

Whether it should be a legally enforceable duty to disclose one's HIV status to a sexual partner: Critical analysis of article 14(1)(e) of the African Women's Protocol

Submitted in partial fulfillment of the requirements of the degree

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DECLARATION

I, Ngcimezile Nia Mbanu, declare that the work presented in this dissertation is original. It has never been presented to any other university or institution. Where other people's works have been used, references have been provided, and in some cases, quotations made. In this regard, I declare this work as originally mine. It is hereby presented in partial fulfillment of the requirement for the award of the LLM Degree in Human Rights and Democratisation in Africa.

Signed.....

Date

Supervisor: Dr Pratrice E. Vahard

Signature.....

Date.....

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DEDICATION

To the women of Africa...the likes of Nya Phakati, our day is coming sooner than later!

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
AMIS	African Union Mission in Sudan
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
FGM	Female Genital Mutilation
GBV	Gender-based violence
GIPA	Greater Involvement of People Living with HIV/AIDS
HIV	Human Immuno-deficiency Virus
HTC	HIV testing and counselling
ICCPR	Covenant on Civil and Political Rights
ICTR	International Criminal Tribunal of Rwanda
IPPF	International Planned Parenthood Federation
NGO	Non governmental organisation
SADC	Southern African Development Community
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population
UNGA	United Nations General Assembly
UNICEF	United Nations Children Fund
UNIFEM	United Nation Development fund for Women
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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CHAPTER 1: Introduction

1.1 Background

HIV and AIDS pandemic continues to bring about unparalleled havoc in Africa where the largest number of deaths and new infections in the whole worldwide are registered.¹ In 2007, nearly 23 million out of the total 33.2 million people who were estimated to be living with HIV were in Africa and over 1.6 million out of 2.1 million AIDS deaths were also estimated to be of Africans.² Sub-Saharan Africa is the most affected region with more than three in four (76%) of all AIDS deaths in 2007 occurring there.³ According to United Nations Economic Commission for Africa (UNECA), an estimated 1.7 million new infections occurred in Africa in 2007, half of these were young people aged 15 – 24 with the majority of them being women.⁴

The alarming rates of HIV prevalence in the face of many prevention mechanisms have sent the world on its feet for new solutions to arrest and reverse the accelerating rate of HIV infection.⁵ Successful prevention programmes are the key to halting the progress of HIV however the challenge remains in identifying the best suited programme or strategies to address a country or community specific context.⁶ Prevention programmes have included messages advocating for 'Abstinence, being faithful to one's partner and condom use every time one engages in sex (ABC), voluntary and compulsory HIV testing, criminalising wilful transmission, and vaccine development attempts. However, it is HIV

¹ Department of Social Affairs 'African Union commission HIV/AIDS strategic plan 2005-2007 and AIDS Watch Africa (AWA) strategic framework: Accelerating action to combat a continental emergency' 2005 2.

² UNAIDS/WHO 2007 AIDS epidemic update' 41
<http://www.youandaids.org/Infocus/epidemic%20update%202007.pdf> (accessed on 20 February 2008).

³ As above 7.

⁴ NK Poku & Others 2008 'Securing our future: Report of the Commission on HIV/AIDS and Governance in Africa' (CHGA)
http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080609_Securing_our_future.asp (accessed on 19 August 2008) 2.

⁵ See The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (The Abuja Declaration) 26 -27 April 2001, UNGASS 'Declaration on commitment on HIV/AIDS' 25-27 June 2001.

⁶ UNECA 2008 'Report of the Commission on HIV/AIDS and Governance in Africa' 73
<http://www.unaids.org/> (accessed on 27 October 2008).

testing that has long been a focal point of concern for those committed to the struggle against HIV.⁷

Although the benefits of knowing one's status are numerous, after a person tests HIV positive, he or she faces many difficult issues, including whether to disclose their HIV positive status to partners, friends, family, and health care providers as well as how to enter and adhere to care.⁸ HIV disclosure or partner notification (PN) over the last decade has received a lot of attention as a preventative measure to HIV. It has been considered that the principles of confidentiality and informed consent that accompany HIV testing and disclosure contribute to the spread of HIV as they allow people who test positive to keep their status confidential and refuse to share it with their partners.⁹ This has resulted into policies or laws that make disclosure compulsory by creating a legal duty on people who test positive to disclose their HIV status to sexual partners¹⁰ or allowing breach of confidentiality by health care providers through PN.

Article 14 (1) (e) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa¹¹ (Women's Protocol) provides for the right to be informed on the health status of one's partner if affected with sexually transmitted infections including HIV/AIDS. The article provides as follows:

'States parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

(e) the right to be informed on one's health status and 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...'

⁷ N Chingore 'Routine testing of individuals attending public health facilities: Are SADC countries really ready?' in F Viljoen & S Precious (eds) *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* (2007) 55.

⁸ Unpublished: BNN Mdlalose 'The stigma related to HIV and disclosure of their status' unpublished MA dissertation, University of Pretoria, 2006 2.

⁹ UNAIDS/WHO 'Opening up the HIV/AIDS epidemic; Guidance on encouraging beneficial disclosure, ethical partner counseling & appropriate use of HIV case reporting' 2000 8 http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp_en.pdf (accessed on 19 September 2008) .

¹⁰ This is usually through criminalising HIV exposure or transmission while accepting consent as a defence to the offence. See L Gable *et al Legal aspects of HIV/AIDS: A guide for policy and law reform* (2007) 13.

¹¹ Adopted in Maputo, Mozambique on 11 July 2003 and entered into force on 24 November 2005.

This article creates not only the right to know one's sexual partner's HIV status but also a duty on persons who have tested positive or alternatively health care providers to disclose such status to their sexual partners. The Women's Protocol is the only human rights instrument that specifically protects women's rights in relation to HIV and AIDS pandemic and to create the right to health information of one's partner as regards HIV and AIDS.¹² The above article creating the right and duty is however vague and unclear on how exactly states are to enforce the right and duty created.

1.2 Scope of study

This study will look at the possible interpretations and implementation methods that a state may adopt in accordance with internationally recognised standards and best practices. This will be in light of the special context of Africa and specifically as regards the disposition of women in the HIV and AIDS pandemic.

The study has chosen to focus on women specifically in recognition of the feminisation of HIV and AIDS pandemic due to gender inequality, low socio-economic status of women and gender-based violence (GBV).¹³ Any successful program to reverse the spread of HIV must address the needs of the most affected and vulnerable groups among which women top the list. In Sub-Saharan Africa which is the epicentre of the pandemic, young women between 15 – 24 years account for 75 % of HIV infections and are approximately three times more at risk of infections than young men of the same age.¹⁴ This is also in order to contribute to literature on promoting enjoyment of women's rights and ultimately gender equality in line with the objectives of the Women's Protocol.

¹² It is also the first human rights instrument to identify protection from HIV as a key component of sexual and reproductive rights. See E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 195.

¹³ An African common position to the high level meeting of the UN General Assembly Special Session(UNGASS) on AIDS' New York, 29 May – 2 June 2006, Poku(n4 above) xxv, 6 & 11: the continent accounts for nearly 80% of women with HIV/AIDS globally, Common Position 3 Brazzaville Commitment on Scaling up Towards Universal Access to HIV and AIDS prevention, Treatment, Care and Support in Africa by 2010 Assembly/AU/5 (VII) para 3.

¹⁴ WHO 'Violence against women and HIV/AIDS: Critical intersections' Information bulletin series, Number 1 .

1.3 Objective of the study

The objective of the study is to critically analyse article 14(1) (e) and establish possible interpretations that best advance the public health goal of arresting the spread of HIV in Africa.

1.4 Research questions

The following questions will inform the study on the implementation of article 14(1) (e) of the Women's Protocol:

- a) What possible interpretations may be attached to article 14(1) (e) and how best may these achieve public health goals?
- b) What enforcement mechanisms may be used in ensuring the enjoyment of the right to one's health information and compliance with the duty to disclose one's HIV status?

1.5 Methodology

This study will involve library and internet research. I intend to review relevant books, articles, surveys, reports, international instruments and legal documents on human rights and specifically focusing on women and HIV and comparative legislation on the issues in the study. The research will also involve interviews with experts in women's rights, gender equality and HIV and AIDS.

1.6 Literature Review

As HIV has become the leading cause of deaths among adults¹⁵ new prevention measures are designed to ensure the pandemic is contained. The resort to coercive¹⁶ or compulsory¹⁷ disclosure or shared confidentiality¹⁸ has now become the focus to curb the spread of HIV. Issues around HIV disclosure have in the past decade attracted a lot of attention. This is so not only because of the potential advantages of disclosure that

¹⁵ RJ Cook & others *Reproductive health and Human rights: integrating medicine, ethics and law* 2003 10.

¹⁶ OHCHR & UNAIDS HIV/AIDS and human rights: International guidelines, 1998 Guideline 4 <http://www2.ohchr.org/english/issues/hiv/guidelines.htm> (accessed on 28 January 2008).

¹⁷ Gable(n10 above) 13.

¹⁸ A Zuyderduin & I Melville Shared confidentiality – an ethical dilemma in Botswana Paper prepared for XIII AIDS Conference, Durban, 5 July 2000 <http://www.ditshwanelo.org.bw/images/Shared%20Confidentiality%20Paper.pdf> (accessed on 19 May 2007).

include social support, psychological and physical health benefits and medical treatment¹⁹ but also because of the negative consequences in some instances that include broken relationships, verbal and physical abuse and stigma.²⁰

One dilemma attached to the duty to disclose is how to balance protection of individual's rights against the community's interest in HIV prevention. Exploring the legal aspects of HIV/AIDS, Gable and others explain that the duty to disclose is grounded in the obligation to do no harm to others and the partner's 'right to know' about the risks they may face.²¹ They further explain that although there has been law enacted in some countries that allow public health professionals to disclose a patient's status to a partner who might be at risk, the primary responsibility is placed on the patient herself or himself.²²

The book by Gable briefly explains the different rights implicated as a result of disclosure of information and possible adverse consequences on the individuals' whose information is disclosed. Different approaches to disclosure of information are outlined with examples from different countries which will be a useful guide in the analysis of how best to implement article 14(1) (e). However the book is a general overview on legal aspects of HIV/AIDS and dedicates only a few pages to disclosure and/or PN with no specific focus on any particular group or context in the analysis.

Frans Viljoen explores both legal and practical challenges of disclosure by a patient or health care workers. Based on a study in peri-urban areas near Pretoria, South Africa, his monograph analyses the interface between disclosure of HIV status, the right to privacy and stigma on the basis of HIV/AIDS.²³ He argues that shared confidentiality is based on a mythical and idealised society and rather advocates for shared responsibility in which all sexually active people act with risk-consciousness.²⁴ I totally agree with this approach, however I also explore other approaches that may enforce the duty to disclose without necessary shifting focus or emphasis on the individual responsibility to always

¹⁹ S Maman & A Medley 'Gender dimensions of HIV Status disclosure to sexual partners: Rates barriers and outcomes' 2004 L Kahn 'Experiences of HIV/AIDS diagnosis, disclosure and stigma in an urban informal settlement in the Cape Peninsula: A qualitative exploration' 2004.

²⁰ Human Rights Watch Hidden in the Mealie meal: Gender based abuses and women's HIV Treatment in Zambia 2007 <http://hrw.org/reports/2007/zambia1207/> (accessed on 13 April 2008).

²¹ Gable(n10 above) 13 .

²² As above .

²³ F Viljoen 'Disclosure in an age of AIDS: Confidentiality and community in conflict?' in F Viljoen (eds) *Righting Stigma: Exploring a rights-based approach to addressing stigma* 2005 65.

²⁴ As above 92 .

protect one self.²⁵ I also agree with him that where such duty is imposed, it should not be absolute but rather be dependent on the fear of violence or 'others forms of reprisal'.²⁶

The other dilemma with the duty to disclose is the enforcement mechanism. This is manifested in the debate by authors who have written extensively on the role of coercive legislation in the fight against HIV especially on the use of criminal law.²⁷ By criminalising wilful transmission or exposure, the duty to disclose is enforced as consent to exposure to HIV in such offences is a recognised defence. The use of criminal law is an attempt to deter transmission or exposing others to HIV intentionally or wilfully by punishing those responsible with the belief that the threat of sanction will operate as a deterrent.²⁸

Unlike criminal law, the public health approach relies on the voluntary cooperation of those infected with HIV to consent to disclosure and/or provide details of partners for health workers to notify about the patient's status.²⁹

It has been argued that the functions of criminal law may not necessarily achieve public health goals of preventing the spread of HIV and that any efforts to achieve this have a greater chance of success in a climate of openness, confidentiality and public health education than in one of prohibition and punishment.³⁰ Patrick Eba in *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* analyses the use of both traditional criminal law offences and proposed or adopted new criminal law offences for prosecution of HIV transmission or exposure in SADC. He concludes that these merely add to the problem by disproportionately affecting members of

²⁵ See UNAIDS 2008 'Points for response to "reassessing HIV prevention" in science: Only does not work for HIV prevention' http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080605_UNAIDS_web_posting_Points_for_response_to_Reassessing_HIVprev_in_Science.asp (accessed on 14 September 2008).

²⁶ Viljoen (n 23 above) 93.

²⁷ Gabel JB Liability for 'knowing' transmission of HIV: The evolution of duty to disclose 21 Florida state (1993-94) *University Law Review* 981.

²⁸ Z Lazzarini *et al* Evaluating the impact of criminal laws on HIV Risk Behavior (2002) 30 *J.L. Med. & Ethics* 239.

²⁹ See Medical and Dental Professions Board of the Health Professions Council of South Africa 'Management of patients with HIV infection or AIDS'- professional guidelines that regulate disclosure. Adopted in July 2001 in Pretoria. LE Wolf & R Vezina Crime and punishment: Is there a role for criminal law in HIV prevention (2004) 25 *Whittier Law Review* 821 .

³⁰ G Malera 'The efficacy and limits of criminal punishment as a means of preventing HIV/AIDS in Malawi' 2007 1 *Malawi Law Journal* 48 A Turner 'Criminal liability and AIDS' 1995 *Auckland University Law Review* 875.

vulnerable and marginalised groups, fuelling stigma and discrimination, threatening public health messages and creating the potential for human rights violations.³¹

Eba however acknowledges that criminal law can be an effective tool only if it successfully incapacitates and deters those whose behaviour contributes to the HIV pandemic. With this in mind I intend to look at how criminal law may be adopted to enforce the duty in order to achieve the public health goal. I also intend to explore other possible enforcement mechanisms for the duty and right created in article 14(1) (e).

Reports and surveys have revealed the disadvantages of women in society³² and both the negative and positive outcomes as a result to the right to information to one's partner's HIV status or the duty to disclose.³³ These will inform the reflections of article 14(1) (e) accordingly. Amollo's dissertation; 'A critical reflection on Women's Protocol as a means to combat HIV/AIDS among women in Africa' focuses on inadequacies of regional and global instruments in relation to challenges faced by women in the HIV pandemic era and explores possible solutions under the Women's Protocol.³⁴ In a few paragraphs she highlights the role of the state in ensuring the right to information to one's health status and that of one's partner but also the possible challenges women may face in enforcing this right against their husbands.³⁵ My focus in the study however is on the duty created and how this may affect women when enforced against them.

1.7 Limitation of the study

The Women's Protocol is a relatively new instrument with provisions that are found in no other international instrument but the protocol itself. This is thus a journey among a few to analyse the instrument and explore the possible implementation strategies in order to

³¹ PM Eba 'Pandora's box: The criminalisation of HIV transmission or exposure in SADC countries' in F Viljoen & S Precious *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa* (2007)13- 54 .

³² See UN Reports The 45th Session of the Commission on the Status of Women: Gender discrimination and the HIV Pandemic <http://www.un.org/womenwatch/daw/csw/index.html>. Gender and HIV/AIDS Update on UN response 2002 <http://www.un.org/womenwatch/daw/csw/hivaids/unresponse.htm>. UNICEF The state of the world's children 2007: Women and children -the double dividend of gender equality. UNIFEM (n4 above), UNAIDS (n5 above).

³³ Maman & A Medley (n19 above), Human Rights Watch Hidden in the Mealie (n 20 above).

³⁴ <http://www.chr.com/> (accessed on 29 August 2008).

³⁵ As above 35-56.

achieve the best possible advantage to women in Africa. Further, as stated before the author has chosen to focus the study on women although HIV affects all people.

1.8 Overview of chapters

The study is divided into five chapters. The first chapter introduces the research questions, objectives, scope, methodology and background to the study. Chapter two explores the different reasons that place women in vulnerable status towards HIV and AIDS and the prospects under Women's Protocol. While as chapter three analyses article 14(1)(e) for possible interpretations and prospects, chapter four discusses the implementation strategies while highlighting the possible challenges. In chapter five recommendations are made after concluding the study.

CHAPTER 2: Women's vulnerability to HIV and AIDS

2.1 Introduction

Despite public awareness about the HIV and AIDS pandemic and medical interventions, HIV infection rates remain alarmingly high especially among women. According to the 2008 Joint United Nations Programme on HIV/AIDS (UNAIDS) report on the global AIDS Epidemic , women now account for about half of all people living with HIV and more than 60% of new infections in Africa.³⁶ Violence, negative social values, discriminatory laws, harmful cultural practices, poverty and inequalities are some of the factors that increase women's vulnerability to HIV.³⁷ The protection of the rights of women and girls in Africa and especially sub-Saharan Africa is essential to turning around the continent's AIDS crisis.³⁸

HIV responses must be guided by recognition of the root causes of the spread of the pandemic but also consideration of the realities on the ground especially as regards women's disposition. The Abuja declaration on HIV/AIDS, Tuberculosis and other related infectious diseases (The Abuja Declaration) recognizes biological vulnerability of women and girls to HIV infection and that economic and social inequality and traditionally accepted gender roles leave them in subordinate position to men.³⁹ Gender inequality, poverty and exclusion, early onset sexual activity, lower socio-economic status and economic dependence are some of the recognised root causes of the disproportionate affliction of Africa and women specifically by the pandemic.⁴⁰ Although both global and regional organizations have worked tirelessly in trying to combat the pandemic, no binding instrument was adopted until 11 July 2003 in Maputo, on Mozambique by the African Union.

The Women's protocol is a milestone as it is the first human rights instrument to address HIV and its underlining societal factors that affect HIV risk and vulnerability. Amnesty International has hailed its adoption as a landmark step in enhancing the promotion and

³⁶ UNAIDS 2008 Report on the global AIDS Epidemic http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed on 20 October 2008).

³⁷ UNAIDS et al Facing the future together: Report of the Secretary General's Task Force on Women, Girls and HIV in Southern Africa (2004), UNIFEM 'Turning the tide: CEDAW and the gender dimensions of the HIV/AIDS' pandemic' (2001) 7 http://www.unifem.org/resources/item_detail.php?ProductID=13 (accessed on 4 April 2008).

³⁸ Human Rights Watch 2003 Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa 3 <http://www.hrw.org/reports/2003/africa1203/> (accessed on 13 October 2008).

³⁹ The Abuja Declaration (n5 above).

⁴⁰ AUC Dept. of Social Affairs(n1 above) para 9 3.

protection of women's human rights on the continent, providing a comprehensive legal framework for holding African governments accountable for their violation of those human rights.⁴¹

This chapter will briefly look at some of the factors that contribute to women's vulnerability to HIV and different responses that have been developed in order to prevent the spread of HIV. The chapter will also explore the reasons why and how women have at times failed to fully benefit from or utilise the different strategies developed to combat HIV. It will then also look at how the different provisions under the Women's Protocol offer prospects in addressing such issues.

2.2 Women's vulnerability to HIV and AIDS

2.2.1 GBV

UN Secretary General Report on GBV revealed that violence against women is severe and pervasive throughout the world.⁴² The report also revealed that those who experience violence are at a higher risk of contracting HIV.⁴³ In this study the term GBV will be used synonymously with violence against women (VAW).⁴⁴ Women's Protocol defines VAW as follows:

..'all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm , including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war.'⁴⁵

A study by World Health Organisation (WHO) indicates that women who have experienced GBV show up to three fold increases in risk of HIV compared to those who have not.⁴⁶ GBV

⁴¹ <http://www.amnestyusa.org/document.php?lang=e&id=51444F4B0A2DDB0780256EA900424658>.

⁴² Report of the Secretary General 'in depth study on all forms of violence against women' A/61/122/Add 1 6 July 2006.

⁴³ As above.

⁴⁴ see Declaration on the Elimination of Violence Against Women,(UN Declaration on VAW) adopted by the UN General Assembly on 20 December 1993, UN DOC. A/RES/48/104 defines VAW as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm of suffering of women...'

⁴⁵ Art 1 of the Women's Protocol.

⁴⁶ This is according to studies conducted in Rwanda, Tanzania and South Africa. See WHO on VAW(n14 above).

increases the risk of contracting HIV in several ways that include exposure or transmission during or through sexual violence but also by setting off a cascade of behavioural responses that translate into increased sexual risk-taking by girls during adolescence if exposed to early sexual trauma.⁴⁷

The study by WHO further indicates that women or girls who have experienced violence are more likely to engage in high HIV risk behaviour including having multiple partners and engaging in transactional sex.⁴⁸ A study conducted in Soweto, South Africa by Dunkle and others indicated that women who had experienced intimate partner violence were two to three times more likely to engage in transactional sex than women who did not experience violence.⁴⁹ Lastly women who experience any form of violence in a relationship are less likely able to negotiate safe sex even when aware that their partner is promiscuous.⁵⁰

One common form of GBV is forced or coerced sex intercourse which at times may be with an infected partner without any protection. Further, risk of the transmission is increased during such intercourse as a result of trauma, vaginal lacerations, and abrasions that occur when force is used.⁵¹

Globally, women are reported to experience between 15 and 71 % of physical or sexual violence or both by an intimate partner.⁵² During conflict situations, women and girls are even more vulnerable to all forms of violence, in particular sexual violence and exploitation, including torture, rape, mass rape, forced pregnancy, sexual slavery, enforced prostitution and trafficking.⁵³ GBV, particularly the systematic and rampant use of rape and sexual violence in conflict situations, is acknowledged as a deliberate instrument of war by the

⁴⁷ WHO on VAW (n14 above) 53.

⁴⁸ As above.

⁴⁹ KL Dunkle et al ' Transactional sex among Women in Soweto , South Africa: Prevalence risk factor and association with HIV infection, (2004) 59 8 *Social Science and Medicine* 1581.

⁵⁰ Human Rights Watch 2003 Just die quietly: Domestic Violence and women's vulnerability to HIV in Uganda <http://www.hrw.org/reports/2003> (accessed on 13 October 2008).

⁵¹ WHO on VAW (n14 above) 53.

⁵² C Garcia-Moreno et al WHO Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses 2005 27. This study challenges the perception that a home is a safe haven for women by showing that women are more at risk of experiencing violence in intimate relationships than anywhere else (see page 4). This calls for strong domestic violence laws to ensure women's protection in the home and against GBV generally.

⁵³ See UN Secretary General's Report on Women, Peace and Security 2003.

International Criminal Court of Rwanda (ICCR).⁵⁴ In countries like Rwanda where the ethnicity of the child is determined by the father's ethnicity, rape has been used to alter the ethnic composition of the population.⁵⁵

Social-economic exclusion and deprivation is another form of psychological violence that involves withholding of resources, prevention from engaging in income generating activities or confiscating earnings.⁵⁶ In traditional Africa, the role of women is predominantly restricted to the private sphere of the family where women must fulfil the functions of childbearing, child care, and sustaining a family.⁵⁷ This makes women perpetually economically dependent to their partners as work in the private domain has no monetary value. Economic dependence makes women powerless and of inferior status in the relationship and thus they fail to assert themselves in decisions affecting them and the family or even to leave an abusive relationship. It also places her in service of her husband where sex is a duty and bearing children a survival mechanism to ensure continued relevance.⁵⁸ In such a context a woman is willing to take the risk of contracting HIV as long as she is assured of economic support for herself and her children.

Women's disposition is further reinforced by divorce and property laws and customary practices that disadvantage women who try to escape abusive marriages.⁵⁹ Further stereotypes that view a women's place as the home are socialized into the life of girl children who in turn grow up with the belief that indeed their relevance is in the home and as such do not fully explore their potential in other areas or are in fact denied the chance to do so.⁶⁰

GBV is both a consequence and cause of gender inequality.⁶¹ It is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on the basis of equality

⁵⁴ N Omarjee & U Lau 'Conflict in Africa: Intersectionality of GBV and HIV/AIDS www.powa.co.za/documents/Conflicts%20in%20Africa%20web%20doc.doc (accessed on 9 October 2008).

⁵⁵ www.rhrc.org/pdf/gbv.pdf.

⁵⁶ WHO on VAW (n14 above) 1.

⁵⁷ F Viljoen International human rights law in Africa 2007 Oxford University Press 269.

⁵⁸ See WHO 2003 Integrating Gender into HIV/AIDS programmes: A review paper 13 http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf (accessed on 15 August 2008).

⁵⁹ Human rights Watch Hidden in the Mealie (n20 above) 6.

⁶⁰ E Annan-Yao 'African gender research in the new millennium: Gender relations and perspectives, directions and challenges' 4.

⁶¹ UN Declaration on VAW 9 (44 above)5.

with men.⁶² HIV further complicates women's disposition by further exacerbates pre-existing human rights violations in society such as gender inequality and social-economic exclusion and deprivation.⁶³

2.2.2 Harmful traditional practices and discriminatory laws

In Africa as in many societies, cultural traditions and modern law conspire to marginalize women and girls making them more vulnerable to HIV.⁶⁴ Viljoen summaries traditional practices that predispose women to infection to include:

'...polygamy, the precarious position of widows (through wife inheritance or practices allowing for sex with a widow by the deceased's brother), early marriages, initiation practices (allowing for sexual initiation for girls), and female genital mutilation (FGM).⁶⁵

According to the Centre for Reproductive Rights, FGM is an umbrella term for a number of culturally motivated practices that involve partial or complete cutting of female genitals, usually performed in childhood or adolescence.⁶⁶ The practice is widespread in 28 African countries and the practice is reported to increase the HIV transmission or risk by use of unsterile instruments in cutting and also because some FGM is associated with chronic genital injury and tearing, ulceration, and delayed healing of injuries hence increasing HIV transmission risk.⁶⁷

Discriminatory laws include unequal property and inheritance rights, and divorce laws that exacerbate women's economic dependence on their husbands.⁶⁸ Economic dependence as a result of exclusion or deprivation as discussed above increases women's vulnerability to HIV as they fail to negotiate safe sex or to leave abusive relationships.

⁶² Para 1 General Recommendation 19 of the Committee on the Elimination of All Forms of Discrimination Against Women.

⁶³ Viljoen (n57 above)586.

⁶⁴ As above 595 .

⁶⁵ As above 596.

⁶⁶ Quoted in Human Rights Watch Hidden in the Mealie (n20 above) 53.

⁶⁷ As above 54.

⁶⁸ Human Rights Watch Hidden in the Mealie (n20 above)1.

2.3 HIV prevention mechanism

The HIV and AIDS pandemic continues unabated in Africa and Southern Africa remains the most affected area globally. About 40% of all people living with HIV globally are living in the Southern African Development Community (SADC) region with 37% of all new infections occurring there.⁶⁹ Although HIV and AIDS prevalence is on the rise in most countries, some countries like Kenya, Uganda, Senegal and Zimbabwe have recorded a decline in adult prevalence. This has been linked to investments made in prevention interventions as well as increased deaths.⁷⁰

The prevention and control of HIV infection depends on the successfulness of strategies to prevent new infections and treat currently infected individuals.⁷¹ The collective stock of knowledge about gender determinants of risk and vulnerability to HIV and the consequences of AIDS that has grown substantially over the past decade must be put in use as it is key to successful prevention mechanisms.⁷² This is because of the feminization of HIV and AIDS as discussed before which requires that women and their particularities be considered as priority in preventing the spread of the HIV and AIDS pandemic.

The most common prevention mechanism has been HIV testing and counselling. It is believed that once a person knows their HIV status coupled with safe sex messages, this will inspire behaviour change that will greatly reduce the number of potentially HIV transmission sex acts.⁷³ Further knowledge of one's status may lead to access to treatment, care and support where the results are positive. However, only 10% of people in Africa have access to testing and counselling services.⁷⁴ This situation is because of several reasons however as regards Women and girls, human rights abuses are some of the major factors that impede their access to HIV information and services including testing and treatment.⁷⁵

⁶⁹ SADC Expert think tank meeting on HIV prevention in high-prevalence countries in Southern Africa report 2006 http://data.unaids.org/pub/Report/2006/20060601_sadc_meeting_report_en.pdf (accessed on 21 September 2008).

⁷⁰ As above 8.

⁷¹ Maman & Meadley (n 19 above) 4.

⁷² WHO 2003 Integrating Gender into HIV/AIDS programmes: A review paper http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf (accessed on 15 August 2008).

⁷³ Chingore (n7 above) 61.

⁷⁴ UNAIDS, 'Consultative meeting on HIV testing and counselling in the Africa region' Johannesburg South Africa (15 -17 November 2004) 15.

⁷⁵ Human Rights Watch (n50 above) 6.

Some women in Zambia interviewed by the Human Rights Watch revealed that their husbands and other intimate partners, beat, kicked or emotionally abused them when discussing HIV testing and treatment.⁷⁶ The survey by Human Rights Watch also revealed a perception by women that they required permission from their husbands before going for HIV testing.⁷⁷ This perception is rooted in the cultural norms that women must be submissive and subordinate to their husbands in every aspect of their life especially regarding sexual and reproductive issues.

The other approach to HIV prevention has been advocating for abstinence, being faithful, and the use of condoms (ABC). Abstinence may at times not be a choice to women and girls whose first sexual encounters are usually forced or coerced.⁷⁸ Being faithful is only effective where both partners adhere to it however in the African context, marriages are potentially polygamous and it is socially acceptable for men to have multiple parties.⁷⁹ Condom use is predominantly a male decision while alternative contraceptives remain unavailable or inaccessible by women.⁸⁰

However, although this section has highlighted some of the challenges women may face in benefiting from the two main approaches in combating the spread of HIV and AIDS pandemic, this is not to say that the two approaches have been totally ineffective. However, long-term responses to the HIV and AIDS pandemic requires a human rights-based approach that will address the human rights violations and gender inequality that tremendously contribute to HIV vulnerability in collaboration with other approaches in the fight against HIV.

A human rights-based approach to HIV ensures that matters that are often considered discretionary are recognized as legitimate entitlements of all individuals and may be enforced accordingly.⁸¹ This is the approach that is being adopted by many responses to HIV including the Women's Protocol.

⁷⁶ Human Rights Watch Hidden in the Mealie meal (n20 above) 22.

⁷⁷ As above 24.

⁷⁸ Garcia-Moreno (n 54 above) 7.

⁷⁹ UNAIDS 'Facing the future together: Report of the Secretary General's Task force on Women, Girls and HIV/AIDS in Southern Africa' 2004 9 <http://womenandaids.unaids.org/regional/docs/Report%20of%20SG's%20Task%20Force.pdf> (accessed on 3 April 2008).

⁸⁰ As above.

⁸¹ UNAIDS (n36 above) 66.

2.4 The Women's Protocol

2.4.1 Drafting and adoption

Having recognized the insufficient protection of women's rights in the existing regional human rights instruments, Women in Law and Development in Africa (WILDAF) and other non-governmental organizations (NGOs) working in the field of women's rights spearheaded campaign for the drafting and adoption of the Women's Protocol.⁸² Although the African Charter on Human and People's Rights (The African Charter) guarantees the rights of both men and women, it was argued that it did not specifically address several women specific concerns like FGM, forced marriages and inheritance by women.⁸³

The process of coming up with the Women's Protocol began in 1995, after its need was affirmed by OAU Assembly of Heads by resolution.⁸⁴ Several consultative meetings were held where drafts were drawn in Banjul, Dakar and Kigali were the final draft was made.⁸⁵ The Kigali draft was eventually merged with a draft Convention on Harmful Traditional Practices by the OAU Gender Unit within the OAU Education, Science, Culture and Social Affairs Department in collaboration with the Inter-African Committee on traditional Practices.⁸⁶

It took eight years after the drafting process began for African leaders to finally agree on a text and adopt the Women's Protocol on 11 July 2003 during its second ordinary summit in Maputo, Mozambique. The protocol guarantees both civil and political rights of women as well as economic, social and cultural rights. It is the first human rights instrument that addresses issues of polygamy, HIV, FGM and medical abortion in a binding framework.⁸⁷

The Women's Protocol entered into force on 24 November 2005 having attained the required 15 ratifications by member states. Currently 23 member states have ratified the Women's Protocol out of the 53 member states of the AU.

⁸² MS Nsibirwa, 'A brief analysis of the draft protocol to the African Charter on Human and Peoples Rights o the Rights of Women' (2001) 1 *African Human Rights Law Journal* 40 .

⁸³ WILDAF 'The African Charter on Human and Peoples' Rights and the Additional Protocol on Women's Rights' <http://www.wildaf.org.zw/news4.html> (accessed on 29 August 2008).

⁸⁴ OAU Doc AHG/Res 240 (XXXI), Nsibirwa (n 82 above) 41.

⁸⁵ Viljoen (n57 above) 267.

⁸⁶ As above See also Letter by OAU Legal Counsel to the Chair of the African Commission, OAU DOC CAB/LEG/72/Vol II, dated 7 March 2000

⁸⁷ As above

2.4.2 Overview of relevant provisions

The Women's Protocol comprises of a preamble and twenty-nine articles that aim to give greater attention to the human rights of women in Africa. The preamble to the Women's Protocol recognizes the existence of other human rights instruments dealing with women's rights and the defiance in implementation of such instrument as the major problem to the promotion of women's right. Determined that women's rights are promoted, the Women's Protocol in article 1 incorporates clear and expansive definitions of discrimination against women, harmful practices and Violence against women. Discrimination against women deals with both the effects of such treatment and the objective while violence against women includes even economic harm apart.⁸⁸

As an aspect of the right to life, integrity and security, article 4 requires that states parties enact laws and enforce laws that prohibit and punish all forms of violence against women including unwanted or forced sex whether this takes place in private or public. The provision also urges states to identify the causes and consequences of VAW while taking appropriate measures to prevent and eliminate such acts and to make provision for victims including rehabilitation and reparation.

Article 5 prohibits harmful practices that includes FGM and calls upon state parties to put in place legislative, educational and health services measures that respond to harmful practices which negatively affect the human rights of women and are contrary to recognized international standards. Marriage and divorce rights are provided for in articles 6 and 7. States are required to ensure that marriage is by consent of both parties who must be 18 years or above.⁸⁹ Further states are to ensure that every marriage is registered in order to be legally recognized and that monogamy is encouraged while protecting the rights of women in polygamous marriages.⁹⁰ Article 6(j) requires member states to ensure separate ownership of property by women during marriage. This is to do away with African customs that perpetually regard women as minors who have no separate personality or identity from their husbands.⁹¹ During separation, divorce or annulment of marriage, states parties must

⁸⁸ Art 1(f) and (j) Women's Protocol

⁸⁹ Art 6 (a) & (b) Women's Protocol

⁹⁰ Art 6 (c) &(d) Women's Protocol

⁹¹ KSA Ebeku 'A new hope for African women: Overview of Africa's protocol on women's rights (2004) 13 *Nordic Journal of African studies* 267

ensure that this is by judicial order and that both parties have the right to equitable sharing of joint property.⁹²

Article 10 and 11 provide for the right to peace and protection of women in armed conflicts. States parties are enjoined to protect women against all forms of violence, rape and other forms of sexual exploitation which must be considered as war crimes, genocide and/or crimes against humanity.⁹³ Perpetrators must accordingly be brought to justice and the AU has set a good example on this through the establishment of an Independent Commission of Enquiry by the African Union Commission in response to allegations of sexual misconduct by the African Union Mission in Sudan (AMIS).⁹⁴

Article 14 provides for health and reproductive rights that include the right to protect one-self and to be protected against sexually transmitted infections, including HIV/AIDS. The article also guarantees the right to one's fertility, to decide whether to have children, the number and spacing of children, and the right to have family planning education. This approach is a shift of paradigm that recognizes that health is more than just the absence of disease and infirmity but a state of complete physical, mental and social well-being.⁹⁵

The women's Protocol also provides for widows' rights and rights to inheritance in articles 20 and 21. States are to take appropriate legal measures that ensure widows enjoyment of all human rights and that they are not subjected to inhuman, humiliating or degrading treatment.⁹⁶ Widows are further guaranteed the right to an equitable share in the inheritance of the property of her husband.⁹⁷

Finally states parties are enjoined to provide appropriate remedies to any woman whose rights or freedoms as recognized in the Women's Protocol are violated.⁹⁸ Further state parties are to ensure implementation of the Women's Protocol at the national level through

⁹² Art 7(a) and (d) Women's Protocol

⁹³ Art 11(3) Women's Protocol

⁹⁴ 'AU inaugurates inquiry panel on allegations of sexual abuse in Darfur' Sudan Tribune http://www.sudantribune.com/article.php3?id_article=15092

⁹⁵ C Kisoona *et al* Whose right? AIDS review 2002 14

⁹⁶ Art 20 (a) Women's Protocol

⁹⁷ Art 21(1) Women's Protocol

⁹⁸ Art 25 Women's Protocol

legislative and budgetary provision and that this shall be monitored through submission of periodic reports.⁹⁹

2.4.3 Prospects under the Women's Protocol

The Women's protocol came as a result of African born initiative and it addresses the most relevant issues affecting women in the continent. It provides a good legal framework that advances gender equality, women socio-economic empowerment and prevention of GBV which are priorities for scaling up access to HIV prevention, treatment and care measures.¹⁰⁰ It also addresses harmful traditional views that take shape into stereotypes, customs and norms which, in turn, give rise to a multitude of legal, political and economic constraints on the advancement of women.¹⁰¹ This is done by guaranteeing enforceable rights that include specific health and reproductive rights, widows' and inheritance rights, and special protection to elderly women. Implementation of the Women's Protocol offers great opportunity to women in Africa who suffer abuse and infringement of their rights in these areas.

Further the Women's Protocol sets the right standards for women treatment in Africa that guarantees the advancement of women's rights which has been agreed upon by the African leaders themselves. Once implemented, the status of women in Africa will improve tremendously and thus it is important that all African countries embrace the Women's Protocol as their working guide in all matters affecting women through ratification and domestication of the Women's Protocol.

2.5 Conclusion

The adoption of the Women's Protocol is a step in the right direction in advancing women's rights and combating the HIV pandemic. This is because the Women's Protocol provides a critical framework that addresses underlying causes and consequences of gender inequality, human rights abuses and cultural norms that perpetuate the vulnerability of women to HIV and act as barriers to their full enjoyment of their rights. The Women's Protocol also fills a major gap in the regional human rights system, which until now had not developed a comprehensive legally binding framework for the promotion and protection of women's human rights.

⁹⁹ Art 26 Women's Protocol

¹⁰⁰ AU (13 above) 2

¹⁰¹ BSN Khutsoane 'gender-based violence and the Convention on the Elimination of All Forms of Discrimination Against Women' in Centre for Human Rights Gender-based violence in Africa: *Perspectives from the Continent* 3

CHAPTER 3: The right to know

3.1 Introduction

In order for women to enjoy health and reproductive rights, the Women's Protocol provides for the right to be protected and to protect self from sexually transmitted infections that include HIV.¹⁰² In order to be protected from HIV, one must be aware of the causes and transmission modes of HIV and also have access to prevention technologies. Knowledge of one's status and the status of one's sexual partner can influence couples behavior towards protecting themselves from HIV risk.

Under article 14(1) (e) member states to the Women's Protocol are obliged to ensure that women's right to be informed of their health status and of the health status of their partner is respected especially where infected with HIV. The purpose of such information is to arguably enable women and their partners to protect themselves from HIV infection. This chapter will explore ways of ensuring the enjoyment of both the right to information and the right to know in combating HIV.

3.2 The right to information

3.2.1 HIV and AIDS education and information

HIV and AIDS education and information promote public awareness about the causes, modes of transmission, consequences, and modes of prevention and management of the pandemic. States through its various relevant Ministries, Departments, authorities or and agencies at national and local levels must ensure that its citizens are well equipped with the right information on HIV and on how to protect one self.¹⁰³

The known modes of HIV transmission are: i) by an injection of infected blood, ii) by unprotected sex with an infected person, li) by sharing needles, iv) by an infected mother to a fetus, and v) an infected mother to a new born through breast-feeding.¹⁰⁴ A study by United Nations International Children Fund (UNICEF) in 2006 revealed that many young women did not know how HIV is transmitted or how to protect one-self through use of a condom.¹⁰⁵ In

¹⁰² Art 14(1)(d) of the Women's Protocol.

¹⁰³ SADC PF Draft Model Law on HIV (unpublished).

¹⁰⁴ Centre for disease control HIV and its transmission <http://www.cdc.gov/hiv/pubs/facts/transmission.htm>(accessed on 7 August 2008).

¹⁰⁵ UNICEF/UN Statistics Division millennium indicators database <http://www.millenniumindicators.unorg> (accessed on 4 September 2008).

the absence of a vaccine or cure for HIV and AIDS, education remains the single most important method of prevention.¹⁰⁶ The Abuja Declaration recognises the essential role of education in combating HIV and AIDS.¹⁰⁷ It states that;

[e]ducation constitutes the most powerful, cost effective tool for reaching the largest number of people with information and personal development strategies that promote long-term behavior change.'

Information, education and communication (IEC) on prevention must be specifically designed to ensure behavioral change that translates in reduced high risk activities by addressing entrenched social and religious norms and encourage condom use and monogamy.¹⁰⁸ IEC must be accurate, clear, comprehensible and suitable to local languages and literacy levels; it must take into account the local dynamics of the epidemic while addressing both the risk and the vulnerability factors of vulnerable groups.¹⁰⁹ IEC not only form the basis for successful HIV prevention programmes but also helps reduce widespread discrimination and stigma against those who are infected through the right knowledge of how HIV is transmitted.¹¹⁰

States must involve different levels of stakeholders that must include religious and traditional leaders in disseminating IEC to have a wide influence in the targeted areas or communities. There is widespread awareness of HIV and AIDS; however more needs to be done to ensure behavioral change and to address issues of fear and stigma associated with the pandemic and this must be through both the formal and informal education sectors accessible to all both in urban and rural areas.

An analysis of two countries in Africa, Senegal and Uganda where they have been able to reduce HIV prevalence reveal that maximum use of existing structures was made to provide information and services to communities at high risk.¹¹¹ Through political leaders, dialogue was made with religious and community leaders on prevention mechanisms and government also collaborated with other stakeholder in providing both prevention messages and

¹⁰⁶ LO Gostin & Z Lazzarini *Human rights and public health in the AIDS pandemic* 1997 30.

¹⁰⁷ The Abuja Declaration para 10.

¹⁰⁸ Kisoona (n98 above) 54.

¹⁰⁹ Gostin (n107 above) 30.

¹¹⁰ 'HIV/AIDS prevention through Information, Education and Communication.' <http://www.gtz.de/9> (accessed on 20 March 2008).

¹¹¹ UNECA 'Securing our future: Report of the Commission on HIV/AIDS and Governance in Africa' 74.

services.¹¹² Such broad based education work can change behaviour that enables transmission of HIV which is mediated directly by human behaviour.

IEC must be accompanied with the appropriate HIV prevention technologies for knowledge alone will not reduce the risk of HIV transmission. According to UN guidelines the state must make available prevention technologies that include condoms, lubricants, sterile injection equipment, antiretroviral medicines that prevent mother-to-child transmission, safe and effective microbicides and vaccines once available.¹¹³ All this must be done along with empowerment of the marginalized and most vulnerable to HIV by addressing human rights abuses and societal factors like women's low socio-economic status as discussed in the previous chapter.

3.2.2 HIV testing and counseling (HTC)

Widespread testing facilitates both increase access to HIV treatment and prevention of new infections by bringing more people into the health care system where their status is discovered and provision of information on how to prevent and manage HIV transmission is given.¹¹⁴ Counseling is linked to HIV testing to ensure that a client makes informed consent decision before undergoing the test but also to maximize the benefits of the process.¹¹⁵ Informed consent is emphasized due to the consequences that may follow as a result of undergoing the process. Although knowing one's serostatus has its benefits, it also has negative consequences that include emotional stress, stigma and discrimination and the question of disclosure and its consequences.¹¹⁶

HTC provides information and support that leads to HIV prevention, care and treatment services. It is the first step towards early care and treatment services and also opportunity to distribute appropriate tools and information to reduce the risk of HIV transmission.¹¹⁷ According to UNAIDS, HTC has proven to reduce risk behavior in people who test positive

¹¹² As above.

¹¹³ UNAIDS/UNHCHR (n 16 above) guideline 6.

¹¹⁴ Viljoen (n57 above) 602 .

¹¹⁵ UNAIDS/WHO Policy statement on HIV testing http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf (accessed on 7 September 2008).

¹¹⁶ BNN Mdlalose 'The stigma related to HIV and disclosure of their status' unpublished dissertation MA(clinical psychology) 2006 2.

¹¹⁷ AU progress report on the implementation of the commitments of the May 2006 Abuja Special Summit on HIV/AIDS, Tuberculosis and Malaria (ATM) Assembly/AU/4(XI) 11.

but less so in HIV negative people.¹¹⁸ It is also an important entry point for intervention that prevents HIV infection to infants and young children.¹¹⁹ HTC is also believed to be an important component of the normalization of the epidemic which is then thought to reduce HIV related stigma and discrimination.¹²⁰

HTC may be voluntary or mandatory. Voluntary counseling and testing (VCT) is when an individual submits himself or herself, out of free will and consent to undergo the HIV test. This is also known as client-initiated HTC. VCT may be anonymous or name-based with the latter being one where the identity of the individual is recorded and kept in confidence (also known as confidential test) while the former requires no name and results are received under a code system.¹²¹ With the realities of stigma and discrimination assorted with HIV, anonymous testing is hoped to encourage more people to undergo the process without the risk of being discovered by others if tests HIV positive.¹²²

One recently adopted approach to HTC is routine testing which is not client-initiated but by a health care provider, provider-initiated. As treatment schemes are being rolled out, the concept of making HIV testing a routine practice performed on people during their first contact with a health service or when symptoms suggest the possibility of HIV infection has received wide promotion.¹²³ The HIV test is made part of the services a person gets once in contact with a health system just like any other test a health provider may recommend or as a standard component of medical care.¹²⁴

Routine testing is a reaction to the realities that fewer than one in ten people with HIV-positive serostatus are aware because of poor access to HIV testing or serious problems with its delivery and intake.¹²⁵ There are two models of routine testing namely 'opt-in' or 'opt-

¹¹⁸ UNAIDS (n25 above).

¹¹⁹ WHO Increasing access to knowledge of HIV status: Conclusions of a WHO consultation, 3-4 December 2001.

¹²⁰ Viljoen (n57 above) 603.

¹²¹ RNC Pottler-Fishel 'Improper bedside manner: why state partner notification laws are ineffective in controlling the proliferation of HIV (2007) 17 *Health Matrix* 151, see also UNAIDS/WHO Policy statement on HIV testing <http://www.who.int/hiv/pub/vct/statement/en/>.

¹²² As above.

¹²³ D Tarantola 'HIV testing; Breaking the deadly cycle 8 (2) *Health and Human Rights* 38,.

¹²⁴ WHO/UNAIDS 2007 Guidance on provider-initiated HIV testing and counselling in health facilities 5 http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf (accessed on 17 October 2008).

¹²⁵ WHO The right to know: New approaches to HIV testing and counseling 2003 1 <http://who.int/hiv/en> (accessed on 21 August 2008).

out' testing. Opt-in involves the patients explicit consent to HTC after being offered while opt-out requires that the patient expressly refuses or declines to be tested for otherwise consent is inferred after notifying the patient that the test will be carried out.¹²⁶ This is to ensure that more people know their HIV status and access treatment promptly where available however this approach has been criticized as implicating human rights. This is because it is questionable whether 'opting out' is really an option for many of the patients who may feel coerced by virtue of the relationship of patient and health care provider.¹²⁷

VCT with its specific requirement of counseling, informed consent and confidentiality, for the most part meet both public and human rights concerns and as such it must be encouraged.¹²⁸ Where routine testing is the approach adopted, government must address the concerns of coercion and reduced counseling during the process due to insufficiently trained or inadequate staff that have to cope with the numbers of those undergoing the process.¹²⁹ As HIV and AIDS programs are being expanded, health systems of low and middle income countries are stretched and unable to cope with the additional burden, unless additional resources are located as noted in the AU status report on HIV/AIDS in Africa.¹³⁰ Both quality and quantity must be emphasized for otherwise routine testing may undermine the trust of communities in the health providers and result in people avoiding visiting Health service providers.¹³¹ Further it must ensure that full consent of the patient is obtained before the test.

The other type of HIV testing is mandatory or compulsory testing which does not require the consent of the individual for the process. Some countries require HIV testing on a mandatory basis for immigration, non-citizen employment¹³² and, military personal to assess fitness¹³³

¹²⁶ Chingore (n7 above) 58.

¹²⁷ AIDS and Human Rights Research Unit 2007 *Human rights protected? Nine Southern African country reports on HIV/Aids and the law* Pretoria University Law press 19 In Botswana less than 5 % of people involved in routine testing opted out in 2005 and this raised concerns of whether free and full consent is really exercised in such an approach.

¹²⁸ Chingore (n7 above) 59.

¹²⁹ AU progress report (n117 above) noted several factors that hamper effective promotion of health that included weak health systems due to inadequacies in human resources.

¹³⁰ As above 8.

¹³¹ See Tarantola (n123 above) 39 & AIDS and Human Rights Research Unit(n127 above) 19.

¹³² For instance in Botswana as stated in AIDS and Human Rights Research Unit(n127 above) 23

¹³³ See Lesotho new Recruitment Policy for Lesotho Defense Force quoted in above 63,

All mandatory testing must be accompanied by counseling both pre-testing and post testing and referrals to medical psychosocial services for those who receive a positive test result.¹³⁴

Information on one's status coupled with how to prevent infection may help individuals protect themselves from HIV but also their partners where they test positive. Governments must therefore scale up access to HIV testing and prevention mechanisms as well as treatment for those already infected. In doing this it must also be remembered that women, sometimes due to gender inequality, socio-economic status and human rights abuses fail to protect themselves even when aware of the risk and prevention mechanisms. These factors must therefore be taken into account and addressed alongside provision of information.

3.3 The right to be informed on the health status of one's partner

The right to be informed on the health status of one's partners is an important part of managing sexually transmitted infections if the knowledge of the potential risk translates into reduced risky behaviour and access to necessary treatment.¹³⁵ This right creates a duty of disclosure where a person tests HIV positive and it is grounded in the obligation to 'do no harm' to others and the partner's 'right to know' about the risks they may face.¹³⁶ To ensure the enjoyment of this 'right to know', states must adopt mechanisms that ensure PN or shared confidentiality.

PN is a process whereby a patient who undergoes HIV testing is asked to disclose this fact to their sexual partners especially where the result is for a positive serostatus. If the patient is unable or unwilling to do so, health care providers are authorized to do so where it is considered that there is potential risk of infection.¹³⁷ PN in which the patient herself or himself takes up the responsibility of notifying sexual partners is known as patient referral while the other one by the health care provider is provider referral.

Provider referral or contact tracing involves gathering of information from a person who is newly diagnosed with HIV in order to identify and notify the person's contacts of their risk to contracting HIV with or without the patient's consent.¹³⁸ The purpose of PN is to encourage

¹³⁴ UNAIDS/WHO (n 124 above)

¹³⁵ Maman & A Medley (n 20 above) 3

¹³⁶ Gable(n10 above)13

¹³⁷ See Lesotho National HIV and AIDS policy 2006 as quoted in AIDS and Human Rights Research Unit (n above) 59 See also South African Medical Association's Guidelines on Human Rights and Ethical guidelines on HIV as above 239.

¹³⁸ Pottker-Fishel (n122 above) 153.

HIV testing, to protect the public from future HIV spread, and to acknowledge the contact's right to know that he/she may be infected with HIV.¹³⁹

Shared confidentiality or beneficial disclosure on the other hand is confidentiality that is shared with others including sex partners, family members and close friends at the discretion of a person who has been tested for HIV.¹⁴⁰ This is also known as voluntary disclosure which is premised on the free will of the patient and may be general 'coming out' or more circumscribed, personally directed, disclosure.¹⁴¹ Although there has been law enacted in some countries that allow public health professionals to disclose a patient's status to a partner who might be at risk, the primary responsibility is placed on the patient herself or himself.¹⁴² This may be confirmed by a review of laws or policies of nine countries by the AIDS and Human Rights research Unit.¹⁴³

In Botswana national policy on HIV and AIDS emphasise the responsibility of persons with HIV to protect others but prohibits health provider disclosure.¹⁴⁴ In Lesotho, the National policy framework on HIV provides that the patient must be counselled and encouraged to inform their partner of their HIV test results and only when they request the health provider to do so must the provider carry out PN. This responsibility is made into a legally enforceable duty by the Sexual Offences Act of Lesotho which criminalises any sexual act of an infected person without disclosure of their Status.¹⁴⁵ Malawi provides that the patient must be encouraged to disclose but if persistently refuses to do so, the health provider is empowered to do so without the patient's consent.¹⁴⁶ Mozambique has no disclosure requirement whatsoever while Namibia authorises provider disclosure only where it is considered that there is a real risk of transmission to the partner exists and the patient has refused to notify the partner.¹⁴⁷ Swaziland's National Policy encourages partner disclosure and makes

¹³⁹ As above .

¹⁴⁰ Viljoen (n 23 above) WHO 2000 'Opening up the HIV/AIDS epidemic:(n9 above). See also www.3.who.int/whosis/factsheets, Fact Sheet 1.

¹⁴¹ As above 67.

¹⁴² Gable (n10 above) 13.

¹⁴³ AIDS and Human Rights Research Unit (n127 above).

¹⁴⁴ As above 18.

¹⁴⁵ As above 71.

¹⁴⁶ As above 99.

¹⁴⁷ As above 182.

disclosure of one's status a legally enforceable duty in Sexual Offences Act of 2003.¹⁴⁸ Zambia and Zimbabwe encourages individual responsibility for PN without creating a distinct or direct legal duty of disclosure.¹⁴⁹ South Africa's Medical association's Guidelines on human rights and ethical guidelines on HIV state that the health provider may be breached with consent of patient or where absolutely necessary to protect third party.¹⁵⁰

3.4 International standards and best practices

3.4.1 The right to be informed on one's HIV status

UNAIDS and WHO position on HTC is that it should always be carried out in an environment of free consent made after relevant information has been provided.¹⁵¹ VCT is thus strongly supported and encouraged as the best way of ensuring that many people have access to virtual information on prevention and treatment of HIV. However having recognised the need for additional approaches in order to increase access to HIV testing and counseling, UNAIDS and WHO recommends provider initiated HIV testing. This is as a result of low numbers of people aware of their HIV status and the great opportunity health care providers can be utilized to fill the gap.

The two organizations endorse the opt-out approach to provider-initiated HIV testing whereby the patient equipped with the right pre-testing information has to specifically refuse the test which is offered as part of the normal medical services one can get at a health service provider.¹⁵² WHO and UNAIDS do not support mandatory or coercive HIV testing and emphasize that provider-initiated HIV testing must be carried out with the patient full consent having been equipped to make an informed and voluntary decision to be tested.¹⁵³

HIV testing should be voluntary as mandatory HIV testing is neither effective for public purposes nor ethical, because it denies individuals choice, and violates their rights including the right to health, right to privacy and ethical duties to obtain informed consent and maintain confidentiality.¹⁵⁴ UNAIDS and WHO only support mandatory screening for HIV and other

¹⁴⁸ As above 297.

¹⁴⁹ As above 376.

¹⁵⁰ As above 239.

¹⁵¹ UNAIDS/WHO (n124 above) 5.

¹⁵² As above 5.

¹⁵³ As above 6.

¹⁵⁴ WHO (n124 above) 2.

blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products.¹⁵⁵

Best practices are therefore policies or laws in countries where HTC is voluntary at all times as research has shown that otherwise the public health goals are undermined however there is no single established country hailed as the best example on this issue. It is therefore imperative that the Social affairs department in the AUC that is mandated with overseeing health issues carries out research and establishes specific best practices in countries within the region for others to emulate.

3.4.2 The right to be informed of the HIV status of one's partner

UNAIDS and WHO encourage voluntary disclosure between partners and the provision of professional counselling for both the HIV-infected client and their partner.¹⁵⁶ This is the same approach adopted in the UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights.¹⁵⁷ However where the patient is unable or unwilling to notify his or her partner and it is considered necessary to inform the partner this must be done after weighing the harms and benefits of all parties. It is therefore recommended that 'public health legislation should authorize, but not require that health care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their sexual partners of the HIV status of their patient.'¹⁵⁸

Internationally accepted standards and best practices in advancing public health goals especially as regards HIV demand that voluntariness be promoted. However, again there was no established best practice example found in the form of a country whose practices are upheld in this regard.

3.5 Conclusion

This chapter has explored the possible mechanisms government may adopt in order to guarantee the right to information on one's HIV status and the status of one's partner. This has been done in the light to protection and to protect one-self for contracting HIV. It has further high lightened the internationally recognised standards and best practices by the global organisations.

¹⁵⁵ UNAIDS/WHO (n124 above).

¹⁵⁶ UNAIDS/WHO (n9 above).

¹⁵⁷ International Guidelines on HIV/AIDS and human rights (1998).

¹⁵⁸ As above¹³

Chapter 4: Enforcement considerations

4.1 Introduction

The right created in the Women's Protocol implicates several rights and has potential challenges in its implementation that will be discussed below. Further the chapter will also look at the role of criminal law or coercive legislation in the fight against HIV. It will also explore the best possible balance between competing interests with the aim of advancing public health alongside women's rights.

4.2 Enforcing the duty to disclose: use of criminal law

Each right that is guaranteed has an accompanying duty attached to it. Duties to rights ensure that the rights are enjoyed by those entitled to them. States are primary duty bearers that must ensure that the rights are promoted, protected, respected and fulfilled by adopting legislative and other measures to give effects to the rights.¹⁵⁹ Adoption of legislative measure is an important characteristic of rights as it offers protection by establishing a legally enforceable claim.¹⁶⁰ States carry the primary responsibility of ensuring enjoyments of rights; however individuals are also duty bearers to ensure that the enjoyment of their rights does not infringe the rights of others. Individuals may also be required to fulfil other people's rights through specific actions like for instance parents having to give a name to a child in fulfilment of child's right to have a name under the African charter on the Rights and Welfare of the Child (The African Children's Charter).¹⁶¹

Where an individual violates another's right, the state may be held responsible if this is as a result of the state's failure to fulfil its own part of the duty. In *Zimbabwe Human Rights NGO Forum v Zimbabwe*, the African Commission on Human and Peoples' Rights (the African Commission) stated that what would otherwise be wholly private conduct is transformed into a constructive act of state because of lack of due diligence to prevent the violation or respond to it as required.¹⁶²

The fulfillment of the right to know one's sexual partner's HIV status requires that individuals who have tested positive play a part in fulfilling it. It is not practical that the state may

¹⁵⁹ Art 26(2) Women's Protocol, art 1 African Charter.

¹⁶⁰ Viljoen (n57 above) 63.

¹⁶¹ Art 6 (!) of the African charter on the Rights and Welfare of the Child.

¹⁶² Communication 245/2002 – 21st Activity Report (2006) *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

guarantee this right without relying on individuals themselves as the use of health care providers is limiting in both human and financial resource capacity. Therefore to guarantee the enjoyment of this right, the states may adopt law that requires the infected party to disclose his or her status to their sexual partners.¹⁶³ The use of criminal law is examined policy makers are considering implementing this duty.¹⁶⁴

There are several justifications for turning to criminal law whose focus differs to public health although the two may share the same goal. While as public health focuses on the community wide basis to prevent harm before it occurs, criminal law focuses on the individual and pursues the goal of preventing the spread of HIV by punishing an individual after violation occurs.¹⁶⁵

The functions of criminal law are called upon to bring about behavior modification in people who are infected with HIV and engage in behavior that put others at risk. The main functions of criminal law are incapacitation, deterrence, rehabilitation and retribution. Incapacitation through imprisonment of an HIV-positive person who willfully or negligently exposes others to the infection is believed to prevent that individual from causing harm to the community during the length of this or her term of imprisonment.¹⁶⁶ Deterrence is achieved when the offender and others stop engaging in the prohibited conduct in the future.¹⁶⁷ Rehabilitation is believed to educate and reform the offender whilst retribution allows society to express its moral outrage at the conduct of the offender.¹⁶⁸

¹⁶³ Public health law may also be used to enforce the duty to disclose by requiring health care providers to notify third parties who are considered at risk of contracting HIV from a patient or HTC client. According to UNAID the major difference with criminal law is that public health law is tailor made to an individual's circumstances and its coercive interventions are preferable to and more effective than the former. However public law will not form part of the discussion in paper because criminal law is the tool widely used to enforce the duty to disclose and most states are considering HIV specific legislation with criminal sanctions, e.g. the SADC PF is drafting HIV model legislation for SADC members states to use once adopted and this legislation has criminal sanctions included.

¹⁶⁴ LE Wolf & R Vezina Crime and punishment: Is there a role for criminal law in HIV prevention policy? (204) 25 Whittier Law Review 859, In the United States, many states have adopted this approach by enacting HIV specific exposure laws that criminalize intentional exposure to HIV. Several countries in Africa have drafted or enacted similar legislation See Eba (n31 above).

¹⁶⁵ As above 837.

¹⁶⁶ UNAIDS (2002) Criminal law, public health and HIV transmission: A policy Options paper http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf (accessed on 7 August 2008) 6.

¹⁶⁷ As above

¹⁶⁸ Wolf & Vezina (n201 above) 838.

Further those who support the use of criminal law in achieving public health goals state that although public health approaches are the primary mechanisms, there is a need to call upon criminal sanctions to force compliance with social norms where public health cannot.¹⁶⁹ In order to achieve this goal however it is advised that HIV specific statutes be enacted with narrowly defined prohibited acts or behavior that is based on medically proven modes of transmitting HIV.¹⁷⁰ The use of traditional criminal law offences to enforce the duty of disclosure is discouraged due to its inadequacies to enforce the duty.¹⁷¹ This is as result of the strict requirements to prove intent to cause harm in order to secure a conviction in traditional criminal offences.

To ensure that the duty to disclose is enforced, the HIV specific statutes must criminalize the act of exposing another person to HIV when one is aware of the risk but does not warn the potential partner. It must not require specific intention to bring about infection neither should it require actual harm to occur.¹⁷² Informed consent to exposure must be provided as a defense to a charge under the statute.¹⁷³

Before adopting this approach however, states need to weigh competing interest against the potential advantaged to be achieved.¹⁷⁴ For instance enforcing such a law would entail breach of confidentiality by public health providers who might at times be required by court to testify against a patient who is accused of breaching the statute.¹⁷⁵ Further enforcing such a law would require resources, staffing and a change in several policies including adopting a name based approach to HIV testing to that potential offenders are readily traced and evidence of knowledge of one's status is available against them. The cost of embarking on this journey and its effectiveness must be weighed against other proven effective measures in combating HIV. However UNAIDS/OHCHR discourage the use of criminal law in the fight against HIV.¹⁷⁶

¹⁶⁹ J Mosiello 'Why intentional sexual transmission of Human Immunodeficiency Virus (HIV) should be criminalized through the use of specific HIV criminal statutes (1999)XV N.Y.L Sch. J. Hum. Rts. 609.

¹⁷⁰ As above.

¹⁷¹ See Eba (n31 above).

¹⁷² Mosiello (n208 above) 611.

¹⁷³ As above.

¹⁷⁴ EM O'Toole 'HIV-specific crime legislation: targeting an epidemic for criminal prosecution (1995-96) Journal of Law and Health 10 (183) 206.

¹⁷⁵ As above 207.

¹⁷⁶ UNAIDS/OHCHR (n 16 above) guideline 4

4.3 Ethical and practical challenges to the duty of disclosure

4.3.1 Ethical challenges

The duty to disclose may implicate the right to privacy of an individual by removing the autonomy to decide who and when to share HIV positive serostatus. The right to privacy is an important right that is rooted in the ethical principles of autonomy and dignity.¹⁷⁷ Although the African Charter does not guarantee this right it is a well established right that exists based on other rights recognized in the Charter like the right to dignity,¹⁷⁸ and right to liberty and security¹⁷⁹ which entail protection of self-wealth and integrity.¹⁸⁰ Further the right to privacy is explicitly provided for in article 12 of the Universal Declaration on Human Rights (Universal Declaration) but also in article 17 of the International Covenant on Civil and Political Rights (ICCPR).

The concept of privacy not only covers private acts and physical space within one's home but also personal information including health information.¹⁸¹ An HIV positive individual under this right has the free choice on how and to whom they will disclose their HIV status if they decide to do so or not to disclose at all. Therefore compulsory disclosure through the creation of a duty to disclose would be an infringement on this right. However as most rights, the right to privacy is subject to limitations especially in order not to infringe on the enjoyment of the rights of others. The Universal Declaration recognizes individual's duty to the community in article 29 which provides that 'everyone has duties to the community in which alone the free and full development of his personality is possible'. This is also provided for in article 27 of the African Charter which also provides that individual rights may be limited to secure the rights of others, collective security, morality and common interest. The respect for other people's human rights includes respect for the right to health which entails that one does not place others at danger which would undermine the enjoyment of the right.¹⁸²

As provided for in article 27 of the African Charter, rights of an individual may also be limited to secure common good of the entire community. Unlike the west where individuals' rights are emphasized, in Africa as also reflected in the African Charter emphasis is on group rights

¹⁷⁷ Gable (n10 above) 10

¹⁷⁸ Art 5 of the African Charter, art 3 of the Women's Protocol

¹⁷⁹ Art 6 of the African Charter

¹⁸⁰ *Prince v South Africa* (2004) AHRLR 105 (ACHPR 2004), Gostin (n 107above) 14

¹⁸¹ Gostin (n106 above)16

¹⁸² Gostin (n106 above) 4.

and recognition of centrality of the family and the community as opposed to the individual.¹⁸³ Any limitation on the rights however must be reasonable and proportionate to the end sought and be necessary in the circumstances of any given case.¹⁸⁴ In *Media Rights Agenda and others v Nigeria*, the African Commission stated that the reasons for possible limitations must be found in legitimate state interest and the evils of limitations of rights must be strictly proportionate with and absolutely necessary with advantages which are to be obtained.¹⁸⁵

4.2.2 Practical challenges

Disclosing HIV status especially where the results are a positive serostatus may cause psychological, verbal and violent abuse, abandonment, stigma and discrimination.¹⁸⁶ UNAIDS policy brief on greater involvement of people living with HIV (PLHIV) acknowledges both the benefits of living openly with HIV and the negative consequences that are faced by PLHIV who in fact live openly or disclose their status.¹⁸⁷

It is reported that sometimes psychological abuse, verbal and physical violence, and abandonment are experienced as a result of discussing HIV testing and disclosing results.¹⁸⁸ Such consequences just like the HIV and AIDS pandemic are born disproportionately by women. This is so because of a number of reasons. Firstly as already noted HIV and AIDS is more prevalent among women than men although many women infected are as a result of a single partner usually a husband,¹⁸⁹ it is women rather than men, who are most likely to be blamed as vectors of the pandemic and stigmatised as promiscuous for contracting the

¹⁸³ Gable (n10 above) 10.

¹⁸⁴ *Toonen v Australia* Communication No. 488/1992: Australia. 04/04/94. CCPR/C/50/D/488/1992. In the case criminalizing homosexuality found not to be reasonable means or appropriate for HIV prevention. Para 8.5.

¹⁸⁵ (2000)AHRLR 200 (ACHPR 1998).

¹⁸⁶ UNAIDS policy brief: Criminalization of HIV transmission http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf (accessed on 9 September 2008) 5.

¹⁸⁷ UNAIDS Policy Brief: The Greater involvement of people living with HIV (GIPA) http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf (accessed on 4 October 2008).

¹⁸⁸ As above, WHO 'Intimate partner violence and HIV/AIDS Information Bulletin Series, Number 1, Human Rights Watch *Hidden in the Mealie meal* (n 20 above), AC Gielen others, 'Women living with HIV: Disclosure, violence and social support' (2000) 77 (3) *Journal of Urban Health* reported 44% negative consequences as a result of disclosure, S Maman & et al, 'The intersections of HIV and violence: directions for future research and interventions (2000) 50 *Social Science medicine* 459.

¹⁸⁹ M Latigo 'Marriage laws' http://ocw.mit.edu/NR/rdonlyres/Special-Programs/SP-253Spring-2005/B7165652-1EE7-4128-98C8-475C29BC728E/0/melissa_latigo.pdf (8 October 2008) 2.

disease.¹⁹⁰ Further, they are blamed for bringing HIV in the relationship because they are usually the first to know their status as a result of being in contact with health service facilities more often than men.¹⁹¹ This aggravates blame on women as it is assumed that the first one to discover their HIV status is the one who first contracted the virus. In other instances merely bringing up the issue of HIV testing has resulted into women being called prostitutes and accused of having extra marital affairs.¹⁹² Further as already discussed before, many women are victims of GBV perpetrated by intimate partners, and disclosure of HIV-positive results for such women may provide a trigger for additional violence.¹⁹³

A 2004 review paper published by WHO found that of 31 studies reporting on outcomes of disclosure 26 mentioned negative outcomes but for the most part these affected a small percentage of respondents.¹⁹⁴ The studies on outcomes of disclosing are not very conclusive as to whether indeed high incidences of violence or abuse have ensued as result of it. This is because high percentages of women have decided not to disclose their status due to fear of anticipated violence. Those who have disclosed and received understanding and acceptance have usually been those who were previously in trusting and loving relationship.¹⁹⁵ For those who have in fact experienced negative outcomes, these have been severe even when results of the test have been negative.¹⁹⁶

As stated before HIV status disclosure may also result into stigma and discrimination which fuels the transmission and greatly increases the negative impact of the pandemic by creating major barriers to prevention, treatment and care.¹⁹⁷ Societies usually relate HIV with death, promiscuous sex, bewitchment and sin hence stigma and discrimination.¹⁹⁸ According to Concise Oxford dictionary, stigma is a mark of disgrace associated with a particular circumstance, quality or person.¹⁹⁹ According to UNAIDS stigma is a dynamic process of

¹⁹⁰ See UNAIDS(n186 above) 5.

¹⁹¹ UNAIDS 'HIV-Related stigma, discrimination and human rights violations: Case studies of successful programmes (UNAIDS best practices collection) <http://www.unaids.org> (accessed on 7 October 2008).

¹⁹² Human Rights Watch *Hidden in the Mealie meal* (n 20 above) 22.

¹⁹³ Maman (n 188 above) 475.

¹⁹⁴ Maman & Medley (n19 above) 18.

¹⁹⁵ As above 20.

¹⁹⁶ The Centre for the Study of Violence & Reconciliation, *Domestic violence and AIDS* (2001) 11.

¹⁹⁷ UNAIDS (n186 above) 4.

¹⁹⁸ Viljoen (n 23 above) 70.

¹⁹⁹ See also Siyam'kela project *HIV/AIDS resource pack* The Centre for the Study of AIDS 6.

devaluation that significantly discredits an individual in the eyes of others.²⁰⁰ Women rather than men are disproportionately victims of stigma or the fear of stigma because they are usually blamed for the infection even when the source of their infection is a husband but also because they are less likely to be accepted by their communities.²⁰¹ Further women are usually victims because the root causes of stigma are social, gender, sexuality and, wealth inequalities.²⁰² There are two main types of stigma namely internal and external stigma. Internal stigma which may be as a result of felt or imagined stigma refers to how a PLHIV feels about them self.²⁰³ Manifestations of internalised stigma include shame, fear of disclosure, withdrawal from social and intimate contact, and self –exclusion from services or opportunities for fear of being discovered.²⁰⁴ Stigma therefore may prevent PLHIV from seeking treatment, care and support and exercising other rights, such as working.²⁰⁵

Once stigma is acted upon it results into discrimination against PLHIV as they are treated unfairly or differently from other people and this is what is called external stigma.²⁰⁶ According to UNAIDS discrimination against PLHIV is defined;

..’as any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of a person’s confirmed or suspected HIV-positive status, irrespective of whether or not there is any justification for these measures.’²⁰⁷

Discrimination may occur at various levels that include at family and community levels, institutional and national levels. Examples of discrimination include the practice of forcing women to return to their kin upon being diagnosed HIV positive or after their partner have died of AIDS, verbal harassment, physical violence, denial of access to care and treatment, breaches of confidentiality, exclusion from pension and through compulsory testing and screening of groups and individuals.²⁰⁸

²⁰⁰ UNAIDS (n186 above) 4.

²⁰¹ As above 8.

²⁰² Viljoen (n 23 above) 71.

²⁰³ Siyam’kela(199 above) 6.

²⁰⁴ As above.

²⁰⁵ UNAIDS (n186 above) 8.

²⁰⁶ Siyam’kela(n199 above) 6.

²⁰⁷ UNAIDS 2000 Protocol for identification of discrimination against people living with HIV as quoted in Siyam’kela(n199 above) .

²⁰⁸ UNAIDS (n186 above)9 & 10, UNAIDS Policy Brief: GIPA(n 187 above) 2.

Discrimination against a person based on prohibited grounds is internationally recognised as a human rights violation that calls for measures to prevent its occurrence.²⁰⁹ HIV status is a prohibited ground under the words 'other status' in non discrimination clauses.²¹⁰ The prohibition of unfair discrimination is grounded on the recognition that all human beings regardless of their position in society must be treated with dignity and that dignity is impaired when a person is subjected to unfair discrimination.²¹¹ Further discrimination directed at PLHIV leads to violation of other human rights such as the right to health, equality before the law and freedom from inhuman degrading treatment or punishment.²¹²

Stigma, fear and discrimination remain major impediments to the success of VCT according to the findings by National Democratic Institute for International Affairs (NDI) and SADC parliamentary forum (SADC PF)²¹³ Stigma and discrimination negates the human rights of people infected and affected by HIV, and still constitute a major barrier to an effective management to the pandemic.²¹⁴ These and all other negative consequences need to be considered against the positives that come as a result of right to information of the HIV status of one's partner.

Women bear the greatest burden of all the negative consequences than men and this is because of the wide power imbalances and inequalities rooted in economic inequalities, GBV and the fact that women are the first and most likely to discover their status as a result of being in contact with health facilities frequently. PN procedures for women's partners must place women's safety as a paramount consideration for otherwise such a program might aggravate violations to their rights and undermine public health goals by scaring them away from health facilities.

²⁰⁹ Arts 2 of the African Charter, UDHR & Women's Protocol , Art 26 of ICCPR.

²¹⁰ UNAIDS 2006, 2006 Report on the Global AIDS Epidemic http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp. See also UNAIDS & OHCHR 2006, 'International Guidelines on HIV/AIDS and Human Rights', Consolidated version http://data.unaids.org/Publications/IRC-pub07/jc1252-InternGuidelines_en.pdf?preview=true, calls upon states to enact anti-discrimination and other protective laws that protect vulnerable groups and PLHIV among others.

²¹¹ *Hoffman v South African Airways* CCT 17/00 2001 (1) SA 1 2000 (11) BCLR 1235 para 27 & *S v Makwanyane* 1995 (3) SA 391 (CC) where it was stated that the right to dignity is a foundation of many human rights.

²¹² UNAIDS (n186 above)11.

²¹³ UNDP/UNHCR 'A review of regional and national human rights based HIV and AIDS policies and framework in Eastern and Southern Africa' http://www.unaidsrsta.org/userfiles/file/review_regional_national_HR_HIV_ESA.pdf (accessed on 23 September 2008) 12

²¹⁴ AU Africa's common position to the high level meeting of the UN general Assembly special session on AIDS June 2006 2

4.4 Striking the balance

The requirement of mandatory HIV status disclosure, whether through criminalizing HIV exposure or PN without the patient's consent implicates the patient's rights to privacy, dignity, autonomy and security. These rights are not absolute as discussed above and may be limited in given circumstances for a good cause. Such limitation must be reasonable and proportionate to the object to be achieved.

The right to be informed of one's partners health information is believed to achieve HIV prevention as those in a relationship with an infected person will be made aware of the potential risk of contracting HIV from the partner with HIV positive serostatus. It is believed that such information will empower the individual into making decisions of protecting him or herself from the eminent danger of contracting HIV. Further it may lead to the person seeking HIV testing and hence access to treatment and support where tests positive. Once the information is translated into behavior change resulting into reduced high risky behavior leading to prevention of transmission the object of limiting the rights of the individual is fulfilled. The information is therefore in the interest of the community at whose alter the individual's rights are surrendered to secure prevention as persons in sexual contact with the infected person are made aware of risk of HIV resulting into prevention.

Thus the object of limiting the rights is to prevent the spread of the deadly disease HIV that has claimed a lot of lives and adversely affected Africa as all sectors including socio-economic development, family structure and even survival of African's Civilization.²¹⁵ As noted before, African heads of state consider HIV and AIDS as a state of emergency and are committed to the fight against the spread of the HIV pandemic as a priority in national development plans.²¹⁶ It is in this spirit of arresting HIV and its impact that the right to one's partner's health information is created in the women's Protocol.

The objectives for which the rights of an infected person are being limited are justifiable in view of the adverse effects of HIV however one may question the reasonability of such an objective. This is because the evidence regarding PN's efficacy is inconclusive and remains doubtful as of yet to significantly reduce HIV infection rates in a given population. As noted before, UNAIDS has on record that only 10 -12 % of the people infected with HIV in Africa are aware of their status and as such the resultant prevention that is hoped for will not be significant even if every HIV positive came out with their serostatus. Further, the objective is

²¹⁵ The Outcome of the African summit on HIV/AIDS, Tuberculosis and Other Related Diseases Nigeria 24 – 27 April 2001.

²¹⁶ The Abuja declaration 2001 para 22 and 23.

not reasonable as it disproportionately passes a greater responsibility on persons who have known their status to ensure prevention of transmission when in fact this must be a responsibility of each individual who engages in sexual acts. The fact that this duty is mandatory as provided in the Women's Protocol and that states may put legislative measures to enforce it might bring a false hope of security to people that only partner's whose HIV status is known to be positive pose potential risk while the others are thereby presumed 'safe'.

The HIV pandemic and prevailing fact that only few people are in fact aware of their status calls for greater responsibility by every consenting person to high risk behavior to take responsibility in protecting themselves. Just as it would be unreasonable for women of sound mind to blame a sexual partner after falling pregnant that they were not forewarned of this possibility, the same should apply to HIV once information on how one can be infected is made reasonably available.²¹⁷ Of course this is not to argue that people who are HIV infected must not take responsibility to protect their partners as indeed the law requires that individuals do no harm to others. However mandatory disclosure that is legally enforceable may not be the best way of decreasing HIV infection due to the possible implication such duty may cause.

Mandatory disclosure may also drive the pandemic underground as people would be afraid to come forward and know their status due to the implications of such a disclosure. WHO and UNAIDs rightly recognized the problem stating that without widely recognized assurance of confidentiality the progress of awareness, prevention, treatment and care is impeded as those in need of it are reluctant to come forward.²¹⁸ Further the potentially negate consequences of disclosure which include abandonment, blame, violence, stigma and discrimination makes one question the proportionality of pursuing such an object in this manner. In the light of less intrusive alternatives of ensuring disclosure it is unreasonable and unjustified to make PN mandatory as it is an infringement on an individual's rights which may set another chain of human rights abuses. It may also undermine public health goals for which it purports to promote and as such would not be the best course to take in the fight against HIV.

²¹⁷ R Bennett & others 'Ignorance is bliss? HIV and moral duties and legal duties to forewarn' (2000) 26 *Journal of Medical Ethics* 11.

²¹⁸ UNAIDS best practices collection 'The role of name-based notification in public health and HIV surveillance 2000 4.

Dr Noerine Kaleeba states that mandatory PN does not have any public value due to the insignificance of positive results and enormous potential negative results.²¹⁹ Concentrating on the 10-12% would be misplaced focus on the real problem which remains with individual responsibility to protect self and also to know ones status in order to access treatment and support where necessary. Dr Grace kalimugogo in the Social Affairs department at the AUC emphasized the need for IEC in order to equip people with the right information that would help them in the fight against HIV.²²⁰ She further pointed out the scarcity of resources in implementing proved and effective HIV prevention mechanism that include user friendly IEC, HTC services coupled with the right treatment, care and support. It is therefore imperative that states do not misuse resource by pumping them into retributive and potentially negligible result programs like mandatory PN.

4.5 Conclusion

The right to information on one's partner's HIV status if implemented through mandatory PN will yield little success in the broader fight against HIV. This is because it would undermine the rights on an individual which are essential in the fight against HIV. The potential negative consequences of such an approach include reluctance to know ones HIV status, violence, abandonment, stigma and discrimination. Further there is no research to support the effectiveness of mandatory PN which may only achieve negligible results in preventing the spread of HIV while on the other hand research results on the contrary points to negative public health consequences if this is pursued. It is therefore not justifiable to limit the rights of a person who has tested positive by enforcing the duty to disclose through coercive measures in light of the above considerations.

²¹⁹ Founder and patron of The AIDS Support Organization (TASO) Uganda Ltd interviewed at AUC, Addis Ababa 1 October 2008.

²²⁰ Head of AIDS Watch Africa, department of Social Affairs, AUC Interviewed on 1 October 2008.

Chapter 5: Conclusion and recommendations

5.1 Conclusion

The Women's protocol is the first binding instrument to specifically address the issues of HIV and AIDS. It has been hailed as a big milestone in the regional context especially because Africa bears the burden of HIV and AIDS disproportionately from the rest of the world. Having such an instrument with the commitment of the leaders would help combat the epidemic that has been recognized as a public health emergency requiring priority consideration at national level.²²¹

Article 14(1)(e) provides for the right to be informed of one's HIV status and the HIV status of one's partner in a bid to enhance prevention mechanisms and strategies. This places a duty on the state as well as infected individuals to disclose their HIV status to sexual partners. The paper has looked at several ways on how such a duty and right may be implemented or enforced in the light of the several considerations that include effectiveness in advancing public health goals, international standards and the specific concerns for women in Africa.

Firstly, the state has a duty to ensure availability of prevention, treatment, support and care to all in need of it through the provision of IEC and HTC. The state parties to the Women's Protocol must ensure that national wide programmes are put in place that disseminate the right information on transmission and prevention of HIV coupled with the right preventative mechanisms and treatment for those infected, This must be done in consideration of the different societal needs and context together with necessary measures to protect women and girl children whose exposure to HIV is as a result of their vulnerability in society that limits their enjoyment of basic rights and freedoms.

Root causes of the spread of HIV includes, poverty, human rights violations and harmful cultural practices among others that disproportionately affect women and hence they bear the greatest burden of the pandemic.²²² Any successful fight against HIV and AIDS pandemic must have serious regard to the disposition of women in society. It must first address the root causes and empower women so that they may be able to benefit from prevention and treatment mechanisms that are in place.

The right to be informed on the HIV status of one's partner is grounded on the principle 'not to do harm' to others however such a right has less public health value when implemented in

²²¹ Abuja Declaration para 22

²²² AU/UNECA & others 'Scoring African leadership for better health, 2004 10

a coercive or mandatory framework. The benefit of disclosing an HIV person's status include reduced risky behavior, increased numbers of people seeking HTC, early entry into treatment and support and care. It is also believed that openness about HIV and AIDS may reduce stigma and discrimination attitudes towards people infected resulting into greater support, care and respect for them. Negative consequences of disclosing one's status includes blame, violence, abandonment, stigma and discrimination.

States must put in place measures that encourage individuals who have a positive serostatus to take up the responsibility to inform their sexual partners of their status and ensure that safer sex is practiced. Where the individual himself or herself is unable to do so, a healthcare provider must with the consent of the patient carry out such a responsibility. Such a responsibility whether on the individual or healthcare provider must not be made into a legally enforceable duty as this would be contrary to internationally recognized standards and best practices which must guide the implementation of the right to be informed of one's sexual partner's HIV status. Further, if made mandatory, such a right has potential of impeding the public health goals that seek to control and contain the spread of HIV. For any coercive measures in public health strategies have over the years proved to drive people away especially as regards the HIV and AIDS pandemic.

Respect for human rights has been recognized as a strategy that may help contain the spread of HIV as human violations are part of the driving force in the spread of HIV. Further both human rights and public health share the same goal; that of promoting and protecting the rights and well-being of all individuals.²²³ A right based approach must therefore always inform public health goals in the fight against HIV.

Due to the feminization of HIV and AIDS in Africa as a result of gender inequality, low socio-economic status of women and GBV, scaling up universal access to prevention, treatment, care and support should prioritize gender equality, women social and economic empowerment and prevention of GBV.²²⁴ All these areas are addressed in the Women's protocol that obliges states to take concrete steps in advancing the rights of women through adoption and implementation of appropriate measures that include budgetary allocation for their social development and promotion.

²²³ International guidelines 1998 para 73 37

²²⁴ AU Africa's common position to the high level meeting of the UN general Assembly special session on AIDS June 2006 3

5.2 Recommendations

5.2.1 Advancement of women's rights

At national level

It is extremely difficult if not impossible for individuals alone to change the socio-economic, legal, cultural and political institutions which perpetrate gender inequalities hence the state has a critical role play in this.²²⁵ The success in implementation of the Women's Protocol is mainly dependant on the commitment of the state party members living to the commitment they demonstrate when ratifying the instrument.

However it is individuals and mainly civil society organisations that play a big role in holding governments accountable where they fall short of their commitments. In order to do this, the Women's Protocol must be brought home through domestication but also public awareness so that women in the member states' countries may be aware of their rights and enforce them.²²⁶ I therefore recommend that the different non-governmental organizations (NGOs) that spearheaded the drafting and adoption of the Women's Protocol take up the responsibility of lobbying for more ratifications and domestication of the Women's protocol that is outstanding as less than half of the AU member states have ratified it. Further that such NGOs network with local civil society organizations in bringing about public awareness of the Women's Protocol for the local woman. Unlike any other commitments made before for the advancement of women's rights, the Women's Protocol is the first binding instrument that is African born and comprehensively deals with issues at the heart of ensuring gender equality and women's rights as a whole. Let the vigor and vision that drove the different NGOs and actors in giving birth to the Women's Protocol continue to bring about what is on paper into living realities for women in Africa.

At the regional level

The African Commission has a big role in monitoring the implementation of the Women's Protocol however AUC must also make the Women's Protocol as its working tool in all its programs and activities if women's rights are to be advanced in member states' countries and Africa as a whole. The AUC's mandates and activities involve a lot of interaction or

²²⁵ Dr M Maboreke, then Head, Women, Gender and Development Division Special address at the lecture-cum-roundtable discussion on 'empowering women – building national capacity to combat HIV/AIDS' 16 June 2001 6

²²⁶ Through interactions with different gender experts from different countries that attended the Joint ECA and AU gender conference in Addis Ababa, Ethiopia, concerns of publicity and awareness of the Women's Protocol were raised.

impact on women in Africa. Although the primary overseers of the Women's Protocol at that level is the Women and Gender Directorate, the provisions of the Women's Protocol overlap with the different departments mandates that have an impact on the lives of women and must thus inform its activities and programmes.

For instance the rural economy and agriculture portfolio in the AUC mandated with overseeing rural economy, agriculture and food security among others has great opportunities in advancing women's rights by integrating the Women's Protocol in its activities. This is because women account for a high percentage in agricultural work in Africa. For instance in Rwanda women produce 70% of the country's agricultural outputs²²⁷ while in Benin, Congo, Morocco, Namibia, Sudan, Tanzania and Zimbabwe women are reported to carry out approximately 60% of all agriculture work.²²⁸ The rural economy and agriculture division through its activities therefore impact many women in Africa and through incorporation of the Women's Protocol it can ensure that their work translates into their economic development that would contribute in alleviating gender inequalities.²²⁹

During conflicts women and girls are disproportionately subjected to gross human rights abuses threatening life, security and dignity but also aggravating their vulnerability to HIV and AIDS.²³⁰ The Peace and Security Council (PSC) was established with objectives include promoting peace, security and stability in Africa.²³¹ Articles 10 and 11 of the Women's Protocol guarantee women's right to peace and protection during armed conflicts and this may be promoted and protected through the work of PSC. The same goes for other divisions like the social affairs department in charge of issues of the elderly, health and reproductive issues among others which are all covered in the Women's Protocol.²³²

²²⁷ H Hamilton 'Rwanda's women: the key to reconstruction' as quoted in K Njogu & E Orchardson-Mazrui 'Gender inequality and women's rights in the great lakes: can culture contribute to women's empowerment' 15

²²⁸ Women in agriculture in selected African countries <http://www.greenfacts.org/en/agriculture-iaastd/figtableboxes/figure-sr-wa3.htm> (accessed on 30 October 2008)

²²⁹ Art 13 of the Women's Protocol guarantees women's economic rights while art 19 guarantees the right to sustainable development which includes promoting women's access to land which is crucial if their work is to be meaningful. Most customary laws exclude women from owning land.

²³⁰ See UN Secretary General's Report on Women, Peace and Security 2003

²³¹ Protocol relating to the Establishment of the Peace and Security Council of the African Union (Peace and Security Protocol), art 3(a)

²³² See arts 14, 20, 21, 22 & 23 of the Women's protocol

I, therefore recommend that the Women's Protocol be integrated in the workings of different departments and programs to ensure that women who are in contact with or influenced or impacted by with whichever department, benefit from the dictates of the Women's Protocol.

There should also be greater coordination between the different departments and the Women and Gender Directorate to ensure that their activities are coordinated to ensure better results in advancing women's rights while saving resources through joint programmes.²³³

5.2.2 Implementation of article 14(1)(e)

The paper has shown how the creation of a legally enforceable duty may not be the best approach in ensuring that HIV prevention, treatment and care are achieved. It is therefore recommended that states adopt an approach that is akin to the UNAIDS and WHO approach whereby individuals are encouraged to voluntarily disclose their status to sexual partners. Where real risk is considered eminent to a third party, then, only then and having considered the potential benefits and harm to both parties must the health care provider breach confidentiality and disclose the positive HIV status. This must be after thoroughly counseling the patient and encouraging him or her to notify their partner on their own.

Creation of the duty to disclose legally enforceable is further discouraged as implementation of such a course may divert much needed resources that would otherwise be put to better use that yields greater progress in combating HIV pandemic. As already highlighted in the paper, there is still a need to ensure that IEC on the modes and prevention of transmission of HIV are disseminated wide and far. Once people are made aware of the HIV and its prevention mechanisms, the emphasis will be placed on each individual to protect themselves from infection by taking responsibility each time they are involved in high risk behavior. This is a better option in the context where only 12 % of those infected are aware of their HIV status. Instead of burdening the few responsible individuals who have known their status, let government explore ways of reaching out to the 80 % plus who remain in ignorant and also instill responsibility in each individual.

Governments must also ensure that much needed treatment regimes are available and accessible to all in need of it so that those who test positive may have access to them. This will help mitigate the adverse effects of HIV and AIDS but also act as an incentive for HIV testing. I therefore recommend that governments implement article 14(1) (e) on the right to

²³³ Talking to members in different departments indicated that although the departments interact with the women, Gender and Development Directorate, no meaningful coordination was yet underway. Delegates sort to have identities concealed. Interviews conducted at the AUC, September 2008

information on the status of one's partner HIV status through measures that do not create a mandatory enforceable duty of disclosure.

5.2.3 Where legally enforceable duty is created

Where a state party opts to create a legally enforceable duty of disclosure, with punitive sanctions, I recommend that self-defense be incorporated to exonerates any individual from sanction where successfully pleaded. Where a defendant or accused person is able to show that disclosure would have resulted into substantial hardship or harm, the court should accept this as a defense for failing to discharge the duty of disclosure.

To enforce the duty of disclosure in circumstances where it would result into harm to the HIV infected person would be discriminatory. This is because in such circumstances requiring disclosure would mean that the HIV-positive person be treated with less consideration or care and protection for the sake of another person believed not to be infected. HIV status is a prohibited ground under non-discrimination clauses in all human rights instruments including the African Charter. States or national courts should therefore adhere to this principle by respecting, promoting and protecting the rights of PLHIV and taking their circumstances into account where harm is reasonably feared or expected according to the available evidence when enforcing the duty to disclose.

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BIBLIOGRAPHY

BOOKS

AIDS and Human Rights Research Unit (2007) *Human rights protected? Nine Southern African county reports on HIV/Aids and the law* Pretoria: Pretoria University Law Press

Gable L, Gamharter K, Gostin LO, Hodge JG Jr. & Van Puymbroeck RV (2007) *Legal aspects of HIV/AIDS: A guide for policy and law reform* Washington DC: The International Bank for Reconstruction and Development/The World Bank

Gostin LO & Lazzarini Z (1997) *Human rights and public health in the AIDS pandemic* Oxford: Oxford University Press

Khutsoane, BSN; Stefiszyn, K, Warioba C, Luhanga AG, Sellers, PV, Stewart J, Nyirinkindi L & Olagbegi BO *Gender-based violence in Africa: Perspectives from the continent* Pretoria: Centre for human rights

Kisoon C; Caesar M & Jithoo T (2002) *Whose right? AIDS Review 2002* Pretoria: Centre for the Study of AIDS

Marais H (2005) *Buckling: The impact of AIDS in South Africa 2005* Pretoria: Centre for the Study of AIDS

Siyam'kela project *HIV/AIDS resource pack* Pretoria: Centre for the Study of AIDS

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

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

Viljoen F (ed) (2005) *Righting stigma: exploring a rights-based approach to addressing stigma* Pretoria: AIDS and Human Rights Research Unit

JOURNALS AND REVIEWS

Alfred J 'The HIV/AIDS pandemic and the role of CSW' (2002) XVIII *N.Y.L., Sch. J. Hum. Rts.* 439

Altman D 'Rights matter: 'Structural Interventions and vulnerable communities' (2003) 8 (2) *Health and Human Rights* 203

Arriaga A 'HIV/AIDS and violence against women' (2002) *Human Rights* 18

Bennett R, H Draper & L Frith 'Ignorance is bliss? HIV and moral duties and legal duties to forewarn' (2000) 26 *Journal of Medical Ethics* 11

Bezanson R & Kurtz SF 'Model Health Information Disclosure Act' (1999) *The Journal of Corporation Law* 121

Csete J and Elliott R 'Scaling up HIV testing: Human rights and hidden costs' (2006) 11 (1) *HIV/AIDS policy & law review* 4

Desai S 'HIV and domestic violence intersections in the lives of married women in India' (2005) 8 (2) *Health and human Rights* 140

Dunkle KL et al 'Transactional sex among Women in Soweto , South Africa: Prevalence risk factor and association with HIV infection' (2004) 59 (8) *Social Science and Medicine* 1581

Durojaye E 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 195

Ebeku KSA 'A new hope for African women: Overview of Africa's protocol on women's rights' (2004) 13 (3) *Nordic Journal of African studies* 267

Gabel JB 'Liability for 'knowing' transmission of HIV: The evolution of duty to disclose 21 Florida state' (1993-94) *University Law Review* 981

Garcia-Moreno C et al 'WHO Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses' (2003) 6 (2) *Health and Human Right* 112

Gray RH & others 'Uganda's HIV prevention successes: The role of sexual behaviour change and the national response. Commentary on Green *et al* ' (2006) 10 (4) *AIDS and Behaviour* 347

Haber E 'The United Nations' response to HIV/AIDS in Africa' (2002) XVIII *N.Y.L., Sch. J. Hum. Rts.* 467

Hermes JS 'The criminal transmission of HIV: A proposal to eliminate Iowa's statute' (2002) 6 *The Journal of Gender, Race & Justice* 5

Klitzman R 'Naming names: perceptions of name-based HIV reporting, partner notification, and criminalization of non-disclosure among persons living with HIV' (2004) 1 (3) *Journal of National Sexuality Resource Center* 38

Malera G 'The limits of criminal punishment in preventing HIV/AIDS' (2007) 1 *Malawi Law Journal* 48

McGuire AL 'AIDS as a weapon: Criminal prosecution of HIV exposure' (1999) 36 *Houston Law Review* 1787

Miller AM & Vance CS 'Sexuality, human rights and health' (2004) 7 (2) *Health and Human Rights* 5

Mosiello J 'Why the intentional sexual transmission of Human Immunodeficiency Virus(HIV) should be criminalized through the use of specific HIV criminal statutes' (1999) XV *N.Y.L. Sch. Hum. Rts.* 595

Muhammad A 'Mandatory HIV notification: Bioethical concerns vs. Public health concerns, health and medical dilemmas (2006) 2 (1) *Journal of American Science* 42

Niemeier DP 'The criminal transmission of AIDS: A critical examination of Missouri's HIV-specific statute' (2001) 45 *Saint Louis University Law Journal* 667

Nsibirwa MS 'A brief analysis of the draft protocol to the African Charter on Human and Peoples Rights o the Rights of Women' (2001) 1 *African Human Rights Law Journal* 40

Pottler-Fishel RNC 'Improper bedside manner: why state partner notification laws are ineffective in controlling the proliferation of HIV' (2007) 17 *Health Matrix* 15

Rediger, BB 'Living in a world with HIV; Balancing privacy, privilege and the right to know between patients and health care professionals' (1999) 21 *Journal of Public Law & Policy* 443

Rennert S 'AIDS/HIV and confidentiality: Model policy and procedures' (1991) 39 *Kansas Law Review* 653

Shriver CM 'State Approaches to criminalizing the exposure to HIV: Problems in statutory construction, constitutionality and implications' (2001) 21 *Northern Illinois University Law Review* 319

Souza JM 'Doe v. Town of Plymouth and Officer Paul Tibbetts: When is the disclosure of HIV status beyond the call of duty?' (1994-95) 29 *New England Law Review* 391

Tan D 'The Cuerrier decision: Public health and the criminalization of HIV serostatus non-disclosure' (1999) 76 (3) *University of Toronto Medical Journal* 170

Tarantola D 'HIV testing; Breaking the deadly cycle' (2005) 8 (2) *Health and Human Rights* 37

Turner A 'Criminal liability and AIDS' (1995) *Auckland University Law Review* 875

UNAIDS reference group on HIV/AIDS and Human Rights 'Ensuring a right-based approach to HIV testing' (2005) 8 (2) *Health and Human Rights* 41

Wolf LE & Vezina R 'Crime and punishment: Is there a role for criminal law in HIV prevention' (2004) 25 *Whittier Law Review* 821

PAPERS AND ARTICLES

Amon J (2006) 'Preventing further spread of HIV/AIDS: The essential role of human rights' <http://www.hrw.org/wr2k6/hivaids/hivaids.pdf> (accessed 4 September 2008)

Karanja LW 'Domestic violence and HIV infection in Uganda' Fall 2003 http://www.cceia.org/resources/publications/dialogue/2_10/articles/1046.html (accessed on 24 September 2008)

Latigo M 'Marriage laws' http://ocw.mit.edu/NR/rdonlyres/Special-Programs/SP-253Spring-2005/B7165652-1EE7-4128-98C8-475C29BC728E/0/melissa_latigo.pdf (8 October 2008)

Luanda, IRIN 'Should intentional infection be a crime?' www.africafiles.org (accessed on 26 May 2008)

Moon DC 'Voluntary disclosure of HIV/AIDS status a public health official to law enforcement agents: Shortcomings South Dakota's law section 34-22-12.1(6) and traditional public health measures' http://works.bepress.com/cgi/viewcontent.cgi?article=1000&context=daniel_moon (accessed on 1 October 2008)

Omarjee N & Lau U 'Conflict in Africa: Intersectionality of GBV and HIV/AIDS' www.powa.co.za/documents/Conflicts%20in%20Africa%20web%20doc.doc (accessed on 9 October 2008)

Zuyderduin A & Melville I 'Shared confidentiality – an ethical dilemma in Botswana' Paper prepared for XIII AIDS Conference, Durban, 5 July 2000 <http://www.ditshwanelo.org.bw/images/Shared%20Confidentiality%20Paper.pdf> (accessed on 19 May 2007)

DISSERTATIONS

Amollo R 'A critical reflection on Women's Protocol as a means to combat HIV/AIDS among women in Africa' 2006 unpublished LLM dissertation

Mdlalose BNN 'The stigma related to HIV and disclosure of their status' unpublished dissertation MA (clinical psychology) 2006 2

INTERNATIONAL INSTRUMENTS AND LEGAL DOCUMENTS

Convention on the Elimination of All Forms of Violence Against Women

Declaration on the Elimination of Violence Against Women,(UN Declaration on VAW) adopted by the UN General Assembly on 20 December 1993, UN DOC. A/RES/48/104

General Recommendation 19 of the Committee on the Elimination of All Forms of Discrimination Against Women

International Covenant on Civil and Political Rights

Protocol relating to the Establishment of the Peace and Security council of the African Union adopted on 10 July 2002 and entered into force 26 December 2003

SADC PF Draft Model Law on HIV (unpublished)

The Abuja declaration on HIV/AIDS, Tuberculosis and other related infectious diseases 2001

The African Charter on Human and Peoples' Rights adopted on 27 June 1981 and entered into force 21 October 1986

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted on 11 July 2003 and entered into force on 25 November 2005

Constitutive Act of the African Union adopted on 11 July 2000 and entered into force 26 May 2001

Solemn Declaration on Gender Equality Assembly adopted in July 2004

CASES

Hoffman v South African Airways CCT 17/00 2001 (1) SA 1 2000 (11) BCLR 1235

Media Rights Agenda and others v Nigeria(2000)AHRLR 200 (ACHPR 1998)

Prince v South Africa (2004) AHRLR 105 (ACHPR 2004)

S v Makwanyane 1995 (3) SA 391 (CC).

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

Toonen v Australia Communication No. 488/1992: Australia. 04/04/94. CCPR/C/50/D/488/1992.

REPORTS

Apoola, A Radcliffe, KW, Das S 'Patient preferences for partner notification' <http://sti.bmj.com/cgi/content/full/82/4/327/DC1> (accessed on 22 August 2008)

AU 'An African common position to the high level meeting of the UN General Assembly Special Session(UNGASS) on AIDS' New York, 29 May – 2 June 2006

AU 'AU inaugurates inquiry panel on allegations of sexual abuse in Darfur' Sudan Tribune http://www.sudantribune.com/article.php3?id_article=15092 (accessed 3 June 2008)

AU 'The Outcome of the African summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases Abuja, Nigeria 24 – 27 April 2001

AU Outcomes of the special summit on HIV/AIDS, Tuberculosis and Malaria (ATM) Abuja, Nigeria 2-4 May 2006

Centre for disease control HIV and its transmission <http://www.cdc.gov/hiv/pubs/facts/transmission.htm>(accessed on 2 September 2008)

Human Rights Watch (2005) A dose of reality: Women's rights in the fight against HIV/AIDS <http://hrw.org/reports/2005/> (accessed on 29 April 2008)

Human Rights Watch 2003 Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls. <http://www.hrw.org/reports/2003/africa1203/> (accessed on 13 October 2008)

Human Rights Watch *Hidden in the Mealie meal: Gender based abuses and women's HIV Treatment in Zambia* (2007) <http://hrw.org/reports/2007/zambia1207/> (accessed on 13 April 2008)

Kahn (2004) L 'Experiences of HIV/AIDS diagnosis, disclosure and stigma in an urban informal settlement in the Cape Peninsula: A qualitative exploration' (2004)

Maman S, Mbwambo J, Hogan M, Kilonzo, G, Sweat M & Weiss E (2001) HIV and partner violence implications for HIV voluntary counselling and testing in Dar es Salaam, Tanzania <http://www.popline.org/docs/1367/156067.html> (accessed on 12 September 2008)

National Center for Ethics in Health Care (2005) 'Disclosing patients' protected health information to surrogates: A report by the National Ethics Committee of the Veterans Health Administration

OHCHR/UNAIDS (1998) HIV/AIDS and human rights: International guidelines <http://www2.ohchr.org/english/issues/hiv/guidelines.htm> (23 January 2008)

Report of the Secretary General 'in depth study on all forms of violence against women' A/61/122/Add 1 6 July 2006

SADC (2006) Expert think tank meeting on HIV prevention in high-prevalence countries in Southern Africa report 2006 http://data.unaids.org/pub/Report/2006/20060601_sadc_meeting_report_en.pdf (accessed on 21 September 2008)

The Centre for the Study of Violence & Reconciliation, Domestic violence and AIDS (2001)

UN Reports The 45th Session of the Commission on the Status of Women: Gender discrimination and the HIV Pandemic <http://www.un.org/womenwatch/daw/csw/index.html>. (accessed on 14 August 2008)

UNAIDS & OHCHR (2006) 'International Guidelines on HIV/AIDS and Human Rights', Consolidated version http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (accessed on 21 February 2008)

UNAIDS (2000) Best practices collection 'The role of name-based notification in public health and HIV surveillance' <http://www.unaids.org> (accessed on 5 July 2008)

UNAIDS (2002) Criminal law, public health and HIV transmission: A policy Options paper http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf (accessed on 7 August 2008)

UNAIDS (2004) Facing the future together: Report of the Secretary General's Task force on Women, Girls and HIV/AIDS in Southern Africa <http://womenandaids.unaids.org/regional/docs/Report%20of%20SG's%20Task%20Force.pdf> (accessed on 3 April 2008)

UNAIDS (2005) HIV – related stigma, discrimination and human rights violations: Case studies of successful programmes (UNAIDS best practices collection) <http://www.unaids.org> (accessed on 7 October 2008)

UNAIDS (2008) 'The global HIV challenge: assessing progress, identifying obstacles, renewing commitment' http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp11_28_en.pdf (28 August 2008) 318 - 332

UNAIDS Points for response to 'reassessing HIV Prevention' in science: Only does not work for HIV prevention http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080605_UNAIDS_web_posting_Points_for_response_to_Reassessing_HIVprev_in_Science.asp (accessed on 14 September 2008)

UNAIDS policy brief: Criminalization of HIV transmission http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf (accessed on 9 September 2008)

UNAIDS Policy Brief: The Greater involvement of people living with HIV (GIPA) http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf (accessed on 4 October 2008)

UNAIDS/WHO (2000) 'Opening up the HIV/AIDS epidemic: Guidelines on encouraging beneficial ethical partner counselling & appropriate use of case reporting' http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp_en.pdf (accessed on 19 September 2008)

UNAIDS/WHO (2004) Policy statement on HIV testing http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf (accessed on 7 September 2008)

UNAIDS/WHO (2006) Sub-Saharan Africa 2006 AIDS epidemic update. http://data.unaids.org/pub/EpiReport/2006/04-Sub_Saharan_Africa_2006_EpiUpdate_eng.pdf

UNAIDS/WHO 2007 AIDS epidemic update <http://www.youandaids.org/Infocus/epidemic%20update%202007.pdf> (accessed on 20 February 2008)

UNDP/UNHCR 'A review of regional and national human rights based HIV and AIDS policies and framework in Eastern and Southern Africa'
http://www.unaidsrستا.org/userfiles/file/review_regional_national_HR_HIV_ESA.pdf
(accessed on 23 September 2008)

UNECA (2008) 'Securing our future: Report of the Commission on HIV/AIDS and Governance in Africa'
http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080609_Securing_our_future.asp (accessed on 19 August 2008)

UNECA 2008 'Report of the Commission on HIV/AIDS and Governance in Africa'

UNFPA/IPPF integrating HIV voluntary counseling and testing services into reproductive health settings: Stepwise guidelines for programme planners and service providers.2004 UK: Vitesse Printing Co. Ltd
http://www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf (16 August 2008)

UNICEF The state of the world's children 2007: Women and children -the double dividend of gender equality

UNICEF/UN Statistics Division millennium indicators database
<http://www.millenniumindicators.unorg> (accessed on 25 September 2008)

UNIFEM (2001) Turning the tide: CEDAW and the gender dimensions of the HIV/AIDS' pandemic' http://www.unifem.org/resources/item_detail.php?ProductID=13 (accessed on 4 April 2008)

UNIFEM/ATHENA (2008) 'The power of participation: Women leaders speak'
http://www.unifem.org/attachments/stories/ThePowerOfParticipation_ExecutiveSummary_SinglePages_200808.pdf (Accessed on 18 August 2008)

UNSC (2002) Report of the Secretary General on women, peace and security 2003
<http://www.peacewomen.org/un/UN1325/sgreport.pdf> (accessed on 14 September2008)

Vetten L & Kailash B (2008) 'A preliminary investigation into the links between violence against women and HIV/AIDS in South Africa'
http://www.apwld.org/pdf/Dorcas_WiLDAF_the_story_so_far.pdf (accessed on October 2008)

WHO (2003) 'The right to know: New approaches to HIV testing and counselling'
<http://who.int/hiv/en> (accessed on 21 August 2008)

WHO (2003) Integrating Gender into HIV/AIDS programmes: A review paper 13
http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf (accessed on 15 August 2008)

WHO (2004) HIV status disclosure to sexual partners: Rates, barriers and outcomes for women'
http://www.who.int/gender/documents/en/VCTinformationsheet_%5b92%20KB%5d.pdf
(accessed on 9 August 2008)

WHO (2004) Rapid HIV tests: Guidelines for use in HIV testing and counselling services in resource-constrained settings' <http://www.who.int/hiv/pub/vct/en/rapidhivtestsen.pdf>
(Accessed on 1 October 2008)

WHO (2005) 'Multi-country study on women' health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses'
http://www.who.int/gender/violence/who_multicountry_study/en/index.html (accessed on 2 September 2008)

WHO 'Intimate partner violence and HIV/AIDS Information Bulletin Series, Number 1'
<http://www.who.int/gender/violence/en/vawinformationbrief.pdf> (accessed on 8 September 2008)

WHO Gender Dimensions of HIV Status Disclosure: Rates, Barriers and Outcomes
<http://www.who.int/gender/documents/en/genderdimensions.pdf> (accessed on 21 August 2008)

WHO Increasing access to knowledge of HIV status: Conclusions of a WHO consultation, 3-4 December 2001

WHO(2003) Gender and HIV/AIDS <http://who.int/gender/documents/en> (accessed on 6 October 2008)

WHO/UNAIDS 2007 Guidance on provider-initiated HIV testing and counselling in health facilities 5 http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf (accessed on 17 October 2008)

WEBSITES

HIV partner notification www.health.state.ny.us/nysdoh/hiv aids/hivpartner/intro.htm
(accessed on 5 June 2008)

<http://www.genderandaids.org/> (accessed on 24 September 2008)

<http://www.unifem.org/> (accessed on 1 October 2008)

On pre-nuptial testing; Zambia should enforce mandatory HIV/AIDS pre-nuptial testing with partner notification <http://ocw.mit.edu/NR/rdonlyres/Special-Programs/SP-253Spring-2005/C5C6D5BC-281A-4FBA-BD28-62225F81600F/0/priyadesai.pdf> (accessed on 29 September 2008)

Partner telebriefing transcript announces final recommendations for routine HIV screening in health care settings www.cd.gov/hiv/topics/testing/healthcare (accessed on 29 September 2008)

The Protocol on the rights of women in Africa: Strengthening the promotion and protection of women's human rights in Africa <http://www.amnestyusa.org/document.php?lang=e&id=51444F4B0A2DDB0780256EA900424658> (accessed on 30 August 2008)

The reality and the paper <http://www.pambazuka.org/en/category/features/22722> (accessed on 8 October 2008)

WILDAF 'The African Charter on Human and Peoples' Rights and the Additional Protocol on Women's Rights' <http://www.wildaf.org.zw/news4.html> (accessed on 29 August 2008)

INTERVIEWS

Bineta Diop Executive Director Femmes Africa Solidarite 28 August 2008, Addis Ababa, Ethiopia

Dr Akinyi Nzioki Executive Director , Centre for Land, Economy and Rights of Women (CLEAR), Chairlady of Eastern African Sub-regional Support Initiative for Advancement of Women (EASSI), 28 August 2008, Addis Ababa, Ethiopia

Dr Grace kalimugogo Head of AIDS Watch Africa, department of Social Affairs, on 1 October 2008, Addis ababa, Ethiopia

Dr Laban O Masimba Social affairs Department 1 October 2008, Addis ababa, Ethiopia

Dr Noerine Kaleeba Founder and patron of The AIDS Support Organization (TASO) Uganda Ltd 1 October 2008, Addis Ababa

Mary I Legwaila Director Women Affairs Department Ministry of labour and Home Affairs 28 August 2008, ECA Addis Ababa, Ethiopia

Peter Nsefula Director Women and Child Development 28 August 2008, ECA Addis Ababa, Ethiopia