THE PROTECTION OF THE RIGHT OF WOMEN UNDER THE AFRICAN HUMAN RIGHTS SYSTEM IN LIGHT OF THE HIV/AIDS PANDEMIC: A CASE STUDY OF MOZAMBIQUE

Submitted in partial fulfilment of the requirements for the degree LLM
(Human Rights and Democratisation in Africa)

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DECLARATION

I, Isatou Harris, 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. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfilment of the requirements for the award of the LL.M Degree in Human Rights and Democratisation in Africa.

Signed…….

Date…….

Supervisor: Mr. Leopoldo de Amaral

Signature…….

Date……..

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DEDICATION

To all women specially those living or affected by the HIV/AIDS pandemic in Africa, to the victims of past atrocities of this continent; to whose pain, deprivation and justice unrelenting global effort is allocated, and to posterity, for the record.

LIST OF ABBREVIATIONS

African Commission on Human and Peoples' Rights	(ACHPR)
Anti-Retro-Virals	(ARVs)
Fourth World Conference on Women held in Beijing	(Beijing Conference)
Human Immuno-Deficiency Virus/ Acquired Immuno Deficiency Syndrome	(HIV/AIDS)
International	(Int'l)
International Covenant on Civil and Political Rights	(ICCPR)
Medecins Sans Frontieres	(MSF)
Office of the High Commissioner for Human Rights	(OHCHR)
Southern Africa Development Community	(SADC)
South African Journal for Human Right	(SAJHR)
Sexual Transmitted Diseases	(STDs)
The African Charter on Human and Peoples' Rights	(Charter)
The Convention on the Elimination of all Forms of Discrimination Against Women	(CEDAW)
The International Covenant on Economic, Social and Cultural Rights	(ICESCR)
The International Labour Organisation	(ILO)
United Nations	(UN)
United Nation Programme on HIV/AIDS	(UNAIDS),
United Nations Children's Fund	(UNICEF)

Universal Declaration of Human Rights	(UDHR)
Volume	(Vol.)
World Health Organisation	(WHO)
World Trade Organisation	(WTO)
Young Women's Christian Association	(YWCA)

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CHAPTER I: INTRODUCTION

1.1 Background to the study

The obligation of African States to respect and protect human rights under the African Regional Human Rights System remains very much on paper; African States are continually in breach of the obligation to respect and promote the rights of women especially those living with HIV/AIDS. The fact is that when the African Charter on Human and Peoples' Rights (African Charter} was drafted, the HIV/AIDS pandemic was not an issue and therefore not taken into account. Thus the few provisions of the African Charter, which do afford protection to women's rights, are inadequate to address HIV/AIDS.[1] Consequently, a number of declarations and resolutions were made on the issue to address the problem and yet African governments failed to take adequate measures to protect women with HIV/AIDS in their respective countries. This situation can explain the harmful cultural practices that threaten the lives of most African women. Lack of education, forced marriage, polygamy, sexual cleansing have been identified as ~~a~~ particular causes that make women vulnerable and being victim to the HIV/AIDS pandemic. As a result of this situation and other problems women in Africa face, a Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol on Women), has been adopted by the African Union on July 2003[2]. This instrument is intended not only to address the problems, which are unique to Africa but also to remedy the deficiencies of the Convention of all forms of Discrimination against Women (CEDAW),[3] at an international level and the African Charter at the regional level.[4]

1.2 Statement of the research problem

All over the world women face a higher risks of being infected by AIDS as well as increasingly bearing the brunt of its impact. This is especially true in sub-Saharan Africa, the region hardest hit by HIV and AIDS. In this region, more than half of all adults living with HIV and AIDS are women[5]. This is due to their vulnerability that is attributable to a number of factors including culture, illiteracy and their relative position of economic disempowerment.

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1 Delport, E "The African regional system of human rights – Why a protocol on the rights of women? Available at: http://www.up.ac.za/chr/gender/sadc%20intro%20african%20system%20and%20draft%20protocol.doc (accessed on 09 February 2004).

2 During the intervening nine months 29 states have signed the Protocol; yet only three countries has ratified which is Comoros, Libya and Rwanda.

3 Some scholars perceive CEDAW, as reflecting only western values. Thus it is unable to address the problems which are related to Africa. In addition, while many countries has ratified this instrument, many African States have made reservations thereto and as such are under no obligation to comply with certain provisions, in particular those relating to harmful practices. (See note above 1).

4 See above note 1

5 UNAIDS report 2002.

Distinguish between infection rate and effect. Despite this, available legal standards at the African level do not sufficiently address this problem. Given that HIV/AIDS is no longer merely a health issue, but equally a Human Rights issue, a new approach, including elaboration of existing standards should be adopted. These existing standards such as the provisions in the African Charter relating to discrimination (Art.2), to the principle of equality before the law (Art. 3) to the right to health (Art.16), to education and free participation in the cultural life of one's community (Art.17 (2) and (3)), to protection of the family (Art.18 (1), and also the right of women (Art. 18(3)) and the child as stipulated in international conventions and declarations.

1.3 Focus and objectives of the study

This dissertation first explores specific issues highlighting the weaknesses in the legal provisions on Women's Rights and HIV/AIDS problem and its resulting effect on the obligation of African States to take adequate measures to protect women especially those living with HIV/AIDS. Secondly, it examines, for purpose of meeting the first objective, into what is provided for by the African Regional Human Rights System through the Charter provisions, declarations and resolutions relating to the HIV/AIDS and the protocol on the rights of women. Thirdly, the dissertation inquire into the extent to which Mozambique is meeting its obligations to address the problem of discrimination against women and to provide health care to women living with HIV/AIDS. Finally, in the light of the lacunae found within the African Regional Human Rights System in addressing women's rights and HIV/AIDS, this dissertation will make recommendations to fill the void and better protect the rights of women in Africa, especially those living with HIV/AIDS.

1.4 Significance of the study

Despite the fact that attempts have been made to protect the rights of women under the African Regional Human Rights System, the need has arisen to address this problem in the domestic level also. The problems experienced on the regional level in providing adequate measures to protect women's rights raise concerns on protection at the domestic level for women living with HIV/AIDS. Thus, the extent to which Mozambique is fulfilling its obligations domestically in this direction will be brought into sharp focus.

My interest in pursuing this research has been stimulated by my realisation of an apparent lack of cohesion among some authors on women's rights and HIV/AIDS and the general inadequacy of the regional human rights system in addressing a thorny problem in Africa in the new millennium in spite of the provisions in the African Charter mentioned above.

I also embark on this research because I would like to develop a more inclusive framework for consideration and discussion of the impact of HIV/AIDS on women in Africa and how the African Regional Human Rights System can develop better and more comprehensive principles to ensure the protection of HIV women rights by African States.

My own experience resonates with what I have found in the literature that many women infected with HIV/AIDS especially in Mozambique have suffered from egregious human rights abuses. Thus my point of contention is the adoption of a comprehensive human rights approach in dealing with the issue of HIV/AIDS.

The protection of the rights of women on the African continent will continue to be a thorny problem until effectively addressed. One of the ways of achieving this goal is by eradicating those cultural practices that are that are harmful to women's existence and also by providing adequate health care to women's with HIV/AIDS.

1.5 Hypotheses

In the first place, given the circumstances of African Women in terms of high levels of illiteracy, exposure to harmful cultural practices and economic disempowerment, they are more vulnerable to the HIV/AIDS pandemic than men and this necessitates special protection. Secondly, this dissertation conceives that African Human Rights System as at present does not adequately provide for the protection of women in light of their vulnerability to HIV/AIDS. And lastly that HIV/AIDS is a Human Rights issue that requires commitment from States in implementing their obligations.

1.6 Literature survey

To protect women with HIV/AIDS in Africa remains a work in progress. The Lome Declaration on HIV/AIDS in Africa[6] adopted by the African Commission on Human and Peoples' Rights reveals a frank and extensive discussion on the epidemic of HIV/AIDS in our countries but not enough to ensure the protection of women with HIV/AIDS in the continent. Wojcik argues that in reviewing the relative short history of responses to the HIV/AIDS pandemic, a common denominator of effective programmes has been the respect for human rights and dignity of persons.[7] HIV/AIDS is therefore a human rights issue, which has to be approached by applying human rights principles. In this regard various authors also address the issue of implementing human rights instruments dealing specifically with women's rights.

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6 *AHG/Decl.3 (XXXVI) 2000.*

7 Wojcik M. (1997) Global Aspects of AIDS' in DW Webber (Ed. 3rd) *AIDS and the Law* 454.

Askin et *al*[8] identifies the possible difficulty of implementing instruments of this nature in so far as this relates to the state's role. In this regard CM Cerna and JC Wallace maintain that:

> [In] case of cultural tradition, accountability by the state is rarely sufficient and that harmful practices may continue even when governments try to force compliance'.

Therefore Antilla rightly argues that HIV/AIDS-related discrimination is a problem not only to HIV positive persons and AIDS victims, but also to those persons belonging to the so-called risk groups.[9] In the African context, the so-called risk groups include women sex workers (e.g. Mozambique), and those who are victims of sexual cleansing (e.g. Zambia, Malawi).

1.7 Methodology

In order to examine such a broad topic it is necessary for the research to be interdisciplinary in nature. My own background includes law, which has narrowed to human rights law, as an area of specialisation. As a researcher and as well as being personally interested in the field of HIV/AIDS and human rights, other fields such as sociology will be necessary in undertaking this research. A number of instruments and sources will be consulted. This will include: various international and regional human rights instruments; resolutions and declarations adopted by African at the regional level; various pieces of legislation and policy documents; text books, articles and Internet sources. Interviews with various people will also be undertaken.

1.8 Limitations

This study is limited in so far as it examines the African Regional Human Rights System that exists to protect women's rights. The reason for this approach relates particularly to the fact that despite being ratified by African States, the African Charter shows its ineffectiveness to adequately address the issue of the rights of women in light of the HIV/AIDS pandemic.

In relation to the difficulties experience with regard to this paper, is the lack of political will on the part of the states to implement effectively the provisions of the Charter and other regional human rights instruments relating to the right of women and especially those living with HIV/AIDS.

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8 Cerna C. and Wallace J *(1998)* 'culture and women' in KD Askin and DM Koenig *women and international human rights law (vol 1) 647.*

9 Anttila M (1999) 'Aids does not discriminate but people does' in L Hannikainen *et al New Trends in Discrimination Law-International Perspectives* 3 Turku Law School and the Authors. 223.

Another limitation highlighted by addressing this particular topic, is that the discussion can only be focused on one particular country to ensure a detailed study of the state's obligations under the African Regional Human Rights System to provide health care and protect women against all form of discrimination. This paper will consider the case of Mozambique.

1.10 Overview of chapters

The study will consist of five chapters. Chapter one provides the context in which the study is set. It highlights the basis and structure of the study. Chapter two outlines specific issues on the inability of the various legal provisions on women's rights and HIV/AIDS to effectively protect women from the scourge of HIV/AIDS. Chapter three discusses the African Regional Human Rights System. Here specific reference is made to some provisions of the African Charter relating to the right of women as well as some declarations and resolutions on the HIV/AIDS pandemic. Also reference is made to the Protocol on the Rights of Women. Chapter four highlights and addresses the gaps relating to the protection of women from HIV/AIDS in the African Regional Human Rights System and finally chapter five will consist of a summary of the dissertation and the conclusions drawn from the entire study. It will also make some recommendations as to how HIV/AIDS should be dealt with both at the regional level (the role of the African Commission) and at the domestic level (the role of the state) in relation to the violation of women's rights.

CHAPTER II: SPECIFIC ISSUES HIGHLIGHTING VULNERABILITY OF WOMEN'S RIGHTS AND HIV/AIDS

There is a direct correlation between women's low status, the violation of their human rights and HIV/AIDS transmission. The reason that AIDS has escalated into a pandemic is because of inequality between women and men continue to be pervasive and persistent. African girls and women face numerous human rights abuses at all stages of life –as children in school or, as is increasingly the situation of girls affected by HIV/AIDS, out of school; as adults, in long-term unions where decision-making authority over sex is too rarely theirs and where economic dependence and inequality under the law limit their options for redress; in widowhood where gender discrimination is the rule rather than the exception for inheritance and control of property; and in war and civil conflict where rape is used strategically as a weapon, sexual abuse, violence and discrimination are the overarching violations they face at all stages of life.[10]

The vulnerability of women to the HIV pandemic is attributable to a number of factors including women's biological vulnerability[11], culture, illiteracy and their relative economic disempowerment.[12] Such problems are described below.

2.1 Women's biological vulnerability

Regardless of the type of partner relationship, specific conditions and sexual practices place women at special risk if their partners are infected.[13] "Classic" STDs, which often led to reproductive health problems in the past, have become epidemic. Their presence substantially increases the risk of acquiring HIV from an infected sex partner. Because signs are often subtle and many men do not notify their partners, women may not know when they are infected.[14] Even when they suspect an infection, shame may prevent women from seeking treatment. Often the care available is inadequate, prohibitively expensive, or undignified and lacking in confidentiality.[15]

Trauma causing tears in the vaginal skin (mucosa) allows the HIV to enter. This may occur at first intercourse, particularly in the case of girls and young adolescents penetrated by

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10 Human Rights Watch Reports on Gender-Related Abuses and AIDS in Africa, *A call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa,* 2002.

11 Brooke G., *AIDS, Gender, and sexuality during Africa's Economic Crisis,* in African Feminism: The Politics of Survival in Sub-Saharan Africa 310-11, 315-30 (Gwendolyn Mikell, ed. 1997).

12 Women and International Human Rights Law, vol.2, ed. Kelly D. Askin et al. ; 1998.

13 Women and law in Sub-Saharan Africa, Cynthia Grant Bowman et al. 2003, p280.

14 See note 11 above.

15 Ibid.

mature men.[16] The condition of the vagina is also a factoring adult trauma. For example, in many cultures, men who prefer intercourse in a tight, dry vagina may omit erotic foreplay.[17]

In the presence of high levels of background infection, these conditions, taken together with the likelihood of acquiring other STDs from sexually experienced male partners, help to explain the high susceptibility of young females, many of whom become infected at first coitus.[18]

Following menopause, the female genital mucosa again become thin and fragile due to lack of estrogen, and secretions are often limited.[19] Men may return often to their first wives, even as they seek sex with younger women. Few men protect their wives by using condoms at home.[20]

2.2 Harmful cultural practices

Social and cultural systems in many African countries dictate that women have no control over their sex lives or their husband's sex lives outside marriage.[21] Bridal payments, or dowry as popularly known, perpetuate the idea that the woman is her husband's property[22]. Culturally, wives are not allowed to refuse sex from their husbands or to use a condom even when a man may be infected with AIDS.[23] Evidence also suggests that a large share of new HIV infections are due to gender-based violence in homes, schools, the workplace and other social arenas. Forced or coerced sex renders a woman even more vulnerable to infection, and the younger she is, the more likely it is that she will contract HIV.[24]

Women and girls are physiologically more vulnerable to infection, and gender-based inequities compound their risks.[25] They are more likely to be poor and powerless[26], have less education, less access to land, credit or cash, and to social services. Influence of culture and armed conflict on women and AIDS spread. It is widely recognized that the influence of negative aspects of culture and tradition has exacerbated AIDS infection in women. Cultural factors have played and still play a massive part in the spread of HIV/AIDS.

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16 See note above 11.
17 Ibid.
18 Ibid.
19 Ibid.
20 Ibid.
21 Human Rights Watch Reports on Gender-Related Abuses and AIDS in Africa, *A call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa, 2002.*
22 See note above 11.
23 Ibid.
24 Ibid.
25 Ibid.
26 Lisa K. Women's Human Rights and Article 18 of the Banjul Charter ,*East African Journal of peace & Human Rights,* vol.3:1, 1996.

This section will study in details only some most harmful cultural practices that are considered to be major problem among others of the HIV transmission to women.

2.2.1 Female genital mutilation

Female genital mutilation (FGM) is an umbrella term for a number of culturally motivated practices that involve partial or complete cutting of female genitals, usually performed in child hood or adolescence as reported by the Center for reproductive rights.[27] The World Health Organisation (WHO) estimates that between100 and 140 million women and girls have undergone FGM and that about 2 million more are added to that number each year.[28] According to WHO, the practice is widespread in twenty eight African countries, which account for the vast majority of FGM cases worldwide, with Burkina Faso, Central African Republic, Gambia among the countries in which more than 40 percent of girls are estimated to be affected.[29] Some 15 percent and women and girls who have undergone FGM have suffered the most severe form, infibulation,[30] whereby the clitoris and labia are removed and the vaginal opening is stitched shut, leaving only a small space.[31] But over 80 percent of FGM cases in Somalia, Djibouti, and Sudan involve infibulation.[32] Although few clinical studies have been conducted, it is clear that at least some forms of FGM increase the HIV transmission risk faced by women and girls, both in that unsterilised instruments may be used in the cutting and because some FGM is associated with chronic genital injury and tearing, ulceration, and delayed healing of injuries, all of which may increase HIV risk.[33]

Twelve countries have criminalized FGM by law, including some of those noted above as having high prevalence of the practice. According to the Center for Reproductive Rights,[34] as of January 2003 perpetrators of FGM had been prosecuted only in Burkina Faso, Ghana, Senegal, and Sierra Leone among sub-Saharan countries.[35] In spite of legislation, FGM gets little policy and program attention in Africa, and there is certainly little evidence that is linked at the policy level to HIV/AIDS.[36] Attention to HIV/AIDS program and policy and to the

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27 Centre for Reproductive Rights, " Female circumcision-female genital mutilation (FC/FGM): Legal prohibitions worldwide (fact sheet)," June 2003 [online] at http://www.crlp.org/pub_fac_fgmicpd.html accessed may 2004.

28 World Health Organisation, female genital mutilation. (fact sheet no. 241, June 2000).

29 WHO estimated prevalence rates of FGM, available at http://www.who. Int/docstore/frh-whd/FGM/FGM%20 prev%update.html or www..Hrw.org/reports/2003/Africa 1203/6.htm (aaccessible July 2004).

30 See note above 26.

31 United Nations Population Fund, " Forms of gender-based violence and their consequences: *female genital mutilation*" available at http://www.unfpa.org/inter-center/violence/gender2c.htm (accessed on 12 July 2004).

32 Centre for reproductive rights, FGM Fact Sheet.

33 Margaret Brady, ''*female genital mutilation: complication and risk of HIV transmission,''* AIDS patient care and STDs, vol. 13. no. 12, December 1999, pp. 709-716.

34 Note 27 above.

35 Ibid.

36 Dawit, *Culture as a Human Rights Concern: Highlights for Action With the African Charter on Human and Peoples' Rights, in* Gender Violence and Women's Human Rights in Africa 42 (Center for Women's Global Leadership ed., 1994).

importance of basic protections for women and girls provides an opportunity to energise decision makers to enforce existing legislation and take other measures to limit the practice of FGM.[37]

Recently an international conference on FGM has ended in Kenya with a fresh call to ban the practice.[38] The protocol on women's rights, which has so far been ratified by only three states, Rwanda, Libya and Comoros, provides that women should be protected from harmful customs. It appears that this practice is widespread. It is reported that 90 million African women are victims of female circumcision and other forms of genital mutilation.[39]

In terms of the human rights instruments, there is no doubt that the practice is a violation of the rights of women and girls and an assault on their human dignity. Although FGM is banned in 14 African countries, including Ethiopia, Uganda, Ghana and Togo, the practice is still widely carried out. However, form evidence gathered on the ground, this practice is not a major problem in Mozambique.[40]

2.2.2 Dry sex

In some part of Africa, so-called ''dry sex'' is frequently practiced whereby girls and women attempt to dry out their vaginas in an effort to provide more pleasurable sex to men.[41] Human Rights Watch found that in Zambia, dryness is achieved by using certain herbs and ingredients that reportedly reduce vaginal fluids and increase friction during intercourse. Given the likelihood that dry sex will cause tears and lacerations in the vaginal wall, especially among adolescent girls, the practice increases the risk of HIV transmission.[42] In the1999 report by the Zambian Ministry of Health and the Central Board of health stated: ''to enhance male pleasure, a number a women continue to practice dry sex, which can increase vulnerability to infection through exposing genital organs to bruising and laceration.''[43] While in Zambia the practice is being discouraged by counsellors working with young people and in official government documents, it is hard to know whether it is on the decline. It has been stated that "like condoms, it is difficult to say if people follow what they know.''[44] AIDS educators discuss the dangers of dry sex in outreach programs, explaining that it is an easy way to transmit HIV. But, as one

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37 Violence Against Women and HIV/AIDS: Setting the research Agenda, Meeting report, WHO-Geneva, 23-25 October 2000.

38 BBC news, http://news.bbc.co.uk/go/pr/fr/-/2/hi/africa/3669762.stm, 2004/09/19.

39 See note above 38.

40 This came out of two interviews conducted by the author with Marcia Colquhoun, Senior Development Advisor at the Canadian High Commission, (22nd September 2004), and Dr. Angela Melo, Commissioner and Special Rapporteur on the Rights of Women in Africa, (29th October 2004) Maputo-Mozambique.

41 National HIV/AIDS/STD/TB council, ''strategic framework 2001-2003,'' (Lusaka, October 2000), p.9.

42 Note above 15.

43 Republic of Zambia, gender in development division, office of the president, "*national gender policy,''* (Lusaka: March 2000), p 2,9-11; Ministry of health/central board of health ''HIV/AIDS in Zambia: Background, projections, impacts, interventions," (Lusaka: September 1999),p.49.

44 UN Integrated Regional Information Networks news at http://www allAfrica.com accessible, September 20, 2004.

counsellor told Human Rights Watch, 'men love dry sex. If you are wet, they think it's not normal. So we talk about it in outreach; we say 'stop using those herbs.'''[45]

Counsellors at the Young Women's Christian Association (YWCA) drop-in center in Lusaka, Zambia, one of the main NGOs providing counselling for abused girls, explained that girls are made to believe that they are supposed to be dry. There is even a name given to girls who are wet - Chambeshi River, referring to a river in Zambia.[46] Some men tell girls that being wet mean they have been with too many men. Service providers working with sex workers noted that they do not generally practice dry sex; rather it occurs more in 'stable' unions where the girl or woman is seeking to maintain the relationship.[47] In Mozambique, there are no known cases of the practice of dry sex.[48]

2.3 Poverty, women sex workers and HIV/AIDS

Lack of education for girls results in poverty and economic dependence on men.[49] Economic dependence on men may force women into risky situations. Inadequate opportunities for women to access job/career opportunities, as well as the fact that they are largely and absent from decision making are major factors in this debate.

In the context of the entrenched poverty and the absence of organized sex worker collectives in sub-Saharan Africa, sex workers are at particular risk because they often do not have the luxury of refusing clients who are violent or who insist on sex without condoms. In several African countries, according to Human Rights Watch, they spoke with girls and young women working in the sex trade who understood the risks of sex without condoms but did not feel they had much choice in the matter.

However in Mozambique, sex workers receive counselling and condoms from NGOs and have also, at least in Maputo, a medical clinic that operates at night where they get medical assistance and counselling. The Mozambique National Strategic Plan to combat STDs/HIV/AIDS for 2000-2002 identifies the need for political action in the preparation and adoption of an alternative law concerning commercial sex and its protection. Section 3.3.4.3 of the National Strategic Plan deals with strategies to improve the national response in the area of commercial sex workers. The strategies are aimed at increasing education projects for truck

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45 Human Rights Watch interview with women from PALS, Lusaka May 23, 2002 " (Policy Paralysis ''*A call for action on HIV/AIDS-related human rights abuses against women and girls in africa'' p.22).*

46 Human Rights Watch interviews with the counsellors at YWCA, Lusaka, May 23, 2002. (Policy Paralysis ''*A call for action on HIV/AIDS-related human rights abuses against women and girls in africa'' p.22)*

47 Human Rights Watch interview with professor Nkandu Luo, May 21, 2002. (Policy Paralysis ''*A call for action on HIV/AIDS-related human rights abuses against women and girls in africa'' p.22)*

48 See note above 45.

49 Presentation on Gender and HIV/AIDS, made at the Conference on " Gender and HIV/AIDS: *Mobilising African Leadership for Prevention and Access to Treatment"* by Litha Musvimi-Ogana, Gender and Civil Society Advisor, NEPAD Secretariat.

drivers and sex workers, and defining and access strategy for the two vulnerable groups to health services and the condom distribution and sale system.[50]

Worsening poverty as HIV/AIDS strikes the lifeline of society that women represent, a vicious cycle develops. Most of the world's women are poor and most of the world's poor are women.[51] Women make up almost two thirds of the world's illiterate people and are often denied property rights or access to credit. Women's economic vulnerability and dependence on men increases their vulnerability to HIV by constraining their ability to negotiate safe sex. More catastrophically than elsewhere, the HIV/AIDS epidemic has deepened poverty and exacerbated myriad deprivations in sub-Saharan Africa.[52] As a result of AIDS, poorer women are becoming economically disempowered and less secure. They are often deprived of inheritances or even adequate health services.[53]

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50 Lepoldo & Lyrette, HIV/AIDS and Human Rights in Mozambique, Centre for Human Rights and the Centre for Human Rights, University of Pretoria, p 26.

51 Women and International Human Rights Law, vol.2, ed. Kelly D. Askin et al. ; 1998.

52 See note above 49.

53 International Center for Research on Women, *Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa,* Working paper, June 2004.

CHAPTER III: HIV/AIDS AS A HUMAN RIGHTS ISSUE: INTERNATIONAL RESPONSES

The "universal" foundation of women human rights are inscribed in Several International documents, including, among others, The Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the U.N. Declaration on the Elimination of Violence Against Women, the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (Vienna Declaration), and the Fourth World Conference on Women held in Beijing (1995). The main points of these documents were encapsulated in the mission statement to the Platform for Action of the Fourth World Conference on Women, of which the second articles state:

> The Platform for Action reaffirms the fundamental principle set forth in the Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights, that the Human Rights of Women and the girl child are an inalienable, integral and indivisible part of universal human rights. As an agenda for action, the Platform seeks to promote and protect the full enjoyment of all human rights and the fundamental freedoms of all women throughout their life cycle.[54]

The Platform for Action identifies twelve focus areas as particularly germane to women's rights, among them: Poverty, education, health, violence against women, economic structures and politics, inequality of men and women in decision making, gender equality, women's human rights, environment, and the girl child.[55]

It is also important to point out at the outset that whilst there has been an international trend towards the recognition of civil and political rights by governments,[56] there has been stagnation, and often a regression in the progressive realization of social and economic rights.[57] This is reflected in the United Nation Human Development Report for 2000 and is a major factor explaining the inability of governments to control and slow down the spread of HIV.[58] At the same time, the AIDS epidemic constitutes a particular threat to a state ongoing ability to

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54 See note above 50.

55 Women and International Human Rights Law, vol.2, ed. Kelly D. Askin et al.; k644-w564, 1998

56 Frederick M. The Right to Health in the Global Economic: *Reading Human Rights Obligations into the Patent Regime of the WTO-TRIPS Agreement,* International Yearbook of Regional Human Rights- Masters Programmes- 2001, p205

57 See note above 26

58 Dr Evian C, AIDS and Social Security, paper presented at Southern African Conference on AIDS and Employment, 1994: ÒA home implies or promotes a family, the likelihood of a more permanent and loyal partner, a location within the context of a community, out and about less and living in a more secure and humane environment.

deliver social and economic rights in the long term. Increasing pressure on health[59] and education systems,[60] for example, depletes the resources and capacity of a state, especially in the developing world, to maintain the delivery of these services.[61]

On 10 September 2002, the Office of the UN High Commissioner for Human Rights (OHCHR) and the joint UN Program on HIV/AIDS (UNAIDS) released a revised international guideline on "Access to prevention, treatment, care and support." The update to guideline 6 of HIV/AIDS and Human Rights: International Guidelines reflects significant therapeutic, political, and legal developments in this area since the 12 guidelines were originally published in 1998. The new guideline 6 significantly expands the guidance given to governments on what international human rights norms require of them in relation to HIV/AIDS prevention, treatment, care, and support.

3.1 International guidelines adopted by UNAIDS and Office of the United Nations High Commissioner for Human Rights

3.1.1 Background

In 1995, the UN Secretary-General recommended to the UN Commission on Human Rights the development of guidelines outlining to government " how human rights standards apply in the area of HIV/AIDS" and identifying " concrete and specific measures, both in terms of legislation and practice, that should be undertaken" to protect and promote respect for human rights in the context of HIV/AIDS.[62] The Commission agreed.[63] In 1996, UNAIDS and the OHCHR held the second International Consultation on HIV/AIDS and Human Rights, bringing together a group of experts who drafted 12 guidelines for state action as well as recommendation for their implementation. They also produce a detailed discussion of how international human rights obligations apply to issue raised by HIV/AIDS. These materials were released by UNAIDS and the OHCHR in 1998. The Commission for Human Rights has urged states to ensure their laws, policies, and practices comply with the guidelines and to report on the steps they have taken to promote and implement them.[64]

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59 At the same time if women as a group are more vulnerable to HIV/AIDS than men, womenÕs vulnerability in relation to each other is further fragmented by a combination of factors such as race, class, age, ethnicity, urban/rural location, sexual orientation, religion and culture

60 Research across the world has found that the conditions and timing of sex are defined by male partners, giving women little or no opportunity to discuss or practice safer sex. See T Barnett and P Blaikie *AIDS in Africa: Its Present and Future Impact* (1992); Wood, K and Jewkes, R (1988), *ÔLove is a dangerous thingÕ: Microdynamics of Violence in Sexual Relationships of Young People in Umtata*, CERSA, WomenÕs Health

61 Report Prepared for the CHRI by Cathi Albertyn and Mark Heywood of the Centre for Applied Legal Studies, University of the Witwatersrand, released in April, 30 2001 on the website http://www.alp.org.za

62 Report of the UN Secretary General, UN Doc E/CN.4/1995/45.para 135.

63 Resolution 1996/43.

64 Resolution 1997/33, 1999/49, 2001/51.

Since the Guidelines were first released, there have been many developments related to access to HIV/AIDS treatment, care, and support. Some key developments can be highlighted. The UN Commission on Human Rights has adopted a resolution by confirming that access to HIV/AIDS medication is a key component of the human right to the highest attainable standard of health.[65] The UN Committee on Economic, Social and Cultural Rights, which monitors states' compliance with the International Covenant on Economic, Social and Cultural Rights, has issued a "General Comment" on the right to health that makes it clear that the right to health includes access to treatment and HIV-related education.[66] The World Trade Organization has issued a Ministerial Declaration on its intellectual property agreement and public health.[67] The World Health Assembly has adopted resolutions on HIV/AIDS generally and the issue of access to HIV/AIDS medicines specifically.[68] The International Labour Organisation has issued a *Code of Practice on HIV/AIDS and the world of work* that includes some guidance on care and support of workers infected and affected by HIV/AIDS.[69]

Increasing awareness has seen cases being brought successfully before some domestic courts in some countries, to compel government action to ensure access to antiretroviral and other medicines for either therapeutic treatment of people living with HIV/AIDS or to prevent mother to child transmission of HIV.[70]

In light of these and other developments, UNAIDS and OHCHR decided to convene the Third International Consultation on HIV/AIDS and Human Rights in order to update guideline 6. The consultation, held in July 2002, reviewed advances in HIV/AIDS-related treatment, and political and legal developments, and produced an updated draft text for a new Guideline.

3.2 Revised Guideline 6

The expert consultation agreed that guidance to states in this area should be based on a number of key premises articulating that: access to HIV/AIDS-related treatment is fundamental to realising the right to health; prevention, treatment, care, and support are a continuum; access to medication is one element of comprehensive treatment, care and support; ensuring sustainable access to medication requires action on numerous fronts; and international cooperation is vital

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65 Resolution 2001/33, 2002/32.

66 UN Committee on Economic, Social and Cultural Rights. General Comment No. 14: The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic and Social Rights), adopted 11 May 2000, CESCR 22nd Session, UN Doc E/C. 12/2000/4.

67 Declaration on the TRIPS Agreement and Public Health. WT/MIN(01)/DEC/W/2 adopted 14 November 2001.

68 Eg. See: Resolutions WHA55.12 (2002).

69 ILO Code of Practice on HIV/AIDS and the world of work, June 2001

70 Eg. see the Treatment Campaign case vs Ministry of Health of the Republic of South Africa-

in realising equitable access to treatment, care, and support to all in need. This is a detailed version of original Guideline 6 which had had advised that ´´States should enact legislation regulating HIV-related goods, services and information, and safe and effective medication at an affordable price."

Five accompanying recommendations addressed the use of mass media to provide information about HIV/AIDS; regulations to ensure the quality and availability of HIV testing and counselling; legal quality control of condoms and access to these and other preventive measures such as clean needles; the revision of duties, customs laws, and value-added taxes to maximise access to safe and effective medication at an affordable price; and the importance of consumer protection laws to prevent fraudulent claims regarding drugs, vaccines, and medical devices.

The revised Guideline adds to this, expressly indicating that:[71]

> " States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions.

States are further required to take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

The recommendations accompanying the revised Guideline have now been expanded to 26, incorporating the existing ones and adding new recommendations. These include recommendations to the effect that: States should develop and implement national plans to progressively realise access to comprehensive treatment, care, and support, in consultation with non-governmental organisations and ensuring the active participation of people living with HIV/AIDS and vulnerable groups; States have an immediate obligation to take steps toward realising access for all to HIV/AIDS prevention, treatment, care, and support, and this requires, among other things, setting benchmarks and targets for measuring progress; States should ensure their laws, policies, programs, and practices do not exclude, stigmatise, or discriminate against people living with HIV/AIDS with respect to access to health-care goods, services and information; States should ensure domestic law provides for prompt and effective remedies in cases in which a person is denied or not provided access to treatment, care and support; States should increase funds allocated to the public sector for researching, developing, and promoting therapies and technologies for HIV/AIDS prevention, treatment, care, and support, and should

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[71] Also see recommendations at HIV/AIDS and Human Rights in SADC "*HIV/AIDS and Human Rights in Mozambique"* Lirette Louw et Leopoldo de Amaral, ed 2004, pg.21

encourage the private sector to undertake such research and development and make the resulting options widely and promptly available at affordable prices; States should increase national budget allocations for measures promoting secure and sustainable access to affordable prevention, treatment, care and support at both the domestic and international levels. This includes making contributions, in proportions to their resources, to mechanisms such as the Global Fund to Fight AIDS etc...Furthermore, developed countries should meet international targets for official development assistance to which they have agreed...; States should ensure that, in international forums and negotiations, they take due account of international norms, principles, and standards relating to human rights and avoid taking measures that undermine access to HIV/AIDS prevention, treatment, care, and support, either domestically or in other countries. This includes ensuring that the interpretation and implementation of international agreements, such as those on trade and investment, do not impede efforts to fully realise access to HIV/AIDS prevention, treatment, care, and support.

In releasing the updated Guideline 6, Mary Robinson, the UN High Commissioner for Human Rights, reminded the governments that:

> "*Access to HIV/AIDS treatment is key to realising the fundamental human right to health. Under international human rights law, states have an obligation to take positive legislative, budgetary and administrative measures that progressively advance the right to the highest attainable standard of health. This commitment should be matched by resources, including from donors and the international community."*[72]

Dr. Peter Piot, UNAIDS Executive Director, highlighted that:

> *" With the advent of life-prolonging HIV treatment, and price barriers falling, access to treatment is now at the heart of realising the human rights of people living with HIV/AIDS. The new Guideline 6 will help governments and civil society focus on the need to scale up access to prevention and treatment. Today's unequal and limited access to treatment is unacceptable, with less than 5% of people in the developing world who need HIV medicines having access to them."*[73]

It will now be up to civil society organisations, as well as UN bodies such as UNAIDS and the OHCHR, to promote the revised International Guidelines and encourage states to follow the recommendations. Further reports from the UN Secretary-General to the UN Commission on Human Rights provide one mechanism for this, and both UNAIDS and the OHCHR should promote the revised Guidelines in various UN and regional forums, for example, human rights committees, commissions, courts, and other relevant conferences and

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72 United Nations Entrenches Human Rights Principles in AIDS Response: Updates International HIV/AIDS and Human Rights Guidelines Calls on Governments to Take Significant Human Rights Action." Joint UNAIDS/OHCHR press release, Geneva, 10 September 2002.

73 Note 36 above.

meetings. Treatment activists and civil society organisations can also make use of the revised Guideline 6 in their advocacy in such international forums and directly with their national governments.[74]

Furthermore, in April 2002, the United Nations Commission on Human Rights adopted two resolutions that are important in the context of access to treatment. The Commission is the UN's leading body with respect to international human rights issues. It consists of 53 UN member states and meets annually.[75]

3.3. World Health Organisation (WHO) policy relating to HIV/AIDS and women

In mid-2002, the WHO estimated that some six million people with HIV/AIDS in developing countries are currently in need of life-sustaining antiretroviral (ARV) therapy, but that only 230,000 have access to these medicines, half of whom live in one country, Brasil. The WHO believes that, with a concerted international effort to expand access to HIV treatment and care, three million people could have access to ARVs by the end of 2005. A number of recent initiatives provide some useful tools towards reaching this goal.[76]

3.3.1 Guidelines for ARV Therapy in poor countries

In June 2002, the WHO released its 165-page document providing technical guidelines to promote the rational and safe use of ARVs in poor countries through standardised regimens and simplified monitoring that is feasible in settings with limited resources.[77] The guidelines were developed through international consultations involving more than 200 clinicians, scientists, government representatives, civil society representatives, and people living with HIV/AIDS from more than 60 countries. The guidelines are based on a review of the evidence and current best practices, supplemented by expert consensus where the body of evidence was not conclusive. The guidelines will be updated as required by new evidence.

Additional materials produced by the WHO, or in collaboration with others, support the use of these guidelines to increase access to treatment in developing countries such as Africa. Several tools have been released in recent months.[78]

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74 HIV/AIDS and Human Rights, *International Guidelines, Revised Guideline 6, Access to prevention, treatment, care and support,* UNAIDS 2002.

75 Www.unhchr.ch (access 14 July 2004).

76 United Nation Development Programme report at http://www.undp.org accessed on 12 October 2004.

77 Scaling Up Antiretroviral Therapy in Resource-Poor settings: Guidelines for a Public Health Approach. Geneva: World Health Organisation, June 2002.

78 See note 72.

3.3.2 List of quality-Approved Medicines and Manufacturers

In March 2002, the World Health Organisation published its first list of HIV-related medicines found to meet its recommended quality standards, as part of its " Access to Quality HIV/AIDS Drugs and Diagnostics" project. The initial list consisted of 40 products from eight brand-name and generic manufacturers, including anti-retroviral drugs (allowing for several triple therapy combinations) and drugs for opportunistic infections. The WHO updates the list regularly, adding new products and suppliers that meet the WHO's quality standards. The inclusion of generic manufacturers on the list is important, assisting countries that do not have strong drug-review systems but need to access less-expensive generic medicines.

3.3.3 Updated information on ARV price reductions

As a result of concerted activism, significant reductions in drug prices have been achieved that will assist in increasing access to affordable HIV/AIDS treatment in developing countries. But the lack of clear information on the various prices available on the international market makes it more difficult to make informed decisions and negotiate affordable prices.

In July 2002, Medecins Sans Frontieres (MSF), the WHO, UNAIDS, and UNICEF issued their second, updated report on the current state of price reductions on ARVs available to developing countries.[79] The report aims to assist developing countries "by providing them with ARV prices offered by originator companies and some generic companies in low and middle-income countries. It is intended for use by government and non-profit procurement agencies, as well as other bulk purchasers of ARVs, including health facilities and NGOs." The information is intended to be used in conjunction with the WHO information about quality-approved medicines and manufacturers.[80]

3.3.4 Reports on trade and access to medicines

In addition to producing these useful tools for accessing and using more affordable medicines in developing countries, the WHO has also addressed the question of legal barriers to access posed by its agreement on drug patents (the "TRIPS Agreement").[81]

In June 2002, it released another paper in its series on essential drugs and medicines policy, entitled *Implication of the Doha Declaration on the Trips Agreement and Public Health.* The paper examines the significance of the Declaration adopted by the trade ministers

[79] See www. Accessmed-msf.org.
[80] Ibid.
[81] See note above 55.

of WTO member countries in Doha, Qatar, in November 2001. It argues that WTO panels and the Appellant Body should, in cases of ambiguity, opt for interpretations of the TRIPS Agreement that are effectively "supportive of WTO Members' right to protect public health." It affirms the argument put forward by some activists and commentators that the Declaration is not only a political statement, but also one with legal effects on the members of the WTO and its dispute-settlement mechanisms.

The WHO also "partnered" with the WTO to jointly produce a report[82] on WTO *Agreements and Public Health.* The report, released in August 2002, examines the way WTO trade agreements may influence health and health policies in a variety of areas, including the question of intellectual property rights and access drugs. The study highlights areas where the links between trade and health require more careful analysis.[83]

[82] See www. wto.org or www.who.int.
[83] See www. Who.int/hiv or www.who.int/medicines.

CHAPTER IV: AFRICAN HUMAN RIGHTS SYSTEM'S RESPONSES TO WOMEN LIVING WITH HIV/AIDS

4.1. The African Charter

The African Charter on Human and Peoples' Rights (Charter)[84] is the principal instrument for the promotion and protection of human and peoples' rights. Van Boven rightly described the Charter as a human rights instrument specifically designed to respond to 'African concerns, African traditions and African conditions.'[85] The Charter never anticipated the existence of the HIV/AIDS pandemic, the substantive provisions of the Charter are to some extent flexible to address the denial of human rights as a result of HIV/AIDS.[86]The human and peoples' rights provided for in the Charter can include, at least in implied terms, those associated with people infected and affected by HIV/AIDS. The HIV/AIDS pandemic has become one of the contemporary African concerns.

In order to uphold the right to life, there is an urgent need to uphold the right to enjoy the best attainable state of physical and mental health which is provided for under article 16 (1) of the Charter.[87] More importantly, article (16) (2) obliges State parties to the Charter to take measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[88] This is very crucial for people living with HIV/AIDS. The right to health involves the provision of anti retroviral drugs which is necessary for the prevention of parent-to-child transmission of HIV.[89] In the *Treatment Action Campaign and others v Minister of Health and Others*,[90] the Constitutional Court held that the South African government's policy

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84 OAU Doc.CAB/LEG/67/3 rev. 5. Adopted June 27, 1981 and entered into force in October 21, 1986.

85 T Van Boven 'The relations between peoples' rights and human rights in the African Charter' 7 Human Rights Law Journal (1986) 186. Also cited in Ankumah 1996: 1. (1996).

86 One criticism levelled against the substantive provisions of the Charter is by Ouguergouz who argues that none of the human rights guaranteed in the African Charter carries an absolute guarantee because the exercise of most of these rights is circumscribed ab initio by limitation clauses or the so-called 'clawback clauses'. See F Ouguergouz *The African Charter on Human and Peoples' Rights: A comprehensive agenda for human dignity and sustainable democracy in Africa* (2002) 429.

87 The right to health is closely related to and dependent upon the realization of other human rights, such as the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health. See Paragraph 3 of the UN General Comment No. 14, Twenty-second session (2000), HRI/GEN/1/Rev.5.

88 See the South African case of *Karen Perreira* v *Sr Helga's Nursery School and another*, Case No 02/4377. In this case a foster mother, of a three year old child elected to disclose her child's HIV status to the a nursery school, believing that it was in the child's best interest for the school to be aware of her medical condition. The school expressed fears of admitting the child and indicated that it did not consider itself equipped to admit a child with HIV as none of its teachers had received any training on how to deal with children with HIV. The school opted to defer the application until such time as it considered itself ready to admit children with HIV and until child was "past the biting stage". The High Court found that since the school had not made a final decision to exclude the child, its conduct did not amount to unfair discrimination. Currently the decision is being appealed.

89 See WHO 'Prevention of Mother-to-Child Transmission of HIV: Selection and use of Nevirapine' WHO/HIV_AIDS/2001.03WHO/RHR/01.21 <http://www.who.int/docstore/hiv/PMTCT/who_hiv_aids_2001.03.pdf> (Accessed 17 March 2004).

of confining the provision of nevirapine to research sites was unreasonable and in contravention of the State's obligation in terms of the Constitution and in particular section 27 (1) of the Constitution which provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of the right to have access health care services, among other things. In *Communication 25/89, 47/90, 56/91, 100/93 (Joined Free legal Assistance Group v Zaire,*[91] the Commission held, among other things, that the shortage medicine constitutes a violation of article 16 of the African Charter.[92]

The recognition of the right to health is interrelated to the right to dignity.[93] The right to dignity cannot be achieved without the right to equality[94] and/or the right against discrimination.[95]

Article 1 of the Charter specifically provides that the State Parties to the Charter shall recognize the rights, duties and freedoms enshrined therein and shall undertake to adopt legislative or other measures to give effect to them. On the issue of HIV/AIDS, the Commission should play a pivotal role by developing guidelines which are Africa specific to assist State Parties in the adoption of legislative or other measures such as policy making, aimed at giving effect to the rights, duties and freedoms associated with HIV/AIDS.

Article 18 of the African Charter has the potential to act as a strong grid for the protection of the human rights of women in Africa, particularly women within the family.[96] At the superficial level, the bulk of the criticism appears to be appropriately directed at the Charter for its apparently hollow promises for the rights of women, much as there is only scant reference to them. It may seem somewhat paradoxical for the framers of the Charter to have placed, side by side, language regarding traditional values with language calling for the elimination of discrimination against women.

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90 2002 (5) SA 721 (CC). The decision in this case captures a fundamental transformation in the conception of judicial enforcement of socio-economic rights under the South African jurisprudence in particular the question of remedies and also illustrates the value of socio-economic rights, and their ability to influence the policy of a government. See David Bilchitz 'Towards a Reasonable Approach to the Minimum core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 SAJHR 1.

91 University of Minnesota Human Rights Library <http://www1.umn.edu/humanrts/africa/comcases/25-89_47-90_56-91_100-93.html> Accessed 17 March 2004).

92 See E Baimu 'The government's obligation to provide anti-retrovirals to HIV-positive pregnant women in an African human rights context: The South African *Nevirapine* Case' (2001) 1 AHRLJ 160.

93 Article 5 of the Charter.

94 Article 3 of the Charter.

95 Article 2 of the Charter. Also see the South African case of *Hoffman v South African Airways*,[95] a job applicant living with HIV/AIDS was refused employment as a South African Airways cabin attendant as a result his HIV-positive status. The Constitutional Court held that people living with HIV/AIDS 'must not be condemned to 'economic death' by the denial of equal opportunity in employment'[95] and ordered South African Airways to employ the appellant. In another South African case, *A v SAA*[95] the South African Airways refused to hire the applicant an account of his HIV status. See also South African case, *A v SAA*[95] the South African Airways refused to hire the applicant an account of his HIV status.

96 Lisa K. Women's Human Rights and Article 18 of the Banjul Charter ,*East African Journal of peace & Human Rights,* vol.3:1, 1996

The Charter contains no article devoted solely to the rights of women or the elimination of discrimination against them. The text of the charter nevertheless suggests that the drafters did, at some level, contemplate the situation of women in Africa. The proof of such consideration is found through the implicit and explicit identification of discrimination against women as an obstacle impeding the full enjoyment of the human rights of women. Implicitly, the drafters identified the existence of sex-based discrimination through their inclusion of "sex" in the general statement of non-discrimination found in both the preamble to the charter and in article 2.[97] Additionally, Article 18, which specially addresses the family, contains a provisions directing states to eliminate all existing forms of discrimination against women and to protect the rights of women.

Despite the apparent dearth of substantive consideration afforded to the rights of women within the Charter, Article 18 provides a basis of strong protection for the rights of women-particularly women within the family. Article 18 creates a mechanism that may be utilized to alleviate the common tension arising out of the state's responsibility to protect the rights of the family unit and the unit and the duty to protect the rights of women within the family. Additionally, the elimination of all forms of discrimination against women articulated in Article 18 has been identified by the African Commission as one of the "main topics" of the Charter.[98] Article 18, which is quoted in whole asserts that:

> 1. The family shall be the natural unit and basis of society. It shall be protected by the state which shall take care of its physical and moral health.
> 2. The State shall have the duty to assist the family which is the custodian of morals and traditional values recognized by the community.
> 3. The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

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97 The preamble sets the tone of the Charter, as it relates to issues involving gender, by calling on states to "dismantle…all forms of discrimination, particularly those base on…race, ethnic group, colour, sex, language, religion or political opinion." Banjul Charter, preamble. The principle of non-discrimination is further articulated by Article 2 which states that "[e]very individual shall be entitled to the enjoyment of the rights, and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national or social origin, fortune, birth or other status." *Id* art.2. The articulation of the non-discrimination principle in article 2 gives force to the non-discrimination objective introduced in the preamble. Further, the extension in Article 2 of the list of non-discrimination grounds suggests that those grounds, such as sex, that comprise the preamble's list have a somewhat higher status than those additional grounds listed in Article 2. Thus, while states must "dismantle" discrimination based on "race, ethnic group, colour, sex, language, religion or political opinion" they do not have the same affirmative duty with regards to "any other opinion [other than political opinion], national or social origin, fortune, birth or other status." Id.

98 Other main topics include "Civil and Political Rights, Economic and Social Rights; [and the] Elimination of all Forms of Racial Discrimination." *See Promotion, Protection and Restoration of Human and Peoples' Rights: Guidelines for National Periodic Reporting,* 17 – 26 October 1986, AFR/COM/HPR.5 (IV) at 3 para 4 [hereinafter Guidelines].

4. The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.[99]

Upon a cursory reading of Article 18, it may strike the reader as somewhat paradoxical for the framers to have placed, side-by-side, language regarding traditional values and language calling for the elimination of discrimination against women.[100] A closer reading[101] and careful analysis of Article 18 clarifies the dictates of the Article. According to the Vienna Convention on the Law of Treaties, "[a] treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose.''[102] Consequently, all provisions of the Charter must be read to be consistent with the object and purpose of the Charter – the protection of human rights.

The language of Article 18 provides a basis upon which to distinguish the different elements prescribed by the Article. The drafters created a distinction between language asserting certain African realities and those ascribing affirmative state duties. Article 18(1) provides an example of the way in which the framers differentiated between fact and duty. The articulation that "[t] family shall be the natural unit and basis of society" differs substantially from the assertion that "[the family] shall be protected by the State which shall take care of its physical and moral health."[103] Common to both regional[104] and global[105] human rights instruments is the identification of the family as the "primary," "fundamental," or "natural" unit of society. Although the classification of the family as such may create a certain level of conceptual tension,[106] the first clause of subsection one, which states that "[t]he family shall be

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99 The same special protection must goes also to people living with the HIV/AIDS especially women. See *Bragon v Abbort (*524 US 624) where the United States Supreme Court decided that people living with HIV are protected by the non-discrimination section of the Americans with Disabilities Act No. 42 of 1990.

100 This perceived paradox derives from the fact that claims of custom and tradition have been used in Africa to justify practices that harm women. *See generally* Dawit, *Culture as a Human Rights Concern: Highlights for Action With the African Charter on Human and Peoples' Rights, in* Gender Violence and Women's Human Rights in Africa 42 (Center for Women's Global Leadership ed., 1994).

101 See note above 70, p 93.

102 Vienna Convention (1969).

103 Article 2 of the Women's Human Rights Treaty also provides an implementation directive. See Women's Human Rights Treaty, U.N. Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, Supp. No.46 at 193, U.N. Doc. A/RES/34/180, 19 I.L.M. 33 [hereinafter Women's Human Rights Treaty]. Regional Instruments contain similar provisions. The African Charter on Human and Peoples' Rights, for example, asserts the state's affirmative duty to give effect to the rights enumerated in the Charter in Article 1. African Charter on Human and Peoples' Rights, June 27, 1981, OAU/AU Doc. CAB/LEG/67/3/Rev. 5 [hereinafter Charter], art. 18(1).

104 The American Convention on Human Rights, for example, defines the family as the "natural and fundamental group unit of society." American Convention on Human Rights, Nov. 22, 1969, O.A.S. Treaty Series No. 36, at 1, OEA/Ser. L/V/I.23 Doc. Rev. 2 entered into force July 18, 1978, art. 17(10.

105 The Universal Declaration , the ICCPR, and the ICESCR all define the family as "natural and fundamental group unit of society." Universal Declaration adopted Dec. 10, 1948, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, Doc. A/6316 (1966) [hereinafter ICCPR]; and the International Covenant on Economic, Social and Cu;tural Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1996) [hereinafter ICESCR].

106 There are varying degrees of truth and tension implicit in statements that the family is either the "primary," "fundamental," or "natural" unit in society. Although the procreative and child rearing functions of families may add validity to such definitions, procreation and child rearing is not confined to the purview of the traditional of the traditional family. Thus, such assertions give rise to a certain level of uncertainty

the natural unit and basis of society,"[107] neither requires nor restricts state action. This contrast significantly with the second clause of subsection one, "[the family] shall be protected by the State which shall take care of its physical and moral health."[108] This is a direction to states to protect the family and an articulation of a purview of such protection. Thus, whereas the second clause of subsection one ascribes an affirmative duty to the state to ensure the physical and moral health of the family, the first clause merely serves to put the African family within the context of African societies.

Article 18(1) requires the state to take care of the family's physical and moral health. Thus, when the state fails to fulfil this duty and the family's health suffers, it accrues responsibility. Domestic violence unquestionably exemplifies poor family health. Therefore, Article 18(1) categorically obliges states to protect women from the violence that occurs within the realm of the family. This directive dramatically departs from the traditional hands-off approach to the family assumed by most human rights instruments.[109] By providing a clear statement of state responsibility for family health, Article 18(1) provides an unprecedented invocation of state responsibility within the " private" sphere.[110]

Further Article 18(3) articulates an unequivocal duty of states to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman…as stipulated in international declarations and conventions." Not only did the drafters again utilize the language of obligation in subsection three but they also provided an evolutionary definition of discrimination against women and the rights of women as defined by international declarations and conventions. In so doing, the drafters created one of the strongest human rights protections available to women by eliminating a step in the usual process by which states bind themselves through international law.[111]

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and exclusivity that calls into question the definition of the family. While I cannot agree that, "[h]ostility to both marriage and the family seems to be a recurring theme in [Western] feminist theory", the conceptual framework of family is indeed being challenged and redefined. See Ronald Thandabantu Nhlapo, *International Protection of Human Rights and the family: African Variations on a Common Theme,*3 INT'LJ.L.& FAMILY II (1989). Thus to declare the family as "primary," "fundamental," or "natural" is to exclude those who do not neatly fit into traditional familial categories. Furthermore, it implies that non-traditional people, groups, or units are secondary, nonessential, or unnatural.

107 African Charter, note above 76.

108 Ibid.

109 The Universal Declaration, the ICESCR and the ICCPR each provide a special blanket of protection for the family with little consideration given to structural gender inequalities. Universal Declaration, *note above 78* (stating in Article 16(2) that the family "is entitled to protection by society and the State" and in Article 12, that "[n]o one shall be subjected to arbitrary (or unlawful) interference with his privacy, family [or] home") ; ICESCR, *note above 78* (stating, in Article 23(1), that "[t]he widest possible protection and assistance should be accorded the family"); and ICCPR, *note above 78 (*stating, in Article 23(1), that the family "is entitled to protection by society and the State" and, in Article 17, that "[n]o one shall be subjected to arbitrary (or unlawful) interference with his privacy, family, [or] home").

110 Lisa K, see note above 70, p 100.

111 See note above 70, p 101

States parties to the Charter have given their *de facto* consent to be bound to any international conventions or declarations that address women's human rights. In fact, according to the African Commission's Guidelines for National Periodic Reports, state parties to the African Charter must turn to the reporting requirements of the women' s Human Rights Treaty when reporting to the African Commission regarding the elimination of discrimination against women in Africa.[112] Thus, information regardless to of whether or not a country has ratified this treaty, state parties to the Charter must comply with its reporting procedures as well as its definition of discrimination against women.

Article 18(3) of the African Charter defines discrimination against women not only in terms of international conventions, such as the Women's Human Rights Treaty, but also in accordance with international declarations. By including declarations in the equation, the drafters established a broad conceptualization of discrimination against women. Reference to both convention and declarations requires the African Commission to look to all international instruments whether binding or not, in assessing states compliance with the elimination of discrimination. Consequently, the African Commission can rely upon new instrument such as the Declaration on the Elimination of violence against Women.[113] or even the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women[114] for guidance in the interpretation of Article 18(3).[115]

Although the African Charter includes the duty of states to eliminate discrimination against women in the article that specifically addresses the family, such placement does not preclude states from the responsibility of protecting women from the discrimination that occurs outside the family sphere. Rather, Article recognizes the reality that the home is often the most dangerous place for women as well as the lace in which women spend a disproportionate amount of time.[116] By mandating that states "ensure the elimination of every discrimination against women," the drafters have provided protection against discrimination in the charter.

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112 *See Promotion, Protection and Restoration of Human and Peoples' Rights: Guidelines for National Periodic Reporting,,* 17-26 October 1986, AFR/COM/HPR.5 (IV) AT 3 para 4

113 U.N. Declaration on the Elimination of Violence against Women affirmed this approach by calling for the modification of social and cultural practices that exacerbate gender-based discrimination. U.N.Declaration on the Elimination of Violence against Women, Feb. 23, 1994, G.A. RES. 48/104, 31 I.L.M. 1049. The declaration defines " 'violence against Women' [to mean] any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. (art.1). Article 2 further explicates that "[v]iolence against women shall be understood to encompass… the following: a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence related to exploitation; b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."

114 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, June 9, 1994, 33 I.L.M. 1534.

115 See note above 70, p 102.

116 *See* Connors, JF Violence Against Women in the Family, ST/CSDHA/2 (United Nations, 1989).

According to both preamble and Article 2, sex is an unacceptable ground for discrimination. Furthermore, Article 3 provides a general statement of equal protection.[117] Thus, the strong statement on the elimination of discrimination against women in Article 18 should neither detract from nor restrict the rights of all African women, whether or not they fit neatly into traditional conceptions of the notion of family. In asserting state responsibility for ensuring family health, family assistance and the elimination of discrimination against women, Article 18 of the African Charter provides the potential for comprehensive protection of women in general, and women within the family in particular.[118]

4.2. The African Commission in addressing women' rights living with HIV/AIDS

Article 30 of the Charter establishes the African Commission on Human and Peoples' Rights (Commission) as a promoter and protector of human and peoples' rights within the continent. Thus, the promotion and protection of those human rights associated with the HIV/AIDS pandemic falls within the mandate of the Commission. The Commission considers the HIV/AIDS pandemic a serious threat to the human rights of Africans and underscores the difficulties that the HIV/AIDS patients face in accessing treatment as a major obstacle to exercise their right to health as provided for by the Charter.[119]

The right to equality and the entitlement to equal protection of the law provided under article 3 of the Charter is one of the most important rights to be accorded to those infected and affected by HIV/AIDS. With regard to above articles, in *Communication 241/2001, Purohit and Moore v The Gambia*,[120] the Commission held that:

> Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. These provisions are non-derogable and therefore must be respected in all circumstances in order for anyone to enjoy all the rights provided under the African Charter.[121]

The Charter clearly provides that every individual shall have duties towards his family and society, the State and other legally recognized communities and the international

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117 According to Article 3, "[e]very individual shall be equal before the law [and] every individual shall be entitled to equal protection of the law, African Charter on Human and Peoples' Rights, June 27, 1981, OAU/AU Doc. CAB/LEG/67/3/Rev. 5 . See note above 70.

118 See note above 70, p103

119 See Paragraph 7 of the Final Communiqué of the 29th Ordinary Session of the African Commission on Human and Peoples' Rights. See UNAIDS, accessible at <http://www.unaids.org>.

120 Sixteenth Annual Activity Report of the African Commission on Human and Peoples' Rights 2000-2003. Assembly/AU/7(II), accessible at <http://www.au2003.gov.mz/maputodocs/assachpr.pdf> Accessed 14 July 2003.

121 At 69.

community.[122] According to Mutua,[123] the use of duties alongside rights emphasizes the non-individualistic, but communal nature of African societies. Further, the Charter states that the rights and freedoms of each individual shall be exercised with due regard to the rights of others, collective security, morality and common interest.[124] The same is true with all the human rights associated with HIV/AIDS.

The Charter provisions do not differentiate between people infected or affected by HIV/AIDS. While special emphasis should undoubtedly be placed on the rights of the infected individuals, specially women, otherwise known as people living with HIV/AIDS, individuals should enjoy their human rights regardless of whether or not they are living with HIV/AIDS.

Article 2 of the Charter provides that every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, or any other opinion, national or social origin, fortune, birth or other status. This includes people living with HIV/AIDS. While the Charter does not specifically provide for HIV/AIDS as a prohibited ground for discrimination, it may be argued that the HIV/AIDS status falls under 'other status' within the meaning of article 2 of the Charter. The question, therefore, is how best can the Commission take the HIV/AIDS aboard its mandate? The Commission can best address the issue of HIV/AIDS by making use of its mandate to promote and protect human and peoples' rights associated with the epidemic.[125]

Other rights, which complement the above, include the right to liberty and to the security of person, provided under article 6; the right to have equal access to the public service of his or her country, provided under article 13; the right to work under equitable and satisfactory conditions, provided under article 15; the right health, provided under article 16; the right to a family, provided under 18; the right to economic, social and cultural development, provided under article 22; and the right to a general satisfactory environment, provided under article 24. The above articles are not conclusive. All these rights are interlinked to the HIV/AIDS pandemic and women and one cannot address the issue of HIV/AIDS without making reference to them. The duty to enforce these rights rests upon the Commission.[126]

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122 Article 27 (1) of the Charter.

123 Mutua M. (2002) *Human Rights: A political critique* 339.

124 Article 27 (2) of the Charter.

125 See Nsibirwa, M. *2001* 'A brief analysis of the Draft Protocol to the African Charter on Human and Peoples´ Rights on the Rights of Women' 1 *AHR L.*

126 See note above 11.

Within the African human rights system, the Commission is therefore one such mechanism established to undertake the issue of HIV/AIDS aboard its mandate. However, relevant OAU/AU resolutions on HIV/AIDS was adopted.

4.3 Relevant OAU/AU resolutions on HIV/AIDS

Over the years, the Assembly of Heads of State and Government of the Organisation of African Unity (OAU, now called the African Union or AU) adopted a number of resolutions addressing the HIV/AIDS epidemic. Only those relevant to HIV/AIDS and human rights are discussed here.

In June 1994, the *Tunis Declaration on AIDS and the Child in Africa* was adopted by the OAU at the Assembly of Heads of State and Government in Tunisia.[127] The *Declaration* declares a commitment to: " Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues"[128]

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a *Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa* was adopted by the Assembly.[129] The *Resolution* urged African leaders to implement those declarations and resolution that had been adopted in the past, specifically referring to the *Tunis Declaration.*

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases,* aimed at implementation of the principles set forth in the *Abuja Declaration.*[130] In the *Abuja Declaration,* the Heads of States acknowledged that " stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it"[131] The *Abuja Framework* conceptualises the commitments made in the *Abuja Declaration* into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas. The following strategies are identified: development of a multi-sectoral national programme for awareness of an sensitivity to the

127 AHG/Decl I (XXX) 1994.
128 Paragraph 2(1).
129 AHG/Res 247 (XXXII) 1996. <http://www.onusida-aoc.org/Eng/Abuja%Declaration.html>
130 http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm
131 Paragraph 12.

negative impact of the pandemic on people, especially vulnerable groups; enactment of relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB; strengthening of existing legislation to address human rights violations and gender inequities and respect and protect the rights of infected and affected people; harmonization of the approaches to human rights between nations for the whole continent; and assistance to women in taking appropriate decisions to protect themselves against HIV infection.[132]

Another instrument, the Grand Bay Declaration provides that among other things, African Governments must work towards ensuring the full respect of rights of people with disability and people living with HIV/AIDS in particular women and children.[133] This is in line with the UN recommendation that programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies, which make them especially vulnerable to HIV infection.[134] While the statement in the Grand Bay Declaration is a good statement, however, the Commission must itself take a robust initiative in addressing the issue of HIV/AIDS within its mandate and to assist African States in the fight against the scourge.

4.4 The African Protocol of the Right of Women

The *Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Protocol of Women)* has been adopted but is not yet in force, in its article 14 states that: " States Parties shall ensure that the right to health of women, including sexual and reproductive, is respected. This include... (d) the right to self-protection and to be protected against sexually transmitted infections including HIV/AIDS...". Unfortunately the Protocol of Women does not adequately address the issue, given the impact of HIV/AIDS on African Women.

4. 5. SADC HIV/AIDS framework

In September 1997, the SADC Council of Ministers adopted the first relevant document addressing HIV/AIDS-related issues, the Code of HIV/AIDS and Employment in SADC, as developed by the Employment and Labour Sector. The main objectives of the Code are sensitise employers to the issue of employee rights and HIV/AIDS, and to provide a framework for states to consolidate national employment codes on HIV/AIDS-related issues. It addresses public sector employers, legislators, employees and trade unions.

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132 HIV/AIDS and Human Rights in Mozambique, *Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria* P18.

133 Paragraph 7 of the Grand Bay Declaration.

134 See UN General Recommendation No. 15, Avoidance of discrimination against women in national strategies for the prevention and control of acquired Immunodeficiency syndrome (AIDS).

In August 1999, the 14 member states adopted the SADC *Health Protocol.*[135] Article 10 specifically deals with HIV/AIDS and sexually transmitted diseases (STDs). The article urges states parties to harmonise policies and approaches for the prevention and management of HIV/AIDS and STDs, and to develop regional policies and plans that work towards an inter-sectoral approach to the epidemic.

In December 1999, the SADC HIV/AIDS Task Force adopted the vision document *A SADC Society with Reduce HIV/AIDS.* It was adopted to guide the work of the SADC in the development and implementation of a multi-sectoral HIV/AIDS Framework for 2000-2004 (hereinafter referred to as the Strategic Framework). The Strategic Framework is in principle guided by Article 10 of the SADC *Health Protocol;* all SADC sectors agree to use their comparative advantages to address the needs of those sectors and the communities they serve, whether transport, mining, tourism, etc One of the principles that has been acknowledged as important in the development of the *Strategic Framework* is the respect for the rights of individuals.[136]

The only sector in the Strategic Framework that specially mentions stigmatisation and discrimination is the Human Resources Development. This sector aims to provide information to reduce stigma and to change attitudes by, amongst other initiatives, integrating HIV/AIDS education and life skills into school curricula across the region.[137]

In September 2000, the SADC Council of Ministers approved the *Health Sector Policy Framework Document,* as developed by the SADC Health Ministers.[138] A significant part of the programme focuses on HIV/AIDS and sexually transmitted diseases. One of the policy objectives in the programme, geared towards HIV/AIDS control, is to protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS.

A month prior to the adoption of the *Health Policy Framework* , the SADC Health Ministers adopted *Principles to Guide Negotiations with Pharmaceutical Companies on Provision of Drugs for Treatment of HIV/AIDS-Related Conditions in SADC Countries.*[139] This principles focus on enabling SADC countries to make informed decisions in their negotiations with pharmaceutical companies and consider factors such sustainability, affordability,

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135 SADC Health Protocol. <http:// 196.36.153.56/doh/department/sadc/docs/protocol99.html

136 Managing the impact of HIV/AIDS in SADC, August 2000, at page 8. Accessible at <http://196/36/153/56/doh/departement/sadc/docs.

137 Note above 48.

138 See <http:// 196.36.153.56/doh/department/sadc/docs/framework/html> accessed on 9 September 2004.

139 See <http://196.36.153.56/doh/department/sadc/docs/negotiate_principles.htm> accessed on 12 July 2004.

accessibility, appriateness, accessibility and equity before accepting offers for free drugs or reduced prices on HIV/AIDS-related drugs.

In July 2003, the SADC Heads of Government signed the SADC *Declaration on HIV/AIDS.*[140] The Declaration affirms the commitment to address the pandemic and the issues relating to HIV/AIDS in the SADC region through multi-sectoral intervention. A new *SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007* was also issued.[141]

[140] <http:// www.sadc.int/index.php?lang=english&pth=legal/declarations/&page=declaration_on_HIV_AIDS >, accessed on 23 July 2004.

[141] HIV/AIDS and Human Rights in Mozambique, *Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria* P17

CHAPTER V: NATIONAL LEGAL RESPONSES TO WOMEN LIVING WITH HIV/AIDS: MOZAMBIQUE

The People's Republic of Mozambique is located in Southern Africa. It is 799 380 km² in area with a population of 14 174 300 inhabitants, of whom 51 per cent are women. Mozambique was born out of a struggle for a just society, a society that would be free from discrimination and exploitation.[142]

The domestic legal system belongs to the Roman-German Law or Civil or Continental Law System. This system was inherited by Mozambique from the former colonial power, Portugal. Most of the legislation, particularly the Codes, in force in Mozambique were also inherited from Portugal but are subject to the rules and principles established by the Constitution, the supreme law of the land.[143]

The Supreme Court, through the Chief Justice, heads the judicial branch. The Supreme Court is the court of final appeal. The 1990 Constitution includes other courts such as the Administrative Court, Customs Courts, Maritime Courts, Marshal Courts, Labour Courts and a Constitutional Court. The Constitutional Court and the Labour Courts are not yet established. The Supreme Court replaces and acts as the Constitutional Court on electoral issues and constitutional matters while the latter is not yet in place.

5.1 Human Rights Provisions within the National HIV/AIDS Strategic Framework and the National Policy

The first AIDS case was diagnosed in Mozambique in 1986. Shortly thereafter, the government engaged in an educational campaign on HIV/AIDS through the Ministry of Health. This was followed in 1998 by the creation of a National AIDS Commission with 50 members. The creation of the HIV/AIDS Epidemic Alert System followed in 1990. In 1995, a program known as the National Program for Combating STD/AIDS was established to integrate the control of sexually transmitted diseases into the program against HIV/AIDS. In 1998, an Inter-Ministerial AIDS Commission involving eight ministries was created, and the Ministry of Health created the National Program to Fight AIDS and implemented a short-term plan, followed by three medium-term plans. In March 2000, following on the last medium-term plan, the government published the multi-sectoral Mozambique *National Strategic Plan* to Combat

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142 Casimiro, I. The Legal Situation of Women in Mozambique, *Journal of Southern African Studies, Vol. 12, No. 1, October 1985*

143 Gita H. Transforming family law: *New directions in Mozambique, Journal of Southern African Studies, Vol. 12, No. 1, October 1985*

STDs/HIV/AIDS for the period 2000-2002.[144] The government established National Council to assist in the implementation of the National Strategy *(Estratégia Nacional).*[145]

The guiding principles of the *Strategic Plan* do not directly include any reference to human rights. Guideline 3.2.2.2 entitled ´´the human beings giving the greatest cause for concern: priority vulnerable groups," girls have been identified as a priority. Guideline 3.2.2.4 entitled: "involving people living with HIV/AIDS." The only further mention of human rights principles is in Section 3.3.5.10 where the strategies for the Ministry of Justice are outlined. This section states that:

> "*In keeping in its mandate, the Ministry of Justice will be responsible for helping to implement integrated activities in the political area, and approving legislation concerning human rights protection for PLWHAs…The Ministry will carry out a survey of situations for which there is no legislation [such as]: discrimination against PLWHAs; the prohibition of promoting condoms in prisons; the Mother and Child Statute; succession rights to orphans' property; decriminalizing prostitution; sexual violence against women and children; judicial responsibility of health workers to respect bio-security; and confidentiality concerning HIV status."*

In November 2000, the *Action Plan to Fight HIV/AIDS in Mozambique- Resource Requirements for 2001-2003* was released. This document operationalises the strategies put forth in the *Strategic Plan.* With regard to human rights, the Action Plan declares: "The government of Mozambique is committed to enacting legislation protecting the basic human rights of people living with HIV/AIDS." However, no further reference is made to human rights in the *Action Plan.*

5.2 Domestification of international and regional human rights treaties

Mozambique has a dualist system for incorporating treaties. A treaty or an agreement becomes the law in Mozambique when its ratification or accession is followed by its publication in the National Gazette (*Boletim da República* or "BR"). The Constitution distinguishes between international treaties (*tratados*) and agreements (*acordos*), and both the legislative and the executive are assigned different roles with respect thereto.

Regarding international treaties, it is the responsibility of the Council of Ministers, the Cabinet to prepare the conclusion of such treaties, the Head of State to sign it[146] and the

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144 See note above 139.

145 Dr. Joana Mangueira, Director of National Council of AIDS, said that there is a new National Strategic Plan but not available yet. (Interview on 30th September 2004, Maputo- Mozambique).

146 Section 123 (b).

Parliament to ratify such treaties.[147] After ratifying the treaty, Parliament sends the treaty by means of resolution with the text of the treaty attached to it directly to the National Printing Office for publication in the National Gazette.

With respect to international agreements, it is the responsibility of the Council of Ministers to conclude, ratify and adhere to such agreements. The Prime Minister sends the agreement for publication to the National Printing Office. After being published in the National Gazette, an international instrument becomes law and it can be invoked or enforced through the courts and the executive. Nevertheless, many of these treaties and agreements require the state to incorporate or enact domestic legislation and since this not often done, the treaty provisions remain out of reach for the general population.

There is no government department with primary responsibility for the implementation of human rights treaties. The government issues decrees to give effect international treaties in domestic law. Currently, there is a Commission in Parliament, call the Commission for Legal Affairs, Human Rights and Legality (*Comissão dos Assuntos Jurídicos, Direitos Humanos e Legalidade or* "CAJDHL") which drafts and proposes to Parliament laws aimed at the implementing the principles enshrined in the Bill of Rights in the Constitution. There is, however, no indication that the Commission is engaged in proposing the adoption of laws implementing international instruments.

5.3 Domestic incorporation of the International Guideline on HIV/AIDS and Human Rights

According to the UNAIDS delegation in Maputo, the government is aware of the document *HIV/AIDS and Human Rights-International Guidelines.* Several pieces of domestic legislation have been modelled on these *International Guideline* in recent years. The government signed the *Paris AIDS Declaration* IN 1994 prior to the introduction of the *International Guidelines.* A pledge was made to respect the fundamental rights and liberties of all those infected by HIV/AIDS, irrespective of their circumstances, whilst fighting against poverty, stigmatization and discrimination.[148]

147 Section 135 (2)(k).

148 HIV/AIDS and Human Rights in SADC "*HIV/AIDS and Human Rights in Mozambique"* Lirette Louw et Leopoldo de Amaral, ed 2004, pg.21

5.4 HIV/AIDS within the government's social assistance plan

The following must be met to qualify for social security in Mozambique:[149]registration as an employee with the National Institute of Social security (*Instituto National de Seguranca Social); and* payment of a monthly contribution towards the allocated fund. Currently, the contribution is 7% of the monthly salary for employees from the private sector.[150] Former military employees or their families, army personnel and public servants automatically qualify for disability referred to as a disability, HIV- positive employees may be entitled to a grant.

The *Action plan For the Reduction of Absolute Poverty* (2001-2005) states that with reference to social justice: "The state is concerned with ensuring respect for the equality of rights and opportunities for all citizens and segments of society…The state is responsible for providing support for their participation in the normal life of society and protection for those at risk of falling into destitution and delinquency."[151] The *Plan* identifies women among others as the main target groups for social action. It also states, however, than financial resource restrictions limit the state's ability to provide subsidized basic health and education services to the population.[152]

5.5 HIV/AIDS and the right of access to health care

Section 94 of the *Constitution* states: "All citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and preserve health." It is clear that enjoyment of this right is subject to the law in place (*nos termos da lei)*. The right to health care in Mozambique cannot be directly applied or enforced through the courts. To date, this has not been challenged in court.

The Ministry of health has established countrywide Sentinel Posts for Voluntary Testing and Group Counselling (*Gabinete de Atendimento e Teste Voluntario* or "GATV"). These efforts are directed mainly at youth. The government provides free condom distribution in rural areas and has developed a policy on the importation and sale of anti-retroviral drugs. In order to assist those infected, the Ministry of Health has also established specialized medical clinics, known as Hospital de Dia (Day Hospitals). Government is set to start a pilot project to provide anti-retroviral drugs to pregnant women in public hospitals. The government, in acknowledging the potential risk of infection to medical personnel, has put in place legislation

149 See note above 62
150 Public servants have their own social assistance scheme.
151 See page 84 of the Action Plan For the Reduction of Absolute Poverty.
152 See note above 65.

that guaranties assistance to medical personnel infected in the line of duty.[153] This legislation also regulates the use of the anti-retroviral drugs within the national health system.

Within the Ministry of Health, a structure called the NPC STD/AIDS co-ordinates the governmental response. The NPC STD/AIDS aims, as a general objective, to prevent HIV infection and provide health care to PLWHAs and their families, focusing on the following six components:[154] the prevention of sexually transmitted diseases through diagnosing and treating STDs and by promoting condom use; the prevention of HIV transmission via blood; health care and social support for PLWHAs; program planning and management; monitoring and assessment of the Program; and epidemiological surveillance.

The *Action Plan For the Reduction of Absolute Poverty* (2001-2005), published in April 2001, recognizes the fight against HIV/AIDS as one of the main objectives to protect productivity, which will only be achieved by addressing the problems in the health sector. A number of principal measures to be undertaken are specifically highlighted:[155] focus on preventive measures, including the treatment of STDs, counselling and voluntary testing, controlling blood transfusions and testing for syphilis; establishment and operation of VCT centers, and carrying out education and information campaigns on HIV/AIDS and the distribution of condoms to HIV-positive persons.

However, HIV/AIDS is not a notifiable disease in Mozambique.[156] Furthermore, there is no national policy in place to regulate voluntary HIV testing. Certain principles pertaining to testing are nevertheless incorporated in different pieces of legislation. For example, Law 5/2002 provides in Article 4 that forcing prospective employees or employees to undergo compulsory HIV testing is prohibited, and decree 42/2000 of 31 October stipulates that compulsory testing of public servants is illegal.

Therefore, Article 5 of Law 5/2002 stipulates that medical personnel from both the public and private spheres are under an obligation to keep a person's HIV status confidential. Breaching this Article can result in a penalty corresponding to about US$35 or an even harsher sentence. Efforts to extend the protection of patients' rights are also evident in the *Strategic Plan* envisions the formulation of guidelines concerning the ethical norms of health care workers.[157]

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153 Ministerial Order 183-A/2001 of 18 December.
154 See page 13 of the National Strategic Framework.
155 See page 54 of the Action Plan for the Reduction of Absolute Poverty.
156 See above 70.
157 See page 35 of the Strategic Plan.

In 2000, the government adopted the *National Guideline Policy on the Use of the Ant-retroviral Drugs and the Treatment of Opportunistic Infections,* Ministerial Order 183-A/2001 of 18 December. It defines the norms that apply within the National Health Services Organisation for the treatment of opportunistic diseases. The Order also includes technical guidelines on the administration of ARVs.

The treatment of STDs and opportunistic infections and the provision of counseling services to HIV-infected people are amongst the core activities identified for the realization of the objectives of the *National Strategic Plan to Combat STDs/HIV/AIDS.* More specifically, the Action Plan to fight HIV/AIDS in Mozambique identifies that increased access to health care facilities is required generally, but also in the workplace, at schools, in community centers and other similar venues.[158]

There are no regulations in place in Mozambique to protect the rights of volunteers in medical experiments. The Constitution, however, guarantees the right to physical integrity.[159]

The government only provides condoms free of charge in rural areas, that is mean that the urban areas are not covered and the government must do that. There is a unique brand of condoms available countrywide, call Jeito ("Manner"). A pack of three costs 1000 MT (one thousand meticais). The female condom is more expensive and is rarely available in pharmacies.

Section 3.3.4.2 of the *Mozambique National Strategic Plan to Combat STDs/HIV/AIDS 2000–2002* sets out the specific strategies for the promotion of condoms usage. Four strategic stages are highlighted:[160]establishing a consultancy group for the promotion of condoms, involving the business sector; assessing the way in which condoms are promoted amongst young people, highly mobile people and sex workers in urban and rural areas, and their relevance to the social and cultural obstacles identified in the national survey; ensuring that condoms may be purchased through the General State Budget for the period the *Strategic Plan* is in place; and supervising and training professionals and activists involved in the promotion of sex education for partners on the distribution and sale of condoms.

One of the five core activities in the *National Strategic Plan* is the massive distribution and availability of condoms according to the *Action Plan to Fight HIV/AIDS in Mozambique-Resource Requirements for 2001-2003.* The *Action Plan* States that: "in addition to the

158 Page 4 of the Action Plan.
159 1990 Constitution, Section 70.
160 See page 39 of the *National Strategic Framework.*

purchase of condoms, in-depth consideration will be given to logistics issues for distribution and the identification of points of availability."[161]

5.6 The legal status of women and the role of cultural practices

Section 67 of the Constitution states that women and men are equal before the law and in all spheres of the political, economic, social and cultural domains. The Constitution further states that while it promotes the values and cultural practices of the people, the practice cannot directly or indirectly violate the written laws of the country. Nevertheless, customary rules and traditions that amount to discrimination against women such as polygamy are common. Female genital mutilation is not a general or widespread practice in Mozambique. However it appears that cultural practices play a crucial role in the spread of HIV/AIDS in rural areas.[162] For example, the media have reported that in certain areas of the country, some priests and traditional leaders have been advising their followers not to accept condoms that are distributed by the government, alleging that they might bring bad luck to the community.[163]

Some cultural practices identified by the National Strategic Framework for 2000-2002 are polygamy, early marriages, sexual 'purification' of widows, also known as *pita kufa* or *kutchinga*. These have not been challenge in court to date.

Therefore, there are no special measures, either policy or legislation, in place to protect women and other vulnerable groups. NGOs and the government are currently disseminating information relating to HIV and sexual practices throughout the country. Rape, sexual assault and physical violence are addressed in the *Criminal Code* of Mozambique, but there are no provisions for harsher sentences for HIV-positive rapists. Domestic violence, which includes psychological violence, is not yet criminalized.

There are no measures in place to administer anti-retroviral drugs to women who have been raped. However, various stakeholders are lobbying the government and Parliament to provide drugs to raped women.[164]

In order to reduce mother-to-child transmission of HIV, the government is engaging in pilot projects in certain hospitals to assess the social and cost implications of full-scale implementation, before expansion to other public hospitals. The drugs are naturally accessible for people who can afford to pay for them.

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161 See page 4 of the *Action Plan.*
162 See note 144 above, pg.25.
163 See note above 158.

164 See note above 75.

Section 3.3.5.3 of the *National Strategic Plan* sets out the strategies to be followed within the Ministry for the Co-ordination of Social Action. These strategies are specifically geared towards children and specially orphans. Amongst other strategies, it is stated that the Ministry "must prepare a national strategy to mobilise community support for orphans and families affected by HIV/AIDS, integrated in the community based support programme."[165]

The criminal law does not address the issue of harmful HIV-related behaviour. Various civil society organisations have called for the criminalisation of high-risk HIV behaviour and legislation is being considered.[166]

[165] Page 43 of the *National Strategic Plan.*
[166] See note above 75 p26.

CHAPTER VI: CONCLUSIONS AND RECOMMENDATIONS

The Provisions of the African Charter relating to rights of women cannot presume to comprehensively explore the situation of women in Africa. As a continent of 53 independent countries and more than 700 million people,[167] of whom the majority are women,[168] Africa embodies numerous ethnic groups, religions, languages, ideologies, political systems and histories. Although African women share certain common realities, an examination of the situation of women in Africa is difficult to accomplish due to both the size and the diversity of the continent.

Cultural barriers interacting with low levels of development create a situation in Africa whereby women suffer disproportionately compared with women and men throughout the world.[169] That women in Africa suffer discrimination is indisputable. The access of African women to participate in the public domain has been impeded by traditional roles defined in terms of the "private" sphere.[170] Thus, due to their sexual status, African women as a group represent the poorest of the world's poor.[171] In fact, since 1979, the year in which the Women's Human Rights Treaty was adopted, African people in general and African women in particular have experienced a severe deterioration of their living standards.[172] Therefore with all this discrimination that African women encounter, women are exposed and more vulnerable to the HIV/AIDS pandemic.[173]

Nonetheless, despite some attempts to incorporate women in the development process in Africa, the economic reality of African women has not substantially improved.[174]

Apart from the violence against women, the other issues which most keep the attention on women are undoubtedly female genital mutilation and AIDS. Tradition and culture are the most common justifications given for the perpetuation of these practices.[175] Many African women, however, note the dynamic nature of tradition and culture and call for a distinction to

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167 *See* World Almanac at 839 (1995).

168 *See* Chaloka Beyani, *Toward a more effective guarantee of women's Rights in the African Human Rights System,* in Human Rights of Women: National and International Perspectives 285, 289 (Rebecca Cook ed., 1994).

169 See e.g., Khadija Elmadmad's remarks in Regional Systems of Human Rights in Africa, America, and Europe: Proceedings of the conference, 17(Wolfgang Heinz, eds., 1992). Also cited in claude E. Welch J., *Human Rights and African Women: A Comparison of protection Under Two Major Treaties,* 15 Hum. RTs. Q.AT 549,555. Elmadmad contends that "[t]he African Charter has placed the rights of women in a 'legal coma.'"

170 Gwendolyn Mikell, *Culture, Law and Social Policy: Changing the Economic Status of Ghanaian Women, 17 Yale J. Int'l L. 225, (1992).*

171 *See* Women in Sub-Saharan Africa (The minorities rights group, 1988)

172 See note above 134

173 Brooke G., *AIDS, Gender, and sexuality during Africa's Economic Crisis,* in African Feminism: The Politics of Survival in Sub-Saharan Africa 310-11, 315-30 (Gwendolyn Mikell, ed. 1997).

174 *See* Caroline O. Gender Planning and Development 2 (Routledge ed., 1993).

175 *See What's Culture got to do with it? Excising the Harmful Tradition of female Circumcision,* 106 HARV. L. REV. 1944, 1946 (1993).

be made between positive aspects of tradition or culture from those aspects that inflict pain and bodily harm such as female genital mutilation.[176] AIDS is spreading among women in Africa at intolerable rates[177].

Gender-based violence and numerous other human rights violations have long been experienced and fought against by African women.[178] Violence against women in Africa takes many forms, manifesting itself in both physical and structural forms. Human rights advocates, for example, cite structural adjustment programs as exemplifying structurally violent economic policies directed at women.[179] In Africa, not only is violence perpetrated by physical acts of aggression, but also through the failure of states to recognize the existence of women's fundamental human rights.[180] African women experience, among other violations, domestic violence, rape, female genital mutilation, prostitution, sexual harassment, sexual cleansing, polygamy marriage.[181] Although levels of violence against women are difficult to uncover due to cultural constraints on the reporting of such issues, it is clear that incidents of violence against women in Africa are widespread.[182]

There has to be action on those factors which make women vulnerable, action for economic empowerment of women, action on property and inheritance laws, action on prevention, and action on care. Thus, men and women must work together to counter gender discrimination and subordination of women. The time is now! Central to this is the participation of policy makers and other people in power who need to recognise the link between women economic empowerment and social status and their vulnerability to HIV infection. Empowerment of women is at the center of the response to build. How will this be achieved? Stephen Lewis (2004) strongly asserts:

> "*Empowerment [of women aimed at reducing HIV/AIDS infection]… it is time country by country …support the struggle for gender equality…women should call press conferences, demand audiences, with the political and religious authorities, form coalitions, demonstrate, boycott, …the cause of women will have to be advanced. Gender inequality and AIDS is a preordained equation to deat*h"

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176 Frene G. of the African National Congress Women's League, for example has asserted the importance of distinguishing between those cultural practices that provide harmless social cohesion for communities and those that harm people. According to Ginwala, "[w]e must protect positive practices and outlaw harmful ones."

177 See note above 138.

178 Nahid T., *Women's Reproductive and Sexual Rights, in* Gender Violence and Women's Human Rights in Africa, 14 (Centre for Women's Global Leadership ed., 1994).

179 *See* Chilangwa-N'gambi, *Violence Against Women and Children, in* New Lease on life, Towards Economic Policies for the Prevention of Serious Human Rights Violations, 103

180 See note above 73

181 *See generally* Gender Violence and Women's Human Rights in Africa, (note above 73); Chilangwa -N'gambi, note above 144.

182 Violence Against Women and HIV/AIDS: Setting the research Agenda, Meeting report, WHO-Geneva, 23-25 October 2000

In the words of Mandela, 'the challenge of HIV/ AIDS can be overcome if we work together as a global community. Let us join hands in a caring partnership for health and prosperity…'[183] This will be essential in reversing the declaration by the British Prime Minister, Tony Blair, that the state of Africa is a 'scar to the conscience of the world'.[184] While the international community focuses on Africa in order to heal it from the scandalous disease of HIV/AIDS, the continent must also take steps to heal itself through its own available means. As long as the Commission does not take the issue of HIV/AIDS in a more robust manner, joining hands with other organizations in caring partnership not only for health and prosperity, but for instilling a culture of human rights among our African States, which is seriously lacking, the full enjoyment of human rights in Africa will remain a pipe dream.

There is a need to encourage the exchange of information and experiences between countries in implementing the measures and commitments contained in the Declaration and in particular to facilitate an intensified South–South and triangular cooperation.[185] Different countries have responded differently to HIV/AIDS. Some countries have succeeded in containing the pandemic while others have not. The Commission may therefore coordinate the exchange of such information and experiences between Member States in order to address the human rights concerns relating to HIV/AIDS.

Thus, in relation to Mozambique, the country representative, Petra Lantz[186] has said if Mozambique is to halt the spread of HIV/AIDS, it needs a development concept centred on human beings. He estimated that at least 45 percent of new HIV infections occurred among Mozambicans aged between 20 and 24, with four times more women becoming infected than men.[187]

As a matter of fact, the Charter's capacity to serve as a mechanism for the protection and promotion of the rights of women in Africa should not be ignored. Least of all should it be vilified. Rather, human rights advocates, both in Africa and among the international community must strive to develop interpretations of the Charter that allow for optimal utilization of its potential. With the Charter in hand, advocates of the rights of women in Africa have a tool that can prove a useful aid in the battle. It might not be quite a sword, but it can act as an effective shield.[188]

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183 Mandela in his address at the World Economic Forum session on AIDS on 3 February 1997. <http://www.polity.org.za/html/govdocs/speeches/1997/sp0203.html> Accessed 7 October 2004. Tony Blair as quoted by George Monbiot in the *Guardian Unlimited* dated June 3, 2003. <http://www.guardian.co.uk/comment/story/0,3604,969210,00.html> (Accessed 7 October 2004).

185 Paragraph 99 of the Declaration of Commitment.

186 UN Population Fund (UNFPA) country representative Mozambique

187 UN Integrated Regional Information Networks news at http://www allAfrica.com accessible, September 20, 2004

188 See note above 70.

The protection of the right of women in Africa in light of the HIV/AIDS pandemic should be one of the priorities in the mandate of the Special rapporteur on the right of women in Africa or It would be necessary for the African Commission as a unique mechanism in protecting and promoting Human and Peoples' Rights in Africa, to consider a possibility of appointing a Special Rapporteur on HIV/AIDS in order to strengthen the work of the Commission in so far as addressing HIV/AIDS in the continent is concerned.

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