS revised the 1998 National Policy on HIV/AIDS (1998) which itself is the revision of the 1993 National Policy on HIV/AIDS.

²²⁶ n 225 above, 20.

²²⁷ n 225 above, 20-21.

²²⁸ It is not sufficiently clear as to whether the concept of 'shared confidentiality' as included in this document shall include mandatory disclosure of HIV status. As discussed below, however, the Botswana Medical Council (Professional Conduct) (Amendment) Regulations No 77 of 1999 unequivocally incorporates disclosure of HIV status without the consent of the individual.

With respect to confidentiality, it is important to refer to the Botswana Medical Council (Professional Conduct) (Amendment) Regulations, 1999²²⁹ that amends section 21 of Botswana Medical Council (Professional Conduct) Regulations, 1988.²³⁰ The amendment states that:

...a person taking care of, living with or otherwise coming into regular close contact with the patient shall be informed about the patient's medical condition where the said patient is suffering from a communicable disease or has an infection which may be passed to such person if appropriate precautions are not taken.

By discarding the consent of the patient, this amendment requires the status of the HIV positive person to be shared with others.²³¹ Its human rights implication is discussed in the next section.

4.3.1.2 The 2004 Guidelines on Routine HIV Testing

In 2003, a testing strategy focused on VCT alone was eventually deemed insufficient by the Government of Botswana to increase the number of people who will avail themselves of ART.²³² Consequently, on November 10, 2003, President Festus Mogae, President of Botswana, announced that effective January 2004 'the detection of HIV should become a regular part of blood tests conducted in government health facilities for medical purposes. Such tests will be routine, but not compulsory. In other words, HIV will be tested for unless an individual declines to be so tested'.²³³ Under the new policy of routine HIV testing, therefore, all²³⁴ people in Botswana would automatically be offered an HIV test when they utilized health services. People receive a pre-test information session, have the right to 'opt-out' of testing, and those who are tested receive post-test counselling.²³⁵

4.3.1.3 Botswana HIV/AIDS and Human Rights Charter

From the outset, it must be noted that the HIV/AIDS and Human Rights Charter²³⁶ is not a legal document and so does not seek to assert a set of legally enforceable or actionable claims. Rather,

²²⁹ Statutory Instrument Number 77 of 1999.

²³⁰ Statutory Instrument Number 56 of 1988.

²³¹ F Viljoen 'Disclosing in an age of AIDS: Confidentiality and community in conflict?' in F Viljoen (ed) *Righting Stigma: Exploring a rights-based approach to addressing stigma* (2005) 65.

²³² By early 2003, after three years of VCT operation, no more than 28 percent of citizens in Botswana's most populous districts had been tested for HIV, and the approximately 10,000 people then receiving ART was far below the target that the government and its partners hoped to reach. Many of those 10,000 people under treatment had been identified only because their progressive and severe AIDS illness had compelled them to seek care from the health system. See Open Society Institute (n 187 above).

²³³ F Mogae, State of the Nation Address, 'Meeting the Global Challenge', First Meeting of the Fifth Session of the Eighth Parliament (2003) section 53.

²³⁴ This is a radical departure from the 2002 Revised National Policy on HIV/AIDS which restricts the application of routine testing to individuals with HIV suggestive symptoms.

²³⁵ Ministry of Health *Guidelines on Routine HIV Testing* (2004). See also K Kenyon 'Routine HIV testing: A view from Botswana' (2005) 8 *Health and Human Rights* 22.

²³⁶ Botswana HIV/AIDS and Human Rights Charter (2002 revised version).

it is a statement of aspirations of a particular group of PLWHA. One of its aims is to enrich constitutional rights and freedoms and to highlight the Botswana National Policy on HIV/AIDS so as to give it priority and help to put it into practice.²³⁷ Accordingly, it envisages some important guidelines on consent and confidentiality of test results.

Reiterating the position of the National Policy on HIV/AIDS, under paragraph 3, it declares that HIV testing shall be voluntary and accompanied by pre- and post-test counselling. With respect to capacity to consent, it provides that all individuals that are 14 years old and above should have the right to request or refuse an HIV test. According to the same paragraph, HIV testing for people who can not consent, because of mental illness or incapacity, should only be done with the consent of the guardian/parent, and only if it is or the benefit of the person involved. The Charter extends confidentiality of test results even after death. Paragraph 4 provides that '[p]eople have the right to privacy and confidentiality even after death. The status of a person who has died of HIV/AIDS related illnesses should only be disclosed with the fully informed consent of the family'.

4.3.1.4 The Penal Code (Amendment) Act No. 5 of 1998

The Penal Code (Amendment) Act No. 5 of 1998 amended the definition of the crime of rape under section 141, and introduced, in section 142, minimum and maximum sentencing for rape, and the requirement for compulsory HIV testing for all convicted rapists before sentencing.²³⁸

It is clear that these provisions that provide for compulsory testing aim at gathering evidence for sentencing purposes. No provision is made for disclosure of the HIV test results obtained to the victims of these crimes. As far as it can be ascertained no official protocols or guidelines regarding the provision of post-exposure prophylaxis to victims of rape or other sexual offences operate in Botswana.²³⁹

Few cases of direct relevance to compulsory testing of convicted sexual offenders have reached the Botswana Court of Appeal. In the case of *Qam Nqubi v The State*,²⁴⁰ the Court held that in the absence of proof that the offender was HIV positive at the time the rape was committed, the precondition for the imposition of the minimum of 15 years imprisonment in terms of section

²³⁷ As above.

²³⁸ Section 142(3) reads as follows: 'Any person convicted of the offence of rape shall be required to undergo a HIV test before he or she is sentenced by the court.' Section 142(4)(a) continues by stating that: '[a]ny person who is convicted under subsection (1) or subsection (2) and whose test for the Human Immuno-deficiency Virus under subsection (3) if positive shall be sentenced: (a) to a maximum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being HIV positive; or (b) to a minimum term of 20 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being HIV positive.'

²³⁹ Centre for the Study of AIDS (n 207 above).

²⁴⁰ Criminal Appeal No. 49/2000.

142(4)(a) of Penal Code (as amended), was not met.²⁴¹ The Court was not obliged to impose the 15-year minimum sentence for lack of proof, and HIV status was therefore not regarded as an aggravating factor. The Court of Appeal relied on the decision made in the same Court in the matter of *Dijaje Makuto v The State*.²⁴² In this case it was stated that: '[a]s it was not shown that the appellant had the HIV syndrome at the time the offence of rape was committed, the precondition for the imposition of the minimum of 15 years imprisonment by section 142(4)(a) as amended has not been established.' This position was reconfirmed in *Lefang Gare v The State*²⁴³ and in *Shima Matlapeng v The State*.²⁴⁴

4.3. 2 Legislative and policy framework in Ethiopia

Since the first HIV infections in Ethiopia were identified in 1984, and the first AIDS cases were reported in 1986,²⁴⁵ HIV/AIDS increased rapidly in the country.²⁴⁶ To address this, the Government of Ethiopia has responded by establishing institutions²⁴⁷ in charge of coordinating the efforts to combat the epidemic. Adoption and implementation of policies, strategies and legislation that regulate the efforts has also been made part of the response. The following sub-sections summarise the policies, strategies and legislation that relevant to HIV testing.

4.3.2.1 The 1998 Policy on HIV/AIDS

The 1998 Policy on HIV/AIDS²⁴⁸ is a comprehensive policy that dedicates a few paragraphs for HIV testing.²⁴⁹ Paragraph 3 (2) lays down the principle by saying 'testing and counselling shall be voluntary and shall be encouraged along with counselling devices'. The Policy incorporates two exceptions to voluntary nature of testing. The first of these two exceptions is that HIV screening for job recruitment purpose where the nature of the occupation (pilots - civil aviation and air force) 'justifies' to do so.²⁵⁰ Whether the nature of the job really rationalises pre-employment HIV testing

²⁴¹ Section 142(4) (a) is replicated in footnote 238 above.

²⁴² Criminal Appeal No. 31 of 1999.

²⁴³ Court of Appeal Criminal Appeal No. 48/2000.

²⁴⁴ Criminal Appeal No. 45 of 2000.

²⁴⁵ L Garbus *HIV/AIDS in Ethiopia* (2003) <http://www.etharc.org/amhara/Asset/Downloadables /Ethiopia %20AIDS%20Policy%20Analysis.pdf> (accessed September 2007).

²⁴⁶ As the Ministry of Health of Ethiopia, 2004 showed, with an estimated 1.5 million people living with HIV/AIDS and a national prevalence rate of 4.4% (12.6% urban and 2.6 rural), Ethiopia was one of the countries hardest hit by HIV/AIDS epidemic. Cited in Ethiopian Strategy Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004-2008).

²⁴⁷ In 1985 (before the first AIDS case had been officially diagnosed), the government of Ethiopia established a national task force to address prevention and control of HIV/AIDS. In September 1987, the government established an HIV/AIDS department within the Ministry of Health. In 2002, the government established the National HIV/AIDS Prevention and Control Council by Proclamation No.276/2002. See Gabrus (245 above); and n 246 above.

²⁴⁸ Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia (1998).

²⁴⁹ The Strategic Framework for the National Response to HIV/AIDS in Ethiopia 2000-2004 replicates provisions of the 1998 Policy on HIV/AIDS with respect to HIV testing and hence it is not discussed.

²⁵⁰ n 248 above, para 3(3).

of prospective employees shall be discussed in detail in sub-section 4.4.3. The other exception is testing of blood donors.²⁵¹

The policy also affirms confidentiality of testing results.²⁵² PLWHA shall, nevertheless, be encouraged through repeated counselling to accept the need for notifying his/her sero-status to others (spouse, friends, and family).²⁵³ In cases of altered state of consciousness or of difficult cases where a person refuses to notify after adequate counselling and his/her partner is at risk of infection, based on circumstances, the endangered partner has the right to directly access the information regarding the sero-status of the partner.²⁵⁴

4.3.2.2 The 2007 Guidelines for HIV Counselling and Testing in Ethiopia

As pointed out in the introductory part of the Guidelines,²⁵⁵ one of the main aims of adopting these Guidelines is to scale up HIV testing. Scaling up of HIV testing is justified by the development of affordable and effective medical care for people living with HIV. The Guidelines encompass detailed provisions on the requirements of consent, counselling and confidentiality both in VCT and PITC.

According to paragraph 1(1) of the Guidelines, informed consent for testing shall be obtained in all cases, except in mandatory testing. People should be encouraged to seek, but not be coerced into, testing. To ensure genuine consent, counsellors should make sure that clients adequately understand benefits, implications and consequences of testing; and recognise the right of clients to withdraw consent at any time, even after blood has been taken for HIV testing.²⁵⁶

As regards capacity to give consent,²⁵⁷ individuals that are 15 years old and above are considered mature enough to give informed consent. HIV testing for children under 15 shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child.²⁵⁸ However children aged 13-15, who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as 'mature minors' who can consent to HIV testing. HCT (HIV counselling and testing) for a mentally impaired individual

²⁵¹ n 248 above, paras 3.5 and 3(6).

²⁵² n 248 above, para 8(1).

²⁵³ n 248 above, para 5 (5).

²⁵⁴ n 248 above, para 5 (6).

²⁵⁵ Federal HIV/AIDS Prevention and Control Council /Federal Ministry of Health *Guidelines for HIV Counselling and Testing in Ethiopia* (2007).

²⁵⁶ n 255 above, para 3(2)(2).

²⁵⁷ n 255 above, para 1(4).

²⁵⁸ Recognising that parents and guardians may abuse their authority, the Guidelines under consideration, in paragraph 1 (4) (1), provide that 'a counsellor may refuse a testing request when not in the best interests of the child'.

requires the knowledge and consent of his/her guardian, and should be for the benefit of the individual or patient.²⁵⁹

As it is the case with consent, the Guidelines state that 'adequate pre- and post-test counselling shall be offered to all clients'.²⁶⁰ In provider-initiated testing and counselling, the pre-test session consists of education or information to individuals, couples or groups, and should be brief and focus on the benefits of testing and services available.²⁶¹ Unlike pre-test counselling, post-test counselling should be provided in person.²⁶² The form of the post-test counselling session depends on the test result; this is often brief in provider-initiated testing.²⁶³

Clients' confidentiality will be maintained at all times. Results can be shared with other persons only at clients' request or agreement.²⁶⁴ It is the client's decision to learn the test results, which should never be issued in a public area but in private, in a session alone or as a couple.²⁶⁵ HCT sites should not provide written HIV test results to clients to ensure confidentiality and avoid misuse of result.²⁶⁶

The Guidelines allows two exceptions for confidentiality of testing results. Firstly, in cases where testing is ordered by a court of law, results should be communicated directly to the appropriate authority.²⁶⁷ Secondly, partner notification shall be encouraged in cases where one partner receives the results alone. When a client fails to disclose positive status to his/her partner for any reason, however, the endangered partner has the right to know the positive partner's HIV status.²⁶⁸

As mentioned above, the Guidelines, besides VCT, introduced PITC. PITC refers to HIV testing and counselling that is recommended during treatment by health care providers. Individuals may specifically decline to undergo HIV testing after having received pre-test information, without this decision affecting their clinical care. PITC is voluntary and the 3C principles–informed Consent, Counselling and Confidentiality– must be observed at all times.²⁶⁹

²⁵⁹ n 255 above, para 1(5).

²⁶⁰ When para 1(1) is read together with para 3.2, it tells us how adequate the counselling should be. It is provided that the counselling must enable clients to understand and make informed decisions on whether to be tested for HIV, and to understand the results and facilitate future planning.

²⁶¹ n 255 above, para 3(2) (1).

²⁶² This paragraph must be read in conjunction with paragraph 1(1) which encourages couples to be counselled, tested and receive results together.

²⁶³ n 255 above, para 3(2) (4).

²⁶⁴ n 255 above, para 1(1).

²⁶⁵ n 255 above, para 3(2) (3).

²⁶⁶ n 255 above, para 3(2) (7).

²⁶⁷ As above.

²⁶⁸ n 255 above, paras 1(6) and 3(2) (8).

²⁶⁹ n 255 above, para 2(1) (2).

For clients presenting with symptoms or signs of illness possibly attributable to HIV and women²⁷⁰ during pregnancy and labour, it is a basic responsibility of health care providers to recommend HIV testing and counselling as part of routine clinical management. PITC also aims at identifying unrecognized or unsuspected HIV infection in persons attending health facilities. Providers may therefore recommend HIV testing and counselling to patients who do not exhibit obvious HIV-related symptoms and signs.²⁷¹

Mandatory HIV testing is, in principle, prohibited.²⁷² It is permissible only in exceptional cases by order of a court of law. Mandatory testing will also be done on all voluntary blood, tissue and organ donors before transfusion or transplantation.

4.3.2.3 The 2007 Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia

Similar to the 2007 Guidelines for HCT in Ethiopia, informed consent, pre- and post-counselling and confidentiality of testing results underpin the 2007 Guidelines for PMTCT of HIV in Ethiopia.²⁷³ Provider-initiated routine counselling and testing using the opt-out approach is recommended for all clients seen within the context of maternal care (i.e. antenatal, labour, immediate postpartum). This means that HIV testing is offered as a routine component of standard maternal health care. The client is given pre-test information in a group or individually on HIV/AIDS and PMTCT and told that routine antenatal laboratory tests will include an HIV test unless she says 'no' which shall be clearly communicated. The provider must also inform the client that she has the right to say 'no' (to opt out), and this decision by no means affects the services she will get from the health facility.

4.3.2.4 Legislation

There is no specific legislation in Ethiopia addressing HIV/AIDS in general and HIV testing in particular. A few proclamations, however, incorporate provisions on HIV testing. The first of these proclamations is the Federal Civil Servants Proclamation No.515/ 2007. In prohibiting pre-employment mandatory testing in civil service institutions, article 13 (1) of this Proclamation states that '[t]here shall be no discrimination among job seekers or civil servants in filling up vacancies because of their ethnic origin, sex, religion, political outlook , disability, *HIV/AIDS* or any other ground' (Emphasis added). While the Proclamation provides for production of medical certificate as a pre-condition for candidates who qualify for a job, it unequivocally states that the medical

²⁷⁰ As cross-referred to by para 3(4) (4), women receiving counselling and testing in antenatal clinic settings should be managed according to the 2007 National PMTCT Guidelines which is discussed in the next sub-section.

²⁷¹ n 255 above, paras 2 (1) (2) and 1 (3).

²⁷² n 255 above, paras 1 (1) and 2 (1) (3).

²⁷³ Federal HIV/AIDS Prevention and Control Council /Federal Ministry of Health *Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia* (2007) paras 5 (3) (2) cum 1 (2).

certificate does not have to include HIV test result.²⁷⁴ The Proclamation also prohibits HIV testing of civil service employees.²⁷⁵

The second proclamation is the Labour Proclamation²⁷⁶ that prohibits HIV testing of employees that fall under its scope of application, notably workers in private business companies and profit-motivated government enterprises.

Moreover, article 34 of the 1961 Criminal Procedure Code of Ethiopia is interpreted as allowing compulsory testing of accused sexual offenders.²⁷⁷ This article states that:

... where an investigating police officer considers it necessary, having regard to the offence with which the accused is charged, that a physical examination of the accused should be made, he may require a registered medical practitioner to make such examination and require him to record in writing the results of such examination. Examination under this Article shall include the taking of a blood test.

4.3. 3 Legislative and policy framework in Uganda

In order to guide a coordinated national response to the epidemic, the Uganda AIDS Commission and Partners developed the National Strategic Framework for HIV/AIDS Activities in Uganda 2000/01-2005/06.²⁷⁸ With a view to incorporate new developments in the fight against HIV/AIDS that were not anticipated when the National Strategic Framework was formulated in 2000/01, a mid-term review of the Strategy was also conducted that culminated with the adoption of the Revised National Strategic Framework for HIV/AIDS Activities in Uganda 2003/04-2005/06.²⁷⁹ None of these Strategies, nevertheless, clearly integrates guidelines on HIV testing and counselling. In this regard, the 2005 National Policy on HCT²⁸⁰ is the most important and thus it is discussed below.

²⁷⁴ Federal Civil Servants Proclamation No.515/ 2007, art 17.

²⁷⁵ In this regard, article 63 (1) of the Proclamation states that '[a]ny civil servant shall have the obligation to take medical examination, with the exception for HIV/AIDS, when required by the government institution on sufficient ground related to the service'.

²⁷⁶ Proclamation No 377/2003. Article 14 (2) (d) states that '[i]t shall be unlawful for the worker to, except for HIV/AIDS test, refuse to submit himself for medical examination when required by law or by the employer for good cause'.

²⁷⁷ This can be understood from decided cases in the Federal High Court as can be exemplified by the case of *Public Prosecutor v Tesfaye Mamo*. The justification given for compulsory testing of rape offenders is that the result of the HIV test is important to determine with which specific offence the offender should be charged and sentenced. If the test result reveals that the accused is positive, the charge is amended to attempted murder. If, on the other hand, his or her test shows negative result, the case will continue as rape. See Tesfaye (n 207 above) 98-99.

²⁷⁸ n 206 above.

²⁷⁹ The Revised National Strategic Framework for HIV/AIDS Activities in Uganda: 2003/04-2005/06 (2004).

²⁸⁰ Ministry of Health, Republic of Uganda *Uganda National Policy on HIV Counselling and Testing* (2005). As stated in the introduction of the Policy, the Policy is issued with a view to enhance diversification of HIV testing approaches that include PITC. These approaches are designed to remove the barriers to testing and then to treatment, care and support imposed by the VCT approach.

The Policy incorporates VCT and PITC²⁸¹ as the preferred approaches for the delivery of HCT. Mandatory and compulsory testing are completely rejected.²⁸² Even in the case of accidental exposure to bodily fluids, the source person is not compelled to be tested. He or she must consent to the testing. This is completely different from the position taken by previous national guidelines which, by way of exception, allow mandatory and compulsory testing in tissue donation cases and medical-legal cases e.g. rape, defilement, indecent assault.²⁸³

Although not exclusive, VCT has been and remains the primary approach for delivery of HCT services in Uganda.²⁸⁴ It is supplemented by PITC. PITC is done routinely as part of health services. The PITC approach is a provider-initiated and shifts the burden of seeking services from the individual to the service provider. In PITC, HIV testing and counselling services are offered during the clinical evaluation of all patients along with any other tests, or investigations being recommended to the patient. If the resources are available, PITC may be offered to any and all patients presenting for services of any kind. However, if personnel or supplies are limited, PITC should be offered first in hospital units or clinics where HIV rates are likely to be highest such as antenatal clinics, labour and delivery wards, medical wards, sexually transmitted infections, and general medical units of hospitals. Patients to whom testing has been offered always have the right to accept, reject or to defer testing.²⁸⁵

Be it in the case of VCT or PITC, the three 3 C principles have to be observed. Detailed guidelines are laid down to ensure compliance with these principles. According to these guidelines, all HIV testing should be done with the client's knowledge and consent. The individual should feel free to grant or withhold consent. Where possible, consent should be documented by the client's signature or thumb print. Where not possible, after thorough verbal explanation, the provider may document consent in the patient's records. For adults unable to consent due to unconsciousness, a relative may provide the consent.²⁸⁶ In case of hearing, language or other disability that makes consent difficult to obtain, the provider must use his or her best judgment and obtain consent through a translator or guardian if need be. The client may use a translator or interpreter of his or her own choice to interpret counselling sessions.²⁸⁷

In terms of capacity to give consent, children are grouped into two categories. Children that are 12 years and older may receive HIV testing services at all HCT sites without knowledge or consent of their parent(s) or guardian(s) provided that they have the capacity to understand the implications of

²⁸¹ The phrase used in the policy to name PITC is 'routine testing and counselling'. To maintain consistency of usage of terminologies, the thesis uses the abbreviation PITC.

²⁸² n 280 above, para 4(4) (5).

²⁸³ n 280 above, para 1(2) (5).

²⁸⁴ n 280 above, para 4(1).

²⁸⁵ n 280 above, para 4(4) (3).

²⁸⁶ n 280 above, para 4(2).

²⁸⁷ n 280 above, para 4(5) (3).

the results of the HIV test. For children below 12 years of age, consent by parents or guardians must be documented. For children below 12 years of age without a parent or guardian, the head of the institution, health centre, hospital, clinic or any responsible person may give consent. When children are brought for testing by parents or guardians, the HIV antibody test is to be done only to facilitate the medical care of the child. Testing must be clinically indicated or a health provider must concur that a risk of infection is present. The test is not to be used to screen children or to satisfy the curiosity of parents, guardians, providers, or care takers.²⁸⁸

In both VCT and PITC, pre-test and post test provision of information has to be carried out by qualified staff.²⁸⁹ In the case of PITC, full pre-counselling for HIV testing is not, however, required. What is required is supplying general information, either individually or in a group, about all investigations being planned (including the HIV test) rather than specific pre-test HIV counselling.²⁹⁰

Strict confidentiality of test results is also the underlying principle of HCT services. HIV test results should be kept in a locked file with access limited to HCT personnel. The HCT sites will not release test results to anyone other than the client unless the client requests release in writing or a court order requires it. Post-counselling must be conducted in an area where privacy and confidentiality can be assured.²⁹¹ The principle of confidentiality is equally applicable to children 12 years and older in that the test results are not shared with parents or guardians except at the request of the child.²⁹²

4.4 A human rights analysis of HIV testing related legislation and policies of Botswana, Ethiopia and Uganda in the light of African human rights instruments

The preceding two sections summarised the nature of different types of testing and the policies and laws of Botswana, Ethiopia and Uganda relevant to HIV testing. This section goes to the crux of the matter and assesses whether the laws and policies of these countries applicable to HIV testing are compatible with the relevant human rights norms in the African human rights system.

As discussed in chapter two, a rights-based approach to HIV testing requires compliance with three inter-woven principles, namely, both pre-test and post-test counselling, informed consent and confidentiality of test results.²⁹³ These principles are grounded in African human rights norms.

²⁸⁸ n 280 above, para 4(5).

²⁸⁹ n 280 above, para 4 (3) (3).

²⁹⁰ n 280 above, para 4(4)(3).

²⁹¹ n 280 above, para 4(1).

²⁹² n 280 above, para 4(5).

²⁹³ OHCHR/UNAIDS (n 36 above) para 28 and 31 (b) See also UNAIDS/WHO (n 5 above). Such principles are also reaffirmed by the May 2007 PITC Guidelines (n 26 above).

Informed consent is basically based on the right to physical integrity²⁹⁴ and privacy²⁹⁵ both of which prohibit HIV testing without the informed consent of the individual.²⁹⁶ Counselling is founded on the right to highest attainable standard of health²⁹⁷ and the right to freedom of information²⁹⁸ both of which include the right to seek and receive HIV-related prevention information.²⁹⁹ The requirement of confidentiality of test results is grounded in both the right to highest attainable standard of health which, *inter alia*, requires the treatment of personal health data confidentially,³⁰⁰ and the right to privacy which, among others, aims at safeguarding confidentiality of all information relating to a person's HIV status.³⁰¹

Thus, any model of HIV testing that is conducted in breach of one of the 3C principles is a violation of the human rights (the right to privacy, the right to physical integrity, the right to freedom of information and the right to highest attainable standard of health) which these principles seek to safeguard. The right to equality³⁰² and non-discrimination³⁰³ are also violated when HIV testing is utilised as a condition for the enjoyment of rights or where it results in differential treatment or violations of other human rights.³⁰⁴

4.4.1 VCT

As elaborately discussed in chapter two, VCT emerged as response to earlier preventive measures of the virus that undermined human rights and contributed to more vulnerability.³⁰⁵ As the three 3 C principles are at the heart VCT model of testing, it is possible to draw a general conclusion that the VCT policies of the countries under the case study are compatible with the relevant human rights norms of the African human rights system.

In respect of confidentiality of testing results, however, the Botswana Medical Council (Amendment) Regulations that requires the status of the HIV positive person to be shared with others and the 2007 Guidelines for HCT in Ethiopia³⁰⁶ which gives the endangered partner the right to know the positive partner's HIV status require close scrutiny. The main issue in relation to these

²⁹⁴ The right to physical integrity is guaranteed both under article 4 of the ACHPR and article 4 (1) of the Women's Protocol.

²⁹⁵ Guaranteed in article 10 of the ACRWC. In chapter three, it is also argued that, although the right to privacy is not explicitly recognised in ACHPR and the Women's Protocol, this right can be implied from the right to physical integrity (article 4 of the ACHPR and article 4 (1) of the Women's Protocol) and the right to respect for one's dignity (article 5 of the ACHPR and article 3 of the Women's Protocol).

²⁹⁶ UNAIDS/UNHCHR (n 43 above) para 119.

²⁹⁷ n 130 above, art 16, n 132, art 14 and n 134, art 14.

²⁹⁸ Recognised in article 9 (1) of the ACHPR (n 130 above) and article 7 of the ACRWC (n 132 above).

²⁹⁹ Consolidated Guidelines (n 43 above) para 138. See also Canadian HIV/AIDS Legal Network (n 81 above).

³⁰⁰ n 78 above, para 12(b).

³⁰¹ UNAIDS/OUNHCHR (n 43 above) para 119. See also n 86 above, para 24.

³⁰² n 130 above, art 3.

³⁰³ n 130 above, arts 2 and art 3 of the ACRWC (n 132 above).

³⁰⁴ The term 'other status' in both article 2 of the ACHPR and article 3 of the ACRWC can be construed to include prohibition of discrimination on this ground. For such interpretation, see n 99 above.

³⁰⁵ Consolidated Guidelines (n 43 above) Para 94.

³⁰⁶ n 255 above para 1(6) and 3(2) (8).

provisions is: are these provisions that authorise the sharing of confidential test results compatible with the right to privacy and the right to health of the HIV positive person?

To begin with the 2007 Guidelines for HCT in Ethiopia, it provides for mandatory partner notification should the HIV positive person fail to share his or her status voluntarily. In this regard, article 14 (1) (e) of the Women's Protocol is relevant. It inculcates 'the right to be informed...on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS.'³⁰⁷ Thus although the rights of the HIV positive person is subjected to limitations, this is done to protect the rights of the other partner. This is a justifiable limitation within the meaning of article 27 (2) of the ACHPR that subjects rights to be exercised with due regard to the right of others.

Unlike Ethiopian Guidelines, the Botswana Medical Council (Amendment) Regulations provides for disclosure of the HIV status of the person to broad categories of persons including those whom the patient has 'regular close contact'. These Regulations create the avenue for potentially unlimited disclosure of the HIV status of the patient and pave the way for grave human rights abuses. The problem is serious particularly when viewed from the fact that none of these persons have a legal duty of confidentiality towards the infected person and there is no guarantee that the confidential information disclosed will remain confidential.³⁰⁸

4.4.2 PITC

In addition to VCT, the HIV/AIDS policies and strategies of Botswana, Ethiopia and Uganda incorporate PITC at least as a supplementary model of HIV testing. The policies and the strategies also lay down guidelines that health care providers are supposed to follow while applying the PITC services. In all cases, the guidelines emphasised that, like VCT, the three 3C principles shall be observed. There are, however, three areas of concern for human rights that should be discussed in detail.

First, unlike the VCT model, in the case of PITC, testing is initiated by the provider, not by the client. People are tested unless they expressly opt out of testing.³⁰⁹ Commentators warn that PITC could in practice amount to mandatory testing which is a violation of human rights.³¹⁰ Such concern

³⁰⁷ Such limitation is included in the Women's Protocol taking into consideration the existing reality that women are more vulnerable to HIV/AIDS than men. It is argued, however, that the limitation should be applicable to men as well, in view of the principle of equality and non-discrimination provisions of the ACHPR and article 60 of the same.

³⁰⁸ A Zuyderduin *et al* *Shared confidentiality: An ethical dilemma in Botswana* (2000) http://www.dits.hwanelo.org/bw/index/Current_Issues/HIV_AIDS/Shared%20Confidentiality%20Paper.pdf (accessed 29 September 2007).

³⁰⁹ n 235 above; n 255 above; and n 280 above, paras 2 (1) (2) and 4(4) (3).

³¹⁰ Nieburg (n 192 above). See also Kenyon (n 235 above) 22.

arises from the fact that the skewed power relationship between health care worker and patient, particularly in developing countries, could cause the patient to be intimidated into testing.³¹¹

It is submitted that so long as the policies and the strategies in the countries under this case study are effectively implemented, there is a vary narrow possibility for those concerns to materialise. The HIV testing and counselling policies of these countries clearly provide that persons wishing to opt out must be reassured that such a decision will not result in the loss of services beyond HIV care. Moreover, the guidelines unequivocally impose a duty on health service providers to clearly communicate to the patient that he or she has an absolute right to refuse testing. Besides, so as to avoid ignorance and incapacity in the implementation of the PITC services, the policies and the strategies incorporate training programmes to health care providers.³¹² If all these policies are put into practice, the concern that PITC would lead to human rights violations should not become a reality.

Second, while it is admitted that PITC has the potential to increase uptake of HIV testing, concern has mounted as regards human rights violations of PLWHA, the most notorious and serious violation being discrimination.³¹³ Although the countries under consideration are not exceptions in this respect, the recognition and implementation of confidentiality of test results as included in their policies and strategies (with few exceptions) will contribute to minimize the problem. Moreover, it is believed that if more people get tested and more know their HIV status (as a result of their PITC policies) and benefit from affordable treatment, it is more likely that the levels of stigma and discrimination in their respective societies will decrease.³¹⁴

The third concern pertains to the counselling aspect of PITC model. As discussed in the preceding sections, one area in which PITC differs from VCT is in so far as it replaces fully-fledged individual counselling by simplified pre-test information which may be undertaken in a group. This is also the case in Botswana, Ethiopia and Uganda. The 2004 Botswana Guidelines on Routine Testing provide that standard pre-test counselling would not be required and that pre-test information, including public service announcements, group sessions and videos would be acceptable alternatives.³¹⁵ The 2007 Guidelines for HCT in Ethiopia, on its part, provides that in PITC, the pre-

³¹¹ Aids Law Project (n 189 above).

³¹² Para 4 (4) Federal HIV/AIDS Prevention and Control Council (n 255 above) provides that counselling and testing providers shall receive standard comprehensive training enabling them to provide counselling, constitute a professional association and do rapid testing under close supervision of lab personnel. It continues to provide that the training curriculum for all categories of counsellors must include: 1. Overview of HIV/AIDS and comprehensive prevention, care and treatment information 2. Principles of HIV counselling 3. Techniques and implementation of the rapid HIV test 4. Couple and child counselling 5. Program management/coordination and supervision, referrals, monitoring and evaluation related activities, such as record keeping and reporting formats 6. Provider-initiated approach for health professionals. In the same manner, the 2005 Uganda HCT Guidelines under paragraph 3 (1) provides that only trained counsellors or health workers trained in HCT should provide HIV pre- and post-counselling and information. Furthermore, it provides that HCT sites should ensure that all HCT providers have sufficient skills to offer comprehensive HCT services.

³¹³ Russo (n 28 above).

³¹⁴ Open Society Institute (n 187 above).

³¹⁵ n 235 above 8.

test session consists of education or information to individuals, couples or groups, and should be brief and focus on the benefits of testing and services available.³¹⁶ In the same way, the Ugandan 2005 National Policy on HCT states that in the PITC model, full pre-counselling for HIV testing is not required. What is required is supplying general information, either individually or in a group, about all investigations being planned (including the HIV test) rather than specific pre-test HIV counselling.³¹⁷

The issue here is whether the replacement of pre-test counselling with the so-called individual or group pre-test information poses a threat to human rights which would have not been the case in the case of pre-test counselling. There are two reasons why the writer of this thesis does not think so. First of all, because of extensive awareness raising programmes about the nature, means of transmission, ways of prevention and treatment of HIV/AIDS, awareness of HIV/AIDS is now high in Africa, including in Botswana, Ethiopia and Uganda.³¹⁸ This renders the need for extensive pre-test counselling unnecessary. In fact, extensive pre-test counselling consumes unnecessarily the time of health care providers and resources of health care services. This in turn has the effect of reducing the number of people able to be tested and thereby the number of people, who will benefit from treatment, care and support.

This does not, however, mean that people should be tested without the required information. In this regard, as discussed in section 4.3, the relevant guidelines of the countries under this case study clearly enshrine the minimum pre-test information that the health care provider is bound to communicate. The health care provider must provide a simplified form of pre-test counselling that allows people to understand the benefits and risks associated with HIV testing, the voluntary nature of testing as well as the right to refuse testing.

4.4.3 Mandatory HIV testing

As defined in section 4.2, mandatory testing could/may occur as a condition for some status, service or other benefit. Among the countries under this case study, Ethiopia and Botswana incorporate aspects of mandatory HIV testing in their HIV testing policies while Uganda does not.³¹⁹ In general, mandatory testing is allowed in Ethiopia where there is a court order to that effect.³²⁰ Particularly, two specific areas are provided. First, mandatory testing is allowed for job recruitment purpose where the nature of the occupation (pilots- civil aviation and air force) justifies

³¹⁶ n 255 above, para (3) (2).

³¹⁷ n 280 above, para 4(4) (3).

³¹⁸ Open Society Institute (n 187 above).

³¹⁹ Paragraph 4(4) (5) of the 2005 Uganda National Policy on HCT (n 280) has completely rejected mandatory testing. However, in reality, some organisations in Uganda subject prospective employees to a mandatory HIV screening test before recruitment, and the infected ones are denied job opportunities. Those who get infected during employment are often discriminated against and their job contracts terminated on the basis of their sero-status. See n 206 above, para 2 (3) (7). One can also think of the unavoidability of mandatory HIV screening of tissue and blood donors.

³²⁰ n 255 above, para 1 (1) and 2(1)(3).

to do so.³²¹ Second, mandatory testing will also be done on all voluntary blood, tissue and organ donors before transfusion or transplantation.³²² In Botswana, the 2002 Revised National Policy on HIV/AIDS sets forth mandatory screening of donated blood.

Mandatory testing, unlike compulsory testing, does not totally disregard the 'consent' of the individual subject to test. The individual has the 'option' to avoid the test under the pain of losing the status, service or other benefit to which HIV testing is attached as a condition. Strictly speaking, it is the circumstance (status, services or other benefit to which testing is prescribed as a prerequisite) that compels the individual to undergo the test. The likelihood of this happening is high. For instance, a person desperately seeking for a job will easily submit to the pre-employment test attached to the job. Thus, even if there is some element of 'consent' in mandatory testing, such consent is by no means a free and full one.

As a result, this particular model of testing, as envisaged in HIV/AIDS Policies of Botswana and Ethiopia, is a violation of the right to physical integrity and privacy, both of which prohibit HIV testing without the free and full consent of the individual. As the testing relates only to specific categories of people, it is also a violation of the right to equality and freedom from discrimination. If this is so, the next issue worth consideration is whether the violation of these rights is a justifiable limitation within the meaning of article 27 (2) of the ACHPR.

The justifiability of mandatory HIV testing of donors of body tissues (blood and organs) before transfusion or transplantation is self evident. It has a legitimate public health rationale of protecting those who will receive the tissues. If the blood or organ is not tested before transfusion or transplantation, there is a high risk for the donee to be infected with the virus. That is why the International Guidelines on HIV/AIDS and Human Rights allow as an exception mandatory testing 'in cases of blood/organ/tissue donations where the human product, rather than the person, is tested before use on another person'.³²³

What is problematic is the 2007 Guidelines for HTC in Ethiopia that permit mandatory testing where there is a court order to that effect. In the absence of clear guidelines, this provision gives the court an absolute discretion to determine who should be tested and in what situation testing should take place. Such unlimited judicial discretion opens a room for arbitrary limitations to human rights. This problem is fuelled by lack of clear indication in the Guidelines as to which court shall exercise jurisdiction on this matter. Of course, in the absence of clear indication to that effect, it is possible to say that all courts, including the lowest courts in the country, have jurisdiction in such matters. In most cases, the lowest courts of Ethiopia are, however, staffed by inexperienced and

³²¹ n 248 above, para 3(3).

³²² n 255 above, para 1 (1) and 2(1) (3).

³²³ OHCHR/UNAIDS (n 36 above) para 98.

unskilled judges³²⁴ who may not properly articulate the balancing of different interests in determining whether mandatory testing may be ordered in a particular context. In short, it suffices to say that such broad power on the parts of courts is a potential threat to illegitimate human rights violations.

As has been mentioned above, the Ethiopian 1998 Policy on HIV/AIDS also expressly allows HIV screening test for job recruitment purpose where the nature of the occupation (pilots-civil aviation and air force) requires doing so.³²⁵ It seems on the basis of this provision that the Ethiopian Airlines in practice orders those who apply for pilot positions to undergo screened for HIV before being employed.³²⁶ Two justifications are forwarded. First, HIV/AIDS causes 'brain disorder' which may bring about cognitive or judgment impairment that renders HIV positive persons unfit for the job. The second ground is purely financial. That is, the company needs to hire individuals who can reliably serve the company for a long period which HIV positive persons may not be able to do.³²⁷

Do these justifications hold water in the light of article 27 (2) of the ACHPR which stipulates respect for the right of others, collective security, morality and common interest as the only grounds for limitations to the rights in the Charter? It is submitted that the financial justification upon which the mandatory testing of prospective pilots rests does not fit any of these limitation criteria and is hence unjustifiable for two reasons. Firstly, the justification does not work in the contemporary HIV/AIDS treatment era where PLWHA can live long as uninfected people. The idea that the life expectancy of PLWHA is short rests on the wrong belief that equates HIV/AIDS with death. Secondly, it is in the public interest to strengthen community support, economic support (including employment) and non-discrimination of PLWHA. If PLWHA are discriminated against and are not assisted, they may contribute to the underground transmission of the disease. Thus, in order to halt the spread of HIV/AIDS, supporting PLWA must be one of the strategies to battle HIV/AIDS.

There is no jurisprudence in the African Commission in this respect. Cases of a similar nature are, however, dealt in domestic courts. As mentioned earlier, in *Hoffman v South African Airways*, the applicant challenged the latter's refusal to employ him as a cabin attendant because of his HIV positive status. South African Airways defended its action, *inter alia*, on the basis of the undue costs of training Hoffman, given his short life expectancy (because of his HIV positive status). In its reasons for judgment, the South African Constitutional Court did not comment directly upon the Airway's arguments as to the undue costs of training Hoffman due to his life expectancy. In view of

³²⁴ G Aneme 'Apology and trials: The case of the red terror in Ethiopia' (2006) 6 *African Human Rights Law Journal* 78.

³²⁵ n 248 above, para 3 (3).

³²⁶ Interview with Dr. Saba Teklu, a medical examiner in the Ethiopian Airlines, on April 16, 2004, cited in S Tesfaye (n 23 above).

³²⁷ As above.

the decision of the Court against South African Airways, however, one can deduce the unacceptability of this argument.

In another employment case³²⁸ outside air transportation setting, Justice Tipnis of the High Court of Judicature of Bombay rejected an employer's argument that it ought to be entitled to refuse to employ HIV positive persons on the ground that the disease was 'most likely to assume serious proportions in due course' imposing significant financial and administrative costs. The employee in question was asymptomatic and the evidence established that it would be at least 8-10 years before he developed AIDS. Justice Tipnis stated:

*In our opinion, the State and public Corporation like respondent No. 1 cannot take a ruthless and inhuman stand that they will not employ a person unless they are satisfied that the person will serve during the entire span of service from the employment till superannuation. The most important thing in respect of persons infected with HIV is the requirement of community support, economic support and non-discrimination of such person. This is also necessary for prevention and control of this terrible disease. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn the victims of HIV infection, many of whom may be truly unfortunate, to certain economic death. It is not in the general public interest to refuse to employ HIV infected persons. The interests of the HIV positive persons, the interests of the employer and the interests of the society will have to be balanced in such case.*³²⁹

Thus the justification of the Ethiopian Airlines not to employ HIV positive people as pilots is not only absurd in view of the existence of life-prolonging ART, but also against overall public interest.

The other justification given by the Ethiopian Airlines is a bit controversial and thus requires separate treatment. It is said that since HIV/AIDS affects the mental faculty of HIV positive people, they can not make prompt and appropriate operational decisions (operation) in critical situations. There is a fear that as a result of mental problems, life and property may be endangered. The underlying consideration behind this limitation can be considered as respect for the rights of others (which in this case may include the right to life and the right to property of the passengers and the Airlines) which is one of the grounds of limitations under article 27 (2) of the ACHPR. The question however is: does the mere contracting of HIV/AIDS render the HIV positive person incapable of performing operational duties that are expected of any 'normal' pilot?

In answering this question, the *Hoffman* case is in point. The evidence adduced before the Court established that Hoffman was able to perform the work of a cabin attendant competently despite his HIV positive status. On the basis of this evidence, the Court held that Hoffman's HIV status

³²⁸ n 144 above.

³²⁹ n 144 above, para 56.

alone was not determinative of his fitness for service as a cabin attendant and was not a reasonable basis upon which to reject his application for employment.³³⁰ The issue as to whether HIV positive individuals could be refused employment in military setting on the ground of their HIV status was also addressed in Labour Court of Namibia. In *N. v. Minister of Defence (Namibia)*,³³¹ N. challenged the Namibian's Defence Force (NDF's) refusal to accept him as an enlisted soldier based on his HIV positive status. The NDF defended its action on the basis of stated concern for the physical and mental capacity of its recruits for the demands of military service. The Labour Court of Namibia ruled that the NDF's conduct amounted to unfair discrimination. The evidence established that notwithstanding N's HIV infection, he was 'in sound and good health and capable of performing his duties anywhere in Namibia'. As such, N's HIV status alone was not determinative of his fitness for military service and was not a reasonable basis upon which to refuse to enlist him.

Although the unfitness of HIV persons was raised as a defence for refusal to employ HIV positive people, decisions of courts have affirmed that HIV status alone is not a determinative factor for fitness. In this light, the HIV/AIDS policy of Ethiopia that allows pre-employment mandatory testing and the pre-employment HIV testing practice of the Ethiopian Airlines are contrary to the right to privacy, bodily integrity and freedom from discrimination of a person subject to such test. Moreover, the limitations imposed by these policies and practices can not be justified under article 27 (2) of the ACHPR.

4.4.4 Compulsory HIV testing

As defined in section 4.2 and as its very name implies, compulsory testing is defined as testing without informed consent and at the request of someone or some institution other than the person tested. This type of test is completely rejected in Uganda.³³² An aspect of this specific type of testing is, however, retained in Botswana and Ethiopia.

In Botswana, the Penal Code (Amendment) Act No. 5 of 1998 requires compulsory HIV testing for all convicted rapists before sentencing.³³³ The amended Act makes provision for harsher sentencing of any person whose test for HIV is found to be positive.³³⁴ It is clear that the Amended Act provisions providing for compulsory testing aim at gathering evidence (for sentencing purpose).

³³⁰ n 144 above, para 15.

³³¹ n 144 above.

³³² n 280 above, para 4(4) (5).

³³³ Penal Code (Amendment) Act No. 5 of 1998, sec 142(4).

³³⁴ As above.

Article 34 of the 1961 Criminal Procedure Code of Ethiopia is also interpreted as allowing compulsory testing of accused sexual offenders.³³⁵ Although this is different from the Amended Act of Botswana in that testing is ordered before the accused is convicted, it has the same purpose. Even in the Ethiopian case, the purpose of compulsory testing is to gather evidence for the purpose of prosecution. That is, if the accused is found out to be positive, the original charge of rape will be amended to attempted murder.³³⁶

Since the testing is done without the consent of the person subject to the test, compulsory HIV testing of accused or convicted persons and the disclosure thereafter of the test results would represent a considerable intrusion into the right to privacy and bodily integrity of such persons as contained in various African instruments. Given the fact that the testing is undertaken on a specific category of people, it is also an encroachment of the right to equality and freedom from discrimination. These rights are not, however, absolute, and other interests listed in article 27 (2) of the ACHPR may justify or necessitate their limitation.

It is submitted that the limitations to the rights to privacy, bodily integrity, equality and freedom from discrimination (as a consequence of compulsory testing) for the purpose of securing evidence either for prosecution or sentencing purposes meets the legitimate limitation grounds in article 27 (2) of the ACHPR. The information regarding HIV status is in general necessary for the effective prosecution of crime or imposing appropriate sentence according to the gravity of the offence.³³⁷ Prosecution of criminals and imposing appropriate penalties proportional to the offence committed are, in turn, crucial measures for the prevention of crimes.³³⁸ If a person who transmitted HIV/AIDS, knowingly or unknowingly, is not prosecuted and duly punished, there is no way that the criminal justice system will deter potential perpetrators from giving effect to their malicious criminal activities. Thus, the ultimate purpose of securing evidence for prosecution or sentencing is the prevention of crimes.

Finally, it must be borne in mind that limitations must be absolutely necessary for the advantages which are to be obtained.³³⁹ In the issue at hand, the limitation is legitimate only if there is no other way in which the HIV status of a person accused or convicted can be ascertained than by taking a blood sample from that person and testing it for HIV antibodies. Thus, if the HIV status of the individual can be gathered from his previous testing results, subsequent compulsory testing of

³³⁵ Discussion based on S Tesfaye (n 207 above) 98-99.

³³⁶ As above.

³³⁷ South African Law Commission (33 above) para 7(11) (2). As discussed in sub-section 4.2.4, the information regarding HIV status is useful not only for prosecution and sentencing purposes, but also for the ascertainment of the sero-status of the victim of the crime and to apply PEP to minimize the risk of HIV transmission (as exemplified by the South African Criminal law (Sexual Offences and Related Matters) Amendment Bill (B50B-2003) (n 219 above)) . In Ethiopia and Botswana context, nevertheless, its purpose is confined to the prosecution and sentencing of the perpetrator respectively.

³³⁸ Although prevention of crime is not specifically mentioned as a legitimate ground of limitation of rights, the term 'common interest' under article 27 (2) of the ACHPR is broad enough to include prevention of crimes.

³³⁹ n 180 above, para 69.

accused or convicted persons would be an illegitimate invasion and thus a violation of human rights.

4.5 Conclusion

The discussion in this Chapter sought primarily to identify the HIV testing policies and laws of Botswana, Ethiopia and Uganda, and to explore their compatibility with the norms of African human rights system. With the exception of Uganda which totally outlaws mandatory and compulsory testing, the discussion reveals that all the three countries incorporate, in their respective policies and laws, VCT, PITC, mandatory and compulsory HIV testing.

As to the compatibility of the different models of HIV testing with human rights norms, the discussion reveals that the VCT model accords with the principles of human rights with the exception of the Botswana Medical Council (Amendment) Regulations that require sharing of HIV testing results to broad category of people (in which case the Guidelines violate the right to privacy and health of the individual). The PITC model has become the source of human rights concerns particularly in view of its brief pre-test information provision and the unequal power relationship between the health care provider and patients. Nevertheless, it does not violate human rights *per se*.

The discussion has also revealed that mandatory and compulsory models of HIV testing are contrary to human rights norms. With the exception of mandatory testing of tissue donors, mandatory testing cannot be justified. Compulsory testing of accused or convicted sexual offenders is found out to be a justifiable limitation under article 27 (2) of the ACHPR.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

HIV/AIDS prevention strategies with coercive or punitive features had a counterproductive effect. They contributed to the underground transmission of the epidemic. Because of this, behavioural change became the major focus of the strategy for combating the pandemic. To promote behavioural modification, it was found vital that information about the existence, modes of transmission and means of prevention of infection should be given to all those at risk of acquiring it in circumstances that they would trust, believe and follow it. This was the hallmark of the rights-based approach in the struggle against HIV/AIDS.

With particular reference to HIV testing, a rights-based approach to HIV testing means that HIV testing shall be undertaken in compliance with the 3C principles, i.e. involving, both pre-test and post-test counselling, informed consent and confidentiality of test results.

The 3C principles have a clear foundation in African regional human rights documents. The right to the highest attainable standard of health; the right to freedom of expression; the right to privacy; the right to physical integrity; the right to equality, freedom from discrimination and the right to respect for one's dignity are the core rights upon which the 3C are based. Thus HIV testing should be undertaken in conformity with these rights. These rights are not, however, absolute and thus they may be subject to limitation to promote and protect the rights of others, for collective security, morality and common interest.

The study has explored the compatibility of HIV testing related policies and legislation of Botswana, Ethiopia and Uganda with the afore-mentioned human rights norms. The discussion has revealed that the VCT model accords with human rights principles with the exception of the Botswana Medical Council (Amendment) Regulations that require sharing of HIV test results to broad a category of people (in which case the Guidelines violate the right to privacy, the right to physical integrity and the right to health of the individual). But the PITC model has become the source of human rights concerns, particularly in view of its brief pre-test information and the unequal power relationship between the health care provider and patients. If properly implemented, however, its principles are consonant with human rights norms.

Mandatory and compulsory models of HIV testing are contrary to human rights norms. With the exception of mandatory testing of tissue and blood donors, mandatory testing can not be justified. However, compulsory testing of accused or convicted sexual offenders was argued to be a justifiable limitation under article 27 (2) of the ACHPR.

5.2 Recommendations

One of the principles that should be complied with in context of HIV testing is ensuring confidentiality of test results. Any breach of this principle entails the violation of the right to privacy, the right to physical integrity and the right to health. In this light, the Botswana Medical Council (Amendment) Regulations that provides for disclosure of the HIV status of sero-positive person to broad categories of persons including those with whom the patient has 'regular close contact', creates the avenue for unlimited disclosure of the HIV status of the patient and paves the way for grave human rights abuses. This provision should be deleted and replaced by a provision which encourages consensual disclosure of testing results.

The PITC model of testing may easily lead to human rights violations unless it is cautiously implemented. To prevent this from happening, the countries under this case study, should, as stated in their respective policies, create and strengthen the necessary mechanisms to closely monitor and evaluate its implementation. More specifically, they should provide the appropriate training to health service providers and ensure that patients, in practice, receive the required pre-test information and have an absolute right to refuse testing.

As mandatory testing is undertaken without the free and full consent of the individual, the study has argued that it is a violation of the human rights unless such violation is a justifiable limitation of the rights. In view of this, the 2007 Guidelines for HTC in Ethiopia that authorises courts to order mandatory testing opens a 'Pandora's box' for human rights abuses. Thus, this provision should be totally removed. Likewise, the Ethiopian 1998 Policy on HIV/AIDS which expressly allows HIV screening for job recruitment purposes violates human rights which informed consent seeks to safeguard. It is believed that HIV status alone cannot be determinative of fitness for service of the job seekers. This Policy, therefore, imposes unjustifiable limitations up on the human rights of job seekers. Hence, it should be repealed.

Finally, it must be noted that having good policies and legislation does not by itself guarantee protection of human rights in HIV testing. HIV screening of job seekers in Uganda and insurance applicants in Ethiopia and Botswana are done despite clear laws and polices prohibiting them. Thus, considerable efforts have to be exerted to ensure that the policies and laws are implemented practically both in private and public spheres.

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