



Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa



ISBN No: 978-0-9802658-9-7



Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa
PULP



COMPENDIUM OF KEY DOCUMENTS RELATING TO HUMAN RIGHTS AND HIV IN EASTERN AND SOUTHERN AFRICA

Pretoria University Law Press
PULP

2008

Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa

Commissioned by UNDP, Regional Service Centre for Eastern and Southern Africa

Researched and edited by the AIDS and Human Rights Research Unit, Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria

First published 2008
Copyright©2008
UNDP and
Pretoria University Law Press (PULP)
All rights reserved

Disclaimer

The opinions expressed in this *Compendium* are those of its authors and may not necessarily reflect the views or policies of UNDP. As far as possible, the documents and information in this *Compendium* reflect the position as at 31 December 2007.

Acknowledgment

This *Compendium* has been compiled and edited by the AIDS and Human Rights Research Unit for the United Nations Development Programme-Regional Service Centre (UNDP-RSC) as part of a UNDP initiative on human rights, gender, and HIV and AIDS in Eastern and Southern Africa.

Staff of the AIDS and Human Rights Research Unit, who participated in developing this tool, are: Susan Precious, Karen Stefiszyn, Adiam Woldeyohannes, Patrick Eba and Frans Viljoen. The dedicated assistance of the following interns working with the Unit is also gratefully acknowledged: Joshua Cohen, Marloes Stammen, Emma Chase Bellamy, Alastair Crewe, Isabel De Bruin-Cardoso, Alaric Vandenberghe and Titilola Uliem. Translation of French texts are by Mianko Ramaroson, and of Portuguese texts by Miguel Angelo de Almeida.

The support of Mary Crewe, Pierre Brouard and, in particular, Rakgadi Mohlahlane, at the Centre for the Study of AIDS is also much appreciated and acknowledged.

The editors acknowledge the support of Shivaji Bhattacharya and Irene Akiy of UNDP-RSC for Eastern and Southern Africa.

To order, contact:

Shivaji Bhattacharya, Senior Policy Advisor, UNDP
Email: shivaji.bhattacharya@undp.org
or
United Nations Development Programme
Regional Service Centre
7 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: +27 11 603 5000

or PULP
Faculty of Law
University of Pretoria
South Africa
0002
Tel: +27 12 420 4948
Fax: +27 12 362 5125
pulp@up.ac.za
www.pulp.up.ac.za

ISBN: 978-0-9802658-9-7



FOREWORD



We, the global community, are almost three decades into the HIV epidemic and today there is indisputable evidence that the destructive force of the HIV and AIDS epidemic is fuelled by a wide range of human rights violations. Contemporary development practitioners agree that the inadequate realisation of human rights accelerates the spread of HIV and worsens the impact of AIDS in the world. Hence, a strengthened and coherent human rights-based response to the epidemic will go a long way towards increasing social cohesion and the community's ability to respond to the epidemic in our midst.

Based on feedback from a set of stakeholder consultations involving diverse groups of people, including parliamentarians, from 22 countries in Eastern and Southern Africa, UNDP's HIV and AIDS Team located at the Regional Service Centre in Johannesburg, South Africa, identified the need to develop advocacy and information material on human rights-based responses to HIV in the region. The initiative culminated in the development of a set of tools designed to support policy and legislative review and reform. These include:

1. *Guide to an effective human rights response to the HIV epidemic: The Guide* gives information on using the framework of international human rights law as the basis for shaping national laws addressing HIV in Eastern and Southern Africa. The *Guide* will assist stakeholders to develop strategies to strengthen national law in ways that uphold the human rights of people living with HIV.
2. *Checklist of human rights obligations to effectively address HIV and AIDS in Eastern and Southern Africa*: This tool will assist government and civil society to assess and inform policy from the context of human rights obligations as they relate to HIV.
3. *Powerpoint cum Flip Chart presentation*: Change agents and advocacy groups can use these communication tools to enhance the capacity of their constituencies to understand the obligations of states and suggest possible steps towards the domestication of international human rights frameworks.
4. *Compendium and CD-Rom of key documents relating to human rights and HIV in Eastern and Southern Africa*: These tools provide a comprehensive and accessible catalogue of international, regional and national human rights documents in a single source. They aim to inform the response of stakeholders, in particular when reviewing and drafting legislation and policy,

and when interpreting laws. The *Compendium* is the printed version, and the *CD-Rom* the electronic version.

It is envisaged that the tools would strengthen the capacity of stakeholders in Eastern and Southern Africa to advocate for a human rights-based response to HIV. The tools also provide guidelines to facilitate the evaluation and strengthening of policy and legislation.

It should be stressed that these are not 'one size fits all' tools. Although differences between countries are taken into account, universal obligations form the pivots of the position. Those making use of the tools at the national level will, no doubt, be in the best position to incorporate local features into their responses. The information has been captured at a given point in time and may have evolved in the passing months.

Strengthening the capacity and commitment of states to respect, protect and promote human rights is of course a central strategy of all development and public health efforts, not just the response to HIV. The severity, consequences and complexities of the HIV epidemic make human rights efforts all the more important. How can countries go beyond necessary but insufficient biomedical responses to the epidemic to address the fundamental social issues that drive new infections and undermine care, treatment and impact mitigation? How can countries ensure that responses to crises like gender-based violence and its association to HIV are effective rather than counter-productive? Only a human rights framework can respond to these challenges, and we hope that the tools will assist a cross section of stakeholders to understand and promote such an approach.

We believe that tools of this nature are rarely complete in themselves and need to supplement existing tools and efforts on the ground. We look forward to feedback and advice which will enable the tools to remain contextual and evolve over time to appropriately address the changing nature of the epidemic and our responses to it.

Jeffrey O'Malley
Director, HIV/AIDS Practice
UNDP

TABLE OF CONTENTS

FOREWORD	III
LIST OF ACRONYMS AND ABBREVIATIONS	XI
GLOSSARY OF TERMS	1
INTRODUCTION	3
A GLOBAL DOCUMENTS	4
B REGIONAL DOCUMENTS	59
C SUB-REGIONAL DOCUMENTS FROM REGIONAL ECONOMIC COMMUNITIES IN EASTERN AND SOUTHERN AFRICA	97
D DOMESTIC DOCUMENTS FROM EASTERN AND SOUTHERN AFRICAN COUNTRIES	119
E LEGISLATION, POLICIES AND CASE LAW FROM OTHER REGIONS	259

A GLOBAL DOCUMENTS

A1 UN treaties, with General Comments and Concluding Observations	4
A1.1 ILO Discrimination (Employment and Occupation) Convention, No 111 (1958/1960)	4
A1.2 Convention on the Elimination of all Forms of Racial Discrimination (1965/1969)	4
A1.3 International Covenant on Civil and Political Rights (1966/1976)	5
A1.4 International Covenant on Economic, Social and Cultural Rights (1966/1976)	6
General Comment 14 (2000)	7
Concluding Observations – Sudan (2000)	9
Concluding Observations – Zambia (2005)	9
A1.5 Convention on the Elimination of All Forms of Discrimination against Women (1979/1981)	10
General Recommendation 15 (1990)	11
General Recommendation 24 (1999)	12
Concluding Observations – Kenya (2003)	14
Concluding Comments – Malawi (2006)	15
Concluding Comments – Namibia (2007)	17
A1.6 ILO Occupational Safety and Health Convention, No 155 (1981/1983)	18
A1.7 Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984/1987)	19
A1.8 Convention on the Rights of the Child (1989/1990)	19
General Comment 3 (2003)	22
Concluding Observations – Angola (2004)	27
Concluding Observations – Botswana (2004)	28
Concluding Observations – Uganda (2005)	30
Concluding Observations – Mauritius (2006)	32
Optional Protocol on the Involvement of Children in Armed Conflict (2000/2002)	34
Optional Protocol on the Sale of Children (2000/2002)	34
A1.9 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990/2003)	35
A1.10 Convention on the Rights of Persons with Disabilities (2006)	37
A2 UN declarations and similar documents	39
A2.1 UN Standard Minimum Rules for the Treatment of Prisoners (1955)	39
A2.2 Ottawa Charter for Health Promotion (1986)	39
A2.3 World Health Assembly Resolution 41.24 on the Avoidance of Discrimination in relation to HIV-infected People and People with AIDS (1988)	39
A2.4 WHO Guidelines on HIV Infection and AIDS in Prison (1993)	40
A2.5 UN Millennium Development Goals (MDGs) (2000)	41
A2.6 UNCHR Resolution on the Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (2001)	42
A2.7 UNGASS Declaration of Commitment on HIV/AIDS (2001)	42
A2.8 ILO Code of Practice on HIV/AIDS and the World of Work (2001)	46
A2.9 International Guidelines on HIV/AIDS and Human Rights (2002)	50
A2.10 Political Declaration on HIV/AIDS (2006)	51

A3	WTO documents	54
A3.1	Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) (1994)	54
A3.2	Doha Declaration on the TRIPS Agreement and Public Health (2001)	55
A3.3	Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (2003)	56

B REGIONAL DOCUMENTS

B1	AU treaties	59
B1.1	Constitutive Act of the African Union (2000/2001)	59
B1.2	African Charter on Human and Peoples' Rights (1981/1986)	59
B1.3	Protocol on the Rights of Women (2003/2005)	60
B1.4	African Charter on the Rights and Welfare of the Child (1990/1999)	61
B2	AU declarations and similar documents	64
B2.1	Tunis Declaration on AIDS and the Child in Africa (1994)	64
B2.2	Grand Bay (Mauritius) Declaration and Plan of Action (1999)	65
B2.3	Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)	65
B2.4	Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Disease (2003)	66
B2.5	Solemn Declaration on Gender Equality in Africa (2004)	67
B2.6	AU Commission Chairperson's 2nd Progress Report on the Implementation of the Solemn Declaration on Gender Equality in Africa	68
B2.7	Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care (2005)	70
B2.8	Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa (2005)	71
B2.9	Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006)	72
B2.10	Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)	73
B2.11	Africa's Common Position to the UN General Assembly Special Session on AIDS (2006)	76
B2.12	Progress Report on the Implementation of the Plans of Action of the Abuja Declarations on Malaria (2000), HIV/AIDS and Tuberculosis (2000/1 to 2005) (2006)	78
B3	ACHPR concluding observations and resolutions	80
B3.1	Concluding Observations and Recommendations on South Africa's Initial Report to the African Commission (1999)	80
B3.2	Resolution on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity (2001)	80
B3.3	Resolution on the Situation of Women and Children in Africa (2004)	81
B4	New Partnership for Africa's Development (NEPAD)	82
B4.1	NEPAD Framework Document (2001)	82
B4.2	NEPAD Health Strategy (2003)	83
B4.3	African Peer Review Mechanism (APRM) Declaration on Democracy, Political, Economic and Corporate Governance (Governance Declaration) (2001)	85
B 4.4	Country Review Reports to the APRM	87
	Country Review Report – Rwanda (2005)	87
	Country Review Report – Kenya (2006)	91

C SUB-REGIONAL DOCUMENTS FROM REGIONAL ECONOMIC COMMUNITIES IN EASTERN AND SOUTHERN AFRICA

C1	Common Market for Eastern and Southern Africa (COMESA)	97
C1.1	Treaty establishing COMESA (1993/1994)	97
C1.2	Addis Ababa Declaration on the COMESA Gender Policy (2002)	97
C1.3	COMESA Gender Policy (2005)	98
C2	East African Community (EAC)	99
C2.1	Treaty establishing the EAC (1999/2000)	99

C2.2	Second EAC Development Strategy 2001-2005 (2001)	99
C2.3	Third EAC Development Strategy 2006-2010: Deepening and Accelerating Integration (2006)	100
C2.4	EAC Regional Integrated Multisectoral HIV and AIDS Strategic Plan 2007-2012 (2007)	100
C 3	Intergovernmental Authority on Development (IGAD)	104
C3.1	Agreement Establishing IGAD (1996/1996)	104
C3.2	Declaration of Ministers in charge of HIV/AIDS (2007)	104
C4	Southern African Development Community (SADC)	106
C4.1	Treaty of SADC (1992/1993)	106
C4.2	SADC Protocol on Health (1999/2004)	106
C4.3	SADC Code on HIV/AIDS and Employment (1997)	107
C4.4	SADC Declaration on Gender and Development (1997)	108
C4.5	Addendum to the SADC Declaration on Gender and Development (1998)	109
C4.6	Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003)	110
C4.7	HIV and AIDS Strategic Framework and Programme of Action 2003-2007 (2003)	111
C4.8	HIV and AIDS Business Plan: Strategic 5-Year Business Plan 2005-2009 (2004)	114
C5	Economic Community of Central African States (ECCAS)	116
C5.1	Treaty establishing ECCAS (1983/1984)	116
C6	Indian Ocean Commission (IOC)	117
C6.1	General Agreement of Cooperation between Member States of the Indian Ocean (1984/1984)	117

D DOMESTIC DOCUMENTS FROM EASTERN AND SOUTHERN AFRICAN COUNTRIES

D1	Constitutional provisions	119
D1.1	Relationship between international and national law: monist constitutions	119
D1.2	Relationship between international and national law: dualist constitutions	119
D1.3	Equality and non-discrimination	120
D1.4	Socio-economic rights	122
	D1.4.1 Justiciable socio-economic rights	122
	D1.4.2 Socio-economic rights under directive principles of state policy	123
D1.5	Right to dignity and privacy	124
D1.6	Property and inheritance rights of women	125
D1.7	Customary practices	125
D1.8	Rights and protection of children	126
D1.9	Rights and protection of other vulnerable groups	128
D2	Legislation (including bills)	129
D2.1	HIV specific laws/bills	129
	Angola: Law 8/04 on HIV and AIDS (2004)	129
	Burundi: Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005)	131
	Kenya: HIV and AIDS Prevention and Control Act 14 of 2006	133
	Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2006)	139
	Mauritius: HIV and AIDS Act 31 of 2006	142
	Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	144
	Uganda: Human Immunodeficiency Virus Control Bill (2007)	150
D2.2	Equality and non-discrimination	153
	Angola: Law 8/04 on HIV and AIDS (2004)	153
	Burundi: Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005)	153
	Kenya: HIV and AIDS Prevention and Control Act 14 of 2006	153
	Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)	153
	Mauritius: HIV and AIDS Act 31 of 2006	153
	South Africa: Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000	153
	Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	154
	Uganda: Human Immunodeficiency Virus Control Bill (2007)	154
D2.3	Employment	154
	Angola: Law no 8/04 on HIV and AIDS (2004)	154
	Angola: Decree 43/03 - Regulations on HIV/AIDS, Employment, and Professional Training (2003)	154
	Lesotho: Labour Code (Amendment) Act no 5 of 2006	156
	Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)	158

Mauritius: Labour (Amendment) Act 1 of 2004	158
Mozambique: Law 5 of 2002	158
Namibia: Labour Act 15 of 2004	159
South Africa: Occupational Health and Safety Act 85 of 1993	160
South Africa: Compensation for Occupational Injuries and Diseases Act 130 of 1993	161
South Africa: Labour Relations Act 66 of 1995	161
South Africa: Basic Conditions of Employment Act 75 of 1997	162
South Africa: Employment Equity Act 55 of 1998	162
South Africa: Public Service Regulations (2001)	163
Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	164
Uganda: Human Immunodeficiency Virus Control Bill (2007)	164
Zimbabwe: Statutory Instrument 202 of 1998: Labour Relations (HIV and AIDS) Regulations	164
D2.4 Right to health care	165
Angola: Law no 8/04 on HIV and AIDS (2004)	165
Burundi: Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005)	165
Djibouti: Law 48 on the Orientation of Health Policy (1999)	165
Kenya: HIV and AIDS Prevention and Control Act (2006)	166
Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of the Rights of People Living with HIV (2005)	166
Mauritius: HIV and AIDS Act 31 of 2006	166
South Africa: Medicines and Related Substances Control Amendment Acts 90 of 1997 and 59 of 2002	166
South Africa: Medical Schemes Act 131 of 1998	167
South Africa: National Health Act 61 of 2003	168
Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	169
Uganda: Human Immunodeficiency Virus Control Bill (2007)	169
Zimbabwe: Public Health Act 19 of 1924	170
D2.5 Property rights and inheritance	171
Botswana: Abolition of Marital Power Act 34 of 2004	171
Lesotho: Legal Capacity of Married Persons Act 9 of 2006	171
Malawi: Deceased Estates (Wills, Inheritance and Protection) Bill (2004)	172
Namibia: Married Persons Equality Act 1 of 1996	172
Namibia: Communal Land Reform Act 5 of 2002	173
D2.6 Customary practices	173
Eritrea: Female Circumcision Abolition Proclamation No 158/2007	173
Kenya: Children Act 8 of 2001	173
D2.7 Domestic violence	174
Lesotho: Legal Capacity of Married Persons Act (2006)	174
Malawi: Protection against (Prevention of) Domestic Violence Act 5 of 2006	174
Namibia: Combating of Rape Act 8 of 2000	174
Namibia: Combating of Domestic Violence Act 4 of 2003	174
Mauritius: Sex Discrimination Act 43 of 2002	175
Mauritius: Protection from Domestic Violence (Amendment) Act 11 of 2004	175
South Africa: Domestic Violence Act 116 of 1998	175
Uganda: The Domestic Relations Bill (2003)	175
Zimbabwe: Criminal Law (Codification and Reform) Act 23 of 2004	176
D2.8 Children's rights and protection of vulnerable groups	176
Djibouti: Law 48 on the Orientation of Health Policy (1999)	176
Kenya: Children Act 8 of 2001	176
Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)	177
Malawi: Child (Care, Protection and Justice) Bill (2003)	177
Mauritius: The Child Protection (Amendment) Bill 36 of 2005	179
Rwanda: Law 27 of 2001 Relating to the Rights and Protection of the Child Against Violence	180
South Africa: Children's Act 38 of 2005	182
Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	183
Uganda: Human Immunodeficiency Virus Control Bill (2007)	183
Zambia: Penal Code (Amendment) Act 15 of 2005	183
D2.9 HIV and criminal law	184
Angola: Law 8/04 on HIV and AIDS (2004)	184
Botswana: Penal Code (Amendment) Act 5 of 1998	184
Botswana: Public Health Act 44 of 1971	185
Kenya: Sexual Offences Act 3 of 2006	185
Kenya: HIV and AIDS Prevention and Control Act 14 of 2006	186
Madagascar: Law no 2005-040 on the fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2006)	186
Namibia: Combating of Rape Act 8 of 2000	186
South Africa: Criminal Procedure Second Amendment Act 85 of 1997	186
South Africa: Criminal Law Amendment Act 105 of 1997	186
South Africa: Criminal Law (Sexual Offences and Related Matters) Bill (2003)	187
Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)	189
Uganda: Human Immunodeficiency Virus Control Bill (2007)	190
Zimbabwe: Criminal Law (Codification and Reform) Act 23 of 2004	190
D2.10 Legislation providing institutional mechanisms for HIV and AIDS	190
South Africa: North West Provincial Council on AIDS Act 5 of 2001	190
Tanzania: Tanzania Commission for AIDS Act 22 of 2001	191
Zimbabwe: National AIDS Council of Zimbabwe Act 26 of 1999	191

D3	Policies and other similar documents	193
	Malawi: National HIV/AIDS Policy (2003)	193
	Namibia: National Code on HIV/AIDS in Employment (2000)	200
	South Africa: National HIV/AIDS Strategic Plan 2007-2011 (2007)	202
	South Africa: National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training (1999)	204
	South Africa: Human Rights and Ethical Guidelines on HIV: A Manual for Medical Practitioners of South Africa (2001)	207
D4	Case law of Eastern and Southern African national courts	209
D4.1	HIV-related discrimination	209
	<i>Hoffmann v South African Airways</i> 2001 (1) SA 1 (SACC 2000)	209
	<i>Nanditume v Minister of Defence</i> (2002) AHRLR 119 (NaLC 2000)	210
	<i>Diaa v Botswana Building Society (BBS)</i> 2003 (2) BLR 409 (BwIC)	212
	<i>Jimson v Botswana Building Society</i> (2005) AHRLR 3 (BwIC 2003)	214
	<i>Lemo v Northern Air Maintenance (Pty) Ltd</i> (2004) (2) BLR 317 (IC)	216
D4.2	Access to HIV-related treatment	219
	<i>Mangani v Register Trustees of Malamulo Hospital</i> (1991) High Court of Malawi	219
	<i>Minister of Health and Others v Treatment Action Campaign and Others</i> 2002 (5) SA 717 (SACC)	220
D4.3	HIV prevention and care in prison	223
	<i>Van Biljon and Others v Minister of Correctional Services and Others</i> 1997 (4) SA 441 (C) (SAHC 1997)	223
	<i>Stanfield v Minister of Correctional Services and Others</i> 2004 (4) SA 43 (C) (SAHC 2003)	225
	<i>Magida v S</i> 2005 JOL 15294 (SASCA)	226
	<i>EN and Others v Government of the RSA and Others</i> 2007 (1) BCLR 84 (SAHC Durban 2006)	227
	<i>Mazibuko v Minister of Correctional Services and Others</i> 2007 JOL 18957 (SAHC 2005 T)	229
D4.4	HIV and family law	230
	<i>Midwa v Midwa</i> 2000 (2) EA 453 (CAK 2000)	230
	<i>Dindi v Dindi and Kamaloni</i> (2004) Supreme Court of Zambia	230
D4.5	HIV and confidentiality	231
	<i>Van Vuuren and Another NNO v Kruger</i> 1993 (4) SA 842 (SAA)	231
	<i>NM and Others v Smith and Others (Freedom of Expression Institute as Amicus Curiae)</i> 2007 (5) SA 250 (CC)	233
D4.6	HIV and testing	235
	<i>C v Minister of Correctional Services</i> 1996 (4) SA 292 (T)	235
	<i>Thebe v Mbewe t/a Checkpoint Laboratory Services</i> 2000 JOL 7142 (ZS)	237
	<i>Joy Mining Machinery v National Union of Metal Workers of South Africa and Others</i> 2002 (23) ILJ 391 (SALC 2002)	239
	<i>Irvin and Johnson Ltd v Trawler and Line Fishing Union and Others</i> 2003 (4) BLLR 379 (SALC)	242
	<i>VRM v Health Professions Council of SA & Others</i> 2003 JOL 11944 (T)	243
D4.7	HIV and the law of delict (tort)	246
	<i>Venter v Nel</i> 1997 (4) SA 1014 (SAHC D)	246
D4.8	HIV and criminal law	247
	<i>Republic v Cidreck</i> 1995 MLR 695 (High Court of Malawi 1994)	247
	<i>Makuto v The State</i> 2000 (2) BLR 130 (CA)	247
	<i>Lejony v State</i> 2000 (2) BLR 145 (BwCA)	249
	<i>Nquibi v The State</i> (Practice direction) 2001 (1) BLR 154 (BwCA)	250
	<i>S v Nzara</i> 2001 JOL 8529 (ZHC)	251
	<i>Attorney General's Reference: In re: The State v Marapo</i> 2002 (2) BLR 26 (BwCA 2002)	251
	<i>Snoti v S</i> 2007 JOL 19383 (SAHC E)	252
D4.9	HIV and freedom of expression	253
	<i>South Africa Human Right Commission v SABC & Another</i> (SABCT 2003)	253
	<i>Allen v SAFM</i> (SABCT 2006)	254
	<i>De Vos v Talk Radio 702</i> (SABAT 2006)	255

E LEGISLATION, POLICIES AND CASE LAW FROM OTHER REGIONS

E1	Legislation	259
E1.1	HIV specific laws/bills	259
	Benin: Law No 2003-04 relating to Sexual and Reproductive Health (2003)	259
	Benin: Law No 2005-31 relating to the Prevention, Care and Control of HIV/AIDS in the Republic of Benin (2005)	259
	Cambodia: Law on the Prevention and Control of HIV/AIDS (2002)	262
	Kazakhstan: Law of 5 October 1994 on the Prevention of AIDS	264
	Papua New Guinea: HIV/AIDS Management and Prevention Act 4 of 2003	266
	Philippines: AIDS Prevention and Control Act 8504 of 1998	270
	United States of America: State of New Jersey: An Act Concerning Testing of Pregnant Women and Newborns for HIV (2007)	273
E1.2	Equality and non-discrimination	274
	Canada: Canadian Human Rights Act (1977)	274
E1.3	Employment	274
	The Bahamas: Bahamas Employment Act 27 of 2001	274

E2	Policies and other similar documents	275
	Australia National HIV Strategy (2005-2008) (2005)	275
	Nigeria National Policy on HIV and AIDS (2003)	278
	West and Central Africa: Law # of 2004 on HIV/AIDS Prevention and Control	279
E3	Case law	284
E3.1	HIV-related discrimination	284
	<i>Canada (Attorney General) v Thwaites (TD)</i> (1994) FC (3rd) 38	284
	<i>Mr X v Hospital Z</i> (1998) India Supreme Court	284
	<i>A, C & Others v Union of India & Others</i> (InBHCJ 1999)	285
E3.2	Access to HIV-related treatment	288
	<i>Jorge Odir Miranda Cortez et al v El Salvador</i> (2001) Inter-American Commission on Human Rights	288
	<i>AIDS Access Foundation et al v Bristol Myers-Squibb Company and Department of Intellectual Property</i> (ThCIPITC 2002)	290
E3.3	HIV prevention and care in prison	290
	<i>Prisoners A-XX Inclusive v State of New South Wales</i> (1995) New South Wales Supreme Court	290
	<i>R v Secretary of State for Home Department Ex Parte Glen Fielding</i> (1999) EWHC Admin 641	291
	<i>Odafe and Others v Attorney-General and Others</i> (2004) AHRLR (NgHC 2004)	292
E3.4	HIV and disability	293
	<i>Bragdon v Abbott</i> (1998) 107 F 3d 934 (USSC 1998)	293
E3.5	HIV and confidentiality	295
	<i>Harvey & Another v PD</i> (2004) NSWCA 97	295
E3.6	HIV and PMTCT	300
	<i>C (A Child)</i> (EWCA Civ 1999) 3007	300
E3.7	HIV and deportation/extradition	301
	<i>D v The United Kingdom</i> (1997) ECHR	301
	<i>De Bruyn v Minister for Justice & Customs</i> (2004) FCAFC 334	303
	<i>N v Secretary of State for the Home Department</i> 2005 (4) All ER 1017 (UKHL 2005 31)	307
E3.8	HIV and sexual orientation	311
	<i>Toonen v Australia</i> (1994) Human Rights Committee	311
	USEFUL WEBSITES	313

LIST OF ACRONYMS AND ABBREVIATIONS

ACHPR	African Commission on Human and Peoples' Rights	FGM	Female genital mutilation
AD	Appellate Division Reports (South Africa)	GATT	General Agreement on Tariffs and Trade
AEC	African Economic Community	GDP	Gross domestic product
AHRLR	African Human Rights Law Reports	GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
AIDS	Acquired Immunodeficiency Syndrome	GLIA	Great Lakes Initiative on AIDS
All ER	All England Law Reports	GNP	Gross national product
APRM	African Peer Review Mechanism	HCA	High Court of Australia
ART	Antiretroviral treatment	HIV	Human Immunodeficiency Virus
Art	Article	HRC	Human Rights Commission (South Africa)
ARV	Antiretroviral	IACHR	Inter-American Commission on Human Rights
ASO	AIDS service organisations	ICBo	Industrial Court of Botswana
ATM	HIV/AIDS, tuberculosis and malaria	ICCPR	International Covenant on Civil and Political Rights
AU	African Union	ICESCR	International Covenant on Economic, Social and Cultural Rights
BCLR	Butterworths Constitutional Law Reports (South Africa)	IDP	Internally displaced person
BFOR	<i>bona fide</i> occupational requirement (Canada)	IDU	Injection drug user
BHRC	Butterworths Human Rights Cases (United Kingdom)	IC	Industrial Court
BJJ	<i>bona fide</i> justification (Canada)	IEC	Information, education and communication
BLLR	Butterworths Labour Law Reports (South Africa)	IGAD	Intergovernmental Authority on Development
BLR	Botswana Law Reports	ILO	International Labour Organisation (United Nations)
BwCA	Botswana Court of Appeal	IMCI	Integrated management of childhood illnesses
BwIC	Industrial Court of Botswana	InBHCJ	Bombay [Mumbai] High Court of Judicature (India)
CD4 or CD4+	Cluster of differentiation 4[+]	IOC	Indian Ocean Commission
CP	Common Pleas [Reports] (United Kingdom)	IOM	International Organisation for Migration
CAF	Canadian Armed Forces	IP	Intellectual property
CaFC TD	Federal Court of Canada - Trial Division	JOL	Judgements Online
CAK	Court of Appeal of Kenya	KABP	Knowledge, attitude, behaviour and practice
CALD	Culturally and Linguistically Diverse	KeCA	Court of Appeal of Kenya
Cap	Chapter	MCH	Maternal and child health
CAT	Convention Against Torture	MDGs	Millennium Development Goals
CBO	Community-based organisation	M&E	Monitoring and evaluation
CCMA	Commission for Conciliation, Mediation and Arbitration of South Africa	MLR	Malawi Law Reports
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women	MP	Member of Parliament
CHBC	Community home-based care	MTCT	Mother-to-child transmission
CHR	Centre for Human Rights (University of Pretoria)	MSM	Men who have sex with men
CHRC	Canadian Human Rights Commission	N	Naira (currency of Nigeria)
CLR	Commonwealth Law Reports (Australia)	NAC	National AIDS Council
COMESA	Common Market of Eastern and Southern Africa	NACC	National AIDS Control Council (Kenya)
CRC	Convention on the Rights of the Child	NaLC	Labour Court of Namibia
CRM	Country Review Mission (African Peer Review Mechanism)	NAPWA	National Association of People Living with HIV (Australia)
CSA	Centre for the Study of AIDS (University of Pretoria)	NDF	Namibian Defence Force
CSAR	Country Self-Assessment Report (African Peer Review Mechanism)	NEPAD	New Partnership for Africa's Development
CSO	Civil society organisations	NgHC	Nigeria (Federal) High Court
CSOs	Community service organisations	NGO	Non-governmental organisation
DPSP	Directive Principles of State Policy	NSP	National Strategic Plan
EA	Eastern Africa Law Reports	NSW	New South Wales (Australia)
EAC	East African Community	NSWCA	New South Wales Court of Appeal (Australia)
ECA	Economic Commission for Africa (United Nations)	OAU	Organisation of African Unity
ECCAS	Economic Community of Central African States	OHCHR	UN Office of the High Commissioner for Human Rights
ECHR	European Court of Human Rights	OHS	Occupational Health Services
EEA	Employment Equity Act 55 of 1998 (South Africa)	OI	Opportunistic infection
EHHR	European Human Rights Reports	ORID	Other related infectious disease
ELISA test	Enzyme-linked immunosorbent assay test (an HIV antibody test)	OVC	Orphans and vulnerable children
EWCA Civ	England and Wales Supreme Court of Appeal (Civil Division) (United Kingdom/ England and Wales)	P	Pula (currency of Botswana)
FCAFC	Federal Court of Australia Full Court	PEP	Post-exposure prophylaxis
FAO	Food and Agriculture Organisation (United Nations)	PEPFAR	President's Emergency Fund for HIV and AIDS Relief Programme (United States of America)
FBO	Faith-based organisation	PLG	Parliamentary Liaison Group (Australia)
FCR	Federal Courts Reports (Canada)	PLWA	People living with AIDS
		PLWH	People living with HIV
		PLWHA	People living with HIV
		PLHIV	People living with HIV
		PMTCT	Prevention of mother-to-child transmission

PRSP	Poverty Reduction Strategies Paper	Three ones	One HIV and AIDS Action Framework, One Executing Authority and One Monitoring and Evaluation System
RBM	Roll Back Malaria		
REC	Regional Economic Community	TRIPS	Trade-Related Aspects of Intellectual Property Rights
SA	South African Law Report	UK	United Kingdom (of Great Britain and Northern Ireland)
SAA	Appellate Division of South Africa	UKHL	United Kingdom House of Lords
SAA	South African Airways	UN	United Nations
SABAT	Broadcasting Appeal Tribunal of South Africa	UNAIDS	Joint United Nations Programme on HIV/AIDS
SABC	South African Broadcasting Corporation	UNCHR	United Nations Commission on Human Rights
SABCC	Broadcasting Complaints Commission of South Africa	UNDP	United Nations Development Programme
SABCT	Broadcasting Complaints Tribunal of South Africa	UNECA	United Nations Economic Commission for Africa
SACC	Constitutional Court of South Africa	UNESCO	United Nations Educational, Scientific and Cultural Organisation
SADC	Southern African Development Community	UNFPA	United Nations Population Fund
SADC PF	Southern African Development Community Parliamentary Forum	UNGASS	United Nations General Assembly Special Session on HIV/AIDS
SAHC	High Court of South Africa	UNICEF	United Nations Children's Fund
SALC	Labour Court of South Africa	USA	United States of America
SAMA	South African Medical Association	USSC	Supreme Court of the United States of America
SASCA	Supreme Court of Appeal of South Africa	USSR	Union of Soviet Socialist Republics
Sec	Section	VCCT	Voluntary confidential counselling and testing
SPLM	Sudanese People's Liberation Movement	VCT	Voluntary Counselling and Testing
SRH	Sexual and reproductive health	WCC	Westville Correctional Centre (South Africa)
STD	Sexually transmissible/transmitted disease	WFP	World Food Programme
STI	Sexually transmissible/transmitted infection	WHA	World Health Assembly
TAC	Treatment Action Campaign	WHO	World Health Organisation
TB	Tuberculosis	WID	Women in Development
TBA	Traditional birth attendant	WTO	World Trade Organisation
TD	Trial Division	ZHC	Zimbabwe High Court (also ZH)
ThCIPITC	Thailand Central Intellectual Property & International Trade Court	ZS	Zimbabwe Supreme (Court)

GLOSSARY OF TERMS

Acquired Immunodeficiency Syndrome (AIDS) – A condition characterised by a combination of signs and symptoms caused by HIV, which attacks and weakens the body's immune system, making the afflicted person susceptible to other life-threatening infections.

Anonymous testing – HIV testing procedure whereby the person being tested does not reveal his true identity. An identifying number or symbol is used to substitute for the name and allows the laboratory conducting the test and the person on whom the test is conducted to match the test results with the identifying number or symbol.

Antiretroviral (ARV) – A medication that interferes with the ability of a retrovirus (such as HIV) to make more copies of itself.

Case law – The body of law made by judges through legal decisions, in which legislation has been interpreted.

CD4 cell count – A measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS. A normal CD4 cell count is between 500 and 1,400 cells/mm³ of blood, but a person's CD4 count can vary. In HIV-infected person's, a CD4 count at or below 200 cells/mm³ is considered an AIDS-defining condition.

Compulsory licence – The licence granted when a state forces the holder of a patent to grant use of that patent to the state or to others. Compulsory licensing promotes access to generic medicines through local production by allowing a government agency or a private company to manufacture pharmaceutical products without the patent holder's consent and usually at a lower cost. Compulsory licensing has been applied to anti-retroviral drugs used to treat HIV.

Compulsory HIV testing – HIV testing imposed upon a person attended or characterised by the lack of or vitiated consent, use of physical force, intimidation or any form of compulsion.

Concluding Observations – Observations issued by a treaty body after it considers a state's report. Concluding observations refer both to positive aspects of a state's implementation of the treaty and areas where the treaty body recommends that a state takes further action. Concluding observations are sometimes referred to as concluding comments.

Contact tracing – The method of finding and counselling the sexual partner(s) of a person who has been diagnosed as having sexually transmitted disease.

Constitution – An overarching law that defines the fundamental political principles and establishes the structure, procedures, powers and duties of a government. Most national constitutions also guarantee specified human rights.

Declaration – A document that reflects the commitment made by states to address certain issues. A declaration is not legally binding on a state.

Directive Principles of State Policy (DPSP) – Constitutional guidelines that guide the actions of a government but are not enforceable in a court of law.

Discordant couples – A situation where one of the partners is HIV positive and the other partner is HIV negative in an unsafe sexual relationship.

Dualism – A country that is 'dualist' is required to adapt its national legislation before international treaties can be invoked at national level.

Enzyme-Linked Immunosorbent Assay (ELISA) – A highly sensitive laboratory test used to determine the presence of antibodies to HIV in the blood or saliva. Positive ELISA test results indicate that a person is HIV infected, but these results should be confirmed with a highly specific laboratory test called a Western blot.

Epidemic – A disease that grows in a human population at a very rapid rate.

Epidemiological surveillance – mechanism through which disease evaluation and evolution is controlled over a determined period of time.

General Comments – A treaty body's interpretation of human rights provisions, thematic issues, or its methods of work. General Comments are often written in an attempt to clarify the reporting duties of state parties regarding certain provisions. They also suggest approaches to implementing treaty provisions. General Comments are sometimes called general recommendations.

Human Immunodeficiency Virus (HIV) – The virus which causes AIDS.

HIV/AIDS monitoring – The documentation and analysis of the number of HIV/AIDS infections and the pattern of its spread.

HIV/AIDS prevention and control – Measures aimed at protecting non-infected people from contracting HIV and minimising the impact of the condition of persons living with HIV.

HIV-positive – The presence of HIV infection as documented by the presence of HIV or HIV antibodies in the sample being tested.

HIV-negative – The absence of HIV or HIV antibodies upon HIV testing.

HIV testing – Any validated, medically recognised and virally sensitive test for determining the presence or absence of HIV infection in a person.

HIV transmission – The transfer of HIV from one infected person to an uninfected person, most commonly through sexual intercourse, blood transfusion, sharing of intravenous needles and during pregnancy.

High-risk behaviour – A person's frequent involvement in certain activities which increase the risk of transmitting or acquiring HIV.

Incidence – The rate of occurrence of new cases of a particular disease in a given population, often reported as number of cases per 100,000 people.

Informed consent – A person's agreement to participate in a clinical trial after understanding all aspects of the trial, including potential risks and benefits.

Instrument – Any type of international document.

International law – Law between two or more states, at a sub-regional, regional or global level.

Legislation – Law that has been enacted by a legislative body or another governing body. The term may refer to a single law or the collective body of enacted law. The term 'statute' is also used to refer to a single law.

Medical confidentiality – The relationship of trust and confidence created or existing between a patient or a person with HIV and his attending physician, consulting medical specialist, nurse, medical technologist and all other health workers or personnel involved in any counselling, testing or professional care of the former; it also applies to any person who, in any official capacity, has acquired or may have acquired such confidential information.

Monism – A country that is 'monist' is not required to adapt national legislation for international law to become applicable at country level. Rather, the international law becomes part of domestic law when the international law is ratified.

Nevirapine – A medication that is used for the treatment of infections with HIV. It is in a class of drugs called reverse transcriptase inhibitors which also includes zalcitabine (Hivid), zidovudine (Retrovir), didanosine (Videx), and lamivudine (Epivir).

Opportunistic infections (OIs) – Illnesses caused by various organisms that occur in people with weakened immune systems, including people living with HIV.

Pandemic – An outbreak of an infectious disease, such as HIV, that affects people or animals over an extensive geographical area. Also known as a global epidemic.

People Living With HIV (PLHIV) – Infants, children, adolescents, and adults infected with HIV.

Pre-test counselling – The process of providing a person with information on the biomedical aspects of HIV/AIDS and emotional support to any psychological implications of undergoing HIV testing and the test result itself before he or she is subjected to the test.

Prevalence – The number of people in a population affected with a particular disease or condition at a given time. Prevalence can be thought of as a snapshot of all existing cases of a disease or condition at a specified time.

Protocol – An international agreement that adds to an existing international instrument.

Prophylactic – Any agent or device used to prevent the transmission of a disease. Roughly, prophylactic measures are divided between *primary* prophylaxis (to prevent the development of a disease) and *secondary* prophylaxis (whereby the disease has already developed and the patient is protected against the worsening of this process).

Policy – Statement of commitment and framework for future conduct, but not legally binding, as such.

Post-exposure prophylaxis – the administration of one or a combination of anti-retroviral drugs after probable exposure to HIV, for the purpose of preventing transmission.

Post-test counselling – The process of providing risk-reduction information and emotional support to a person who submitted to HIV testing at the time that the test result is released.

Ratification – A formal action under international law that makes a state a party to a particular treaty and indicates a state's consent to be bound by that treaty.

Resolution – Decision of treaty body or other institution, indicating the position of the body or institution on a particular issue; does not have formal legal force.

Serostatus – Is the presence or absence of antibodies in a person's blood serum. A person can be seropositive (if antibodies are present) or seronegative (if anti-bodies are not present).

Sexually transmitted diseases – Any infection spread by the transmission of organisms from person to person during sexual contact.

State party – A state that has become bound to a particular treaty, either by way of accession or ratification of that treaty.

State report – A document prepared by a state, as required by a treaty, showing its implementation of the provisions of that particular treaty. Sometimes, civil society organisations produce 'shadow reports' for a particular treaty, especially if they do not agree with the state report or wish to highlight some issue.

Signature – An act that indicates a state's intention to be bound by a treaty at a later date. It is an early step on the way to a state's ratification of the treaty.

Treaty – International instrument that becomes binding on a state after ratification. Treaties are also referred to as conventions, international agreements, protocols, covenants, and charters.

Voluntary HIV testing – HIV testing conducted on an person who, after having undergone pre-test counselling, willingly submits himself or herself to such test.

Window period – The time period between a person's infection with HIV and the appearance of detectable HIV antibodies. Because antibodies to HIV take some time to form, an HIV antibody test will not be positive immediately after a person is infected. The time delay typically ranges from 14 to 21 days, but varies for different people. Nearly everyone infected with HIV will have detectable antibodies 3 months after infection.

INTRODUCTION

The *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* is a collection, in five parts, of global, regional, sub-regional and national human rights instruments, policies, legislation and case law that are relevant to HIV and AIDS. In most instances, only excerpts pertinent to HIV and AIDS are provided. When applicable, reference is made to a source where the full text may be accessed.

Part A: The global documents include UN conventions, declarations, concluding observations and other relevant documents as well as instruments adopted by the World Trade Organisation.

Part B: The regional documents include those adopted within various organs and institutions of the African Union including concluding observations and resolutions from the African Commission on Human and Peoples' Rights, and relevant documents from the New Partnership for Africa's Development (NEPAD) and the African Peer Review Mechanism (APRM). Abstracts of country review reports of the APRM are also provided.

Part C: The *Compendium* also contains HIV-related documents adopted at the sub-regional level. The sub-regional documents provided in this *Compendium* emanate from the Common Market for Eastern and Southern Africa (COMESA), the East African Community (EAC), the Economic Community of Central African States (ECCAS), the Indian Ocean Commission (IOC), the Intergovernmental Authority on Development (IGAD) and the Southern African Development Community (SADC).

Part D: Full text versions and pertinent excerpts of national constitutions, legislation, policies and case law from Eastern and Southern African countries are included in the *Compendium*.

Part E: For purposes of comparison and experience sharing, the *Compendium* also contains relevant documents (legislation, case law and policies) from other regions. These regions include other parts of Africa.

In spite of their efforts to provide a comprehensive overview of HIV-related legislation, policies and case law from Eastern and Southern African countries, the compilers and editors of the *Compendium* acknowledge the difficulties inherent in such an endeavour. Paramount among these difficulties is the lack of accessibility of some relevant documents. This *Compendium* therefore does not cover all documents related to HIV in Eastern

and Southern Africa. It should still be useful to parliamentarians, members of the judiciary, lawyers, civil society organisations, people living with HIV and all interested institutions and individuals as a reference book that provides a comparative overview of the legal and policy frameworks on HIV in Eastern and Southern African countries.

Efforts have been made to ensure accuracy in the translation of legislation and policies of francophone and lusophone countries. It should be noted that these translations remain unofficial.

In addition, some of the original texts and case law in this *Compendium* have been edited for consistency. Footnotes have also been omitted from excerpted case law. However, the editing and omissions do not alter the substance of the reprinted documents.

Dates provided after treaties (such as '1958/1960') indicate the date of the treaty's adoption (first date '1958') and subsequent entry into force (second date '1960').

The *Compendium* is one of a series of tools developed by the AIDS and Human Rights Research Unit for the UNDP's HIV and AIDS Team at the Regional Service Centre in Johannesburg. These tools are aimed to reinforce the response to HIV of countries in Eastern and Southern Africa.

The other tools are: *Guide to an effective human rights response to the HIV epidemic*, *Checklist of human rights obligations to effectively address HIV and AIDS in Eastern and Southern Africa*, *powerpoint cum Flip Chart presentation*, and *CD-Rom of key documents relating to human rights and HIV in Eastern and Southern Africa*. The complete version of the tools may be accessed on the following websites: <http://www.chr.up.ac.za/undp> and http://www.undp.org/hiv/pa_africa.htm

As far as possible, the documents and information in this *Compendium* reflect the position as at 31 December 2007.

Editors

AIDS and Human Rights Research Unit, a collaboration between the Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria

A GLOBAL DOCUMENTS

- A1 UN treaties, with General Comments and Concluding Observations**
A2 UN declarations and similar documents
A3 WTO documents
-

A1 UN treaties, with General Comments and Concluding Observations

A1.1 ILO Discrimination (Employment and Occupation) Convention, No 111 (1958/1960)

Adopted by the General Conference of the International Labour Organisation on 25 June 1958 at its 42nd session and entered into force on 15 June 1960. Full text available at www.ilo.org.

Excerpts

...

Article 1

1. For the purpose of this Convention the term discrimination includes

- (a) any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation;
- (b) such other distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation as may be determined by the Member concerned after consultation with representative employers' and workers' organisations, where such exist, and with other appropriate bodies.

Article 2

Each Member for which this Convention is in force undertakes to declare and pursue a national policy designed to promote, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in respect thereof.

Article 3

Each Member for which this Convention is in force undertakes, by methods appropriate to national conditions and practice

- (a) to seek the co-operation of employers' and workers' organisations and other appropriate bodies in promoting the acceptance and observance of this policy;
- (b) to enact such legislation and to promote such educational programmes as may be calculated to secure the acceptance and observance of the policy;
- (c) to repeal any statutory provisions and modify any administrative instructions or practices which are inconsistent with the policy;
- (d) to pursue the policy in respect of employment under the direct control of a national authority;
- (e) to ensure observance of the policy in the activities of vocational guidance, vocational training and placement services under the direction of a national authority; and
- (f) to indicate in its annual reports on the application of the Convention the action taken in pursuance of the policy and the results secured by such action.

Article 4

Any measures affecting an individual who is justifiably suspected of, or engaged in, activities prejudicial to the security of the State shall not be deemed to be discrimination, provided that the individual concerned shall have the right to appeal to a competent body established in accordance with national practice.

Article 5

1. Special measures of protection or assistance provided for in other Conventions or Recommendations adopted by the International Labour Conference shall not be deemed to be discrimination.

2. Any Member may, after consultation with representative employers' and workers' organisations, where such exist, determine that other special measures designed to meet the particular requirements of persons who, for reasons such as sex, age, disablement, family responsibilities or social or cultural status, are generally recognised to require special protection or assistance, shall not be deemed to be discrimination.

...

A1.2 Convention on the Elimination of all Forms of Racial Discrimination (1965/1969)

Adopted by General Assembly resolution 2106 (XX) 21, opened for signature, ratification and accession in December 1965 and entered into force on 4 January 1969, in accordance with article 19. Full text available at www.ohchr.org.

Excerpts

...

PART I

Article 1

1. In this Convention, the term 'racial discrimination' shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

...

3. Nothing in this Convention may be interpreted as affecting in any way the legal provisions of states parties concerning nationality, citizenship or naturalisation, provided that such provisions do not discriminate against any particular nationality.

4. Special measures taken for the sole purpose of securing adequate advancement of certain racial or ethnic groups or individuals requiring such protection as may be necessary in order to ensure such groups or individuals equal enjoyment or exercise of human rights and fundamental freedoms shall not be deemed racial discrimination, provided, however, that such measures do not, as a consequence, lead to the maintenance of separate rights for different racial groups and that they shall not be continued after the objectives for which they were taken have been achieved.

Article 2

1. States parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races, and, to this end: (a) Each state party undertakes to engage in no act or practice of racial discrimination against persons, groups of persons or institutions and to ensure that all public authorities and public institutions, national and local, shall act in conformity with this obligation;

...

2. States parties shall, when the circumstances so warrant, take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms. These measures shall in no case entail as a consequence the maintenance of unequal or separate rights for different racial groups after the objectives for which they were taken have been achieved.

...

Article 5

In compliance with the fundamental obligations laid down in article 2 of this Convention, states parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law.

Article 6

States parties shall assure to everyone within their jurisdiction effective protection and remedies, through the competent national tribunals and other State institutions, against any acts of racial discrimination which violate his human rights and fundamental freedoms contrary to this Convention, as well as the right to seek from such tribunals just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination.

Article 7

States parties undertake to adopt immediate and effective measures, particularly in the fields of teaching, education, culture and information, with a view to combating prejudices which lead to racial discrimination and to promoting understanding, tolerance and friendship among nations and racial or ethnical groups, as well as to propagating the purposes and principles of the Charter of the United Nations, the Universal Declaration of Human Rights, the United Nations Declaration on the Elimination of All Forms of Racial Discrimination, and this Convention.

...

A1.3 International Covenant on Civil and Political Rights (1966/1976)

Adopted by General Assembly resolution 2200A (XXI) and opened for signature, ratification and accession on 16 December 1966. It entered into force on 23 March 1976, in accordance with article 49. Full text available at www.ohchr.org.

Excerpts

...

PART II

...

Article 2

1. Each state party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant,

without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. Where not already provided for by existing legislative or other measures, each state party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognised in the present Covenant.

3. Each state party to the present Covenant undertakes

(a) To ensure that any person whose rights or freedoms as herein recognised are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;

(b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that the competent authorities shall enforce such remedies when granted.

Article 3

The states parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.

...

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognised herein or at their limitation to a greater extent than is provided for in the present Covenant.

2. There shall be no restriction upon or derogation from any of the fundamental human rights recognised or existing in any state party to the present Covenant pursuant to law, conventions, regulations or custom on the pretext that the present Covenant does not recognise such rights or that it recognises them to a lesser extent.

PART III

Article 6

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

...

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

...

Article 9

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

...

Article 10

1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

...

Article 12

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.

2. Everyone shall be free to leave any country, including his own.

3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognised in the present Covenant.

4. No one shall be arbitrarily deprived of the right to enter his own country.

...

Article 14

1. All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. The press and the public may be excluded from all or part of a trial for reasons of morals, public order (ordre public) or national security in a democratic society, or when the interest of the private lives of the parties so requires, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice; but any judgement rendered in a criminal case or in a suit at law shall be made public except where the interest of juvenile persons otherwise requires or the proceedings concern matrimonial disputes or the guardianship of children.

...

Article 17

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. Everyone has the right to the protection of the law against such interference or attacks.

...

Article 19

1. Everyone shall have the right to hold opinions without interference.

2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary

(a) For respect of the rights or reputations of others;

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

...

Article 22

1. Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests.

...

Article 26

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

PART IV

...

Article 40

1. The states parties to the present Covenant undertake to submit reports on the measures they have adopted which give effect to the rights recognised herein and on the progress made in the enjoyment of those rights: (a) Within one year of the entry into force of the present Covenant for the states parties concerned; (b) Thereafter whenever the Committee so requests.

2. All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit them to the Committee for consideration. Reports shall indicate the factors and difficulties, if any, affecting the implementation of the present Covenant.

...

Article 41

1. A state party to the present Covenant may at any time declare under this article that it recognises the competence of the Committee to receive and consider communications to the effect that a state party claims that another state party is not fulfilling its obligations under the present Covenant. Communications under this article may be received and considered only if submitted by a state party which has made a declaration recognising in regard to itself the competence of the Committee.

...

A1.4 International Covenant on Economic, Social and Cultural Rights (1966/1976)

Adopted by General Assembly resolution 2200A (XXI) and opened for signature, ratification and accession on 16 December 1966. It entered into force on 3 January 1976, in accordance with article 27. Full text available at www.ohchr.org.

Excerpts

...

PART II

Article 2

1. Each state party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The states parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognised in the present Covenant to non-nationals.

Article 3

The states parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Article 4

The states parties to the present Covenant recognise that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for

the purpose of promoting the general welfare in a democratic society.

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights or freedoms recognised herein, or at their limitation to a greater extent than is provided for in the present Covenant.

2. No restriction upon or derogation from any of the fundamental human rights recognised or existing in any country in virtue of law, conventions, regulations or custom shall be admitted on the pretext that the present Covenant does not recognise such rights or that it recognises them to a lesser extent.

PART III

Article 6

1. The states parties to the present Covenant recognise the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.

2. The steps to be taken by a state party to the present Covenant to achieve the full realisation of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.

...

Article 9

The states parties to the present Covenant recognise the right of everyone to social security, including social insurance.

Article 10

The states parties to the present Covenant recognise that

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.

2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

Article 11

1. The states parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The states parties will take appropriate steps to ensure the realisation of this right, recognising to this effect the essential importance of international co-operation based on free consent.

...

Article 12

1. The states parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the states parties to the present Covenant to achieve the full realisation of this right shall include those necessary for

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

...

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

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

...

Article 15

1. The states parties to the present Covenant recognise the right of everyone

...

(b) To enjoy the benefits of scientific progress and its applications;

(c) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

...

PART IV

Article 16

1. The states parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognised herein.

2(a) All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit copies to the Economic and Social Council for consideration in accordance with the provisions of the present Covenant;

...

Article 17

1. The states parties to the present Covenant shall furnish their reports in stages, in accordance with a programme to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the states parties and the specialised agencies concerned.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Covenant.

...

General Comment 14 (2000) The right to the highest attainable standard of health (article 12)

General Comment 14 provides an interpretation of article 12 of the International Covenant on Economic, Social and Cultural Rights according to the Committee on Economic, Social and Cultural Rights. Full text available at www.ohchr.org.

Excerpts

...

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realisation of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organisation (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.

2. The human right to health is recognised in numerous international instruments. Article 25(1) of the Universal Declaration of Human Rights affirms: 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services'. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12(1) of the Covenant, states parties recognise 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', while article 12(2) enumerates, by way of illustration, a number of 'steps to be taken by the states parties ... to achieve the full realisation of this right'. Additionally, the right to health is recognised, *inter alia*, in article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11(1)(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognise the right to health, such as the European Social Charter of 1961 as revised (art 11), the African Charter on Human and Peoples' Rights of 1981 (art 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

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

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualises health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. However, the reference in article 12(1) of the Covenant to 'the highest attainable standard of physical and mental health' is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12(2) acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

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

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

Normative content of article 12

7. Article 12(1) provides a definition of the right to health, while article 12(2) enumerates illustrative, non-exhaustive examples of states parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of 'the highest attainable standard of health' in article 12(1) takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realisation of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12(1), as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

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

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

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

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

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population,

especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

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

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

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

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

13. The non-exhaustive catalogue of examples in article 12(2) provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12(1), thereby illustrating the content of that right, as exemplified in the following paragraphs.

Concluding Observations – Sudan (2000)

The Committee on Economic Social and Cultural Rights considered the initial report of the Sudan on the implementation of the International Covenant on Economic, Social and Cultural Rights (E/1990/5/Add.41) at its 38th to 41st meetings, held on 21 and 22 August 2000, and adopted these concluding observations at its 53rd meeting, held on 30 August 2000. Full text available at www.ohchr.org.

Excerpts

...

D. Principal subjects of concern

...

27. The Committee expresses its concern regarding the persisting problem of malaria, often a cause of death in the state party, as well as the increasing incidence of HIV/AIDS. A lack of medicines at affordable prices compounds these difficulties.

...

E. Suggestions and recommendations

...

38. It is recommended that the state party develop specific measures to eliminate ingrained harmful traditions, customs and prejudices against women, such as female genital mutilation, the limitation of their freedom of movement and expression, and any obstacles that hinder women's full participation in society.

...

40. The Committee urges the state party to devote adequate attention to identifying its most urgent problems and concerns about economic, social and cultural rights under the Covenant and to formulate these priorities in a comprehensive plan of action for human rights, in which the possible measures to be taken are categorised according to feasibility of realisation in terms of time and resources. The state party is encouraged to request the assistance of the Office of the High Commissioner for Human Rights in this regard.

...

Concluding Observations – Zambia (2005)

The Committee on Economic, Social and Cultural Rights considered the initial report of Zambia on the implementation of the International Covenant on Economic, Social and Cultural Rights (E/1990/5/Add.60) at its 3rd, 4th and 5th meetings, held on 26 and 27 April 2005 (see E/C.12/2005/SR.3-5), and adopted these concluding observations at its 27th meeting, held on 13 May 2005. Full text available at www.ohchr.org.

Excerpts

...

D. Principal subjects of concern

...

23. The Committee is concerned about the large number of widows and orphans, a situation further exacerbated by the HIV/AIDS pandemic. It is also concerned about the harsh living conditions of widows and girl orphans due to, among other things, harmful traditional practices such as 'widow-cleansing', early marriages and denial of inheritance.

24. The Committee is concerned about the large number of street children, especially in the capital, Lusaka, who are particularly exposed to physical and sexual abuse, prostitution, and a high risk of being infected with HIV/AIDS.

...

26. The Committee is deeply concerned that the extent of extreme poverty in the state party has negatively affected the enjoyment of economic, social and cultural rights as enshrined in the Covenant, especially by the most disadvantaged and marginalised groups, including girl children and those afflicted by HIV/AIDS.

...

30. The Committee is alarmed about the devastating impact of the HIV/AIDS pandemic on the enjoyment of economic, social and cultural rights by the people of Zambia. The Committee is also concerned that people afflicted with HIV/AIDS seldom have adequate access to the necessary health care services, including antiretroviral drugs, appropriate facilities and food.

31. The Committee is deeply concerned about the high incidence of child-headed households, a phenomenon that it is linked to the HIV/AIDS pandemic and which negatively impacts on children's access to education.

E. Suggestions and recommendations

...

53. The Committee recommends that the state party intensify its efforts to control the spread of HIV/AIDS, including by strengthening the policy of both providing and encouraging the use of condoms. The Committee also recommends that the state party continue with its prevention and care efforts in the field of health by providing sexual and reproductive health services, particularly to women and young people. The Committee further requests the state party to provide detailed statistical data, disaggregated on a yearly basis, on the incidence of HIV/AIDS and on the measures taken to combat the pandemic, including

public information programmes, in its next periodic report. The Committee, in line with its General Comment 14 (2000) on the right to the highest attainable standard of health, recommends that the state party provide adequate health care for people suffering from HIV/AIDS, taking into account the particular needs of widows and orphans.

...

A1.5 Convention on the Elimination of All Forms of Discrimination against Women (1979/1981)

Adopted by General Assembly resolution 34/180 and opened for signature, ratification and accession on 18 December 1979 and entered into force on 3 September 1981, in accordance with article 27(1). Full text available at www.ohchr.org.

Excerpts

...

Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,

Concerned that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs,

...

Convinced that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields,

Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognised, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole,

Aware that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women,

Determined to implement the principles set forth in the Declaration on the Elimination of Discrimination against Women and, for that purpose, to adopt the measures required for the elimination of such discrimination in all its forms and manifestations,

Have agreed on the following

PART I

Article 1

For the purposes of the present Convention, the term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 2

States parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realisation of this principle;

(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

...

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

...

Article 3

States parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

...

Article 6

States parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

...

PART III

...

Article 11

1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular

(a) The right to work as an inalienable right of all human beings;

(b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;

(c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;

(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;

(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

...

Article 12

1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, states parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 13

States parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular

- (a) The right to family benefits;
- (b) The right to bank loans, mortgages and other forms of financial credit;

...

PART IV**Article 16**

1. States parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women

...

- (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

- (f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;

...

- (h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

...

PART V**Article 17**

1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination against Women (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth state party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by states parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution and to the representation of the different forms of civilisation as well as the principal legal systems.

...

Article 18

1. States parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect

- (a) Within one year after the entry into force for the State concerned;

- (b) Thereafter at least every four years and further whenever the Committee so requests.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.
- ...

General Recommendation 15 (1990) Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)

This General Recommendation by the Committee on the Elimination of All Forms of Discrimination against Women focuses on the impact of HIV/AIDS on women. Full text available at www.ohchr.org.

The Committee on the Elimination of Discrimination against Women,

Having considered information brought to its attention on the potential effects of both the global pandemic of acquired immunodeficiency syndrome (AIDS) and strategies to control it on the exercise of the rights of women,

Having regard to the reports and materials prepared by the World Health Organisation and other United Nations organisations, organs and bodies in relation to human immunodeficiency virus (HIV), and, in particular, the note by the Secretary-General to the Commission on the Status of Women on the effects of AIDS on the advancement of women and the Final Document of the International Consultation on AIDS and Human Rights, held at Geneva from 26 to 28 July 1989,

Noting World Health Assembly resolution WHA 41.24 on the avoidance of discrimination in relation to HIV-infected people and people with AIDS of 13 May 1988, resolution 1989/11 of the Commission on Human Rights on non-discrimination in the field of health, of 2 March 1989, and in particular the Paris Declaration on Women, Children and AIDS, of 30 November 1989,

Noting that the World Health Organisation has announced that the theme of World AIDS Day, 1 December 1990, will be 'Women and AIDS',

Recommendations

- (a) That states parties intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them;

- (b) 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;

- (c) That states parties ensure the active participation of women in primary health care and take measures to enhance their role as care providers, health workers and educators in the prevention of infection with HIV;

- (d) That all states parties include in their reports under article 12 of the Convention information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS.

General Recommendation 24 (1999) Article 12 of the Convention (women and health)

General recommendation 24 provides an interpretation of article 12 of the Convention on the Elimination of All Forms of Discrimination against Women by the Committee on the Elimination of Discrimination against Women. Full text available at www.ohchr.org.

Excerpts

1. The Committee on the Elimination of Discrimination against Women, affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women, decided at its twentieth session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention.

Background

2. States parties' compliance with article 12 of the Convention is central to the health and well-being of women. It requires States to eliminate discrimination against women in their access to health care services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period. The examination of reports submitted by states parties pursuant to article 18 of the Convention demonstrates that women's health is an issue that is recognised as a central concern in promoting the health and well-being of women. For the benefit of states parties and those who have a particular interest in and concern with the issues surrounding women's health, the present general recommendation seeks to elaborate the Committee's understanding of article 12 and to address measures to eliminate discrimination in order to realise the right of women to the highest attainable standard of health.

4. The Committee notes the emphasis that other United Nations instruments place on the right to health and to the conditions that enable good health to be achieved. Among such instruments are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

5. The Committee refers also to its earlier general recommendations on female circumcision, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), disabled women, violence against women and equality in family relations, all of which refer to issues that are integral to full compliance with article 12 of the Convention.

6. While biological differences between women and men may lead to differences in health status, there are societal factors that are determinative of the health status of women and men and can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

7. The Committee notes that the full realisation of women's right to health can be achieved only when states parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions. To this end, states parties should take steps to facilitate physical and economic access to productive resources, especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.

Article 12

8. States parties are encouraged to address the issue of women's health throughout the woman's lifespan. For the purposes of the present general recommendation, therefore, 'women' includes girls and adolescents. The general recommendation will set out the Committee's analysis of the key elements of article 12.

Key elements

Article 12(1)

9. States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, states parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.

10. States parties are encouraged to include in their reports information on diseases, health conditions and conditions hazardous to health that affect women or certain groups of women differently from men, as well as information on possible intervention in this regard.

11. Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

12. States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors that differ for women in comparison to men, such as

(a) Biological factors that differ for women in comparison to men, such as their menstrual cycle, their reproductive function and menopause. Another example is the higher risk of exposure to sexually transmitted diseases that women face;

(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, unequal power relationships between women and men in the home and workplace may negatively affect women's nutrition and health. They may also be exposed to different forms of violence which can affect their health. Girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;

(c) Psychosocial factors that vary between women and men include depression in general and post-partum depression in particular as well as other psychological conditions, such as those that lead to eating disorders such as anorexia and bulimia;

(d) While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.

13. The duty of states parties to ensure, on a basis of equality of men and women, access to health care services, information and education implies an obligation to respect, protect and fulfil

women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action. Failure to do so will constitute a violation of article 12.

14. The obligation to respect rights requires states parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care. For example, states parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorisation of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalise medical procedures only needed by women punish women who undergo those procedures.

15. The obligation to protect rights relating to women's health requires states parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organisations. Since gender-based violence is a critical health issue for women, states parties should ensure

(a) The enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services;

(b) Gender-sensitive training to enable health care workers to detect and manage the health consequences of gender-based violence;

(c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health care professionals guilty of sexual abuse of women patients;

(d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

16. States parties should ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees.

17. The duty to fulfil rights places an obligation on states parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realise their rights to health care. Studies such as those that emphasise the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for states parties of possible breaches of their duties to ensure women's access to health care. The Committee asks states parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as tuberculosis and HIV/AIDS. The Committee is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organise governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties and to protect their health and the measures they have taken to ensure the provision of such services.

18. The issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose

girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, states parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

19. In their reports, states parties should identify the test by which they assess whether women have access to health care on a basis of equality of men and women in order to demonstrate compliance with article 12. In applying these tests, states parties should bear in mind the provisions of article 1 of the Convention. Reports should therefore include comments on the impact that health policies, procedures, laws and protocols have on women when compared with men.

20. Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

21. States parties should report on measures taken to eliminate barriers that women face in access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access, such as high fees for health care services, the requirement for preliminary authorisation by spouse, parent or hospital authorities, distance from health facilities and the absence of convenient and affordable public transport.

22. States parties should also report on measures taken to ensure access to quality health care services, for example, by making them acceptable to women. Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilisation, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

23. In their reports, states parties should state what measures they have taken to ensure timely access to the range of services that are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.

24. The Committee is concerned about the conditions of health care services for older women, not only because women often live longer than men and are more likely than men to suffer from disabling and degenerative chronic diseases, such as osteoporosis and dementia, but because they often have the responsibility for their ageing spouses. Therefore, states parties should take appropriate measures to ensure the access of older women to health services that address the handicaps and disabilities associated with ageing.

25. Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.

Article 12(2)

26. Reports should also include what measures states parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period. Information on the rates at which these measures have reduced

maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included.

27. States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of states parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.

...

Recommendations for government action

29. States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

30. States parties should allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs.

31. States parties should also, in particular

(a) Place a gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women;

(b) Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;

(c) Prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion;

(d) Monitor the provision of health services to women by public, non-governmental and private organisations, to ensure equal access and quality of care;

(e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;

(f) Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

Concluding Observations – Kenya (2003)

The Committee on the Elimination of Discrimination against Women considered the combined third and fourth periodic report of Kenya (CEDAW/C/KEN/3-4) at its 592nd and 593rd meetings, on 15 January 2003 (see CEDAW/C/SR.592 and 593). The Committee issued these concluding observations on 20 March 2003. Full text available at www.ohchr.org.

Excerpts

...

Positive aspects

202. The Committee welcomes the draft constitution which will come into force by June 2003, as it addresses issues of the reform of existing discriminatory laws.

...

Principal areas of concern and recommendations

206. The Committee recommends that the state party incorporate the provisions of the Convention on the Elimination of All Forms of Discrimination against Women into domestic law without delay and requests the state party to ensure that the provisions of the Convention are fully reflected in the constitution and in all legislation.

...

208. The Committee recommends that the state party take appropriate action to eliminate all discriminatory laws, practices and traditions and to ensure women's equality with men particularly in marriage and divorce, burial and devolution of property upon death in accordance with the provisions of the Convention. In this regard, the Committee recommends speedy enactment of the relevant bills, including the Domestic violence (family protection) bill of 2002; the Equality bill of 2001; the National Commission on Gender and Development bill of 2002; the Criminal law amendment bill of 2002; the HIV/AIDS Prevention and Control bill of 2002; and the Public Offices Code of Ethics bill of 2002. The Committee also recommends that the state party's relevant ministries continue working with civil society, including non-governmental organisations, in order to create an enabling environment for legal reform, effective law enforcement and legal literacy.

...

210. The Committee requests the state party to increase its efforts to create awareness in society about the need to change stereotypical attitudes and discriminatory behaviour towards women and girls through, inter alia, specific programmes directed at both women and men in this regard. The Committee further encourages the media to project a positive image of women and to promote the equal status of women and men in both the public and private spheres. It also calls upon the state party to periodically review the measures taken in order to identify shortcomings and to adjust and improve those measures accordingly.

...

212. The Committee urges the state party to accord priority attention to the adoption of comprehensive measures to address violence against women and girls, taking into account its general recommendation 19 on violence against women. The Committee calls on the state party to enact or review, as appropriate, legislation on all forms of violence against women, including domestic violence, as well as legislation concerning all forms of sexual harassment, in order to ensure that women and girls who are victims of violence and sexual harassment have access to protection and effective redress and that perpetrators of such acts are prosecuted and punished. The Committee also recommends gender-sensitive training for public officials, particularly law enforcement personnel, the judiciary and health services providers. It also recommends the establishment of shelters and counselling services for victims of violence and sexual harassment.

...

214. The Committee recommends that the state party develop a plan of action, including a public-awareness campaign, targeted at both women and men, with the support of civil society, including non-governmental organisations, to eliminate the practice of female genital mutilation and encourages the state party to create an enabling environment for effective law enforcement and to devise programmes for alternate sources of income for those who perform female genital mutilation as a means of livelihood.

...

220. The Committee requests the state party to study the phenomenon of prostitution and to take appropriate measures to

combat the exploitation of prostitution in urban areas. It recommends that a holistic approach be pursued in order to facilitate the reintegration of prostitutes into Kenyan society and urges the state party to provide rehabilitation and other programmes to women exploited in prostitution. It also recommends prosecution and punishment for those who profit from the sexual exploitation of women and girls.

221. While noting the state party's commitment to combating the spread of HIV/AIDS and the reduction in infection rates from 14 per cent to 10.2 per cent in 2002, the Committee is concerned at the lack of sex-disaggregated data on HIV/AIDS and the absence of strategic measures for the care of women and girls infected with and affected by HIV/AIDS.

222. The Committee urges the state party to take comprehensive measures to combat the HIV/AIDS pandemic, to take strong preventive measures and to ensure that women and girls infected with HIV/AIDS are not discriminated against and are given appropriate assistance. The Committee also emphasises that the collection of reliable data on HIV/AIDS is critical in order to understand the impact of the pandemic on women and men.

...

230. The Committee requests the wide dissemination in Kenya of the present concluding comments in order to make the people of Kenya, in particular government administrators and politicians, aware of the steps that have been taken or are intended to be taken to ensure the *de jure* and *de facto* equality of women. It also requests the state party to continue to disseminate widely, in particular to women's and human rights organisations, the Convention, its Optional Protocol, the Committee's general recommendations and the Beijing Declaration and Platform for Action, as well as the results of the twenty-third special session of the General Assembly, entitled 'Women 2000: gender equality, development and peace for the twenty-first century'.

Concluding Comments – Malawi (2006)

The Committee on the Elimination of Discrimination against Women considered the combined second, third, fourth and fifth periodic report of Malawi (CEDAW/C/MWI/2-5) at its 727th and 728th meetings, on 19 May 2006 (see CEDAW/C/SR.727 and CEDAW/C/SR.728). Full text available at www.ohchr.org.

Excerpts

...

Introduction

...

4. The Committee commends the Government for withdrawing its reservations to the provisions of the Convention concerning traditional customs and practices, and notes that Malawi signed the Optional Protocol to the Convention in September 2000.

Positive aspects

5. The Committee notes with appreciation that the state party has embarked on a constitutional review process. It welcomes the efforts of the Government to review its legislation with a view to amending it and drafting new legislation so as to comply with its obligations under the Convention, in particular the Marriage, Divorce and Family Relations Bill, the Citizenship Act, the Immigration Act, and the Wills and Inheritance Act.

6. The Committee appreciates the recent adoption of the Prevention of Domestic Violence Act.

...

Principal areas of concern and recommendations

9. The Committee is concerned that, although Malawi ratified the Convention in 1987, the Convention's status in the domestic legal system is still unclear. It notes with concern that, short of

such full domestication, the primacy of the Convention over domestic law is not clarified, nor is the Convention justiciable and enforceable in Malawian courts.

10. The Committee urges the state party to place high priority on ensuring that the Convention can be invoked and applied in the national courts. It calls on the state party to ensure that the provisions of the Convention and related domestic legislation are made an integral part of legal education and the training of judicial officers, including judges, lawyers and prosecutors, so as to firmly establish in the country a legal culture supportive of women's equality and non-discrimination.

...

12. The Committee encourages the state party to incorporate in its Constitution, or the Gender Equality Statute, which is currently being drafted, the full definition of discrimination, encompassing both direct and indirect discrimination, in line with article 1 of the Convention, and explicitly prohibiting discrimination by private actors, in accordance with article 2(e) of the Convention. It also encourages the state party to include provisions for temporary special measures, in accordance with article 4(1) of the Convention and the Committee's General Recommendation No 25, and to set a time frame for the drafting and adoption of the Gender Equality Statute.

13. While welcoming the law reform process currently being undertaken by the special Law Commission on Gender-Related Laws aimed at the elimination of discrimination against women in various fields such as marriage, divorce, citizenship and inheritance, the Committee is concerned about the continuing lack of compliance of these laws with the Convention and the contradictions between some existing laws and the Constitution. The Committee is particularly concerned about the contradictions between the Marriage Act, which establishes 21 as the minimum age for marriage, and the Constitution, which allows child marriages. The Committee is further concerned about the contradictions between the Constitution and the Citizenship and Immigration Acts, which provide that upon marrying a foreign man, the Malawian woman loses her right to a Malawian citizenship, and that married women are not allowed to migrate unless they are under the custody of a husband.

14. The Committee urges the state party to accelerate its law review process and ensure that its discriminatory legislation is speedily brought into compliance with the Convention so as to establish women's *de jure* equality. It urges the state party to set a clear time frame for the adoption of the revised Citizenship Act, Immigration Act and the Wills and Inheritance Act and for the new Marriage, Divorce and Family Relations Bill, designed to eliminate discrimination against women. The Committee encourages the state party to develop and implement comprehensive educational measures and an awareness-raising campaign upon completion of the review process, so as to ensure knowledge of the legal framework and its effective implementation.

...

18. The Committee requests the state party to remove impediments women may face in gaining access to justice. It further urges the state party to take special measures to enhance women's awareness of their rights, legal literacy and access to the courts to claim all their rights. The Committee recommends that the state party ensures the constitutionality of the customary courts and that their rulings are not discriminatory against women.

...

20. The Committee urges the introduction, without delay and in conformity with articles 2(f) and 5 (a) of the Convention, of concrete measures to modify or eliminate customs and cultural and harmful traditional practices that discriminate against women so as to promote women's full enjoyment of their human rights. In particular, the Committee urges the state party to eliminate practices such as forced and early marriages and discriminatory widowhood inheritance practices and other practices enumerated in the state party's report which constitute violations of women's human rights under the Convention. It invites the state party to increase its efforts to design and

implement comprehensive education and awareness-raising programmes targeting women and men at all levels of society, including village head persons and chiefs, with a view to changing discriminatory social and cultural patterns of conduct and to creating an enabling and supportive environment for women to exercise their human rights. The Committee encourages the state party to implement the necessary efforts, in collaboration with civil society organisations, women's non-governmental organisations and community leaders. It further calls upon the state party to review periodically the measures taken to assess the impact of those efforts and take appropriate remedial measures, and to report on the results to the Committee in its next report.

...

22. The Committee urges the state party to accord priority attention to the adoption of comprehensive measures to address violence against women and girls, in accordance with its General Recommendation 19 on violence against women and the Declaration on the Elimination of Violence against Women. The Committee calls on the state party to enact legislation outlawing discriminatory customs and practices and criminalising marital rape, as well as legislation concerning all forms of sexual abuse, including sexual harassment, as soon as possible. Such legislation needs to ensure that violence against women and girls constitutes a criminal offence, that women and girls who are victims of violence have access to immediate means of redress and protection and that perpetrators are prosecuted and punished. The Committee recommends the implementation of training for the judiciary, law enforcement personnel, health-service providers and teachers to ensure that they are sensitised to all forms of violence against women and can respond adequately to it. The Committee urges the state party to take immediate measures to put an end to all exploitation of school girls by teachers and to prosecute offenders effectively. The Committee also urges the state party to take concrete measures, including visible leadership from the highest level of Government, towards modifying those social, cultural and traditional attitudes that constitute, or are permissive of, violence against women. The Committee requests the state party to provide information in its next report on the laws and policies in place to deal with violence against women and the impact of such measures.

...

24. The Committee urges the state party to pursue a holistic approach that aims at providing women and girls with educational and economic alternatives to prostitution, to facilitate the reintegration of prostitutes into society and to provide rehabilitation and economic empowerment programmes to women and girls exploited in prostitution. The Committee further calls on the state party to take appropriate measures to suppress the exploitation of prostitution of women, including through the discouragement of the demand for prostitution. The Committee requests that the state party provide information and data on measures taken to combat this phenomenon in its next report. It also requests the state party to provide in its next report detailed information on trafficking in women and measures taken, including legislation, to prevent trafficking, protect victims and punish traffickers, as well as on the impact of such measures.

...

28. The Committee urges the state party to raise awareness of the importance of education as a human right and as a basis for the empowerment of women. It also encourages the state party to take steps to overcome traditional attitudes that constitute obstacles to girls' education. It recommends that the state party take steps to ensure equal access of girls and young women to all levels of education, to retain girls in school and to strengthen the implementation of re-entry policies so that girls return to school after pregnancy. The Committee recommends that the state party make every effort to improve the literacy level of girls and women, particularly rural and elderly women, through the adoption of comprehensive programmes, in collaboration with civil society, at the formal and non-formal levels and through adult education and training.

...

30. The Committee urges the state party to ensure equal opportunities for women and men in the labour market, in accordance with article 11 of the Convention, and the full implementation of the provisions of the Employment Act and the Labour Relations Act by the public and private sectors. The Committee further recommends that the state party pay particular attention to the conditions of women workers in the informal sector with a view to ensuring their access to social services. The Committee urges the state party to intensify its efforts to ensure that all employment-generation programmes are gender-sensitive and that women can fully benefit from these programmes. It invites the state party to improve women's access to credit, with special emphasis on rural women. It calls on the state party to provide in its next report detailed information illustrated by data about the situation of women in the field of employment and work, including in the informal sector, and measures taken and their impact on realising equal opportunities for women.

31. The Committee expresses concern about the lack of access of women and girls to adequate health care services, including prenatal and post-natal care and family planning information, particularly in rural areas. The Committee is also concerned about the alarming rate of teenage pregnancy and multiple pregnancies, which presents a significant obstacle to girls' educational opportunities and economic empowerment. The Committee is alarmed at the persistent high maternal mortality rate, particularly the number of deaths resulting from unsafe abortions, high fertility rates and inadequate family planning services, especially in rural areas, low rates of contraceptive use and lack of sex education. The Committee is also alarmed at the rising trends in HIV/AIDS infection rates of women and the direct linkage between harmful traditional practices and the spread of HIV/AIDS.

32. The Committee urges the state party to continue its efforts to improve the country's health infrastructure and to ensure sufficient budgetary allocations for accessible health services. It calls on the state party to integrate a gender perspective in all health sector reforms, while also ensuring that women's sexual and reproductive health needs are adequately addressed. In particular, the Committee recommends that the state party undertake appropriate measures to improve women's access to health care and health-related services and information, including access for women who live in rural areas. It calls upon the state party to improve the availability of sexual and reproductive health services, including family planning information and services, as well as access to antenatal, post-natal and obstetric services to reduce maternal mortality and to achieve the Millennium Development Goal to reduce maternal mortality. It encourages the state party to seek technical support from the United Nations Population Fund in these areas. It also recommends that programmes and policies be adopted to increase knowledge of and access to affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children. It further recommends that sex education be widely promoted and targeted at girls and boys, with special attention paid to the prevention of early pregnancy and the control of sexually transmitted diseases and HIV/AIDS. It also calls on the state party to ensure the effective implementation of its HIV/AIDS law and policies, to seek technical support from the World Health Organisation and the Joint United Nations Programme on HIV/AIDS. It encourages the state party to enhance work with community leaders and health workers so as to decrease and eliminate the negative impact of traditional practices on women's health.

34. The Committee urges the state party to make the promotion of gender equality an explicit component of its national development plans and policies, in particular those aimed at poverty alleviation and sustainable development. It urges the state party to pay special attention to the needs of rural women, ensuring that they participate in decision-making processes and have full access to justice, education, health services and credit facilities. The Committee also urges the state party to take appropriate measures to eliminate all forms of discrimination against women with respect to ownership and inheritance of land. The Committee invites the state party to place emphasis on women's human rights in all development cooperation

programmes with international organisations and bilateral donors, so as to address the socio-economic causes of discrimination against women, including those impacting women in rural areas, through all available sources of support.

...

43. The Committee requests the wide dissemination in Malawi of the present concluding comments in order to make the people, including government officials, politicians, parliamentarians and women's and human rights organisations, aware of the steps that have been taken to ensure de jure and de facto equality of women, as well as the further steps that are required in that regard. The Committee requests the state party to continue to disseminate widely, in particular to women's and human rights organisations, the Convention, its Optional Protocol, the Committee's general recommendations, the Beijing Declaration and Platform for Action and the outcome of the twenty-third special session of the General Assembly, entitled 'Women 2000: gender equality, development and peace for the twenty-first century'.

...

Concluding Comments – Namibia (2007)

The Committee on the Elimination of Discrimination against Women considered the combined second and third periodic report of Namibia (CEDAW/C/NAM/2-3) at its 759th and 760th meetings, on 17 January 2007 (see CEDAW/C/SR.759 and 760). Full text available at www.ohchr.org.

Excerpts

...

Positive aspects

...

7. The Committee commends the state party on the range of recent legal reforms and policies aimed at eliminating discrimination against women and promoting gender equality. In particular, it welcomes the Married Persons Equality Act (Act No 1 of 1996), which abolishes the marital power of the husband that was previously applied in civil marriages, the Affirmative Action (Employment) Act (Act No 29 of 1998), which encourages the participation of women in the formal workforce, the Combating of Rape Act (Act No 8 of 2000), which provides protection to victims of rape and sexual abuse and prescribes stiffer sentences for perpetrators, the Communal Land Reform Act (Act No 5 of 2002), which provides for equal opportunities for men and women to apply for and be granted land rights in communal areas, the Maintenance Act (Act No 9 of 2003), which confers equal rights and obligations on spouses with respect to the support of their children, and the Domestic Violence Act (Act No 4 of 2004), which provides for protection measures in domestic violence cases. It also welcomes the 1997 National Gender Policy, which outlines the framework and sets out principles for the implementation and coordination of activities on gender equality.

8. The Committee notes with appreciation that, in 2000, the Department of Women Affairs was upgraded to a full-fledged Ministry of Gender Equality and Child Welfare.

Principal areas of concern and recommendations

...

11. The Committee calls upon the state party to enhance its collection of data in all areas covered by the Convention, disaggregated by sex as well as by ethnicity, age and by urban and rural areas, as applicable, in order to assess the actual situation of women and their enjoyment of human rights and to track trends over time. It also calls upon the state party to monitor, through measurable indicators, the impact of laws, policies and programmes and to evaluate progress achieved

towards realisation of women's de facto equality. It encourages the state party to use those data and indicators in the formulation of laws, policies and programmes for the effective implementation of the Convention. The Committee requests the state party to include in its next report such statistical data and analysis. The Committee further calls upon the state party to take steps to implement the results of the SWOT analysis in order to ensure the effective and systematic use of the gender mainstreaming strategy in the state party's programmes and policies.

...

13. The Committee calls upon the state party to take measures to disseminate information about the Convention, the procedures under the Optional Protocol and the Committee's general recommendations and to implement programmes for prosecutors, judges, ombudspersons and lawyers that cover all relevant aspects of the Convention and the Optional Protocol. It also recommends that sustained awareness-raising and legal literacy campaigns targeting women, including rural women as well as non-governmental organisations working on women's issues, be undertaken to encourage and empower women to avail themselves of available procedures and remedies for violations of their rights under the Convention.

...

17. The Committee calls upon the state party to take measures to bring about change in the widely accepted stereotypical roles of men and women. Such efforts should include comprehensive awareness-raising and educational campaigns that address women and men and girls and boys, with a view to eliminating the stereotypes associated with traditional gender roles in the family and in society, in accordance with articles 2(f) and 5(a) of the Convention. The Committee urges the state party to monitor carefully the impact of these measures and to report on the results achieved in its next periodic report. The Committee also calls on the state party to study the impact of the implementation of the Traditional Authorities Act (Act No 25 of 2000) and the Community Courts Act (October 2003) so as to ensure that customs and cultural and traditional practices that are harmful to and discriminate against women are discontinued.

...

19. The Committee calls upon the state party to take steps to fully implement and enforce laws on violence against women and to ensure that women victims of violence are able to benefit from the existing legislative framework. It also calls upon the state party to ensure that all violence against women is effectively prosecuted and adequately punished. It requests that the state party put in place an effective data collection system on all forms of violence against women and to provide statistical data and information in its next report on the number of cases of violence reported to the police and other relevant authorities, as well as on the number of convictions. It further calls upon the state party to establish a monitoring and evaluation mechanism in order to regularly assess the impact and effectiveness of relevant laws, their enforcement, as well as of programmes aimed at preventing and redressing violence against women.

...

24. The Committee expresses its concern about the lack of access of women to adequate health care services, including to sexual and reproductive health services. It remains concerned at the widespread use of unsafe illegal abortions, with consequent risks on women's life and health. The Committee is also concerned about the steady increase in the number of HIV/AIDS infected women, who account for 53 per cent of all reported new HIV cases. The Committee further expresses its concern over the increasing rate of maternal mortality and the fact that reliable data on this subject is not available.

25. The Committee urges the state party to take concrete measures to enhance women's access to health care, in particular to sexual and reproductive health services, in accordance with article 12 of the Convention and the Committee's general recommendation 24 on women and health. It also recommends the adoption of measures to increase knowledge of and access to affordable contraceptive methods, so that women and men can

make informed choices about the number and spacing of children, as well as access to safe abortion in accordance with domestic legislation. It further recommends that sex education be widely promoted and targeted at adolescent girls and boys, with special attention paid to the prevention of early pregnancy and the control of sexually transmitted diseases and HIV/AIDS. The Committee also calls upon the state party to ensure that its National Strategic Plan (MTP III) 2004-2009 is effectively implemented and its results monitored and that the socio-economic factors that contribute to HIV infection among women are properly addressed. The Committee urges the state party to improve women's access to maternal health services, including antenatal, post-natal, obstetric and delivery services. It encourages the state party to take steps to ensure accurate recording of maternal deaths and to obtain assistance for this from the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Health Organisation (WHO).

...

29. The Committee calls upon the state party to review the Married Persons Equality Act (Act No 1 of 1996), with a view to eliminating discrimination against women in customary marriages related to property rights in order to bring such rights in customary marriages into line with those in civil marriages. The Committee also calls upon the state party to take all necessary steps, including the process of consulting traditional leaders, women and civil society organisations, in order to draft a bill on the registration of customary marriages. The Committee recommends that the state party take steps to ensure that the legal age of marriage is respected.

...

31. The Committee urges the state party, in its implementation of its obligations under the Convention, to utilise fully the Beijing Declaration and Platform for Action, which reinforce the provisions of the Convention, and requests the state party to include information thereon in its next periodic report.

32. The Committee also emphasises that full and effective implementation of the Convention is indispensable for achieving the Millennium Development Goals. It calls for the integration of a gender perspective and explicit reflection of the provisions of the Convention in all efforts aimed at the achievement of the Millennium Development Goals and requests the state party to include information thereon in its next periodic report.

...

35. The Committee requests the state party to respond to the concerns expressed in the present concluding comments in its next periodic report under article 18 of the Convention. The Committee invites the state party to submit its fourth periodic report, which was due in December 2005, and its fifth periodic report, due in December 2009, in a combined report in 2009.

...

A1.6 ILO Occupational Safety and Health Convention, No 155 (1981/1983)

Adopted on 22 June 1981 and entered into force on 11 August 1983. Full text available at www.ilo.org.

Excerpts

...

Article 3

For the purpose of this Convention

...

(e) the term health, in relation to work, indicates not merely the absence of disease or infirmity; it also includes the physical and

mental elements affecting health which are directly related to safety and hygiene at work.

Article 4

1. Each Member shall, in the light of national conditions and practice, and in consultation with the most representative organisations of employers and workers, formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment.

2. The aim of the policy shall be to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising, so far as is reasonably practicable, the causes of hazards inherent in the working environment.

Article 5

The policy referred to in article 4 of this Convention shall take account of the following main spheres of action in so far as they affect occupational safety and health and the working environment

(a) design, testing, choice, substitution, installation, arrangement, use and maintenance of the material elements of work (workplaces, working environment, tools, machinery and equipment, chemical, physical and biological substances and agents, work processes);

(b) relationships between the material elements of work and the persons who carry out or supervise the work, and adaptation of machinery, equipment, working time, organisation of work and work processes to the physical and mental capacities of the workers;

(c) training, including necessary further training, qualifications and motivations of persons involved, in one capacity or another, in the achievement of adequate levels of safety and health;

(d) communication and co-operation at the levels of the working group and the undertaking and at all other appropriate levels up to and including the national level;

(e) the protection of workers and their representatives from disciplinary measures as a result of actions properly taken by them in conformity with the policy referred to in article 4 of this Convention.

...

Article 7

The situation regarding occupational safety and health and the working environment shall be reviewed at appropriate intervals, either over-all or in respect of particular areas, with a view to identifying major problems, evolving effective methods for dealing with them and priorities of action, and evaluating results.

...

Article 11

To give effect to the policy referred to in article 4 of this Convention, the competent authority or authorities shall ensure that the following functions are progressively carried out

...

(c) the establishment and application of procedures for the notification of occupational accidents and diseases, by employers and, when appropriate, insurance institutions and others directly concerned, and the production of annual statistics on occupational accidents and diseases;

(d) the holding of inquiries, where cases of occupational accidents, occupational diseases or any other injuries to health which arise in the course of or in connection with work appear to reflect situations which are serious;

...

Article 13

A worker who has removed himself from a work situation which he has reasonable justification to believe presents an imminent and serious danger to his life or health shall be protected from undue consequences in accordance with national conditions and practice.

Article 14

Measures shall be taken with a view to promoting in a manner appropriate to national conditions and practice, the inclusion of questions of occupational safety and health and the working environment at all levels of education and training, including higher technical, medical and professional education, in a manner meeting the training needs of all workers.

...

Article 19

There shall be arrangements at the level of the undertaking under which

- (a) workers, in the course of performing their work, co-operate in the fulfilment by their employer of the obligations placed upon him;
- (b) representatives of workers in the undertaking co-operate with the employer in the field of occupational safety and health;
- (c) representatives of workers in an undertaking are given adequate information on measures taken by the employer to secure occupational safety and health and may consult their representative organisations about such information provided they do not disclose commercial secrets;
- (d) workers and their representatives in the undertaking are given appropriate training in occupational safety and health;
- (e) workers or their representatives and, as the case may be, their representative organisations in an undertaking, in accordance with national law and practice, are enabled to enquire into, and are consulted by the employer on, all aspects of occupational safety and health associated with their work; for this purpose technical advisers may, by mutual agreement, be brought in from outside the undertaking;
- (f) a worker reports forthwith to his immediate supervisor any situation which he has reasonable justification to believe presents an imminent and serious danger to his life or health; until the employer has taken remedial action, if necessary, the employer cannot require workers to return to a work situation where there is continuing imminent and serious danger to life or health.

...

A1.7 Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984/1987)

Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984 and entered into force 26 June 1987, in accordance with article 27(1). Full text available at www.ohchr.org.

Excerpts

...

PART I**Article 1**

1. For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.

Article 2

1. Each state party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.

...

Article 3

1. No state party shall expel, return ('refouler') or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

Article 4

1. Each state party shall ensure that all acts of torture are offences under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture.

...

Article 10

1. Each state party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

...

Article 13

Each state party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill-treatment or intimidation as a consequence of his complaint or any evidence given.

Article 14

1. Each state party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

...

A1.8 Convention on the Rights of the Child (1989/1990)

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 and entered into force 2 September 1990, in accordance with article 49. Full text available at www.ohchr.org.

Excerpts

...

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

...

Article 4

States parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present Convention. With regard to economic, social and cultural rights, states parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

...

Article 6

1. States parties recognise that every child has the inherent right to life.

2. States parties shall ensure to the maximum extent possible the survival and development of the child.

...

Article 12

1. States parties shall assure to the child who is capable of forming his own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary

(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

...

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

...

Article 17

States parties recognise the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his social, spiritual and moral well-being and physical and mental health.

...

Article 19

1. States parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

...

Article 20

1. A child temporarily or permanently deprived of his family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States parties that recognise and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration ...

...

Article 23

1. States parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States parties recognise the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognising the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his cultural and spiritual development

...

Article 24

1. States parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his right of access to such health care services.

2. States parties shall pursue full implementation of this right and, in particular, shall take appropriate measures

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;

...

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his placement.

Article 26

1. States parties shall recognise for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

...

Article 28

1. States parties recognise the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular

- (a) Make primary education compulsory and available free to all;
- (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
- (c) Make higher education accessible to all on the basis of capacity by every appropriate means;
- (d) Make educational and vocational information and guidance available and accessible to all children;
- (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States parties agree that the education of the child shall be directed to

- (a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;
- (b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
- (c) The development of respect for the child's parents, his own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he may originate, and for civilisations different from his own;
- (d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;
- (e) The development of respect for the natural environment.

2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

...

Article 32

1. States parties recognise the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

...

Article 33

States parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, states parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent

- (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
- (b) The exploitative use of children in prostitution or other unlawful sexual practices;
- (c) The exploitative use of children in pornographic performances and materials.

...

Article 35

States parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

...

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realisation of the rights of the child and which may be contained in

- (a) The law of a state party; or
- (b) International law in force for that State.

PART II**Article 42**

States parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by states parties in achieving the realisation of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child ...

...

Article 44

1. States parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognised herein and on the progress made on the enjoyment of those rights

- (a) Within two years of the entry into force of the Convention for the state party concerned;
- (b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

...

General Comment 3 (2003) HIV/AIDS and the rights of the child

Issued by the Committee on the Rights of the Child at its 32th session held from 13 to 31 January 2003. Full text available at www.ohchr.org.

Excerpts

...

I. INTRODUCTION

1. The HIV/AIDS epidemic has drastically changed the world in which children live. Millions of children have been infected and have died and many more are gravely affected as HIV spreads through their families and communities. The epidemic impacts on the daily life of younger children, and increases the victimisation and marginalisation of children, especially those living in particularly difficult circumstances. HIV/AIDS is not a problem of some countries but of the entire world. To truly bring its impact on children under control will require concerted and well-targeted efforts from all countries at all stages of development.

2. Initially children were considered to be only marginally affected by the epidemic. However, the international community has discovered that, unfortunately, children are at the heart of the problem. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the most recent trends are alarming: in most parts of the world the majority of new infections are among young people between the ages of 15 and 24, sometimes younger. Women, including young girls, are also increasingly

becoming infected. In most regions of the world, the vast majority of infected women do not know that they are infected and may unknowingly infect their children. Consequently, many States have recently registered an increase in their infant and child mortality rates. Adolescents are also vulnerable to HIV/AIDS because their first sexual experience may take place in an environment in which they have no access to proper information and guidance. Children who use drugs are at high risk.

3. Yet, all children can be rendered vulnerable by the particular circumstances of their lives, especially (a) children who are themselves HIV-infected; (b) children who are affected by the epidemic because of the loss of a parental caregiver or teacher and/or because their families or communities are severely strained by its consequences; and (c) children who are most prone to be infected or affected.

II. THE OBJECTIVES OF THE PRESENT GENERAL COMMENT

4. The objectives of the present General Comment are

- (a) To identify further and strengthen understanding of all the human rights of children in the context of HIV/AIDS;
- (b) To promote the realisation of the human rights of children in the context of HIV/AIDS, as guaranteed under the Convention on the Rights of the Child (hereafter 'the Convention');
- (c) To identify measures and good practices to increase the level of implementation by States of the rights related to the prevention of HIV/AIDS and the support, care and protection of children infected with or affected by this pandemic;
- (d) To contribute to the formulation and promotion of child-oriented plans of action, strategies, laws, policies and programmes to combat the spread and mitigate the impact of HIV/AIDS at the national and international levels.

III. THE CONVENTION'S PERSPECTIVES ON HIV/AIDS: THE HOLISTIC CHILD RIGHTS-BASED APPROACH

5. The issue of children and HIV/AIDS is perceived as mainly a medical or health problem, although in reality it involves a much wider range of issues. In this regard, the right to health (article 24 of the Convention) is, however, central. But HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights - civil, political, economic, social and cultural. The rights embodied in the general principles of the Convention - the right to non-discrimination (art 2), the right of the child to have his interest as a primary consideration (art 3), the right to life, survival and development (art 6) and the right to have his views respected (art 12) - should therefore be the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support.

6. Adequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected. The most relevant rights in this regard, in addition to those enumerated in paragraph 5 above, are the following: the right to access information and material aimed at the promotion of their social, spiritual and moral well-being and physical and mental health (art 17); the right to preventive health care, sex education and family planning education and services (art 24(f)); the right to an appropriate standard of living (art 27); the right to privacy (art 16); the right not to be separated from parents (art 9); the right to be protected from violence (art 19); the right to special protection and assistance by the State (art 20); the rights of children with disabilities (art 23); the right to health (art 24); the right to social security, including social insurance (art 26); the right to education and leisure (arts 28 and 31); the right to be protected from economic and sexual exploitation and abuse, and from illicit use of narcotic drugs (arts 32, 33, 34 and 36); the right to be protected from abduction, sale and trafficking as well as torture or other cruel, inhuman or degrading treatment or punishment (arts 35 and 37); and the right to physical and psychological recovery and social reintegration (art 39). Children are confronted with serious challenges to the above-mentioned rights as a result of the epidemic. The Convention, and in particular the four general principles with their comprehensive approach, provide a powerful framework for efforts to reduce the negative impact of the pandemic on the lives of children. The holistic rights-based approach required to implement the Convention is the optimal tool for addressing the

broader range of issues that relate to prevention, treatment and care efforts.

A. The right to non-discrimination (art 2)

7. Discrimination is responsible for heightening the vulnerability of children to HIV and AIDS, as well as seriously impacting the lives of children who are affected by HIV/AIDS, or are themselves HIV infected. Girls and boys of parents living with HIV are often victims of stigma and discrimination as they too are often assumed to be infected. As a result of discrimination, children are denied access to information, education (see the Committee's General Comment 1 on the aims of education), health or social care services or community life. At its extreme, discrimination against HIV-infected children has resulted in their abandonment by their family, community and/or society. Discrimination also fuels the epidemic by making children in particular those belonging to certain groups like children living in remote or rural areas where services are less accessible, more vulnerable to infection. These children are thus doubly victimised.

8. Of particular concern is gender-based discrimination combined with taboos or negative or judgemental attitudes to sexual activity of girls, often limiting their access to preventive measures and other services. Of concern also is discrimination based on sexual orientation. In the design of HIV/AIDS-related strategies, and in keeping with their obligations under the Convention, states parties must give careful consideration to prescribed gender norms within their societies with a view to eliminating gender-based discrimination as these norms impact on the vulnerability of both girls and boys to HIV/AIDS. States parties should, in particular, recognise that discrimination in the context of HIV/AIDS often impacts girls more severely than boys.

9. All the above-mentioned discriminatory practices are violations of children's rights under the Convention. article 2 of the Convention obliges states parties to ensure all the rights set forth in the Convention without discrimination of any kind, 'irrespective of the child's or his parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status'. The Committee interprets 'other status' under article 2 of the Convention to include HIV/AIDS status of the child or his parent(s). Laws, policies, strategies and practices should address all forms of discrimination that contribute to increasing the impact of the epidemic. Strategies should also promote education and training programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS.

B. Best interests of the child (art 3)

10. Policies and programmes for the prevention, care and treatment of HIV/AIDS have generally been designed for adults with scarce attention to the principle of the best interests of the child as a primary consideration. Article 3(1), of the Convention states 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'. The obligations attached to this right are fundamental to guiding the action of States in relation to HIV/AIDS. The child should be placed at the centre of the response to the pandemic, and strategies should be adapted to children's rights and needs.

C. The right to life, survival and development (art 6)

11. Children have the right not to have their lives arbitrarily taken, as well as to benefit from economic and social policies that will allow them to survive into adulthood and develop in the broadest sense of the word. State obligation to realise the right to life, survival and development also highlights the need to give careful attention to sexuality as well as to the behaviours and lifestyles of children, even if they do not conform with what society determines to be acceptable under prevailing cultural norms for a particular age group. In this regard, the female child is often subject to harmful traditional practices, such as early and/or forced marriage, which violate her rights and make her more vulnerable to HIV infection, including because such practices

often interrupt access to education and information. Effective prevention programmes are only those that acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to preventive measures.

D. The right to express views and have them taken into account (art 12)

12. Children are rights holders and have a right to participate, in accordance with their evolving capacities, in raising awareness by speaking out about the impact of HIV/AIDS on their lives and in the development of HIV/AIDS policies and programmes. Interventions have been found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made. In this regard, the participation of children as peer educators, both within and outside schools, should be actively promoted. States, international agencies and non-governmental organisations must provide children with a supportive and enabling environment to carry out their own initiatives, and to fully participate at both community and national levels in HIV policy and programme conceptualisation, design, implementation, coordination, monitoring and review. A variety of approaches are likely to be necessary to ensure the participation of children from all sectors of society, including mechanisms which encourage children, consistent with their evolving capacities, to express their views, have them heard, and given due weight in accordance with their age and maturity (art 12(1)). Where appropriate, the involvement of children living with HIV in raising awareness, by sharing their experiences with their peers and others, is critical both to effective prevention and to reducing stigmatisation and discrimination. States parties must ensure that children who participate in these awareness-raising efforts do so voluntarily, after being counselled, and that they receive both the social support and legal protection to allow them to lead normal lives during and after their involvement.

E. Obstacles

13. Experience has shown that many obstacles hinder effective prevention, delivery of care services and support for community initiatives on HIV/AIDS. These are mainly cultural, structural and financial. Denying that a problem exists, cultural practices and attitudes, including taboos and stigmatisation, poverty and patronising attitudes towards children are just some of the obstacles that may block the political and individual commitment needed for effective programmes.

14. With regard to financial, technical and human resources, the Committee is aware that such resources may not be immediately available. However, concerning this obstacle, the Committee wishes to remind states parties of their obligations under article 4. It further notes that resource constraints should not be used by states parties to justify their failure to take any or enough of the technical or financial measures required. Finally, the Committee wishes to emphasise in this regard the essential role of international cooperation.

IV. PREVENTION, CARE, TREATMENT AND SUPPORT

15. The Committee wishes to stress that prevention, care, treatment and support are mutually reinforcing elements and provide a continuum within an effective response to HIV/AIDS.

A. Information on HIV prevention and awareness-raising

16. Consistent with the obligations of states parties in relation to the rights to health and information (arts 24, 13 and 17), children should have the right to access adequate information related to HIV/AIDS prevention and care, through formal channels (eg through educational opportunities and child-targeted media) as well as informal channels (eg those targeting street children, institutionalised children or children living in difficult circumstances). States parties are reminded that children require relevant, appropriate and timely information which recognises the differences in levels of understanding among them, is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality in order to protect themselves from HIV infection. The Committee wishes to

emphasise that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (art 6), states parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.

17. Dialogue with community, family and peer counsellors, and the provision of 'life skills' education within schools, including skills in communicating on sexuality and healthy living, have been found to be useful approaches to delivering HIV prevention messages to both girls and boys, but different approaches may be necessary to reach different groups of children. States parties must make efforts to address gender differences as they may impact on the access children have to prevention messages, and ensure that children are reached with appropriate prevention messages even if they face constraints due to language, religion, disability or other factors of discrimination. Particular attention must be paid to raising awareness among hard-to-reach populations. In this respect, the role of the mass media and/or oral tradition in ensuring that children have access to information and material, as recognised in article 17 of the Convention, is crucial both to providing appropriate information and to reducing stigmatisation and discrimination. States parties should support the regular monitoring and evaluation of HIV/AIDS awareness campaigns to ascertain their effectiveness in providing information, reducing ignorance, stigmatisation and discrimination, as well as addressing fear and misperceptions concerning HIV and its transmission among children, including adolescents.

B. The role of education

18. Education plays a critical role in providing children with relevant and appropriate information on HIV/AIDS, which can contribute to increased awareness and better understanding of this pandemic and prevent negative attitudes towards victims of HIV/AIDS (see also the Committee's General Comment 1 on the aims of education). Furthermore, education can and should empower children to protect themselves from the risk of HIV infection. In this regard, the Committee wishes to remind states parties of their obligation to ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS. In many communities where HIV has spread widely, children from affected families, in particular girls are facing serious difficulties staying in school and the number of teachers and other school employees lost to AIDS is limiting and threatening to destroy the ability of children to access education. States parties must make adequate provision to ensure that children affected by HIV/AIDS can stay in school and ensure the qualified replacement of sick teachers so that children's regular attendance at schools is not affected, and that the right to education (art 28) of all children living within these communities is fully protected.

19. States parties must make every effort to ensure that schools are safe places for children, which offer them security and do not contribute to their vulnerability to HIV infection. In accordance with article 34 of the Convention, states parties are under obligation to take all appropriate measures to prevent, inter alia, the inducement or coercion of a child to engage in any unlawful sexual activity.

C. Child and adolescent sensitive health services

20. The Committee is concerned that health services are generally still insufficiently responsive to the needs of children under 18 years of age, in particular adolescents. As the Committee has noted on numerous occasions, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgmental, do not require parental consent and are not discriminatory. In the context of HIV/AIDS and taking into account the evolving capacities of the child, states parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (art

16) and non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, and free or low-cost contraceptive methods and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV/AIDS, eg tuberculosis and opportunistic infections.

21. In some countries, even when child- and adolescent-friendly HIV-related services are available, they are not sufficiently accessible to children with disabilities, indigenous children, children belonging to minorities, children living in rural areas, children living in extreme poverty or children who are otherwise marginalised within the society. In others, where the health system's overall capacity is already strained, children with HIV have been routinely denied access to basic health care. States parties must ensure that services are provided to the maximum extent possible to all children living within their borders, without discrimination, and that they sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live.

D. HIV counselling and testing

22. The accessibility of voluntary, confidential HIV counselling and testing services, with due attention to the evolving capacities of the child, is fundamental to the rights and health of children. Such services are critical to children's ability to reduce the risk of contracting or transmitting HIV, to access HIV-specific care, treatment and support, and to better plan for their futures. Consistent with their obligation under article 24 of the Convention to ensure that no child is deprived of his right of access to necessary health services, states parties should ensure access to voluntary, confidential HIV counselling and testing for all children.

23. The Committee wishes to stress that, as the duty of states parties is first and foremost to ensure that the rights of the child are protected, states parties must refrain from imposing mandatory HIV testing of children in all circumstances and ensure protection against it. While the evolving capacities of the child will determine whether consent is required from him or her directly or from his parent or guardian, in all cases, consistent with the child's right to receive information under articles 13 and 17 of the Convention, states parties must ensure that, prior to any HIV testing, whether by health care providers in relation to children who are accessing health services for another medical condition or otherwise, the risks and benefits of such testing are sufficiently conveyed so that an informed decision can be made.

24. States parties must protect the confidentiality of HIV test results, consistent with the obligation to protect the right to privacy of children (art 16), including within health and social welfare settings, and information on the HIV status of children may not be disclosed to third parties, including parents, without the child's consent.

E. Mother-to-child transmission

25. Mother-to-child transmission (MTCT) is responsible for the majority of HIV infections in infants and young children. Infants and young children can be infected with HIV during pregnancy, labour and delivery, and through breastfeeding. States parties are requested to ensure implementation of the strategies recommended by the United Nations agencies to prevent HIV infection in infants and young children. These include: (a) the primary prevention of HIV infection among parents-to-be; (b) the prevention of unintended pregnancies in HIV-infected women, (c) the prevention of HIV transmission from HIV-infected women to their infants; and (d) the provision of care, treatment and support to HIV-infected women, their infants and families.

26. To prevent MTCT of HIV, states parties must take steps, including the provision of essential drugs, eg anti-retroviral drugs, appropriate antenatal, delivery and post-partum care, and making HIV voluntary counselling and testing services available to pregnant women and their partners. The Committee recognises that anti-retroviral drugs administered to a woman during pregnancy and/or labour and, in some regimens, to her

infant, have been shown to significantly reduce the risk of transmission from mother to child. However, in addition, states parties should provide support for mothers and children, including counselling on infant feeding options. States parties are reminded that counselling of HIV-positive mothers should include information about the risks and benefits of different infant feeding options, and guidance on selecting the option most likely to be suitable for their situation. Follow-up support is also required in order for women to be able to implement their selected option as safely as possible.

27. Even in populations with high HIV prevalence, the majority of infants are born to women who are not HIV-infected. For the infants of HIV-negative women and women who do not know their HIV status, the Committee wishes to emphasise, consistent with articles 6 and 24 of the Convention, that breastfeeding remains the best feeding choice. For the infants of HIV-positive mothers, available evidence indicates that breastfeeding can add to the risk of HIV transmission by 10-20 per cent, but that lack of breastfeeding can expose children to an increased risk of malnutrition or infectious diseases other than HIV. United Nations agencies have recommended that, where replacement feeding is affordable, feasible, acceptable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended; otherwise, exclusive breastfeeding is recommended during the first months of life and should then be discontinued as soon as it is feasible.

F. Treatment and care

28. The obligations of states parties under the Convention extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a basis of non-discrimination. It is now widely recognised that comprehensive treatment and care includes anti-retroviral and other drugs, diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections and other conditions, good nutrition, and social, spiritual and psychological support, as well as family, community and home-based care. In this regard, states parties should negotiate with the pharmaceutical industry in order to make the necessary medicines locally available at the lowest costs possible. Furthermore, states parties are requested to affirm, support and facilitate the involvement of communities in the provision of comprehensive HIV/AIDS treatment, care and support, while at the same time complying with their own obligations under the Convention. States parties are called upon to pay special attention to addressing those factors within their societies that hinder equal access to treatment, care and support for all children.

G. Involvement of children in research

29. Consistent with article 24 of the Convention, states parties must ensure that HIV/AIDS research programmes include specific studies that contribute to effective prevention, care, treatment and impact reduction for children. States parties must, nonetheless, ensure that children do not serve as research subjects until an intervention has already been thoroughly tested on adults. Rights and ethical concerns have arisen in relation to HIV/AIDS biomedical research, HIV/AIDS operations, and social, cultural and behavioural research. Children have been subjected to unnecessary or inappropriately designed research with little or no voice to either refuse or consent to participation. In line with the child's evolving capacities, consent of the child should be sought and consent may be sought from parents or guardians if necessary, but in all cases consent must be based on full disclosure of the risks and benefits of research to the child. States parties are further reminded to ensure that the privacy rights of children, in line with their obligations under article 16 of the Convention, are not inadvertently violated through the research process and that personal information about children, which is accessed through research, is, under no circumstances, used for purposes other than that for which consent was given. States parties must make every effort to ensure that children and, according to their evolving capacities, their parents and/or their guardians participate in decisions on research priorities and that a supportive environment is created for children who participate in such research.

V. VULNERABILITY AND CHILDREN NEEDING SPECIAL PROTECTION

30. The vulnerability of children to HIV/AIDS resulting from political, economic, social, cultural and other factors determines the likelihood of their being left with insufficient support to cope with the impact of HIV/AIDS on their families and communities, exposed to the risk of infection, subjected to inappropriate research, or deprived of access to treatment, care and support if and when HIV infection sets in. Vulnerability to HIV/AIDS is most acute for children living in refugee and internally displaced persons camps, children in detention, children living in institutions, as well as children living in extreme poverty, children living in situations of armed conflict, child soldiers, economically and sexually exploited children, and disabled, migrant, minority, indigenous, and street children. However, all children can be rendered vulnerable by the particular circumstances of their lives. Even in times of severe resource constraints, the Committee wishes to note that the rights of vulnerable members of society must be protected and that many measures can be pursued with minimum resource implications. Reducing vulnerability to HIV/AIDS requires first and foremost that children, their families and communities be empowered to make informed choices about decisions, practices or policies affecting them in relation to HIV/AIDS.

A. Children affected and orphaned by HIV/AIDS

31. Special attention must be given to children orphaned by AIDS and to children from affected families, including child-headed households, as these impact on vulnerability to HIV infection. For children from families affected by HIV/AIDS, the stigmatisation and social isolation they experience may be accentuated by the neglect or violation of their rights, in particular discrimination resulting in a decrease or loss of access to education, health and social services. The Committee wishes to underline the necessity of providing legal, economic and social protection to affected children to ensure their access to education, inheritance, shelter and health and social services, as well as to make them feel secure in disclosing their HIV status and that of their family members when the children deem it appropriate. In this respect, states parties are reminded that these measures are critical to the realisation of the rights of children and to giving them the skills and support necessary to reduce their vulnerability and risk of becoming infected.

32. The Committee wishes to emphasise the critical implications of proof of identity for children affected by HIV/AIDS, as it relates to securing recognition as a person before the law, safeguarding the protection of rights, in particular to inheritance, education, health and other social services, as well as to making children less vulnerable to abuse and exploitation, particularly if separated from their families due to illness or death. In this respect, birth registration is critical to ensuring the rights of the child and is also necessary to minimise the impact of HIV/AIDS on the lives of affected children. States parties are, therefore, reminded of their obligation under article 7 of the Convention to ensure that systems are in place for the registration of every child at or immediately after birth.

33. The trauma HIV/AIDS brings to the lives of orphans often begins with the illness and death of one of their parents, and is frequently compounded by the effects of stigmatisation and discrimination. In this respect, states parties are particularly reminded to ensure that both law and practice support the inheritance and property rights of orphans, with particular attention to the underlying gender-based discrimination which may interfere with the fulfilment of these rights. Consistent with their obligations under article 27 of the Convention, states parties must also support and strengthen the capacity of families and communities of children orphaned by AIDS to provide them with a standard of living adequate for their physical, mental, spiritual, moral, economic and social development, including access to psychosocial care, as needed.

34. Orphans are best protected and cared for when efforts are made to enable siblings to remain together, and in the care of relatives or family members. The extended family, with the support of the surrounding community, may be the least traumatic and therefore the best way to care for orphans when there are no other feasible alternatives. Assistance must be

provided so that, to the maximum extent possible, children can remain within existing family structures. This option may not be available due to the impact HIV/AIDS has on the extended family. In that case, states parties should provide, as far as possible, for family-type alternative care (eg foster care). States parties are encouraged to provide support, financial and otherwise, when necessary, to child-headed households. States parties must ensure that their strategies recognise that communities are at the front line of the response to HIV/AIDS and that these strategies are designed to assist communities in determining how best to provide support to the orphans living there.

35. Although institutionalised care may have detrimental effects on child development, states parties may, nonetheless, determine that it has an interim role to play in caring for children orphaned by HIV/AIDS when family-based care within their own communities is not a possibility. It is the opinion of the Committee that any form of institutionalised care for children should only serve as a measure of last resort, and that measures must be fully in place to protect the rights of the child and guard against all forms of abuse and exploitation. In keeping with the right of children to special protection and assistance when within these environments, and consistent with articles 3, 20 and 25 of the Convention, strict measures are needed to ensure that such institutions meet specific standards of care and comply with legal protection safeguards. States parties are reminded that limits must be placed on the length of time children spend in these institutions, and programmes must be developed to support any children who stay in these institutions, whether infected or affected by HIV/AIDS, to successfully reintegrate them into their communities.

B. Victims of sexual and economic exploitation

36. Girls and boys who are deprived of the means of survival and development, particularly children orphaned by AIDS, may be subjected to sexual and economic exploitation in a variety of ways, including the exchange of sexual services or hazardous work for money to survive, support their sick or dying parents and younger siblings, or to pay for school fees. Children who are infected or directly affected by HIV/AIDS may find themselves at a double disadvantage - experiencing discrimination on the basis of both their social and economic marginalisation and their, or their parents', HIV status. Consistent with the right of children under articles 32, 34, 35 and 36 of the Convention, and in order to reduce children's vulnerability to HIV/AIDS, states parties are under obligation to protect children from all forms of economic and sexual exploitation, including ensuring they do not fall prey to prostitution networks, and that they are protected from performing any work likely to be prejudicial to, or to interfere with, their education, health, or physical, mental, spiritual, moral or social development. States parties must take bold action to protect children from sexual and economic exploitation, trafficking and sale and, consistent with the rights under article 39, create opportunities for those who have been subjected to such treatment to benefit from the support and caring services of the State and non-governmental entities engaged in these issues.

C. Victims of violence and abuse

37. Children may be exposed to various forms of violence and abuse which may increase the risk of their becoming HIV-infected, and may also be subjected to violence as a result of their being infected or affected by HIV/AIDS. Violence, including rape and other forms of sexual abuse, can occur in the family or foster setting or may be perpetrated by those with specific responsibilities towards children, including teachers and employees of institutions working with children, such as prisons and institutions concerned with mental health and other disabilities. In keeping with the rights of the child set forth in article 19 of the Convention, states parties have the obligation to protect children from all forms of violence and abuse, whether at home, in school or other institutions, or in the community.

38. Programmes must be specifically adapted to the environment in which children live, to their ability to recognise and report abuses and to their individual capacity and autonomy. The Committee considers that the relationship between HIV/AIDS and the violence or abuse suffered by children in the context of

war and armed conflict requires specific attention. Measures to prevent violence and abuse in these situations are critical, and states parties must ensure the incorporation of HIV/AIDS and child rights issues in addressing and supporting children - girls and boys - who were used by military or other uniformed personnel to provide domestic help or sexual services, or who are internally displaced or living in refugee camps. In keeping with states parties' obligations, including under articles 38 and 39 of the Convention, active information campaigns, combined with the counselling of children and mechanisms for the prevention and early detection of violence and abuse, must be put in place within conflict- and disaster-affected regions, and must form part of national and community responses to HIV/AIDS.

Substance abuse

39. The use of substances, including alcohol and drugs, may reduce the ability of children to exert control over their sexual conduct and, as a result, may increase their vulnerability to HIV infection. Injecting practices using unsterilised instruments further increase the risk of HIV transmission. The Committee notes that greater understanding of substance use behaviours among children is needed, including the impact that neglect and violation of the rights of the child has on these behaviours. In most countries, children have not benefited from pragmatic HIV prevention programmes related to substance use, which even when they do exist have largely targeted adults. The Committee wishes to emphasise that policies and programmes aimed at reducing substance use and HIV transmission must recognise the particular sensitivities and lifestyles of children, including adolescents, in the context of HIV/AIDS prevention. Consistent with the rights of children under articles 33 and 24 of the Convention, states parties are obligated to ensure the implementation of programmes which aim to reduce the factors that expose children to the use of substances, as well as those that provide treatment and support to children who are abusing substances.

VI. RECOMMENDATIONS

40. The Committee hereby reaffirms the recommendations, which emerged at the day of general discussion on children living in a world with HIV/AIDS (CRC/C/80), and calls upon states parties

- (a) To adopt and implement national and local HIV/AIDS-related policies, including effective plans of action, strategies, and programmes that are child-centred, rights-based and incorporate the rights of the child under the Convention, including by taking into account the recommendations made in the previous paragraphs of the present General Comment and those adopted at the United Nations General Assembly special session on children (2002);
- (b) To allocate financial, technical and human resources, to the maximum extent possible, to supporting national and community-based action (art 4), and, where appropriate, within the context of international cooperation (see paragraph 41 below);
- (c) To review existing laws or enact new legislation with a view to implementing fully article 2 of the Convention, and in particular to expressly prohibiting discrimination based on real or perceived HIV/AIDS status so as to guarantee equal access for all children to all relevant services, with particular attention to the child's right to privacy and confidentiality and to other recommendations made by the Committee in the previous paragraphs relevant to legislation;
- (d) To include HIV/AIDS plans of action, strategies, policies and programmes in the work of national mechanisms responsible for monitoring and coordinating children's rights and to consider the establishment of a review procedure, which responds specifically to complaints of neglect or violation of the rights of the child in relation to HIV/AIDS, whether this entails the creation of a new legislative or administrative body or is entrusted to an existing national institution;
- (e) To reassess their HIV-related data collection and evaluation to ensure that they adequately cover children as defined under the Convention, are disaggregated by age and gender ideally in five-year age groups, and include, as far as possible, children

belonging to vulnerable groups and those in need of special protection;

(f) To include, in their reporting process under article 44 of the Convention, information on national HIV/AIDS policies and programmes and, to the extent possible, budgeting and resource allocations at the national, regional and local levels, as well as within these breakdowns the proportions allocated to prevention, care, research and impact reduction. Specific attention must be given to the extent to which these programmes and policies explicitly recognise children (in the light of their evolving capacities) and their rights, and the extent to which HIV-related rights of children are dealt with in laws, policies and practices, with specific attention to discrimination against children on the basis of their HIV status, as well as because they are orphans or the children of parents living with HIV. The Committee requests states parties to provide a detailed indication in their reports of what they consider to be the most important priorities within their jurisdiction in relation to children and HIV/AIDS, and to outline the programme of activities they intend to pursue over the coming five years in order to address the problems identified. This would allow activities to be progressively assessed over time.

41. In order to promote international cooperation, the Committee calls upon UNICEF, World Health Organisation, United Nations Population Fund, UNAIDS and other relevant international bodies, organisations and agencies to contribute systematically, at the national level, to efforts to ensure the rights of children in the context of HIV/AIDS, and also to continue to work with the Committee to improve the rights of the child in the context of HIV/AIDS. Further, the Committee urges States providing development cooperation to ensure that HIV/AIDS strategies are so designed as to take fully into account the rights of the child.

42. Non-governmental organisations, as well as community-based groups and other civil society actors, such as youth groups, faith-based organisations, women's organisations and traditional leaders, including religious and cultural leaders, all have a vital role to play in the response to the HIV/AIDS pandemic. States parties are called upon to ensure an enabling environment for participation by civil society groups, which includes facilitating collaboration and coordination among the various players, and that these groups are given the support needed to enable them to operate effectively without impediment (in this regard, states parties are specifically encouraged to support the full involvement of people living with HIV, with particular attention to the inclusion of children, in the provision of HIV/AIDS prevention, care, treatment and support services).

Concluding Observations – Angola (2004)

The Committee on the Rights of the Child considered the initial report of Angola (CRC/C/3/Add.66) at its 991st to 992nd meetings (see CRC/C/SR.991 and 992), held on 27 September 2004, and adopted these concluding observations at its 999th meeting (CRC/C/SR.999), held on 1 October 2004. Full text available at www.ohchr.org.

Excerpts

...

D. Principal subjects of concern, suggestions and recommendations

...

2 General principles

Non-discrimination

22. The Committee recommends that the state party take the necessary legislative measures to explicitly prohibit all forms of discrimination, in accordance with article 2 of the Convention. In this regard, it encourages the state party to include 'disability' as a legally unacceptable ground for discrimination in the new

constitution currently under consideration. The Committee also recommends that the state party undertake the necessary actions, including awareness-raising and educational campaigns, to reduce and prevent discrimination in practice, particularly against girls.

...

4 Family environment and alternative care

Children deprived of a family environment/alternative care; adoption; and periodic review of placement

34. The Committee expresses its concern that the care of children deprived of their family in the state party is insufficient. Although children's placement in foster families is given priority, many children are placed in homes that are poorly equipped and understaffed, as there is a lack of foster care and family-based alternative care. The inadequate monitoring and follow-up of placements in institutions is also a cause of concern.

35. The Committee recommends that the state party take effective measures to develop and promote an effective and extended system of foster care and other family-based alternative care. The state party should also take measures to ensure that the situation of children living in institutions, both public and private, is regularly monitored.

Abuse and neglect

36. The Committee is concerned about the growing number of cases of abuse and violence against children, including sexual abuse in their homes, in schools and in other institutions.

37. The Committee recommends that the state party strengthen current efforts to address the problem of child abuse, including by ensuring that

(a) Child-sensitive mechanisms to receive and investigate complaints regarding ill-treatment and abuse are established;

(b) Public education campaigns about the negative consequences of ill-treatment and preventive programmes, including family development programmes, promoting positive, non-violent forms of discipline are conducted;

(c) Counselling and assistance with recovery and reintegration are provided to all victims of violence;

(d) Adequate protection to child victims of abuse in their homes is provided;

(e) The national plan of action to combat sexual abuse of minors is effectively implemented.

...

5 Basic health and welfare

...

Health and health services

43. The Committee urges the state party to strengthen its efforts to improve the health situation of children in the state party, including through

(a) A continuation and strengthening of its efforts to ensure that all children have access to basic health care services;

(b) Strengthening vaccination programmes;

(c) Improving the nutritional status of children;

...

Adolescent health

44. The Committee is concerned at the lack of adolescent health services and the large number of teenage pregnancies.

45. The Committee recommends that the state party pay close attention to adolescent health, taking into account the Committee's General Comment 4 on adolescent health and development. In particular, the state party should strengthen sexual and reproductive health education for adolescents, including family planning measures, especially in schools and out-of-school programmes, with a view to reducing the incidence of teenage pregnancy, and provide pregnant teenage girls with the necessary assistance and access to health care and education. It is also recommended that a comprehensive study be undertaken to assess the scope and nature of adolescent health

problems, including the prevalence and negative impact of STIs and HIV/AIDS.

Harmful traditional practices

46. The Committee notes with concern the customary practice of early marriage.

47. The Committee recommends that the state party ensure the effective enforcement of the minimum age for contracting marriage stipulated in the Family Code. Such measures should be accompanied by awareness-raising campaigns to prevent early marriages.

HIV/AIDS

48. The Committee expresses its concern about the high and growing incidence of HIV/AIDS in the state party and the high number of children who are infected with HIV or have become AIDS orphans.

49. The Committee refers the state party to its General Comment 3 on HIV/AIDS and the rights of the child and recommends that the state party reinforce its efforts to combat HIV/AIDS, including by

- (a) Accelerating the adoption and implementation of a national plan of action for orphans, vulnerable children and children affected by HIV/AIDS, as envisaged in the 2004 National Forum on Early Childhood Care and Development;
- (b) Continuing and strengthening measures taken under the National Programme to Combat HIV/AIDS;
- (c) Developing youth-sensitive and confidential counselling, care and rehabilitation facilities that are accessible without parental consent when this is in the best interests of the child;
- (d) Seeking technical cooperation from, among others, UNAIDS.

Social security and childcare services and facilities/standard of living

50. The Committee expresses its concern at the high and increasing number of children living in poverty and extreme poverty in the state party, especially in rural areas. It notes with particular concern the very poor living conditions of many internally displaced children and children living in so-called informal settlements.

51. The Committee recommends that the state party strengthen its efforts to provide acceptable living conditions for children and their families, in particular in view of the child's right to protection, health and education. Such efforts should include target measures to improve the living conditions of those children and families most in need.

...

Sexual exploitation and trafficking

66. The Committee is concerned about the extent of the problem of sexual exploitation of and trafficking in children in the state party and notes that internally displaced and street children are particularly vulnerable to such abuse.

67. The Committee recommends that the state party further strengthen its efforts to identify, prevent and combat trafficking in children for sexual and other exploitative purposes, including by finalising the national plan of action in this area and providing the appropriate legal framework and sufficient human and financial resources for its implementation. The Committee also encourages the state party to define 'trafficking' as a special criminal offence under the Penal Code.

...

Concluding Observations – Botswana (2004)

The Committee on the Rights of the Child considered the initial report of Botswana (CRC/C/51/Add.9), submitted on 10 January 2003 at its 977th and 978th meetings (see CRC/C/SR.977 and CRC/C/SR.978), held on 16 September 2004, and adopted these concluding observations at its 999th meeting (CRC/C/SR.999), held on 1 October 2004. Full text available at www.ohchr.org.

Excerpts

...

B. Positive aspects

...

4. The Committee takes note with appreciation the establishment of the National AIDS Council, chaired by the President, and of the recently revised National Policy on HIV/AIDS.

...

6. The Committee also welcomes the ratification of the African Charter on the Rights and Welfare of the Child.

C. Factors and difficulties impeding the implementation of the Convention

7. The Committee notes that the large-scale HIV/AIDS epidemic has had a serious negative impact on the overall development of the state party and in particular on the implementation of children's rights.

D. Principle areas of concern and recommendations

1 General measures of implementation

...

Legislation

...

11. The Committee recommends that the state party complete its general review of the Children's Act as soon as possible and use the recommendations from that review as a basis for the necessary changes of the law in order to bring it in conformity with the principles and provisions of the Convention. It further recommends that the state party expedite this process of change of the law as much as possible and ensure the implementation of the revised Children's Act. The Committee also recommends that the Convention be incorporated in domestic law and to undertake the necessary steps to bring customary law in conformity with the Convention.

...

Resources for children

...

19. The Committee recommends that the state party allocate more resources for the full implementation of article 4 of the Convention by prioritising budgetary allocations to ensure implementation of the economic, social and cultural rights of children, in particular those belonging to economically disadvantaged groups, including children and families infected and affected by HIV/AIDS 'to the maximum extent of ... available resources and, where needed, within the framework of international cooperation'.

20. In this regard, the Committee also recommends that the state party ensure that regional and other free trade agreements do not have a negative impact on the implementation of children's rights and, more specifically, that these will not affect the possibility of providing children and other victims of HIV/AIDS with effective medicines for free or at the lowest price possible.

2 Definition of the child

...

26. With reference to paragraph 11 of these concluding observations, the Committee recommends that the state party expedite the necessary legislative reform in order to establish a definition of the child in conformity with article 1 of the Convention of the Rights of the Child and also applicable with customary law.

3 General principles

Non-discrimination

27. The Committee is concerned that, as noted by the state party, the Constitution is inconsistent with the non-discrimination provision of the Convention. The Committee is also concerned that societal discrimination persists against vulnerable groups of children, including children with disabilities, street and rural children, children born out of wedlock, orphans and fostered children and children affected or infected by HIV/AIDS. The Committee is deeply concerned at the situation of girls, in particular adolescent girls who, as acknowledged by the state party, suffer marginalisation and gender stereotyping, compromising their educational opportunities and are more vulnerable to sexual violence, abuse and HIV/AIDS.

28. The Committee recommends that the state party

- (a) Amend the existing legislation and adopt new laws to ensure that all children within its territory enjoy all rights set out in the Convention without discrimination, in accordance with article 2;
- (b) Prioritise and target social services for children belonging to the most vulnerable groups;
- (c) Pay special attention to the situation of girls through education campaign, participation, support and protection of girls;
- (d) Include specific information in the next periodic report on the measures, legislative and otherwise, undertaken by the state party to combat discrimination on any grounds and against all vulnerable groups.

...

Best interests of the child

...

31. The Committee recommends that the state party take all appropriate measures to ensure that the principle of the best interests of the child is appropriately integrated into all legislation and judicial and administrative decisions as well as into projects, programmes and services which have an impact on children. The Committee encourages the state party to take all necessary measures to ensure that customary law does not impede the implementation of this general principle, notably through raising awareness among community leaders.

5 Family environment and alternative care

Parental responsibilities

...

39. The Committee recommends that the state party

- (a) Take all necessary measures to provide parents and families in particularly difficult circumstances with the necessary financial and other support as much as possible;
- (b) Take the necessary legislative and other measures to ensure that the best interests of the child are of primary consideration and that guardianship with one of the parents after divorce is not automatically granted to the father;
- (c) Take measures to improve the enforcement of child support by fathers, in particular of children born out of wedlock, *inter alia*, by providing mothers with information about the legal provisions in this regard and with the necessary legal or other assistance free of charge for mothers who cannot afford it, not only for initiating legal actions but also for enforcing court decisions.

Alternative care

...

41. The Committee urges that the state party

(a) Undertake without further delay the necessary steps for the full and effective implementation of the Alternative Care Guidelines and for the drafting and adoption of legislation governing the various forms of alternative care, including those provided by civil society organisations in compliance with the Convention;

(b) Better coordinate and provide adequate financial support to civil society involved in the area of child support.

Adoption

42. The Committee is also concerned that the rules and the procedures of the Adoption Act are not applicable under customary law.

43. The Committee recommends that the state party

- (a) Expedite the review of the Adoption Act in order to bring existing rules and practices regulating adoption into full compliance with the Convention to ensure that in cases of informal adoption, the rights of the child are well protected to encourage formal domestic adoptions;
- (b) Consider ratifying the Hague Convention No 33 on the Protection of Children and Cooperation in Respect of Intercountry Adoption.

Child abuse and neglect

44. While taking note that the Women's Affairs Department commissioned a study in 1998 on the socio-economic implications of violence against women, the Committee remains concerned at the increasing level of domestic violence, at both physical and sexual abuse of children and at the lack of a comprehensive legal and policy framework.

45. In the light of articles 19 and 39 of the Convention, the Committee recommends that the state party

- (a) Adopt legal measures and comprehensive and responsive policies which will help to change attitudes and improve the prevention and treatment of cases of violence against children;
- (b) Introduce an effective system for reporting cases of abuse, including sexual abuse, of children;
- (c) Properly investigate cases of violence against children through a child-sensitive judicial procedure and impose sanctions on perpetrators, with due regard to the right to privacy of the child;
- (d) Take measures to ensure the care and rehabilitation of victims as well as perpetrators;
- (e) Take measures to prevent the criminalisation and stigmatisation of child victims of abuse; and
- (f) Seek technical assistance from, among others, UNICEF and the World Health Organisation (WHO).

6 Basic health and welfare

Children with disabilities

...

47. In the light of the Standards Rules on the Equalization of Opportunities for Persons with Disabilities (General Assembly resolution 48/96) and the Committee's recommendations adopted at its day of general discussion on the rights of the children with disabilities (CRC/C/69, paras 310-339), the Committee recommends that the state party continue to strengthen its efforts to combat discriminatory attitudes towards children with disabilities, particularly amongst children and parents, and promote their participation in all aspects of social and cultural life. The state party should also ensure that all children with disabilities have access to health care facilities and education and, wherever possible, they are integrated into the mainstream education system.

Health services

...

49. The Committee recommends that the state party continue to strengthen its primary health care strategy by ensuring adequate staffing and providing the highest attainable standard of health

for all children. The Committee recommends that the state party reduce regional disparities and lower maternal mortality rates by improving prenatal care services and providing training of birth attendants in healthy midwifery practices.

HIV/AIDS

50. While welcoming the establishment of the National AIDS Council, chaired by the president, the National AIDS Coordinating Council, the National Policy on HIV/AIDS, the Prevention of Mother to Child Transmission Programme and the programme for AIDS orphans, the Committee shares the serious concern of the state party at the still exceedingly high prevalence rate of HIV/AIDS, especially among women in their child-bearing years compounded, in part, by inappropriate traditional practices, stigmatisation and lack of knowledge on prevention methods.

51. In the light of General Comment 3 on HIV/AIDS and the rights of children (CRC/GC/2003/3), the Committee urges the state party to strengthen its efforts in combating the spread and effects of HIV/AIDS by, inter alia, training professionals, conducting education campaigns on prevention, improving the prevention of mother to child transmission programme, by providing free and universal antiretroviral medication and improving protection and support for AIDS orphans.

Adolescent health

...

53. In the light of General Comment 4 on adolescent health and development in the context of the Convention on the Rights of the Child (CRC/GC/2003/4), the Committee recommends that the state party establish adequate health care services for adolescents, focusing on reproductive and mental health programmes.

...

Sexual exploitation

...

59. The Committee recommends that the state party

(a) Undertake a study of children involved in commercial sexual exploitation and use its data to design policies and programmes to prevent commercial sexual exploitation of children, including through the development of a national plan of action on commercial sexual exploitation of children, as agreed at the first and second World Congresses Against Commercial Sexual Exploitation of Children, held in 1996 and 2001;

(b) Train law-enforcement officials, social workers and prosecutors on how to receive, monitor, investigate and prosecute complaints, in a child-sensitive manner that respects the privacy of the victim;

(c) Prioritise recovery assistance and ensure that education and training as well as psychosocial assistance and counselling are provided to victims.

...

63. The Committee recommends that the state party ratify the Optional Protocol to the Convention on the involvement of children in armed conflict.

10 Follow-up and dissemination

Follow-up

64. The Committee recommends that the state party take all appropriate measures to ensure full implementation of the present recommendations, inter alia, by transmitting them to the members of the Council of Ministers or the Cabinet or a similar body, the Parliament, and to provincial or State governments and parliaments, when applicable, for appropriate consideration and further action.

Dissemination

65. The Committee further recommends that the initial report and written replies submitted by the state party and related recommendations (concluding observations) that it adopted be made widely available, including through Internet (but not exclusively), to the public at large, civil society organisations,

youth groups, professional groups and children, in order to generate debate and awareness of the Convention, its implementation and monitoring.

Concluding Observations – Uganda (2005)

The Committee on the Rights of the Child considered the second periodic report of Uganda (CRC/C/65/Add.33) at its 1058th and 1059th meetings (see CRC/C/SR.1058 and 1059), held on 15 September 2005, and adopted these concluding observations at its 1080th meeting (CRC/C/SR.1080), held on 30 September 2005. Full text available at www.ohchr.org.

Excerpts

...

B. Follow-up measures undertaken and progress achieved by the state party

The Committee welcomes a number of positive developments in the reporting period, inter alia

(a) The adoption of the Children Act in 2000 (previously the Children Statute), which is in compliance with the Convention on the Rights of the Child;

...

(c) The National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children (2005/06-2009/10).

...

The Committee also welcomes the ratification of the following international human rights instruments

(a) The Optional Protocols to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, in January 2002 and on the involvement of children in armed conflict, in June 2002;

...

(e) The Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court of Human and Peoples' Rights, in 2001 ...

D. Principal areas of concern and recommendations

1 General measures of implementation

Independent monitoring

...

19. The Committee recommends that the state party establish within the Uganda Human Rights Commission a separate department or mechanism with the necessary expertise to independently monitor the implementation of the Convention on the Rights of the Child. It should also be provided with the necessary human and financial resources to receive and investigate complaints from or on behalf of children on violations of their rights. In this regard, the Committee draws the attention of the state party to its General Comment 2 (2002) on national human rights institutions.

2 Definition of the child

Age of marriage

...

29. The Committee recommends that the state party fully enforce the age of marriage set out in the law for all forms of marriage and for both boys and girls. It also recommends that the state party expedite its reform of the marriage laws undertaken by the Uganda Law Reform Commission. It further recommends that the state party undertake sensitisation campaigns, especially among local traditional leaders, on the negative impact that early and forced marriage has, particularly on girls.

3 General principles

Non-discrimination

30. The Committee notes that the Ugandan Constitution prohibits discrimination on grounds of sex, race, colour, ethnic origin, tribe, creed, religion, social or economic standing, or political opinion. It also welcomes the information provided by the delegation that the Equal Opportunity Commission will be established within a year. However, the Committee is concerned at the fact that discrimination against certain groups of children still exists in practice, particularly with regard to girls, children with disabilities, children living in poverty, refugee children, children affected by and/or infected with HIV/AIDS, former child soldiers and Batwa children.

31. The Committee urges the state party to take adequate measures, including expediting the establishment of the Equal Opportunity Commission, to ensure the practical application of the constitutional and legal provisions guaranteeing the principle of non-discrimination and full compliance with article 2 of the Convention, and to adopt a comprehensive strategy to eliminate discrimination on any grounds and against all vulnerable groups.

...

5 Family environment and alternative care

Children without parental care

41. The Committee is deeply concerned about the impact the high rate of HIV/AIDS has for children who have lost one or both parents and the need to provide them with adequate alternative care. In addition, poverty, preventable diseases, conflict in the country and other problems deprive children of parental care and/or a family environment.

42. The Committee recommends that the state party strengthen and effectively implement its National Strategic Plan of Interventions for Orphans and Other Vulnerable Children for the years 2005/06-2009/10. In particular, the Committee recommends that the state party put more focus, inter alia, on

- (a) Effective support programmes for children in vulnerable families, such as those affected by HIV/AIDS, single-parent families and families suffering from poverty;
- (b) Effective support to extended families which care for children of parents who have died of AIDS and for child-headed families; and
- (c) The promotion of and support for family-type forms of alternative care for children deprived of parental care, in order to reduce the resort to residential care.

Child abuse and neglect

43. The Committee notes the information, including in the state party's written replies to the list of issues, of the reported cases of child abuse and neglect in four major regions. It is further concerned at the lack of a comprehensive policy for the prevention and combat of child abuse and neglect in the family.

44. The Committee recommends that the state party

- (a) Take the necessary measures to prevent child abuse and neglect;
- (b) In addition to existing procedures, establish effective mechanisms to receive, monitor and investigate complaints;
- (c) Carry out preventive public education campaigns about the negative consequences of the ill-treatment of children.

45. In the context of the Secretary-General's in-depth study on the question of violence against children and the related questionnaire to Governments, the Committee acknowledges with appreciation the written replies of the state party to this questionnaire and its participation in the Regional Consultation for Eastern and Southern Africa, held in South Africa from 18 to 20 July 2005. The Committee recommends that the state party use the outcome of this regional consultation as a tool for taking action, in partnership with civil society, to ensure that every child is protected from all forms of physical, sexual or mental violence, and for generating momentum for concrete and, where appropriate, time-bound actions to prevent and respond to such violence and abuse.

6 Basic health and welfare

...

Health and health services

49. Notwithstanding the various measures undertaken by the state party to develop primary health care and lower infant and child mortality, the Committee remains deeply concerned at the state of health of children in the state party, which, as stated in the report (para 132), is among the lowest in sub-Saharan Africa. In particular, the Committee is deeply concerned that infant, under-five and maternal mortality rates remain very high. It is also concerned at the decrease in vaccination uptake, the prevalence of malaria and the high incidence of malnutrition, undernutrition and stunting among children. The Committee is also concerned that the current plans, policies and programmes initiated to improve the health situation are challenged, in particular by a lack of human and financial resources. The Committee is further concerned at the availability of health care services whose quality varies dramatically between the different areas of the state party.

50. The Committee recommends that the state party take all necessary measures to strengthen its programmes for improving health care by, inter alia, supporting these programmes with adequate resources and paying particular and urgent attention to mortality rates, vaccination uptakes, nutrition status, and the management of communicable diseases and malaria.

HIV/AIDS

51. The Committee, while noting the ABC strategy, is concerned that despite the reduction in the HIV/AIDS infection rate, children and women of child-bearing age remain highly vulnerable to contracting HIV/AIDS and that not all have access to anti-retroviral drugs, testing and counselling.

52. With reference to the Committee's General Comment 3 (2003) on HIV/AIDS and the rights of the child and the International Guidelines on HIV/AIDS and Human Rights, the Committee recommends, in particular, that the state party

- (a) Strengthen its efforts to combat HIV/AIDS, including through awareness-raising campaigns, and to prevent discrimination against children infected with and affected by HIV/AIDS;
- (b) Ensure the full and effective implementation of a comprehensive policy to prevent HIV/AIDS that includes all preventive measures, and the complementarity of the different approaches for different age groups;
- (c) Ensure access to child-sensitive and confidential counselling, without the need for parental consent, when such counselling is required by a child;
- (d) Continue to strengthen its efforts to prevent mother-to-child transmission of HIV;
- (e) Seek international assistance from, among others, UNAIDS and UNICEF, to that effect.

Adolescent health

53. The Committee is concerned that insufficient attention has been paid to adolescent health issues, including developmental, mental and reproductive health concerns, and substance abuse. The Committee is also concerned at the particular situation of girls, given, for instance, the relatively high per centage of early marriages and early pregnancies, which can have a negative impact on their health.

54. The Committee recommends that the state party, taking into account the Committee's General Comment 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child

- (a) Undertake a comprehensive study to assess the nature and extent of adolescent health problems and, with the participation of adolescents, use it as a basis to formulate adolescent health policies and programmes with a particular focus on the prevention of early pregnancies and sexually transmitted infections (STIs), especially through reproductive health education; and
- (b) Strengthen adolescent-sensitive mental health counselling services and make them known and accessible to adolescents.

Harmful traditional practices

55. The Committee notes with appreciation the efforts undertaken by the state party to address the practice of female genital mutilation (FGM), including a number of programmes in cooperation with UNFPA. However, it remains concerned that FGM is not specifically prohibited by law and is still widely practised in the state party. Concern is also expressed about the persistence of other harmful traditional practices, including early marriage.

56. The Committee recommends that the state party adopt legislative measures to prohibit FGM and conduct awareness-raising campaigns to combat and eradicate this and other traditional practices harmful to the health, survival and development of children, especially girls. The Committee recommends that the state party introduce sensitisation programmes for practitioners and the general public to encourage change in traditional attitudes and discourage harmful practices, engaging with the extended family and the traditional and religious leaders. It further recommends that the state party provide retraining, where appropriate, for practitioners and support them in their efforts to find alternative sources of income.

...

8 Special protection measures

Sexual exploitation

75. The Committee is concerned that according to some recent studies a considerable number of children are victims of sexual exploitation. Furthermore, the Committee is deeply concerned at the very high incidence of defilement of girls, constituting more than half of the cases of child abuse. In addition, it notes that the law on sexual abuse is biased against the boy child.

76. The Committee recommends that the state party

- (a) Take appropriate legislative measures, including adoption of the long-standing bill on sexual offence, and develop an effective and comprehensive policy addressing the sexual exploitation of children, including the factors that place children at risk of such exploitation;
- (b) Undertake awareness-raising educational measures to prevent and eliminate the defilement of girls;
- (c) Avoid criminalising child victims of sexual exploitation;
- (d) Implement appropriate policies and programmes for the prevention, recovery and social reintegration of child victims, in accordance with the Declaration and Agenda for Action and the Global Commitment adopted at the 1996 and 2001 World Congresses against Commercial Sexual Exploitation of Children.

...

Concluding Observations – Mauritius (2006)

The Committee on the Rights of the Child considered the second periodic report of Mauritius (CRC/C/65/Add.35) at its 1105th and 1107th meetings (see CRC/C/SR.1105 and 1107), held on 19 January 2006, and adopted these concluding observations at its 1120th meeting, held on 27 January 2006. Full text available at www.ohchr.org.

Excerpts

...

B. Follow-up measures undertaken and progress achieved by the state party

4. The Committee notes with appreciation the efforts made by the state party in the field of law reform and in particular the adoption of the following legislation

(a) The Protection of the Child (Miscellaneous Provisions) Act 1998 which amended the Child Protection Act 1994 together with 23 pieces of legislation;

...

(c) The Protection from Domestic Violence (Amendment) Act in 2004 to cover all cases of domestic violence;

(d) The Sex Discrimination Act of 2002;

...

(g) The National Children's Council (Amendment) Act in 2005 which created the Rodrigues Children's Council.

...

C. Principle areas of concern and recommendations

1 General measures of implementation (arts 4, 42 and 44(6) of the Convention)

...

Legislation

10. The Committee notes with appreciation the various measures undertaken by the state party to amend existing laws and introduce new laws to ensure compliance with the CRC. However, the Committee remains concerned about the fact that some of the legislation does not conform to the principles and provisions of the Convention, including in the area of adoption and juvenile justice.

11. The Committee recommends that the state party strengthen its efforts to continue reviewing its legislation with the aim of ensuring full compliance with the principles and provisions of the Convention. Furthermore, the Committee encourages the state party to consider enacting a comprehensive Children's Act to consolidate the various pieces of legislation covering all aspects of child rights.

...

2 General principles (arts 2, 3, 6 and 12 of the Convention)

...

Non-discrimination

26. While appreciating that several measures have been introduced to support vulnerable groups, the Committee expresses its concern at the fact that discrimination against certain groups of children still exists in practice, particularly with regard to children with disabilities, children affected and/or infected by HIV/AIDS, children from disadvantaged families and girls.

27. The Committee recommends that the state party undertake all necessary measures to eliminate de facto discrimination in full compliance with article 2 of the Convention.

...

Best interests of the child

29. The Committee notes that although the principle of the best interests of the child is not specifically stated in the Constitution, various national laws provide for the best interests of the child. However, the Committee is concerned that this principle is not fully applied and duly integrated in the implementation of the policies and programmes of the state party or in administrative and judicial decisions for instance in cases of custody and visitation rights.

30. The Committee recommends that the principle of the best interests of the child enshrined in article 3 be systematically implemented in judicial and administrative decisions as well as in programmes, projects and services with regard to children in various situations.

...

3 Civil rights and freedoms (arts 7, 8, 13 to 17 and 37(a) of the Convention)

...

Right to privacy

35. The Committee shares the state party's concern that the privacy of children who have been victims of abuse or in conflict with the law is not always respected by the press, as certain newspapers continue to report cases in a manner that makes it easy to identify the child, publish their photograph and names or make the child relate the details of the abuse. The Committee also notes that there is no legislation to ensure children's privacy by the media.

36. The Committee recommends that the state party take all necessary legislative measures to fully protect the right of the child to privacy and to support the initiatives of the Ombudsperson for Children in this domain, including the proposals of drafting a Code of Ethics. In addition, the Committee recommends that the state party provide trainings on the principles and provisions of the Convention to chief editors and journalists.

4 Family environment and alternative care (arts 5, 18(1 and 2), (9 to 11), (19 to 21), (25), 27(4), and 39 of the Convention)

Adoption

45. The Committee is concerned about the lack of a specific requirement to have a social report to assist judges in their decisions that adoption is in the best interests of the child. The Committee is further concerned about the lack of a follow-up system.

46. The Committee recommends that the state party take legislative measures to ensure that in cases of adoption the decision of the judge is supported by relevant information regarding both the child and the adopting parents in order to ensure that adoption is in the best interests of the child.

Child abuse, violence and neglect

47. The Committee is concerned about the incidence of child abuse and neglect, including sexual abuse in the state party. Furthermore, the Committee is concerned about the lack of specialised and comprehensive units with specialised personnel to care for the recovery, rehabilitation and reintegration of abused children. In addition, the Committee is concerned about the lack of alternative homes for children, particularly girls who may be forced to go back to the same homes where the abusers live.

48. The Committee recommends that the state party

- (a) Provide facilities for the care, recovery and reintegration for child victims of violence;
- (b) Ensure that the child victim's privacy is protected in legal proceedings; and
- (c) Train parents, teachers, law enforcement officials, care workers, judges, health professionals and children themselves in the identification, reporting and management of cases of violence and abuse, using a multidisciplinary and multisectoral approach.

49. In the context of the Secretary-General's ongoing in-depth study on the question of violence against children (A/RES/56/138) and the related questionnaire to Governments, the Committee acknowledges with appreciation the written replies of the state party and its participation in the sub regional consultation for Indian Ocean Island States held in Madagascar from 25 to 27 April 2005 and Regional Consultation for Eastern and Southern Africa held in South Africa from 18 to 20 July 2005. The Committee recommends that the state party use the outcome of this regional consultation in order to take action, in partnership with civil society, to ensure the protection of every child from all forms of physical or mental violence, and to gain momentum for concrete and, where appropriate, time-bound actions to prevent and respond to such violence and abuse.

5 Basic health and welfare (arts 6, 18(3), 23, 24, 26, 27(1 to 3) of the Convention) Children with disabilities

50. The Committee notes the progress made by the state party, especially in codifying the Mauritian sign language and in launching a dictionary of such language. However, it remains concerned about the low proportion of children with disabilities attending schools, particularly due to the poor accessibility to schools most of which are located in the urban areas. It is further concerned about the reluctance of schools to admit children with disabilities as this is perceived to slow down teaching. The Committee is also concerned that the Constitution does not provide for protection from discrimination on the ground of disability.

51. The Committee recommends that the state party, taking into account the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (General Assembly resolution 48/96) and the Committee's recommendations adopted at its day of general discussion on the rights of children with disabilities (CRC/C/69 (310-339)), further encourage the integration of children with disabilities into the regular educational system and their fullest possible social integration. The Committee also recommends that the state party

- (a) Collect adequate statistical data on children with disabilities, allowing for disaggregated analysis of the problems facing such children;
- (b) Establish a national system of early detection, referral and intervention; and
- (c) Seek further technical assistance and cooperation for the creation of more effective specialised institutions, including day-care centres, and for the training of parents and professional staff working with and for children.

Health and health services

52. Notwithstanding the various measures undertaken by the state party to develop health care services, antenatal and post-natal care and make them accessible for free to all, the Committee remains concerned about

- (a) Regional disparities in accessibility to health services;
- (b) High infant mortality rates;
- (c) Infant and maternal malnutrition;
- (d) The sharp decrease in breastfeeding; and
- (e) Limited access to clean and safe drinking water in Rodrigues.

53. The Committee recommends that the state party

- (a) Prioritise the allocations of financial and human resources to the health sector in order to ensure equal access to quality health care by children in all areas of the country;
- (b) Continue its efforts to improve prenatal care, including training programmes for midwives and traditional birth attendants, and take all necessary measures to reduce infant mortality rates, especially in rural areas;
- (c) Improve the nutritional status of infants, children and mothers;
- (d) Ensure access to safe drinking water and sanitation in all areas of the country and particularly in Rodrigues; and
- (e) Encourage exclusive breastfeeding for at least six months after birth with the addition of an appropriate infant diet thereafter.

Adolescent health

54. The Committee is concerned about the high rate of teenage pregnancies and the limited access to reproductive health services for adolescents.

55. The Committee recommends that the state party, taking into account its General Comment 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child (CRC/GC/2003/4)

- (a) Strengthen its efforts to ensure access to reproductive health services for all adolescents;
- (b) Incorporate reproductive health education in the school curriculum;

(c) Conduct awareness-raising campaigns among adolescents to inform them about their reproductive health rights and the prevention of STDs, HIV/AIDS, and early pregnancies; and

(d) Provide particular support to pregnant teenagers, including through community structures and social security benefits and ensure their completion of education.

HIV/AIDS

56. The Committee welcomes the adoption of the National Strategic HIV/AIDS Action Plan 2001-2005 and the provision of anti-retroviral drugs to pregnant women free of charge to reduce the mother-to-child transmission. Nevertheless, the Committee is concerned about the lack of awareness about HIV/AIDS which leads to fear and discriminatory attitudes against those infected or affected.

57. The Committee recommends that the state party integrate respect for the rights of the child into the development and implementation of its HIV/AIDS policies and strategies, taking into account its General Comment 3 (2003) on HIV/AIDS and the rights of the child (CRC/GC/2003/3).

...

Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (2000/2002)

Adopted and opened for signature, ratification and accession by General Assembly resolution A/RES/54/263 of 25 May 2000 and entered into force on 12 February 2002. Full text available at www.ohchr.org.

Excerpts

...

Article 1

States parties shall take all feasible measures to ensure that members of their armed forces who have not attained the age of 18 years do not take a direct part in hostilities.

Article 2

States parties shall ensure that persons who have not attained the age of 18 years are not compulsorily recruited into their armed forces.

Article 3

1. States parties shall raise in years the minimum age for the voluntary recruitment of persons into their national armed forces from that set out in article 38, paragraph 3, of the Convention on the Rights of the Child, taking account of the principles contained in that article and recognising that under the Convention persons under the age of 18 years are entitled to special protection.

2. Each state party shall deposit a binding declaration upon ratification of or accession to the present Protocol that sets forth the minimum age at which it will permit voluntary recruitment into its national armed forces and a description of the safeguards it has adopted to ensure that such recruitment is not forced or coerced.

3. States parties that permit voluntary recruitment into their national armed forces under the age of 18 years shall maintain safeguards to ensure, as a minimum, that

- (a) Such recruitment is genuinely voluntary;
- (b) Such recruitment is carried out with the informed consent of the person's parents or legal guardians;
- (c) Such persons are fully informed of the duties involved in such military service;
- (d) Such persons provide reliable proof of age prior to acceptance into national military service.

4. Each state party may strengthen its declaration at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall inform all states parties. Such notification shall take effect on the date on which it is received by the Secretary-General.

5. The requirement to raise the age in paragraph 1 of the present article does not apply to schools operated by or under the control of the armed forces of the states parties, in keeping with articles 28 and 29 of the Convention on the Rights of the Child.

Article 4

1. Armed groups that are distinct from the armed forces of a State should not, under any circumstances, recruit or use in hostilities persons under the age of 18 years.

...

Article 5

Nothing in the present Protocol shall be construed as precluding provisions in the law of a state party or in international instruments and international humanitarian law that are more conducive to the realisation of the rights of the child.

Article 6

1. Each state party shall take all necessary legal, administrative and other measures to ensure the effective implementation and enforcement of the provisions of the present Protocol within its jurisdiction.

...

Article 8

1. Each state party shall, within two years following the entry into force of the present Protocol for that state party, submit a report to the Committee on the Rights of the Child providing comprehensive information on the measures it has taken to implement the provisions of the Protocol, including the measures taken to implement the provisions on participation and recruitment.

2. Following the submission of the comprehensive report, each state party shall include in the reports it submits to the Committee on the Rights of the Child, in accordance with article 44 of the Convention, any further information with respect to the implementation of the Protocol. Other states parties to the Protocol shall submit a report every five years.

3. The Committee on the Rights of the Child may request from states parties further information relevant to the implementation of the present Protocol.

...

Optional Protocol to the Convention on the Rights of the Child on the Sale of Children (2000/2002)

Adopted and opened for signature, ratification and accession by General Assembly resolution A/RES/54/263 of 25 May 2000 and entered into force on 18 January 2002. Full text available at www.ohchr.org.

Excerpts

...

Article 1

States parties shall prohibit the sale of children, child prostitution and child pornography as provided for by the present Protocol.

Article 2

For the purposes of the present Protocol

- (a) Sale of children means any act or transaction whereby a child is transferred by any person or group of persons to another for remuneration or any other consideration;

- (b) Child prostitution means the use of a child in sexual activities for remuneration or any other form of consideration;
- (c) Child pornography means any representation, by whatever means, of a child engaged in real or simulated explicit sexual activities or any representation of the sexual parts of a child for primarily sexual purposes.

Article 3

1. Each state party shall ensure that, as a minimum, the following acts and activities are fully covered under its criminal or penal law, whether such offences are committed domestically or transnationally or on an individual or organised basis

(a) In the context of sale of children as defined in article 2

(i) Offering, delivering or accepting, by whatever means, a child for the purpose of

a. Sexual exploitation of the child;

...

(ii) Improperly inducing consent, as an intermediary, for the adoption of a child in violation of applicable international legal instruments on adoption;

(b) Offering, obtaining, procuring or providing a child for child prostitution, as defined in article 2;

(c) Producing, distributing, disseminating, importing, exporting, offering, selling or possessing for the above purposes child pornography as defined in article 2.

2. Subject to the provisions of the national law of a state party, the same shall apply to an attempt to commit any of the said acts and to complicity or participation in any of the said acts.

...

4. Subject to the provisions of its national law, each state party shall take measures, where appropriate, to establish the liability of legal persons for offences established in paragraph 1 of the present article. Subject to the legal principles of the state party, such liability of legal persons may be criminal, civil or administrative.

5. States parties shall take all appropriate legal and administrative measures to ensure that all persons involved in the adoption of a child act in conformity with applicable international legal instruments.

...

Article 8

1. States parties shall adopt appropriate measures to protect the rights and interests of child victims of the practices prohibited under the present Protocol at all stages of the criminal justice process ...

2. States parties shall ensure that uncertainty as to the actual age of the victim shall not prevent the initiation of criminal investigations, including investigations aimed at establishing the age of the victim.

3. States parties shall ensure that, in the treatment by the criminal justice system of children who are victims of the offences described in the present Protocol, the best interest of the child shall be a primary consideration.

4. States parties shall take measures to ensure appropriate training, in particular legal and psychological training, for the persons who work with victims of the offences prohibited under the present Protocol.

Article 9

1. States parties shall adopt or strengthen, implement and disseminate laws, administrative measures, social policies and programmes to prevent the offences referred to in the present Protocol. Particular attention shall be given to protect children who are especially vulnerable to such practices.

Article 10

1. States parties shall take all necessary steps to strengthen international cooperation by multilateral, regional and bilateral arrangements for the prevention, detection, investigation, prosecution and punishment of those responsible for acts

involving the sale of children, child prostitution, child pornography and child sex tourism. States parties shall also promote international cooperation and coordination between their authorities, national and international non-governmental organisations and international organisations.

...

Article 11

Nothing in the present Protocol shall affect any provisions that are more conducive to the realisation of the rights of the child and that may be contained in

(a) The law of a state party;

(b) International law in force for that State.

Article 12

1. Each state party shall, within two years following the entry into force of the present Protocol for that state party, submit a report to the Committee on the Rights of the Child providing comprehensive information on the measures it has taken to implement the provisions of the Protocol.

2. Following the submission of the comprehensive report, each state party shall include in the reports they submit to the Committee on the Rights of the Child, in accordance with article 44 of the Convention, any further information with respect to the implementation of the present Protocol. Other states parties to the Protocol shall submit a report every five years.

3. The Committee on the Rights of the Child may request from states parties further information relevant to the implementation of the present Protocol ...

A1.9 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990/2003)

Adopted and opened for signature, ratification and accession by General Assembly resolution 45/158 on 18 December 1990 and entered into force in July 2003. Full text available at www.ohchr.org.

Excerpts

...

PART I: Scope and definitions

Article 1

1. The present Convention is applicable, except as otherwise provided hereafter, to all migrant workers and members of their families without distinction of any kind such as sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth or other status.

2. The present Convention shall apply during the entire migration process of migrant workers and members of their families, which comprises preparation for migration, departure, transit and the entire period of stay and remunerated activity in the State of employment as well as return to the State of origin or the State of habitual residence.

Article 2

For the purposes of the present Convention

1. The term 'migrant worker' refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he is not a national.

2.(a) The term 'frontier worker' refers to a migrant worker who retains his habitual residence in a neighbouring State to which he normally returns every day or at least once a week;

(b) The term 'seasonal worker' refers to a migrant worker whose work by its character is dependent on seasonal conditions and is performed only during part of the year;

(c) The term 'seafarer', which includes a fisherman, refers to a migrant worker employed on board a vessel registered in a State of which he is not a national;

(d) The term 'worker on an offshore installation' refers to a migrant worker employed on an offshore installation that is under the jurisdiction of a State of which he is not a national;

(e) The term 'itinerant worker' refers to a migrant worker who, having his habitual residence in one State, has to travel to another State or States for short periods, owing to the nature of his occupation;

(f) The term 'project-tied worker' refers to a migrant worker admitted to a State of employment for a defined period to work solely on a specific project being carried out in that State by his employer;

(g) The term 'specified-employment worker' refers to a migrant worker

(i) Who has been sent by his employer for a restricted and defined period of time to a State of employment to undertake a specific assignment or duty; or

(ii) Who engages for a restricted and defined period of time in work that requires professional, commercial, technical or other highly specialised skill; or

(iii) Who, upon the request of his employer in the State of employment, engages for a restricted and defined period of time in work whose nature is transitory or brief; and who is required to depart from the State of employment either at the expiration of his authorised period of stay, or earlier if he no longer undertakes that specific assignment or duty or engages in that work;

(h) The term 'self-employed worker' refers to a migrant worker who is engaged in a remunerated activity otherwise than under a contract of employment and who earns his living through this activity normally working alone or together with members of his family, and to any other migrant worker recognised as self-employed by applicable legislation of the State of employment or bilateral or multilateral agreements.

...

Article 4

For the purposes of the present Convention the term 'members of the family' refers to persons married to migrant workers or having with them a relationship that, according to applicable law, produces effects equivalent to marriage, as well as their dependent children and other dependent persons who are recognised as members of the family by applicable legislation or applicable bilateral or multilateral agreements between the States concerned.

Article 5

For the purposes of the present Convention, migrant workers and members of their families

(a) Are considered as documented or in a regular situation if they are authorised to enter, to stay and to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which that State is a party;

(b) Are considered as non-documented or in an irregular situation if they do not comply with the conditions provided for in subparagraph a of the present article.

Article 6

For the purposes of the present Convention

(a) The term 'State of origin' means the State of which the person concerned is a national;

(b) The term 'State of employment' means a State where the migrant worker is to be engaged, is engaged or has been engaged in a remunerated activity, as the case may be;

(c) The term 'State of transit' means any State through which the person concerned passes on any journey to the State of employment or from the State of employment to the State of origin or the State of habitual residence.

PART II: Non-discrimination with respect to rights

Article 7

States parties undertake, in accordance with the international instruments concerning human rights, to respect and to ensure to all migrant workers and members of their families within their territory or subject to their jurisdiction the rights provided for in the present Convention without distinction of any kind such as to sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth or other status.

PART III: Human rights of all migrant workers and members of their families

Article 8

1. Migrant workers and members of their families shall be free to leave any State, including their State of origin. This right shall not be subject to any restrictions except those that are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognised in the present part of the Convention.

2. Migrant workers and members of their families shall have the right at any time to enter and remain in their State of origin.

Article 9

The right to life of migrant workers and members of their families shall be protected by law.

Article 10

No migrant worker or member of his family shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

...

Article 14

No migrant worker or member of his family shall be subjected to arbitrary or unlawful interference with his privacy, family, home, correspondence or other communications, or to unlawful attacks on his honour and reputation. Each migrant worker and member of his family shall have the right to the protection of the law against such interference or attacks.

...

Article 16

1. Migrant workers and members of their families shall have the right to liberty and security of person.

2. Migrant workers and members of their families shall be entitled to effective protection by the State against violence, physical injury, threats and intimidation, whether by public officials or by private individuals, groups or institutions.

...

Article 17

1. Migrant workers and members of their families who are deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person and for their cultural identity.

...

Article 25

1. Migrant workers shall enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of remuneration.

...

Article 27

1. With respect to social security, migrant workers and members of their families shall enjoy in the State of employment the same treatment granted to nationals in so far as they fulfil the

requirements provided for by the applicable legislation of that State and the applicable bilateral and multilateral treaties. The competent authorities of the State of origin and the State of employment can at any time establish the necessary arrangements to determine the modalities of application of this norm.

2. Where the applicable legislation does not allow migrant workers and members of their families a benefit, the States concerned shall examine the possibility of reimbursing interested persons the amount of contributions made by them with respect to that benefit on the basis of the treatment granted to nationals who are in similar circumstances.

Article 28

Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

...

Article 30

Each child of a migrant worker shall have the basic right of access to education on the basis of equality of treatment with nationals of the State concerned. Access to public pre-school educational institutions or schools shall not be refused or limited by reason of the irregular situation with respect to stay or employment of either parent or by reason of the irregularity of the child's stay in the State of employment.

...

PART VII: Application of the Convention

Article 72

1. (a) For the purpose of reviewing the application of the present Convention, there shall be established a Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (hereinafter referred to as 'the Committee').

...

Article 73

1. States parties undertake to submit to the Secretary-General of the United Nations for consideration by the Committee a report on the legislative, judicial, administrative and other measures they have taken to give effect to the provisions of the present Convention

(a) Within one year after the entry into force of the Convention for the state party concerned;

(b) Thereafter every five years and whenever the Committee so requests.

2. Reports prepared under the present article shall also indicate factors and difficulties, if any, affecting the implementation of the Convention and shall include information on the characteristics of migration flows in which the state party concerned is involved.

3. The Committee shall decide any further guidelines applicable to the content of the reports.

4. States parties shall make their reports widely available to the public in their own countries.

A1.10 Convention on the Rights of Persons with Disabilities (2006)

Adopted on 13 December 2006 in New York and opened for signature, ratification and accession on 30 March 2007. Full text available at www.ohchr.org.

Excerpts

...

Article 1: Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2: Definitions

For the purposes of the present Convention

...

'Discrimination on the basis of disability' means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

...

Article 3: General principles

The principles of the present Convention shall be

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- (b) Non-discrimination;
- (c) Full and effective participation and inclusion in society;
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (e) Equality of opportunity;
- (f) Accessibility;
- (g) Equality between men and women;
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 4: General obligations

1. States parties undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, states parties undertake

- (a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention;
- (b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- (c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
- (d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
- (e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise;
- (f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;

(g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;

(h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;

(i) To promote the training of professionals and staff working with persons with disabilities in the rights recognised in this Convention so as to better provide the assistance and services guaranteed by those rights.

2. With regard to economic, social and cultural rights, each state party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realisation of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.

...

A2 UN declarations and similar documents

A2.1 UN Standard Minimum Rules for the Treatment of Prisoners (1955)

Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Full text available at www.ohchr.org.

Excerpts

...

22.(2) Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

...

25.(1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

...

62. The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

63.(1) The fulfilment of these principles requires individualisation of treatment and for this purpose a flexible system of classifying prisoners in groups; it is therefore desirable that such groups should be distributed in separate institutions suitable for the treatment of each group.

A2.2 Ottawa Charter for Health Promotion (1986)

A World Health Organisation document, launched at the first international conference for health promotion held in Ottawa, Canada. The Charter defines health promotion as 'the process of enabling people to increase control over their health'. At the heart of the process is the empowerment of communities to improve their health and welfare. Full text available www.who.int.

Excerpts

...

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

...

Health promotion action means

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

...

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility.

...

Strengthen community actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavors and destinies.

...

Develop personal skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

...

Reorient health services

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

...

A2.3 World Health Assembly Resolution 41.24 on the Avoidance of Discrimination in relation to HIV-infected People and People with AIDS (1988)

The World Health Assembly (WHA) is the supreme decision-making body of the World Health Organisation. This document of the WHA, adopted on 13 May 1988, illustrates the central place given to human rights in the response to HIV in the 1980's. Among other things, the document urged member states: '... (1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS ...; (2) to protect the human rights and dignity of HIV-infected people and people with AIDS ... and to avoid discriminatory action against, and stigmatisation of them in the provision of services, employment and travel; and (3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services ...'.

A2.4 WHO Guidelines on HIV Infection and AIDS in Prisons (1993)

These guidelines were prepared on the basis of technical advice provided to WHO prior to and during a consultation of experts convened in Geneva in September 1992. The consultation included representatives of international and non-governmental organisations and government departments with a wide range of experience and background in the health, management, and human rights aspects of HIV/AIDS in prisons. Full text available at www.who.int.

Excerpts

...

The guidelines provide standards - from a public health perspective - which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS. It is expected that the guidelines will be adapted by prison authorities to meet their local needs.

A. General principles

1. All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.
2. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.
3. In each country, specific policies for the prevention of HIV/AIDS in prisons and for the care of HIV-infected prisoners should be defined. These policies and the strategies applied in prisons should be developed through close collaboration among national health authorities, prison administrations, and relevant community representatives, including non-governmental organisations. These strategies should be incorporated into, a wider programme of promoting health among prisoners.
4. Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.
5. The needs of prisoners and others in the prison environment should be taken into account in the planning of national AIDS programmes and community health and primary health care services, and in the distribution of resources, especially in developing countries.
6. The active involvement of non-governmental organisations, the involvement of prisoners, and the non-discriminatory and humane care of HIV-infected prisoners and of prisoners with AIDS are prerequisites for achieving a credible strategy for preventing HIV transmission.
7. It is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should, therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information, and in avoiding discrimination.
8. Prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.
9. Independent research in the field of HIV/AIDS among prison populations should be encouraged to shed light on - among other things - successful interventions in prisons. Independent examination by an ethical review committee should be carried out for all research procedures in prisons, and ethical principles must be strictly observed. The results of such studies should be used to benefit prisoners, for example by improving treatment

regimens or HIV/AIDS policies in prisons. Prison administrations should not seek to influence the scientific aspects of such research procedures, their interpretation or their publication.

B. HIV testing in prisons

10. Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited.
11. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following.
12. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.
13. Unlinked anonymous testing for epidemiological surveillance should only be considered if such a method is used in the general population of the country concerned. Prisoners should be informed about the existence of any epidemiological surveillance carried out in the prison where they are, and the findings of such surveillance should be made available to the prisoners.

C. Preventive measures

(i) Education and information

14. Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community. Information intended for the general public (through posters, leaflets, and the mass media) should also be available to prisoners. All written materials distributed to prisoners should be appropriate for the educational level in the prison population; information should be made available in a language and form that prisoners can understand, and presented in an attractive and clear format.

...

D. Management of HIV-infected prisoners

27. Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds, and as provided for by public health standards and regulations. HIV-infected prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programmes available to the general prison population.

...

E. Confidentiality in relation to HIV/AIDS

31. Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.
32. Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff, applying to disclosure the same principles as those generally applied in the community. Principles and procedures relating to voluntary partner notification in the community should be followed for prisoners.
33. Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.

F. Care and support of HIV-infected prisoners

34. At each stage of HIV-related illness, prisoners should receive appropriate medical and psychosocial treatment equivalent to that given to other members of the community. Involvement of all prisoners in peer support programmes should be encouraged. Collaboration with health care providers in the community should be promoted to facilitate the provision of medical care.

35. Medical follow-up and counselling for asymptomatic HIV-infected prisoners should be available and accessible during detention.

36. Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community.

37. Treatment for HIV infection, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.

38. Prisoners should have the same access as people living in the community to clinical trials of treatments for all HIV/AIDS-related diseases. Prisoners should not be placed under pressure to participate in clinical trials, taking into account the principle that individuals deprived of their liberty may not be the subjects of medical research unless they freely consent to it and it is expected to produce a direct and significant benefit to their health.

39. The decision to hospitalise a prisoner with AIDS or other HIV-related diseases must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available to the community, must be assured.

40. Prison medical services should collaborate with community health services to ensure medical and, psychological follow-up of HIV-infected prisoners after their release if they so consent. Prisoners should be encouraged to use these services.

...

H. Women prisoners

44. Special attention should be given to the needs of women prisoners. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.

45. Women prisoners, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners may engage in sexual intercourse during detention or release on parole, they should be enabled to protect themselves from HIV infection, eg through the provision of condoms and skills in negotiating safer sex. Counselling on family planning should also be available, if national legislation so provides. However, no pressure should be placed on women prisoners to terminate their pregnancies. Women should be able to care for their young children while in detention regardless of their HIV status.

46. The following should be available in all prisons holding women

- gynaecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of STDs;
- family planning counselling services oriented to women's needs;
- care during pregnancy in appropriate accommodation;
- care for children, including those born to HIV-infected mothers; and
- condoms and other contraceptives during detention and prior to parole periods or release.

I. Prisoners in juvenile detention centres

47. Health education programmes adapted to the needs of young prisoners should be organised to foster attitudes and behaviour conducive to the avoidance of transmissible diseases including HIV/AIDS. Decisions concerning children and adolescents, such as notifying parents of their children's HIV status, or obtaining consent to treatment should be taken on the same grounds as in the community, with due regard for the principle that the best interests of the child are paramount.

J. Foreign prisoners

48. The needs of foreign prisoners should be respected without discrimination. Prison authorities should be trained to respond to requirements such as assistance with languages, oral contact with families and counselling services. Adequate measures should be adopted to provide for the protection of HIV-infected foreign prisoners in the case of prisoner transfer/exchange programmes between different countries, extradition proceedings and other interchanges.

...

M. Contacts with the community and monitoring

53. Cooperation with relevant non-governmental and private organisations, such as those with expertise in AIDS prevention, counselling and social support, should be encouraged. HIV-infected prisoners should have access to voluntary agencies and other sources of advice and help.

...

N. Resources

57. Adequate resources for prison health care, for related staffing and for specific HIV/AIDS-related activities should be ensured by authorities. The resources made available should be used for preventive measures, counselling, outpatient consultation, medication, and hospitalisation.

...

A2.5 UN Millennium Development Goals (MDGs) (2000)

The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015 that respond to the world's main development challenges. The MDGs are drawn from the actions and targets contained in the UN Millennium Declaration adopted by 189 nations and signed by 147 heads of state and governments during the UN Millennium Summit on 8 September 2000. Goal six urges states to halt and reverse the spread of HIV/AIDS by 2015. Full text available at www.un.org.

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Build a global partnership for development

A2.6 UNCHR Resolution on the Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (2001)

This resolution of the UN Commission on Human Rights, adopted on 24 April 2001, emphasises the importance of human rights in the response to the HIV epidemic. Among other things, it reiterates past UNCHR's resolutions in which the term 'or other status' in non-discrimination provisions of international human rights texts is interpreted to cover health status, including HIV-positive status. Full text available at www.ohchr.org.

Excerpts

...

Recalling its resolutions 1999/49 of 27 April 1999 and 1997/33 of 11 April 1997 and other relevant resolutions and decisions adopted by organisations of the United Nations system, as well as by other competent forums,

...

Also welcoming the fact that many positive steps in implementing its previous resolutions have been taken, including the enactment of legislation in some countries to promote human rights in the context of HIV/AIDS and to prohibit discrimination against persons infected or presumed to be infected and members of vulnerable groups,

...

Emphasising, in view of the increasing challenges presented by HIV/AIDS, the need for intensified efforts to ensure universal respect for and observance of human rights and fundamental freedoms for all so as to reduce vulnerability to HIV/AIDS and to prevent HIV/AIDS-related discrimination and stigma,

Concerned that lack of full enjoyment of human rights by persons suffering from economic, social or legal disadvantage heightens the vulnerability of such persons to the risk of HIV infection and to its impact, if infected,

Also concerned that, in many countries, many people infected and affected by HIV, as well as those presumed to be infected, continue to be discriminated against in law, policy and practice,

...

Reiterating that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term 'or other status' in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS,

...

1. Invites States, United Nations organs, programmes and specialised agencies and international and non-governmental organisations to continue to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related human rights as contained in the Guidelines on HIV/AIDS and Human Rights;

...

5. Urges States to ensure that their laws, policies and practices respect human rights in the context of HIV/AIDS, prohibit HIV/AIDS-related discrimination, promote effective programmes for the prevention of HIV/AIDS, including through education and awareness-raising campaigns and improved access to high-quality goods and services for preventing transmission of the virus, and promote effective programmes for the care and support of persons infected and affected by HIV, including through improved and equitable access to safe and effective medication for the treatment of HIV infection and HIV/AIDS-related illnesses;

6. Requests States to establish coordinated, participatory, gender-sensitive, transparent and accountable national policies and programmes for HIV/AIDS response and to translate national policies to district level and local action, involving in all

phases of development and implementation non-governmental and community-based organisations and people living with HIV; 7. Also requests States to develop and support services, including legal aid where appropriate, to educate people infected and affected by HIV/AIDS about their rights and to assist them in realising their rights;

...

9. Requests States, in consultation with the relevant national professional bodies, to ensure that codes of professional conduct, responsibility and practice respect human rights and dignity in the context of HIV/AIDS, including access to care for people infected and affected by HIV/AIDS;

10. Also requests States, in consultation with relevant national bodies, including national human rights institutions, to develop and support appropriate mechanisms to monitor and enforce HIV/AIDS-related human rights;

...

A2.7 UNGASS Declaration of Commitment on HIV/AIDS (2001)

Adopted by Heads of State and Government and Representatives of States and Governments assembled at the United Nations from 25 to 27 June 2001 for the 26th special session of the General Assembly to review and address the problem of HIV/AIDS in all its aspects, as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat the pandemic in a comprehensive manner. Full text available at www.un.org.

Excerpts

...

'Global crisis — Global action'

1. We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;

2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society — national, community, family and individual;

3. Noting with profound concern, that by the end of the year 2000, 36.1 million people worldwide were living with HIV, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;

4. Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realisation of the global development goals we adopted at the Millennium Summit;

6. Recalling and reaffirming our previous commitments on HIV/AIDS made through

- The United Nations Millennium Declaration of 8 September 2000;

- The Political Declaration and Further Actions and Initiatives to Implement the Commitments made at the World Summit for Social Development of 1 July 2000;
 - The Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of 10 June 2000;
 - Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development of 2 July 1999;
 - The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;
 - The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001;
 - The Declaration of the Ibero-America Summit of Heads of State of November 2000 in Panama;
 - The Caribbean Partnership Against HIV/AIDS, 14 February, 2001;
 - The European Union Programme for Action: Accelerated Action on HIV/ AIDS, malaria and tuberculosis in the Context of Poverty Reduction of 14 May 2001;
 - The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000;
 - The Central Asian Declaration on HIV/AIDS of 18 May 2001;
7. Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;
8. Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;
9. Welcoming the commitments of African Heads of State or Government, at the Abuja Special Summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic; and recognising that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;
10. Recognising also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV, the Latin America region with 1.5 million people living with HIV, and the Central and Eastern European region with very rapidly rising infection rates; and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;
11. Recognising that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;
12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;
13. Noting further that stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;
14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;
15. Recognising that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental

elements to achieve progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

16. Recognising that the full realisation of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognising the need to achieve the prevention goals set out in this Declaration in order to stop the spread of the epidemic and acknowledging that all countries must continue to emphasise widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health care services;

19. Recognising that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV and vulnerable groups in close contact with health care systems and facilitating their access to information, counselling and preventive supplies;

20. Emphasising the important role of cultural, family, ethical and religious factors in the prevention of the epidemic, and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;

23. Recognising that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;

24. Recognising also that the cost availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;

25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continue to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people and recalling efforts to make drugs available at low prices for those in need;

26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations; and noting that the impact of international trade agreements on access to or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated;

27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with

HIV and vulnerable groups; and the active promotion and protection of human rights; and recognising the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North/South, South/South cooperation and triangular cooperation;

28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;

29. Recognising the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;

30. Recognising that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;

31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;

32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organisations, people living with HIV and vulnerable groups, medical, scientific and educational institutions, non-governmental organisations, the business sector including generic and research-based pharmaceutical companies, trade unions, media, parliamentarians, foundations, community organisations, faith-based organisations and traditional leaders are important;

33. Acknowledging the particular role and significant contribution of people living with HIV, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognising that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;

34. Further acknowledging the efforts of international humanitarian organisations combating the epidemic, including among others the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;

35. Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the UNAIDS Programme Coordinating Board; noting its endorsement in December 2000 of the Global Strategy Framework for HIV/AIDS, which could assist, as appropriate, member states and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;

36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Leadership

Strong leadership at all levels of society is essential for an effective response to the epidemic

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector. Leadership involves personal commitment and concrete actions.

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that: address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalisation; involve partnerships with civil society and the business sector and the full participation of people living with

HIV, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional organisations and partners to: be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum Consensus and Plan of Action: Leadership to Overcome HIV/AIDS; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Diseases; the CARICOM Pan-Caribbean Partnership Against HIV/AIDS; the ESCAP Regional Call for Action to Fight HIV/AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; the European Union Programme for Action: Accelerated Action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction;

41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national organisations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions within their respective mandates and resources to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant United Nations system organisations, including their full participation in the development and implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in this Declaration;

45. Support greater cooperation between relevant United Nations system organisations and international organisations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors and by 2003, establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV and vulnerable groups in the fight against HIV/AIDS;

Prevention

Prevention must be the mainstay of our response.

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

48. By 2003, establish national prevention targets, recognising and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which

currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection;

49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV;

50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

51. By 2003, implement universal precautions in health care settings to prevent transmission of HIV infection;

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

Care, support and treatment

Care, support and treatment are fundamental elements of an effective response

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organisations as well as with civil society and the business sector, to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity. Also, in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen

family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psycho-social care;

57. By 2003, ensure that national strategies are developed in order to provide psycho-social care for individuals, families, and communities affected by HIV/AIDS;

HIV/AIDS and human rights

Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV drives an effective response.

58. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that globally women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

...

Follow-up

Maintaining the momentum and monitoring progress are essential.

At the national level

94. Conduct national periodic reviews involving the participation of civil society, particularly people living with HIV, vulnerable groups and caregivers, of progress achieved in realising these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV;

At the regional level

97. Include HIV/AIDS and related public health concerns as appropriate on the agenda of regional meetings at the ministerial and Head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organisations of progress in implementing regional strategies and addressing regional priorities and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in this Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual General Assembly session to review and debate a report of the Secretary-General on progress achieved in realising the commitments set out in this Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow-up issues raised in this Declaration and in this regard encourage participation in and wide dissemination of the outcomes of: the forthcoming Dakar Conference on Access to Care for HIV Infection; the Sixth International Congress on AIDS in Asia and the Pacific; the XII International Conference on AIDS and Sexually Transmitted Infections in Africa; the XIV International Conference on AIDS, Barcelona; the Xth International Conference on People Living with HIV, Port of Spain; the II Forum and III Conference of the Latin American and the Caribbean Horizontal Technical Cooperation on HIV/AIDS and Sexually Transmitted Infections, La Habana; the Vth International Conference on Home and Community Care for Persons Living with HIV, Changmai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organisations and other concerned partners, systems for voluntary monitoring and reporting of global drug prices;

We recognise and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments, and concerted efforts with full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement this Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.

A2.8 ILO Code of Practice on HIV/AIDS and the World of Work (2001)

Adopted by the ILO Governing Body in June 2001, the code is the product of collaboration between the ILO, its tripartite constituents and its international partners. The code is instrumental in helping to prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease. It covers key principles such as the recognition of HIV/AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention, care and support, as the basis for addressing the epidemic in the workplace. Full text available at www.ilo.org.

Excerpts

...

1. Objective

The objective of this code is to provide a set of guidelines to address the HIV/AIDS epidemic in the world of work and within the framework of the promotion of decent work. The guidelines cover the following key areas of action

- (a) prevention of HIV/AIDS;
- (b) management and mitigation of the impact of HIV/AIDS on the world of work;
- (c) care and support of workers infected and affected by HIV/AIDS;
- (d) elimination of stigma and discrimination on the basis of real or perceived HIV status.

2. Use

This code should be used to

- (a) develop concrete responses at enterprise, community, regional, sectoral, national and international levels;
- (b) promote processes of dialogue, consultations, negotiations and all forms of cooperation between governments, employers and workers and their representatives, occupational health personnel, specialists in HIV/AIDS issues, and all relevant stakeholders (which may include community-based and non-governmental organisations (NGOs));
- (c) give effect to its contents in consultation with the social partners: - in national laws, policies and programmes of action,
 - in workplace/enterprise agreements, and
 - in workplace policies and plans of action.

3. Scope and terms used in the code

3.1. Scope

This code applies to

- (a) all employers and workers (including applicants for work) in the public and private sectors; and
- (b) all aspects of work, formal and informal.

3.2. Terms used in the code

HIV: the Human Immunodeficiency VIRUS, a virus that weakens the body's immune system, ultimately causing AIDS.

Affected persons: persons whose lives are changed in any way by HIV/AIDS due to the broader impact of this epidemic.

AIDS: the Acquired Immunodeficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure.

Discrimination is used in this code in accordance with the definition given in the Discrimination (Employment and Occupation) Convention, 1958 (No 111), to include HIV status. It also includes discrimination on the basis of a worker's perceived HIV status, including discrimination on the ground of sexual orientation.

Persons with disabilities is used in this code in accordance with the definition given in the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (159),

namely individuals whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment.

Employer: a person or organisation employing workers under a written or verbal contract of employment which establishes the rights and duties of both parties, in accordance with national law and practice. Governments, public authorities, private enterprises and individuals may be employers.

Occupational health services (OHS) is used in this code in accordance with the description given in the Occupational Health Services Convention, 1985 (No 161), namely health services which have an essentially preventative function and which are responsible for advising the employer, as well as workers and their representatives, on the requirements for establishing and maintaining a safe and healthy working environment and work methods to facilitate optimal physical and mental health in relation to work. The OHS also provide advice on the adaptation of work to the capabilities of workers in the light of their physical and mental health.

Reasonable accommodation: any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.

Screening: measures whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication.

Sex and gender: there are both biological and social differences between men and women. The term 'sex' refers to biologically determined differences, while the term 'gender' refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by the geographical, economic and political environment.

STI: sexually transmitted infection, which includes, among others, syphilis, chancroid, chlamydia, gonorrhoea. It also includes conditions commonly known as sexually transmitted diseases (STDs).

Termination of employment has the meaning attributed in the Termination of Employment Convention, 1982 (No 158), namely dismissal at the initiative of the employer.

Universal Precautions are a simple standard of infection control practice to be used to minimise the risk of blood-borne pathogens (see full explanation in Appendix II).

Workers in informal activities (also known as informal sector): this term is described in Appendix I.

Workers' representatives, in accordance with the Workers' Representatives Convention, 1971 (No 135), are persons recognised as such by national law or practice whether they are:

- (a) trade union representatives, namely, representatives designated or elected by trade unions or by members of such unions; or
- (b) elected representatives, namely, representatives who are freely elected by the workers of the undertaking in accordance with provisions of national laws or regulations or of collective agreements and whose functions do not include activities which are recognised as the exclusive prerogative of trade unions in the country concerned.

Vulnerability refers to socio-economic disempowerment and cultural context, work situations that make workers more susceptible to the risk of infection and situations which put children at greater risk of being involved in child labour (for more detail see Appendix I).

4. Key principles

4.1. Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, and should be treated like any other serious illness/ condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a

role to play in the wider struggle to limit the spread and effects of the epidemic.

4.2. Non-discrimination

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatisation of people living with HIV inhibits efforts aimed at promoting HIV/AIDS prevention.

4.3. Gender equality

The gender dimensions of HIV/AIDS should be recognised. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

4.4. Healthy work environment

The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No 155).

A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.

4.5. Social dialogue

The successful implementation of an HIV/AIDS policy and programme requires co-operation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS.

4.6. Screening for purposes of exclusion from employment or work processes HIV/AIDS screening should not be required of job applicants or persons in employment.

4.7. Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.

4.8. Continuation of employment relationship

HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

4.9. Prevention

HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive.

Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment.

The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

4.10. Care and support

Solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to

and receipt of benefits from statutory social security programmes and occupational schemes.

5. General rights and responsibilities

5.1. Governments and their competent authorities

(a) *Coherence.* Governments should ensure coherence in national HIV/AIDS strategy and programmes, recognising the importance of including the world of work in national plans, for example by ensuring that the composition of national AIDS councils includes representatives of employers, workers, people living with HIV and of ministries responsible for labour and social matters.

(b) *Multi-sectoral participation.* The competent authorities should mobilise and support broad partnerships for protection and prevention, including public agencies, the private sector, workers' and employers' organisations, and all relevant stakeholders so that the greatest number of partners in the world of work are involved.

(c) *Coordination.* Governments should facilitate and coordinate all interventions at the national level that provide an enabling environment for world of work interventions and capitalise on the presence of the social partners and all relevant stakeholders. Coordination should build on measures and support services already in place.

(d) *Prevention and health promotion.* The competent authorities should instigate and work in partnership with other social partners to promote awareness and prevention programmes, particularly in the workplace.

(e) *Clinical guidelines.* In countries where employers assume a primary responsibility for providing direct health care services to workers, governments should offer guidelines to assist employers in the care and clinical management of HIV/AIDS. These guidelines should take account of existing services.

(f) *Social protection.* Governments should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. In designing and implementing social security programmes, governments should take into account the progressive and intermittent nature of the disease and tailor schemes accordingly, for example by making benefits available as and when needed and by the expeditious treatment of claims.

(g) *Research.* In order to achieve coherence with national AIDS plans, to mobilise the social partners, to evaluate the costs of the epidemic on workplaces, for the social security system and for the economy, and to facilitate planning to mitigate its socioeconomic impact, the competent authorities should encourage, support, carry out and publish the findings of demographic projections, incidence and prevalence studies and case studies of best practice. Governments should endeavour to provide the institutional and regulatory framework to achieve this. The research should include gender-sensitive analyses that make use of research and data from employers and their organisations and workers' organisations. Data collection should, to the extent possible, be sector-specific and disaggregated by sex, race, sexual orientation, age, employment and occupational status and be done in a culturally sensitive manner. Where possible, permanent impact assessment mechanisms should exist.

(h) *Financial resourcing.* Governments, where possible, in consultation with the social partners and other stakeholders, should estimate the financial implications of HIV/AIDS and seek to mobilise funding locally and internationally for their national AIDS strategic plans including, where relevant, for their social security systems.

(i) *Legislation.* In order to eliminate workplace discrimination and ensure workplace prevention and social protection, governments, in consultation with the social partners and experts in the field of HIV/AIDS, should provide the relevant regulatory framework and, where necessary, revise labour laws and other legislation.

(j) *Conditionalities for government support.* When governments provide start-up funding and incentives for national and international enterprises, they should require recipients to adhere to national laws and encourage recipients to adhere to this

code, and policies or codes that give effect to the provisions of this code.

(k) *Enforcement.* The competent authorities should supply technical information and advice to employers and workers concerning the most effective way of complying with legislation and regulations applicable to HIV/AIDS and the world of work.

They should strengthen enforcement structures and procedures, such as factory / labour inspectorates and labour courts and tribunals.

(l) *Workers in informal activities (also known as informal sector).* Governments should extend and adapt their HIV/AIDS prevention programmes to such workers including income generation and social protection. Governments should also design and develop new approaches using local communities where appropriate.

(m) *Mitigation.* Governments should promote care and support through public health care programmes, social security systems and/or other relevant government initiatives. Governments should also strive to ensure access to treatment and, where appropriate, to work in partnership with employers and workers' organisations.

(n) *Children and young persons.* In programmes to eliminate child labour, governments should ensure that attention is paid to the impact of the epidemic on children and young persons whose parent or parents are ill or have died as a result of HIV/AIDS.

(o) *Regional and international collaboration.* Governments should promote and support collaboration at regional and international levels, and through intergovernmental agencies and all relevant stakeholders, so as to focus international attention on HIV/AIDS and on the related needs of the world of work.

(p) *International assistance.* Governments should enlist international assistance where appropriate in support of national programmes. They should encourage initiatives aimed at supporting international campaigns to reduce the cost of, and improve access to, antiretroviral drugs.

(q) *Vulnerability.* Governments should take measures to identify groups of workers who are vulnerable to infection, and adopt strategies to overcome the factors that make these workers susceptible. Governments should also endeavour to ensure that appropriate prevention programmes are in place for these workers.

5.2. Employers and their organisations

(a) *Workplace policy.* Employers should consult with workers and their representatives to develop and implement an appropriate policy for their workplace, designed to prevent the spread of the infection and protect all workers from discrimination related to HIV/AIDS. A checklist for workplace policy planning and implementation appears in Appendix III.

(b) *National, sectoral and workplace/enterprise agreements.* Employers should adhere to national law and practice in relation to negotiating terms and conditions of employment about HIV/AIDS issues with workers and their representatives, and endeavour to include provisions on HIV/AIDS protection and prevention in national, sectoral and workplace /enterprise agreements.

(c) *Education and training.* Employers and their organisations, in consultation with workers and their representatives, should initiate and support programmes at their workplaces to inform, educate and train workers about HIV/AIDS prevention, care and support and the enterprise's policy on HIV/AIDS, including measures to reduce discrimination against people infected or affected by HIV/AIDS and specific staff benefits and entitlements.

(d) *Economic impact.* Employers, workers and their organisations, should work together to develop appropriate strategies to assess and appropriately respond to the economic impact of HIV/AIDS on their particular workplace and sector.

(e) *Personnel policies.* Employers should not engage in nor permit any personnel policy or practice that discriminates against workers infected with or affected by HIV/AIDS. In particular, employers should

- not require HIV/AIDS screening or testing unless otherwise specified in section 8 of this code;

- ensure that work is performed free of discrimination or stigmatisation based on perceived or real HIV status;
 - encourage persons with HIV and AIDS-related illnesses to work as long as medically fit for appropriate work; and
 - provide that, where a worker with an AIDS-related condition is too ill to continue to work and where alternative working arrangements including extended sick leave have been exhausted, the employment relationship may cease in accordance with anti-discrimination and labour laws and respect for general procedures and full benefits.
- (f) *Grievance and disciplinary procedures.* Employers should have procedures that can be used by workers and their representatives for work-related grievances. These procedures should specify under what circumstances disciplinary proceedings can be commenced against any employee who discriminates on the grounds of real or perceived HIV status or who violates the workplace policy on HIV/AIDS.
- (g) *Confidentiality.* HIV/AIDS-related information of workers should be kept strictly confidential and kept only on medical files, whereby access to information complies with the Occupational Health Services Recommendation, 1985 (171), and national laws and practices. Access to such information should be strictly limited to medical personnel and such information may only be disclosed if legally required or with the consent of the person concerned.
- (h) *Risk reduction and management.* Employers should ensure a safe and healthy working environment, including the application of Universal Precautions and measures such as the provision and maintenance of protective equipment and first aid. To support behavioural change by individuals, employers should also make available, where appropriate, male and female condoms, counselling, care, support and referral services. Where size and cost considerations make this difficult, employers and/or their organisations should seek support from government and other relevant institutions.
- (i) *Workplaces where workers come into regular contact with human blood and body fluids.* In such workplaces, employers need to take additional measures to ensure that all workers are trained in Universal Precautions, that they are knowledgeable about procedures to be followed in the event of an occupational incident and that Universal Precautions are always observed. Facilities should be provided for these measures.
- (j) *Reasonable accommodation.* Employers, in consultation with the worker(s) and their representatives, should take measures to reasonably accommodate the worker(s) with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements.
- (k) *Advocacy.* In the spirit of good corporate citizenship, employers and their organisations should, where appropriate, encourage fellow employers to contribute to the prevention and management of HIV/AIDS in the workplace, and encourage governments to take all necessary action to stop the spread of HIV/AIDS and mitigate its effects. Other partnerships can support this process such as joint business trade union councils on HIV/AIDS.
- (l) *Support for confidential voluntary HIV counselling and testing.* Employers, workers and their representatives should encourage support for, and access to, confidential voluntary counselling and testing that is provided by qualified health services.
- (m) *Workers in informal activities (also known as informal sector).* Employers of workers in informal activities should investigate and, where appropriate, develop prevention and care programmes for these workers.
- (n) *International partnerships.* Employers and their organisations should contribute, where appropriate, to international partnerships in the fight against HIV/AIDS.

5.3. Workers and their organisations

- (a) *Workplace policy.* Workers and their representatives should consult with their employers on the implementation of an appropriate policy for their workplace, designed to prevent the spread of the infection

and protect all workers from discrimination related to HIV/AIDS. A checklist for workplace policy planning and implementation appears in Appendix III.

(b) *National, sectoral and workplace/enterprise agreements.* Workers and their organisations should adhere to national law and practice when negotiating terms and conditions of employment relating to HIV/AIDS issues, and endeavour to include provisions on HIV/AIDS protection and prevention in national, sectoral and workplace enterprise agreements.

(c) *Information and education.* Workers and their organisations should use existing union structures and other structures and facilities to provide information on HIV/AIDS in the workplace, and develop educational materials and activities appropriate for workers and their families, including regularly updated information on workers' rights and benefits.

(d) *Economic impact.* Workers and their organisations should work together with employers to develop appropriate strategies to assess and appropriately respond to the economic impact of HIV/AIDS in their particular workplace and sector.

(e) *Advocacy.* Workers and their organisations should work with employers, their organisations and governments to raise awareness of HIV/AIDS prevention and management.

(f) *Personnel policies.* Workers and their representatives should support and encourage employers in creating and implementing personnel policy and practices that do not discriminate against workers with HIV/AIDS.

(g) *Monitoring of compliance.* Workers' representatives have the right to take up issues at their workplaces through grievance and disciplinary procedures and/or should report all discrimination on the basis of HIV/AIDS to the appropriate legal authorities.

(h) *Training.* Workers' organisations should develop and carry out training courses for their representatives on workplace issues raised by the epidemic, on appropriate responses, and on the general needs of people living with HIV and their carers.

(i) *Risk reduction and management.* Workers and their organisations should advocate for, and cooperate with, employers to maintain a safe and healthy working environment, including the correct application and maintenance of protective equipment and first aid. Workers and their organisations should assess the vulnerability of the working environment and promote tailored programmes for workers as appropriate.

(j) *Confidentiality.* Workers have the right to access their own personal and medical files. Workers' organisations should not have access to personnel data relating to a worker's HIV status. In all cases, when carrying out trade union responsibilities and functions, the rules of confidentiality and the requirement for the concerned person's consent set out in the Occupational Health Services Recommendation, 1985 (No 171), should apply.

(k) *Workers in informal activities (also known as informal sector).* Workers and their organisations should extend their activities to these workers in partnership with all other relevant stakeholders, where appropriate, and support new initiatives which help both prevent the spread of HIV/AIDS and mitigate its impact.

(l) *Vulnerability.* Workers and their organisations should ensure that factors that increase the risk of infection for certain groups of workers are addressed in consultation with employers.

(m) *Support for confidential voluntary HIV counselling and testing.* Workers and their organisations should work with employers to encourage and support access to confidential voluntary counselling and testing.

(n) *International partnerships.* Workers' organisations should build solidarity across national borders by using sectoral, regional and international groupings to highlight HIV/AIDS and the world of work, and to include it in workers' rights campaigns.

...

8. Testing

Testing for HIV should not be carried out at the workplace except as specified in this code. It is unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts

and implications of testing. Even outside the workplace, confidential testing for HIV should be the consequence of voluntary informed consent and performed by suitably qualified personnel only, in conditions of the strictest confidentiality.

8.1. Prohibition in recruitment and employment

HIV testing should not be required at the time of recruitment or as a condition of continued employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing.

8.2. Prohibition for insurance purposes

(a) HIV testing should not be required as a condition of eligibility for national social security schemes, general insurance policies, occupational schemes and health insurance.

(b) Insurance companies should not require HIV testing before agreeing to provide coverage for a given workplace. They may base their cost and revenue estimates and their actuarial calculations on available epidemiological data for the general population.

(c) Employers should not facilitate any testing for insurance purposes and all information that they already have should remain confidential.

8.3. Epidemiological surveillance

Anonymous, unlinked surveillance or epidemiological HIV testing in the workplace may occur provided it is undertaken in accordance with the ethical principles of scientific research, professional ethics and the protection of individual rights and confidentiality. Where such research is done, workers and employers should be consulted and informed that it is occurring. The information obtained may not be used to discriminate against individuals or groups of persons. Testing will not be considered anonymous if there is a reasonable possibility that a person's HIV status can be deduced from the results.

8.4. Voluntary testing

There may be situations where workers wish at their own initiative to be tested including as part of voluntary testing programmes. Voluntary testing should normally be carried out by the community health services and not at the workplace. Where adequate medical services exist, voluntary testing may be undertaken at the request and with the written informed consent of a worker, with advice from the workers' representative if so requested. It should be performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements. Gender-sensitive pre- and post-test counselling, which facilitates an understanding of the nature and purpose of the HIV tests, the advantages and disadvantages of the tests and the effect of the result upon the worker, should form an essential part of any testing procedure.

...

9.7. Privacy and confidentiality

(a) Governments, private insurance companies and employers should ensure that information relating to counselling, care, treatment and receipt of benefits is kept confidential, as with medical data pertinent to workers, and accessed only in accordance with the Occupational Health Services Recommendation, 1985 (171).

(b) Third parties, such as trustees and administrators of social security programmes and occupational schemes, should keep all HIV/AIDS-related information confidential, as with medical data pertinent to workers, in accordance with the ILO's code of practice on the protection of workers' personal data.

A2.9 International Guidelines on HIV/AIDS and Human Rights (2002)

Issued by the Office of the High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1998. These Guidelines are based on expert advice and integrate the principles and standards of international human rights law into the HIV/AIDS response. The Guidelines were revised in 2002 to reflect new standards in HIV-related treatment and evolving international law norms on the right to health. Full text available at www.unaids.org.

Excerpts

...

Guideline 1: States should establish an effective national framework for their response to HIV/AIDS, which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

Guideline 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

Guideline 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

Guideline 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

Guideline 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.

Guideline 6 [as revised in 2002]: States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of equality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

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 should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

Guideline 7: States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilise means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

Guideline 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by

addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Guideline 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance.

Guideline 10: States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

Guideline 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

Guideline 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

A2.10 Political Declaration on HIV/AIDS (2006)

Adopted by the General Assembly after a review of the progress achieved in realising the targets set out in the Declaration of Commitment on HIV/AIDS, held on 31 May and 1 June 2006, and the High-Level meeting, held on 2 June 2006. Full text available at www.unaids.org.

Excerpts

18. Reaffirm our commitment to implement fully the Declaration of Commitment on HIV/AIDS, entitled 'Global Crisis – Global Action', adopted by the General Assembly at its twenty-sixth special session, in 2001; and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases, the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development;

19. Recognise the importance, and encourage the implementation, of the recommendations of the inclusive, country-driven processes and regional consultations facilitated by the Secretariat and the Co-sponsors of the Joint United Nations Programme on HIV/AIDS for scaling up HIV prevention, treatment, care and support, and strongly recommend that this approach be continued;

20. Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

21. Emphasise the need to strengthen policy and programme linkages and coordination between HIV/AIDS, sexual and reproductive health, national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of HIV/AIDS on national development plans and strategies;

22. Reaffirm that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic, and therefore commit ourselves to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections;

23. Reaffirm also that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the pandemic;

24. Commit ourselves to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

25. Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status;

26. Commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services;

27. Commit ourselves also to ensuring that pregnant women have access to antenatal care, information, counselling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counselling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

28. Resolve to integrate food and nutritional support, with the goal that all people at all times will have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences, for an active and healthy life, as part of a comprehensive response to HIV/AIDS;

29. Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic;

30. Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; and take all necessary measures to create an enabling

environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality;

31. Commit ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

32. Commit ourselves also to addressing as a priority the vulnerabilities faced by children affected by and living with HIV; providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them;

33. Emphasise the need for accelerated scale-up of collaborative activities on tuberculosis and HIV, in line with the Global Plan to Stop TB 2006–2015, and for investment in new drugs, diagnostics and vaccines that are appropriate for people with TB-HIV co-infection;

34. Commit ourselves to expanding to the greatest extent possible, supported by international cooperation and partnership, our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems, including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, hepatitis C, sexually transmitted infections, nutrition, children affected, orphaned or made vulnerable by HIV/AIDS, as well as formal and informal education;

35. Undertake to reinforce, adopt and implement, where needed, national plans and strategies, supported by international cooperation and partnership, to increase the capacity of human resources for health to meet the urgent need for the training and retention of a broad range of health workers, including community-based health workers; improve training and management and working conditions, including treatment for health workers; and effectively govern the recruitment, retention and deployment of new and existing health workers to mount a more effective HIV/AIDS response;

36. Commit ourselves, invite international financial institutions and the Global Fund to Fight AIDS, tuberculosis and malaria, according to its policy framework, and encourage other donors, to provide additional resources to low- and middle-income countries for the strengthening of HIV/AIDS programmes and health systems and for addressing human resources gaps, including the development of alternative and simplified service delivery models and the expansion of the community-level provision of HIV/AIDS prevention, treatment, care and support, as well as other health and social services;

37. Reiterate the need for Governments, United Nations agencies, regional and international organisations and non-governmental organisations involved with the provision and delivery of assistance to countries and regions affected by conflicts, humanitarian emergencies or natural disasters to incorporate HIV/AIDS prevention, care and treatment elements into their plans and programmes;

38. Pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities;

39. Commit ourselves to reducing the global HIV/AIDS resource gap through greater domestic and international funding to enable

countries to have access to predictable and sustainable financial resources and ensuring that international funding is aligned with national HIV/AIDS plans and strategies; and in this regard welcome the increased resources that are being made available through bilateral and multilateral initiatives, as well as those that will become available as a result of the establishment of timetables by many developed countries to achieve the targets of 0.7 per cent of gross national product for official development assistance by 2015 and to reach at least 0.5 per cent of gross national product for official development assistance by 2010 as well as, pursuant to the Brussels Programme of Action for the Least Developed Countries for the Decade 2001–2010, 0.15 per cent to 0.20 per cent for the least developed countries no later than 2010, and urge those developed countries that have not yet done so to make concrete efforts in this regard in accordance with their commitments;

40. Recognise that the Joint United Nations Programme on HIV/AIDS has estimated that 20 to 23 billion United States dollars per annum is needed by 2010 to support rapidly scaled-up AIDS responses in low- and middle-income countries, and therefore commit ourselves to taking measures to ensure that new and additional resources are made available from donor countries and also from national budgets and other national sources;

41. Commit ourselves to supporting and strengthening existing financial mechanisms, including the Global Fund to Fight AIDS, tuberculosis and malaria, as well as relevant United Nations organisations, through the provision of funds in a sustained manner, while continuing to develop innovative sources of financing, as well as pursuing other efforts, aimed at generating additional funds;

42. Commit ourselves also to finding appropriate solutions to overcome barriers in pricing, tariffs and trade agreements, and to making improvements to legislation, regulatory policy, procurement and supply chain management in order to accelerate and intensify access to affordable and quality HIV/AIDS prevention products, diagnostics, medicines and treatment commodities;

43. Reaffirm that the World Trade Organisation's Agreement on Trade-Related Aspects of Intellectual Property Rights does not and should not prevent members from taking measures now and in the future to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, reaffirm that the Agreement can and should be interpreted and implemented in a manner supportive of the right to protect public health and, in particular, to promote access to medicines for all including the production of generic antiretroviral drugs and other essential drugs for AIDS-related infections. In this connection, we reaffirm the right to use, to the full, the provisions in the TRIPS Agreement, the Doha Declaration on the TRIPS Agreement and Public Health and the World Trade Organisation's General Council Decision of 2003 and amendments to article 31, which provide flexibilities for this purpose;

44. Resolve to assist developing countries to enable them to employ the flexibilities outlined in the TRIPS Agreement, and to strengthen their capacities for this purpose;

45. Commit ourselves to intensifying investment in and efforts towards the research and development of new, safe and affordable HIV/AIDS-related medicines, products and technologies, such as vaccines, female-controlled methods and microbicides, paediatric antiretroviral formulations, including through such mechanisms as Advance Market Commitments, and to encouraging increased investment in HIV/AIDS-related research and development in traditional medicine;

46. Encourage pharmaceutical companies, donors, multilateral organisations and other partners to develop public-private partnerships in support of research and development and technology transfer, and in the comprehensive response to HIV/AIDS;

47. Encourage bilateral, regional and international efforts to promote bulk procurement, price negotiations and licensing to lower prices for HIV prevention products, diagnostics, medicines and treatment commodities, while recognising that intellectual property protection is important for the development

of new medicines and recognising the concerns about its effects on prices;

48. Recognise the initiative by a group of countries, such as the International Drug Purchase Facility, based on innovative financing mechanisms that aim to provide further drug access at affordable prices to developing countries on a sustainable and predictable basis;

49. Commit ourselves to setting, in 2006, through inclusive, transparent processes, ambitious national targets, including interim targets for 2008 in accordance with the core indicators recommended by the Joint United Nations Programme on HIV/AIDS, that reflect the commitment of the present Declaration and the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010, and to setting up and maintaining sound and rigorous monitoring and evaluation frameworks within their HIV/AIDS strategies;

50. Call upon the Joint United Nations Programme on HIV/AIDS, including its Co-sponsors, to assist national efforts to coordinate the AIDS response, as elaborated in the 'Three Ones' principles and in line with the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors; assist national and regional efforts to monitor and report on efforts to achieve the targets set out above; and strengthen global coordination on HIV/AIDS, including through the thematic sessions of the Programme Coordinating Board;

51. Call upon Governments, national parliaments, donors, regional and sub-regional organisations, organisations of the United Nations system, the Global Fund to Fight AIDS, tuberculosis and malaria, civil society, people living with HIV, vulnerable groups, the private sector, communities most affected by HIV/AIDS and other stakeholders to work closely together to achieve the targets set out above, and to ensure accountability and transparency at all levels through participatory reviews of responses to HIV/AIDS;

52. Request the Secretary-General of the United Nations, with the support of the Joint United Nations Programme on HIV/AIDS, to include in his annual report to the General Assembly on the status of implementation of the Declaration of Commitment on HIV/AIDS, in accordance with General Assembly resolution S-26/2 of 27 June 2001, the progress achieved in realising the commitments set out in the present Declaration;

53. Decide to undertake comprehensive reviews in 2008 and 2011, within the annual reviews of the General Assembly, of the progress achieved in realising the Declaration of Commitment on HIV/AIDS, entitled 'Global Crisis – Global Action', adopted by the General Assembly at its twenty-sixth special session, and the present Declaration.

A 3 WTO documents

A3.1 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) (1994)

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) is an international agreement administered by the World Trade Organisation (WTO) that sets minimum standards for many forms of intellectual property (IP) regulations. The TRIPS Agreement is Annex 1C of the Marrakesh Agreement Establishing WTO, signed in Marrakesh, Morocco on 15 April 1994. Full text available at www.wto.org.

Excerpts

...

Article 4: Most-favoured-nation treatment

With regard to the protection of intellectual property, any advantage, favour, privilege or immunity granted by a Member to the nationals of any other country shall be accorded immediately and unconditionally to the nationals of all other Members.

...

Article 7: Objectives

The protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations.

Article 8: Principles

1. Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.

...

Article 27: Patentable subject matter

...

2. Members may exclude from patentability inventions, the prevention within their territory of the commercial exploitation of which is necessary to protect ordre public or morality, including to protect human, animal or plant life or health or to avoid serious prejudice to the environment, provided that such exclusion is not made merely because the exploitation is prohibited by their law.

3. Members may also exclude from patentability diagnostic, therapeutic and surgical methods for the treatment of humans or animals;

...

Article 28: Rights conferred

Patent owners shall also have the right to assign, or transfer by succession, the patent and to conclude licensing contracts.

...

Article 30: Exceptions to rights conferred

Members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties.

Article 31: Other use without authorisation of the right holder

Where the law of a Member allows for other use of the subject matter of a patent without the authorisation of the right holder, including use by the government or third parties authorised by the government, the following provisions shall be respected:

- (a) authorisation of such use shall be considered on its individual merits;
- (b) such use may only be permitted if, prior to such use, the proposed user has made efforts to obtain authorisation from the right holder on reasonable commercial terms and conditions and that such efforts have not been successful within a reasonable period of time. This requirement may be waived by a Member in the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use. In situations of national emergency or other circumstances of extreme urgency, the right holder shall, nevertheless, be notified as soon as reasonably practicable. In the case of public non-commercial use, where the government or contractor, without making a patent search, knows or has demonstrable grounds to know that a valid patent is or will be used by or for the government, the right holder shall be informed promptly;
- (c) the scope and duration of such use shall be limited to the purpose for which it was authorised, and in the case of semiconductor technology shall only be for public non-commercial use or to remedy a practice determined after judicial or administrative process to be anti-competitive;
- (d) such use shall be non-exclusive;
- (e) such use shall be non-assignable, except with that part of the enterprise or goodwill which enjoys such use;
- (f) any such use shall be authorised predominantly for the supply of the domestic market of the Member authorising such use;
- (g) authorisation for such use shall be liable, subject to adequate protection of the legitimate interests of the persons so authorised, to be terminated if and when the circumstances which led to it cease to exist and are unlikely to recur. The competent authority shall have the authority to review, upon motivated request, the continued existence of these circumstances;
- (h) the right holder shall be paid adequate remuneration in the circumstances of each case, taking into account the economic value of the authorisation;
- (i) the legal validity of any decision relating to the authorisation of such use shall be subject to judicial review or other independent review by a distinct higher authority in that Member;
- (j) any decision relating to the remuneration provided in respect of such use shall be subject to judicial review or other independent review by a distinct higher authority in that Member;
- (k) Members are not obliged to apply the conditions set forth in subparagraphs b and f where such use is permitted to remedy a practice determined after judicial or administrative process to be anti-competitive. The need to correct anti-competitive practices may be taken into account in determining the amount of remuneration in such cases. Competent authorities shall have the authority to refuse termination of authorisation if and when the conditions which led to such authorisation are likely to recur;
- (l) where such use is authorised to permit the exploitation of a patent ('the second patent') which cannot be exploited without infringing another patent ('the first patent'), the following additional conditions shall apply
 - (i) the invention claimed in the second patent shall involve an important technical advance of considerable economic significance in relation to the invention claimed in the first patent;
 - (ii) the owner of the first patent shall be entitled to a cross-licence on reasonable terms to use the invention claimed in the second patent; and the use authorised in respect of the first patent shall be non assignable except with the assignment of the second patent.

...

Article 65: Transitional arrangements

1. Subject to the provisions of paragraphs 2, 3 and 4, no Member shall be obliged to apply the provisions of this Agreement before the expiry of a general period of one year following the date of entry into force of the WTO Agreement.

2. A developing country Member is entitled to delay for a further period of four years the date of application, as defined in paragraph 1, of the provisions of this Agreement other than articles 3, 4 and 5.

3. Any other Member which is in the process of transformation from a centrally-planned into a market, free-enterprise economy and which is undertaking structural reform of its intellectual property system and facing special problems in the preparation and implementation of intellectual property laws and regulations, may also benefit from a period of delay as foreseen in paragraph 2.

4. To the extent that a developing country Member is obliged by this Agreement to extend product patent protection to areas of technology not so protectable in its territory on the general date of application of this Agreement for that Member, as defined in paragraph 2, it may delay the application of the provisions on product patents of section 5 of Part II to such areas of technology for an additional period of five years.

...

Article 66: Least-developed country members

1. In view of the special needs and requirements of least-developed country Members, their economic, financial and administrative constraints, and their need for flexibility to create a viable technological base, such Members shall not be required to apply the provisions of this Agreement, other than articles 3, 4 and 5, for a period of 10 years from the date of application as defined under paragraph 1 of article 65. The Council for TRIPS shall, upon duly motivated request by a least-developed country Member, accord extensions of this period.

2. Developed country Members shall provide incentives to enterprises and institutions in their territories for the purpose of promoting and encouraging technology transfer to least-developed country Members in order to enable them to create a sound and viable technological base.

Article 67: Technical cooperation

In order to facilitate the implementation of this Agreement, developed country Members shall provide, on request and on mutually agreed terms and conditions, technical and financial cooperation in favour of developing and least-developed country Members. Such cooperation shall include assistance in the preparation of laws and regulations on the protection and enforcement of intellectual property rights as well as on the prevention of their abuse, and shall include support regarding the establishment or reinforcement of domestic offices and agencies relevant to these matters, including the training of personnel.

...

A3.2 Doha Declaration on the TRIPS Agreement and Public Health (2001)

Adopted by the WTO Ministerial Conference of November 2001 in Doha on 14 November 2001. The Doha Declaration reaffirms the flexibility of TRIPS and the possibilities for member states to circumvent patent rights for better access to essential medicines. The provisions in the Declaration allows governments to issue compulsory licenses on patents for medicines, or take other steps to protect public health. Text available at www.wto.org.

Excerpts

...

1. We recognise the gravity of the public health problems afflicting many developing and least-developed countries,

especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.

2. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.

3. We recognise that intellectual property protection is important for the development of new medicines. We also recognise the concerns about its effects on prices.

4. We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.

In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognise that these flexibilities include

In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.

Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of articles 3 and 4.

6. We recognise that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.

7. We reaffirm the commitment of developed-country Members to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country Members pursuant to article 66(2). We also agree that the least-developed country Members will not be obliged, with respect to pharmaceutical products, to implement or apply sections 5 and 7 of Part II of the TRIPS Agreement or to enforce rights provided for under these sections until 1 January 2016, without prejudice to the right of least-developed country Members to seek other extensions of the transition periods as provided for in article 66(1) of the TRIPS Agreement. We instruct the Council for TRIPS to take the necessary action to give effect to this pursuant to article 66(1) of the TRIPS Agreement.

A3.3 Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (2003)

Decision of WTO member governments made on 30 August 2003 to implement paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health. The members agreed on legal changes that will make it easier for poorer countries to import cheaper generics made under compulsory licensing if they are unable to manufacture the medicines themselves. Full text available at www.wto.org.

The General Council,

Having regard to paragraphs 1, 3 and 4 of article IX of the Marrakesh Agreement Establishing the World Trade Organisation ('the WTO Agreement');

Conducting the functions of the Ministerial Conference in the interval between meetings pursuant to paragraph 2 of article IV of the WTO Agreement;

Noting the Declaration on the TRIPS Agreement and Public Health (WT/MIN(01)/DEC/2) (the 'Declaration') and, in particular, the instruction of the Ministerial Conference to the Council for TRIPS contained in paragraph 6 of the Declaration to find an expeditious solution to the problem of the difficulties that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face in making effective use of compulsory licensing under the TRIPS Agreement and to report to the General Council before the end of 2002;

Recognising, where eligible importing Members seek to obtain supplies under the system set out in this Decision, the importance of a rapid response to those needs consistent with the provisions of this Decision;

Noting that, in the light of the foregoing, exceptional circumstances exist justifying waivers from the obligations set out in paragraphs f and h of article 31 of the TRIPS Agreement with respect to pharmaceutical products;

DECIDES as follows

1. For the purposes of this Decision

(a) 'pharmaceutical product' means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognised in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included;

(b) 'eligible importing Member' means any least-developed country Member, and any other Member that has made a notification to the Council for TRIPS of its intention to use the system as an importer, it being understood that a Member may notify at any time that it will use the system in whole or in a limited way, for example only in the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use. It is noted that some Members will not use the system set out in this Decision as importing Members and that some other Members have stated that, if they use the system, it would be in no more than situations of national emergency or other circumstances of extreme urgency;

(c) 'exporting Member' means a Member using the system set out in this Decision to produce pharmaceutical products for, and export them to, an eligible importing Member.

2. The obligations of an exporting Member under article 31(f) of the TRIPS Agreement shall be waived with respect to the grant by it of a compulsory licence to the extent necessary for the purposes of production of a pharmaceutical product(s) and its export to an eligible importing Member(s) in accordance with the terms set out below in this paragraph

(a) the eligible importing Member(s) has made a notification to the Council for TRIPS, that

(i) specifies the names and expected quantities of the product(s) needed;

(ii) confirms that the eligible importing Member in question, other than a least developed country Member, has established that it has insufficient or no manufacturing capacities in the pharmaceutical sector for the product(s) in question in one of the ways set out in the Annex to this Decision; and

(iii) confirms that, where a pharmaceutical product is patented in its territory, it has granted or intends to grant a compulsory licence in accordance with article 31 of the TRIPS Agreement and the provisions of this Decision;

(b) the compulsory licence issued by the exporting Member under this Decision shall contain the following conditions

(i) only the amount necessary to meet the needs of the eligible importing Member(s) may be manufactured under the licence and the entirety of this production shall be exported to the Member(s) which has notified its needs to the Council for TRIPS;

(ii) products produced under the licence shall be clearly identified as being produced under the system set out in this Decision through specific labelling or marking. Suppliers should distinguish such products through special packaging and/or special colouring/shaping of the products themselves, provided that such distinction is feasible and does not have a significant impact on price; and

(iii) before shipment begins, the licensee shall post on a website the following information

- the quantities being supplied to each destination as referred to in indent (i) above; and
- the distinguishing features of the product(s) referred to in indent (ii) above;

(c) the exporting Member shall notify the Council for TRIPS of the grant of the licence, including the conditions attached to it. The information provided shall include the name and address of the licensee, the product(s) for which the licence has been granted, the quantity(ies) for which it has been granted, the country(ies) to which the product(s) is (are) to be supplied and the duration of the licence. The notification shall also indicate the address of the website referred to in subparagraph b(iii) above.

3. Where a compulsory licence is granted by an exporting Member under the system set out in this Decision, adequate remuneration pursuant to article 31(h) of the TRIPS Agreement shall be paid in that Member taking into account the economic value to the importing Member of the use that has been authorised in the exporting Member. Where a compulsory licence is granted for the same products in the eligible importing Member, the obligation of that Member under article 31(h) shall be waived in respect of those products for which remuneration in accordance with the first sentence of this paragraph is paid in the exporting Member.

4. In order to ensure that the products imported under the system set out in this Decision are used for the public health purposes underlying their importation, eligible importing Members shall take reasonable measures within their means, proportionate to their administrative capacities and to the risk of trade diversion to prevent re-exportation of the products that have actually been imported into their territories under the system. In the event that an eligible importing Member that is a developing country Member or a least-developed country Member experiences difficulty in implementing this provision, developed country Members shall provide, on request and on mutually agreed terms and conditions, technical and financial cooperation in order to facilitate its implementation.

5. Members shall ensure the availability of effective legal means to prevent the importation into, and sale in, their territories of products produced under the system set out in this Decision and diverted to their markets inconsistently with its provisions, using the means already required to be available under the TRIPS Agreement. If any Member considers that such measures are proving insufficient for this purpose, the matter may be reviewed in the Council for TRIPS at the request of that Member.

6. With a view to harnessing economies of scale for the purposes of enhancing purchasing power for, and facilitating the local production of, pharmaceutical products

(i) where a developing or least-developed country WTO Member is a party to a regional trade agreement within the meaning of article XXIV of the GATT 1994 and the Decision of 28 November 1979 on Differential and More Favourable Treatment Reciprocity and Fuller Participation of Developing Countries (L/4903), at least half of the current membership of which is made up of countries presently on the United Nations list of least developed countries, the obligation of that Member under article 31(f) of the TRIPS Agreement shall be waived to the extent necessary to enable a pharmaceutical product produced or imported under a compulsory licence in that Member to be exported to the markets of those other developing or least developed country parties to the regional trade agreement that share the health problem in question. It is understood that this will not prejudice the territorial nature of the patent rights in question;

(ii) it is recognised that the development of systems providing for the grant of regional patents to be applicable in the above Members should be promoted. To this end, developed country Members undertake to provide technical cooperation in accordance with article 67 of the TRIPS Agreement, including in conjunction with other relevant intergovernmental organisations.

7. Members recognise the desirability of promoting the transfer of technology and capacity building in the pharmaceutical sector in order to overcome the problem identified in paragraph 6 of the Declaration. To this end, eligible importing Members and exporting Members are encouraged to use the system set out in this Decision in a way which would promote this objective. Members undertake to cooperate in paying special attention to the transfer of technology and capacity building in the pharmaceutical sector in the work to be undertaken pursuant to article 66(2) of the TRIPS Agreement, paragraph 7 of the Declaration and any other relevant work of the Council for TRIPS.

8. The Council for TRIPS shall review annually the functioning of the system set out in this Decision with a view to ensuring its effective operation and shall annually report on its operation to the General Council. This review shall be deemed to fulfil the review requirements of article IX:4 of the WTO Agreement.

9. This Decision is without prejudice to the rights, obligations and flexibilities that Members have under the provisions of the TRIPS Agreement other than paragraphs f and h of article 31, including those reaffirmed by the Declaration, and to their interpretation. It is also without prejudice to the extent to which pharmaceutical products produced under a compulsory licence can be exported under the present provisions of article 31(f) of the TRIPS Agreement.

10. Members shall not challenge any measures taken in conformity with the provisions of the waivers contained in this Decision under subparagraphs 1(b) and 1(c) of article XXIII of GATT 1994.

11. This Decision, including the waivers granted in it, shall terminate for each Member on the date on which an amendment to the TRIPS Agreement replacing its provisions takes effect for that Member. The TRIPS Council shall initiate by the end of 2003 work on the preparation of such an amendment with a view to its adoption within six months, on the understanding that the amendment will be based, where appropriate, on this Decision and on the further understanding that it will not be part of the negotiations referred to in paragraph 45 of the Doha Ministerial Declaration (WT/MIN(01)/DEC/1).

B REGIONAL DOCUMENTS

- B1 AU treaties**
- B2 AU declarations and similar documents**
- B3 ACHPR concluding observations and resolutions**
- B4 New Partnership for Africa's Development (NEPAD)**

B 1 AU treaties

B1.1 Constitutive Act of the African Union (2000/2001)

Adopted in Lomé, Togo on 11 July 2000 and entered into force on 26 May 2001. Full text available at www.africa-union.org.

Excerpts

...

Article 3: Objectives

The objectives of the Union shall be to

...

(h) promote and protect human and peoples' rights in accordance with the African Charter on Human and Peoples' Rights and other relevant human rights instruments;

...

(n) work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent.

B1.2 African Charter on Human and Peoples' Rights (1981/1986)

Adopted in Nairobi, Kenya on 27 June 1981 and entered into force on 21 October 1986. Full text available at www.africa-union.org.

Excerpts

...

PART I – Rights and duties

CHAPTER I – Human and peoples' rights

Article 1

The member states of the Organization of African Unity parties to the present Charter shall recognise the rights, duties and freedoms enshrined in this Chapter and shall undertake to adopt legislative or other measures to give effect to them.

Article 2

Every 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, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.

Article 3

1. Every individual shall be equal before the law.
2. Every individual shall be entitled to equal protection of the law.

Article 4

Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.

Article 5

Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

Article 6

Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

...

Article 9

1. Every individual shall have the right to receive information.
2. Every individual shall have the right to express and disseminate his opinions within the law.

...

Article 12

1. Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
2. Every individual shall have the right to leave any country including his own, and to return to his country. This right may only be subject to restrictions, provided for by law for the protection of national security, law and order, public health or morality.
3. Every individual shall have the right, when persecuted, to seek and obtain asylum in other countries in accordance with laws of those countries and international conventions.
4. A non-national legally admitted in a territory of a state party to the present Charter, may only be expelled from it by virtue of a decision taken in accordance with the law.
5. The mass expulsion of non-nationals shall be prohibited. Mass expulsion shall be that which is aimed at national, racial, ethnic or religious groups.

...

Article 14

The right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws.

Article 15

Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.

Article 16

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

2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 17

1. Every individual shall have the right to education.
2. Every individual may freely, take part in the cultural life of his community.
3. The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State.

...

Article 19

All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.

...

Article 25

States parties to the present Charter shall have the duty to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that these freedoms and rights as well as corresponding obligations and duties are understood.

CHAPTER II – Duties

...

Article 28

Every individual shall have the duty to respect and consider his fellow beings without discrimination, and to maintain relations aimed at promoting, safeguarding and reinforcing mutual respect and tolerance.

...

PART II: Measures of safeguard

CHAPTER I – Establishment and organisation of the African Commission on Human and Peoples' Rights

Article 30

An African Commission on Human and Peoples' Rights, hereinafter called 'the Commission', shall be established within the Organization of African Unity to promote human and peoples' rights and ensure their protection in Africa.

...

Article 62

Each state party shall undertake to submit every two years, from the date the present Charter comes into force, a report on the legislative or other measures taken with a view to giving effect to the rights and freedoms recognised and guaranteed by the present Charter.

...

B1.3 Protocol to the African Charter on the Rights of Women in Africa (2003/2005)

Adopted in Maputo, Mozambique in July 2003 and entered into force in November 2005. Full text available at www.africa-union.org.

Excerpts

...

Article 1: Definitions

For the purpose of the present Protocol

- (a) 'African Charter' means the African Charter on Human and Peoples' Rights;
- (b) 'African Commission' means the African Commission on Human and Peoples' Rights;
- (c) 'Assembly' means the Assembly of Heads of State and Government of the African Union
- (d) 'AU' means the African Union;
- (e) 'Constitutive Act' means the Constitutive Act of the African Union;
- (f) 'Discrimination against women' means any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life;
- (g) 'Harmful Practices' means all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity;
- (h) 'NEPAD' means the New Partnership for Africa's Development established by the Assembly;
- (i) 'States parties' means the states parties to this protocol;
- (j) 'Violence against women' means all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war;
- (k) 'Women' means persons of female gender, including girls;

Article 2: Elimination of discrimination against women

1. States parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard they shall

- (a) include in their national constitutions and other legislative instruments, if not already done, the principle of equality between women and men and ensure its effective application;
 - (b) enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women;
 - (c) integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life;
 - (d) take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist;
 - (e) support the local, national, regional and continental Initiatives directed at eradicating all forms of discrimination against women.
2. States parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.

Article 3: Right to dignity

1. Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights;
2. Every woman shall have the right to respect as a person and to the free development of her personality;
3. States parties shall adopt and implement appropriate measures to prohibit any exploitation or degradation of women;
4. States parties shall adopt and implement appropriate measures to ensure the protection of every woman's right to

respect for her dignity, and protection of women from all forms of violence, particularly sexual and verbal violence.

Article 4: The Rights to life, integrity and security of the person

1. Every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.

2. States parties shall take appropriate and effective measures to (a) enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;

(b) adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;

(c) identify the causes and consequences of violence against women and take appropriate measures to prevent and climate such violence;

...

(h) prohibit all medical or scientific experiments on women without their informed consent;

(i) provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women;

...

Article 5: Elimination of harmful practices

States parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States parties shall take all necessary legislative and other measures to eliminate such practices.

...

Article 6: Marriage

States parties shall ensure that women and men enjoy equal rights and are regarded as equal partners in marriage. They shall enact appropriate national legislative measures to guarantee that

(a) no marriage shall take place without the free and full consent of both parties;

(b) the minimum age of marriage for women shall be 18 years;

(c) monogamy is encouraged as the preferred form of marriage and that the rights of women in marriage and family, including in polygamous marital relationships are promoted and protected;

...

(i) during her marriage, a woman shall have the right to acquire her own property and to administrate and manage it freely.

...

Article 8: Access to justice and equal protection before the law

Women and men are equal before the law and shall have the right to equal protection and benefit of the law.

...

Article 13: Economic and social welfare rights

States parties shall adopt and enforce legislative and other measures to guarantee women equal opportunities in work and career advancement and other economic opportunities ...

Article 14: Health and reproductive rights

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

(a) the right to control their fertility;

(b) the right to decide whether to have children, the number of children and the spacing of children;

(c) the right to choose any method of contraception;

(d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;

(e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with international recognised standards and best practices;

...

(g) the right to have family planning education.

2. States parties shall take all appropriate measures to

(a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;

(b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding;

(c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the unborn child;

...

Article 21: Right to inheritance

1. A widow shall have the right to an equitable share in the inheritance of the property of her husband. A widow shall have the right to continue to live in the matrimonial house. In case of remarriage, she shall retain this right if the house belongs to her or she has inherited it.

2. Women and men shall have the right to inherit, in equitable shares, their parents' properties.

...

Article 26: Implementation and monitoring

1. States parties shall ensure the implementation of this Protocol at national level, and in their periodic reports submitted in accordance with article 62 of the African Charter, indicate the legislative and other measures undertaken for the full realisation of the rights herein recognised.

2. States parties undertake to adopt all necessary measures and in particular shall provide budgetary and other resources for the full and effective implementation of the rights herein recognised.

B1.4 African Charter on the Rights and Welfare of the Child (1990/1999)

Adopted in Addis Ababa, Ethiopia in 1990 and entered into force on 29 November 1999. Full text available at www.africa-union.org.

Excerpts

...

PART I: Rights and duties

CHAPTER ONE: Rights and welfare of the child

Article 1: Obligation of states parties

1. Member states of the Organization of African Unity parties to the present Charter shall recognise the rights, freedoms and duties enshrined in this Charter and shall undertake to the necessary steps, in accordance with their Constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this Charter.

...

Article 2: Definition of a child

For the purposes of this Charter a child means every human being below the age of 18 years.

Article 3: Non-discrimination

Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.

Article 4: Best interests of the child

1. In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.

2. In all judicial or administrative proceedings affecting a child who is capable of communicating his own views, and opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law.

Article 5: Survival and development

1. Every child has an inherent right to life. This right shall be protected by law.

2. States parties to the present Charter shall ensure, to the maximum extent possible, the survival, protection and development of the child.

...

Article 10: Protection of privacy

No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.

Article 11: Education

1. Every child shall have the right to an education.

2. The education of the child shall be directed to

(a) the promotion and development of the child's personality, talents and mental and physical abilities to their fullest potential;
(b) fostering respect for human rights and fundamental freedoms with particular reference to those set out in the provisions of various African instruments on human and peoples' rights and international human rights declarations and conventions;

(c) the preservation and strengthening of positive African morals, traditional values and cultures;

(d) the preparation of the child for responsible life in a free society, in the spirit of understanding tolerance, dialogue, mutual respect and friendship among all peoples ethnic, tribal and religious groups;

(e) the preservation of national independence and territorial integrity;

(f) the promotion and achievements of African Unity and Solidarity;

(g) the development of respect for the environment and natural resources;

(h) the promotion of the child's understanding of primary health care.

3. States parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular

(a) provide free and compulsory basic education;

(b) encourage the development of secondary education in its different forms and to progressively make it free and accessible to all;

(c) make the higher education accessible to all on the basis of capacity and ability by every appropriate means;

(d) take measures to encourage regular attendance at schools and the reduction of drop-out rates;

(e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.

4. States parties to the present Charter shall respect the rights and duties of parents, and where applicable, of legal guardians to choose for their children's schools, other than those established by public authorities, which conform to such minimum standards may be approved by the State, to ensure the religious and moral education of the child in a manner with the evolving capacities of the child.

...

Article 13: Handicapped children

1. Every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under conditions which ensure his dignity, promote his self-reliance and active participation in the community.

2. States parties to the present Charter shall ensure, subject to available resources, to a disabled child and to those responsible for his care, of assistance for which application is made and which is appropriate to the child's condition and in particular shall ensure that the disabled child has effective access to training, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible social integration, individual development and his cultural and moral development.

3. The states parties to the present Charter shall use their available resources with a view to achieving progressively the full convenience of the mentally and physically disabled person to movement and access to public highway buildings and other places to which the disabled may legitimately want to have access to.

Article 14: Health and health services

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.

2. States parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures

(a) to reduce infant and child mortality rate;

(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) to ensure the provision of adequate nutrition and safe drinking water;

(d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;

(e) to ensure appropriate health care for expectant and nursing mothers;

(f) to develop preventive health care and family life education and provision of service;

(g) to integrate basic health service programmes in national development plans;

(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;

(i) to ensure the meaningful participation of non-governmental organisations, local communities and the beneficiary population in the planning and management of a basic service programme for children;

(j) to support through technical and financial means, the mobilisation of local community resources in the development of primary health care for children.

...

Article 16: Protection against child abuse and torture

1. States parties to the present Charter shall take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse, while in the care of the child.

2. Protective measures under this article shall include effective procedures for the establishment of special monitoring units to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention and for identification, reporting referral investigation, treatment, and follow-up of instances of child abuse and neglect.

...

Article 19: Parent care and protection

1. Every child shall be entitled to the enjoyment of parental care and protection and shall, whenever possible, have the right to reside with his parents. No child shall be separated from his parents against his will, except when a judicial authority determines in accordance with the appropriate law, that such separation is in the best interest of the child.

2. Every child who is separated from one or both parents shall have the right to maintain personal relations and direct contact with both parents on a regular basis.

3. Where separation results from the action of a state party, the state party shall provide the child, or if appropriate, another member of the family with essential information concerning the whereabouts of the absent member or members of the family. States parties shall also ensure that the submission of such a request shall not entail any adverse consequences for the person or persons in whose respect it is made.

4. Where a child is apprehended by a state party, his parents or guardians shall, as soon as possible, be notified of such apprehension by that state party.

...

Article 21: Protection against harmful social and cultural practices

1. States parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular

(a) those customs and practices prejudicial to the health or life of the child; and

(b) those customs and practices discriminatory to the child on the grounds of sex or other status.

2. Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

...

Article 24: Adoption

States parties which recognise the system of adoption shall ensure that the best interest of the child shall be the paramount consideration and they shall

(a) establish competent authorities to determine matters of adoption and ensure that the adoption is carried out in conformity with applicable laws and procedures and on the basis of all relevant and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and guardians and that, if necessary, the appropriate persons concerned have given their informed consent to the adoption on the basis of appropriate counselling;

(b) recognise that inter-country adoption in those States who have ratified or adhered to the International Convention on the Rights of the Child or this Charter, may, as the last resort, be considered as an alternative means of a child's care, if the child

cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) ensure that the child affected by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) take all appropriate measures to ensure that in inter-country adoption, the placement does not result in trafficking or improper financial gain for those who try to adopt a child;

(e) promote, where appropriate, the objectives of this article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework to ensure that the placement of the child in another country is carried out by competent authorities or organs;

(f) establish a machinery to monitor the well-being of the adopted child.

...

Article 27: Sexual exploitation

1. States parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent

(a) the inducement, coercion or encouragement of a child to engage in any sexual activity;

(b) the use of children in prostitution or other sexual practices;

(c) the use of children in pornographic activities, performances and materials.

...

Article 29: Sale, trafficking and abduction

States parties to the present Charter shall take appropriate measures to prevent

(a) the abduction, the sale of, or traffic in children for any purpose or in any form, by any person including parents or legal guardians of the child;

(b) the use of children in all forms of begging.

...

PART II

CHAPTER TWO: Establishment and organisation of the Committee on the Rights and Welfare of the Child

Article 32: The Committee

An African Committee of Experts on the Rights and Welfare of the Child hereinafter called 'the Committee' shall be established within the Organization of African Unity to promote and protect the rights and welfare of the child.

...

Article 43: Reporting procedure

1. Every state party to the present Charter shall undertake to submit to the Committee through the Secretary-General of the Organization of African Unity, reports on the measures they have adopted which give effect to the provisions of this Charter and on the progress made in the enjoyment of these rights

(a) within two years of the entry into force of the Charter for the state party concerned; and

(b) and thereafter, *every three years*.

2. Every report made under this article shall

(a) contain sufficient information on the implementation of the present Charter to provide the Committee with comprehensive understanding of the implementation of the Charter in the relevant country; and

(b) shall indicate factors and difficulties, if any, affecting the fulfilment of the obligations contained in the Charter.

...

B 2 AU declarations and similar documents

B2.1 Tunis Declaration on AIDS and the Child in Africa (1994)

This declaration was adopted at the Thirtieth Ordinary Session of the Assembly of Heads of State and Government of the OAU held in Tunis, Tunisia from 13 to 15 June 1994. The Declaration affirms the commitment of African Heads of States and Government to implement 'appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues'. Full text available at www.chr.up.ac.za.

Excerpts

We the Heads of State and Government of the Organization of African Unity, meeting at the Thirtieth Ordinary Session of the Assembly of Heads of State and Government in Tunis, Tunisia, from 13 to 15 June, 1994.

Recognising the devastating effect facing our African people, we adopted in Dakar in 1992, Declaration AHG/Decl.1 (XXVIII) in AIDS Epidemic in Africa as an integral part of our earlier declaration AHG/Decl.3 (XXVII) on the current African Health Crisis adopted in Abuja in 1991;

In spite of the above concerted actions we resolved to undertake, the magnitude of the problem of the HIV infection and AIDS in our countries on the increase especially among the African children who are the most vulnerable section of our population. We take note that

1. Some 1 million infections occur annually in men, women and children and that by the year 2000, about twenty million Africans will be infected with the human immunodeficiency virus (HIV);
2. The acquired immunodeficiency syndrome (AIDS) causes sickness and despair, kills young and middle-aged adults, who are parents, the mainstay of the family, the backbone of the work force, and the care givers to our young;
3. Children are infected by various modes of transmission and that girls are particularly vulnerable to infection by adults through sexual intercourse;
4. The positive gains in the health status of children and women brought about by successful primary health care programmes of immunisation, and child survival efforts in most African States are being threatened and will actually be reversed by AIDS;
5. As a consequence of less-than-aggressive preventive efforts in the past millions of children will die from AIDS or be orphaned over the coming decade and will require care and supportive efforts.

II Commitment

- (a) Prevention is the key to slowing the spread of AIDS in Africa and curtailing its ultimate impact, attention should also be given to care of patients living with HIV including those with accompanying illness such as tuberculosis;
- (b) Effective national HIV/AIDS programmes require broad-based, multi-sectoral support from all sectors of government and commit ourselves to undertake the following measures to protect our African children

In the light of the foregoing we commit ourselves

1. 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.

We must recognise that an effective response to the needs of AIDS infected children requires a multidisciplinary, multi-sectoral response effectively co-ordinated to avoid duplication of effort and encourage the rational use of resources.

We must recognise that the serious effect the AIDS epidemic is having on children must be seen as a national issue, not just the concern of the communities most directly affected.

The largest group of AIDS-affected children are those whose parents have died in the epidemic. But in the hardest hit communities, nearly all children – not just those whose family members have died of AIDS – are adversely affected because of the loss of people they are close to, the trauma of watching their friends become orphaned, and the effects on the community of the loss of so many of its most productive members.

The immediate policy responses should address issues related to food and nutrition, education, nurture of parentless children, medical care for the sick as well as addressing the psychosocial problems resulting from the loss of loved ones and security.

Children who are not at present infected or affected may soon join this group as the epidemic is rapidly developing.

The various actors include concerned ministries, national and international non-governmental organisations, donor organisations and, most importantly, the communities themselves. Communities have the capacity to convert rejection into acceptance and risk-taking into risk prevention. Moreover the individual capacity to act can be reinforced by a supportive community.

2. Protect young people from HIV infection

We must recognise not only the vulnerability of young people to HIV Infection but that they provide a window of opportunity to eventually break the chain of transmission.

We must therefore encourage and develop strong prevention strategies and interventions based on, among other things, moral and ethical values of our society, appropriate sex education in schools, and as a matter of urgency plans must be drawn up to reach out-of-school youth. Furthermore, young people must be given access to reproductive health care and the knowledge and skills to avoid sexual exploitation and unprotected sex.

We must give particular attention to the prevention of transmission of infection by adults of young people, through legislation designed to regulate the age consent and by the production of measures to improve the economic status of families.

In addition, we must institute measures to prevent parenteral transmission through transfusion of infected blood or use of contaminated needles and syringes or traditional surgical manipulation made with inadequately sterilised equipment. We should intensify all efforts including social mobilisation and introduce legislation to discourage harmful traditional practices.

Furthermore, to prevent perinatal transmission we must institute unselling services to advise HIV infected women.

3. Promote and support applied research

Promote research efforts based on African experience and tradition and support institutes of research in Africa working mainly in the field of determining the magnitude and extent of HIV infection among children and women and the underlying factors relating to HIV infection in order to orient our response aimed at preventing the spread of infection and alleviating its consequences on children and women.

4. Make definite and substantial budgetary provision to meet the identified requirements for preventive programmes among children and for the care and support of those infected and/or affected by HIV/AIDS.

Recognising the socio-economic constraints to which our countries are subject and the multisectoral impact of the AIDS epidemic we shall draw on all possible resources, community, national, bilateral and international, to meet the needs of the programme.

5. Continuously monitor the epidemiological situation and the impact of the action programme and regularly evaluate its implementation in order to effect any necessary modifications or reorientation.

III We commit ourselves to follow closed the implementation of this Declaration.

B2.2 Grand Bay (Mauritius) Declaration and Plan of Action (1999)

Adopted at the end of the First OAU Ministerial Conference on Human Rights in April 1999 in Grand Bay, Mauritius. It provides an important set of recommendations which need to be taken forward in order to achieve better promotion and protection of human rights in Africa. Full text available at www.achpr.org.

Excerpts

...

1. The Ministerial Conference affirms the principle that human rights are universal, indivisible, interdependent and inter-related and urges governments, in their policies, to give parity to economic, social and cultural rights as well as civil and political rights.

2. The Conference also affirms that the right to development, the right to a generally satisfactory healthy environment and the right to national and international peace and security are universal and inalienable rights which form an integral part of fundamental human rights.

3. The Conference further affirms the interdependence of the principles of good governance, the rule of law, democracy and development.

4. The Conference recognises that the development of the rule of law, democracy and human rights calls for an independent, open, accessible and impartial judiciary, which can deliver justice promptly and at an affordable cost. To this end, such a system requires a body of professional and competent judges enjoying conducive conditions.

5. The Conference recognises that the core values on which human rights are founded, particularly (a) respect for the sanctity of life and human dignity (b) tolerance of differences, and (c) desire for liberty, order, fairness, prosperity and stability, are shared across all cultures. In this connection, integrating positive traditional and cultural values of Africa into the human rights debate will be useful in ensuring their transmission to future generations.

6. The Conference notes that women and children's rights issues remain of concern to all. The Conference, therefore, welcomes the decision to elaborate a protocol to the African Charter for the more effective protection of women's rights and calls on the OAU to convene a meeting of government experts to examine the instrument. It urges all African States to work assiduously towards the elimination of discrimination against women and the abolition of cultural practices which dehumanise or demean women and children. The Conference also recommends that States adopt measures to take the necessary measures to stop the phenomenon and use of child-soldiers and to reinforce the protection of civilian populations, particularly children in conflict situations. The Conference further recommends that States adopt measures to eradicate violence against women and children, child labour, sexual exploitation of children, trafficking in children and to protect children in conflict with the law as well as refugee children.

7. The Conference notes that the rights of people with disability and people living with HIV, in particular women and children are not always observed and urges all African States to work towards ensuring the full respect of these rights.

8. The Conference is aware that violations of human rights in Africa are caused, among others, by

- (a) Contemporary forms of slavery;
- (b) Neo-colonialism, racism and religious intolerance;
- (c) Poverty, disease, ignorance and illiteracy;
- (d) Conflicts leading to refugee outflows and internal population displacement;
- (e) Social dislocations which may arise from the implementation of certain aspects of structural adjustment programmes;

- (f) The debt problem;
- (g) Mismanagement, bad governance and corruption;
- (h) Lack of accountability in the management of public affairs;
- (i) Monopoly in the exercise of power;
- (j) Harmful traditional practices;
- (k) Lack of independence of the judiciary;
- (l) Lack of independent human rights institutions;
- (m) Lack of freedom of the press and association;
- (n) Environmental degradation;
- (o) Non-compliance with the provisions of the OAU Charter on territorial integrity and inviolability of colonial borders and the right to self-determination;
- (p) Unconstitutional changes of governments;
- (q) Terrorism;
- (r) Nepotism; and
- (s) Exploitation of ethnicity.

There is, therefore, need to adopt a multi-faceted approach to the task of eliminating the causes of human rights violations in Africa.

...

B2.3 Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)

Adopted by the Heads of State and Government of the Organization of African Unity (OAU) in April 2001, in Abuja (Nigeria) at a Special Summit specifically devoted to addressing the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. African leaders declared that AIDS is an 'emergency in the continent' and pledged to place the response to HIV at the forefront and as the highest priority issue in their respective national development plans. Full text available at www.un.org.

Excerpts

...

WE SOLEMNLY DECLARE AS FOLLOWS

22. We consider AIDS as a State of Emergency in the continent. To this end, all tariff and economic barriers to access to funding of AIDS related activities should be lifted.

23. To place the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans. To that end, WE ARE RESOLVED to consolidate the foundations for the prevention and control of the scourge of HIV/AIDS, tuberculosis and Other Related Infectious Diseases through a comprehensive multi sectoral strategy which involves all appropriate development sectors of our governments as well as a broad mobilisation of our societies at all levels, including community level organisations, civil society, NGOs, the private sector, trade unions, the media, religious organisations, schools, youth organisations, women organisations, people living with HIV organisations and individuals who care for, support and sensitise our population to the threat of HIV/AIDS and associated opportunistic infections and also to protect those not yet infected, particularly the women, children and youth through appropriate and effective prevention programmes.

24. To that effect, WE COMMIT OURSELVES TO TAKE PERSONAL RESPONSIBILITY AND PROVIDE LEADERSHIP for the activities of the National AIDS Commissions/Councils. WE THEREFORE RESOLVE to lead from the front the battle against HIV/AIDS, tuberculosis and Other Related Infectious Diseases by personally ensuring that such bodies were properly convened in mobilising our societies as a whole and providing focus for unified national policy-making and programme implementation, ensuring coordination of all sectors at all levels with a gender perspective and respect for human

rights, particularly to ensure equal rights for people living with HIV (PLHIV).

25. WE ALSO COMMIT OURSELVES TO ENSURE that leadership role is exercised by everyone in his area of responsibility in the fight against HIV/AIDS and other related diseases. WE THEREFORE ENDORSE the 'African Consensus and Plan of Action: Leadership to overcome HIV/AIDS' adopted during the Second African Development Forum on 'AIDS: The Greatest Leadership Challenge' organised by the United Nations Economic Commission for Africa (UNECA) in collaboration with the OAU, UNAIDS and ILO (Addis Ababa, 3-7 December 2000).

26. WE COMMIT OURSELVES to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilised. In addition, WE PLEDGE to set a target of allocating at least 15 per cent of our annual budget to the improvement of the health sector. WE ALSO PLEDGE to make available the necessary resources for the improvement of the comprehensive multi-sectoral response, and that an appropriate and adequate portion of this amount is put at the disposal of the National Commissions/Councils for the fight against HIV/AIDS, tuberculosis and Other Related Infectious Diseases.

27. WE REQUEST the OAU Secretariat, in collaboration with ADB, ECA, and all other partner institutions, especially WHO and UNAIDS, to assist member states in formulating a continental-wide policy for an international assistance strategy for the mobilisation of additional financial resources.

28. WE CALL UPON Donor countries to complement our resources mobilisation efforts to fight the scourge of HIV/AIDS, tuberculosis and Other Related Infectious Diseases. Bearing in mind that Africa cannot, from its weak resource base, provide the huge financial resources needed. In this regard, WE URGE those countries to, among others, fulfil the yet to be met target of 0.7 per cent of their GNP as official Development Assistance (ODA) to developing countries.

29. WE SUPPORT the creation of a Global AIDS Fund capitalised by the donor community to the tune of US \$5 - 10 billion accessible to all affected countries to enhance operationalisation of Action Plans, including accessing Anti-retroviral programmes in favour of the populations of Africa.

30. WE UNDERTAKE to mobilise all the human, material and financial resources required to provide CARE and SUPPORT and quality treatment to our populations infected with HIV, tuberculosis and Other Related Infections, and to organise meetings to evaluate the status of implementation of the objective of access to care.

31. WE RESOLVE to enact and utilise appropriate legislation and international trade regulations to ensure the availability of drugs at affordable prices and technologies for treatment, care and prevention of HIV/AIDS, tuberculosis and Other Infectious Diseases. WE ALSO RESOLVE to take immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs in health care services for accelerated improvement of the health of our populations.

32. WE COMMIT OURSELVES to explore and further develop the potential of traditional medicine and traditional health practitioners in the prevention, care and management of HIV/AIDS, tuberculosis and Other Related Infectious Diseases.

33. WE COMMIT OURSELVES to support the development of effective affordable, accessible HIV vaccine relevant to Africa. We, therefore, support 'The Africa AIDS Vaccine Programme' (AAVP), its collaborative partners, International partners and Institutions committed to the facilitation of HIV vaccine research and testing in Africa.

34. WE COMMIT OURSELVES to documenting and sharing these successful and positive experiences with a view to sustaining and scaling them up for wider coverage; mindful that there are still challenges that confront us, particularly in the area of infant feeding.

35. WE COMMIT OURSELVES to scaling up the role of education and information in the fight against HIV/AIDS in

recognition of the essential role education, in its widest sense plays as a cost-effective tool for reaching the largest number of people.

36. WE COMMIT OURSELVES to the strengthening and development of special youth programmes to ensure an AIDS - free generation.

37. WE, within the framework and spirit of our Sirte Declaration of 9 September 1999, RENEW THE MANDATE of our brothers, President Bouteflika of Algeria, President Mbeki of South Africa and President Obasanjo of Nigeria to continue discussion with our debt creditors, on our behalf, with the view to securing the total cancellation of Africa's external debt in favour of increased investment in the social sector.

38. WE ENDORSE the Abuja Declaration on HIV/AIDS, tuberculosis and Other Related Infectious Diseases; and WE PLEDGE to promote advocacy at the national, regional and international levels; and WE ALSO PLEDGE to ensure massive participation of Heads of State and Government at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS slated for 25 - 27 June 2001 so as to ensure that the session comes up with concrete and urgent decisions for the fight against HIV/AIDS in Africa including the fight against poverty and deduction of Africa's debt.

39. WE REQUEST the OAU Secretary General, in collaboration with ECA, ADB, UNAIDS, WHO, UNICEF, UNDP, ILO, UNFPA, FAO, UNESCO, UNIFEM, 10M, UNDCP and other partners, to follow-up on the implementation of the outcome of this Summit and submit a report to the Ordinary Sessions of our Assembly.

40. WE MANDATE the Government of the Federal Republic of Nigeria to submit a report on the outcome of this African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to the next Ordinary OAU Summit, which will be held in Lusaka, Zambia in July 2001.

B2.4 Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria, and Other Related Infectious Diseases (2003)

The Declaration emerged from a special session to review and debate the situation of HIV and AIDS, tuberculosis, malaria and other infectious disease in Africa at the Second Ordinary Session of the AU Assembly of Heads of State and Government from 10 to 12 July 2003. African leaders reaffirmed the commitments enshrined in the Abuja Declaration and reiterated their commitment to intensify and consolidate their efforts. Full text available at www.chr.up.ac.za.

Excerpts

...

Note that the majority of those infected with and affected by HIV/AIDS in our continent are women, children and young people; especially the poor who have limited access to effective care and support. This reflects their vulnerability particularly in societies marked by gender inequality, where the burden of care for the sick and for the children orphaned by AIDS falls overwhelmingly on women. In this connection, we recognise the need to redouble efforts in giving particular attention to women and young people's participation and access to information, life skills and services;

...

Recognise that health systems in our region need to be strengthened, adequately equipped and financed to provide quality and effective care against diseases and particularly against HIV/AIDS, TB, malaria and ORID in view of their devastating effects on society;

Reaffirm our commitment to achieving the goals we set concerning health sector financing in our States and recommit ourselves to meet the target of 15 per cent of national budget to

be allocated to health. We reiterate our readiness to mobilise more internal resources for this struggle, in partnership with the private sector, civil society and all other stakeholders. We are convinced that the scaling up of health interventions for HIV/AIDS, TB, malaria and ORID prevention, care treatment and support can significantly contribute to the overall reduction of morbidity and mortality and to the improvement of the quality of life of those infected and affected by these diseases;

...

Are Aware that provision of quality care, support and treatment to patients with HIV are important aspects of prevention and control, and require coordination and harmonisation of policies, strategies and programs to obtain maximum efficiency and cost-effectiveness. We are convinced that HIV/AIDS care, support and treatment are essential components of prevention and control and can help address the stigma and discrimination associated with this disease and thus significantly contribute to the reduction of its spread and to the survival of those infected and affected;

Recognise the urgent need to alleviate the impact of the HIV/AIDS on the lives of orphans and their long-term development prospects. In this regard, appropriate policies including legal and programmatic frameworks, as well as essential services for the most vulnerable children, should be adopted and applied at all levels. The challenge is to keep parents alive through effective treatment and prevention as a first vital step;

WE, THEREFORE, SOLEMNLY

1. REAFFIRM the commitments enshrined in the Abuja Declaration and Plan of Action on Roll Back malaria, and the Abuja Declaration and Framework Plan of Action on HIV/AIDS, TB and ORID and REITERATE our commitment to intensify and consolidate efforts for their implementation;

2. URGE the international community to honour their pledges by disbursing the funds needed to fully execute the programs for prevention, care, support and treatment of HIV/AIDS, TB, malaria and ORID, especially through the Global Fund, the World Bank Multi-country AIDS Programmes and other initiatives, including removing conditionalities associated with debt relief and others that contribute to constraining health sector spending

3. ALSO URGE the Global Fund and recipients of its funding, to work together to develop simpler and expeditious mechanisms to ensure that these large additional financial flows are quickly and easily available to institutions in Africa that can utilise them effectively in the fight against the diseases. We further urge the Global Fund, UNAIDS family and the recipient countries to work together to ensure the realisation of our common objectives;

4. EXPRESS OUR DETERMINATION to ensure that all opportunities for scaling up treatment for HIV/AIDS are pursued energetically and creatively, and in this connection, seek diverse and effective partnerships with international donors, civil society, business sector and people living with HIV, in order to extend effective care, support and treatment to the maximum number of people, particularly women, orphaned children and others made vulnerable by HIV/AIDS, in conformity with the principles of equal access and gender equity;

5. COMMIT OURSELVES to promote partnerships with the private sector and relevant UN Specialised Agencies, pharmaceutical companies and other partners to increase local and regional capacity for production and distribution of affordable generic pharmaceuticals for the management of HIV/AIDS, TB, malaria and ORID - the diseases with the highest impact on Africa's socio-economic development;

6. RESOLVE to continue to support the implementation of the Plan of Action for the AU Decade for African Traditional Medicine (2000-2010), especially research in the area of treatment for HIV/AIDS, TB, malaria and ORID;

7. REQUEST the Commission in collaboration with UNAIDS and its joint UN Co-sponsoring Agencies, ECA and other partners, to coordinate and intensify efforts among member

states, monitor implementation of this Declaration and report regularly to our Assembly.

...

B2.5 Solemn Declaration on Gender Equality in Africa (2004)

Adopted by the heads of state and government of member states of the African Union in Addis Ababa, Ethiopia from 6 to 8 July 2004, at the Third Ordinary Session of the Assembly. The objective was to develop a concerted and collective leadership and effort to challenge issues related to gender inequalities. Full text available at www.chr.up.ac.za.

Excerpts

...

Deeply concerned about the status of women and the negative impacts on women of issues such as the high incidence of HIV/AIDS among girls and women, conflict, poverty, harmful traditional practices, high population of refugee women and internally displaced women, violence against women, women's exclusion from politics and decision-making, and illiteracy, limited access of girls to education;

Aware of the policies and programmes we have put in place to curb the spread of HIV/AIDS pandemic as well as the current challenges in this campaign;

Concerned that, while women and children bear the brunt of conflicts and internal displacement, including rapes and killings, they are largely excluded from conflict prevention, peace-negotiation, and peace-building processes in spite of African women's experience in peace-building;

Aware of the fact that low levels of women's representation in social, economic and political decision-making structures and feminisation of poverty impact negatively on women's ability to derive full benefit from the economies of their countries and the democratisation process;

Aware of the digital divide between the North and the South, men and women and the role of information telecommunication technologies (ICTs) in the advancement of the gender issue as stated in the e-gender Forum Declaration of Tunis, May 2004 in preparation for the World Summit on Information Society (WSIS) 2005;

HEREBY AGREE TO

1. Accelerate the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both Abuja and Maputo Declarations on malaria, HIV/AIDS, tuberculosis and other related infectious diseases. More specifically we will ensure that treatment and social services are available to women at the local level making it more responsive to the needs of families that are providing care; enact legislation to end discrimination against women living with HIV and for the protection and care for people living with HIV, particularly women; increase budgetary allocations in these sectors so as to alleviate women's burden of care;

2. Ensure the full and effective participation and representation of women in peace process including the prevention, resolution, management of conflicts and post-conflict reconstruction in Africa as stipulated in UN Resolution 1325 (2000) and to also appoint women as Special Envoys and Special Representatives of the African Union;

3. Launch, within the next one year, a campaign for systematic prohibition of the recruitment of child soldiers and abuse of girl children as wives and sex slaves in violation of their Rights as enshrined in the African Charter on Rights of the Child;

4. Initiate, launch and engage within two years sustained public campaigns against gender based violence as well as the problem of trafficking in women and girls; Reinforce legal mechanisms

that will protect women at the national level and end impunity of crimes committed against women in a manner that will change and positively alter the attitude and behaviour of the African society;

5. Expand and Promote the gender parity principle that we have adopted regarding the Commission of the African Union to all the other organs of the African Union, including its NEPAD programme, to the Regional Economic Communities, and to the national and local levels in collaboration with political parties and the National parliaments in our countries;

6. Ensure the active promotion and protection of all human rights for women and girls including the right to development by raising awareness or by legislation where necessary;

7. Actively promote the implementation of legislation to guarantee women's land, property and inheritance rights including their rights to housing;

8. Take specific measures to ensure the education of girls and literacy of women, especially in the rural areas, to achieve the goal of 'Education for All' (EFA);

9. Undertake to Sign and ratify the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa by the end of 2004 and to support the launching of public campaigns aimed at ensuring its entry into force by 2005 and usher in an era of domesticating and implementing the Protocol as well as other national, regional and international instruments on gender equality by all states parties;

10. Establish AIDS Watch Africa as a unit within the Office of the Chairperson of the Commission who should render annual report on HIV/AIDS situation in the continent during annual Summits; and promote the local production of anti-retroviral drugs in our countries;

11. Accept to establish an African Trust Fund for Women for the purpose of building the capacity of African women and further request the African Union Commission to work out the modalities for the operationalisation of the Fund with special focus on women in both urban and rural areas;

12. Commit ourselves to report annually on progress made in terms of gender mainstreaming and to support and champion all issues raised in this Declaration, both at the national and regional levels, and regularly provide each other with updates on progress made during our Ordinary Sessions;

13. We request the chairperson of the African Union Commission to submit, for our consideration, an annual report, during our ordinary sessions, on measures taken to implement the principle of gender equality and gender mainstreaming, and all issues raised in this Declaration both at the national and regional levels.

B2.6 AU Commission Chairperson's 2nd Progress Report on the Implementation of the Solemn Declaration on Gender Equality in Africa

Submitted by the African Union Commission Chairperson pursuant to the obligation under article 13 of the Solemn Declaration on Gender Equality in Africa (SDGEA) to submit an annual report on measures taken to implement the principle of gender equality and gender mainstreaming at national, regional and continental levels to the heads of state and government. Full text available at www.fasngo.org.

Excerpts

...

Article 1: Accelerate implementation of gender specific economic, social and legal measures aimed at combating the HIV/AIDS pandemic, Malaria and other Related Infectious Diseases

...

13. Many countries have developed or are developing policies on HIV/AIDS focusing on interventions that include building the capacity of key sectors in terms of technical knowledge, infrastructure and systems, integrating issues of marginalised groups such as women as well as issues aimed at preventing and reducing HIV vulnerability and encouraging a multi-sectoral approach to tackling the problem of HIV/AIDS. Many States and organisations are also implementing HIV/AIDS related programmes as part of their responsibility under the millennium development goals.

...

15. Many States are implementing health programmes that target the youth (especially female youth) as a particularly vulnerable group. Many countries are also implementing programmes targeted at orphans and other vulnerable children.

16. States need to address the continuing challenges in the area of HIV/AIDS, malaria and other Infectious diseases, especially as regards cultural perceptions and impediments that would militate against women and which cause or increase their vulnerability to disease.

...

Article 3: Launch a campaign for systematic prohibition of recruitment of child soldiers and abuse of girl children as wives and sex slaves

21. In most countries, labour laws set the age limit for work by children at 18 years. In essence, this means that countries are not allowed to recruit child soldiers. For those that do have the problem of child soldiers, programmes are in place to prevent the practice and to demobilise child soldiers and re-integrate them into society.

22. States have worked with International Agencies such as UNICEF, World Vision, WFP and others in implementing demobilisation programmes for children. Such programmes include provision of food, provision of trauma counselling and psychosocial care, re-unification of child combatants with their families, facilitation of access to education and recreation in communities of settlement.

23. Laws are in place that prohibit child marriages and that punish perpetrators of sexual violence against girl children. Law enforcement officers have been trained in handling children that are victims of sexual abuse and ensuring their access to a speedy trial in order to minimise the trauma related to court processes.

24. Inadequate funding to the Justice, Law and Order sector, which is the chief sector responsible for issues related to protection of children from abuse, is a major challenge for many states. That means that enforcement of laws related to sexual abuse is often a challenge. Culture and custom also play a key role in the continuance of sexual abuse and exploitation of girl children. States are encouraged to allocate more resources to the key relevant ministries as well as create awareness among communities about the ills of sexual exploitation of children.

Article 4: Initiate, launch and engage within two years, sustained public campaigns against gender-based violence

25. Measures are in place to develop or revise laws so that they specifically address issues of violence against women both in the private and in public. The laws address a range of concerns including prohibition of harmful traditional practices, domestic violence including femicide, sexual violence, and trafficking and child prostitution.

26. Measures aimed at addressing violence against women have also sought to strengthen the institutional mechanisms for coordinating violence against women and enforcing the rights of victims and survivors. Measures include having specialised desks [such as family protection units] at police stations to handle cases of violence against women, having closed court sessions for sexual violence crimes, and specialised treatment centres for violence victims and survivors.

27. Several states have also dedicated resources for public education and awareness raising on issues of gender based violence. Many states partner with civil society organisations during the International Campaign dubbed '16 days Against

Violence Against Women' to focus attention on the issue of violence.

28. Not many states have gone far in addressing trafficking in women. States are encouraged to consider this issue along side other violence issues. States are encouraged to start at the level of initiating comprehensive studies on trafficking to inform law reform measures aimed at achieving a holistic and integrated response to trafficking in women and children. Member states are also urged to ratify the United Nations' Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially women and children (also known as the Palermo Protocol) to maximise cross-border collaborations to end trafficking.

...

Article 6: Ensure the active promotion and protection of all human rights for women and girls

35. As stated in the introduction to this report, many States derive their gender equality mandate from their own constitutions, which ably spell out the rights of women. Most States are also signatory to international and regional human rights instruments that require them to promote and protect the rights of women and girls.

36. Many countries have gone a step further from ratification to domestication of the international and regional human rights standards set out therein. Many States have reformed or are in the process of reforming national laws to make them compliant with international human rights standards.

37. Other measures to ensure protection and promotion of the rights of women and girls include strengthening of national institutions, statutory bodies and administrative mechanisms that have been created to support women's rights. States also run human rights education and legal literacy programmes to enable the vast majority of their populations to understand women's rights in order to enable them apply them. The mass media has been instrumental in this regard.

38. States have also collaborated with civil society organisations, particularly women and children rights organisations to disseminate international human rights instruments and to popularise new laws and policies that relate to the protection and promotion of the rights of women and girls.

39. Despite these measures however, protection of the rights of women and girls continues to be a challenge for many States because of several factors such as

(a) Weak institutional mechanisms for implementation: This in particular refers to government gender machinery. Most governments have established machineries, either in the form of ministries or departments, to oversee government initiatives for the empowerment of women. However, at the recent review in Addis Ababa in October 2004 of the Beijing Declaration and Platform for Action, 10 years after it was agreed, there was considerable concern raised about these machineries' performance. In particular, it was noted that their capacities to spearhead the women's rights agenda are extremely limited due to severe (and in many cases disproportionate) cuts in budget allocation and human resources. Given that it is this machinery that will be largely responsible for monitoring the process of domestication and implementation of the protocol, it is of major concern that it will not be in a position to do so effectively.

(b) The slow process of change: This is particularly at legislative and policy levels. Different countries have different legal regimes. As a general rule, those countries that have inherited the French legal system have some advantage. Under these systems, ratification of the international human rights instruments automatically qualifies it as national law. However, those of the British system have to undergo a process in which national parliaments effect a law that meets the agreed standard. Many countries that have ratified CEDAW and other instruments protecting women's rights have so far failed to incorporate these standards in national law.

This is further complicated by the existence of dual legal systems in much of Africa. In most African countries, the existence of customary and religious law on the one hand and statutory law on the other often means that women's rights are compromised.

When drawing up laws on matters relating to women's rights, often customary and religious law is given precedence.

(c) The challenge in promoting the culture of Constitutionalism and respect for the rule of law has serious implications for the domestication of the Protocol. Recent developments in a number of countries indicate a direct correlation between the failure of governments to respect the rule of law and to protect the human rights of citizens. As governments subvert Constitutions and compromise the rule of law in order to entrench their power bases, so too do cases of increased arbitrary detentions, curtailing media freedoms, harassment of political opponents and so on. The state apparatus is used to clamp down on rights and also to silence the voices of dissent. In these instances, the priority will not be to implement laws and regulations that promote rights, particularly those of women.

40. States are encouraged to put in place mechanisms that address the continuing challenges related to protection and promotion of the rights of women and girls.

Article 7: Actively promote the implementation of legislation to guarantee women's land, property, inheritance and housing rights

41. The rights to land and other property for many African women is enshrined in national constitutions. Many States also have legislation that promotes women's access to and ownership of land and other property. Many countries also have laws that protect a widow's right to inherit her deceased husband's property.

42. In a comprehensive region-wide study titled 'Bringing Equality Home: Promoting and Protecting the Inheritance Rights of Women, A Survey of Law and Practice in Sub Saharan Africa' research in ten countries across the continent (Botswana, Nigeria, Ghana, Ethiopia, Swaziland, Rwanda, Zambia, Senegal, South Africa and Zimbabwe) indicates that under both statutory and customary law, the overwhelming majority of women in sub Saharan Africa, regardless of their marital status, cannot own or inherit land, housing or other property in their own right. Instead, in respect to land and housing, women are made entirely dependant on their relationship to a male.

43. This report demonstrates that issues of women's inheritance extend far beyond the crucial challenges of establishing the necessary legal frameworks that would allow women to own and inherit property. For in almost all the 10 sub Saharan countries examined, the fact that women generally cannot rent, lease, own or inherit land and housing is not just the result of gender-biased statutory laws, it is also due to discriminatory customary laws and traditions as well as social norms and attitudes.

44. The report proposes, and I agree, that in order to adequately address issues of women's land, property, inheritance and housing rights, States should

Review their existing laws in a comprehensive and participatory manner to ensure that all laws adequately protect women's housing and land rights including inheritance rights, and where necessary, adopt new legislation and policies to ensure the complete fulfilment of these rights.

Design and implement extensive popular education and sensitisation programmes to raise awareness of women's rights to equality and non-discrimination. States should ensure that such programmes address laws and standards related to human rights, especially the right to adequate housing, land and inheritance.

Design and implement legal education programmes specially targeted at women in all segments of society and geographical areas, especially rural areas, where rights awareness is usually minimal. All these women should be made aware not only of their rights, but also how to claim and enforce them.

Establish enforcement systems, including a special police unit and legal aide, to ensure that women are freely able to claim their rights without fear of reprisal. Such enforcement mechanisms should be generously supported with all necessary financial and other resources.

Establish shelters for women who are victims of property grabbing, and offer them legal, financial and other necessary support while their property claims are pending. The main aim

should be to ensure that such women do not become homeless after their housing, land and other property is stolen.

Ensure that women benefit equally with men from all legal and land reform procedures.

Ensure that legal systems are readily accessible to women, which requires a non-discriminatory and unbiased judiciary, administrative system that adequately protects women's rights and affordable or even free legal aid for women who cannot afford lawyers.

Article 8: Take specific measures to ensure education for girls and literacy for women

45. The efforts to achieve Education for All have resulted in substantial gross enrolment ratio of primary education, which reached 93 per cent in 2004, from 72 per cent in 1990. Primary completion rate as per centage of relevant age group rose to 62 per cent in 2004, from 51 per cent in 1991. But gender completion of primary education remained a problem, as the ratio of girls to boys hardly changed. In addition to the increasing schooling-age population, these educational outcomes have put pressure on governments to expand post-primary education.

46. Remarkable efforts have been made to ensure that every child gets access to quality basic education. Although enrolment has increased considerably in many countries, it has not been adequate to accommodate rapid population growth and rural-to-urban migration, thereby giving an impression of being static relative to population size.

...

52. While progress has been made in the area of developing and/or implementing EFA policies, and most have been successful at the primary level, it is imperative that States put as much effort in encouraging increase in post-primary education access for girls.

...

B2.7 Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care (2005)

This Declaration was the result of the 2nd ordinary session of the conference of African ministers of health, held in Gaborone, Botswana on 13 and 14 October 2005. African Ministers of Health committed themselves to the UN Millennium Development Goals and requested that the African Union Commission produce a roadmap for sustainable universal access to prevention, treatment and care. They also pledged to report on progress made. Full text available at www.africa-union.org.

Excerpts

...

Concerned about the increasing disease burden in Africa particularly due to HIV and AIDS, malaria, tuberculosis and other communicable diseases,

Aware that, in spite of the various efforts by member states, access to prevention, treatment and care still remains limited and costly,

Further aware that the success of these efforts largely depends on well functioning health systems, accessible to all corners of our countries;

Acknowledging that more than a third of the people on the continent do not have adequate access to essential medicines and care;

...

Recognising that the human resources for health crisis affecting the continent is a severe impediment to health system strengthening and a constraint to accessing prevention, treatment and care;

...

Alarmed by the persistently high levels of maternal, newborn and child morbidity, mortality and disability, mostly due to preventable causes and curable conditions;

...

WE HEREBY

1. Reaffirm our commitment to the development of *Sustainable Access to Prevention, Treatment and Care for the Achievement of the Millennium Development Goals (MDGs)* and for the realisation of the ICPD Goals and Objectives;

2. Commit ourselves to the achievement of Universal Access to Prevention, Treatment and Care by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client through the following

(i) Promotion of a pro-poor health care system through strengthening of primary health care;

(ii) Scaling up of the treatment of AIDS, tuberculosis and malaria through proven effective drug combinations;

(iii) Distribution of free insecticide-treated bed-nets to pregnant women and all under 5 children in malaria-endemic zones and the use of indoor residual spraying where applicable;

(iv) Strengthen Health Systems to promote universal access by implementing the Abuja Recommendation of allocating at least 15 per cent of the national budget to health;

(v) Prepare and implement costed human resources for health development plans;

(vi) Strengthen partnerships, including through the 3 ones strategy, for improving access to treatment and care with communities, local government, youth networks, civil society, Regional Economic Communities (RECs), development partners and other stakeholders.

3. Undertake to pursue, with the support of our partners, the local production of generic medicines on the continent and to making full use of the flexibilities in the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on TRIPS and Public Health;

4. Call upon our Ministers of Trade to seek a more appropriate permanent solution at the World Trade Organisation (WTO) that revises the TRIPS agreement and removes all constraints, including procedural requirements, relating to the export and import of generic medicines.

5. Call upon member states and regional economic communities to ensure that TRIPS plus provisions which go beyond TRIPS obligations are not introduced in bilateral/regional trade agreements or in economic partnership agreements.

6. Undertake to implement the revised Africa Regional Nutrition Strategy.

7. Recommit ourselves to the Bamako Initiative on access to Primary Health care for the reduction of disease-burden in our countries and the development of functional and equitable health systems;

8. Resolve to recommit ourselves to the implementation of the 2001 Lusaka Decision on the African Union Decade for African Traditional Medicine (AHD/DEC.164 (XXXVII) and its plan of action;

9. Resolve to recommit ourselves to the implementation of the ICPD Goals and Objectives by adopting the Sexual and Reproductive Health Policy Framework (SRH);

10. Call for the harmonisation of gender disaggregated databases for the monitoring of progress towards the Millennium Development Goals, particularly 4, 5, and 6, on an annual basis;

11. Also call upon member states to expand DOTS with a view to achieving Universal coverage of TB treatment by 2015;

12. Express our determination to eradicate polio and ensure that every child is protected from Polio and urge Regional Economic Communities to initiate and intensify synchronised polio vaccination campaigns;

13. Mandate the AU Commission to alert the Heads of State of the imminent threat of an avian influenza pandemic and to seek technical guidance and assistance for member states on strengthening their integrated disease surveillance and response strategies, community education, and procurement and stockpiling of antiviral agents and vaccines.

14. Urge the International Community to honour their pledges to ensure availability of resources for sustainable access to treatment and care for the achievement of the millennium development goals and the G8 and other donor countries to fulfil their commitment for an additional US\$50 billion in global aid by 2010;

15. Request the African Union Commission to

(i) develop mechanisms for advocating for and sharing of best practices in the delivery of pro-poor treatment and care for the achievement of the Millennium Development Goals;

(ii) accelerate the development and facilitation of implementation of a Pharmaceutical Manufacturing Plan for Africa;

(iii) come up with a Roadmap for Sustainable Universal Access to Prevention, Treatment and Care for the Achievement of the Millennium Development Goals within one year;

(iv) report on progress made on Sustainable Universal Access to Prevention, Treatment and Care for the Achievement of the Millennium Development Goals at the next Ordinary Session of the Conference of African Ministers of Health and other relevant organs of the African Union.

B2.8 Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa (2005)

Developed by high-level experts in human rights and HIV management at national, regional, continental and international levels organised by the AU Commission in Addis Ababa, Ethiopia, from 29 to 30 November 2005. The objective was to harmonise related approaches and integrate the rights of PLWH including migrants or people in conflict situations within national human rights frameworks. Full text available at www.africa-union.org.

Excerpts

...

I. Introduction/ Background

1. The world has had to contend with the HIV/AIDS pandemic for over two decades. This is particularly so for Africa which bears the heaviest burden and yet, is least prepared to contain it. As was underscored by African Leaders at their African Summit on HIV/AIDS, Tuberculosis (TB) and Other Related Infectious Diseases held in Abuja, Nigeria, 24-27 April 2004, stigma, silence, denial and discrimination against PLWH/A, intensify the impact and are a major challenge to effective control of the pandemic. The situation may have improved progressively as awareness was raised, 'stigma reduced and silence broken', but comprehensive promotion of the rights of PLWH/A is still a challenge; and much more needs to be done to reduce their vulnerability and exclusion.

2. It was in this regard that the African Leaders elected 'Protection For Human Rights' as a priority in the Plan of Action for implementation of the Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases. They requested that the Continental Forum on Human Rights and People Infected and Affected by HIV/AIDS be organised, aimed at developing a Continental framework to harmonise related approaches and integrate the rights of PLWH/A including migrants or people in conflict situations within National Human Rights Frameworks. The Continental Forum was duly organised by the AU Commission in Addis Ababa, Ethiopia from 29 to 30 November 2005. The high level experts in human rights and control of HIV/

AIDS at national, regional, continental and international levels devised the Continental Framework.

3. The outcome of the Abuja Summit was Africa's contribution to the 2001 UN General Assembly Special Session (UNGASS) on AIDS. Amongst the key themes, the Declaration of Commitment of the UNGASS on AIDS also noted that PLWH/A deserve the highest possible standard of physical and mental health. It was also clearly specified that governments were committed to enforcing legislation and policies that stop discrimination against PLWH/A and at risk groups. Governments were also charged with addressing vulnerabilities of PLWH/A.

4. In adopting the African Charter on Human and Peoples' Rights, African Leaders were 'Convinced that it is henceforth essential to pay a particular attention to the right to development and that civil and political rights cannot be dissociated from economic, social and cultural rights in their conception as well as universality and that the satisfaction of economic, social and cultural rights is a guarantee for the enjoyment of civil and political rights'. Article 3 on non-discrimination, African Charter on the Rights and Welfare of the Child (1990) also states that 'Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his parents' or legal guardians' race, ethnic group, color, sex, language, relation, political or other opinion, national and social origin, fortune, birth or other status.'

5. Furthermore, the July 2004 Solemn Declaration on Gender Equality in Africa, states that 'the Heads of State are ready to accelerate the implementation of gender specific economic, social and legal measures aimed at combating the HIV/AIDS pandemic ... In this regard, they would ensure that treatment and social services are available to women at local level, enact legislation to end discrimination against women living with HIV and for protection and care of PLWH/A, particularly women'.

6. Respect for human rights includes, among others freedom from stigma and discrimination, access to health services, nutrition, employment, inheritance, education and other requirements for basic human security. People living with HIV comprise those who are HIV positive or have AIDS as well as those affected by HIV/AIDS through loss, or close association with PLWH/A. Others are affected by HIV/AIDS because they are obliged to take up responsibilities they normally would not be shouldering. The people affected by HIV/AIDS are vulnerable, liable to be marginalised and some are the poorest among the poor. Due to lack of information, many people infected and affected by HIV/AIDS are not even aware of their rights or that support services are available, hence the need to involve them at all levels of planning and implement action of programmes.

7. Depending on the nature of the epidemic and the legal, social and economic conditions in each country, some groups are more vulnerable to and thus disproportionately affected by HIV/AIDS. These include women, children, youth, old people living in poverty, minorities, indigenous peoples, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men who have sex with men and injecting drug users. That is to say, groups who already suffer from a lack of human rights protection, and from discrimination and/or are marginalised by their legal status. Lack of human rights protection disempowers these groups to avoid infection and to cope with HIV/AIDS if affected by it.

8. The objectives of the framework for Harmonisation of Approaches to Human Rights for People Infected and Affected by HIV/AIDS include

(a) To raise awareness on and reverse the negative impact of HIV/AIDS to communities, particularly the vulnerable and marginalised groups;

(b) To advocate for enactment or strengthening of legislation to protect PLWH/A, in the framework of National Human Rights Strategies;

(c) To address known cases of violation of human rights of PLWH/A (where applicable);

(d) To integrate policies on human rights for people infected and affected by HIV/AIDS into national Human Rights Frameworks;

(e) To harmonise approaches to human rights of PLWH/A at regional and continental level.

9. The Framework has eight Priority Areas, each with respective strategies, activities and indicators for monitoring implementation. The Priority areas are as follows

- (i) National Frameworks
- (ii) Greater Involvement of People Living with HIV
- (iii) Community Partnerships
- (iv) International Partnerships
- (v) Resource Mobilisation
- (vi) Law Review, Reform and Support Services
- (vii) Promotion of Gender Equality and Equity
- (viii) Promotion of Supportive and Enabling Environment
- (ix) Monitoring and Enforcement of Human Rights.

10. Implementation, monitoring and reporting will be undertaken as indicated in the mechanism Framework for Monitoring Follow-up and Reporting, through the collaboration of stakeholders at national, regional, continental and international level. Annual reports will be prepared at regional and national level and biennial reports at continental level. After five years, a mid-term review will be undertaken.

11. In order to implement the Continental Framework effectively, transparent, accountable, participatory and responsive governments are needed. It was also noted that some countries had already developed national frameworks, which they are implementing. This Continental Framework will help to strengthen their frameworks and implement them more effectively. For those countries without National Frameworks, the Continental Framework will guide them as they develop and implement respective National Frameworks relevant to their particular needs.

...

B2.9 Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006)

The Brazzaville Commitment is the outcome of a continental consultation conducted from 6 to 8 March 2006 by representatives from 53 countries of the African Union in Brazzaville, Republic of Congo. It aims to set the direction for HIV and AIDS policy in Africa until 2010. Among other things, the participants proposed legal and policy protection against stigmatisation, discrimination, and sexual or gender-based violence of the most vulnerable, who experience barriers in accessing HIV-related services. Full text available at www.unaids.org.

Excerpts

...

5. We identified the following as the main obstacles to rapid and sustainable scale up of existing national programmes and services

- (a) A very high dependence on external funds which are unpredictable and often subject to excessive conditions. This is compounded by insufficient allocation of national resources, due in part to debt servicing, and uneven distribution of resources by sector, geographic region and thematic area.
- (b) Lack of harmonisation and alignment to national priorities and the imposition of spending ceilings and heavy conditions. In addition, donors allocate their funding between and within countries and across thematic areas in ways that do not match needs.
- (c) Inadequate skilled human resources due to (i) the absence of appropriate human resource development plans and policies to train and retain staff, (ii) the unequal participation of key stakeholders such as civil society organisations representing people living with HIV and young people, women's groups, faith

based organisations and the private sector, and (iii) the brain drain of professionals.

(d) Weak health systems and delivery services, including human resources and infrastructures.

(e) Inadequate coordination, lack of good governance, weak management and M&E systems across all sectors, which affects service delivery, oversight and accountability.

(f) Inequitable distribution of services between urban and rural areas, which still leave large areas of the population underserved, especially among the vulnerable groups.

(g) Widespread stigma and discrimination against people living with HIV and marginalised groups, including orphans, migrants and sex workers, compounded by weak legal frameworks to enforce basic rights.

(h) The high vulnerability of women and girls which is not adequately addressed through existing legal and programmatic measures.

(i) Continuing challenges with respect to the affordability, accessibility, and acceptability of commodities for prevention and diagnosis, in addition to essential medicines for treatment. These include weak procurement and distribution systems and the limited ability of countries to use the flexibilities presented by TRIPS.

(j) Recurring conflicts and natural disasters that result in massive displaced populations and the degradation of infrastructure and social fabric.

6. We recommend that the following actions to overcome the identified obstacles to universal access be undertaken in an urgent and exceptional manner, in line with the seriousness of the epidemic.

Financing

(a) Increase the level of domestic resources committed to HIV and AIDS and align national budgets to the national AIDS plans, which includes balanced allocation between prevention, treatment, care and support; and simplification of financial procedures.

(b) Generate new national and regional resources in the HIV and AIDS response, including for example mutual insurances, solidarity funds, national levies on various services and merchandise.

(c) AU to mobilise countries to increase national resources for HIV and AIDS to accelerate the achievement of the 15 per cent target for health, including HIV and AIDS, and, in cooperation with WHO and UNAIDS, to develop national account systems to monitor expenditure and resource allocations.

(d) AU and other regional entities to advocate for the implementation and monitoring of international recommendations on harmonisation of donors around national priorities.

(e) Negotiate for debt cancellation and the availability of grants at national and regional level that would go specifically to finance HIV services in prevention, treatment, care and support,

(f) The African Union, the ECA and the Regional Economic Communities to establish innovative ways to mobilise resources for AIDS at the sub-regional level, including by strengthening the role of the ADB to raise resources and influence allocation especially for HIV and AIDS.

(g) Regional advocacy to multi-lateral and bilateral donors to end all conditionally except normal fiduciary requirements.

(h) Recommend that the AU calls on the international community to revisit existing financing mechanisms, for longer-term predictable financing for acceleration 'towards universal access'.

Human resources and systems

(i) Massively scale up service delivery systems by enhancing training, sector-wide solutions to retention, and effective and innovative use of Africa's available human resources, including those offered by civil society, and by making such services responsive and accessible to all communities, without sacrificing quality. Such scale-up must be based on costed plans linked to targets and timelines.

(j) Establish regional mechanisms to coordinate and provide training, capacity building, accreditation and quality assurance within the continent, with the collaboration of WHO as appropriate; establish or enhance the use of centres of excellence and the sharing of best practices and human resources on the continent.

Building and strengthening systems

(k) Strengthen multi-sector coordination, oversight, and foster good management across all sectors.

(l) WHO to support countries to carry out assessments of health infrastructures and service delivery systems to support scaling up processes towards universal access.

Affordable commodities, technology and essential medicines

(m) The African Union, in cooperation with the World Bank, the Global Fund, the African Development Bank, the EGA, the United Nations system (UNICEF, WHO, UNFPA, UNAIDS Secretariat) and other development partners urgently to support Regional Economic entities to set up regional and national bulk purchasing, technology transfer, south-south collaboration and sub-regional production of AIDS-related medicines and commodities (eg male and female condoms), including support in using TRIPS flexibilities.

(n) Accelerate research on HIV and AIDS on the African continent including into traditional medicines. Protect indigenous knowledge.

(o) Regional Economic Communities and national governments to address issues of strengthening and harmonising regulatory procedures for medicines and other commodities and removing cross-border taxation on essential medicines and commodities.

Human rights and gender

(p) Reduce stigma and discrimination through social mobilisation, using government, media, educational, community and religious leaders and increase the visibility, involvement and empowerment of people living with HIV and other vulnerable groups. Encourage sharing of best practice.

(q) Support people to exercise their right to know their HIV status without fear of discrimination and expand opportunities for counselling and testing and access to ARVs while preserving confidentiality.

(r) Promote a supportive environment, including enacting or repealing laws and policies related to gender and human rights, and strengthening implementation of relevant laws, jurisdictions and policies, in line with the AU framework on human rights and HIV and AIDS.

(s) Launch a Universal Access 'Know Your Rights and Duties' campaign and the campaign for Acceleration of HIV Prevention.

(t) The AU promote and support an audit of legal instruments to verify harmonisation of laws and policies with national AIDS goals on stigma, discrimination and all equity issues.

(u) Promote proactive and affirmative action for people infected and affected by HIV and AIDS, including children and young people.

(v) Promote legal and programmatic measures to address the high vulnerability of women and girls.

Fostering accountability

(w) Recommend that African Heads of States lead a social movement, from 2006 to 2010, in their respective countries, to provide accurate and reliable information and to make a package of services available, within the context of a rights-based framework.

(x) Recommend that the Pan-African Parliament Committee on Health, Labour and Social Affairs provide advocacy, oversight and accountability for the implementation of the commitment towards universal access. This group will work within the framework of the African Union, making use of, inter alia, Aids Watch Africa and NEPAD peer review mechanisms.

(y) Develop and strengthen national monitoring and evaluation systems, with support from Regional Economic Commissions, UNAIDS, WHO and the World Bank, in line with Three Ones, which would produce an annual report on progress.

(z) By the end of 2006, set national targets, inspired by regional targets on prevention, treatment, care and support, for 2008 and 2010 to aid Africa's development and in order to be on track for the Millennium Development Goal 6 - 'to halt and begin to reverse the spread of HIV/AIDS by 2015'.

(aa) The UN system and other development partners, including the civil society, to develop a framework under which they are held accountable.

B2.10 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)

This document was adopted at a Special summit convened by the Heads of State and Government of the African Union in Abuja, Nigeria from 2 to 4 May 2006. The objective of the meeting was to review progress made in implementing the 2000 and 2001 Abuja commitments. The summit adopted a renewed commitment to halting and then reversing the impact of these diseases by ensuring universal access to services by 2010. Full text available at www.africa-union.org.

Excerpts

...

I. Introduction

1. We the Heads of State and Government of the African Union, meeting in Abuja, Nigeria, from 2-4 May 2006 to review the progress made in implementing the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of 2000, and the Abuja Declaration and Plan of Action on HIV and AIDS, Tuberculosis and Other Infectious Diseases (ORID) of 2001; focused our deliberations on the Theme: 'Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by a United Africa by 2010'. We recall that the twelve priorities for our Abuja Plan of Action on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases included leadership at national, regional and continental levels to mobilise the society as a whole; resource mobilisation; protection for human rights, poverty, health and development; strengthening health systems; prevention of primary and secondary infections; improvement of information, education and communication; access to treatment, care and support; access to affordable drugs and technologies; research and development on HIV and AIDS, tuberculosis and ORID; partnership; and monitoring and evaluation.

2. We also recall that at the same 2001 Abuja Summit Eight African Heads of State and Government deeply, concerned with the impact of the HIV and AIDS epidemic, created AIDS Watch Africa (AWA) as an advocacy platform at the Head of State and Government level and for monitoring the African response and to mobilise resources.

II. Africa's progress towards the achievement of the 2000 and 2001 Abuja commitments in declarations and plans of action

3. Marked progress has been also observed in the proportion of national budgets allocated to health as 33 per cent of countries have allocated at least 10 per cent of their national budget to health while one country has attained the target of 15 per cent. Heads of State have engaged with the G8 countries for additional resources and debt relief.

4. We realise that the movements of people across and within borders spread diseases such as HIV and AIDS, tuberculosis and malaria. In view of this, we take regional level actions and cooperation as vital to the fight against the HIV and AIDS epidemic in the continent. Accordingly, Regional Economic Communities (RECs) have integrated health and social issues in their development programmes. Some RECs are implementing HIV and AIDS strategies. With the coordination of RECs, cross border cooperation and delivery of services is enhanced.

5. We are aware that the AU Commission developed and is implementing the AU Commission HIV and AIDS Strategic Plan

2005-2007, coordinating the implementation of the AIDS Watch Africa Strategic Framework; and is playing its advocacy role through the World AIDS Campaign, World TB Day and Africa Malaria Day campaigns, among other advocacy activities.

6. In 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created as suggested by the OAU/AU Heads of States following the advice by their health ministers and then proposed to the UN Secretary General at the Abuja Special Summit in 2001 and endorsed by the UNGASS on AIDS. Since then, several African countries have been able to access funds from GFATM, and other sources, which include the World Bank Multi-country AIDS Programme (MAP), US President's Emergency Fund for HIV and AIDS Relief Programme (PEPFAR), the Commission for Africa, the initiative by France on air ticket levy and other bilateral and multi-lateral sources. Despite the increased number of donors, the current annual global spending is less than half of the US\$ 12 billion needed by 2005 and less than one-quarter of the amount needed in 2007. However, spending for Africa from this amount accounts for 6-10 per cent of the total AIDS expenditure. According to the Global Fund Observer 2003, Africa was able to secure 60 per cent of the resource of the Global Fund.

III. The challenges and obstacles

7. We have identified the following as the main challenges and obstacles to accelerated action towards universal access to HIV and AIDS, tuberculosis and malaria services in Africa

- The triple burden of disease including non-communicable diseases and injuries;
- The difficulty in ensuring predictable and sustainable financing for HIV, tuberculosis and malaria services;
- Weak planning partly because of lack of institutional and human resource capacity at national level;
- The health crisis reflected in terms of weak health systems, infrastructures inadequate laboratory network for diagnosis of diseases, human resources in terms of numbers, mix of skills, motivation, and retention which have become major barrier to the implementation of disease control programmes in general and HIV and AIDS, TB and malaria programmes in particular;
- Inadequate access to essential medicines, preventative commodities and technologies across much of the continent; inadequate global supply of long lasting Insecticide Treated Nets (ITNs) and Artemisinin-based Combination Therapy (ACTs) and indoor residual spraying (IRS) with effective insecticides;
- Lack of adequate policies and legislation protecting the human rights of PLWH and TB by most countries;
- Failure to take into account the link between HIV and AIDS and sexual and reproductive health;
- Stigma, discrimination and gender inequity, which result in inadequate application of the human rights of people infected or affected by HIV and AIDS and directly hampers their ability to access services;
- Poor or inadequate coordination of regional and national and international partnerships;
- Weak monitoring and evaluation (M&E) systems and cumbersome M&E framework for the Abuja Declaration on HIV and AIDS and TB and ORID;
- Conflicts that result in mass displacement, violence, loss of livelihood and property as well as major breakdowns in essential services;
- Other cross-cutting issues such as ensuring good nutrition and food security, and internal and inter-country migration for reasons other than conflicts;
- Policy planning and programming for addressing health in national development frameworks by most countries which is reflected by inadequate health system development, low coverage and access to services for the three diseases;
- An increasing burden of disease and other development challenges.

IV. Abuja call for accelerated action towards universal access to HIV and AIDS, tuberculosis and malaria services by 2010

Rededication by African Heads of State and Government

8. We still consider AIDS, tuberculosis and malaria as a state of emergency in our continent. They are major threats to our national and continental socioeconomic development, peace and security. We reaffirm the commitments contained in the 2000 and 2001 Abuja Declaration and Plans of Action, the MDGs and subsequent commitments;

9. After reviewing the progress made to date, the challenges confronted by individual and member states, acknowledging *progress made by member-states* and the contributions of civil society and the international community, and bearing in mind that HIV, TB and malaria are preventable and treatable while malaria and TB are curable, we resolve to intensify the fight against HIV and AIDS, TB and malaria and to achieve the targets adopted by the Summit and other internationally agreed goals on health.

10. We therefore, individually and collectively rededicate ourselves and our countries to the following

Leadership at national, regional and continental levels

- To intensify our practical leadership role at national, regional, and continental levels to mobilise society as a whole to fight HIV and AIDS, TB, and malaria more effectively;

Resource mobilisation

- To mobilise local resources for sustainable and predictable financing, including the implementation of the Abuja Declaration Call for 15 per cent of the National Budget to health and strengthen our collaboration with national and international partners to mobilise adequate financial resources to fight the epidemics; and ensure that financial resources mobilised to fight all the three epidemics can actually be spent by the removal of the medium term expenditure ceilings on public spending imposed on African countries by the International Financing Institutions.
- To negotiate for debt cancellation and the availability of grants at national and regional levels that would specifically be targeted at financing prevention, treatment, care and support of the three diseases.
- To undertake collective advocacy with multi-lateral and bilateral donors to end all conditionalities except normal fiduciary requirements.

Protection of human rights

- To continue promoting an enabling policy, legal and social environment that promotes human rights particularly for women, youth and children and ensure the protection of people infected and affected by HIV and AIDS, TB and malaria and to reduce vulnerability and marginalisation including conflict-affected and displaced persons, refugees and returnees;
- Adapting national legislation to take cognisance of HIV and AIDS and TB issues specifically discrimination and stigmatisation and encourage member states to ratify relevant international conventions such as the Convention on Discrimination and Employment.
- To enact or repeal laws and policies related to gender and human rights in order to align them with AU frameworks including the Solemn Declaration on Gender Equality in Africa and the AU Protocol on Women.

Poverty reduction, health and development

- To ensure the integration of HIV and AIDS, TB and malaria programmes into poverty reduction strategies and programmes and country programmes; and thus ensure access to adequate nutrition and food security by pursuing the realisation of an integrated African food production, storage and distribution plan and other social protection measures including adequate social security schemes to address sustainability of treatment as well as treatment, care

and support; ensuring community involvement and participation.

Strengthening health systems

- To strengthen health systems and building on existing structures (infrastructure, human resource, financing, supplies et cetera.) for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV and AIDS, TB and malaria;
- To strengthen data management and surveillance;
- To meet WHO standards for doctors and nurses.

Prevention, treatment, care and support

- To invest heavily in evidence-based prevention as the most cost-effective intervention with focus on young people, women, girls and other vulnerable groups;
- To ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV and AIDS, and sexually transmitted infections (STIs) (including post-exposure prophylaxis following sexual violence), TB and malaria, reduction of vulnerability to HIV and AIDS, TB and malaria;
- To ensure the promotion and integration of access to prevention treatment, care and support in primary health care services, and in education institutions;
- To improve information, education and communication;
- To disseminate, correct, reader-friendly information on prevention, treatment, care and support on HIV and AIDS, malaria and tuberculosis;
- To ensure universal access to male and female condoms for all sexually active persons.
- To integrate HIV and AIDS issues into ongoing immunisation programmes and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV and AIDS programmes;
- Awaken traditional values on abstinence but continually increase condom use.

Access to affordable medicines and technologies

- To enact and utilise appropriate legislation and international trade regulations and flexibilities, to ensure the availability of medicines and commodities at affordable prices as well as technologies for the treatment, care and prevention of HIV and AIDS, TB and malaria including vaccines, medicines and Anti-retroviral Therapy (ART).
- To promote regional bulk purchase and local production of generic medicines and other commodities;
- Support work on regional local production of generic ARV drugs.

Research and development

- To promote and support research and development of microbicides, vaccines, diagnostics and treatment for HIV and AIDS, TB and malaria, including traditional medicine;
- Monitoring of drug resistance in the treatment of HIV and AIDS, tuberculosis and malaria;
- Demographic and Health Surveys every five years;
- Research ethics including for HIV and AIDS;
- Conduct regular incidence surveys on HIV.

Implementation

- Enhance and support implementation of comprehensive strategic programmes at country and regional levels against HIV and AIDS, TB and malaria;
- Prevention of multi-drug resistant TB;
- Accelerate malaria control programmes with a goal to eliminate malaria using all effective strategies such as indoor residual spraying, insecticide treated bed nets, Artemisinin Combination Therapy (ACTs) and Intermittent Presumptive Therapy (IPT);
- Implement the Three-Ones (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan (for HIV and AIDS, tuberculosis and malaria).

Partnerships

- To further develop and support comprehensive frameworks and mechanisms of well-coordinated partnerships, particularly public, private, civil society, regional and international including donors, to promote universal access to prevention, treatment, care and support for HIV and AIDS, TB and malaria;

Monitoring, evaluation and reporting

- To strengthen in collaboration with all relevant stakeholders particularly Civil Society partners affected by the three diseases, planning, monitoring and evaluation and generation of information for quality, sustainability and accountability of programmes, and for advocacy;
- To ensure networking and sharing of best practices and submit progress reports regularly to appropriate Organs of the AU;
- To undertake to strengthen implementation of NEPAD Health Strategy to fight poverty and under-development.

11. We request Ministries of Health, National AIDS Councils or equivalent and Ministries of Finance and Economic Planning to coordinate the realisation of a multi-sectoral and integrated approach to disease control, in collaboration with other sectors, including the involvement of the community in the planning and implementation.

12. Finally, We commit ourselves to the implementation of the recommendations and action points enshrined in the in 'Brazzaville Commitment on Scaling up Universal Access to HIV and AIDS Prevention, Treatment, Care and Support'; and to extend these to TB, malaria and other prevailing diseases. Call to Civil Society and the Private Sector

13. Recognising and commending the progress made by member states, the efforts and achievements of the Civil Society and Private Sector;

We call upon the respective national, regional, continental and international partners including NGOs, and civil society, (including, youth, women, people with disability, religious organisations, trade unions, employers organisations, traditional health practitioners, traditional rulers, people living with HIV and AIDS and other Groups) to

- Intensify their efforts more than ever before for the fight against HIV and AIDS, tuberculosis and malaria;
- In this connection, they should develop and implement well coordinated and harmonised frameworks which will provide concrete results;
- Support the mobilisation of additional resources for prevention, care and support and treatment-related activities;
- Facilitate through enhancing their monitoring role, the operationalisation of commitments at all levels.

Call to Regional Economic Communities (RECs)

14. We call upon Regional Economic Communities (RECs) and other regional groupings to

- Intensify the implementation of inter-country and cross-border health initiatives;
- Coordinate inter-country efforts and provide support to member states;
- Mobilise resources for HIV and AIDS, tuberculosis and malaria programmes in their respective regions;
- Report back to us through the AU Commission on the progress made in the implementation of this Call;
- Accelerate the prevention and control of malaria, learning from best practices on the continent with the aim of eliminating malaria in Africa using all available control strategies including indoor residual spraying, use of insecticide-treated nets, ACT combination therapy and intermittent preventive therapy.

Mandate the AU Commission and AU organs

15. We request the AU Commission and the AU Organs and Programmes to

- Effectively implement the AU Commission HIV and AIDS Strategic Plan and AWA Strategic Framework 2005-2007;
- Promote regional integration and collaboration in the areas of Disease Control;
- Ensure that HIV and AIDS, tuberculosis and malaria are catered for in the NEPAD Health Strategy;
- Ensure that malaria prevention and control is accelerated with the goal to eliminate malaria in Africa by 2010 using all available control strategies;
- Coordinate in broad partnership with Civil Society and the private sector, the effective implementation of the Abuja Call and report annually to the AU Assembly.

16. We further request the Pan-African Parliament Committee on Health, Labour and Social Affairs to provide oversight and accountability for the implementation of the commitments made towards universal access and the implementation of the Abuja Declaration.

17. We also request the Peace and Security Council (PSC), and Economic, Social and Cultural Council (ECOSOCC) of the AU, the NEPAD Programme, other AU Organs and National Parliamentarians to play an effective advocacy role and provide necessary support to member states in the fight against these diseases.

Call to the international community

18. We solemnly call upon

- Development partners to continue to work closely with Member States, the AU Commission and the RECs to ensure long term, predictable financing commensurate with the burden of these diseases and to provide financial and technical support to our efforts in a coordinated, efficient and country and AU led manner.
- The UN Agencies and other development partners to provide technical, material and financial support and to facilitate follow-up on the implementation of this Call.
- The development partners to mobilise additional and adequate resources on long-term basis for the fight against HIV and AIDS, tuberculosis and malaria;
- The international community to reaffirm its commitment to strengthening the partnership with Africa for the fight against HIV and AIDS, tuberculosis and malaria, other major causes of morbidity and mortality.

Follow-up and reporting

19. Recognising and commending the lead role played by the Federal Government of Nigeria for the Abuja 2000, 2001 and 2006 commitments; we mandate H.E President Olusegun Obasanjo, Head of State of the Federal Republic of Nigeria to report the outcome of this Special Summit on HIV and AIDS, TB and malaria to the next Ordinary AU Assembly, and to continue to lead in the follow-up on implementation of the Abuja Call.

20. Finally, we request consultative reviews at two years (2008) and five years (2010) on the status of implementation of the 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by 2010; and of the MDGs.

B2.11 Africa's Common Position to the UN General Assembly Special Session on AIDS (2006)

Adopted at the special summit convened by the Heads of State and Government of the African Union in Abuja, Nigeria from 2 to 4 May 2006. It was presented to the high level meeting of the UN General Assembly (UNGASS) on AIDS in June 2006. The Africa Common Position called, among others, for at least 80 per cent treatment and prevention coverage of sexually transmitted Infections by 2010. www.africa-union.org.

Excerpts

...

Recalling and Reaffirming our previous declarations, decisions and resolutions;

Opportunities/driving forces for intensified actions

Africa is optimistic about the future. It feels that it can do more in all areas of socioeconomic development. Progress made in the last five years is solid foundation for deepening the struggle against the HIV/AIDS epidemic and registering more success stories. Particularly, the following are impetus towards the process of scaling-up HIV prevention, treatment and care in the continent

- The political will and commitment expressed by the leadership at various levels;
- The progress made by some countries in improving access to treatment, care, and support, including ART, as well as access to infrastructure, technologies, and commodities;
- The expansion of DOTS services for TB patients in most countries which contributes to AIDS prevention and treatment;
- The achievements of some countries in reducing HIV prevalence;
- The bold action exercised across all sectors and levels of government to address the burden of HIV/AIDS requires;
- The lessons learnt from the '3 by 5' Initiative, the DOTS strategy and the Roll Back Malaria movement to expand the progress in increasing access to quality prevention, care and support services for HIV/AIDS, TB and malaria control;
- The integration and reinforce of prevention, treatment and care for HIV/AIDS, TB and malaria towards the attainment of Millennium Development Goal No 6, with the focus on prevention, especially for young people;
- The essential role that good nutrition and food security play in HIV prevention, treatment, and care;
- The added value and opportunities provided by GFATM, MAP, PEPFAR, ADB and other global health partnerships, private foundations, bilateral and multilateral partners in terms of innovative financing mechanisms and making additional resources available;
- The cancellation of debt by the G8 countries offers the potential for poverty-reduction and for resources to be committed to health in some countries;
- The fundamental role of intensified research and development efforts in all areas particularly traditional medicine and microbicides;
- The evidence that effective control of HIV/AIDS has high economic benefits;
- Evidence that national and international effort is beneficial, based on the 'three ones' initiatives and the recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors; and
- Partnerships between the public sector and civil society et cetera to be developed.

Guiding Principles to which Africa will adhere

Africa will continue to adhere to the following important guiding principles to effectively and efficiently implement the Abuja 2006 Action Plan and as well continue to

- Build on existing international and continental frameworks, such as the NEPAD programme;
- Foster and strengthen community, national, regional and continental leadership and strong political commitment that builds on and strengthens existing African institutions at all levels, including civil society institutions;
- Integrate the control of HIV/AIDS with broader efforts to combat poverty and food insecurity and fostering development, whilst recognising the urgency and exceptionality of the HIV and AIDS response;
- Respect of human rights, particularly the rights of women and children, with regard to the fight against stigma and discrimination and to advance equity will be promoted;
- Put people at the centre of the HIV and AIDS response, especially vulnerable people (eg the poor; women, young people; orphans and vulnerable children; men who have sex with men;

migrants; prisoners; sex workers; the disabled, people affected by conflicts; and Injection Drug Users (IDUs);

(vi) Adopt gender-centred approaches in order to address the needs of women and girls

(vii) Focus on HIV prevention, care and support of children and young people;

(viii) Ensure mutual accountability (political, moral and programmatic) at every level of the response;

(ix) Maintain an unwavering commitment to deliver a comprehensive package of services for prevention, treatment, care and support for HIV and AIDS, including nutrition and linkages with reproductive health. Ensuring that no good plan go unfunded;

(x) Reinforce and strengthen the central role of strategic partnerships among countries; and within countries between governments and civil society, especially people living with HIV, faith-based organisations, women, young people and the private sector, and which require effective coordination;

(xi) Recognise and respond to the need to build long-term infrastructure and systems and strengthening capacity building at all levels, using as appropriate, the resources available for an exceptional response to HIV/AIDS;

(xii) Consider access to essential medicines and other basic commodities as human right and ensuring that these are available and accessible to all who need it in Africa;

(xiii) Give special consideration to people and countries affected by conflicts, including Internally Displaced People (IDPs) and refugees; and

(xiv) Urges for sustained and increased funding and capacity for AIDS vaccine research and development in Africa, in order to contribute to the control and eventual elimination of the AIDS pandemic.

Targets to be met by 2010

Taking the above opportunities into account, Member States of the African Union will intensify the fight against HIV/AIDS and achieve other internationally agreed goals on health. The national policies, strategies and operational plans will be geared towards achieving the following targets by 2010. The African Union and Regional Economic Communities (RECs) will continue to provide the necessary support wherever possible promote regional integration and play its leadership role. The targets to be met by 2010 include the following

(i) Reduce HIV prevalence in young people between 15 and 24 years, by at least 25 per cent in ALL African countries.

(ii) Protect and support in 2010, 5 million children orphaned by AIDS and ensure that 80 per cent of orphans and vulnerable children have access to basic services.

(iii) At least 80 per cent of pregnant women have access to Prevention of Mother-To-Child Transmission (PMTCT), and treatment for HIV-positive women and children.

(iv) At least 80 per cent access of those in need, particularly children, have access to HIV/AIDS treatment, especially antiretroviral, as well as care and support. Supported by the following

(i) At least 80 per cent of target populations access Voluntary Counseling and Testing (VCT)

(ii) 100 per cent of blood and blood products are safe to reduce the rate of transmission of HIV

(iii) 100 per cent injection safety is ensured

(iv) At least 80 per cent of target populations have access to prevention and treatment of Sexually Transmitted Infections (STI)

(v) At least 80 per cent of target population use condoms for HIV prevention ensured

(vi) 100 per cent of refugees and other displaced persons have access to HIV/AIDS prevention, treatment, care and support when these are available to surrounding host populations

(vii) 100 per cent of all clients accessing HIV care and support services are screened for TB to ensure early detection and treatment

(viii) 100 per cent of TB patients have access to HIV testing and counseling services

(ix) 100 per cent of HIV-positive TB patients access antiretroviral treatment

(x) 100 per cent access to sexual and reproductive health services including antenatal care

1. Since progress towards these bold collective goals can only be assured through decisive action at the country level, we commit to

(a) As appropriate, develop or revise our national HIV/AIDS plans to ensure that they

(i) Are costed and credible, yet sufficiently ambitious to ensure progress towards our collective goals;

(ii) Strengthen planning, monitoring and evaluation and the generation of information for quality, sustainability and accountability of programmes, and for advocacy;

(iii) Ensure that strategies promote access to prevention, treatment, care and support for HIV/AIDS by poor and marginalised populations, including those affected by conflict.

(iv) Reflect an allocation of domestic resources commensurate with the urgent and extraordinary challenge to development that the AIDS epidemic represents.

(v) Enable at least 50 per cent of HIV patients to benefit from care and support, including the treatment of opportunistic infections as well as psychological care;

(vi) By December 2006, include revised, quantified national targets (both interim for 2008 and for 2010) for prevention, PMTCT, AIDS treatment and care and support that are consistent with and contribute to the Africa wide targets articulated above. Specifically, we African Heads of State and Government undertake to

(i) Provide bold and resolute leadership in spearheading efforts in all countries to combat HIV/AIDS, TB and malaria;

(ii) Implement, in all countries, the commitments adopted at the Special Summit in Abuja, Nigeria in 2006;

(iii) Support the implementation of the monitoring and evaluation of country-specific frameworks adopted by the Special Summit;

(iv) Allocate and manage effectively the domestic resources required for sustained implementation of planned HIV/AIDS, TB and malaria prevention and control interventions;

(v) Engage further with development partners to mobilise additional resources towards meeting the Commission on Macroeconomics and Health (CMH) recommended target of US\$34 per capita on health;

(vi) Increase support for research, including developing vaccines, new medicines and other tools including traditional medicines, improving existing technologies to combat the diseases, undertaking operational research such as testing delivery strategies and monitoring drug resistance and drug adverse reactions

(vii) Reduce by 80 per cent, the tariffs and taxes on essential medicines and HIV/AIDS related technologies and commodities;

(viii) Conduct an audit of existing legislation and as appropriate, develop, implement and enforce policies and laws to reduce stigma and discrimination, protect the rights of people living with HIV and address the needs of vulnerable groups especially women and children and support these with advocacy campaigns;

(ix) Establish a national systems of accountability comprising inter alia, civil society and parliamentarians to carry out oversight functions and ensure transparency, accountability and good governance in the management of the HIV response;

2. And at the continental level, we commit ourselves to

(a) Strengthen the advocacy role of the AIDS Watch Africa (AWA) in co-ordinating the efforts of African leaders and mobilising resources from within and outside Africa;

(b) Utilise and strengthen the African Peer Review Mechanism (APRM) on health and establish clear linkages between the APRM and the national systems of accountability and to regularly review progress within the established mechanisms of the African Union;

(c) Member states are urged to adopt the Abuja 2006 common position for the continent in order to inform and strengthen their own plans of action in the framework of the 2001 Abuja Declaration and Plan of Action. In the same vein, the African Union and Regional Economic Communities should make close follow-up the development and implementation of national Action Plans of member states and mechanisms for monitoring and evaluation.

(d) Deploy financial and human resources – integrated in health and social systems – and create the enabling environment for the establishment of three regional training and accreditation centres aimed at rapidly overcoming the human resource crises in HIV/AIDS and broader health service delivery in the African region;

(e) Deploy financial and human resources and create the enabling environment for the establishment of 3 regional centres of excellence for the development and local production of antiretrovirals, condoms, vaccines, microbicides and other HIV/AIDS related commodities and technologies.

(f) Develop and strengthen inter-country cooperation through regional and sub-regional strategies for HIV/AIDS, prevention, treatment, care and support across borders and migratory routes, giving special consideration to conflict affected and displaced persons

3. With the view to ensuring that no sound national HIV/AIDS plan goes unfunded, request that

...

(ii) The international community to reaffirm its commitment to strengthening the partnership with Africa for the fight against HIV/AIDS

(iii) The donor community and health development partners increase HIV allocations to African countries by replenishing the Global Fund Against HIV/AIDS, tuberculosis and malaria

(iv) The donor community increases their support to enable countries to access the technical assistance they require from strengthened national and regional responses in line with the Global Task Team (GTT) recommendations through the United Nations System.

(v) The World Bank through the Multi-Country AIDS Programme (MAP) increase their support for the national mobilisation of sub-Saharan African countries against the AIDS epidemic

(vi) Bilateral organisations such as the US President's Emergency Fund for AIDS Relief (PEPFAR), other members of the G8, the European Union, the Nordic countries and the United Nations System increase their ongoing technical and financial support towards combating HIV in Africa

(vii) Development partners to work with AU member states, the African Union Commission and the RECs to assure long term, predictable finance commensurate with the burden of these diseases and to provide financial and technical support to our efforts in a coordinated, efficient and country-led manner.

Finally, We, the Heads of State and Government of the African Union, mandate

...

(iii) The Chairperson of the AU Commission in collaboration with the Executive Secretaries of the Regional Economic Communities to organise a broadly consultative two year Review (2008) and a similarly consultative five year review (2010) of the status of implementation of the African Common Position on HIV/AIDS concurrently with the reviews of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010; and of the Millennium Development Goals (MDGs).

B2.12 Progress Report on the Implementation of the Plans of Action of the Abuja Declarations on Malaria (2000), HIV/AIDS and Tuberculosis (2000/1 to 2005) (2006)

The AU Heads of State and Government signed The Rollback Malaria Abuja Declaration and Plan of Action (April 2000) and the HIV/AIDS, Tuberculosis and Other Related Infectious Diseases and Framework of Action (April 2001), committing themselves to take concrete steps in their countries to intensify the fight against malaria, HIV/AIDS, TB and Other Infectious Diseases (ORID). This report, published in 2006, describes the progress made in the implementation of the two Abuja Declarations and frameworks for action at national, regional and international levels. Full text available at www.africa-union.org.

Excerpts

...

Executive summary

...

2. The following achievements have been noted in the implementation of the Abuja Declarations.

(a) About 50 per cent of the countries have declared HIV/AIDS as an emergency. Almost all countries have established national coordinating bodies for HIV/AIDS, TB and malaria. Several countries have been able to access funds from the GFATM, MAP, PEPFAR, and other bilateral and multi-lateral sources. There is marked progress in the proportion of national budget dedicated to health and 33 per cent of countries have allocated at least 10 per cent of their national resources to health. In addition, Heads of State have engaged with the G8 for additional resources and cancellation of debts. Most countries however have not established sustainable financing mechanisms for services or supplies. Disbursement of funding, funds reaching operational levels, absorptive capacity, tracking and accountability of funding still remain major challenges.

...

(c) Regarding HIV/AIDS prevention, limited progress has been made in counselling and testing, in PMTCT. With regard to treatment and care, within the context of the 3 by 5 Initiative access to ART has increased. Three countries have already achieved the 3 by 5 targets. Five countries have established local production of ARVs.

(d) With respect to TB most countries have achieved good DOTs coverage. For access to affordable medicines, most countries access TB drugs through the Global Drug Facility and the Global Drug Facility Direct Procurement service has been established even though it is still underused. About 50 per cent of countries have established PSM systems for the three diseases.

3. However, the implementation of the Abuja Declaration faces some critical challenges. Coordination of regional and national partnerships remains weak. Most countries have not adopted policies and legislation protecting human rights of PLWH and TB. Only a few countries have addressed health in their central development frameworks. Health system development shows inadequacies in human resources in terms of numbers, mix of skills, motivation, and retention that are a major barrier to implementing disease control programmes in general and in particular HIV/AIDS, TB and malaria. Nationwide scale coverage and access to services for the three diseases remains a challenge, especially for the poor. Inadequate global supply of long lasting ITNs and Artemisinin-based Combination Therapy (ACTs) has hindered national rollout. Monitoring and evaluation systems are weak, aggravated by the fact that the M&E framework for the Abuja Declaration on HIV/AIDS and TB is cumbersome.

4. This report makes the following recommendations

All countries should

- Be urged to meet the target of allocating at least 15 per cent of national budget to health.

- Have mechanisms put in place to ensure sufficient targeting of district and operational levels, which are efficiently targeted towards the poor.
- Strengthen coordination mechanisms, especially with partners.
- Adopt policies and enact legislation that will minimise stigmatisation and discrimination of PLWH and TB.
- Ensure that HIV/AIDS, TB and malaria issues are addressed in their central development frameworks, and endorse the World Health Declaration of Tuberculosis as an Emergency in Africa and acceleration of HIV prevention.

5. The African Union (AU) and regional Economic Communities (RECs), should intensify efforts to play their respective roles more effectively, through regional cooperation, coordination, harmonisation et cetera.

6. Further more it is recommended that national authorities, donors and cooperating partners should

- Urgently tackle and improve health systems including human resources.
- Strengthen procurement and supply of essential medicines and commodities including, ARVs, ACTs, ITNs, TB drugs whilst exploring mechanisms for regional and local production of essential medicines. In this respect countries are urged to follow accreditation procedures set up by WHO.
- Adopt the Integrated Vector Management (IVM) strategy, including the use of DDT where applicable.
- Strengthen their monitoring and evaluation systems for the three diseases. The AU Commission with assistance from WHO and UNAIDS should revise their Monitoring and Evaluation Framework for the Abuja Declarations.
- Finally, countries, partners and donors should provide adequate resources to support operational research that is relevant to implementation.

...

B3 ACHPR concluding observations and resolutions

B3.1 Concluding Observations and Recommendations on South Africa's Initial Report to the African Commission (1999)

The initial report of the Republic of South Africa was presented at the 25th ordinary session of the Commission held in Bujumbura, Burundi, during the session of 27 and 28 April 1999. These are the Commission's Concluding Observations and Recommendations issued after examination of the report.

Excerpts

...

I. General observations

The Republic of South Africa acceded to the African Charter on 9 July 1996. The submission of its initial report to the Secretariat of the Commission on 14 October 1998 represents strict compliance with article 62 of the Charter, an act that must be underlined and appreciated. The report as presented is in conformity with the directives of the Commission with regard to the presentation of initial and periodic reports.

...

III. Factors of concern

3. The African Commission has taken note of the awareness of South African authorities with regard to the pandemic of HIV/AIDS. Through oral presentations received, it has appreciated the determination of the government of South Africa to wage a resolute struggle against HIV/AIDS. In this connection, the Commission has been informed of the national action plan against HIV/AIDS for the period 1998/2000.

The Commission feels moreover that the health situation in the country with regard to the spread of the disease has not received sufficient coverage in the report considering the seriousness of the situation.

IV. Recommendations

...

2. Due to the impact of economic policies on provisions related to economic and social rights, the African Commission wishes to draw the special attention of the Government to the effects and impacts of unemployment, illiteracy, HIV/AIDS in the context of women's rights and the rights of vulnerable groups.

3. The African Commission expresses its concerns about the occurrences of xenophobia and points out the need for a credible and appropriate legal framework for asylum seekers, refugees and immigrants in the Republic of South Africa.

...

B3.2 Resolution on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity (2001)

Adopted by the African Commission on Human and Peoples' Rights at its 29th ordinary session in Tripoli, Libya, from 23 April to 7 May 2001. Text available at www.achpr.org.

Noting the rampant escalation of the HIV/AIDS pandemic in Africa especially in sub-Saharan Africa where estimates show that some 9 million people have died and within the next decade some 25 million people will become infected;

Noting with satisfaction the convening of the Africa Summit on HIV/AIDS in Abuja, Nigeria, from 24 to 26 April 2001 where the

crisis was declared and interventions of emergency proportions called for;

Welcoming the statement of the Abuja Summit and the emergency measures declared there especially the announcement by the Secretary General of the UN on the establishment of a US\$10 billion war chest to fight HIV/AIDS in Africa;

Welcoming the forthcoming UN General Assembly Special Session on HIV/AIDS to be held in June 2001 and trusting that it will increase awareness of the need for international action to fight the pandemic and devise strategies by international co-operation against HIV/AIDS;

Mindful of the mandate of the Commission in terms of the Charter to 'promote human and peoples' rights and ensure their protection in Africa' and especially in this regard allow the right of every individual to 'enjoy the best attainable state of physical and mental health' (art 16);

1. Declares that the HIV/AIDS pandemic is a human rights issue which is a threat against humanity;

2. Calls upon African Governments, State Parties to the Charter to allocate national resources that reflect a determination to fight the spread of HIV/AIDS, ensure human rights protection of those living with HIV against discrimination, provide support to families for the care of those dying of AIDS, devise public health care programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions;

3. Calls upon the international pharmaceutical industries to make affordable and comprehensive health care available to African governments for urgent action against HIV/AIDS and invites international aid agencies to provide vastly increased donor partnership programmes for Africa including funding of research and development projects.

B3.3 Resolution on the Situation of Women and Children in Africa (2004)

Adopted by the African Commission on Human and Peoples' Rights during its 35th ordinary session held from 21 May to 4 June 2004 in Banjul, The Gambia. Text available at www.achpr.org.

Recalling that the Assembly of Heads of State and Government of the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa at its 2nd Ordinary Session held in July 2003 in Maputo, Mozambique;

Noting that the African Charter on the Rights and Welfare of the Child entered into force on 29 November 1989 and the Committee of Experts on the Rights of Child;

Considering that the situation of the women and children in Africa need to be thoroughly addressed;

Considering that women and children are victims of multiple human rights violations;

Considering deportation, slavery, child trafficking and the proliferation of street children in some countries of our continent;

Considering the persistence of traditional practices that are harmful to women and children in some African countries ('almoudou' children and genital mutilation);

Concerned about widespread poverty among women and the stigmatisation of women and children with HIV/AIDS;

1. Urges member states of the African Union to ratify the Protocol to the African Charter on the Rights of Women in Africa in order to facilitate its entry into force;

2. Urges all AU member states to ratify the United Nations Convention against All Forms of Discrimination against

Women, and member states that have ratified it with reservations to withdraw them;

3. Launches an appeal to member states to incorporate the above-mentioned international instrument into their national laws;

4. Urges member states to set up a special protection mechanism for women and children in war zones;

5. Appeals to member states to disarm and demobilise child soldiers, and put in place a system for their social reintegration;

6. Appeals to member states to implement programmes to fight against HIV/AIDS;

7. Appeals to member states to devise a system to help women benefit from social security.

B4 New Partnership for Africa's Development (NEPAD)

B4.1 NEPAD Framework Document (2001)

NEPAD is an economic development programme of the African Union, adopted at the 37th session of the Assembly of Heads of State and Government in July 2001 in Lusaka, Zambia. African Heads of State proposed and adopted NEPAD to curb Africa's continuing economic and political devastation. With NEPAD, African Heads of State promise adherence to tenets of good political and economic governance that will prompt Africa's development. Full text available at www.nepad.org.

Excerpts

...

I. Introduction

1. This New Partnership for Africa's Development is a pledge by African leaders, based on a common vision and a firm and shared conviction, that they have a pressing duty to eradicate poverty and to place their countries, both individually and collectively, on a path of sustainable growth and development and, at the same time, to participate actively in the world economy and body politic. The Programme is anchored on the determination of Africans to extricate themselves and the continent from the malaise of underdevelopment and exclusion in a globalising world.

...

4. In Africa, 340 million people, or half the population, live on less than US \$1 per day. The mortality rate of children under 5 years of age is 140 per 1000, and life expectancy at birth is only 54 years. Only 58 per cent of the population have access to safe water. The rate of illiteracy for people over 15 is 41 per cent. There are only 18 mainline telephones per 1000 people in Africa, compared with 146 for the world as a whole and 567 for high-income countries.

5. The New Partnership for Africa's Development calls for the reversal of this abnormal situation by changing the relationship that underpins it. Africans are appealing neither for the further entrenchment of dependency through aid, nor for marginal concessions.

6. We are convinced that an historic opportunity presents itself to end the scourge of underdevelopment that afflicts Africa. The resources, including capital, technology and human skills, that are required to launch a global war on poverty and underdevelopment exist in abundance and are within our reach. What is required to mobilise these resources and to use them properly, is bold and imaginative leadership that is genuinely committed to a sustained human development effort and the eradication of poverty, as well as a new global partnership based on shared responsibility and mutual interest.

7. Across the continent, Africans declare that we will no longer allow ourselves to be conditioned by circumstance. We will determine our own destiny and call on the rest of the world to complement our efforts. There are already signs of progress and hope. Democratic regimes that are committed to the protection of human rights, people centred development and market-oriented economies are on the increase. African peoples have begun to demonstrate their refusal to accept poor economic and political leadership. These developments are, however, uneven and inadequate and need to be further expedited.

8. The New Partnership for Africa's Development is about consolidating and accelerating these gains. It is a call for a new relationship of partnership between Africa and the international community, especially the highly industrialised countries, to overcome the development chasm that has widened over centuries of unequal relations.

...

III. The new political will of African leaders

42. The New Partnership for Africa's Development recognises that there have been attempts in the past to set out continent-wide development programmes. For a variety of reasons, both internal and external, including questionable leadership and ownership by Africans themselves, these have been less than successful. However, there is today a new set of circumstances, which lend themselves to integrated practical implementation.

43. The new phase of globalisation coincided with the reshaping of international relations in the aftermath of the Cold War. This is associated with the emergence of new concepts of security and self-interest, which encompass the right to development and the eradication of poverty. Democracy and state legitimacy have been redefined to include accountable government, a culture of human rights and popular participation as central elements.

44. Significantly, the numbers of democratically elected leaders are on the increase. Through their actions, they have declared that the hopes of Africa's peoples for a better life can no longer rest on the magnanimity of others.

45. Across the continent, democracy is spreading, backed by the African Union (AU), which has shown a new resolve to deal with conflicts and censure deviation from the norm. These efforts are reinforced by voices in civil society, including associations of women, youth and the independent media. In addition, African governments are much more resolute about regional and continental goals of economic cooperation and integration. This serves both to consolidate the gains of the economic turnaround and to reinforce the advantages of mutual interdependence.

...

47. The New Partnership for Africa's Development centres on African ownership and management. Through this programme, African leaders are setting an agenda for the renewal of the continent. The agenda is based on national and regional priorities and development plans that must be prepared through participatory processes involving the people. We believe that while African leaders derive their mandates from their people, it is their role to articulate these plans and lead the processes of implementation on behalf of their people.

48. The programme is a new framework of interaction with the rest of the world, including the industrialised countries and multilateral organisations. It is based on the agenda set by African peoples through their own initiatives and of their own volition, to shape their own destiny.

49. To achieve these objectives, African leaders will take joint responsibility for the following

...

- Promoting and protecting democracy and human rights in their respective countries and regions, by developing clear standards of accountability, transparency and participatory governance at the national and subnational levels;

...

- Revitalising and extending the provision of education, technical training and health services, with high priority given to addressing the problem of HIV/AIDS, malaria and other communicable diseases;

- Promoting the role of women in social and economic development by reinforcing their capacity in the domains of education and training; by developing revenue generating activities through facilitating access to credit; and by assuring their participation in the political and economic life of African countries;

- Building the capacity of the states in Africa to set and enforce the legal framework, and to maintain law and order;

...

V. Programme of action: The strategy for achieving sustainable development in the 21st century

...

65. The objective of the New Partnership for Africa's Development is to give impetus to Africa's development by

bridging existing gaps in priority sectors in order to enable the continent to catch up with developed parts of the world.

66. The new long-term vision will require massive, heavy investment to bridge existing gaps. The challenge ahead for Africa is to be able to raise the required funding under the best conditions possible. We therefore call on our development partners to assist us in this endeavour.

67. Long-term objectives

- To eradicate poverty in Africa and to place African countries, both individually and collectively, on a path of sustainable growth and development and thus halt the marginalisation of Africa in the globalisation process;
- To promote the role of women in all activities.

68. Goals

- To achieve and sustain an average gross domestic product (GDP) growth rate of over 7 per cent annum for the next 15 years;
- To ensure that the continent achieves the agreed International Development Goals (IDGs), which are
- To reduce the proportion of people living in extreme poverty by half between 1990 and 2015;
- To enrol all children of school age in primary schools by 2015;
- To make progress towards gender equality and empowering women by eliminating gender disparities in the enrolment in primary and secondary education by 2005;
- To reduce infant and child mortality ratios by two-thirds between 1990 and 2015;
- To reduce maternal mortality ratios by three-quarters between 1990 and 2015;
- To provide access for all who need reproductive health services by 2015;
- To implement national strategies for sustainable development by 2005, so as to reverse the loss of environmental resources by 2015.

69. The strategy has the following expected outcomes

- Economic growth and development and increased employment;
- Reduction in poverty and inequality;
- Diversification of productive activities enhanced international competitiveness and increased exports;
- Increased African integration.

70. Realising that unless something new and radical is done, Africa will not achieve the IDGs and the 7 per cent annual GDP growth rate, the African heads of state propose the programme described below. The programme is anchored on key themes and is supported by detailed programmes of action.

...

(iv) Health

123. Objectives

- To strengthen programmes for containing communicable diseases, so that they do not fall short of the scale required in order to reduce the burden of disease;
- To have a secure health system that meets needs and supports disease control effectively;
- To ensure the necessary support capacity for the sustainable development of an effective health care delivery system;
- To empower the people of Africa to act to improve their own health and to achieve health literacy;
- To successfully reduce the burden of disease on the poorest people in Africa;
- To encourage cooperation between medical doctors and traditional practitioners.

124. Actions

- Strengthen Africa's participation in processes aimed at procuring affordable drugs, including those involving the international pharmaceutical companies and the

international civil society, and explore the use of alternative delivery systems for essential drugs and supplies;

- Mobilise the resources required to build effective disease interventions and secure health systems;
- Lead the campaign for increased international financial support for the struggle against HIV/AIDS and other communicable diseases;
- Join forces with other international agencies such as the World Health Organisation (WHO) and donors to ensure that support for the continent is increased by at least US \$10 billion per annum;
- Encourage African countries to give higher priority to health in their own budgets and to phase in such increases in expenditure to a level to be mutually determined;
- Jointly mobilise resources for capacity-building in order to enable all African countries to improve their health infrastructures and management.

125. Africa is home to major endemic diseases. Bacteria and parasites carried by insects, the movement of people and other carriers thrive, favoured as they are by weak environmental policies and poor living conditions. One of the major impediments facing African development efforts is the widespread incidence of communicable diseases, in particular HIV/AIDS, tuberculosis and malaria. Unless these epidemics are brought under control, real gains in human development will remain an impossible hope.

...

VII. Implementation of the New Partnership for Africa's development

186. Recognising the need to sequence and prioritise, the initiating Presidents propose that these programmes be fast-tracked, in collaboration with development partners

- Communicable diseases: HIV/AIDS, malaria and tuberculosis;
- Information and communications technology;
- Debt reduction; and
- Market access.

187. Work has already been done on all these programmes through a variety of international partnerships and institutions. However, Africa's participation and leadership need to be strengthened for better delivery. We believe that addressing these issues could fast-track the renewal of the continent ...

B4.2 NEPAD Health Strategy (2003)

Adopted by the First Conference of Health Ministers of the African Union, at Tripoli, Libya in April 2003. It recognises the broader socio-economic and political factors that are at the root of much of the ill health on the continent and emphasises the contribution of other strategies in NEPAD to address broader issues that are undermining health. Special attention is afforded to HIV and AIDS in view of the unprecedented challenge that this epidemic poses to Africa's economy and social development and to health services in the continent. Full text available www.nepad.org.

Excerpts

...

SECTION 5: The NEPAD health sector strategic directions

The NEPAD health sector strategy is a medium term strategy that follows a comprehensive, integrated approach to addressing the disease burden of Africa. The strategy comprises seven strategic directions. These are to

- Strengthen commitment by and the stewardship role of government;

- Build secure health systems and services;
- Strengthen programmes to reduce the burden of disease;
- Provide skilled care for pregnancy and childbirth;
- Enable individual action to improve health;
- Mobilise and effectively use sufficient sustainable resources;
- Strive for equity for the poor, displaced and marginalised.

These strategic directions would be complementary to interventions in other priority areas identified in NEPAD, recognising the close linkages between health and overall human development. Thus, the strategy recognises and supports commitments within NEPAD to addressing broader issues that are undermining health, including poor governance, socio-political instability, economic underdevelopment, poverty, marginalisation and displacement, lack of infrastructure (energy, transport and water and sanitation), low educational levels, agricultural vulnerability, environmental degradation and gender inequality. This strategy focuses on the health sector.

5.1 Strengthen commitment by and the stewardship role of government

The NEPAD vision for health development can only be achieved when governments seize their stewardship role. This involves providing effective vision and influence, appropriately leading and steering the health sector and enabling coherent and consistent intersectoral action, in the interests of the nations health and health care. Ministries of Health need to enhance the effectiveness of interventions in the public, private and not-for-profit sectors, appropriately using all the tools potentially at their disposal. Stewardship must be applied not only to responsibilities that mainly fall directly under the jurisdiction of the Ministry of Health (stewardship in health); but also to setting the direction of health development leading to the strategic management of the health system (stewardship of health); as well as stewardship of factors in the broader social, political and economic environment that will enhance health required by government, civil society and regional and international development partners (stewardship for health). Credibility will come not just from pronouncements, but from matching statements with action.

Ministries need to build their capacity to effectively fulfil their stewardship role in an environment that is becoming increasingly complex and that is changing rapidly. A first step is to achieve a high level of visibility for health and to advocate effectively for government commitment to the health sector and for the nation to place a high value on health and with attaining and retaining the resources needed – human, financial and material. These resources must then be equitably allocated and efficiently managed. Successful stewardship will include effective policy and plan formulation, including clarity on the role and nature of the private sector and civil society, health legislation and regulation, co-ordination of effort and development of norms and standards. Ongoing monitoring and evaluation must be tied to interventions to address problems identified.

...

5.2 Build secure health systems and services

The process of building health systems to effectively meet even the basic health needs of Africa's people and support disease control will take time and will require sustained commitment over many years. There can be no single health system recipe, given the diversity of national health systems and service situations in Africa. Furthermore, each country will have different priority areas for attention: in one country this may be access to drugs, in another human resources and in another communication. Thus, each country will need to prepare its own country specific health policy and strategic plan for securing its health system.

...

Although there may be no generic prescriptions, it is possible to identify common requirements of an effective health system. These are service provision and care at all levels, human resource development, essential medicines and supplies, health technologies, health information and research, and institutional public health, capacity.

...

5.3 Strengthen programmes to reduce the burden of disease

Although there is a need to address the full range of health problems affecting Africa, there is little doubt that the immediate priority must be to reduce the burden of disease caused by AIDS and also by TB, malaria and childhood communicable diseases. The NEPAD disease control proposals are broadly aligned to existing international or continental initiatives and the commitments of the action plans of the Abuja Declarations on Malaria and on HIV/AIDS, TB and Other Related Infections and to securing the funding needed for their implementation. While considering this strategy's focus on the health system elements of prevention and control of the health burden, the collaborative multi-sectoral effort required to address them fully must always be seen to be at the forefront of efforts.

NEPAD envisages a massively scaled up AIDS prevention effort incorporating education, access to condoms, voluntary counselling and testing, treatment for sexually transmitted infections (STIs) and prevention of mother-to-child transmission. Targeting of those at high risk, such as sex workers, migrant workers and youth must be stepped up and prioritised. Care includes home-based care and care of orphans, improvements in quality of life, treatment and prophylaxis of opportunistic infections and use of anti-retrovirals. As with other diseases, effective care will require affordable drugs and strengthened health systems, including effective drug distribution, strengthened laboratory services and caring health staff. It also requires community action and empowered individuals and families.

A key element in AIDS prevention is reaching the youth. Investing simultaneously more broadly in health promotion amongst youth will yield many benefits now and in the future. They will be empowered with accurate information to reduce their risk of sexually transmitted infections and HIV/AIDS, early and unwanted pregnancies, alcohol and substance use/abuse and chronic diseases of lifestyle. Young people should be involved in the design, implementation and evaluation of the policies and programmes that affect them.

...

5.4 Provide skilled care for pregnancy and childbirth

The reduction of maternal and newborn morbidity and mortality requires a package of specified promotive and preventive measures and screening for and early care of problems identified during pregnancy. It also requires effective and immediate access to skilled assistance in childbirth and easy access to referral facilities for complications, such as those requiring Caesarian sections. In consequence, the process of making pregnancy safer requires suitable staff and interventions throughout the district health care system from effective client education and participation to functional supply, communication and transport systems. Thus, while this programme will focus on pregnancy and childbirth, it is also a strategic entry point to strengthen the health system, as many of the measures required have to address weaknesses in the system as a whole.

The inclusion of gender mainstreaming in health policy, improving women's rights and the elimination of all forms of violence against women (including female genital mutilation which should be prohibited by law) and access to family planning are important features of the wider women's health programme that is required. The central role played by women in providing health care and in socio-economic development should be recognised and supported.

5.5 Enabling individual and community action to improve health

...

The NEPAD health programme seeks to achieve a real scaling up of community involvement in a range of health issues, starting with the major causes of disease burden. At the core is a commitment to mobilise energy and voluntarism in a manner that is difficult for formal health services to match, and to achieve results in groups that formal services struggle to reach.

On the one hand, it is important that people do not simply wait for government to do things for them, yet on the other, organisations do not arise spontaneously in sufficient numbers. Health ministries will therefore need to create an enabling environment for community involvement, facilitate the emergence of local NGOs and CBOs and provide funding to initiate efforts in underserved areas. As situations vary from country to country, there is no single way of doing this. Each country should consider the local situation and incorporate a deliverable approach to community involvement in its country plan. The details may be different, but the aim is common to all countries: to reach all sectors of society, especially the poorest and most marginalised, in a sustained programme of social mobilisation in support of health. The aim is to combine community energy with equitable, honest and effective government effort – without the latter this can become a way of government excusing itself from its responsibilities and creating a system of second class care for the poor and less powerful.

5.6 Mobilise and effectively use sufficient sustainable resources

The individual and collective efforts of African countries to battle the heavy burden of disease and unnecessary death on the continent must entail the mobilisation of substantial additional resources, both domestic and foreign. African governments and development partners alike must translate the international strategies adopted in the area of health development into concrete financial commitments. Much less will, when distributed, be spread too thin to make the impact required. At the same time recipient and donor countries as well as international institutions and NEPAD must work together to make ODA more effective.

...

As evidence of their own commitment to this programme, Heads of State will lay the ground for sustainable interventions and each country will show its commitment to this programme by setting explicit goals for domestic spending in the health sector and by allotting a higher priority to health in their national budgets. For each country, the amount committed will be different, but will be such that no observer would question the country's resolve to tackling its burden of disease and to moving towards the target of 15 per cent of public expenditure committed to in Abuja. This must be factored into Medium Term Expenditure Frameworks.

...

Emphasis must be placed on untied aid, aid effectiveness and the implementation of monitoring and peer review mechanisms for mutual accountability. The international donor community must strive to streamline its approach to health funding through increased harmonisation and coherence of donor policies and aid practices towards the achievement of the Millennium Development Goals. The resources mobilised, including those of the Global Fund to Fight AIDS, Tuberculosis and Malaria, must not just go into disease specific programmes but also into securing the vehicle that needs to provide much of the specific prevention and care that has to be implemented - the health system. At the same time, the disease programmes must receive enough funds to match the scaling up that are required of them.

NEPAD is committed to strengthening mechanisms in its member countries for accessing, allocating, distributing and managing additional sources of funding. NEPAD countries recognise well that funding flows are in no small part going to be linked to their ability to effectively use and account for funds. Ministries of Finance will need to pay particular attention to this in the health sector and to the capacity building required for effective and accountable use of funds.

5.7 Strive for equity for the poor, displaced and marginalised

Successfully impacting on the disease burden of the poorest and most marginalised people of Africa requires economic recovery pursued in a manner where real benefits reach those in greatest need. A central feature of NEPAD is the war on poverty and marginalisation, the success of which will contribute to health. A strong focus on the needs of the poor, including food security, will provide significant health returns. Strengthening public

services impacts most on the poor, as this is where they access care. Such strengthening is central to this strategy.

...

B4.3 The African Peer Review Mechanism (APRM) Declaration on Democracy, Political, Economic and Corporate Governance (Governance Declaration) (2001)

The African Peer Review Mechanism (APRM) is a mutually agreed upon instrument voluntarily acceded to by the member states of the African Union (AU) as a self-monitoring mechanism. The mandate of the APRM is to encourage conformity in regard to political, economic and corporate governance values, codes and standards, among African countries and the socio-economic development objectives in the New Partnership for Africa's Development. Full text available at www.nepad.org.

Excerpts

...

Preamble

1. We, the participating Heads of State and Government of the member states of the African Union (AU), met in Durban, South Africa, at the inaugural Assembly of the African Union and considered the report of the New Partnership for Africa's Development (NEPAD) Heads of State and Government Implementation Committee established at the Organization of African Unity (OAU) Summit in Lusaka, Zambia, in July 2001.

...

5. Africa faces grave challenges and the most urgent of these are the eradication of poverty and the fostering of socio-economic development, in particular, through democracy and good governance. It is to the achievement of these twin objectives that the NEPAD process is principally directed.

6. Accordingly, we the participating Heads of State and Government of the member states of the African Union have agreed to work together in policy and action in pursuit of the following objectives

- democracy and good political governance
- economic and corporate governance
- socio-economic development
- African peer review mechanism

Democracy and good political governance

7. At the beginning of the new century and millennium, we reaffirm our commitment to the promotion of democracy and its core values in our respective countries. In particular, we undertake to work with renewed determination to enforce

- the rule of law;
- the equality of all citizens before the law and the liberty of the individual;
- individual and collective freedoms, including the right to form and join political parties and trade unions, in conformity with the constitution;
- equality of opportunity for all;

...

9. We are determined to increase our efforts in restoring stability, peace and security in the African continent, as these are essential conditions for sustainable development, alongside democracy, good governance, human rights, social development, protection of environment and sound economic management. Our efforts and initiatives will also be directed at seeking speedy peaceful solutions to current conflicts and at building Africa's capacity to prevent, manage and resolve all conflicts on the continent.

10. In the light of Africa's recent history, respect for human rights has to be accorded an importance and urgency all of its own. One

of the tests by which the quality of a democracy is judged is the protection it provides for each individual citizen and for the vulnerable and disadvantaged groups. Ethnic minorities, women and children have borne the brunt of the conflicts raging on the continent today. We undertake to do more to advance the cause of human rights in Africa generally and, specifically, to end the moral shame exemplified by the plight of women, children, the disabled and ethnic minorities in conflict situations in Africa.

11. In Africa's efforts at democracy, good governance and economic reconstruction, women have a central role to play. We accept it as a binding obligation to ensure that women have every opportunity to contribute on terms of full equality.

12. To fulfil these commitments we have agreed to adopt the following action plan

13. In support of democracy and the democratic process

We will

- ensure that our respective national constitutions reflect the democratic ethos and provide for demonstrably accountable governance;
- promote political representation, thus providing for all citizens to participate in the political process in a free and fair political environment;
- enforce strict adherence to the position of the African Union (AU) on unconstitutional changes of government and other decisions of our continental organisation aimed at promoting democracy, good governance, peace and security;

...

- heighten public awareness of the African Charter on Human and Peoples Rights, especially in our educational institutions.

14. In support of Good Governance

We have agreed to

- adopt clear codes, standards and indicators of good governance at the national, sub-regional and continental levels;
- accountable, efficient and effective civil service;
- ensure the effective functioning of parliaments and other accountability institutions in our respective countries, including parliamentary committees and anti-corruption bodies; and
- ensure the independence of the judicial system that will be able to prevent abuse of power and corruption.

15. To promote and protect human rights

We have agreed to

- facilitate the development of vibrant civil society organisations, including strengthening human rights institutions at the national, sub-regional and regional levels;
- support the Charter, African Commission and Court on Human and People's Rights as important instruments for ensuring the promotion, protection and observance of human rights;
- strengthen co-operation with the UN High Commission for Human Rights; and
- ensure responsible free expression, inclusive of the freedom of the press.

Economic and corporate governance

16. Good economic and corporate governance including transparency in financial management are essential prerequisites for promoting economic growth and reducing poverty. Mindful of this, we have approved eight prioritised codes and standards for achieving good economic and corporate governance.

...

- (a) Code of Good Practices on Transparency in Monetary and Financial Policies;
- (b) Code of Good Practices on Fiscal Transparency;
- (c) Best Practices for Budget Transparency;
- (d) Guidelines for Public Debt Management;

- (e) Principles of Corporate Governance;
- (f) International Accounting Standards;
- (g) International Standards on Auditing; and
- (h) The Core Principles for Effective Banking Supervision.

...

Socio-economic development

20. We believe that poverty can only be effectively tackled through the promotion of

- democracy, good governance, peace and security;
- the development of human and physical resources;
- gender equality;
- openness to international trade and investment;
- allocation of appropriate funds to social sector and ;
- new partnerships between governments and the private sector, and with civil society.

21. We reaffirm our conviction that the development of Africa is ultimately the responsibility of Africans themselves. Africa's development begins with the quality of its human resources. We, therefore, undertake to work towards the enhancement of our human resources through the provision of more and better education and training, especially in Information and Communications Technology (ICT) and other skills central to a globalising world; and better health care, with priority attention to addressing HIV/AIDS and other pandemic diseases.

22. The marginalisation of women remains real despite the progress of recent years. We will, therefore, work with renewed vigour to ensure gender equality and ensure their full and effective integration of women in political and socioeconomic development.

...

24. The regional economic communities remain the building blocks for Africa's economic integration. We will, therefore, continue to strengthen them in every way practicable and to relate their evolution more closely to the development of the African Union.

25. We welcome the strong international interest in and support for NEPAD. It is our intention to build on this promising foundation, working with our development partners and the wider international community to

- forge new forms of international co-operation in which the benefits of globalisation are more evenly shared;
- create a stable international economic environment in which African countries can achieve growth through greater market access for their exports; the removal of trade barriers, especially non-tariff barriers and other forms of protectionism; increased flows of direct foreign investment; debt cancellation; a meaningful increase in ODA; and the diversification of their economies. Africa's prosperity will be a multiplier in world prosperity.

...

28. We have separately agreed to establish an African Peer Review Mechanism (APRM) on the basis of voluntary accession. The APRM seeks to promote adherence to and fulfilment of the commitments contained in this Declaration. The Mechanism spells out the institutions and processes that will guide future peer reviews, based on mutually agreed codes and standards of democracy, political, economic and corporate governance.

Country Review Report – Rwanda (2005)

This report presents the findings of the APRM's Country Review Mission to Rwanda, as well as the Panel's recommendations. It evaluates developments and outstanding challenges in the four APRM focus areas, namely democracy and political governance, economic governance and management, corporate governance, and socio-economic development. Full text available at www.nepad.org.

Excerpts

...

2. Democracy and good political governance

...

2.3 Assessment of APRM objectives relating to democracy and political governance

...

Objective 3: To promote and protect civil and political rights, and economic, social rights, as enshrined in African and international human rights instruments

i. Country self-assessment report

Socio-economic rights

108. The Rwandan Constitution guarantees civil, political, social and cultural rights. It outlaws discrimination on the basis of race, gender, religion and employment. Despite the poverty levels in the State, and its weak economic capacities, attempts are being made to respond to a wide range of socio-economic issues. The Government is attempting to fulfil economic and social rights through employment by creating public works. The 2003 Constitution of Rwanda also recognises the rights of its citizens and duties relating to health. The State is obligated to mobilise and assist the population in these activities. School fees have been waived for orphans, while compulsory universal and free primary education is being provided. There are also special measures for disabled children. The CSAR notes that the Government has provided space for the construction of cheaper houses, especially for families without shelter. Two-roomed *Imidugudu* have emerged to house widows, orphans and returnees.

ii. Mission findings

Socio-economic rights

109. The CRM's consultations show that the Government of Rwanda is making steady progress on both aspects of socio-economic rights. In 2004, MINISANTE (the Ministry of Health) revised its health sector policy to move towards a sector-wide approach. Pilot projects have been undertaken in several provinces, where performance-based health schemes for health services are provided. Between 2002 and 2003, there was an increase of 10 per cent and 7 per cent in the number of physicians and nurses working in the public sector, respectively.

110. The Government has moved to decentralise the health services, making elected local councils take responsibility for their communities, by empowering them and ceding to those bodies the power to deliver health services. Consequently, local communities are taking part in deciding the status of the health situations of their people and how these should be addressed. This is a best practice from which other APR countries can learn how to empower local communities to take charge of their health.

...

Objective 7: To promote and protect the rights of women

i. Country self-assessment report

136. The CSAR points to section V of Rwanda's Constitution which outlaws any form of discrimination based on gender, disability, language or social status. The Family Code has improved the legal position of women in matters relating to marriage, divorce and child custody. The law allows women to inherit property from their fathers and husbands. It allows couples to choose the legal property arrangements they wish to adopt. The Government has committed itself to gender equality by signing the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The issue of gender has been given a very high profile in political life.

137. In addition to constitutional provisions, Rwanda has created a plethora of institutions and development programmes to enhance the status and welfare of women in all walks of life. It has set up the Ministry of Gender and Women in Development (MIGEPROFE) within which the Secretariat has the responsibility to implement the Beijing Accords. The Ministry has the responsibility of coordinating policy implementation in the promotion of gender issues. At the political level, the Constitution sets aside 30 per cent of the seats in Parliament for women. A separate procedure for the election of women to Parliament has been set up, to prevent women from being taken advantage of under the general electoral roll.

138. All political parties are required by law to reserve 30 per cent of their posts for women. Women's rights are also guaranteed by the National Human Rights Commission set up under Law No 04/99 of March 1999. Senior positions such as the Minister in the President's Office; Ministers of Justice; Gender and Family Promotion; Lands, Environment, Forestry and Water are all women (also discussed in the section on Socio-Economic Development). Nearly half (49 per cent) of the seats in the Chamber of Deputies are held by women (the largest representation in the world). Rwanda's record in the number of women in positions of responsibility is unprecedented in Africa, a shining model of best practice worthy of emulation.

139. Several legal reforms have recently been made to enhance the status of women in other areas of society. These include the inheritance law, land law, labour code and family law, all designed to address stark discrimination against women in economic and social relations. Policy actions of the authorities are also focusing on discrimination or inequities in male-female status and opportunities in areas such as education and employment in the formal sector of the economy. The Gender Monitoring Office, established by the Constitution, has been designed to promote gender equity and the rights of women in Rwanda.

ii. Mission findings

140. Despite the tremendous progress, however, the CRM confirmed that women still face societal discrimination. They perform much of the work in the agrarian sector. Worse still, most were left widowed or abused during the genocide. Gaps still exist with regard to control and ownership of key resources and means of production, as evidenced in the section on Socio-Economic Development of this report. There still exists a gender inequality in terms of access to social services such as health and education. Women are yet to be fully integrated into local government processes.

141. Although women are well represented in national decision-making bodies, the downside of the increased representation of women is that capacity building has yet to be upgraded in tandem to empower them. In the CRM's meetings with parliamentarians, for example, women Members of Parliament (MPs) agreed that capacity building in Parliament is crucial for their effectiveness. Still, much remains to be done, particularly in the implementation of laws and gender policies put in place by the Government. The discussion during the CRM centred on additional improvements that the country could make, namely

- The distribution of authority in relationships, an imbalance that typically favours the husband, such as being recognised explicitly by law as head of the family;
- The requirement of the husband's permission for a married woman to carry out commercial activities; and
- The prohibition of an unmarried woman from inheriting property in the event of the death of a man with whom she cohabited under the Rwandan Constitution, which stipulates monogamy as the form of marriage.

142. The representatives of the authorities had the following response. There was no shortage of political will to address the issues raised and to empower women accordingly. The authorities must, nevertheless, contend with the sociological and cultural values of the society, which have tended to place women under men. In addition, the limited formal education and skills development of women have placed them, in general, at a disadvantage in dealing with men and even in advocating for their own improvement and empowerment.

iii. Recommendations

143. The CRM recognises the commendable efforts made towards women representation, particularly in Parliament (Box 2.2). To reinforce and deepen this best practice, it is recommended that the Government

- Engages in more capacity-building activities to enhance the effectiveness of women parliamentarians; and
- Continues the implementation of the gender laws and policies already in place.

Objective 8: To promote and protect the rights of children

...

ii. Mission findings

...

147. The Government has also responded to the problem of orphans on the streets or children-headed households by providing housing under the Imidugudu (villages) scheme for children orphaned by the genocide. Between 2001 and 2004, the Ministry of Local Government and Social Affairs estimated that the number of children living on the streets dropped from between 400 000–500 000 to 7000.

148. In terms of education, school fees have been waived for orphans, while compulsory universal and free primary education is being provided, allowing all young children to go to school. The Cost Sharing and Financial Sector Plan for Tertiary Education has been put in place. A Student Financing Agency for Rwanda was put in place in 2003 and began operating in 2005. State expenditure on education accounts for 25 per cent of the Government's non-interest recurrent expenditure.

iii. Recommendations

149. The efforts made by Rwanda on behalf of children are appreciable. However, the CRM recommends that the Government

- Reinforces the protection of the rights of children, particularly by ratifying the African Charter on the Rights and Welfare of the Child;
- Promotes the reintegration of children by assisting grassroots organisations to support them in developing their physical, psychological and socio-economic potential within the scope of rehabilitation programmes for post-conflict situations; and
- Withdraws reservation on compulsory education and criminalises the act of not sending children to schools.

...

5. Socio-economic development

5.1 Introduction

356. Socio-economic development is one of the four thematic areas of the APRM. It follows the principles that poverty can be effectively tackled through the promotion of a number of key objectives. These include democracy, good governance and security; the development of human and physical resources; gender equality; openness to international trade and investment; allocation of appropriate funds to the social sector; as well as new partnerships between the Government, the private sector and civil society. Rwanda's long history of bad governance and the legacy of genocide pose a major challenge for the Government in view of the massive portion of the population living in dire poverty and lacking access to social amenities.

357. Another obstacle is the limited capacity of the State to tackle these problems efficiently and effectively. The socio-economic development review of Rwanda is intended to highlight the efforts and progress made in designing appropriate policies and delivery mechanisms in key social development areas, while highlighting the outstanding challenges.

358. Currently, poverty in Rwanda is largely concentrated in the rural areas (83 per cent of the total population). Almost half the population (42 per cent) is below 14 years of age. The country is not very rich in natural resources and suffers from severe adverse climatic conditions, such as drought in some parts of the country. Socio-economic indicators are mixed, with improvements in areas such as gender equality and education, and lack of improvements in areas such as maternal and child health. Nonetheless, Rwanda has made exceptional progress in establishing policy and institutional frameworks to improve socio-economic development. Vision 2020, the Poverty Reduction Strategy Paper (PRSP), and Sector Strategies constitute the key long- and medium-term plans and road maps for promoting socio-economic development. These strategies are facilitated by Rwanda's ongoing decentralisation process, which is also supported by the Decentralisation Unit, the Community Development Committee (CDC), and the Poverty Observatory Unit.

...

361. Rwanda is reforming existing laws and designing new laws to comply with the 2003 Constitution and international standards and codes. These new and/or revised laws incorporate social concerns such as the gender issue, the youth, and environmental conservation and protection. Examples of reformulated and new laws passed, or in the process of being passed are

- Family Law;
- Inheritance Law (that considers rights of women);
- Law on Women's Council;
- Land Law;
- Environment Bill;
- Microfinance Law;
- Education Law;
- Health Law; and
- Law on the Rights of Children.

ii. Mission findings

362. The extensive list of regional and international standards and codes shows that Rwanda has demonstrated political will to adhere to these provisions by signing, ratifying and/or adopting all the standards and codes listed in the APRM Questionnaire for Socio-Economic Development. As indicated in the section on democracy and good political governance, Rwanda has not yet signed the Optional Protocols to CEDAW. Nonetheless, Rwanda has signed and ratified the AU Protocol on the Rights of Women, which very few African countries have ratified to date.

363. It is worth noting that Rwandan law establishes the supremacy of international legal instruments over domestic legislation. In the hierarchy of laws, the Constitution is supreme, followed by organic laws, ordinary laws, decree laws,

presidential orders, Prime Minister's orders, Ministerial orders, instructions (by authorities designated by law, eg NBR) and regulations.

364. Compliance with international standards and codes is the important next step after ratification. The official process in Rwanda regarding compliance is to translate these international laws into domestic laws, which are passed by Parliament. Once passed, the laws are published in the official gazette in three languages: Kinyarwanda, English and French. These are then disseminated to the provinces. The allocation of resources must also complement the process for effective implementation. In Rwanda, lack of adequate compliance remains a reality for several reasons ...

365. Worthy of note in the process of formulating such laws is the participation of various stakeholders, including civil society, the private sector as well as women and religious groups.

5.3 Assessment of APRM objectives relating to socio-economic development

...

Objective 2: To accelerate socio-economic development to achieve sustainable development and poverty eradication

...

ii. Mission findings

...

387. On the issue of poverty, the CRM asked civil society and government representatives, including the Ministry of Finance, why the numbers of population living below the national poverty line were increasing, despite augmented investment in poverty-related sectors. Rwanda's CSAR noted that in 2001, 60.3 per cent of its people were living below the poverty line, rising to 63.3 per cent in 2003. Some explanations obtained regarding this paradox were that vulnerable groups (i.e. widows, and persons living with HIV) were not patronising government support; environmental conditions were adverse; and there was a time lag of investments. The Ministry of Finance, however, pointed out that poverty statistics after 2000 are speculative, and that one cannot be certain that poverty indicators are indeed rising. The Ministry is writing the second PRSP and will use actual data from household surveys.

...

Objective 3: To strengthen policies, delivery mechanisms and outcomes in key social development areas, including education for all, combating of HIV/AIDS and other communicable diseases

Country self-assessment report (CSAR)

...

393. On health issues, while the CSAR reports that health indicators have shown signs of improvement since the genocide, it also admits that the indicators are still low in comparison with the average for sub-Saharan Africa. malaria rates, noted to be increasing (50 per cent in 2001 to 61 per cent in 2003) continue to be the leading cause of morbidity for children under five years of age and the general population at large. The national HIV/AIDS prevalence rate is reported to be at a high of 13.5 per cent. The CSAR further states that malaria and HIV rates continue to increase even though the Government has doubled its efforts in the campaign against them. The incidence rate of HIV/AIDS has been increasing in the past five years, and it is evident that HIV/AIDS ranks as the second killer disease after malaria. On HIV/AIDS treatment, there have been 25 operational antiretroviral sites and 6327 patients on such medication as of September 2004. Some 105 Preventing Mother-to-Child Transmission (PMTCT) and 120 voluntary counselling and testing (VCT) sites have been integrated in health facilities.

394. Child health and maternal health have shown no signs of improvement, as indicated in the data provided in the CSAR. In fact, the maternal mortality rates of 1071 per 100 000 is one of the highest in the world and poses the greatest challenge in meeting the MDGs. The health insurance coverage rate was reported to be at a low of 7 per cent in 2003, but the innovative approach being utilised in Rwanda is boosting health insurance coverage in a cost-effective manner. This mechanism, known as Mutuelle de Santé, is a community-based health insurance that is decentralised from provincial level to the cell level. As of August 2004, the coverage rate was 24 per cent. Employees of the Government, however, are provided with RAMA, a government health insurance scheme.

395. In education, the CSAR notes that an Educational Sector Policy was drawn up in 2003/2004. Measures have been taken by the central government to make basic education universal and free for all Rwandans. Rwanda also has an Education Sector Strategic Plan (ESSP) 2004–2008, which utilises a sector-wide approach by involving all partners in the development of the strategic plan and adhering to a global monitoring and evaluation framework. As far as resources are concerned, the share for education has been consistently more than half the total amount of priority spending. Particular attention is being paid to the education of girls and the promotion of Science, Mathematics and ICT (considered the heart of the education system) in schools.

ii. Mission findings

...

398. With regard to the legal framework, there appears to be no recently updated laws on health care in the past fifteen years, as noted by the CSAR. Nonetheless, there are numerous policies and strategies covering many facets of health. A number of institutions (health centres, HIV/AIDS Commission, et cetera) have been established to improve the performance of the health sector. Rwanda is also receiving substantial international assistance in the health sector, most of which is directed at HIV/AIDS. For example, the World Bank-funded MAP is providing assistance for public awareness campaigns and community sensitisation, testing and antiretroviral drugs, as well as health care for those persons living with HIV.

399. On HIV/AIDS, the CRM presented to various stakeholders an issue that is not sufficiently dealt with in the CSAR, namely the large influx of resources to combat HIV/AIDS. This includes funds from the World Bank, the Global Fund and the United States Government. Rwanda is also one of fourteen countries included in the five-year President's Emergency Plan for AIDS Relief (PEPFAR) that began in the 2004 fiscal year. The concern was that the excess of resources for combating HIV/AIDS could undermine the health sector, for example by providing incentives for several doctors to leave their practices in primary health care to find employment in a more lucrative field.

400. Discussions with the Division of Strategic Planning at the Ministry of Finance confirmed that funds for HIV/AIDS were not overshadowing other health concerns, because they were being used broadly (for sensitisation, nutrition, et cetera), which had multiple benefits for society at large.

401. Another concern, which was confirmed during the CRM, was the lack of reliable data for the national and regional estimates of the prevalence of HIV/AIDS. An example of this was clear in the case of the Kibungo province, whereby the CSAR noted an HIV prevalence rate of approximately 6 per cent. Nonetheless, a visit to the province and interactions with provincial leaders led the CRM to believe that Kibungo had the highest rate of HIV/AIDS in the country, near to 13 per cent. The discrepancy in data was eventually put forward to the National Commission.

402. A member of the Commission, who is also a senior expert in the Ministry of Finance, confirmed that data on HIV/AIDS have been problematic in the past, as well as unreliable. Experience showed that people were more likely to respond – and to respond truthfully – depending on their degree of sensitisation on the subject matter. In fact, Rwanda is currently

in the process of initiating another survey of HIV/AIDS, especially for the regions of Umutara and Kibungo. The Commission took note of the recommendation to commit resources to improving data collection and monitoring. The process of establishing an independent statistical institution is under way.

403. Interactions with civil society and the National HIV/AIDS Commission confirmed that Rwanda has made available free Voluntary Counselling and Testing (VCT) centres all over the country. It was disclosed in the provinces that women are more afflicted by HIV than men, with serious adverse effects on households, given the central role of women in the home. Nonetheless, many women have been (and still are) sensitised to undergo testing, and are informed about accessing relevant antiretroviral treatment. Pregnant mothers are encouraged to visit PMTCT sites. Efforts to combat HIV/AIDS have been spearheaded by the Government from the grassroots level. Medication is available in the country and the World Food Programme (WFP) has been instrumental in supplementing treatments with the proper nutritional supplements. The Government is also making money available for income-generating activities to enhance the self-sufficiency of people living with HIV.

404. During a meeting with the President of the National HIV/AIDS Commission, it was disclosed that the Commission is currently designing a strategic plan for HIV/AIDS in conjunction with various stakeholders to be ready around July 2005. The President of the HIV/AIDS Commission confirmed that there is sufficient commitment in terms of resources to HIV/AIDS from the Government and international donors. Nonetheless, there is a gap when it comes to the provision of antiretroviral centres. More resources need to be committed to this, especially in making centres available in rural areas. The President admitted that the bulk of the funding went towards prevention campaigns and workshops. These are beneficial, but there is also a need to focus more on curative centres. The medium-term goal of the Commission is to stabilise the prevalence rates of HIV/AIDS in rural areas, which are currently increasing (compared with urban rates, which are declining).

405. In education, the CRM confirmed that tremendous strides have been made in the educational sector and the efforts are continuing. Rwandans proudly confirmed that basic education is free for all Rwandans and attendance is compulsory, as stipulated in the Constitution. The CRM asked both civil society and the Ministry of Education why enrolment was still not at full capacity in spite of the legal framework – and what was being done about this. It was explained that for several reasons, such as household chores, long distance to schools and the effects of genocide, parents might keep their children at home. Nonetheless, MINEDUC (the Ministry of Education) was in the process of introducing punitive measures for parents who do not send their children to school. To do this, it will work in collaboration with community-based administrations responsible for every ten houses in a district.

406. The lack of continuation on to secondary schools for many students, especially female students, was noted by the CRM and presented for further explanation. Early marriage and financial costs were cited as some of the reasons, but with the plans to extend free tuition up to the third year of secondary school, there should be some improvements in this trend. Most Rwandans consulted were aware of the Government's plan to increase basic education from primary completion up to three years in secondary school.

407. The CRM held a meeting with some senior officials, including the Minister of State at the Ministry of Education, to gain more insight into current developments in the educational sector. The CRM was satisfied with the various policies in place, which were all developed after 2003. They include

- Educational sector policy;
- Policy on education for all;
- Curriculum policy;
- Textbook policy;
- English language policy;
- Technical education policy;

- Teacher development and management policy (not yet finalised);
- Science and technology policy (not yet finalised);
- Distance learning policy (not yet finalised);
- Youth and adult literacy (not yet finalised); and
- HIV/AIDS education policy.

408. These policies are reportedly developed in consultation with NGOs, faith-based organisations, teachers, ministries, and so on. The cluster of institutions continues to expand throughout the consultations and, finally, culminates in a national conference, which operates like a Parliament and adopts the policy.

...

iii. Recommendations

410. The CRM advises the Government to

- Commit to a deadline of a uniform policy of health insurance – Mutuelle de Santé – which sets an amount of Rfr 1000 on membership fees;
- Update laws on health care;
- Make a greater effort in sensitising the public in order to obtain more accurate data on HIV/AIDS;
- Commit more resources to the construction of antiretroviral centres, especially in rural areas; and
- Build more schools close to the communities to increase enrolment to full capacity.

...

Objective 5: To make progress towards gender equality in all critical areas of concern, including equal access to education for all girls at all levels

i. Country self-assessment report

423. The CSAR notes that Rwanda has made good progress in gender equality, particularly in the areas of decision-making, legal reforms and education. The newly adopted Constitution is stated to be highly gender-responsive (i.e. mandating women to hold at least 30 per cent of seats in Parliament). Other legal reforms include: a law on women councils; a labour code providing for equal rights; and a land law. A National Gender Policy is in place and gender issues are being mainstreamed in school curricula. There is a ministerial decree to establish a secretariat as a follow-up to the Beijing Plan of Action. The Ministry of Gender and Family Promotion is reportedly in place and empowered. In terms of statistical information, the CSAR shows that in 2003, women comprised 32 per cent of the Ministers of State; 11.1 per cent of Secretary-Generals; 48.8 per cent of Members of Parliament; 50 per cent Senators and 9.1 per cent Prefects (Provincial Heads).

424. In spite of the legal reforms, the CSAR listed some existing discriminatory laws that have not yet been reformed. Examples include the fact that a woman should live where her husband chooses to live (art 83); and that, in event of temporary separation, a husband can ask that the wife leave the marital home (art 250). These and several other laws have been acknowledged by MIGEPROFE, the Ministry for Gender and Women in Development, as requiring revision.

ii. Mission findings

425. Considering that Rwanda is a country that has made momentous progress in promoting the rights of women, it was surprising that discriminatory laws still existed and were unrevised. This concern was presented to parliamentarians and some civil society groups, in particular the Secretary-General of the Ministry for Justice. The explanation was that these laws were adopted many years ago; they were admittedly archaic and have no place in modern Rwandan society. The CRM was informed that there is a will to revise all these laws. However, several other proposed laws need to be deliberated by Parliament

and those laws concerning justice (in the light of the genocide) have assumed priority. Nonetheless, the CRM took consolation from the fact that the Constitution is the supreme law of the land and would override other laws that contradict it.

...

427. Concerning international standards and codes, Rwanda has signed and ratified CEDAW, but not the optional protocol to CEDAW. Furthermore, to date Rwanda has not submitted any of the reports to the UN as required of signatories to the Convention. The explanation provided to the CRM was that the period after the genocide hampered the capacity to produce these reports. Nonetheless, a report has recently been drafted to be submitted to the UN.

...

iii. Recommendations

429. The CRM recommends as follows

- The Ministry for Gender is advised to consider reporting of the status of women's rights to the UN Commission for CEDAW very seriously.
- The Gender Monitoring Office should be operationalised and the Government needs to commit to a time-frame for this.

Conclusion

...

6.2 The way forward

451. The Rwandan experience so far has demonstrated that the APRM is a useful concept to have in place and a vehicle that can enhance good governance. The success of the APRM is predicated on high-level political will and multi-stakeholder commitment (the private sector and civil society). Accession to the APRM comes with challenges and obligations. If the APRM is to be credible and effective, it will need to be transparent and accessible to all sections of the population. The APRM can be a major instrument for enhancing governance only if it is implemented in a professional, technical and transparent manner and free from political manipulation.

...

454. The ultimate goal of the APRM is assisting the reviewed country to improve its policy-making processes, adopt best practices from other countries, and comply with ratified standards and codes by involving all stakeholders in the country. In this regard, it must not be perceived as an instrument to access foreign resources, but rather as a process to improve national policy-making, sharing of experiences, and the creation of a conducive environment for growth and development, all of which are in the country's best interests.

Country Review Report – Kenya (2006)

This country report marks the third phase of the African Peer Review process in Kenya. It presents the findings of the Country Review Mission to Kenya, as well as the Panel's recommendations. The report evaluates developments and outstanding challenges in the four APRM focus areas. Full text available at www.aprmkenya.org.

Excerpts

...

2. Background

2.3 Overview of macroeconomic performance

Kenya currently ranks among the top ten most unequal countries in the world, and is fifth in Africa. The current inequality has a distinct rural and female face, as rural women and children are hardest hit. Statistics recently released by the United Nations indicate that under-five mortality (per 1000 live births) in 2003 was 117 in rural areas and 93 in urban areas, HIV/AIDS prevalence was 10.05 per cent in rural areas and 5.6 per cent in urban areas, and access to drinking water was 43.5 per cent in rural areas as compared to 89.7 in urban areas. 82 Per cent of the poor live in rural areas, while the figure is 18 per cent in urban areas.

This gross inequality has led to poverty, insecurity, crime, social unrest and has undermined overall economic growth and development in the country. The crime rate in Kenya rose by 51 per cent between 1994 and 2000. Insecurity of persons and property and a weak justice, law and order system pose the greatest threats to investment – both local and foreign and thus the ability of the nation to generate wealth. The 2003 MDG progress report and the recently concluded needs assessment for Kenya show clearly that with the exception of primary education and the fight against HIV/AIDS, the country is not likely to meet the MDG targets.

3. Democracy and political governance

3.1.3 Objective 3: To promote and protect economic, social and cultural rights and civil and political rights as enshrined in African and international human rights instruments

An attempt was made to provide universal health care systems, but this was not formalised. The report reflects that health care services are of poor quality and only a few citizenry access services in private facilities. The HIV pandemic was declared a national disaster, but the plight of orphaned children has not been addressed through policies. There is currently no policy on the procurement or manufacture of antiretroviral drugs.

ii. Findings of the Country Review Mission (CRM)

...

Economic, social and cultural rights

...

Government officials were also quick to point out that the Constituency Development Fund (CDF) monies were a novel channel for funds to the grassroots which, where properly utilised, had the potential of empowering constituents as the money was meant to be spent locally, hence creating employment for public works and health care, to mention but a few. Other MPs also pointed to additional inflow of other funds to the districts – HIV funds, road funds bursary awards, LATF and monies from a variety of NGOs.

The focus on the people's well-being was an anchor of the NARC campaign, and both the associated Bomas and Wako draft constitutions are very strong on health. Indeed, one of the most prominent bills that the parliament had intensively debated was the National Social Health Insurance Fund Bill. This had to be shelved, however, when the civil servants demonstrated the financing obstacles to long-term sustainability of free health care on the same terms as free education. More than previous administrations, the current one has made efforts to address the AIDS pandemic by creating a HIV/AIDS fund that flows through the provincial and district levels to locations and sub-locations, through a chain of hospitals, clinics and NGO providers. In all the Focus Group discussions in Nairobi and the Provinces a high degree of articulation on health issues was noted

...

In the case of women, traditional practices tend to lean so heavily in favour of men as to pose serious cultural limitations. Widowhood rites, the outcast status of HIV-positive women and limited rights of inheritance are all issues that serve to deny women their basic rights as Kenyan citizens.

...

iii. Recommendations

The Panel recommends the following

- Economic, social and cultural right are crucial to individual well being and overall national development. In effect, the authorities are encouraged to accord them the necessary recognition and relevance. [Government of Kenya].
- The Universal Health care Plan be reviewed by Cabinet and subsequently legislated upon by Parliament to facilitate access to medical care for all Kenyans [Cabinet and Parliament].
- The Ministry of Health is to regard private health care providers as well as health providing NGOs as partners in health care delivery and support them in their endeavour [Ministry of Health, NGOs].
- The HIV/AIDS Prevention and Control Bill be passed by Parliament [Parliament].
- Kenya Authorities review its communication strategy and ensure that Kenyans are made aware of the achievements and constraints in addressing governance issues [Government of Kenya].

3.1.7 Objective 7: To promote and protect the rights of women

The Country Self-Assessment Report (CSAR) elaborates on the several forms of violence against women that illustrate the vulnerability of women to physical violence and insecurity. The major manifestations of violence reported are rape, domestic violence and female genital mutilation. This occurs despite international prohibitions against discrimination against women (ICCPR, CEDAW) recognised by Kenya and national policies and institutions established to protect women. Discrimination against women is systemic and is embodied in the legal, administrative and social systems, which reinforce the vulnerability of women. This is especially rife in the area of inheritance and equal protection under the law.

ii. Findings of the CRM

The Constitution forbids discrimination based on sex, and this has far reaching implications for the inclusion of women in all sectors of society. However, this has not been effectively implemented, and discrimination against women is deeply entrenched in the cultural fibre of most social groups in Kenya. Patriarchal norms and structures in the cultural and societal setting remain strongly etched in the psyche of the nation: eg in many districts, boys are often chosen for education over girls, especially in the rural areas. The women stakeholders who addressed the CRM at various points admitted to letting their attitudes and decisions, particularly in the political arena, dictated to by their men folk.

As noted under the section on standards and codes, all forms of violence against women are prohibited. However, there is currently no specific law on domestic violence and the practice is rife. This is aggravated by the fact that Domestic Violence (Family Protection) Bill, which would set up an institutional and policy framework to address gender based violence, is yet to be passed as law. The CSAR also pointed out that the widespread practice of female genital mutilation (FGM) is indicative of the prevailing practice of early marriages in certain parts of Kenya. Constraints in law enforcement in North Eastern and North Western Kenya increase the vulnerability of women with regard to forced FGM in the absence of protection mechanisms.

Lack of access to resources greatly hinders the ability of women to engage in productive income generating projects. Poverty in such instances takes on gendered dimensions. Women in Kenya largely lack properties that can be used to secure credit facilities from formal credit institutions, and this has resulted in their operating at the micro-level and in the informal sector, where labour protections are significantly absent. This is aggravated by lack of social security to enable women cope with their multiple social roles in the employment sector.

Health care is inadequate in the Government health facilities, and this affects women's reproductive rights, including access to ante-natal and maternity services. Some women informed the CRM of instances where patients ran away from hospitals where they had been admitted because they could not afford hospital fees. Women with HIV suffer a lot, especially concerning child neglect by spouses or partners. The rates of women with HIV are higher than those of men, but women often fail to obtain much needed health care and medicine to alleviate opportunistic infections.

Violence against women has a causal-effect correlation to the subordinate status in which many women find themselves, and has increased the incidence and burden of HIV on women. The significant incidence of insecurity in the slum areas, where the majority of ethnic groups live, also makes poor women vulnerable to sexual violence.

iii. Recommendations

The Panel recommends the following

- The Government design and adopt expeditiously a comprehensive affirmative action policy to address the structural challenges and imbalances faced by women at diverse levels in the political, civil, economic, social and cultural spheres. Measures identified to counter these problems should filter down to all districts and local authorities [Government of Kenya].
- ...
- The Law Reform Commission, together with the Ministry of Justice and Constitutional Affairs amend the current Inheritance Laws to allow men and women equal rights to inheritance [Law Reform Commission and Ministry of Justice and Constitutional Affairs].
- Laws prohibiting FGM be enforced. Government and other relevant institutions to strengthen their surveillance and enforcement capacities [Government of Kenya].
- Practical tools at the district level be designed to ensure the education of the girl child. Local authorities be required to identify all the girls in their localities and distribute school bursaries to girls on an equal basis as boys [Local Authorities].
- The Government of Kenya and Civil Society Organisations (CSOs) to promote the elimination of negative cultural attitudes against women in all spheres of Kenyan society and communities [Government of Kenya and CSOs].

3.1.8 Objective 8: To protect and promote the child and young persons

i. Summary of the CSAR

Rights of children and young persons

In the CSAR, serious violations of children's rights are reported, as well as the impact of HIV/AIDS on children. Children in Kenya still face prejudice, discrimination and violence. The acts of abuse noted included child labour, violence against children, defilement and rape, child trafficking and the prostitution of young girls, inadequate health care and child neglect. In a laudable move, the Government has introduced free medical care and universal primary education, both measures being crucial in the welfare and development of children. However, important government schemes like provision of milk in schools and rehabilitation programmes for children, including street children, have come to a halt.

ii. Findings of the CRM

Although Kenya has ratified and domesticated the norms contained in the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, children still suffer abuse, whether by individuals or institutions. This happens despite the high profile institutional framework for children, including the National Council for Children, the

Department of Children's Services, located in the Vice President's Office, local authorities, children's courts and a plethora of child related laws.

Kenyan children are trafficked internally from rural areas to urban centres and coastal areas into involuntary servitude, including working as street vendors and day labourers, and into prostitution. Women and children are also trafficked from Burundi and Rwanda to coastal areas in Kenya for sexual exploitation in the growing sex tourism industry.

iii. Recommendations

The Panel recommends the following

- Kenyan Authorities to develop a time-bound national action plan to combat child trafficking and other forms of child labour. In addition, border security, training for law enforcement officials, and anti trafficking public awareness campaigns be increased. [Government of Kenya].
- The Government to earmark a special fund for youth just as it has done in the case of HIV/AIDS and road funds. This special fund could facilitate access to finance for youths through such mechanisms as collateral free loans, with a view to tapping into their entrepreneurial potentials [Government of Kenya].

3.1.9. Objective 9: To promote and protect the rights of vulnerable groups, including internally displaced persons, refugees and disables persons

i. Summary of the CSAR

Other challenges

The report notes that there have been strong proposals for special attention to be paid to widows, orphans and other vulnerable groups, including single mothers and divorcees, slum dwellers and the poor in general. Other disadvantaged groups identified by respondents included the aged, the unemployed, those infected with HIV/AIDS, the landless, subsistence farmers and ethnic or religious minorities.

Persons living with HIV

It should be noted that Kenya has a programme and a policy for HIV/AIDS. However, the discrimination of people living with AIDS is prevalent. In particular, women living with HIV are facing hardships, coupled with discrimination and stigmatisation by the rest of society. There is treatment for all PLHIV, but some continue to face stigma and marginalisation. Despite positive government policies and political will to mitigate the disease, the approach to HIV/AIDS as a health issue does not address the structural problems faced by this group. Widows and orphans particularly suffer and are affected by the economic and social toll of this pandemic in the lack of adequate income generating projects. Although the CRM did not interact with children and men living with HIV, the absence of a law prohibiting discrimination of those living with HIV must be felt keenly by all affected persons, especially in the health, education and employment sectors.

iii. Recommendations

The Panel recommends the following

- The Government of Kenya to prioritise basic infrastructure projects targeted at improving the lives of vulnerable groups, including tribal minorities [Government of Kenya].

4. Economic governance and management

Kenya faces many challenges in its economic governance and management. These include implementing strong and effective anti-corruption policies; enacting anti-terrorism and money laundering laws; restructuring government expenditure and reducing the government wage bill relative to GDP; improving the efficiency of public sector service delivery; rehabilitating existing infrastructure and building new ones; improving water supply in most areas; maintaining sound macroeconomic policies; and implementing various structural reforms, most notably, within the agricultural sector, needed to reverse slow economic growth. The number of people living in poverty is estimated to have risen from 48 per cent of the population in 1990 to 56 per cent in 2001, and continues to rise. This disappointing development has further been complicated by the upsurge in the infection rates of the HIV/AIDS pandemic, estimated at 14 per cent of the population by 2002. HIV/AIDS, which emerged as a public health issue in Kenya in 1984, has had a devastating effect on the economy. In addition to more than 1.5 million deaths attributed to the disease, which left more than one million children orphaned, the long-term impact on Kenya's workforce has been severe.

4.3.1 Objective 1: Promote macroeconomic policies that support sustainable development

i. Summary of the CSAR

The CSAR covers *sectoral policies and programmes* in the priority sectors listed in the NEPAD Framework Document (2001), namely; human resource development, health, agriculture, environment, and science and technology. As regards *education*, most notable is the introduction of free primary school education. This is an important innovation in the history of Kenya, as it enables children to get equal access to educational opportunities in the public sphere.

The challenges at the primary level include overcrowding in classes, high pupil teacher ratio in some areas, and regional and gender disparities. At the secondary level, school fees that are considered high by many Kenyans are a particular problem. The educational system has had to confront the problem of dropout by AIDS orphans and children of the poor. An important objective is to attain the MDGs and stop the spread of HIV/AIDS. In general, the CSAR states that the health sector suffers from inadequate medical supplies, shortage of staff, and the absence of an appropriate health insurance scheme. The government is trying to address these problems. It has raised health care financing as a fraction of total expenditure (from 5.6 per cent in 2003/04 to 9 per cent in 2004/05), while the Kenya Medical Supplies Agency is being restructured to improve drug supply. In 2004, a Health Bill was passed by Parliament the National Social Health Insurance Fund, with costs to be shared by employers, employees, and the Treasury. The legislation has not been implemented, according to the CSAR, due to 'lack of consensus' among the Parliament, the Executive, and other stakeholders.

5. Corporate governance

5.3.1 Objective 1: To promote an enabling environment and effective regulatory framework for economic activities

i. Summary of the CSAR

Impact of Social, Political and Health Security on Investment Climate

The self-assessment notes that 87.5 per cent of experts surveyed opined that insecurity is a major issue affecting business growth and sustainability in Kenya. This finding is also corroborated by the National Household Survey and focus group discussions. Kenyans also perceive that the political uncertainty created by wrangling in the ruling NARC coalition and the HIV/AIDS

pandemic through lost skills and huge medical bills impact negatively on business activity.

...

ii. Findings of the CRM

...

Competitiveness of the Private Sector

The CRM was perturbed that Kenyan firms demonstrated an alarming indifference to, and ignorance of the HIV/AIDS pandemic. While the infection rate in the workforce is estimate at 15 per cent nationally, some firm managers believe that none of their workforce is at risk. Others, fortunately, have programmes to address the problem, although they are in a minority.

...

iii. Recommendations

...

Competitiveness of the Private Sector

- The Federation of Kenya employers and ministry of trade and industry to include HIV/AIDS education and awareness in programmes developed for workplace sensitisation. The aim of such programmes would be to educate employees on the pandemic and so reduce infection rates nationally.

...

5.3.2 Objective 2: Ensure that corporations act as good corporate citizens with regards to human rights, social responsibility and environmental sustainability

i. Summary of the CSAR

Labour laws, employee rights, rights to unionise

The lax standards on labour and human rights can also be attributed to problems such as the weakness and reluctance of regulatory and supervisory authorities to execute their mandates, the lack of capacity, and the complexity of the judicial process. For example, the poor capacity of the Ministry of Labour in conducting inspections and enforcing compliance with labour laws, especially its safety provisions, has been pointed out. Problems in the labour arena include the lack of observance of minimum wage and workmen compensation rules, discrimination against people living with HIV, nepotism, lack of a conducive business environment and an inability to participate in trade union activities. Many employees in unionisable environments are unaware of their rights or easily intimidated. Employers are rarely prosecuted for human rights and labour law violations, even where there are clear violations of the law. Further, workers organisations are also weak. According to the CSAR, workers perceive trade unions as ineffective in protecting their rights.

ii. Findings of the CRM

Labour laws, employee rights, rights to unionise

Employees who are HIV positive are usually not assisted by the business sector and they are stigmatised by the entire community. Nevertheless, some institutions, such as the Kenya National Governance Council and the Federation of Kenyan Employers, have prepared guidelines which would commit corporations to HIV/AIDS sensitisation programmes for their employees and allocate financial resources to these projects. Further, the HIV/AIDS funds set up by the government do reach the regions, but local communities are currently not involved in the allocation and the decision making process for their communities.

During consultations in North-Eastern Province, the CRM found that there has been no data collection regarding HIV/AIDS in the region. Nomad pastoralists are left ignorant about the pandemic

in their area. In addition, the establishment of military camps at the borders of North Eastern province has resulted in numerous cases of women being raped and these women are neither allowed to sue for redress nor provided with funds for treatment when infected with HIV.

iii. Recommendations

The Panel recommends the following

Labour laws, employee rights, rights to unionise

...

- Trade union representatives to request the ILO to give them appropriate training (legal and regulatory, especially revised laws, financial training, fight against HIV/AIDS, environmental protection) to be able to adequately defend the rights of workers, especially those of women, those who are HIV positive, and the disabled.

...

6. Socio-economic development

6.1 Overview

The recent turnaround has been gradual and the government is building a better environment for development results to occur. It is therefore not surprising that economic growth has rebounded in recent years, albeit confined to a few sectors, such as tourism, horticulture, services, and manufacturing.

Nonetheless, there are several outstanding challenges. The primary drivers for growth—investment and savings ratio relative to GDP, and exports and imports growth—remain low though increasing since 2002. The incidence of absolute poverty remains high, as the number of the poor has increased from 12.5 million in 1997 to 15 million in 2005. An alarming 56 per cent of the population lives in absolute poverty. The 2005 MDG progress report and the recently concluded needs assessment for Kenya show clearly that with the exception of primary education and HIV/AIDS, the country is not likely to meet the MDG targets. There are only limited prospects for achieving the MDGs at the current pace of economic growth, and more importantly for investments in key sectors of the economy, such as agriculture and health.

The HIV/AIDS pandemic has been a major constraint on Kenya's socioeconomic development process. The first case of AIDS was discovered in Kenya in 1984. By 1999, when the prevalence of HIV/AIDS in the country was at its highest point of 13 per cent, HIV/AIDS became a development rather than a health issue. As a response, HIV/AIDS was declared a national disaster, culminating in the setting up of a Cabinet Committee on HIV/AIDS and a National AIDS Control Council. The fact that the President chairs the Cabinet sub-committee on HIV/AIDS underscores the importance placed on the pandemic. The sub-committee strengthens policy formulation and oversight. A Strategic Plan on HIV/AIDS was developed around the five pillars of prevention and advocacy, treatment, mitigation of adverse socio-economic impact of HIV/AIDS, monitoring and evaluation, and management and coordination. This was followed by a strategic plan to mainstream gender into the Kenya National HIV/AIDS Strategic Plan 2000 - 2005.

6.3.3 Objective 3: Strengthen policies, delivery mechanisms and outcomes in key social areas, including education and combating of HIV/AIDS and other communicable diseases

i. Summary of the CSAR

The CSAR notes that within the health sector, the main focus has been to ensure adequate implementation of disease prevention programmes, promotion of primary and overall health care and improvement of health services. In the last five years, efforts to deal with infant mortality, HIV/AIDS, malaria and other communicable and infectious diseases have also intensified, though with limited success. The prevalence of HIV/AIDS has

greatly aggravated the burden of tuberculosis (TB), making Kenya one of the 22 most highly affected countries. In recognition of this growing problem, at the end of 1999 the government declared HIV/AIDS a national disaster.

ii. Findings of the CRM

Best Practice ... Reduction in the prevalence of HIV/AIDS

Kenya's ability to reduce the prevalence rate of HIV/AIDS from 13 per cent to 7 per cent between 1999 and 2004 is commendable. The government's efforts in this regard include declaring HIV/AIDS a national disaster, setting up a Cabinet Committee on HIV/AIDS and a National AIDS Control Council. The Committee, chaired by the President, strengthens policy formulation and oversight. A Strategic Plan on HIV/AIDS was developed around the five pillars of, prevention and advocacy, treatment, mitigation of the socioeconomic impact of HIV/AIDS, monitoring and evaluation, and management and coordination. This was followed by a strategic plan to mainstream gender into the Kenya National HIV/AIDS Strategic Plan 2000 - 2005. The reduction in the monthly cost of Anti-Retroviral (ARV) treatment from about \$1,000 to \$1.40 within 5 years is a remarkable achievement, though buoyed by efforts to reduce treatments globally.

...

6.3.5 Objective 5: To make progress towards gender equality in all critical areas of concern, including equal access to education for all girls at all levels

i. Summary of the CSAR

Legally, women are not adequately protected under the law. They are often excluded from inheritance settlements, particularly if married, or given smaller shares than their male counterparts. The practice of wife inheritance in some communities restricts a woman's right to choose her mate and places her at a high risk of contracting sexually transmitted diseases including HIV/AIDS. Perhaps the most affected women are widows. Overall, women have less access to social services and productive resources compared to men. This situation is changing for the better, though, as the current government has appointed several women to key posts in the Cabinet, the Civil Service and state corporations.

ii. Findings of the CRM

Statistics have shown that more women are infected with HIV in Kenya. According to the Kenya National AIDS Control Council (NACC), out of the 1.4 million Kenyans living with HIV, about two thirds are women. In the 15 to 24 age range, the gender difference is more pronounced, with female prevalence nearly five times higher than that for males.

...

The CRM recognises the efforts made by the National AIDS Control Council to integrate gender concerns into the national HIV/AIDS Strategic Plan. It noted, however, that some key special needs for women have not yet been sufficiently addressed. Examples include empowering women and unmarried girls to practise abstinence, and the popularisation of condoms for women to enable them to freely decide on the most appropriate contraceptives.

ii. Recommendations

The Panel recommends the following

...

- Parliament to enact into law the Affirmative Action Bill, the National Gender and Development Bill, the Equality Bill, the Domestic Violence (Family protection) Bill, and the Gender and Development Policy Bill [Parliament].
- Government of Kenya and CSOs to initiate a dialogue with the different communities in Kenya on harmful cultural

practices and outlaw all forms of discrimination in respect of the CEDAW Convention [Government of Kenya].

- Government of Kenya to provide ARV for treatment of children, enhanced affordability and increased supply of female condoms and adopt measures for the prevention of mother to child transmission [Government of Kenya].

7. Conclusion

7.1.7 Gender inequality

The Government of Kenya has made significant progress in the area of gender policy initiatives, including the creation of a Ministry of Gender, Sports, Culture and Social Services and a National Gender Commission. Moreover, the current government has appointed several women to key positions in the Cabinet, Civil Service and state corporations. However, the government has not yet reached the level expected by the various gender conventions and declarations ratified by Kenya. The laws that disenfranchise women are still intact and the values and culture of the societies that foster discrimination against women have not changed either.

Equal access to wealth remains a challenge for Kenyan women. Though under the current constitution women can acquire, own and dispose of property – in rural areas customary laws prevent them from inheriting land. Culturally, women do not inherit from their fathers. When the husband dies his brothers and parents, in many cases, disinherit the widow and children. As land is the most accepted form of security to acquire credit, this means that Kenyan women's access to credit is highly restricted, even when the husband is alive, as the title deed is always in the name of the husband.

The practice of wife inheritance in some communities restricts a woman's right to choose her mate, and places her at a high risk of contracting sexually transmitted diseases including HIV/AIDS. Statistics from the Kenya National AIDS Control Council (NACC) indicate that of the 1.4 million Kenyans living with HIV, about two thirds are women. In the 15 to 24 age range, the gender difference is more pronounced, with female prevalence nearly five times higher than that for males.

7.3 The way forward

...

APRM have already provided a new initiative and inspired many of the people of the country to work together for the achievement of the objectives of the AU. It is hoped that this momentum and enthusiasm will be retained in the ongoing process of implementation.

...

It must be realised, however, that the APRM presents no miracle solution; neither does it provide a panacea for all the problems encountered by African countries in their search for sustainable growth and development. It is not a substitute for existing initiatives in Kenya, such as the Investment Program for the Economic Recovery Strategy for Wealth and Employment Creation (IPERS), which represents Kenya's PRSP and the MDGs compact, but only a supplement to reinforce such initiatives aimed at the attainment of the common objective of building strong constituencies, restoring self esteem and confidence, mobilising collective synergies and resources to overcome poverty and promote the well-being of all Africans.

For the APRM to succeed in Kenya, it needs the consistent drive and determination of all stakeholders. The APRM takes cognisance of the fact that good governance is a culture, and as such must be embedded in every facet of society. The problem of governance alone; all sectors must be involved. It is for this reason that the APRM is founded on the participation of all stakeholders.

C SUB-REGIONAL DOCUMENTS FROM REGIONAL ECONOMIC COMMUNITIES IN EASTERN AND SOUTHERN AFRICA

- C1 Common Market for Eastern and Southern Africa (COMESA)
- C2 East African Community (EAC)
- C3 Intergovernmental Authority on Development (IGAD)
- C4 Southern African Development Community (SADC)
- C5 Economic Community of Central African States (ECCAS)
- C6 Indian Ocean Community (IOC)

C1 Common Market for Eastern and Southern Africa (COMESA)

The Common Market for Eastern and Southern Africa is a grouping of twenty states (including Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe) dedicated to promoting economic prosperity through regional integration. It was formed in December 1994, replacing a Preferential Trade Area which existed since 1981. COMESA's main achievement is the launch of a Free Trade Area in 2000 (of which thirteen countries were members in April 2007). COMESA is also engaged in various activities relating to HIV and human rights.

C1.1 Treaty establishing COMESA (1993/1994)

Signed on 5 November 1993 in Kampala, Uganda, and entered into force on 8 December 1994. Full text available at www.comesa.int.

Excerpts

...

CHAPTER 14: Co-operation in health matters

Article 110: Scope of co-operation

1. The member states agree to undertake concerted measures to co-operate in health through

- (a) the control of pandemics or epidemics, communicable and water-borne diseases that might endanger the health and welfare of citizens of the Common Market;
- (b) the facilitation of movement of pharmaceuticals within the Common Market and control of their quality;
- (c) joint action in the prevention of drug trafficking;
- (d) the training of manpower to deliver effective health care; and
- (e) the exchange of research, development and information on health issues.

2. For the purposes of paragraph 1 of this article, the member states undertake to

...

- (b) evolve mechanisms for joint action in combating outbreak of epidemics such as AIDS, cholera, malaria, hepatitis and yellow fever as well as co-operation in facilitating mass immunisation and other public health community campaigns;

...

- (d) develop a national drug policy which would include establishing quality control capacities, national formularies and good procurement practices;

...

CHAPTER 24: Women in development and business

Article 154: Role of women in development

The member states agree that women make significant contribution towards the process of socioeconomic transformation and sustainable growth and that it is impossible to implement effective programmes for rural transformation and improvements in the informal sector without the full participation of women. To this end, the member states shall through appropriate legislative and other measures

- (a) promote the effective integration and participation of women at all levels of development especially at the decision-making levels;
 - (b) eliminate regulations and customs that are discriminatory against women and specifically regulations and customs which prevent women from owning land and other assets;
 - (c) promote effective education awareness programmes aimed at changing negative attitudes towards women;
 - (d) create or adopt technologies which will ensure the stability of employment and professional progress for women workers;
- ...

C1.2 Addis Ababa Declaration on the COMESA Gender Policy (2002)

Signed by COMESA Heads of State and Government in Addis Ababa, Ethiopia, on 24 May 2002. Full text available at www.comesa.int.

Excerpts

...

We therefore reaffirm our commitment to articles 154 and 155 of the Treaty establishing COMESA in which we recognised women's significant contribution towards the process of socioeconomic transformation and sustainable growth.

We further reaffirm our commitment to article 154 to

- (a) promote the effective integration and participation of women at all levels of development especially at the decision-making levels;
- (b) eliminate regulations and customs that are discriminatory against women and specifically regulations and customs which prevent women from owning land and other assets;

...

Endorse the decision of the Council of Ministers on: Establishment of a technical committee on gender in line with the COMESA Treaty to facilitate the operationalisation of the Gender Policy; and

Commit ourselves among other issues to

...

- (o) addressing the cross-cutting socio-economic issues such as: HIV/AIDS, human rights, environment, drug abuse, peace and

security within all policies, plans, strategies and programmes of COMESA from a gender perspective;

(p) ensuring the mainstreaming of HIV/AIDS and human rights in all its policies and programmes;

...

C1.3 COMESA Gender Policy (2005)

Modified following the Addis Ababa Declaration on the COMESA Gender Policy. The 2005 version of the text includes provisions relating to the links between gender, HIV and human rights.

Excerpts

...

Preamble

...

13. In the field of health, the HIV/AIDS pandemic is one of the greatest challenges facing the region from a gender perspective. According to WHO estimates 90 per cent of all AIDS cases are on the African continent. In Sub-Sahara Africa, the COMESA region has one of the highest rates of infection, as high as 50 per cent of the population in some countries. Available data indicate that in the majority of countries, the rate of infection is higher among women than men. Women also tend to disproportionately bear the social and economic implications of HIV/AIDS in terms of loss of labour and/or productive time, human suffering et cetera, due to their maternalistic nature; women spend a lot of time in caring for the sick both at home and in hospitals.

14. Women in the region remain disadvantaged in terms of access to and control of economic structures and resources. This is generally due to their subordinate legal status, limited access to productive resources such as land, technology, credit, education and training, formal employment as well as their susceptibility to HIV/AIDS.

...

4. Policy statement

The overall goal of the COMESA Gender Policy is to foster gender equality and equity at all levels of regional integration and cooperation in order to achieve sustainable socio-economic development and in the region.

...

In order to achieve the above policy statement, COMESA is committed to

(a) mainstreaming gender perspectives in the conceptualisation, formulation of all policies, planning, programming, implementation, monitoring and evaluation of all programmes and activities;

...

(e) ensuring that regional interventions encourage and support changes in attitudes, structures and mechanisms in order to eliminate gender biases;

...

(g) ensuring that there is sufficient and permanent expertise on gender issues at all levels in the COMESA Secretariat;

(h) enhancing the capacity of the COMESA Secretariat to facilitate implementation of the Gender Policy.

(i) encouraging the mainstreaming of gender within member states and strengthen co-ordination and linkages between the COMESA Secretariat and member states on policy and practice;

(j) ensuring adequate financial and other resources for mainstreaming gender perspectives into COMESA activities;

(k) ensuring that gender analysis is mainstreamed at the macro-, meso- and micro-levels;

(l) ensuring the generation, collection, analysis and use of sex disaggregated data and information at all levels;

(m) ensuring the equal representation of women and men in the decision-making of member states, COMESA structures and its institutions at all levels;

(n) addressing the cross-cutting socio-economic issues such as: HIV/AIDS, human rights, environment, drug abuse, peace and security within all policies, plans, strategies and programmes of COMESA from a gender perspective;

(o) ensuring the mainstreaming of HIV/AIDS and human rights in all its policies and programmes;

(p) integrating the gender policy measures in each sector to ensure the policy is implemented and that the implementation is co-ordinated, monitored and evaluated;

(q) promoting mainstreaming of gender concerns in regional and international institutions and initiatives that contribute to the enhancement of the COMESA vision;

(r) promoting partnerships with the Private Sector, Civil Society, international and regional institutions and other Stakeholders for effective implementation of the Gender Policy.

...

C2 East African Community (EAC)

The East African Community (EAC) is an intergovernmental organisation which plans to form a country called the East Africa Federation with one President ruling over Tanzania, Kenya, Uganda, Burundi and Rwanda. Kenya, Tanzania and Uganda are the founding members of the EAC, Burundi and Rwanda have joined the organisation on 1 July 2007.

C2.1 Treaty Establishing the EAC (1999/2000)

Adopted on 30 November 1999 and entered into force on 7 July 2000. Under the Treaty, the state parties agree to undertake steps to prevent and control communicable diseases and viruses such as HIV. Full text available at www.eac.int.

Excerpts

...

Article 118: Health

With respect to co-operation in health activities, the Partner States undertake to

- (a) take joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases such as HIV/AIDS, cholera, malaria, hepatitis and yellow fever that might endanger the health and welfare of the residents of the Partner States, and to co-operate in facilitating mass immunisation and other public health community campaigns;
- (b) promote the management of health delivery systems and better planning mechanisms to enhance efficiency of health care services within the Partner States;
- (c) develop a common drug policy which would include establishing quality control capacities and good procurement practices;
- (d) harmonise drug registration procedures so as to achieve good control of pharmaceutical standards without impeding or obstructing the movement of pharmaceutical products within the Community;
- (e) harmonise national health policies and regulations and promote the exchange of information on health issues in order to achieve quality health within the Community;
- (f) co-operate in promoting research and the development of traditional, alternate or herbal medicines;
- (g) co-operate in the development of specialised health training, health research, reproductive health, the pharmaceutical products and preventive medicine;
- (h) promote the development of good nutritional standards and the popularisation of indigenous foods; and
- (i) develop a common approach through the education of the general public and their law enforcement agencies for the control and eradication of the trafficking and consumption of illicit or banned drugs.

C2.2 Second EAC Development Strategy 2001–2005 (2001)

Launched in 1997 to cover the period 1997 to 2000 and formed the basis of the Treaty for the Establishment of the East African Community. The Second Development Strategy, adopted in Arusha, Tanzania on 24 April 2001, succeeded the first one and sets out the priority programmes to be implemented during the period 2001 to 2005 in line with EAC's goal of 'widening and deepening of co-operation in all areas for the mutual benefits of the partner states'. Its main achievement was the launch of the East African Customs Union in 2004 and 2005. Some of its provisions pertain to the link between human rights and HIV. Full text available at www.eac.int.

Excerpts

...

4.6.1 Health

Three working groups for the region have been formed for the purpose of

- Control and prevention of Sexually Transmitted Diseases (STD)/Infections and HIV/AIDS.
- Control of communicable diseases.
- Health research, policy and health system development.

Regional programmes that are being developed in the Health sector include control of communicable and vector-borne diseases such as HIV/AIDS, malaria, yellow fever, cholera and mechanism for response to outbreaks of communicable diseases with particular reference to the Ebola epidemic.

4.6.3 Social welfare

The Partner States have undertaken to cooperate in the field of social welfare. Priority shall be to develop and adopt a common approach towards the welfare of disadvantaged and marginalised groups.

4.7 Co-operation in legal and judicial affairs

In order to promote a smooth transition to the East African Community, Partner States shall harmonise their legal training and certification within the Community. Partner States shall endeavour to

...

- Harmonise all their national laws and regulations in the following areas

...

- Health

...

4.10.1 The role of women

The Partner States recognise that women make a significant contribution towards the process of socioeconomic transformation and sustainable growth. To this end, emphasis is placed on empowerment, effective integration and participation of women at all level of socio-economic development, especially in policy formulation and implementation.

The Partner States will continue to encourage the formulation of national gender policies and formation of national machineries to spearhead and coordinate gender responsive development and in particular ensuring the improvement of women's status. The Partner States will expedite the implementation of agreed areas of cooperation within the Beijing Platform of action especially in the six priority area in line with partner states plans of action to the advancement of women; namely

- Women in decision making;
- Economic empowerment;
- Legal rights of women;
- Education, training and employment;
- Health;
- The girl child.

C2.3 Third EAC Development Strategy 2006-2010: Deepening and Accelerating Integration (2006)

The Third EAC Development Strategy 2006-2010 was adopted on 30 November 2006 in Arusha, Tanzania. It reviews previous development strategies, seeks to consolidate previous strategies, and offers new strategic orientations for the East African Community. The response to HIV is a central element of 'Cooperation in Social Sector Issues' and is identified as one of the 'Cross-cutting Priority Intervention Areas'. Full text available at www.eac.int.

Excerpts

3.2.6 Cooperation in social sector issues

58. Co-operation under social sectors including immigration and labour was supposed to focus on health especially combating HIV/AIDS, communicable diseases and health research, policy and health systems development; culture and sports; social welfare, immigration and adoption of common labour standards. The Draft Protocol of the East African Health Research Council (EAHRC) is being finalised, and efforts to harmonise EAC Partner States HIV/AIDS policies, strategies, and treatment protocols are underway. The East African Integrated Disease Surveillance Network (EAIDSNET) was established to facilitate collaboration in research in the areas of communicable diseases. The EAC Partner States National Regulatory Authorities and Experts Committee on Pharmaceutical and Medical Products have also been established. An EAC regional expert Committee on the incorporation of World Trade Organisation (WTO), Trade-Related Intellectual Property Rights (TRIPS) Agreement into EAC Partner States' National Patents and Pharmaceutical Regulatory Laws has also been established.

4.4 Cross-cutting priority intervention areas

4.4.6 Combating HIV and AIDS pandemic

127. HIV and AIDS continue to pose a serious threat to sustainable development in the region, and its integration agenda. The levels of prevalence and the incidence of HIV and AIDS are still high, in spite of the various measures that have been put in place to address the epidemic. This calls for a radical scaling up of innovative responses at the regional level. The focus should be on the prevention of HIV and AIDS, care and the mitigation of its impact in order to ensure sustainable human development within Partner States.

Development objective

- Reduced incidence of HIV and AIDS infection and its socio-economic impact in the region.

Strategic interventions

- (i) Develop an EAC HIV and AIDS Policy and Strategy;
- (ii) Coordinate and harmonise the development of policies and strategies in major intervention areas;
- (iii) Develop and strengthen capacity to undertake the mainstreaming of HIV and AIDS in all sectors and at all levels in East Africa, and create the skills needed for the integration of HIV and AIDS in all projects and programmes;
- (iv) Develop guidelines and exchange of best practices in major intervention areas such as mainstreaming of HIV and AIDS, Prevention of Mother to Child Transmission (PMTCT), support to orphans, home based care and treatment;
- (v) Coordinate and facilitate the monitoring of regional and global commitments for HIV and AIDS and related indicators, and publish regular reviews for EAC as a whole to supplement the monitoring undertaken at Partner States level;
- (vi) Mainstream HIV and AIDS into the curricula of both primary and secondary schools across the whole of East Africa;
- (vii) Promote cross-border interventions on prevention, care and support;

- (viii) Allocate more resources at the regional level to HIV and AIDS Programmes;
- (ix) Undertake impact studies of HIV and AIDS pandemic on key sectors in the region;
- (x) Mainstreaming HIV/AIDS among universities and other higher institutions of learning and undertake a critical analysis of information gaps on HIV/AIDS in the institutions of higher learning with a view to building a holistic database including follow-up services and staff/student attitude towards the epidemic, infected and affected.

C2.4 EAC Regional Integrated Multisectoral HIV and AIDS Strategic Plan 2007-2012 (2007)

Finalised in 2007, the Regional Integrated Multisectoral HIV and AIDS Strategic Plan provides an overview of the response to HIV in EAC member states and defines key actions and activities to be undertaken for a comprehensive and multisectoral response to HIV in EAC.

Excerpts

Chapter III - The EAC Strategic Plan on HIV and AIDS, 2007-2011

Introduction

This Strategic Plan for HIV and AIDS 2006 - 2010 articulates the broad vision and mission of the EAC Development Strategy (2006-2010), that was adopted by partner states to guide implementation of the regional and national goals and objectives of the EAC Treaty signed in 1999. The Development Strategy has defined key actions in relation to HIV and AIDS, all of which have been incorporated into this strategic plan.

The goal and strategic objective of the strategy plan are outlined with concomitant results; supported by six key objectives that define in more specific terms, the kinds of actions needed to realise the aforesaid.

3.1 Vision and mission as defined in the EAC Development Strategy

3.1.1 The vision as articulated in the EAC Development Strategy is the following

The vision of EAC is to have a prosperous, competitive, secure and politically united East Africa.

It is clear that HIV and AIDS will threaten the intent of the vision as its impacts are pervasive and endemic in the member states that constitute the EAC. This reinforces the criticality of multi-sectoral responses to the pandemic supported by political will and commitment.

3.1.2 The mission is stated as the following

The Mission of EAC is to widen and deepen economic, political, social and cultural integration in order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investment

As noted with the vision statement, HIV and AIDS responses need to underpin all policy, protocol and programmatic commitments of the EAC so that an added dimension to the quality of life referred to is one 'free of the impacts of HIV and AIDS'.

3.2 The vision and mission of the EAC HIV/AIDS Strategic Plan

3.2.1 The vision of this strategic plan is as follows

An East Africa free from HIV/AIDS and all its negative social and economic consequences

3.2.2 The mission of this strategic plan is to

Reduce the incidence of HIV infection and its socio-economic impact in the East African region by strengthening and

expanding regional integration and harmonisation of responses within the EAC member states

3.3 Goal and overall strategic objective of the HIV and AIDS Strategic Plan

The Goal and overall strategic objective articulated below are specific to the HIV and AIDS strategy Plan and outline the overall intent of the plan to address the responses to HIV and AIDS from a regional perspective

3.3.1 The goal is the following

To strengthen and expand responses to HIV and AIDS in the East African region

3.3.2 The overall strategic objective that will give expression to the goal is the following

To scale up access to prevention, treatment, care and support for all people and mitigating the impact of HIV and AIDS on all key sectors in the region

3.3.3 The key results to be achieved in response to the intent of the overall strategic objective are outlined below

- Political leadership, coordination, commitment and accountability to accelerated response to HIV and AIDS increased in the EAC region at regional and national levels;
- Regional integration and harmonisation of key regional policies, legislation, plans and interventions effected;
- An increased level of implementation and monitoring of national, regional and global level HIV and AIDS commitments, declarations, policies and legislation;
- HIV and AIDS competence and technical resource base among EAC partner states enhanced through joint capacity building and shared learning; and
- EAC Institutional capacity developed and in place to implement the EAC HIV and AIDS strategic plan.

3.4 Guiding principles of the EAC HIV and AIDS Strategic Plan

- Multi-sectoral Approach - The principle of multi-sectoral, multi-dimensional and multi-level approaches will be used given that the pandemic has affected every sector of the regional economy and facet of life in the region; including opportunities offered by some sectors in arresting new infections;
- Comparative Advantage and Complementarity - regional level activities must be informed by country priorities and should add value and be guided by subsidiarity. Regional approaches should not undermine national ownership, duplicate country level interventions or create additional layers of bureaucracy;
- Strategic Partnerships – EAC should broker agreements with key regional organisations and manage partnerships with a wide range of partners (civil society, PLWH, multilateral and bilateral organisations etc.);
- Gender Mainstreaming - In accordance with the laws of the EAC, all areas and activities of the organisation have to be gender mainstreamed. Accordingly, the strategic plan will adopt gender mainstreaming as a guiding principle;
- Respect for Human Rights - EAC will develop HIV/AIDS policies and programmes that respect human rights and other rights as enshrined in the international conventions signed by the Partner States; and
- Greater Involvement of People Living with HIV and AIDS (GIPA) - People living with HIV and AIDS will be involved in policy formulation, strategic planning, programme design, implementation and evaluation, personnel training and communication/messaging.

3.5 Strategic objectives

Below is a consolidation of seven strategic objective areas that form the basis of the strategy plan. Each objective area is supported by strategic actions that will drive the operational implications of delivering the plan so that the goal is achieved of mitigating the socio-economic impacts of HIV and AIDS in the region; thereby improving the quality of life for all in the region

as defined in the mission statement of the EAC Development Strategy. The six objectives are the following

- Enhanced institutional capacities of the EAC secretariat and that of the partner states to implement regional and national responses to HIV and AIDS;
- HIV and AIDS responses mainstreamed through all EAC sectors;
- Accelerated action towards regional level integration, harmonised protocols, policies, plans, and interventions; and domesticated agreements and legislation in relation to HIV and AIDS;
- Coordinated EAC access to, use and management of strategic information and knowledge relevant to HIV and AIDS;
- Strengthened political leadership for accelerated action and scale-up of national and regional responses to HIV and AIDS;
- Consolidated EAC partnerships and coordination functions or effective responses to HIV and AIDS; and
- EAC Workplace policy on HIV and AIDS framework and guidelines operationalised.

Each objective is taken in turn with its associated strategic actions.

3.5.1 Strategic objective 1

Enhanced institutional capacities of the EAC secretariat and that of the partner states to implement regional and national responses to HIV and AIDS.

Strategic actions

- Ensure the HIV and AIDS function within the Health Section is transformed into a multi-sectoral HIV and AIDS unit with dedicated staff and its budget;
- Secure longer term sustainable financing for the implementation of the EAC HIV and AIDS strategic plan from partner states and donor partners;
- Promote and strengthen multi-sectoral coordination of HIV and AIDS within the EAC through the proposed establishment of the EAC HIV and AIDS Multi-sectoral Task Force chaired by the Secretary General;
- Develop an Integrated M&E System to track the implementation of the strategic plan with comprehensive performance indicators, tools and supporting mechanisms;
- Establish thematic Technical Working Groups of the EAC to be convened by the EAC Secretariat and involving wider stakeholders – supported by expert think tanks;
- Implementation of the EAC HIV and AIDS Workplace policy; and
- Create a forum for sharing, promoting and scaling up best practices as well as the outcomes of selected regional, continental and global summits and conferences.

3.5.2 Strategic objective 2

HIV and AIDS responses mainstreamed through all EAC sectors.

Strategic actions

- Develop guidelines for the mainstreaming of HIV and AIDS in all EAC sectors and institutions;
- Facilitate through strengthened capacity, the mainstreaming of HIV and AIDS, gender, human rights and the GIPA principle within EAC sectors and program areas such as education, agriculture, transport, tourism, gender, labour and culture, defence, high mobility population groups, among other; and
- Facilitate HIV/AIDS mainstreaming among universities and other institutions of higher learning.

3.5.3 Strategic objective 3

Accelerated action towards regional level integration, harmonised protocols, policies, plans, and interventions; and domesticated agreements and legislation in relation to HIV and AIDS

Strategic actions

- Align and integrate HIV/AIDS responses in EAC with relevant clauses of the Treaties, Articles and Regulations governing the EAC; and national HIV/AIDS policies and strategic plans;
- Review member states' national HIV and AIDS related and policies and plans including OVC in EA Countries to identify gaps and appropriate actions at regional level including harmonising policies and planning approaches;
- Standardise prevention and treatment protocols enabling comprehensive approaches to treatment, nutrition and care;
- Align policies to address interventions aimed at cross border communities;
- Develop a regional harmonised strategy to take advantage of WTO / TRIPS flexibilities and procurement strategy for essential medicines and goods such as ARVs, prophylaxis, medicines for the treatment of sexually transmitted diseases;
- Harmonise HIV and AIDS Workplace Policies for the various sectors of work in EAC countries;
- Develop guidelines and exchange of best practices in major intervention areas Prevention of Mother to Child Transmission (PMTCT), support to orphans, home based care and treatment;
- Develop guidelines for promoting safe male circumcision;
- Hold partner states accountable for combating gender-based violence including the eradication of female genital mutilation; and
- Establish regional 'universal access' to prevention, treatment, care & support targets for all; including children, youth and other vulnerable groups.

3.5.4 Strategic objective 4

Coordinated EAC access to, use and management of strategic information and knowledge relevant to HIV and AIDS

Strategic actions

- Ensure that updated and strategically relevant data, including regional analysis are available and accessible to EAC leadership, partner states and other partners;
- Develop a regional M&E framework to monitor partner states' performance against national, regional and global level commitments;
- Coordinate regional HIV/AIDS research and information sharing processes; and align evidence-based regional research agendas with existing and future initiatives;
- Consolidate comprehensive reviews of studies and assessments of past and present documented research work from partner states and independent organisations to develop a synchronised information database;
- Harmonise ethical research guidelines;
- Coordinate the collection of data on impact studies of the HIV and AIDS pandemic in key sectors in the region;
- Establish a regional HIV and AIDS resource centre within the EAC Secretariat; and
- Strengthen partnerships with regional level media institutions on HIV and AIDS related reporting.

3.5.5 Strategic objective 5

Strengthened political leadership for accelerated action and scale-up of national and regional responses to HIV and AIDS

Strategic actions

- Develop up-to-date advocacy materials and publications for disseminating important information and regional analyses on emerging policy areas, and of evidence of impacts on social, political and economic development in the region;
- Ensure EALA is regularly updated with relevant information, packaged for elected representatives to effectively advocate for mobilisation of resources greater accountability, oversight and monitoring of national, regional and global commitments around HIV and AIDS; and for accelerated regional integration and harmonisation;

- Involve the leadership of the EAC in giving high-profile speeches in HIV/AIDS forums and meetings;
- Mobilise political leaders including Presidents, First Ladies, Vice-Presidents, Ministers, Members of Parliament of Partner States, Members of the East Africa Legislative Assembly, Members of the African Union Parliament, Leaders of Political Parties, local government leaders and former Presidents to provide high-level support to the Strategic Plan as well as political goodwill in the fight against HIV and AIDS; and
- Develop a peer review mechanism on HIV and AIDS for partner states.

3.5.6 Strategic objective 6

Consolidated EAC partnerships and coordination functions or effective responses to HIV and AIDS.

Strategic actions

- Develop mechanisms for partnership coordination and management with key partners, among other
 - EAC institutions: Lake Victoria Basin Commission (LVBC), Lake Victoria Fisheries Organization (LVFO), East Africa Development Bank (EADB) and Inter-University Council of East Africa (IUCEA);
 - EALA and member parliamentarians
 - National AIDS Coordinating Authority Director meetings and forums
 - Regional partnerships with public sector organisations and regional local authority organisations
 - Regional level NGOs – CSO, PLWH, FBO, Federation of EA trade unions
 - Regional level research and resource institutions
 - Regional bilateral and multilateral donor agencies
 - Regional private sector organisations, EAC business council
 - Regional economic commissions (i.e. SADC, IGAD, COMESA etc.), regional initiatives (i.e. GLIA,) and AU
 - Any other organisations deemed relevant by the Council;
- Formalise the establishment of a Partnerships Forum and regular meetings that engage the HIV and AIDS unit of the EAC on a regular basis;
- Develop Memoranda of Understanding with key partners;
- Establish EAC Education AIDS Network responsible for harmonising policies that protect teachers and children affected by HIV/AIDS; and
- Establish an information and database management system for sharing information and networking of partnerships

3.5.7 Strategic objective 7

EAC Workplace policy on HIV and AIDS framework and guidelines operationalised

Strategic actions

- Promote and protect the rights and dignity of management and employees who are infected and affected by HIV and AIDS, as well as strengthen prevention measures to protect employees who are negative to remain free of HIV infection;
- Provide management and employees and their families access to HIV/AIDS information and services, including prevention, care, treatment and support to enable them (workers) to take appropriate actions to protect themselves;
- Mitigate and manage the consequence of the impact of HIV and AIDS on the East African Community as an organisation and the wider community;
- Eliminate stigma and discrimination based on real or perceived HIV status; and
- Promote an environment of gender equality, equity and respect among men and women free of sexual harassment or coercion.

Chapter IV– Proposed institutional arrangements

4.1 Introduction

A pre-requisite for the success of the HIV and AIDS strategic plan is a clearly defined institutional arrangement that ensures adequate capacity is in place to give effect to the plan. The HIV and AIDS function within the Health Section has a current resource capacity that is insignificant relevant to need, and of necessity, must expand its human resource capabilities if this plan is to succeed.

This chapter focuses on the outcomes of a rapid capacity assessment that was done that informs the kinds of institutional arrangements appropriate to successful execution of the strategy plan.

4.2 Capacity assessment

A rapid capacity assessment of the HIV and AIDS function within the Health Section of the Secretariat of the EAC has found that the current staff complement is not adequate to drive the HIV and AIDS strategy plan. At present there is one professional staff member who is the coordinator of the Health Section and has to manage the other priority health programme areas within the section as well. To support the Coordinator is an Administrative Assistant who has to support administrative functions for the section as a whole. This demonstrates that only a percentage of time has been devoted to driving HIV and AIDS imperatives both within the EAC and in support of member states. In addition, no clear evidence was presented of any specific collaboration efforts from among the many sectors within the EAC, demonstrating that inter-sectoral human and financial resources are not available to the HIV and AIDS function to help drive the imperatives of HIV and AIDS as defined in the EAC Development Strategy 2006 – 2010; and in this strategy plan. Finally, when reviewing the current organogram of the EAC, it is clear not only from the organogram but through engagements with sector heads, that HIV and AIDS is not mainstreamed within the organisation.

4.3 Recommended institutional arrangements

The recommended institutional arrangements are informed by strategic considerations that reflect a range of challenges confronting the HIV and AIDS function within the Health Section. A coherent HIV and AIDS unit with dedicated staff is proposed as the required institutional arrangement along with designs that must drive a multi-sectoral disposition in the fight against HIV and AIDS.

Strategic considerations

- The HIV and AIDS function within the Health Section of the EAC fulfils a regional role in driving policy issues, monitoring member state commitments, etc. and is not intended to get involved in direct delivery regarding HIV and AIDS, especially at country level;
- The mainstreaming of HIV and AIDS within the EAC in the various institutional forms and in each of the sectors is of paramount importance. The various institutional forms include the Legislative Assembly, EAC Court of Justice, East Africa Development Bank, Lake Victoria Fisheries Organisation, Inter-University Council of East Africa and the Lake Victoria Basin Commission. These are in addition to the sectoral committees in the EAC;
- In order to effect the abovementioned, a pre-requisite to successful mainstreaming will be to achieve political buy-in of the Ministers and General Assembly so that the multi-sectoral and multi-dimensional nature of HIV and AIDS is fully appreciated; and concomitant institutional arrangements and actions endorsed at the highest level;
- The institutionalisation of resource capabilities is critical to the sustainability of such capabilities; especially in the case where donor agencies make expert resources available to the EAC on a fixed term contract. The proposed HIV and AIDS unit should have a critical mass of its own staff preferably supported by consultant resources from time to time. Longer term consulting contracts in excess of two years should be avoided as far as possible;

- Many of the sectors that have a direct bearing on interventions related to HIV and AIDS such as the 'Education, Science and Technology Section' and the 'Gender, Community Development, Culture & Sports, Civil Society Section' under the Division 'Social Sectors Development Division' have resources that should be accessible to the HIV and AIDS unit. The recommendation is that the human resources in the various sectors such as the Liaison Office in the Defense Section, must become strong advocates in the fight against HIV and AIDS. The key challenge is building into job descriptions or work commitments, responsibilities related to HIV and AIDS so that there is accountability for work done in this regard;
- It is recommended that the Workplace Policy on HIV and AIDS be driven by the Directorate of Human Resource and Administration in collaboration with the HIV and AIDS Unit; and
- Focal persons at country level and within the key institutions of the EAC (such as EAC Court of Justice and the EAC Development Bank) will be an important supplement to the human resources of the HIV and AIDS unit and sectoral resources to help implement the HIV and AIDS Strategy plan. It is recommended that terms of reference be drafted for the identification of focal persons and their specific roles and tasks in helping to drive implementation from the perspectives of these institutions and countries.

4.4 EAC HIV and AIDS Unit

The recommendation is that the HIV and AIDS function within the Health Section becomes a fully-fledged HIV and AIDS unit with its own dedicated staff complement and budget. This in line with the imperative of establishing an HIV and AIDS Desk as articulated in the EAC Development Strategy.

Conceptually and given national lessons of where best to locate the HIV and AIDS unit, it is recommended by way of principle that the unit be located in the office in the Deputy Secretary General – Projects and Programmes as this Office Supervises the Cross-cutting programmes and projects such as education, Gender, Labour, agriculture, transport, Tourism etc. which require mainstreaming. However, the process to get approval for the relocation of the HIV and AIDS may be protracted, requiring political buy-in and the endorsement of the full Council of Ministers. As a transitional strategy, it is envisaged to take one to two years. This is because it has to be channeled from the technical committee to the coordination committee and through the sectoral council to the finance & administration committee and finally to the council of ministers for final approval. Currently, the decision has only been discussed at technical level.

The HIV and AIDS unit will remain in the Health Section under the leadership of the Principal Health Officer. As a next step in its transition, the unit will seek recognition as a coherent function under the 'Director of Productive and Social Sectors' with the coordinator at the level of a Principal Officer.

Four full-time professional posts are recommended to be located in the HIV and AIDS unit. The focus of the posts will be emphasis on policy and programme support in the region, premised on the need to harmonise policies and interventions; and to make real the commitments made by member states. A strong internal mainstreaming focus positioned to help ensure that HIV and AIDS is mainstreamed within the institutional arrangements, policies and programmes of the EAC is needed. There will be a focus on monitoring and evaluation with an emphasis on developing an authoritative knowledge base and repository on HIV and AIDS in the region. A Programmes assistant is recommended given the potential workload at this level based on the assessment that the current administration assistant is overloaded with the other areas of work within the Health Section. The final post is that of a unit Coordinator that will come on board once the unit is reclassified as a 'Section' under the Productive and Social Sectors Directorate; as part of its transition to the office of the SG.

...

C3 Intergovernmental Authority on Development (IGAD)

The Intergovernmental Authority on Development (IGAD) is a regional development organisation composed of Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda. It is the successor to the Inter-Governmental Authority on Drought and Development (IGADD) in Eastern Africa, founded in 1986.

C3.1 Agreement Establishing IGAD (1996/1996)

Adopted on 21 March 1996 in Nairobi, Kenya, the Agreement establishing IGAD entered into force on 25 November 1996. Its provisions relate mainly to economic cooperation. Full text available at www.igad.org.

Excerpts

...

Article 7: Aims and objectives

The Aims and Objectives of the Authority shall be to

(a) Promote joint development strategies and gradually harmonise macroeconomic policies and programmes in the social, technological and scientific fields;

...

(h) Mobilise resources for the implementation of emergency, short-term, medium-term and long-term programmes within the framework of sub-regional cooperation;

...

(k) Develop such other activities as the member states may decide in furtherance of the objectives of this Agreement.

C3.2 Declaration of Ministers in charge of HIV/AIDS (2007)

Adopted by IGAD Ministers of Health and/or Ministers in charge of HIV and AIDS in Nairobi, Kenya, on 9 March 2007.

Recalling the recommendations to the First and Second Conferences on Public Health in the Horn of Africa held in Addis Ababa, Ethiopia in 1996 and 1998, for the improvement of HIV and AIDS control among vulnerable populations in IGAD Region and recommendations from Ministerial meeting on health (November 2006-Djibouti) and other Regional and Sub-regional conferences on major communicable diseases and other key public health priorities,

Acknowledging the strong commitment to improving health and promoting well-being of people in the IGAD region by governments, communities and development partners, to achieve the development goals particularly Declarations adopted by the African Union for control, elimination or eradication of communicable diseases and the Abuja Summit, the Millennium Development Goals and universal access to prevention, treatment, care and support.

...

Concerned about the communicable disease crisis in the IGAD region and its negative impact on health and development of hundreds millions of people, constituting a barrier for poverty reduction and human development, in particular

- High morbidity and mortality from HIV and AIDS, tuberculosis and malaria,

- Increasing levels of drug resistance, further complicating disease management,
- Continued occurrence of complex emergencies during which communicable diseases outbreaks occurred,

...

- Very high maternal and child mortality,

Recognising that countries in the IGAD Region share similar health problems with massive cross-border mobile population movements and that an outbreak in one country can negatively impact others.

Realising the overwhelming need for concerted collaborative actions by countries in the IGAD Region to address the communicable diseases and other health related issues.

Emphasising that opportunities now exist to prevent and control the spread of communicable diseases in the IGAD Region.

Acknowledging the fact that most at risk population have not been adequately served, we recognise the necessity to improve service delivery for the hard to reach and underserved population in order to achieve the universal access goal to HIV and AIDS prevention, treatment, care and support.

Recognising the importance of community mobilisation, empowerment and involvement including education and community awareness in combating HIV and AIDS and others health related issues.

Commit ourselves to

Mobilise and maintain political will at the highest level of each country in support of common regional policies and strategies to prevent and control HIV and AIDS and others health related issues.

Further strengthen the capacity of IGAD Health Section, partnership collaboration in capacity building, health system development including human resource development and research.

Scale up the existing multi-sectoral and multi-country initiatives for HIV and AIDS containment and the control of communicable diseases such as IGAD Regional HIV and AIDS Partnership Program (IRHAPP) and other regional initiatives.

Establishing relationship with other HIV and AIDS initiatives such as Great Lakes Initiatives on AIDS (GLIA), ARCANE and et cetera.

Work with the Ministries of Finance in increasing investment in health as endorsed during the high level forum on achieving health related Millennium Development Goals as well as Abuja Declaration, while using allocated resources efficiently.

Mobilise local and international resources for implementing joint activities including development of joint IGAD Region funding proposals.

Resolve to

Support the realisation of the objectives of the IGAD Regional HIV and AIDS Partnership Programme (IRHAPP).

Improve access to basic HIV and AIDS prevention, treatment, care and support and others health related services to the most at risk populations.

Establish quality Health Information System for timely exchange of essential information and response to HIV and AIDS and others related diseases.

Harmonise guidelines for prevention, treatment and care to facilitate effective prevention and control of HIV and AIDS and other related diseases.

Establish coordination and collaboration mechanisms between countries and border areas by empowering local health authorities at border areas to regularly exchange information and undertake cross-border coordination meetings and activities.

Pay attention to actions against key social determinants of health in the IGAD member states especially poverty, population mobility and displacements, marginalisation, health inequalities mainly to the detriment of remote and border areas.

Call upon all development partners to

Support prevention, treatment, care and support of HIV and AIDS and including other related diseases for Cross Border Mobile Populations,

Strengthen and sustain collaboration with IGAD Secretariat and member states.

C 4 Southern African Development Community (SADC)

Southern African Development Community (SADC) is an inter-governmental organisation which furthers socio-economic cooperation and integration as well as political and security cooperation among 14 Southern African countries: Angola, Botswana, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. The origins of SADC stretches back to the 1970s and 1980s, when the leaders of majority-ruled countries and national liberation movements coordinated their political, diplomatic and military struggles to bring an end to white-minority rule in Southern Africa.

C4.1 Treaty of SADC (1992/1993)

Adopted in Windhoek, Namibia, on 17 August 1992. The Treaty of SADC entered into force on 30 September 1993. An agreement amending the Treaty of SADC was later reached in Blantyre, Malawi, on 14 August 2001 to provide a few changes to the initial treaty. The Agreement entered into force on 14 August 2001. Full text available at www.sadc.int.

Excerpts

Article 5: Objectives

1. The objectives of SADC shall be to

- (a) promote sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation with the ultimate objective of its eradication, enhance the standard and quality of life of the people of Southern Africa and support the socially disadvantaged through regional integration;
- ...
- (c) consolidate, defend and maintain democracy, peace, security and stability;
- ...
- (e) achieve complementarity between national and regional strategies and programmes;
- ...
- (i) combat HIV/AIDS and other deadly or communicable diseases;
- (j) ensure that poverty eradication is addressed in all SADC activities and programmes; and
- (k) mainstream gender in the process of community building.
- ...

Article 6: General undertakings

1. Member states undertake to adopt adequate measures to promote the achievement of the objectives of SADC, and shall refrain from taking any measure likely to jeopardise the sustenance of its principles, the achievement of its objectives and the implementation of the provisions of this Treaty.

2. SADC and member states shall not discriminate against any person on grounds of gender, religion, political views, race, ethnic origin, culture, ill health, disability, or such other ground as may be determined by the Summit.

...

C4.2 SADC Protocol on Health (1999/2004)

Adopted on 18 August 1999 in Maputo, Mozambique. It entered into force on 14 August 2004. Full text available at www.sadc.int.

Excerpts

...

Article 1: Definitions and abbreviations

Definitions

...

‘Expanded response to HIV/AIDS’ means the response that goes beyond the health sector involving all other sectors as equal partners;

...

Article 2: Principles

States parties shall co-operate in addressing health problems and challenges facing them through effective regional collaboration and mutual support under this Protocol for the purposes of achieving the following objectives

...

(d) promoting health care for all through better access to health services; and

...

Article 3: Objectives

States parties shall co-operate in addressing health problems and challenges facing them through effective regional collaboration and mutual support under this Protocol for the purposes of achieving the following objectives

- (a) to identify, promote, co-ordinate and support those activities that have the potential to improve the health of the population within the region;
- (b) to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases;
- ...
- (e) to foster co-operation and co-ordination in the area of health with international organisations and co-operating partners;
- ...
- (g) to develop common strategies to address the health needs of women, children and other vulnerable groups;
- (h) to progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the region; and
- (i) to collaborate and co-operate with other relevant SADC sectors.
- ...

Article 10: HIV/AIDS and sexually transmitted diseases

1. In order to deal effectively with the HIV/AIDS/STDs epidemic in the region and the interaction of HIV/AIDS/STDs with other diseases, states parties shall

- (a) harmonise policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of STDs and HIV infection;
- (b) develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonised and standardised manner;
- (c) develop regional policies and plans that recognise the inter-sectoral impact of HIV/AIDS/STDs and the need for an inter-sectoral approach to these diseases; and
- (d) co-operate in the areas of
 - (i) standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information which has a regional impact;

- (ii) regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and
 - (iii) sharing of information.
2. States parties shall endeavour to provide high-risk and transborder populations with preventative and basic curative services for HIV/AIDS/STDs.
- ...

Article 12: Tuberculosis control

In view of the seriousness of tuberculosis in the region, states parties shall co-operate and assist one another

- (a) to develop strategies for the sustained control of tuberculosis, including the efficient supply and delivery of drugs; and
 - (b) to ensure, where appropriate, the harmonisation of tuberculosis control activities and HIV/AIDS programmes.
- ...

C4.3 SADC Code on HIV/AIDS and Employment (1997)

The Code was approved by SADC Heads of State and Government in Blantyre, Malawi, on 8 September 1997. The intention of the Code is to create a regional standard on the best ways to manage AIDS in the employment setting. It aims to guide employers, employees and governments toward the most economically sustainable and humane ways to respond to HIV and AIDS in the workplace. Text available at www.cosatu.org.za.

1. General statement

Human Immunodeficiency Virus (HIV) infection and the Acquired Immunodeficiency Syndrome (AIDS) in the countries of the Southern African Development Community (SADC) (and globally) is a major health problem with employment, economic and human rights implications. As one response to this problem the SADC Employment and Labour Sector has established this code on the industrial relations standards on HIV/AIDS, the 'Code on AIDS and Employment'. (Termed after this 'the code'). It should be noted that the provisions of this code applies only to workplaces and cannot and should not be construed as applying to other areas of law such as national immigration laws, policies and related administrative procedures.

2. Policy principles

The same ethical principles that govern all health/medical conditions in the employment context apply equally to HIV/AIDS. However, the gravity and impact of the HIV/AIDS epidemic and the potential for discrimination create the need for a specific code on HIV/AIDS and employment. At the same time, given the increased risk of spread of the disease under conditions of economic insecurity, non-discriminatory approaches enable economic and public health management. The code will aim to ensure non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health-medical conditions.

The regional nature and implications of the epidemic and the desire to harmonise national standards in dealing with HIV/AIDS motivate this regional code. This code aims to ensure that SADC member states develop tripartite national codes on AIDS and Employment that shall be reflected in law. It presents guiding principles for and components of these national codes.

The code on AIDS and Employment is based on the fundamental principles of human rights and patients rights, WHO/ILO and regional standards and guidelines, medical and occupational health ethical principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals. The approach aims to achieve a balance in protecting the rights of all parties, including those with and without HIV, employers, employees, state and others. This will include obtaining a balance between rights and responsibilities, and between individual protection and co-operation between parties.

Employees with HIV should be treated the same as any other employee. Employees with HIV related illness, including AIDS, should be treated the same as any other employee with a life-threatening illness.

In its scope, the code should

1. cover all employees and prospective employees;
2. cover all workplaces and contracts of employment; and
3. cover the specific policy components detailed below, viz: job access, workplace testing, confidentiality, job placement, job status, job security, occupational benefits, training, risk reduction, first aid, workers' compensation, education and awareness, prevention programmes, managing illness, protection against victimisation, grievance handling, information, monitoring and review.

SADC member states should ensure that interactions between them are consistent with the principles and policy components of this code and that they share and disseminate information to enable an effective and planned response to the epidemic.

Policy development and implementation is a dynamic process so that the code on AIDS and employment should be

1. communicated to all concerned;
2. routinely reviewed in the light of epidemiological and scientific information; and
3. monitored for its successful implementation and evaluated for its effectiveness.

3. Policy components

1. Education, Awareness and Prevention Programmes

1. Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should where possible incorporate employee families.

2. Essential components of prevention programmes are information provision, education, prevention and management of STDs, condom promotion and distribution and counselling on high risk behaviour. Workplace AIDS programmes should co-operate with and have access to resources of National AIDS Programmes.

2. Job Access

There should be no direct or indirect pre-employment test for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV. Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions related to the assessment of risk behaviour should not be permitted.

3. Workplace Testing and Confidentiality

1. There should be no compulsory workplace testing for HIV. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with informed consent of the employee in accordance with normal medical ethical rules and with pre- and post-test counselling.

2. Persons with HIV or AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of his HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's written consent.

3. Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by the law, ethics, the code or from the employee concerned.

4. *Job Status*

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

5. *HIV Testing and Training*

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical conditions.

6. *Managing Illness and Job Security*

1. No employee should be dismissed merely on the basis of HIV status, nor should HIV status influence retrenchment procedures.

2. Employees with HIV related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions.

3. HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When the employee becomes too ill to perform their agreed functions the standard benefits and conditions and standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

7. *Occupational Benefits*

1. Government, employers and employee representatives should ensure that occupational benefits are non-discriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefit schemes should make efforts to protect the rights and benefits of the dependents of deceased and retired employees.

2. Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.

3. Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.

4. Counselling and advisory services should be made available to inform all employees on their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums to these funds.

8. *Risk Management, First Aid and Compensation*

1. Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work.

2. Employees who contract HIV infection during the course of their employment should follow standard compensation procedures and receive standard compensation benefits.

3. Under conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependents.

4. People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

9. *Protection Against Victimisation*

1. Persons affected by or believed to be affected by HIV or AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

2. Where employers and employees agree that there has been adequate information and education and provisions for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

10. *Grievance Handling*

Standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV related grievances. Personnel dealing with HIV related grievances should protect the confidentiality of the employee's medical information.

11. *Information*

Government should collect, compile and analyse data on HIV/AIDS, sexually transmitted diseases and tuberculosis and make it available in the public domain. SADC member states should co-operate in making available national data for monitoring and planning an effective response to the regional health, human resource, economic and social impact of the AIDS epidemic.

12. *Monitoring and Review*

Responsibility for monitoring and review of the code and its implementation should lie with the parties to the tripartite at national and regional level and with the SADC Employment and Labour Sector.

C4.4 SADC Declaration on Gender and Development (1997)

The Declaration was adopted by SADC Heads of State and Government in Blantyre, Malawi, on 8 September 1997. Full text available at www.sadc.int.

Excerpts

...

A. *Noting that*

(i) Member states undertook in the SADC Treaty (article 6(2)) not to discriminate against any person on the grounds of gender, among others;

(ii) All SADC member states have signed and ratified or acceded to the UN Convention on the elimination of All Forms of Discrimination Against Women (CEDAW), or are in the final stages of doing so;

B. *Convinced that*

(i) Gender equality is a fundamental human right;

(ii) Gender is an area in which considerable agreement already exists and where there are substantial benefits to be gained from closer regional co-operation and collective action.

...

F. *Endorse the decision of Council on*

(i) The establishment of a policy framework for mainstreaming gender in all SADC activities, and in strengthening the efforts by member countries to achieve gender equality.

(ii) Putting into place an institutional framework for advancing gender equality consistent with that established for other areas of co-operation, but which ensures that gender is routinely taken into account in all sectors;

(iii) The establishment of a Standing Committee of Ministers responsible for Gender Affairs in the region;

(iv) The adoption of the existing Advisory Committee consisting of one representative from Government and one member from the Non-Governmental Organisations in each member state whose task is to advise the Standing Committee of Ministers and other Sectoral Committees of Ministers on gender issues.

(v) The establishment of Gender Focal points whose task would be to ensure that gender is taken into account in all

sectoral initiatives, and is placed on the agenda of all ministerial meetings; and

(vi) The establishment of a Gender Unit in the SADC Secretariat consisting of at least two officers at a senior level.

G. *Resolve* that, as leaders, we should spearhead the implementation of these undertakings and ensure the eradication of all gender inequalities in the region; and

H. *Commit* ourselves and our respective countries to, inter alia

(i) Placing gender firmly on the agenda of the SADC Programme of Action and Community Building Initiative;

(ii) Ensuring the equal representation of women and men in the decision-making of member states and SADC structures at all levels, and the achievement of at least thirty per cent target of women in political and decision-making structures by year 2005;

(iii) Promoting women's full access to, and control over productive resources such as land, livestock, markets, credit, modern technology, formal employment, and a good quality of life in order to reduce the level of poverty among women;

(iv) Repealing and reforming all laws, amending constitutions and changing social practices which will still subject women to discrimination, and enacting empowering gender-sensitive laws;

(v) Enhancing access to quality education by women and men, and removing gender stereotyping in the curriculum, career choices and professions;

(vi) Making quality reproductive and other health services more accessible to women and men;

(vii) Protecting and promoting the human rights of women and children;

(viii) Recognising, protecting and promoting the reproductive and sexual rights of women and the girl child;

(ix) Taking urgent measures to prevent and deal with the increasing levels of violence against women and children;

(x) Encouraging the mass media to disseminate information and materials in respect of the human rights of women and children.

...

C4.5 Addendum to the SADC Declaration on Gender and Development (1998)

SADC Ministers in charge of Justice and Gender, legislators, government officials and representatives of non-governmental organisations convened a SADC Conference on the Prevention of Violence Against Women in Durban, South Africa, from 5 to 8 March 1998, which recommended the adoption of certain measures. Following that conference, the Addendum to the 1997 Declaration on Gender and Development was adopted at Grand Baie, Mauritius, on 14 September 1998.

Excerpts

...

We strongly condemn violence against women and children in all its forms, and resolve that the following measures be adopted

...

Legal

8. Enacting laws such as sexual offences and domestic violence legislation making various forms of violence against women clearly defined crimes, and taking appropriate measures to impose penalties, punishment and other enforcement mechanisms for the prevention and eradication of violence against women and children;

9. Adopting legislative measures to ensure the protection and removal of all forms of discrimination against, and empowerment of women with disabilities, the girl-child, the aged, women in armed conflict and other women whose circumstances make them especially vulnerable to violence;

10. Reviewing and reforming the criminal laws and procedures applicable to cases of sexual offences, to eliminate gender bias and ensure justice and fairness to both the victim and accused;

11. Introducing, as a matter of priority, legal and administrative mechanisms for women and children subjected to violence, effective access to counselling, restitution, reparation and other just forms of dispute resolution;

12. Adopting such other legislative and administrative measures as may be necessary to ensure the prevention and eradication of all forms of violence against women and children;

Social, economic, cultural and political

13. Promoting the eradication of elements in traditional norms and religious beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women and children;

14. Introducing and supporting gender sensitisation and public awareness programmes aimed at eradicating violence against women and children;

15. Encouraging the media to play a constructive role in the eradication of violence against women and children by adopting guidelines which ensure sensitive coverage of the issue and avoid the perpetuation of stereotypes;

Services

16. Providing easily accessible information on services available to women and children victims/survivors of violence, including women and children with disabilities;

17. Ensuring accessible, effective and responsive police, prosecutorial, health, social welfare and other services, and establishing specialised units to redress cases of violence against women and children;

18. Providing accessible, affordable and specialised legal services, including legal aid, to ensure the just and speedy resolution of matters regarding violence against women and children;

19. Providing easily accessible, affordable and, where possible, free social, and administrative services for the empowerment of women and children victims/survivors of violence;

Education, training and awareness building

20. Introducing and promoting gender sensitisation and training of all service providers engaged in the administration of justice, such as judicial officers, prosecutors, police, prison, welfare and health officials;

21. Undertaking and sharing research of the gathering of statistics and other information on the causes, prevalence and consequences of violence against women and children;

22. Encouraging the exchange of national, regional and international best practices for the eradication of violence against women and children;

Integrated approaches

23. Ensuring that all these measures are implemented in an integrated manner by all stakeholders;

Budgetary allocations

24. Allocating the necessary resources to ensure the implementation and sustainability of the above programmes;

We further resolve that

25. Regional policies, programmes and mechanisms to enhance the security and empowerment of women and children, be adopted and their implementation monitored;

26. Urgent consideration be given to the adoption of legally binding SADC Instruments on Preventing Violence Against Women and Children, and to ensure that these commitments are translated into tangible actions;

...

C4.6 Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003)

Adopted at the 2003 SADC Heads of State and Government Summit on HIV/AIDS held in Maseru, Lesotho, on 4 July 2003. Full text available at www.sadc.int.

Excerpts

...

Recognising that the objectives of the Southern African Development Community are inter alia, to

- (a) Promote sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation with ultimate objective of its eradication;
- (b) Combat HIV/AIDS and other deadly and communicable diseases;
- (c) Mainstream gender in the process of community and nation building;

Recognising the commitments made by SADC member states in the Abuja and UNGASS Declarations on the need to fight HIV/AIDS and other communicable diseases such as malaria and tuberculosis;

Confirming that the SADC HIV/AIDS Strategic Framework (2000-2004) approved by the SADC Council of Ministers in 2000 showed that State parties are committed to combating the HIV/AIDS pandemic through effective regional collaboration, mutual support and the participation of all key stakeholders;

Convinced that halting and rolling back HIV infection constitutes a top priority in the SADC Agenda and is an integral part of the regional programme for eradicating poverty;

Further convinced that our regional efforts in combating HIV/AIDS constitute an essential part of the continental response to the HIV/AIDS pandemic as contained in the Abuja Declaration (2001) on HIV/AIDS, tuberculosis and other related infectious diseases and in the New Partnership for Africa's Development (NEPAD - 2001);

Welcoming and reaffirming the commitments on HIV/AIDS contained in the United Nations Millennium Declaration (September 2000) and United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration (June 2001), and the United Nations General Assembly Declaration on Children.

Deeply concerned that Sub-Saharan Africa, in particular the SADC Region, is currently the worst affected in the world by the HIV/AIDS pandemic as demonstrated by the rapid spread of the HIV infection, the heavy burden of illness and millions of deaths caused by HIV/AIDS, and that in Southern Africa in particular, the recent adverse humanitarian crisis resulting from the adverse climatic conditions, was exacerbated by the severe HIV/AIDS pandemic;

Noting with profound concern that the HIV/AIDS pandemic is reversing the developmental gains made in the past decades and is posing the greatest threat to sustainable development of the region due to loss of the most productive individuals in all sectors of our economies, decline in productivity, diversion of scarce resources from production to the care and support of the HIV/AIDS infected and affected persons, as well as mitigating the effects on various sectors, and resulting in an increase in the number of orphans and the disruption of family structures;

Recognising that the principal contributory factors to the spread of HIV/AIDS are extreme poverty, ignorance, negative attitudes and practices, and that the general underdevelopment and unfavourable international economic environment reflected in high indebtedness of some of the SADC member states, limited access to international markets and declining official development assistance, further aggravate the pandemic;

Further recognising that inadequate food security, poor nutrition, inadequate essential public services, limited reproductive health services, gender imbalances and high levels

of illiteracy impact negatively on the quality of life of people living with HIV;

Recognising that the HIV/AIDS pandemic can be curbed, and that within the SADC region there have been some successes and best practices in changing behaviour, reducing new HIV infections and mitigating the impact of the HIV/AIDS pandemic, and that these successes need to be rapidly scaled up and

- (a) emulated across the region;
- (b) HIV/AIDS is best tackled through multi-sectoral interventions aimed at poverty eradication, which include the promotion of socio-economic development, fostering positive cultural attitudes and practices, gender equity, and undertaking specific health and nutritional interventions as well as programmes to combat the abuse of alcohol and illicit drugs;
- (c) the upholding of human rights and fundamental freedoms for all including prevention of stigma and discrimination of People Living with HIV (PLWH) is a necessary element in our regional response to the HIV/AIDS pandemic, which would encompass access, inter alia, to education, inheritance, employment, health care, social and health services, prevention, support, treatment, legal protection, while respect for privacy and confidentiality will be upheld, and strategies would be developed to combat stigma and social exclusion connected with the pandemic; and
- (d) partnerships with all stakeholders including civil society, cultural and faith-based organisations, tripartite social partners, Non-Governmental Organisations, traditional health practitioners, the private sector, international institutions, cooperating partners and the media are vital if we are to succeed in our key intervention areas such as HIV surveillance, prevention, treatment, care, support, monitoring, research, nutrition, poverty eradication and adequate resource mobilisation for combating the HIV/AIDS pandemic.

THEREFORE

Reaffirm our commitment, to the combating of the AIDS pandemic in all its manifestations, as a matter of urgency through multi-sectoral strategic interventions as contained in the new SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007; and

Declare the following as the priority areas requiring our urgent attention and action

1. Prevention and social mobilisation by

- (a) Reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values, positive behavioural change and promoting responsible sexual behaviour;
- (b) Intensifying the provision of comprehensive, affordable and user-friendly reproductive health services to youth, men and women and ensuring that essential commodities such as male and female condoms are made available;
- (c) Strengthening initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework;
- (d) Promoting and strengthening programmes for the youth aimed at creating opportunities for their education, employment and self-expression, and reinforcing programmes to reduce their vulnerability to alcohol and drug abuse;
- (e) Rapidly scaling up the programmes for the prevention of Mother-to-Child Transmission of HIV, and ensuring that levels of uptake are sufficient to achieve the desired public health impact;
- (f) Scaling up the role of education and information in partnership with all key stakeholders including the youth, women, parents, the community, health care providers, traditional health practitioners, nutritionists and educators as well as integrating HIV/AIDS education in both the ordinary and extra curricula at all levels of education, including primary and secondary education;
- (g) Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed

forces, and consider ways of using personnel from these services to strengthen awareness and prevention initiatives

2. Improving care, access to counselling and testing services, treatment and support by

- (a) Strengthening health care systems, especially public health;
- (b) Strengthening family and community based care as well as support to orphans and other vulnerable children;
- (c) Facilitating the expansion of workplace programmes on HIV/AIDS prevention and management among all levels of the workforce, supported by appropriate policy and legal frameworks;
- (d) Development of service and caring capacity among all people caring for the HIV/AIDS infected persons, including the home based care providers, as well as upgrading of diagnostic and related technologies;
- (e) Expanding access to voluntary counselling and testing; preventing and removing stigma silence, discrimination, and denial which continue to hamper and undermine HIV control efforts, particularly, towards the people living with HIV and AIDS;
- (f) Putting in place national legislation and regional legal regimes to ensure the availability of technologies and drugs at affordable prices for treatment, including bulk purchasing of drugs and manufacturing of generic medicines in the region;
- (g) Increasing access to affordable essential medicines, including ARVs and related technologies, through regional initiatives for joint purchasing of drugs, with the view of ensuring the availability of drugs through sustainable mechanisms, using funds from national budgets;
- (h) Investing in nutrition programmes and promoting the use of nutritional supplements, production and consumption of locally available foods; and
- (i) Developing a regulatory framework and institutional capacity for the testing and utilisation of traditional medicines.

3. Accelerating development and mitigating the impact of HIV/AIDS by

- (a) Creating and sustaining an enabling environment conducive to gender-balance, rapid and broad-based socio-economic development of the Region and addressing major underlying factors that lead to the spread of the HIV infection;
- (b) Harmonising policies and strategies and undertaking joint programmes in the priority intervention areas including prevention, treatment, care, support, nutrition and food security;
- (c) Enhancing the regional initiatives to facilitate access to HIV/AIDS prevention, treatment, care and support for people living along our national borders, including sharing of best practices;
- (d) Mainstreaming and factoring HIV/AIDS in our regional integration process and focal intervention areas, particularly in the areas of trade liberalisation, infrastructure development, food security, social and human development;
- (e) Evaluating the economic and social impact of the HIV/AIDS epidemic and developing multi-sectoral strategies to address the impact at individual, family, community, national and regional levels;
- (f) Establishing mechanisms for mitigating the impact of the HIV/AIDS pandemic, including the provision of support to families, orphans and other vulnerable children, and strategies to ensure a sustained labour supply.

4. Intensifying resource mobilisation by

- (a) Establishing a Regional Fund for the implementation of the SADC HIV/AIDS Strategic Framework (2003-2007);
- (b) Reaffirming our commitment to implementing the Abuja Declaration on allocating at least 15 per cent of our annual budgets for the improvement of the health sector;
- (c) Urging the international cooperating partners, on humanitarian grounds, to assist our region by substantially increasing the provision of financial and technical support at country and regional levels through various initiatives and commitments such as the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), Official Development Assistance, the Enhanced Heavily Indebted Poor Countries

(HIPC) Initiative; and the Multi-country AIDS Programme (MAP);

(d) Developing and strengthening mechanisms to involve all stakeholders, such as civil society organisations, the private sector, organised labour and business to contribute towards financing HIV/AIDS programmes;

(e) Establishing simplified mechanisms for the timely disbursement of funds to the operational level, ensuring that all communities have adequate access to these funds.

5. Strengthening institutional, monitoring and evaluation mechanisms by

(a) Developing and strengthening institutional mechanisms for HIV surveillance, sharing of experiences and exchange of information on key areas of interventions such as prevention, provision of care to, and support of, HIV/AIDS infected and affected persons and treatment of HIV/AIDS-related conditions;

(b) Intensifying training and research initiatives or programmes to strengthen member states' capacities to manage the epidemic;

(c) Developing and strengthening appropriate mechanisms for monitoring and evaluating the implementation of this Declaration, and other continental and global commitments, and establishing targets and time-frames which will be included in the SADC HIV/AIDS Strategic Framework and Programme of Action (2003 – 2007).

...

C4.7 HIV and AIDS Strategic Framework and Programme of Action 2003-2007 (2003)

Adopted at the 2003 Heads of State and Government Summit on HIV/AIDS in Maseru, Lesotho, on 14 July 2003. The Strategic Framework mainstreams HIV and AIDS within all policies and programmes undertaken by SADC and reflects the challenges and priorities of the region in responding to the epidemic.

Excerpts

...

5. Guiding principles

The following principles have guided the development of the SADC Strategic Framework (2003 to 2007) and will guide the implementation thereof

- The policies and programmes of SADC must be based on a response to the HIV epidemic that is multi-sectoral, consistent with the strategies being followed at the national level, and aimed at mobilising all sectors of the economy and society in support of an effective response to the challenges of HIV and AIDS in the region.
- The principle of subsidiarity implies that all policies and programmes should be developed and implemented at the level at which they can be most effective. This includes the allocation of functions, responsibilities and resources, to levels of organisation in government and civil society where they will be most effective.
- The prioritisation of activities so that what is developed and implemented by SADC reflects the principle of importance and additivity. This means concentrating on those issues that are crucial for the overall success of SADC. In this instance ensuring that SADC supports effective responses to HIV and AIDS in all its programmes – especially those activities that lead to reductions in HIV incidence and mitigation of the socio-economic impact.
- To ensure gender mainstreaming into all policies and programmes being undertaken by SADC in relation to HIV and AIDS. This recognises that the majority of people living with HIV and AIDS in the region are women and that the social and economic status of women increases their vulnerability to HIV and AIDS. This principle acknowledges

that the relationships between men and women are integral to the development of an effective response to the epidemic.

- That SADC activities on HIV and AIDS reflect its comparative advantage as a regional organisation that is best placed to address aspects of the response that is regional. The principle implies that the allocation of responsibilities to the Directorates or sectors should be in line with their mandates and comparative advantage.
- That SADC policies and programmes are complementary to those of member states, to avoid overlap and duplication, and to build on the structures and best practices already in existence and being followed at country level. That the activities of SADC in the response to HIV and AIDS be developed within frameworks that include the explicit recognition of the wide range of other organisations that are active, including national, regional and international players.
- That policies and programmes of SADC be based upon the respect of human rights, and the obligations that member states have agreed to as signatories to international and regional conventions.
- That the SADC response is based on the understanding that HIV and AIDS impact differently on women and men, are multi-sectoral and multidimensional, and that effective and relevant policies and programmes need to be developed in collaboration with partners at national and regional level.

6. The vision, goal and objectives of the SADC strategic framework on HIV and AIDS (2003 – 2007)

Vision

Significantly reduced levels of HIV and AIDS within SADC

Overarching Goal

To decrease the numbers of people living with and affected by HIV and AIDS in the SADC region, so as to ensure that HIV and AIDS is no longer a threat to public health and to the sustained socio-economic development of member states.

Main Objectives

1. To reduce the incidence of new infections among the most vulnerable populations within SADC.
2. To mitigate the socio-economic impact of HIV and AIDS.
3. To review, develop and harmonise policies and legislation relating to HIV prevention, care and support, and treatment within SADC.
4. To mobilise and coordinate resources for a multi-sectoral response to HIV and AIDS in the SADC region.
5. To monitor the implementation of the SADC Framework and regional, continental and global commitments ensuring that gender is fully mainstreamed.

Outputs

1. Reduced incidence and prevalence of HIV and AIDS in the SADC region.
2. Strategies for responding to the socio-economic impact of HIV and AIDS are developed and implemented in all programme areas of SADC.
3. Adequate regional and global resources are mobilised and effectively utilised in a coordinated response in the region.
4. Policies and programmes of SADC are harmonised and effectively coordinated.
5. Monitoring mechanisms are in place, including disaggregated data and information by gender.

7. SADC strategic areas of focus

The situational and response analysis and the principles guiding the development of the Framework have informed the strategic focus areas of SADC aligned to the mandate of a restructured SADC. The following areas have been identified as the main areas of strategic focus

7.1 Policy Development and Harmonisation

SADC will promote policy development, harmonisation and the establishment of protocols in the following areas

- Care and treatment including the use of ARVs;
- Nutrition, nutritional therapies and traditional herbs;
- Human resource needs in all sectors in the context of HIV and AIDS;
- Regional issues such as HIV and AIDS and migrant population/mobile labour, refugees and displaced populations;
- Harmonisation of procedures, regulations and laws of transit at borders and ports;
- Bulk procurement of drugs and medical supplies for HIV and AIDS;
- Regional guidelines for clinical trials;
- Guidelines for program intervention in high transmission areas such as border sites and high traffic sites;
- Sustaining human capital in the context of HIV and AIDS in the region; and
- Policy guidelines on increasing access to care and treatment to the most vulnerable social groups.

7.2 Mainstreaming HIV and AIDS in SADC

The objective of the SADC Strategic Framework (2003 – 2007) is to mainstream HIV and AIDS into all the policies, programmes and activities being developed and implemented by the SADC Directorates, the Department of Strategic Planning, Gender and Policy Harmonisation and all other entities and units of SADC.

The areas for mainstreaming include

- Policy level;
- Programme and project level; and
- Activity level.

7.3 Capacity Building

The SADC Strategic Framework (2003 -2007) aims to strengthen the capacity of SADC to mainstream HIV and AIDS at all levels, and to create the capacity required for the integration of HIV in all policies and programmes, especially the RISDP. A challenge confronting member states and SADC is how to sustain this capacity in the face of attrition of human resources due to HIV and AIDS. As part of its Strategic Framework SADC will establish personnel and workplace programmes for staff and ensure that these are given the required priority and resources by senior management. SADC will prioritise the following

- Enhance the understanding of the interrelationship between HIV and AIDS and development at the Secretariat and member states;
- Strengthen the capacity of the SADC Secretariat and member states to integrate HIV and AIDS into all policies and programmes;
- Develop capacity in the area of monitoring and evaluation of HIV and AIDS programmes; and
- Develop personnel and workplace programmes for staff at the Secretariat and member states in accordance with the SADC and ILO Codes of Practice on HIV and AIDS and the World of Work.

7.4 Facilitating a Technical Response

SADC will establish mechanisms to facilitate regional technical discussions, develop regional guidelines and facilitate the sharing of best practices in the areas of

- Mainstreaming of HIV and AIDS;
- PMTCT;
- Support to orphans;
- Home based care;
- Multi-sectoral response;
- Resource mobilisation;
- Voluntary counselling and testing;
- Access to ARV treatment;
- Use of traditional medicines;

- Research and surveillance taking into account anthropological and epidemiological factors; and
- Mitigation of HIV and AIDS.

7.5 Facilitating Resource Networks

Within member states resources of people and organisations exist that have the necessary technical skills to assist with the response to the epidemic. The SADC Secretariat will undertake an assessment of national and regional resources, seek to mobilise these resources into networks that can facilitate information exchange and collaboration, share scientific research, map available resources, share best practices and focus on activities that support common regional needs. Some of the expected networks and outcomes include

- Network of National AIDS Programs or Councils;
- Collaboration and sharing of research facilities and results;
- Regional training and research;
- Collaboration in inter-country programs such as cross-border initiatives and migrant labour;
- Regional donor coordination;
- Development of a regional management information system; and
- Development of a regional data bank.

7.6 Facilitating the Monitoring of Regional and Global Commitments

SADC will facilitate the monitoring of the performance of member states in meeting their regional, continental and global commitments in the following areas

- Assessment of individual country performances with respect to Maseru, Abuja, MDG and UNGASS targets for HIV and AIDS and related indicators, and the publication of regular reviews for SADC. This will complement the monitoring being undertaken at the level of individual countries; and
- Facilitation of processes to assist member states that are not achieving the various targets, by strengthening national capacities in relevant areas.

Operational plan 2003-2007

...

1. Operationalising the SADC HIV and AIDS framework

The SADC Operational Plan is based upon the situational and response analysis and the opportunities available to SADC to respond to the epidemic as outlined in Part A. The Operational Plan provides an overview of the following

- Crosscutting issues that are to be taken into account by SADC in the implementation of the Operational Plan.
- A brief description of the functions of the SADC Directorates, the Department of Strategic Planning, Gender and Policy Harmonisation and the Organ on Politics, Defence and Security. In each case the programmes are presented in the form of a matrix outlining the objectives, activities, indicators, time-frames, responsibilities and the required budget for the undertaking of the activities.

2. Overall goal of the SADC Operational plan

To decrease the number of individuals living with HIV and AIDS and families affected by the epidemic in the SADC region, so that HIV and AIDS is no longer a threat to public health and the socioeconomic development of member states.

3. Cross cutting issues

Five broad crosscutting issues have been identified which are relevant for the activities to be undertaken by SADC and by member states. These are

Human Capital

The HIV epidemic is concentrated in the working age population, affecting both men and women, skilled and unskilled labour. The loss of human resources has consequences for the entire social, economic and political activities being undertaken by SADC. The protection of human capital from HIV and its

impact forms an integral component of all SADC policies and programmes.

Public Goods

The State in all countries plays a significant role in supporting the processes of growth and development. It does this through regulatory frameworks, the legal and judicial system, and through the direct provision of key services such as the police, military, educational and health service provision, transport systems and telecommunications. The HIV epidemic is eroding the capacity of the public service upon which SADC and its member states depend for effective functioning and public administration, and supply of public goods. SADC policies and programmes will strive to protect and/or minimise the impact of HIV and AIDS on public goods.

Inter-sectoral Relationships

The economic and social system comprises inter-dependent parts whose efficiency depends on the parts working more or less normally. The impact of the HIV epidemic is generalised across different productive sectors including social, political and economic sectors. SADC policies and programmes have to address these linkages to ensure that they will be effective.

Investment Strategies

SADC programmes need to be based on the understanding that labour and capital inputs are essential for development and that loss of human capital and the erosion of the public sector capacity is significantly reducing the performance of new investments. Related to this is the issue that new investments in infrastructure may facilitate the transmission of HIV. Technology can play an important role in reducing some of the adverse impacts of the epidemic on labour productivity, for example through the application of labour saving technology in agriculture. SADC must ensure that investments in different programme areas are coordinated, and are supportive of each other in the response to the epidemic.

Integrating Gender

SADC is committed to mainstreaming gender into all programmes and activities. The need to integrate gender issues is nowhere more essential and urgent than in the programmes and activities relating to HIV and AIDS. Understanding the relationships between men and women is fundamental to HIV prevention throughout the region. Women play a central role in the economy and society of countries in the SADC region, and their capacity to do so is being undermined by HIV and AIDS. Women account for an overwhelming share of agricultural labour, are responsible for the upbringing and socialisation of children, including the passing on of essential skills to the next generation. As the majority of people living with HIV and AIDS in the SADC region are women many of the activities being undertaken by women are threatened by the epidemic, and the consequences for society are extremely serious.

The Department has overall responsibility for the strategic planning and the mainstreaming of gender, poverty and HIV and AIDS into the policies and programmes of the SADC Directorates. To ensure that HIV and AIDS is mainstreamed a new HIV and AIDS Unit is being established within this Department. This Department will also support horizontal integration, given that there are important policy and programme links between gender, poverty and HIV and AIDS.

There are a number of important tasks that the Department will be expected to implement over the planned period, aimed at strengthening the capacity and response of the Secretariat to HIV and AIDS. These include: setting up the new HIV Unit, developing a Business Plan to guide the SADC Secretariat in operationalising the Strategic Framework on HIV and AIDS (2003 - 2007). This Department will also be responsible for monitoring the performance of member states and the region in respect of global, continental and regional commitments and facilitate the strengthening of the capacity of member states in relation to key indicators. There are also important issues that cross all Directorates, including the development of a Resource Mobilization Plan and an Evaluation and Monitoring Plan for HIV and AIDS.

C4.8 HIV and AIDS Business Plan: Strategic 5-Year Business Plan 2005-2009 (2004)

Adopted in 2004 by SADC member states to intensify their interventions to address the AIDS pandemic.

Excerpts

3. Priorities of the business plan

HIV and AIDS feature prominently in the Regional Indicative Strategic Development Plan (RISDP) as one of the key priority areas for intervention. The Business Plan for HIV and AIDS was developed in this context and has, therefore, focused on five key intervention areas, namely

- (i) Policy development and harmonisation
- (ii) Capacity building and mainstreaming HIV and AIDS into all SADC policies and plans
- (iii) Facilitation of a technical response, resource networks, collaboration and coordination
- (iv) Resource mobilisation for the regional multi-sectoral response
- (v) Monitoring and evaluation of the regional multi-sectoral response

Under each of these intervention areas, key activities and performance indicators have been highlighted, as well as the role of various stakeholders and the anticipated timeframes ...

Output 1: Policy development and harmonisation

Policy development and harmonisation makes up much of the work of the HIV and AIDS Unit. Within this intervention area, seven different outputs have been identified.

Output 1.1 under this intervention area states that policies for intervention are harmonised. This includes the need to develop, harmonise and review policies in six different target areas

- Regional guidelines for Behaviour Change Communication (BCC) programmes, including the role of cultural and sporting industries in HIV prevention;
- Guidelines for programming HIV and AIDS in the uniformed forces;
- Programmes and guidelines for special HIV prevention and vulnerability reduction targeted at pre-adolescents, young people and women;
- Guidelines for the prevention of mother to child transmission (PMTCT);
- Regional guidelines for STI/HIV and behavioural surveillance systems; and
- Regional guidelines for reducing HIV and AIDS related stigma and discrimination.

Output 1.2 specifies that policies for care and support are harmonised. This process will take place by reviewing, developing and harmonising guidelines and policies in the following four target areas

- Comprehensive care and support, including nutrition, for people living with HIV and AIDS;
- Policies and programmes for orphans and vulnerable children (OVCs);
- Regional joint procurement of drugs, medical supplies and testing reagents; and
- Guidelines for voluntary counseling and testing (VCT).

Output 1.3 demands that policies for treatment are harmonised. This includes

- The review and harmonisation of protocols for STI treatment, HIV and AIDS, TB and other opportunistic infections
- The implementation of regional guidelines for the use of indigenous knowledge systems in developing and producing alternative drugs and medicines for treatment of common diseases, including HIV and AIDS; and
- The review and harmonisation of guidelines for health delivery systems taking into consideration HIV and AIDS mainstreaming and the roll-out of anti-retroviral (ARV) treatment.

Output 1.4 under this intervention area is that policy on HIV and AIDS migrant/mobile and displaced populations is developed and harmonised. This process will take place by developing and harmonising guidelines, laws and programme interventions in the following four target areas

- High transmission areas like high activity areas, cross border sites and high traffic sites in the context of the proposed SADC protocol on the free movement of people;
- Health issues for displaced and mobile populations including illegal immigrants focusing on treatment continuity, health services, messages, drug labelling information;
- Transit at borders and ports;
- ARV treatment related to migrants and the equity in treatment access across countries.

Output 1.5 outlines that regional policies and plans to sustain increasing human resource needs as a consequence of HIV and AIDS are developed and harmonised in SADC. This is to be achieved by

- Developing and harmonising a regional multi-sectoral Human Resource and HIV and AIDS policy for education and training, retention and safe work environments in the public service;
- Supporting the inclusion of the policy in the country coordinating mechanisms, in HR bilateral funding and in public sector expenditure negotiations with multi-lateral agencies such as the IMF and World Bank.

Output 1.6 specifies that a corporate policy on HIV and AIDS at the SADC Secretariat is developed and implemented. This policy will be developed and the guidelines implemented by the end of 2005.

Output 1.7 targets the SADC sectors and requires that sectoral policies on HIV and AIDS are developed and harmonised in all SADC sectors. These policies will be developed for the Food, Agriculture and Natural Resources Directorate, the Human Social Development and Special Programmes Directorate, the Infrastructure and Services Directorate and the Trade, Finance and Investment Directorate.

Output 2: Capacity building and mainstreaming HIV and AIDS into all SADC policies and plans

The Business Plan's second intervention area covers both capacity building and HIV and AIDS mainstreaming. This intervention area aims to achieve three outputs.

Output 2.1 requires integrating HIV and AIDS in all SADC policies and programmes. The key tasks will involve

- Strengthened capacity of the Secretariat to integrate and facilitate implementation of HIV and AIDS in all sectors of the SADC Programme;
- Support to the mainstreaming of HIV and AIDS in all sectors of SADC at member state level.

Output 2.2 seeks the piloting models of integrating HIV and AIDS. This will take place through developing

- A SADC model to assist children affected by the epidemic to remain in school through 'Circles of Support';
- A model for reducing the vulnerability of transport workers to HIV infection through a multi-country transport initiative;
- A model for integrating HIV and AIDS into water resource management;
- SADC programmes and guidelines for reducing vulnerability to the risk of occupational exposure to HIV infection at the workplace in different sectors.

Output 2.3 requires the improving and sustaining of human resources and technical capacity in member states. The key tasks will involve the

- Provision of technical support to member states to review and strengthen their capacity for multi-sectoral coordination of HIV and AIDS programmes in the context of mainstreaming; and
- Review and strengthening of Human Resource practices and procedures to mitigate the impact of HIV and AIDS on the public service.

Output 3: Facilitation of a technical response, resource networks, collaboration and coordination

The third intervention area has a broad mandate covering two outputs.

Output 3.1 is the enhanced coordination and sharing of technical information and resource in HIV and AIDS among member states and partners, which will be achieved by establishing a regional database, mechanisms for the exchange of scientific and behavioural research results and facilitating information exchange throughout the region and across SADC sectors.

Output 3.2 aims to achieve enhanced collaboration in the response to HIV and AIDS and related diseases in SADC, through better regional collaboration.

Output 4: Resource Mobilization for the Regional Multi-Sectoral Response

The Business Plan's fourth intervention area focuses on the financial side of the multi-sectoral response by ensuring that the funds to match the needs of the regional HIV and AIDS response are secured, through the resource mobilisation plan, the establishment of a SADC trust fund, the implementation of the Project Concept Notes and the maintenance of partnerships from the donor community.

Output 5: Monitoring and evaluation of the regional multi-sectoral response

Effective monitoring of the HIV and AIDS response in the SADC region will be carried out by focusing on the following four key areas

- Implementation of the Maseru Declaration, Abuja Declaration and UNGASS;
- Development and implementation of an M&E Plan for a Regional Multi-Sectoral Response;
- Monitoring the implementation of the existing SADC Code of Conduct on employment and HIV and AIDS; and
- Establishment of an Information Management System for tracking the HIV and AIDS Response at SADC level.

...

C5 Economic Community of Central African States (ECCAS)

ECCAS was created in 1984 from the former Customs and Economic Union of Central Africa (CEUCA), which was founded in 1981. ECCAS was dormant for most of the 1990's due to sustained armed violence in many ECCAS states, but became active again in the 2000's. It aims to increase cooperation between member states in various areas relating to development. States that are part of ECCAS include Angola, Burundi and Rwanda. With regards to the response to HIV, ECCAS states have adopted a Strategic Framework for the Fight against HIV/AIDS, a 2004-2005 Action Plan for the Fight against HIV/AIDS in Central Africa, a Declaration on the Fight against HIV/AIDS, an ECCAS Gender Policy and an Action Plan for the Implementation of the ECCAS Gender Policy.

C5.1 Treaty establishing ECCAS (1983/1984)

Signed on 20 October 1983 in Libreville, Gabon, and entered into force on 18 December 1984. Its provisions cover various activities for cooperation among member states, including health.

Excerpts

...

Article 60: Social affairs

1. Member states shall use their human resources fully and rationally for the development of the Community.
2. Accordingly, they shall
 - (a) promote exchanges of experience and information on literacy, vocational training and employment;
 - (b) develop collective research by appropriate policies aimed at improving the economic, social and cultural status of women in urban and rural areas and increasing their integration in development activities;
 - (c) progressively harmonise their labour laws, social security systems and civil status laws and regulations; and
 - (d) initiate sub-regional cooperation in public health, medical research, promotion of studies in traditional medicine and pharmacy and exchanges of experiences.

C6 Indian Ocean Commission (IOC)

The Indian Ocean Commission is an intergovernmental organisation founded in 1984. Its members are The Comoros, Madagascar, Mauritius, Seychelles and France (for Réunion Island). These states endorsed a Regional Strategic Initiative for the Fight against HIV/AIDS in October 2002. A partnership between the Indian Ocean Commission, the UN system and NGOs, its main purpose is to prevent the spread of HIV in a region that has not yet been very affected by the virus. It runs various projects financed by the African Development Bank and the French government. A Regional Action Plan for the Fight against HIV/AIDS has also been adopted.

C6.1 General Agreement of Cooperation between Member States of the Indian Ocean (1984/1984)

It is the founding treaty of the Indian Ocean Commission, signed in Victoria, Seychelles, on 10 January 1984 between Mauritius, Madagascar and Seychelles and entered into force on the same day. France and The Comoros adhered by protocol on 10 January 1986. The Agreement describes the various areas of cooperation amongst member states and sets up the Indian Ocean Commission to coordinate strategic orientations.

D DOMESTIC DOCUMENTS FROM EASTERN AND SOUTHERN AFRICAN COUNTRIES

- D1 Constitutional provisions
- D2 Legislation (including bills)
- D3 Policies and other similar documents
- D4 Case law of Eastern and Southern African national courts

D1 Constitutional provisions

D1.1 Relationship between international and national law: monist constitutions

Constitution of the Republic of Angola

Adopted on 11 November 1975. The Constitution was amended several times. The original text is in Portuguese and is available at www.angola.org.

Excerpts

...

Article 21

(1) The fundamental rights provided for in the present law shall not exclude others stemming from the laws and applicable rules of international law.

(2) Constitutional and legal norms related to fundamental rights shall be interpreted and incorporated in keeping with the Universal Declaration of Human Rights, the African Charter on Human Rights and Peoples' Rights and other international instruments to which Angola has adhered.

(3) In the assessment of disputes by Angolan courts, those international instruments shall apply even where not invoked by the parties.

...

Constitution of the Federal Democratic Republic of Ethiopia

Adopted on 8 December 1994 and brought into force by Proclamation 1/1995 of 21 August 1995. The original text is in Amharic. The following extract is taken from the official English version which is available at www.ethiobar.net.

Excerpts

...

Article 9

...

(4) All international agreements ratified by Ethiopia are an integral part of the law of the land.

...

Constitution of the Republic of Namibia

Adopted on 9 February 1990 and available at www.namibweb.com.

Excerpts

...

Article 144

Unless otherwise provided by this Constitution or Act of Parliament, the general rules of public international law and international agreements binding upon Namibia under this Constitution shall form part of the law of Namibia.

...

D1.2 Relationship between international and national law: dualist constitutions

Constitution of Malawi

Adopted on 18 May 1994. It has been amended several times. The text is available at www.sdn.org.mw.

Excerpts

...

211. International law

(1) Any international agreement ratified by an act of Parliament shall form part of the law of the Republic if so provided for in the Act of Parliament ratifying the agreement.

(2) International agreements entered into before the commencement of this Constitution and binding on the Republic shall form part of the law of the Republic, unless Parliament subsequently provides otherwise or the agreement otherwise lapses.

(3) Customary international law, unless inconsistent with this Constitution or an act of Parliament, shall have continued application.

...

Constitution of the Republic of South Africa

Adopted by the Constitutional Assembly in 1996 and entered into force early in 1997. Full text available at www.polity.org.za.

Excerpts

...

231. International agreements

(1) The negotiating and signing of all international agreements is the responsibility of the national executive.

(2) An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection 3.

(3) An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time.

(4) Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an act of Parliament.

(5) The Republic is bound by international agreements which were binding on the Republic when this Constitution took effect.

232. Customary international law

Customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.

...

Constitution of the Kingdom of Swaziland

Enacted by the King and the Parliament of Swaziland on 26 July 2005. This is Swaziland's first constitution in over 30 years. The Constitution took effect in February 2006. Full text available at www.chr.up.ac.za.

Excerpts

...

238.(2) An international agreement executed by or under the authority of the Government shall be subject to ratification and become binding on the government by

(a) an act of Parliament; or

(b) a resolution of at least two-thirds of the members at a joint sitting of the two Chambers of Parliament.

(3) The provisions of subsection 2 do not apply where the agreement is of a technical, administrative or executive nature or is an agreement which does not require ratification or accession.

(4) Unless it is self-executing, an international agreement becomes law in Swaziland only when enacted into law by Parliament.

...

Constitution of Zimbabwe

The Constitution took effect on 18 April 1980. It has been amended several times. The last amendment taken into consideration for the purpose of the following extracts is Act No 5 of 2000. Full text available at www.nca.org.zw.

Excerpts

...

111B. Effect of international conventions et cetera

(1) Except as otherwise provided by this Constitution or by or under an Act of Parliament, any convention, treaty or agreement acceded to, concluded or executed by or under the authority of the President with one or more foreign states or governments or international organisations

(a) shall be subject to approval by Parliament; and

(b) shall not form part of the law of Zimbabwe unless it has been incorporated into the law by or under an act of Parliament.

...

(3) Except as otherwise provided by this Constitution or by or under an act of Parliament, the provisions of subsection 1(a) shall not apply to

(a) any convention, treaty or agreement, or any class thereof, which Parliament has by resolution declared shall not require approval in terms of subsection 1(a); or

(b) any convention, treaty or agreement the subject-matter of which falls within the scope of the prerogative powers of the President referred to in section 31H(3) in the sphere of international relations; unless the application or operation of the convention, treaty or agreement requires

...

(ii) any modification of the law of Zimbabwe.

...

D1.3 Equality and non-discrimination

Constitution of the Republic of Burundi

Adopted by the parliament of Burundi on 17 September 2004 and approved by referendum on 28 February 2005. The Constitution of Burundi has a provision prohibiting discrimination based on HIV status. The original text is in French and available at www.unpan1.un.org.

Excerpts

...

Article 22

All citizens are equal before the law, which provides them with equal protection. No one may be subject to discrimination because of their origin, race, ethnicity, sex, color, language, social situation or his religious, philosophical or political convictions or because of a physical or mental handicap or because they are suffering from HIV/AIDS or any other incurable disease.

...

Constitution of Eritrea

Adopted by the Constituent Assembly on 23 May 1997. The original text is in Tigrinya. Full text available at www.unpan1.un.org.

Excerpts

...

Article 14. Equality under the law

(1) All persons are equal before the law.

(2) No person may be discriminated against on account of race, ethnic origin, language, colour, sex, religion, disability, political belief or opinion, or social or economic status or any other factors.

(3) The National Assembly shall, pursuant to the provisions of this article, enact laws that can assist in eliminating inequalities existing in the Eritrean society.

...

Constitution of the Federal Democratic Republic of Ethiopia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information on the Constitution of Ethiopia.

Excerpts

...

Article 25. Right to equality

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall guarantee to all persons equal and effective protection without discrimination on grounds of race, nation, nationality, or other social origin, colour, sex, language, religion, political or other opinion, property, birth or other status.

...

Constitution of Lesotho

Adopted in 1993, the Constitution of Lesotho has been amended several times. The following extracts incorporate the amendments as of 2001. Full text available at www.chr.up.ac.za.

Excerpts

...

4. Fundamental human rights and freedoms

(1) Whereas every person in Lesotho is entitled, whatever his race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status to fundamental human rights and freedoms, that is to say, to each and all of the following -

- (a) the right to life;
- (b) the right to personal liberty;
- (c) freedom of movement and residence;
- (d) freedom from inhuman treatment;
- ...
- (g) the right to respect for private and family life;
- ...
- (i) freedom of conscience; freedom of expression;
- ...
- (n) freedom from discrimination;
- (o) the right to equality before the law and the equal protection of the law; and
- (p) the right to participate in government,

19. Right to equality before the law and the equal protection of the law

Every person shall be entitled to equality before the law and to the equal protection of the law.

...

Constitution of the People's Republic of Mozambique

Adopted in 1990, the Constitution of Mozambique was amended several times. The original text is in Portuguese.

Excerpts

...

Article 36. Principle of equality

Men and women shall be equal before the law in all spheres of political, economic, social and cultural affairs.

...

Constitution of the Republic of South Africa

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

9. Equality

(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

...

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

...

(5) Discrimination on one or more of the grounds listed in subsection 3 is unfair unless it is established that the discrimination is fair.

...

Interim Constitution of Southern Sudan

Adopted in 2005, this is the supreme law by which Southern Sudan shall be governed during the Interim Period (until approximately 2011), six months before the end of which an internationally monitored referendum will be organised for the people of Southern Sudan so that they may choose Sudanese unity or secession. Note that Southern Sudan has a constitutional provision prohibiting discrimination based on HIV status.

Excerpts

...

33.(1) Education is a right for every citizen and all levels of government in Southern Sudan shall provide access to education without discrimination as to religion, race, ethnicity, HIV status, gender or disability.

...

D1.4 Socio-economic rights

D1.4.1 Justiciable socio-economic rights

Constitution of Eritrea

Refer to the section above on 'equality and non-discrimination' for background information.

Excerpts

...

Article 21. Economic, social and cultural rights and responsibilities

(1) Every citizen shall have the right of equal access to publicly funded social services. The State shall endeavour, within the limit of its resources, to make available to all citizens health, education, cultural and other social services.

...

Constitution of the Federal Democratic Republic of Ethiopia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 41. Economic, social and cultural rights

4. The State has the obligation to allocate ever increasing resources to provide to the public health, education and other social services.

...

Constitution of Madagascar

Adopted on 19 August 1992. It was amended in 1995, 1998 and 2007. The following extract incorporates the 2007 amendment. The original text is in French and Malagasy.

Excerpts

...

Article 19

The state recognises to each individual the right to the protection of his health, starting from conception.

...

Article 24

The state organises public education, free and accessible to all. Primary education is obligatory for all.

...

Constitution of Malawi

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

30. Right to development

(1) All persons and peoples have a right to development and therefore to the enjoyment of economic, social, cultural and political development and women, children and the disabled in particular shall be given special consideration in the application of this right.

(2) The State shall take all necessary measures for the realisation of the right to development. Such measures shall include, amongst other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure.

...

Constitution of the People's Republic of Mozambique

Refer to the section above on 'equality and non-discrimination' for background information.

Excerpts

...

Article 88. Right to education

1. In the Republic of Mozambique, education shall be a right and duty of all citizens.

2. The State shall promote the extension of continuous professional education and equal access to the enjoyment of this right by all citizens.

Article 89. Health

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 protect public health.

...

Article 116. Health

1. Medical and health care for citizens shall be organised through a national health system, which shall benefit all Mozambican people.

...

4. The State shall promote the expansion of medical and health care and the equal access of all citizens to the enjoyment of this right.

...

Constitution of the Republic of Somaliland

The state of Somaliland was proclaimed in 1991. A National Charter was signed by the Conference of the Somaliland Communities in 1993. The Constitution was adopted in February 1997. Revisions to the Constitution were approved by the Houses of Parliament in April 2000 and adopted by referendum on 31 May 2001. Full text is available at www.somalilandforum.com.

Excerpts

...

Article 17. Health

1. In order to fulfil a policy of promoting public health, the state shall have the duty to meet the country's needs for equipment to combat communicable diseases, the provision of free medicine, and the care of the public welfare.
2. The state shall be responsible for the promotion and the extension of health care and private health centres.

Constitution of the Republic of South Africa

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

27. Health care, food, water and social security

- (1) Everyone has the right to have access to
 - (a) health care services, including reproductive health care;
 - (b) sufficient food and water; and
 - (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

...

29. Education

- (1) Everyone has the right
 - (a) to a basic education, including adult basic education; and
 - (b) to further education, which the state, through reasonable measures, must make progressively available and accessible.
- (2) Everyone has the right to receive education in the official language or languages of their choice in public educational institutions where that education is reasonably practicable. In order to ensure the effective access to, and implementation of, this right, the state must consider all reasonable educational alternatives, including single medium institutions, taking into account
 - (a) equity;
 - (b) practicability; and
 - (c) the need to redress the results of past racially discriminatory laws and practices.

...

D1.4.2 Socio-economic rights under directive principles of state policy

Constitution of Lesotho

Refer to the section above on 'equality and non-discrimination' for background information.

Excerpts

...

27. Protection of health

- (1) Lesotho shall adopt policies aimed at ensuring the highest attainable standard of physical and mental health for its citizens, including policies designed to
 - (a) provide for the reduction of stillbirth rate and of infant mortality and for the healthy development of the child;
- ...
- (c) provide for the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) create conditions which would assure to all, medical service and medical attention in the event of sickness; and
- (e) improve public health.

28. Provision for education

- Lesotho shall endeavour to make education available to all and shall adopt policies aimed at securing that
- (a) education is directed to the full development of the human personality and sense of dignity and strengthening the respect for human rights and fundamental freedoms;
 - (b) primary education is compulsory and available to all;
 - (c) secondary education, including technical and vocational education, is made generally available and accessible to all by every appropriate means, and in particular, by the progressive introduction of free education;
 - (d) higher education is made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular, by the progressive introduction of free education; and
 - (e) fundamental education is encouraged or intensified as far as possible for those persons who have not received or completed their primary education.

...

30. Just and favourable conditions of work

- Lesotho shall adopt policies aimed at securing just and favourable conditions of work and in particular policies directed to achieving
- ...
 - (b) safe and healthy working conditions;
 - (c) equal opportunity for men and women to be promoted in their employment to an appropriate higher level, subject to no considerations other than those 'of seniority and competence;
 - ...
 - (d) the protection of women who are in employment during a reasonable period before and after childbirth; and
 - ...

Constitution of the Republic of Uganda

Adopted by the Constituent Assembly on 22 September 1995. Full text available at www.parliament.go.ug.

Excerpts

...

XIV. General social and economic objectives

The State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that

...

(ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.

...

D1.5 Right to dignity and privacy

Constitution of Angola

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 20

The State shall respect and protect the human person and human dignity. Every citizen shall be entitled to the free development of his personality, with due respect for the rights of other citizens and the highest interests of the Angolan nation. The life, freedom, personal integrity, good name and reputation of every citizen shall be protected by law.

...

Constitution of Botswana

Adopted in September 1966. The last amendment taken into account here is the Constitution (Amendment) Act 12 of 2002.

Excerpts

...

9. Protection for privacy of home and other property

(1) Except with his own consent, no person shall be subjected to the search of his person or his property or the entry by others on his premises.

...

Constitution of Malawi

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

Privacy

21.(1) Every person shall have the right to personal privacy, which shall include the right not to be subject to

- (a) searches of his person, home or property;
- (b) the seizure of private possessions; or
- (c) interference with private communications, including mail and all forms of telecommunications.

...

Constitution of the Republic of Namibia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 8. Respect for human dignity

(1) The dignity of all persons shall be inviolable.

(2)(a) In any judicial proceedings or in other proceedings before any organ of the State, and during the enforcement of a penalty, respect for human dignity shall be guaranteed.

(b) No persons shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.

Article 13. Privacy

(1) No persons shall be subject to interference with the privacy of their homes, correspondence or communications save as in accordance with law and as is necessary in a democratic society in the interests of national security, public safety of the economic well-being of the country, for the protection of health or morals, for the prevention of disorder or crime or for the protection of the rights or freedoms of others.

...

Interim National Constitution of the Republic of the Sudan

Agreed upon and signed on 8 July 2005 following the Comprehensive Peace Treaty (agreed upon in January 2005) between the Sudanese People's Liberation Movement (SPLM) of Southern Sudan and the government. It is the supreme law of the Republic of the Sudan during the Interim Period (until approximately 2011). The original text is in Arabic. A translation in English is available at www.mpil.de.

Excerpts

...

28. Life and human dignity

Every human being has the inherent right to life, dignity and the integrity of his person, which shall be protected by law; no one shall arbitrarily be deprived of his life.

...

37. Privacy

The privacy of all persons shall be inviolable; no person shall be subjected to interference with his private life, family, home or correspondence, save in accordance with the law ...

Constitution of the United Republic of Tanzania

Adopted in 1977, the Constitution has been amended several times. Full text available at www.chr.up.ac.za.

Excerpts

...

12.(1) All human beings are born free, and are all equal.

(2) Every person is entitled to recognition and respect for his dignity.

...

16.(1) Every person is entitled to respect and protection of his person, the privacy of his own person, his family and of his matrimonial life, and respect and protection of his residence and private communications.

(2) For the purpose of preserving the person's right in accordance with this article, the state authority shall lay down legal procedures regarding the circumstances, manner and extent to which the right to privacy, security of his person, his property and residence may be encroached upon without prejudice to the provisions of this article.

...

D1.6 Property and inheritance rights of women

Constitution of Eritrea

Refer to the section above on 'equality and non-discrimination' for background information.

Excerpts

...

Article 23: Right to property

1. Subject to the provisions of sub-article 2 of this article, any citizen shall have the right, any where in Eritrea, to acquire and dispose property, individually or in association with others, and to bequeath the same to his heirs or legatees.

Constitution of the Federal Democratic Republic of Ethiopia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 35. Rights of women

1. Women shall, in the enjoyment of rights and protections provided for by this Constitution, have equal right with men.

2. Women have equal rights with men in marriage as prescribed by this Constitution.

...

6. Women have the right to acquire, administer, control, use and transfer property. In particular, they have equal rights with men with respect to use, transfer, administration and control of land. They shall also enjoy equal treatment in the inheritance of property.

Constitution of the Republic of Somaliland

Refer to the section above on 'Socio-economic rights' for background information.

Excerpts

...

Article 36. The rights of women

1. The rights, freedoms and duties laid down in the Constitution are to be enjoyed equally by men and women save for matters which are specifically ordained in Islamic Sharia.

...

3. Women have the right to own, manage, oversee, trade in, or pass on property in accordance with the law.

...

Constitution of the Kingdom of Swaziland

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

34. Property rights of spouses

(1) A surviving spouse is entitled to a reasonable provision out of the estate of the other spouse whether the other spouse died having made a valid will or not and whether the spouses were married by civil or customary rites.

(2) Parliament shall, as soon as practicable after the commencement of this Constitution, enact legislation regulating the property rights of spouses including common-law husband and wife.

...

D1.7 Customary practices

Constitution of the Federal Democratic Republic of Ethiopia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 35. Rights of women

4. The State shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited.

(a) Women have the right to maternity leave with full pay. The duration of maternity leave shall be determined by law taking into account the nature of the work, the health of the mother and the well being of the child and family.

(b) Maternity leave may, in accordance with the provisions of law, include pre-natal leave with full pay.

...

Interim Constitution of Southern Sudan

Refer to the section above on 'Equality and non-discrimination' for background information.

Excerpts

...

20. Rights of women

(4) All levels of government in Southern Sudan shall

...

(b) enact laws to combat harmful customs and traditions which undermine the dignity and status of women; and

...

21. Rights of the child

(1) Every child has the right

...

(g) not to be subjected to negative and harmful cultural practices which affect his health, welfare and dignity; and

...

Constitution of the Kingdom of Swaziland

Refer to the section above on "relationship between international and national law: dualist constitutions" for background information.

Excerpts

...

28. Rights and freedoms of women

...

(3) A woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed.

...

D1.8 Rights and protection of children**Constitution of the Republic of Burundi**

Refer to the section above on 'Equality and non-discrimination' for background information.

Excerpts

...

Article 30

...

Every child has the right to have measures be taken by his family, society or the state for his special protection, as required by his being a minor.

...

Article 44

Every child has the right to have special measures be taken to ensure or improve the care required for his well-being, health or physical security, and to be protected against mistreatment, persecution or exploitation.

...

Constitution of the Federal Democratic Republic of Ethiopia

Refer to the section above on 'relationship between international and national law: monist constitutions' for background information.

Excerpts

...

Article 36. Rights of children

Every child has the right

1. To life;

...

4. Not to be subject to exploitative practices, neither to be required nor permitted to perform work which may be hazardous or harmful to his education, health or well-being;

...

6. In all actions concerning children undertaken by public and private welfare institutions, courts of law, administrative authorities or legislative bodies, the primary consideration shall be the best interest of the child.

...

8. Children born out of wedlock shall have the same rights as children born of wedlock.

9. The State shall accord special protection to orphans and shall encourage the establishment of institutions that ensure and promote their adoption and advance their welfare, and education.

...

Constitution of Madagascar

Refer to the section above on 'Socio-economic rights' for background information.

Excerpts

...

Article 23

Every child has the right to instruction and education, under the responsibility of the parents respecting their freedom of choice. Every adolescent has the right to professional training.

...

Constitution of the People's Republic of Mozambique

Refer to the section above on 'Equality and non-discrimination' for background information.

Excerpts

...

Article 47. Rights of children

1. Children shall have the right to protection and the care required for their well being.
2. Children may express their opinion freely on issues that relate to them, according to their age and maturity.
3. All acts carried out by public entities or private institutions in respect of children shall take into account, primarily, the paramount interests of the child.

...

Constitution of the Republic of Somaliland

Refer to the section above on 'Socio-economic rights' for background information.

Excerpts

...

Article 19. The care of the vulnerable of society

The state shall be responsible for the health, care, development and education of the mother, the child, the disabled who have no one to care for them, and the mentally handicapped persons who are not able and have no one to care for them.

...

Constitution of the Republic of South Africa

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

28. Children

- (1) Every child has the right
- ...
- (c) to basic nutrition, shelter, basic health care services and social services;
- ...

Interim Constitution of Southern Sudan

Refer to the section above on 'Equality and non-discrimination' for background information on the Interim Constitution. Also refer to article 21(1)(g) cited in the section above on "cultural practices".

Excerpts

...

21. Rights of the child

- (1) Every child has the right
 - (a) to life, survival and development;
 - (b) to a name and nationality;
 - (c) to know and be cared for by his parents or legal guardian;
 - (d) not to be subjected to exploitative practices or abuse, nor to be required to serve in the army nor permitted to perform work which may be hazardous or harmful to his education, health or well-being;
 - (e) to be free from any form of discrimination;
 - (f) to be free from corporal punishment and cruel and inhuman treatment by any person including parents, school administrations and other institutions;

...

- (h) to be protected from abduction and trafficking.
- (2) In all actions concerning children undertaken by public and private welfare institutions, courts of law, administrative authorities or legislative bodies, the primary consideration shall be the best interest of the child.

- (3) All levels of government in Southern Sudan shall accord special protection to orphans and other vulnerable children; child adoption shall be regulated by law.

...

Constitution of the Republic of Uganda

Refer to the section above on 'socio-economic rights' for background information.

Excerpts

...

Article 34. Rights of children

...

- (2) A child is entitled to basic education which shall be the responsibility of the State and the parents of the child.
- (3) No child shall be deprived by any person of medical treatment, education or any other social or economic benefit by reason of religious or other beliefs.
- (4) Children are entitled to be protected from social or economic exploitation and shall not be employed in or required to perform work that is likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development.
- (5) For the purposes of clause 4 of this article, children shall be persons under the age of sixteen years.

...

- (7) The law shall accord special protection to orphans and other vulnerable children.

...

D1.9 Rights and protection of other vulnerable groups

Constitution of the Republic of South Africa

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

35. Arrested, detained and accused persons

(2) Everyone who is detained, including every sentenced prisoner, has the right

...

(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and

...

Interim Constitution of Southern Sudan

Refer to the section above on 'Equality and non-discrimination' for background information.

Excerpts

...

163. Prisons service

...

(4) The functions of prisons shall, inter alia, be to manage, operate and maintain the prisons of Southern Sudan, and to administer the internment and care for the health of prisoners and inmates.

(5) Prisons authorities shall treat prisoners humanely. Any treatment that is cruel, inhuman, degrading of the dignity of prisoners, or that may expose their health to danger is prohibited and punishable by law.

...

Constitution of the Kingdom of Swaziland

Refer to the section above on 'relationship between international and national law: dualist constitutions' for background information.

Excerpts

...

Protection of right to personal liberty

(6) Where a person is arrested or detained

...

(b) the next-of-kin, legal representative and personal doctor of that person shall be allowed reasonable access and confidentiality to that person; and

(c) that person shall be allowed reasonable access to medical treatment including, at the request and at the cost of that person, access to private medical treatment.

...

D2 Legislation (including bills)

D2.1 HIV specific laws/bills

Angola: Law 8/04 on HIV and AIDS (2004)

Adopted by the National Assembly on 1 November 2004. Its full title, in Portuguese, is *Lei n°8/04 sobre o Vírus da Imunodeficiência Humana (VIH) e a Síndrome de Imunodeficiência Adquirida (SIDA)*. It protects the rights of persons living with HIV, in particular the right to employment, free public health care, and confidentiality.

Excerpts

...

The Acquired Immunodeficiency Syndrome (AIDS) is currently an incurable and deadly disease that has brought the demise of thousands of people all over the world, with a tendency of accelerated spread which constitutes a threat to the socio-economic development of humanity.

The fight against the AIDS epidemic requires the adoption of urgent and efficient measures, with the establishment of norms, on the one hand, aimed at controlling and preventing of infection with Human Immunodeficiency Virus (HIV) and AIDS and, on the other hand, promoting the protection of infected persons.

In these terms, under section 88(b) of the Constitution, the National Assembly approves the following

Chapter 1 – General provisions

Section 1 - Purpose

The present Act aims at

- (a) guaranteeing the protection and promotion of the fundamental health of the people through the adoption of necessary measures for the prevention, control, treatment and investigation of HIV/AIDS;
- (b) establishing the rights and duties of persons infected with HIV or AIDS patients, health personnel and others in state of risk or contamination, as well as the general population.

Section 2 - Definitions

For the purposes of the present Act, the following shall mean

- (a) Anti-retroviral (ARV) – medicine which decreases the aggressive capacity of the HIV virus by retarding the progress of the immunodeficiency and/or restoring, as much as possible, the immunity by increasing the time and quality of life of the person infected;
- (b) Antibodies – substances, that form part of the organism, which recognise or detect foreign agents (antigens) that penetrate the organism;
- (c) Biosecurity – set of preventive measures designed to maintain control of labour risk factors originating from biological, physical or chemical agents that can put at risk the security of employees, patients, visitors or the environment;
- (d) National Commission for the Fight Against AIDS (CNLS) – multi-sectional and multidisciplinary organism created to coordinate and guide the fight against HIV/AIDS as well as establishing the necessary articulation at an international level;
- (e) Diagnosis – determining a disease through suggestive symptoms that an individual presents and laboratorial and/or imagery confirmation;
- (f) Chronic evolution – set of transformations that progress in character over a long time during the course of the disease;
- (g) Blood Condition – status in which plasma or blood of a healthy or ill individual is found;
- (h) Evolution of the illness – sequence of slow or fast transformations that occur during an illness;

- (i) Infected – individual that finds himself exposed to an infectious agent who either does or does not present signs of illness;
- (j) Infectious - that which produces infection (contagious or transmissible);
- (k) Infection – action originated by pathogenic agents inside a living organism;
- (l) Sexual Transmitted Infections (STI) – infections or diseases that are transmitted through unprotected sexual intercourse, that is, without using a condom;
- (m) HIV - Human Immunodeficiency Virus
- (n) Opportunistic Infections (OI) – infections that take advantage of the presence of an organism which allows disabling diseases to accommodate and manifest themselves;
- (o) HIV positive – individual's condition, as diagnosed with blood or plasma which tests positive for the presence of HIV;
- (p) HIV positive individual – individual infected with HIV who is not yet ill, also referred to as HIV carrier;
- (q) Cutting and perforating material – set of objects used to cut or perforate something. eg razor blades, needles, drills et cetera;
- (r) Biological material – any product coming from a living thing that can be manipulated and that contains contagious material which can cause infection or sickness;
- (s) Prescription – medical prescription;
- (t) Therapy – treatment;
- (u) AIDS - Acquired Immunodeficiency Syndrome;
- (v) Epidemiological surveillance – mechanism through which disease evaluation and evolution is controlled over a determined period of time.

Section 3 - State responsibility

1. In the fight against HIV/AIDS the State is obliged to do with the following

- (a) to accept, through the Government, the fight against HIV/AIDS as a national interest, understood in the aspects of prevention and control of its spread, and consider information, education, treatment, infection investigation and protection of the general population, with respect for the rights and duties of HIV infected persons and AIDS patients as fundamental areas;
- (b) to include in the budget funds destined to prevention and control of OI, STI and HIV/AIDS;
- (c) to formulate and execute socio-economic policies aimed at reducing the risk of infection and the worsening of infected and ill persons;
- (d) to improve the health system by guaranteeing the institutional reinforcement of human and financial resources and the purchase and distribution of medicine for OI and ARV to meet the needs in the prevention and treatment of STI's and HIV/AIDS;
- (e) to guarantee public health services and actions towards prevention, treatment and control of OI, STI and HIV/AIDS based on the principle of equal and universal access to all;
- (f) to guarantee the promotion and protection of rights of children that are infected, sick or affected by HIV;
- (g) to guarantee safe blood by being obliged to indemnify persons who are eventually contaminated by blood and/or anything deriving from it that had not been previously tested;

2. The provisions above apply equally to private entities.

Section 4 - Coordination

1. It is the duty of the National Commission for the Fight Against AIDS to coordinate and guide the actions taken in the fight against AIDS.

2. The structure and functioning of the National Commission for the Fight Against AIDS, as well other willing organs, are governed by their own regulation.

Chapter 2 – Rights and duties of persons infected by HIV

Part 1 – Rights of infected persons

Section 5 - Rights

Every person infected with HIV has the right to

- (a) guaranteed public health assistance and antiretroviral medicine;
- (b) information regarding the evolution of the illness and the options and treatment programmes, as well as the ability to make decisions about the presented options;
- (c) be informed about the network and psycho-social support programmes and counselling available;
- (d) be introduced into the community without being discriminated against;
- (e) work, receive employment and professional training;
- (f) confidentiality regarding information referring to his health status;
- (g) access to the education system without discrimination;
- (h) privacy regarding his life;
- (i) free circulation and remain in public places; and
- (j) protection by competent organs when they find themselves in situations that put their physical integrity in danger.

Section 6 - Rights of persons deprived of freedom

1. Persons deprived of freedom must not be subjected to compulsory tests to detect HIV infection, except for those persons whose judicial process or medical condition so demands, nevertheless the confidentiality of the analysis and its results must be kept.
2. Persons deprived of freedom who are infected with HIV or suffering from AIDS have the right to receive medical assistance that is immediately required under conditions which do not lessen their dignity or render treatment inaccessible.
3. A violation of any provision of this section is punishable in terms to be defined by regulation.

Section 7 - Rights of the employee

1. No employee may see his labour status prejudiced due to his health status in relation to HIV/AIDS.
2. In terms of a medical decision on his health status an employee may have his labour status altered, but with respect to his right to equal opportunity, merit and capacity to execute his job, and without changing his salary and other social benefits.
3. The employer is obliged to educate, inform, train and sensitise his employees on HIV/AIDS.
4. A violation of any provision of this section is punishable in terms to be defined by regulation.

Section 8 - Justifiable absence

1. The absence of an employee infected with HIV in the workplace for the purposes of receiving medical assistance for a period not exceeding 120 days, is considered justifiable for reason of illness in terms of legislation currently in place.
2. The employee who finds himself in the conditions referred to above is protected from dismissal, reduction in salary or any other form of labour discrimination.
3. An employee suffering of AIDS who is absent from the workplace for 180 days whether consecutive or not, has the right to receive his full salary as long as the absence is justified by a medical document.

Section 9 - Presentation of the test

The presentation of an HIV test shall not constitute a prerequisite for applying for employment, bank loan and maintenance of a labour-legal relationship, not even for enrollment in defence and security organs.

Section 10 - Blood condition

Health professionals who become aware of the HIV positive status of a patient have the duty to inform that patient of the infectious nature of the disease as well as the duty to inform that patient of the means of transmission and prevention of HIV.

Section 11 - Occupational exposure

1. Transmission of HIV resulting from the exercise of professional activity duly approved by the competent entities is considered a professional illness of serious chronic evolution in terms of the legislation currently in place.
2. Any employee who, in the course of exercising his function, gets infected with HIV has the right to claim reparation in terms to be fixed by regulation.

Section 12 - Confidentiality

1. Health professionals and others who are aware of the status of a patient or treat a person infected with HIV are obliged to keep secrecy regarding the consultation, diagnosis and progress, except in the case of minors where the persons exercising parental authority need to be informed.
2. Confidentiality may not be invoked in the case of information that is not nominal to the detected cases.

Section 13 - Violation of professional secrecy

1. A person who, by reason of his employment or profession, discloses the HIV positive status of another person except in circumstances provided in the present act, is punished in terms of section 290 of the Penal Code.
2. The breach of secrecy is only permitted in the following cases
 - (a) when there is authorisation from the patient or by legal duty, namely notification to health authorities and completion of a death certificate;
 - (b) when there is valid reason for the protection of the life of a third person, namely the spouse, sexual partner or the members of a group of drug users, in case where the patient refuses to furnish information regarding the condition of the infection.

Part 2 – Duties of infected persons

Section 14 - Duties

Persons infected with HIV shall

- (a) adopt a responsible sexual behaviour;
- (b) adopt habits and behaviour which limits the possibility of infecting others;
- (c) use condoms when having sexual relations;
- (d) inform the persons with whom they have or intend to have sexual relations of their status;
- (e) inform the health personnel who attend to them of their situation so that services are administered adequately and appropriate biosecurity measures are taken;
- (f) inform their spouses or sexual partners about their status.

Section 15 - Transmitting

1. The intentional transmission of HIV constitutes a crime and is punishable in terms of section 353 of the Penal Code.
2. A person who, through negligence, inconsideration or failure to observe regulations, infects another, is punished in terms of section 368 of the Penal Code.

Chapter 3 – Information, education and investigation

Section 16 - Social communication organs

Public and private social communication organs shall secure the issuing of free information about HIV/AIDS.

Section 17 - Information

The population must

- (a) be informed and educated about aspects relating to HIV/AIDS in line with the directives formulated by the National Commission for the Fight Against AIDS;
- (b) be informed and educated against the discrimination and stigmatisation of persons with HIV.

Section 18 - Education

1. The Ministry of Education shall proceed to introduce contents referring to sexuality and HIV/AIDS in all school curricula.
2. Learning institutions and workplaces shall adopt norms that aim to inform and educate about HIV/AIDS.
3. State organs of inspection and supervision shall keep watch for adherence to the provisions above.
4. Failure to adhere to the provisions in subsection 3 is punishable by a fine to be defined by self regulation.
5. The revenue from the fines is destined to the Fund for the Fight Against AIDS.

Section 19 - Notion of experimental research

Experimental research refers to activities aimed at producing knowledge and technologies in the applicable field, operational and of basic science, scientifically recognised by its methods of observation, techniques and interferences.

Section 20 - Experimental research on human beings

All investigations that involve human beings, whether individual or group of individuals shall be submitted in specific research protocol in the Portuguese language to the National Ethics and Research Commission.

Section 21 - National Ethics and Research Commission

The Ministry of Health must, within 90 days after this Act comes into force, create the National Ethics and Research Commission which shall establish special provisions to be observed in relation to investigation, vaccine tests, use of placebos, informed consent among other ethical aspects inherent to research on human beings.

Chapter 4 - Prevention, control and treatment

Part 1 - Prevention and control

Section 22 - Tests for the detection of anti-HIV antibodies

1. It is prohibited to realise compulsory tests for the diagnosis of HIV infection, except in the following cases
 - (a) when, in terms of medical consideration to which a clinical process must be conducted, there exists a need to conduct a test for the exclusive purposes of finding the best suitable treatment for the patient;
 - (b) when dealing with the donation of blood, breast milk, semen, organs and human tissue;
 - (c) when required by criminal procedure confirmed by the competent judicial authority; and
 - (d) HIV tests on minors can only be realised with permission from parents or legal guardians of the minor who must be informed of the need for the test and must express their consent in writing for the realisation of the test, save for the exceptions provided in the present Act and the legislation currently in place; while respecting the best interest of the child at all times.

Part 2 - Treatment and biosecurity

Section 23 - Safe blood

1. It is the duty of the State to guarantee safe blood. It has the duty to provide reparation to a person who has been infected by blood which was not previously tested in public hospitals.
2. Blood products for transfusion must meet the norms of the National Blood Centre.
3. The act of transfusing unsafe blood that does not comply with the above provisions is punishable in terms subsection 2 of section 15 of the present act.

Section 24 - Blood and organ donation

1. Persons infected with HIV cannot donate blood, breast milk, organs or tissue for therapeutic use, except in the scope of experimental research.
2. A violation of the above provision is punishable in terms subsection 1 of section 15 of the present Act.

Section 25 - Monitoring and control mechanisms

The Ministry of Health shall establish uniform mechanisms for control and registration appropriate for epidemiologic surveillance which guarantee the anonymous and other exceptional situations predicted by law and/or to be defined according to the guidelines of World Health Organisation.

Section 26 - Laboratories

Laboratories or blood banks where tests for the diagnosis of HIV are conducted shall be properly registered at the National Board of Public Health and are obliged to maintain an up-to-date system of registration and information of health authorities.

Section 27 - Medicine

1. It is the duty of the Minister of Health to sponsor antiretrovirals to be used at each stage of the infection as well as regulate their commercialisation.
2. The provision of antiretroviral medicine is financed by the State.
3. Marketing of medicine and treatment for AIDS must meet the norms established by the Minister of Health.

Section 28 - Hospital waste

The State must create mechanisms for the treatment of hospital waste and biological material in accordance with the norms established by the World Health Organisation.

Section 29 - Exemptions

Reagents, antiretroviral medicine, treatment of opportunistic infections, as well as other material acquired by the State directed at and exclusively used in the scope of fighting HIV/AIDS, are exempt from any form of tax or custom tariffs.

Chapter 5 - Final provisions

Section 30 - Sanctions

A violation of the provisions of the present act is punishable by disciplinary civil and criminal sanctions in terms of the applicable legislation.

Section 31 - Doubts and omissions

Doubts and omissions resulting from the interpretation and application of the present act shall be resolved by the National Assembly.

...

Burundi: Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005)

The full title of the law in French is: *Loi no 1/018 du 12 mai 2005 portant protection juridique des personnes infectées par le virus de l'immunodéficience humaine et des personnes atteintes du syndrome de l'immunodéficience acquise*. The law not only protects the rights of persons living with HIV, but also specifies their 'obligations'.

Excerpts

...

Article 1

The provisions of the present Law establish rights and obligations for everyone, the healthy and the sick, as well as for

public and private institutions that are involved or should be involved in one way or another in the prevention and other actions related to the infection with the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS).

...

Article 3

For the purposes of the present Law, “discrimination” refers to any distinction, exclusion, limitation or stigmatisation founded on HIV status or AIDS, which purpose is to impair or alter equality of treatment.

Article 4

The fight against AIDS is considered a public good. It covers research activities, AIDS diagnosis, treatment, prevention, voluntary testing, counselling and care, as well as any other measures which purpose is to avoid the spread of AIDS such as HIV/AIDS education.

Article 5

The Government shall support counselling and assist activities carried out towards persons who are infected or affected by HIV/AIDS. The particularities of these activities shall be determined by a Decree of the Ministry responsible for the fight against AIDS.

...

Article 9

Any person aware of his or her HIV positive status shall abstain from engaging in unprotected sex. He or she shall take all necessary precautions to avoid contaminating his or her partner.

...

Article 11

HIV testing is practised, especially in the following cases

- (a) in cases of epidemiological precedents, with due respect for the provisions set out in Chapter IV of this present Law;
- (b) in case of a clinical presumption of HIV infection;
- (c) at the person’s request;
- (d) at the request of the judicial services;

...

Article 13

The result of an HIV test shall be communicated to the patient by the family doctor, or by default, to a member of the health personnel qualified for counselling.

...

Article 15

The Ministry responsible for Public Health shall determine by means of Decree, the appropriate measures to ensure an effective prevention both for the health personnel and the public. These measures shall among other things

1. provide guarantees of minimum biosecurity measures to the benefit of the personnel of health institutions and in particular those manipulating biological material of human origin;
2. provide security norms with regards to transfusions of blood, blood components, and blood products;
3. provide security and hygiene norms applicable to persons and institutions involved in skin change, such as hairdressing, cosmetics, pedicure, footcare, acupuncture, tattooing, ear-piercing and others.

Article 16

Any person infected with HIV or suffering from AIDS has the right to be consulted by a doctor of his choice and to receive the medical treatments most appropriate to his state. No health agent or health institution may refuse to deliver the care required for a person infected with HIV or suffering from AIDS, in accordance with the distribution of tasks according to health status and medical deontology.

...

Article 18

The Government shall mobilise the necessary means for the establishment of appropriate mechanisms to ensure the availability of medication against opportunistic infections and antiretroviral treatment.

Article 19

Family members shall participate actively in ensuring that the health of a relative infected with HIV or suffering from AIDS does not deteriorate further, and, if possible, in helping them to return to a regular lifestyle, and, if their relative is in the terminal phase of the disease, in offering them a dignified death.

...

Article 21

Informed consent is required for any person involved in clinical HIV/AIDS research.

Article 22

The public authorities have the obligation to set up all appropriate mechanisms to fight against all forms of discrimination against persons infected with HIV or suffering from AIDS, in addition to providing them with medical and psychosocial care.

Article 23

The national community as a whole shall provide sustained and constant support for the elimination of all forms of discrimination against persons infected with HIV or suffering from AIDS, in addition to the provision of medical and psychosocial care to them.

Article 24

HIV testing is voluntary and confidential except in the cases provided for in article 11.

...

Article 26

Doctors as well as any other person who has or who could have, through their profession, access to information on a person’s HIV status, are obliged to keep this information confidential, or else be subjected to sanctions provided for in the Penal Code relative to breach of confidentiality.

Article 27

The following instances of communicating this information are not considered a breach of confidentiality

1. communicating it to the person infected with HIV, or if this person is not capable, to his legal guardian;
2. communicating it to colleagues and health authorities if this is necessary for the proper administration of medication to the patient
3. communicating it to judicial authorities for the purpose of investigations where such information is necessary.

Article 28

Notwithstanding what is said in the provisions of articles 25 and 26 of this present Law, doctors must reveal to the spouse or sexual partner of a person infected with HIV or suffering from AIDS the latter’s serostatus, if the latter is psychologically incapable of revealing this information or is opposed to this.

...

Article 30

Compulsory HIV testing is prohibited in the following cases

- (a) admission or continued stay in a sports or social education centre;
- (b) access to any professional activity or continued stay within this professional activity.

Article 31

Despite the possible individual and collective sanitary measures [which may be taken] and the right of any person to obtain a certificate of his health status when he deems it necessary, requesting a compulsory certificate [of a person's HIV/AIDS status] is considered ineffective and discriminatory. This practice is thus prohibited.

Article 32

The children of infected persons, whether they themselves are infected or not, may not be denied admission or stay in public or private education centres, nor be the object of discrimination on any given pretext.

Article 33

Persons [in custody] may not be subjected to compulsory HIV testing, except in the cases of a criminal investigations.

Article 34

Any person infected with HIV or suffering from AIDS who applies for paid employment enjoys the same rights as those who do not have HIV, and may not be deprived of any employment opportunity because of his health status. In particular, the hiring of employees may not be conditioned or linked to HIV test results.

Article 35

An employee infected with HIV or suffering from AIDS shall remain employed and enjoy all the advantages recognised by law until he or she is deemed, by a medical commission, physically and/or mentally inept to perform his or her tasks. This ineptitude shall be recorded so that the person who is deemed inept may receive social security benefits provided for by the law.

Article 36

Employers shall ensure that the atmosphere at the workplace is such that persons infected with HIV or suffering from AIDS do not feel rejected or humiliated.

Article 37

Regulations relative to social or professional benefits to workers shall also be of benefit to workers infected with HIV or suffering from AIDS, whilst respecting the provisions in article 38.

Article 38

Persons infected with HIV or suffering from AIDS may subscribe to life insurance from insurance companies. The latter do however have the right to take into account the elements they consider indispensable to provide coverage appropriate to the [higher] risk of death.

Article 39

The insurer has the right to know all the elements he or she deems necessary about the health of an applicant to an insurance policy to determine the risk level.

Article 40

Insurance companies shall respect the confidentiality of their findings in addition to any other medical and personnel information mentioned by an applicant during the determination of the risk level.

Article 41

In addition to the relevant provisions of the Criminal Code, any violation of this present Law is punishable by a fine of 10,000 to 100,000 Burundi Francs.

Article 42

Any person who wilfully transmits HIV by any means will be prosecuted for attempted murder and is punishable according to the provisions of criminal law.

Kenya: HIV and AIDS Prevention and Control Act 14 of 2006

Passed into law on 5 December 2006, the Act has yet to be implemented.

PART I – Preliminary

1. Short title and commencement

This Act may be cited as the HIV and AIDS Prevention and Control Act, 2006 and shall come into operation on such date as the Minister may, by notice in the *Gazette* appoint and different dates may be appointed for different provisions.

2. Interpretation

In this Act, unless the context otherwise requires

‘Acquired Immunodeficiency Syndrome (AIDS)’ means a condition characterised by a combination of signs and symptoms, resulting from depletion of the immune system caused by infection with the Human Immunodeficiency Virus (HIV);

‘anonymous testing’ means an HIV testing procedure whereby the person being tested does not reveal his true identity but instead, an identifying number or symbol is used which allows the testing centre and the tested person to match the test results with the identifying number or symbol;

‘child’ has the meaning assigned to it in the Children Act, 2001;

‘compel’, in relation to HIV testing, refers to an HIV test imposed upon a person characterised by the lack of consent, use of physical force, intimidation or any other form of compulsion;

‘consent’ means consent given without any force, fraud or threat and with full knowledge and understanding of the medical and social consequences of the matter to which the consent relates;

‘health institution’ means a hospital, nursing home, maternity home, health centre, dispensary, pharmacy or other institution, whether private or public, where health care services are rendered;

‘health maintenance organisation’ means a limited liability company established for the purpose of operating and managing health care funding and managed health care systems through membership administration schemes, and which offers hospital and clinical services supported by a contracted health care service provider network of doctors, other health care professionals, and which, in addition, may offer ambulance or rescue services and undertake franchise arrangements in the management of health institutions;

‘health care provider’ means

- (a) a medical practitioner or dentist registered under the Medical Practitioners and Dentists Act;
- (b) a pharmacist or a pharmaceutical technologist registered or enrolled under the Pharmacy and Poisons Act;
- (c) a nurse registered and licensed under the Nurses Act;
- (d) a clinical officer registered and licensed under the Clinical Officers (Training, Registration and Licensing) Act;
- (e) a laboratory technician or technologist registered and licensed under the Medical Laboratory Technicians and Technologist Act, 1999;
- (f) counsellors who have completed training as approved by the Minister for the time being responsible for matters relating to health; and includes any other person approved by the Minister under section 16;

‘health care service’ rendered to a person means

- (a) the physical or mental examination of that person;
- (b) the treatment or prevention of any physical or mental defect, illness or deficiency and the giving of advice in relation to that defect, illness or deficiency;
- (c) the performing of any surgical or other invasive procedure;

- (d) the giving of advice in relation to treatment of any condition arising out of a pregnancy;
- (e) the prescribing, dispensing, supplying or applying of any medicine, appliance or apparatus in relation to any defect, illness or pregnancy;
- (f) X-ray, laboratory and other investigative and diagnostic procedures;
- (g) physiotherapy, speech therapy, occupational therapy and other types and variations of similar rehabilitative treatment;
- (h) nursing or midwifery in health institutions and other places where nursing and midwifery services may be rendered, including home-based nursing and midwifery services by duly qualified registered and experienced nurses and midwives;
- (i) the supply of accommodation in any institution established or registered in terms of any law as a health institution or any other institution or place where surgical or other medical procedures are performed, provided that such accommodation is necessitated by any physical or mental defect, illness, deficiency or a pregnancy;
- (j) the provision of pre-test or post-test counseling services;
- ‘HIV test’ means a prescribed tests or series of tests which determines whether a person is infected with HIV;
- ‘human biomedical research’ means
- (a) any research that involves direct interference or interaction with the physical body of a human subject and that involves a concomitant risk of physical injury or harm however remote;
- (b) any research programme that involves the administration of any drug on a human subject whether it is for the purpose of testing the effects or efficacy of the drug, or whether as a means for establishing any other objective of the research programme;
- (c) any research that involves the trial or use of a medical device on a human subject;
- (d) any research that involves carrying out a test on a human subject's physiological, emotional or mental responses, such test not being conducted for diagnostic purposes with a view to the therapeutic management of the human subject;
- (e) any research involving human tissue, or medical, personal or genetic information relating to both identifiable and anonymous human subjects for the purpose of generating data about medical, genetic or biological processes, diseases or conditions in human subjects;
- ‘Human Immunodeficiency Virus (HIV)’ means the virus which causes AIDS;
- ‘medical insurance provider’ has the meaning assigned to it in section 2 of the Insurance Act;
- ‘medical practitioner’ includes a dentist;
- ‘Minister’ means the Minister for the time being responsible for matters relating to HIV and AIDS and ‘Ministry’ shall be construed accordingly;
- ‘partner’ means a spouse or a person with whom another person is living in a domestic and sexual relationship;
- ‘person with HIV and AIDS’ means a person whose HIV test indicates, directly or indirectly, that he is infected with HIV and AIDS;
- ‘positive’, in relation to the result of an HIV test, means a result which shows that the person who is tested is infected with HIV or which shows evidence of such infection;
- ‘post exposure prophylaxis’ means the administration of one or a combination of anti-retroviral drugs after probable exposure to HIV, for the purpose of preventing transmission;
- ‘post-test counselling’ refers to the process of providing a person who submitted themselves for an HIV test with risk-reduction information and emotional support at the time the test result is released;
- ‘pre-test counselling’ means the process of providing a person, before such person undergoes an HIV test, with information on the biomedical aspects of HIV and AIDS and emotional support with respect to the psychological implications of undergoing an HIV test;

‘self testing’ in relation to HIV infection, means a prescribed test or series of tests carried out entirely by a person on self without the involvement of another person, which determine whether a person is infected with HIV;

‘testing centre’ means a testing centre approved by the Minister under section 16;

‘tissue’ includes an organ or part of a human body, semen, breast milk and any other substance or secretion, other than blood, extracted from the human body or from a part of the human body;

‘Tribunal’ means the HIV and AIDS Tribunal established by section 25.

3. Object and purpose of the Act

The object and purpose of this Act is to

- (a) promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV and AIDS;
- (b) extend to every person suspected or known to be infected with HIV and AIDS full protection of his human rights and civil liberties by
- (i) prohibiting compulsory HIV testing save as provided in this Act;
- (ii) guaranteeing the right to privacy of the individual;
- (iii) outlawing discrimination in all its forms and subtleties against persons with or persons perceived or suspected of having HIV and AIDS;
- (iv) ensuring the provision of basic health care and social services for persons infected with HIV and AIDS;
- (c) promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission; and
- (d) positively address and seek to eradicate conditions that aggravate the spread of HIV infection.

PART II – HIV and AIDS education and information

4. HIV and AIDS education and information

- (1) The Government shall promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV and AIDS through a comprehensive nationwide educational and information campaign conducted by the Government through its various Ministries, Departments, authorities and other agencies.
- (2) The educational and information campaign referred to in subsection 1 shall
- (a) employ scientifically proven approaches;
- (b) focus on the family as the basic social unit;
- (c) encourage testing of individuals; and
- (d) be carried out in schools and other institutions of learning, all prisons, remand homes and other places of confinement, amongst the disciplined forces, at all places of work and in all communities throughout Kenya.
- (3) In conducting the educational and information campaign referred to in this section, the Government shall collaborate with relevant stakeholders to ensure the involvement and participation of individuals and groups infected and affected by HIV and AIDS, including persons with disabilities.

5. HIV and AIDS education in institutions of learning

- (1) The Ministry responsible for education, utilising official information provided by the Ministry, shall integrate instruction on the causes, modes of transmission and ways of preventing HIV and AIDS and other sexually transmitted diseases in subjects taught in public and private schools at primary, secondary, and tertiary levels, including informal, non formal and indigenous learning systems;

Provided that

- (a) where the integration of HIV and AIDS education is not appropriate or feasible at any level, the Ministry responsible for education shall design modules of HIV and AIDS prevention and control;

(b) such integration shall not be used for the sale or distribution of birth control devices;

(c) the formulation and adoption of the appropriate course content, scope and methodology at each educational level shall be determined after consultation with the relevant stakeholders.

(2) The Ministry responsible for education, in consultation with the Ministry, shall ensure that every teacher or instructor of an HIV and AIDS prevention and control course under this section is adequately trained and duly qualified to teach such course.

6. HIV and AIDS education as a health care service

(1) HIV and AIDS education and information dissemination shall form part of the delivery of health care services by health care providers.

(2) For the purposes of subsection 1, the Government shall ensure training of health care providers on proper information dissemination and education on HIV and AIDS, including post-exposure prophylaxis for prevention of transmission.

(3) The training of health care providers under this section shall include education on HIV-related ethical issues such as confidentiality, informed consent and the duty to provide treatment.

(4) The Minister for the time being responsible for matters relating to health shall, in collaboration with relevant stakeholders, provide guidelines for post exposure prophylaxis.

7. HIV and AIDS education in the workplace

(1) The Government shall ensure the provision of basic information and instruction on HIV and AIDS prevention and control to

(a) employees of all Government Ministries, Departments, authorities and other agencies; and

(b) employees of private and informal sectors.

(2) The information provided under this section shall cover issues such as confidentiality in the work-place and attitudes towards infected employees and workers.

8. HIV and AIDS information in communities

Every local authority, in collaboration with the Ministry, shall conduct an educational and information campaign on HIV and AIDS within its area of jurisdiction.

PART III – Safe practices and procedures

9. Testing of donated tissue

(1) A person who offers to donate any tissue shall, immediately before such donation, undergo an HIV test.

(2) No health institution shall not accept a donation of any tissue unless the donor thereof has undergone an HIV test pursuant to subsection 1 and the result thereof is negative.

(3) Notwithstanding the provisions of subsections 1 and 2, the proposed recipient of donated tissue or his immediate relatives shall have the right to demand a second HIV test on such tissue before a transplant or other use of the tissue and such test shall, except in the case of emergencies, be carried out.

10. Testing of donated blood

(1) All donated blood shall, as soon as reasonably practicable after donation, be subjected to an HIV test.

(2) Any blood tested under subsection 1 which is found to be HIV positive shall be disposed of in accordance with the prescribed guidelines on the disposal of medical waste as soon as reasonably practicable after such result is obtained.

11. Guidelines on surgical and similar procedures

(1) The Minister shall, in consultation with registered professional associations of health care providers, prescribe guidelines on

(a) precautions against HIV transmission during surgical, dental, delivery, embalming and similar procedures; and

(b) the handling and disposal of cadavers, body fluids or wastes of persons with HIV.

(2) The Minister shall, at all times, ensure the provision of protective equipment such as gloves, goggles and gowns to all health care providers and other personnel exposed to the risk of HIV infection.

(3) The Minister shall, at all times, ensure the provision of post exposure prophylaxis to health care providers and other personnel exposed to the risk of HIV infection.

(4) In this section, 'Minister' means the Minister for the time being responsible for matters relating to health.

12. Penalty for unsafe practices or procedures

(1) A person who, in the course of his professional practice, knowingly or negligently causes another to be infected with HIV through unsafe or unsanitary practices or procedures contrary to the provisions of this Part, or of any guidelines prescribed hereunder, commits an offence.

(2) Notwithstanding the provisions of any other written law for the time being in force, a court may, in addition to any penalty imposed on a person convicted under subsection 1

(a) in the case of an institution, order the revocation of any business permit or licence in respect thereof; or

(b) in the case of a natural person, order the revocation of licence to practice such person's profession.

PART IV – Testing, screening and access [to] health care services

13. Prohibition against compulsory testing

(1) Subject to this act, no person shall compel another to undergo an HIV test.

(2) Without prejudice to the generality of subsection 1, no person shall compel another to undergo an HIV test as a precondition to, or for continued enjoyment of

(a) employment;

(b) marriage;

(c) admission into any educational institution;

(d) entry into or travel out of the country; or

(e) the provision of health care, insurance cover or any other service.

(3) Notwithstanding the provisions of subsection 1, a person charged with an offence of a sexual nature under the Sexual Offences Act, 2006 may be compelled to undergo an HIV test.

(4) A person who contravenes any of the provisions of this section commits an offence.

14. Consent to HIV testing

(1) Subject to subsection 2, no person shall undertake an HIV test in respect of another person except-

(a) with the informed consent of that other person;

(b) if that person is a child, with the written consent of a parent or legal guardian of the child

Provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test;

(c) if, in the opinion of the medical practitioner who wishes to undertake the HIV test, the other person has a disability by reason of which he appears incapable of giving consent, with the consent of-

(i) a legal guardian of that person;

(ii) a partner of that person;

(iii) a parent of that person; or

(iv) an adult offspring of that person;

Provided that a medical practitioner may undertake the HIV test if the persons referred to in paragraphs (i), (ii), (iii) and (iv) are either absent or are unwilling to give consent;

(d) where the person is required to undergo an HIV test under the provisions of this Act or any other written law.

(2) Notwithstanding the provisions of subsection 1

(a) a person who offers to donate any tissue shall be deemed to have consented to the HIV test required under section 9;

(b) a person who offers to donate blood shall be deemed to have consented to the HIV test required in respect of such blood under section 10;

(c) a medical practitioner responsible for the treatment of a person may undertake an HIV test in respect of that person without the consent of the person if-

(i) the person is unconscious and unable to give consent; and
(ii) the medical practitioner reasonably believes that such a test is clinically necessary or desirable in the interest of that person.

(3) Subject to section 17, a medical practitioner who undertakes an HIV test on a person under this section shall, if the person so requires, disclose the results of the HIV test to that person.

(4) A person who contravenes the provisions of this section commits an offence.

15. Provision of testing facilities

The Minister shall ensure that facilities for HIV testing are made available to persons who

(a) voluntarily request an HIV test in respect of themselves; or
(b) are required under the provisions of this act or any other written law to undergo an HIV test.

16. Testing centres

(1) No person shall carry out an HIV test except in a testing centre approved by the Minister under this section or in the manner specified under paragraph d of subsection 4.

(2) No person shall carry out an HIV test unless such person is a health care provider approved by the Minister for that purpose.

(3) No person shall provide pre-test or post-test counselling for the purposes of section 17 unless such person is approved by the Minister under this section.

(4) The Minister shall, in regulations, prescribe

(a) the standards and the procedure for the approval of testing centres for the purposes of this Act;

(b) the standards and the procedure for the approval of health care providers for the purposes of subsection 2;

(c) guidelines for the provision of pre-test and post-test counselling services at such centres, including the standards and the procedure for approval of persons qualified to provide such services; and

(d) guidelines for self testing.

(5) A person who contravenes the provisions of this section or of any regulations made hereunder commits an offence.

(6) In this section, 'Minister' means the Minister for the time being responsible for matters relating to health.

17. Pre-test and post-test counselling

(1) Every testing centre shall provide pre-test and post-test counselling to a person undergoing an HIV test and any other person likely to be affected by the results of such test.

(2) The Ministry responsible for matters relating to health shall enhance the capacities of testing centres by ensuring the training of competent personnel to provide the services required by this Act to be provided at such centres.

18. Results of HIV test

The results of an HIV test shall be confidential and shall only be released

(a) to the tested person;

(b) in the case of a child, to a parent or legal guardian of such child;

Provided that where any such child consents to an HIV test directly under section 14(1)(b), the results thereof shall be released to the child; or

(c) in the case of a person with a disability which, in the opinion of the medical practitioner undertaking the test, renders him incapable of comprehending such result to

(i) the legal guardian of that person;

(ii) a partner of that person;

(iii) a parent of that person; or

(iv) an adult offspring of that person.

19. Access to health care services

(1) Every health institution, whether public or private, and every health management organisation or medical insurance provider shall facilitate access to health care services to persons with HIV without discrimination on the basis of HIV status.

(2) The Government shall, to the maximum of its available resources, take the steps necessary to ensure the access to essential health care services, including the access to essential medicines at affordable prices by persons with HIV or AIDS and those exposed to the risk of HIV infection.

PART V – Confidentiality

20. Privacy guidelines

(1) The Minister for the time being responsible for matters relating to health shall, in regulations, prescribe privacy guidelines, including the use of an identifying code, relating to the recording, collecting, storing and security of information, records or forms used in respect of HIV test and related medical assessments.

(2) No person shall record, collect, transmit or store records, information or forms in respect of HIV tests or related medical assessments of another person otherwise than in accordance with the privacy guidelines prescribed under this section.

21. Confidentiality of records

No person shall, in any records or forms used in relation to

(a) a request for an HIV test by persons in respect of themselves;

(b) an instruction by a medical practitioner to a laboratory for an HIV test to be conducted;

(c) the laboratory testing for HIV or HIV antibodies; or

(d) the notification to the medical practitioner of the result of the HIV test, include any information which directly or indirectly identifies the person to whom an HIV test relates, except in accordance with the privacy guidelines prescribed under section 20.

22. Disclosure of information

(1) No person shall disclose any information concerning the result of an HIV test or any related assessments to any other person except

(a) with the written consent of that person;

(b) if that person has died, with the written consent of that person's partner, personal representative, administrator or executor;

(c) if that person is a child, with the written consent of a parent or legal guardian of that child: provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts other persons at risk of contracting HIV may in writing directly consent to such disclosure;

(d) if that person is unable to give written consent, with the oral consent of that person or with the written consent of the person with power of attorney for that person;

(e) if, in the opinion of the medical practitioner who undertook the HIV test, that person has a disability by reason of which the person appears incapable of giving consent, with the written consent, in order, of

(i) a legal guardian of that person;

(ii) a partner of that person;

(iii) a parent of that person; or

(iv) an adult offspring of that person;

(f) to a person, being a person approved by the Minister under section 16, who is directly involved in the treatment or counselling of that person;

(g) for the purpose of an epidemiological study or research authorised by the Minister;

(h) to a court where the information contained in medical records is directly relevant to the proceedings before the court or tribunal;

(i) if the person to whom the information relates dies, to the registrar of births and deaths pursuant to section 18 of the Births and Deaths Registration Act; or

(j) if authorised or required to do so under this Act or under any other written law.

(2) Subsection 1 shall not apply to a disclosure of statistical or other information that could reasonably be expected to lead to the identification of the person to whom it relates.

23. Penalty for breach of confidentiality

A person who contravenes any of the provisions of this part or of any guidelines prescribed hereunder commits an offence.

PART VI – Transmission of HIV

24. Prevention of transmission

(1) A person who is and is aware of being infected with HIV or is carrying and is aware of carrying the HIV virus shall-

(a) take all reasonable measures and precautions to prevent the transmission of HIV to others; and

(b) inform, in advance, any sexual contact or person with whom needles are shared of that fact.

(2) A person who is and is aware of being infected with HIV or who is carrying and is aware of carrying HIV shall not, knowingly and recklessly, place another person at risk of becoming infected with HIV unless that other person knew that fact and voluntarily accepted the risk of being infected.

(3) A person who contravenes the provisions of subsections 1 or 2 commits an offence and shall be liable upon conviction to a fine not exceeding five hundred thousand shillings or to imprisonment for a term not exceeding seven years, or to both such fine and imprisonment.

(4) A person referred to in subsection 1 or 2 may request any medical practitioner or any person approved by the Minister under section 16 to inform and counsel a sexual contact of the HIV status of that person.

(5) A request under subsection 4 shall be in the prescribed form.

(6) On receipt of a request made under subsection 4, the medical practitioner or approved person shall, whenever possible, comply with that request in person.

(7) A medical practitioner who is responsible for the treatment of a person and who becomes aware that the person has not, after reasonable opportunity to do so

(a) complied with subsection 1 or 2; or

(b) made a request under subsection 4,

may inform any sexual contact of that person of the HIV status of that person.

(8) Any medical practitioner or approved person who informs a sexual contact as provided under subsection 6 or 7 shall not, by reason only of that action, be in breach of the provisions of this act.

PART VII – The Equity Tribunal

25. Establishment of the Tribunal

(1) There is hereby established a Tribunal to be known as the HIV and AIDS Tribunal which shall consist of members appointed by the Attorney General as follows

(a) a chairman who shall be an advocate of the High Court of not less than seven years standing;

(b) two advocates of the High Court of not less than five years standing;

(c) two medical practitioners recognised by the Medical Practitioners and Dentists Board as specialists under the Medical Practitioners and Dentists Act; and

(d) two persons having such specialised skill or knowledge necessary for the discharge of the functions of the Tribunal.

(2) At least two of the persons appointed under subsection 1(a), (b) and (c) shall be women.

(3) The quorum for a meeting of the Tribunal shall be the chairman and four other members.

(4) All matters before the Tribunal shall be decided by the votes of a majority of the members present.

(5) There shall be paid to the members of the Tribunal such remuneration and allowances as the Minister may in consultation with the Treasury determine.

(6) The office of a member of the Tribunal shall become vacant

(a) at the expiration of three years from the date of his appointment;

(b) if he ceases by any reason to be such advocate or medical practitioner as referred to in subsection 1;

(c) if he is removed from membership of the Tribunal by the Attorney-General for failure to discharge the functions of his office (whether arising from infirmity of body or mind or from any other cause) or for misbehaviours; and

(d) if he resigns the office of member of the Tribunal.

26. Jurisdiction of the Tribunal

(1) The Tribunal shall have jurisdiction

(a) to hear and determine complaints arising out of any breach of the provisions of this act;

(b) to hear and determine any matter or appeal as may be made to it pursuant to the provisions of this act; and

(c) to perform such other functions as may be conferred upon it by this act or by any other written law being in force.

(2) The jurisdiction conferred upon the Tribunal under subsection 1 excludes criminal jurisdiction.

27. Powers of the Tribunal

(1) The Tribunal shall have jurisdiction

(a) to hear and determine complaints arising out of any breach of the provisions of this act;

(b) to hear and determine any matter or appeal as may be made to it pursuant to the provisions of this act; and

(c) to perform such other functions as may be conferred upon it by this Act or by any other written law being in force.

(2) The jurisdiction conferred upon the Tribunal under subsection 1 excludes criminal jurisdiction.

28. Disobedience of summons to give evidence et cetera

Any person summoned by the Tribunal to attend and give evidence or to produce any records, books of account, statements, or other documents or required to answer interrogatories and who, without sufficient cause

(a) refuses or fails to attend at the time and place mentioned in the summons served on him;

(b) refuses or fails to answer, or to answer fully and satisfactorily, to the best of his knowledge and belief all questions lawfully put to him by or with the concurrence of the Tribunal; or

(c) refuses or fails to produce any records, books of account, statements or other documents which are in his possession or under his control mentioned or referred to in any summons served on him, commits an offence and shall be liable upon conviction to a fine not exceeding fifteen thousand shillings or to imprisonment for a term not exceeding two years, or to both.

29. Enforcement of orders for damages and costs

(1) Where the Tribunal awards damages or costs in any matter before it, it shall, on application by the person in whose favour the damages or costs are awarded, issue to him a certificate stating the amount of the damages or costs.

(2) Every certificate issued under subsection 1 may be filed in the High Court by the person in whose favour the damages or costs have been awarded and, upon being so filed, shall be deemed to be a decree of the High Court and may be executed as such.

30. Rules

Except as otherwise provided in this act, the Chief Justice may in consultation with the chairman of the Tribunal, and by notice in the *Gazette* make rules governing the practice and procedure of the Tribunal having regard to the objectives of this act.

PART VIII – Discriminatory acts and policies**31. Discrimination in the workplace**

(1) Subject to subsection 2, no person shall be

(a) denied access to any employment for which he is qualified; or

(b) transferred, denied promotion or have his employment terminated, on the ground only of his actual, perceived or suspected HIV status.

(2) Subsection 1 shall not apply in any case where an employer can prove, on application to the Tribunal that the requirements of the employment in question are that a person be in a particular state of health or medical or clinical condition.

32. Discrimination in schools

No educational institution shall deny admission or expel, discipline, segregate, deny participation in any event or activity, or deny any benefits or services to a person on the grounds only of the person's actual, perceived or suspected HIV status.

33. Restriction on travel and habitation

(1) A person's freedom of abode, lodging, or travel, within or outside Kenya, shall not be denied or restricted on the grounds only of the person's actual, perceived or suspected HIV status.

(2) No person shall be quarantined, placed in isolation, refused lawful entry or deported from Kenya on the grounds only of the person's actual, perceived or suspected HIV status.

34. Inhibition from public service

No person shall be denied the right to seek an elective or other public office on the grounds only of the person's actual, perceived or suspected HIV status.

35. Exclusion from credit and insurance services

(1) Subject to this Act, no person shall be compelled to undergo a HIV test or to disclose his HIV status for the purpose only of gaining access to any credit or loan services, medical, accident or life insurance or the extension or continuation of any such services.

(2) Notwithstanding the provisions of subsection 1, an insurer, re-insurer or health maintenance organisation shall, in the case of life and health care service insurance cover, devise a reasonable limit of cover for which a proposer shall not be required to disclose his HIV status.

(3) Where a proposer seeks a cover exceeding the no test limit prescribed under subsection 2 the insurer, reinsurer or health maintenance organisation may, subject to this Act, require the proposer to undergo an HIV test.

(4) Where a proposer elects to undergo an HIV test pursuant to subsection 3 and the results thereof are positive

(a) the proposer shall, at his own expense, enter into such agreed treatment programme with the insurer as may be prescribed by the Minister in consultation with Commissioner for Insurance; or

(b) the insurer may impose a reasonable additional premium or lien to the benefits ordinarily purchased; or

(c) the insurer may decline granting the cover being sought.

(5) A person aggrieved by a determination as to what is reasonable for the purposes of this section may appeal to the Commissioner of Insurance in accordance with such procedure as may be prescribed in regulations and the Commissioner of Insurance shall make a determination on the basis of statistical and actuarial principles and other relevant considerations.

(6) A person aggrieved by a determination made under subsection 5 may appeal within thirty days to the Tribunal and the decision of the Tribunal shall be final.

36. Discrimination in health institutions

No person shall be denied access to health care services in any health institution, or be charged a higher fee for any such services, on the grounds only of the person's actual, perceived or suspected HIV status.

37. Denial of burial services

A deceased person who had AIDS, or was known, suspected or perceived to be HIV-positive shall not be denied access to any burial services on the grounds only of their said status.

38. Penalty for discriminatory acts and practices

A person who contravenes any of the provisions of this Part commits an offence.

PART IX – Research**39. Requirements for research**

No person shall undertake HIV and AIDS related human biomedical research on another person, or on any tissue or blood removed from such person unless such research conforms to the requirements under the Science and Technology Act or any other written law for the time in force.

40. Consent to research

(1) No person shall undertake HIV or AIDS related human biomedical research on another person or on any tissue or blood removed from such person except

(a) with the written informed consent of that other person; or

(b) if that other person is a child, with the written informed consent of a parent or legal guardian of the child.

(2) The person whose consent is sought to be obtained under subsection 1 shall be adequately informed of the aims, methods, anticipated benefits and the potential hazards and discomforts of the research.

41. Anonymous testing

(1) Notwithstanding anything to the contrary in this act, the Minister for the time being responsible for matters relating to health may prescribe guidelines under which anonymous testing for HIV may be carried out.

(2) Any anonymous testing conducted pursuant to this section shall only be for the purposes of public health.

42. Penalty for unlawful research

A person who contravenes any of the provisions of this part commits an offence.

PART X – Miscellaneous provisions**43. General penalty**

A person convicted of an offence under this Act for which no other penalty is provided shall be liable for imprisonment for a term not exceeding two years or to a fine not exceeding one hundred thousand shillings or to both.

44. Cognisable offences

All offences under the Act shall be cognisable to the police.

45. Regulations

Subject to this Act, the Minister may make regulations

(a) for prescribing anything required by this Act to be prescribed; or

(b) generally for the better carrying out of the objects of this Act.

46. Act to supersede other Acts

Where the provisions of this Act or any regulations made hereunder are inconsistent with the provisions of any other written law, the provision of this Act or of such regulations shall prevail.

Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)

Following its approval by the National Assembly on 16 November 2005 and by the Senate on 15 December 2005 and after its consideration by the High Constitutional Court on 15 February 2006, this Law was promulgated by the President on 20 February 2006. Its full title, in French, is *Loi n°2005-040 sur la lutte contre le VIH/SIDA et la protection des personnes vivant avec le VIH/SIDA*. Among other things, the law addresses issues of stigmatisation and discrimination against people living with HIV.

TITLE I – General provisions

CHAPTER I – Definition and scope of application

Article 1

This legislation has the following objectives

to fight the spread of infections due to the Human Immunodeficiency Virus (HIV), which causes the weakening and loss of immune protections of the body, resulting in the Acquired Immunodeficiency Syndrome (AIDS);

to protect persons living with HIV against all forms of discrimination or stigmatisation;

to reaffirm their rights and fundamental freedoms in accordance with international human rights instruments.

In addition, it spells out measures to be taken to protect the rights of persons living with HIV, their partner(s) and close relatives against all forms of discrimination and stigmatisation.

Article 2

Any difference in treatment, any distinction, restriction, exclusion of a person living with HIV or his or her partner(s) and/or his or her close relatives on the ground of his real or presumed HIV status, that aim to undermine the recognition, the enjoyment or the exercise of their rights or fundamental liberties shall be considered an act of discrimination.

Any behaviour aiming to discredit, despise or ridicule a person living with HIV or his or her partner(s) and/or his or her close relatives on the ground of his or her real or presumed HIV status shall be considered an act of stigmatisation.

Article 3

A National Strategic Plan shall be formulated and implemented to guide the actions of fight against HIV/AIDS.

Article 4

A national body established under the office of the President of the Republic, shall be responsible for the promotion, coordination and supervision of the different activities conducted for the prevention and fight against the pandemic at the national, provincial and local levels.

CHAPTER II – HIV testing

Article 5

HIV testing is voluntary, anonymous and confidential. The informed consent of the person to be tested shall accompany any HIV test. HIV tests performed on children shall, as far as possible, be conducted with the consent of one of his or her parents at least or a person who has authority over the child, unless the best interest of the child requires otherwise or if the child is an emancipated minor, although the absence of consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the children's judge has jurisdiction to decide. However, HIV testing is compulsory in the event of blood donation, tissues donation, donation of human organs and donation of germinal cells.

Article 6

HIV testing shall be preceded and followed by counselling.

Article 7

HIV testing shall be free of charge in testing centres run by the public sector and established at the level of health districts.

Article 8

The results of an HIV test shall be hand-delivered, confidentially and directly to the person concerned. However, the results of a test conducted on a child shall be given, as far as possible, in the presence of one of his parents at least or a person who has authority over him or her unless the best interest of the child requires otherwise or if the child is an emancipated minor. In the event of a dispute, the children's judge has jurisdiction to decide.

Article 9

This information may only be revealed to third parties with the explicit consent of the person concerned or by court order, or when there are imperative and justifiable reasons related to the health of the patient or the health of the community.

Article 10

Any person who is aware of his or her HIV status shall be encouraged to inform his or her partner of his or her HIV status. That person shall, as far as possible, enjoy, with his or her partner(s) and close relatives, psychological support.

Article 11

HIV testing shall not be conducted in the workplace or in schools.

CHAPTER III – Care and treatment

Article 12

Persons living with HIV shall enjoy the same right to care as other patients.

Article 13

Care and treatment for children shall be administered, as much as possible, with the consent of one of his parents at least or a person who has authority over the child unless the best interest of the child requires otherwise or if the child is an emancipated minor, although the absence of consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the children's judge has jurisdiction to decide.

Article 14

Care and antiretroviral treatments shall be provided to persons living with HIV free of charge in public health care facilities.

Article 15

The manufacture, importation, exportation and sale of generic medications to treat AIDS, including medications to treat opportunistic infections, active ingredients necessary to their manufacture and products essential to their use shall be permitted. Generic medications shall be subjected to the same standards of quality as patented medications.

Article 16

As part of the medical and psycho-social support of persons living with HIV, a policy shall define the measures to be taken in order to ensure equality of access to care and treatments.

TITLE II – Prevention

CHAPTER I – Prevention through information, education and communication

Article 17

The State shall be first accountable for actions of prevention, which is the pillar of the fight against HIV/AIDS. In order to fight HIV/AIDS-related discrimination and stigmatisation as well as promote behavioural change, programmes on information, education and communication adapted to the age,

sex, nature of activities, and, where applicable, the sexual orientation of targeted groups shall be elaborated and disseminated across the national territory by the competent organs.

Article 18

Free and regular airtime shall be allocated to the prevention of HIV/AIDS on national public broadcasting networks according to the conditions defined by the competent communication authorities.

Article 19

A committee of ethics responsible for communication comprising at least one representative of persons living with HIV and one representative of the youth, shall be created.

CHAPTER II – Prevention of mother to child transmission through blood

Article 20

HIV testing shall be systematically offered to pregnant women during antenatal consultations.

Article 21

Programmes on the prevention of transmission of the virus from an HIV positive mother to her child shall be implemented for a better ante- and post- natal support. Psychosocial support and follow-up shall be included in such programmes.

CHAPTER III – Epidemiological surveillance

Article 22

In order to better fight the propagation of HIV/AIDS, a regular follow-up of HIV prevalence rates at the national level shall be institutionalised.

Article 23

Local health authorities shall notify the authority so mandated by the Ministry of Health and by way of coded information confirmed cases of HIV and AIDS recorded by all public and private health care institutions operating within their locality.

Article 24

Special measures of surveillance shall be taken for vulnerable groups.

CHAPTER IV – Particular ways and means of prevention

Article 25

Condoms shall be made available to the public in highly frequented places and for free in prisons.

Article 26

Special measures shall be taken to ensure sufficient protection against the transmission of HIV amongst vulnerable groups, in particular, sex workers, youth, women and children, drug users, men who have sex with men and mobile populations.

Article 27

Specific and appropriate means and measures shall be taken by the Ministry of Health to protect health professionals against any risk of contamination in the course of performing their duties.

TITLE III – Protection of the rights of persons living with HIV, their partner(s) and close relatives

CHAPTER I – Rights of persons living with HIV, their partner(s) and close relative(s)

Article 28

Persons living with HIV shall have full and entire legal capacity and shall enjoy all citizens' rights in the Constitution and in international instruments.

Any discrimination and stigmatisation against persons living with HIV, their partner(s) and close relative(s) when exercising their rights shall be prohibited.

Article 29

Persons living with HIV shall have the right to marry and procreate. Their HIV status shall not constitute a valid reason to oppose their marriage nor a cause of divorce, except in the event of misrepresentation.

Article 30

An HIV positive woman shall have the right to motherhood. She shall benefit from all measures implemented by the State within the framework of the programme on the prevention of mother-to-child-transmission of the virus and the policy on reproductive health.

Article 31

The real or presumed HIV status of a person shall not constitute a reason to deny or exclude him or her from the benefits of or terminate a contract of health insurance, nor exclude him or her from entering into a life insurance contract or exclude him or her from the enjoyment of any other right he may claim. Such a protection extends to his or her partner(s) or any of his or her close relatives.

Article 32

Some groups such as health workers, prison authorities, law enforcement agents, employers, educators shall include in their codes of ethics the principles guaranteeing the fundamental rights of persons living with HIV.

Article 33

In addition to the circumstances described in article 44, any person who suffers an act of discrimination or stigmatisation or who suffers from the consequences of the disclosure of his real or presumed HIV status or the disclosure of his partners' or close relatives' HIV status may institute legal proceedings to claim damages.

Associations shall have the capacity and right to institute legal proceedings for and on behalf of persons living with HIV, their partners or close relatives even if the person with real or presumed HIV status is not a member of those associations.

Article 34

Legal proceedings on discrimination or stigmatisation involving a person living with HIV shall be held in camera at the request of one of the parties.

Article 35

Any research related to HIV/AIDS shall be authorised by the national committee of ethics.

CHAPTER II – Rights pertaining to children affected and infected by HIV/AIDS

Article 36

Children infected and affected by HIV/AIDS, including orphans, shall enjoy all rights in the Constitution and in international instruments pertaining to children, in particular the Convention on the Rights of the Child. Special measures of protection, including measures against abuse and exploitation, as well as specific measures with respect to inheritance rights, land tenure and property in general, shall be adopted when necessary.

When exercising his rights, the child shall not be subjected to any discrimination or stigmatisation on the account of his real or presumed HIV status, the status of his partners, parents or legal guardians or close relatives.

Article 37

Notwithstanding the provisions contained in Title III chapter III on education, no child shall be refused access to, excluded from, discriminated against, stigmatised when exercising his right to education or from any programme, institution targeted at children on the account of his real or presumed HIV status, the

status of his partners, parents or legal guardians or close relatives, under pain of a claim for damages.

Article 38

The surviving children of persons deceased due to AIDS shall be taken care of by their families, communities of origin including foster families or, if these are not available, by public or private institutions for a period as short as possible. Adequate measures, namely in respect of the periodic review of the decision of placement of the child, shall be taken by the State to support these children.

CHAPTER III – Protection of persons living with HIV, their partner(s) and their close relatives at school

Article 39

The real or presumed HIV status of a person, of his partners and close relatives shall not constitute an obstacle to the access to education and the enjoyment of the right to education.

Article 40

Medical check-ups conducted in schools in view of admission or allocation of bursaries shall not include an HIV test.

Article 41

The administration of any institution taking care of children, schools, universities and any other educational programmes has the obligation to keep confidential the HIV status of a child, a learner, a student, a teacher or the beneficiary of an educational programme, of any other staff or their partner(s), parents or close relatives if it receives such information. Enquiries and investigations initiated by the administration in this respect shall be prohibited.

Article 42

Any isolation, exclusion or suspension of a person as mentioned in the previous article on the account of his real or presumed HIV status or the real or presumed HIV status of his partners and close relatives shall constitute an act of discrimination.

Article 43

The ministries in charge of education are under the obligation to frame an educational programme that includes HIV/AIDS and according to which teachers shall inform, educate and sensitise children, learners and students on the prevention and fight against HIV/AIDS taking into account the evolution of scientific research, beliefs, cultures and the system of traditional values.

CHAPTER IV – Protection of persons living with HIV, their partner(s) and close relatives in the workplace

Article 44

Any form of discrimination or stigmatisation against a person, his partner(s) or close relatives on the account of his real or presumed HIV status shall be prohibited in the workplace.

The employer shall take the initiative of a disciplinary procedure against any employee who discriminates against another employee on the account of the latter's real or presumed HIV status; legal proceedings may as well be undertaken against that employee by the person who suffered discrimination.

Article 45

The employer shall take the necessary measures to avoid any contamination and respect the conditions of hygiene in the workplace.

The employer shall set up a committee of hygiene, security and environment responsible of informing and educating workers on HIV/AIDS.

Article 46

A person's HIV status, the status of his or her partners, or that of his close relatives shall not under any circumstances constitute a direct or indirect cause of refusal of employment or termination of employment.

HIV testing shall not be required for medical fitness tests and systematic medical check-ups.

Article 47

No employer shall subject anyone to an HIV test prior to recruitment, promotion, training or the allocation of any employment benefit.

Article 48

Employees do not have any obligation to inform their employers of their HIV status or the status of their partner(s) or close relatives.

Article 49

The employer and other staff members shall be bound to respect confidentiality if they are aware of the HIV status of one of their employees or co-workers, or the latter's partner(s) or any of the latter's close relatives.

Article 50

Any worker living with HIV shall be permitted to continue his employment and shall enjoy all usual opportunities for promotion.

Article 51

When employees living with HIV are no longer able to fulfil their duties on the account of poor health, they shall benefit from rights pertaining to workers affected by a long term illness.

Article 52

No retirement and incapacity insurance scheme shall contain any restrictive clause related to a person's real or presumed HIV status.

Article 53

In the event of suspected contamination to HIV in the course of employment, the employee shall be entitled to counselling and to an HIV test at the expense of the employer.

Article 54

Any person infected with HIV in the course of his employment shall have the right to institute legal proceedings to claim damages under the rules of ordinary law.

Article 55

Any dispute related to an act of discrimination or stigmatisation against a person living with HIV, his partner(s) or his close relatives on the account of his real or presumed HIV status in the workplace shall follow the same procedure as in social matters.

CHAPTER V – Protection of persons living with HIV in prison

Article 56

Notwithstanding the provisions of article 22, all means of protection against the risk of HIV infection shall be made available to detainees and prison authorities in prisons and rehabilitation centres.

Article 57

No detainee shall be subjected to compulsory HIV testing. The rules in Title I chapter II, shall be equally applicable in prisons.

Article 58

A detainee living with HIV shall enjoy the same rights pertaining to other sick detainees.

The person infected with HIV shall subject himself to a regular check-up performed by the health authorities of the prison for a medical follow-up.

Article 59

No detainee shall be isolated from the other detainees on the account of his real or her presumed HIV status.

The above rule shall not apply in the event of an attempt to wilfully transmit the virus or sexual abuse. The decision by the

Chief Warden to temporarily isolate a detainee must be confirmed by the competent judicial authority within a period of 48 hours, failing which the measure of isolation shall be lifted.

Article 60

Any detainee or person placed in a rehabilitation centre shall be entitled to the right to be protected against any malpractice, violence – including sexual violence- and shall retain his or her right to institute legal proceedings, notwithstanding disciplinary sanctions against the author of the act of malpractice or violence. The competent authorities shall ensure that the necessary measures are taken to that end.

Article 61

The Ministries of Justice and of Health shall be responsible for the formulation of a joint policy for the fight against HIV/AIDS in prisons.

CHAPTER VI – Obligations of health professionals

Article 62

Any form of discrimination or stigmatisation against any patient on the account of the latter's real or presumed HIV status, or the status of the latter's partner(s) or close relatives shall be strictly prohibited in any health care facility. Such discrimination or stigmatisation shall be punishable by disciplinary sanctions, notwithstanding possible civil or criminal proceedings.

Article 63

The doctor shall have the obligation to inform the patient of his HIV status, which shall remain confidential. Exceptionally, and in conformity with the rules of professional ethics, the doctor may, where a partner is in danger of being infected and without violating confidentiality rules, disclose a patient's HIV status to his or her partner if the patient fails to disclose the same to that partner.

CHAPTER VII – Penal provisions

Article 64

Any act of discrimination or stigmatisation against a person, his partner(s) or close relatives on the account of his real or presumed HIV status shall be punished with a fine of from 100 000 ariary to 400 000 ariary.

Article 65

The disclosure of a person's real or presumed HIV status by another person bound by confidentiality shall be punished with a fine of from 200 000 ariary to 1 000 000 ariary.

Article 66

Any misleading advertisement on medications, care products for the treatment or prevention of HIV/AIDS shall be punished with a fine from 1 000 000 ariary to 2 000 000 ariary.

Article 67

In the event of transmission of HIV by recklessness, carelessness, inattentiveness, negligence or in violation of regulations, the offender shall be punished with imprisonment from 6 months to 2 years and a fine of from 100 000 ariary to 400 000 ariary. The penalty shall be doubled if the act was committed by a health worker or a traditional healer.

TITLE IV – Final provisions

Article 68

Regulatory instruments shall be enacted when need be for the implementation of this law.

Article 69

All provisions contrary to this law are hereby repealed.

Article 70

This law shall be advertised in the Official *Gazette* of the Republic of Madagascar. It shall be enforced as law of the State.

Mauritius: HIV and AIDS Act 31 of 2006

Enacted by the Parliament of Mauritius on 5 December 2006, and approved by the President of Mauritius on 27 December 2006. Its full title is 'An Act to provide for measures for the prevention and containment of HIV and AIDS'.

1. Short title

The Act may be cited as the HIV and AIDS Act 2006.

2. Interpretation

In this Act

'AIDS' means Acquired Immunodeficiency Syndrome;

'dangerous drugs' has the same meaning as in the Dangerous Drugs Act;

'HIV' means Human Immunodeficiency Virus;

'HIV test' means a test which determines whether or not a person is infected with HIV;

'human tissue' includes

- (a) an organ, or part, of a human body; or
- (b) semen or any substance or secretion, taken from the human body, or part of the human body; but
- (c) does not include blood;

'institution' means a hospital, laboratory, pharmacy or centre for the rehabilitation of drug addicts;

'medical practitioner' means a person holding a certificate of registration under section 28 of the Medical Council Act or section 27 of the Dental Council Act;

'Minister' means the Minister responsible for the subject of health;

'nursing officer' means a registered nursing officer or midwife under the Nursing Council Act

'paramedical staff' means a person trained to assist medical professionals and to give first aid treatment, or a person who supplements medical practitioners and nurses in their activities;

'Permanent Secretary' means the Permanent Secretary of the Ministry to which responsibility for the subject of health is assigned, but where the official head of the Ministry is a Senior Chief Executive Officer, reference to the Permanent Secretary shall be reference to the Senior Chief Executive Officer;

'positive' in relation to an HIV test, means a result which shows that the person who is tested was at the time the test was undertaken, infected with HIV;

3. HIV or AIDS not a disability

(1) Any person who is HIV-positive or has AIDS shall not be considered as having a disability or incapacity by virtue of any enactment and his status or presumed status shall not be used as a ground to discriminate against this person.

(2) Subsection 1 shall not affect the operation of a pension law if that law provides for a benefit accruing to a person according to the degree of disability which entitles him to such benefit.

4. HIV testing facilities

(1) No institution or non-governmental organisation shall carry out HIV testing unless it is registered with the Permanent Secretary.

(2) Any institution or non-governmental organisation which wishes to be registered may apply in the prescribed form to the Permanent Secretary and submit

- (a) its certificate of incorporation, where applicable;
- (b) evidence of its capability to carry out the tests, including evidence of the qualifications possessed by the persons who would be carrying out the tests; and

(c) evidence to ensure confidentiality and providing counselling; and

(d) such other particulars or document as the Permanent Secretary may require.

(3) Where the Permanent Secretary is satisfied that the institution or non-governmental organisation is a fit institution or organisation to be registered, it shall register it and issue to it a certificate of registration.

(4) Where an applicant is refused registration, the Permanent Secretary shall give the reasons for his refusal.

(5)(a) The Permanent Secretary may suspend or cancel a registration made under this section where the institution or non-governmental organisation has contravened this Act or such guidelines as may be made by the Permanent Secretary.

(b) Before proceeding to a suspension or cancellation under this subsection, the Permanent Secretary shall call upon the medical institution or non-governmental organisation to show cause why its registration should not be suspended or cancelled.

(6) The Permanent Secretary shall keep a register in which he shall enter

(a) the name and address of every institution or organisation that is registered;

(b) any other particulars as may be prescribed.

5. HIV testing in public health institutions

The Permanent Secretary shall make available facilities in such public hospitals and other public health institutions as he may designate for HIV testing in respect of persons who request an HIV test for themselves.

6. Prohibited testing

(1) No person shall induce or cause another person to undergo an HIV test

(a) as a condition for employment or continued employment of the second person;

(b) as a condition for procurement of goods and services from the second person.

(2) Nothing under subsection 1 shall prevent the requirement of an HIV test in connection with any application relating to immigration, citizenship, defence or public safety.

7. HIV testing

(1) No person, other than a medical practitioner, shall make a request for an HIV test on another person.

(2) Subject to subsections 3 and 5, and section 10, an HIV test on another person shall not be undertaken, except with the informed consent of

(a) the other person;

(b) his legal administrator or guardian, where the other person is a minor; or

(c) the guardian of the other person, where the latter is a "majeur en tutelle".

(3) A medical practitioner may undertake an HIV test on a person without that person's consent where

(a) that person is required to undergo such test under this Act;

(b) that person has a disability by reason of which he appears to the medical practitioner to be incapable of giving his consent, provided that the medical practitioner is responsible for the treatment of that person and he is of opinion that the health of the person would be of immediate risk without the test.

(4) A medical practitioner who, in good faith, undertakes an HIV test under subsection 2 shall not, by reason only of undertaking the test, be liable to any civil or criminal liability under any enactment.

(5) A person may undertake an HIV test on a minor without the consent of his legal administrator or guardian where the minor makes a written request for such test and that person is satisfied that the minor understands the nature of his request.

8. Testing of donated blood

The Permanent Secretary shall issue directions to the blood transfusion service for the purpose of having an HIV test carried out on

(a) any donated blood;

(b) any imported blood product.

9. Testing of human tissue donors and human tissues

(1) A person who offers to donate his tissue or whose tissue is offered to be donated shall undergo an HIV test immediately before such donation is carried out.

(2) Subject to subsection 3, no donated human tissue shall be used unless an HIV test has been carried out prior to the proposed use and the result of that test is not positive.

(3) A person who has offered to donate his tissue, and who has undergone an HIV test under subsection 1, shall not be liable to any civil or criminal action in relation to any subsequent use of that tissue.

10. Pre-test counselling

A medical practitioner, a nursing officer or a paramedical staff of an institution, or any member of a non-governmental organisation, registered under section 4

(a) shall counsel a person who is to undergo an HIV test; and

(b) may counsel any person as is considered by him to be in need of counselling

11. Result of HIV test and counselling

(1) The medical practitioner, nursing officer or paramedical staff of the institution, or member of a non-governmental organisation, registered under section 4, or any public hospital or public health institution referred to in section 5, shall as soon as practicably possible after the results of an HIV test are obtained, inform the tested person in person of those results.

(2) Where the test is positive, the medical practitioner, the nursing officer or paramedical staff of the institution, or member of the non-governmental organisation, or officer of the public hospital or public health institution, as the case may be,

(a) shall inform the Permanent Secretary of the result of the HIV test in such a manner as may be directed by the Permanent Secretary but without disclosing the identity of any tested person;

(b) shall counsel the tested person, or where appropriate, the legal administrator or guardian of that person, on such matters as the Permanent Secretary may deem appropriate, including

(i) the medical consequences of being found positive;

(ii) the modes of transmission and related infections, protection and prevention

(iii) the importance to disclose his status to his spouse, sexual partner or children;

(iv) the medical treatment and social benefit available; and

(c) shall refer the tested person to such centre as may be prescribed for follow-up or treatment; and

(d) may counsel such other person as is considered by him to be in need of counselling on the consequences of the tested person having been found positive.

12. Surgical and dental procedures or treatment

Notwithstanding any other enactment, a medical practitioner or paramedical shall not withhold from carrying out any surgical or dental procedure, or prescribing treatment, where a person refuses to undergo an HIV test.

13. Confidentiality of information

(1) The Permanent Secretary shall, in consultation with such professional organisations as he may deem necessary, issue guidelines on the confidentiality of information relating to recording, collection, storing and security of information, records or forms used in respect of HIV tests and related medical assessments.

(2) No person shall collect, record, transmit or store information in respect of HIV tests or related medical assessments of another

person except in compliance with the guidelines issued under subsection 1.

(3) Subject to subsection 4, a person shall not, in any record or form used in relation to

- (a) a request for an HIV test by a person in respect of himself;
- (b) an instruction by a medical practitioner to a laboratory for an HIV test to be conducted;
- (c) an HIV test; or
- (d) the notification to the medical practitioner of the result of an HIV test, include any information which either directly or indirectly identifies the person to whom an HIV test relates, except in accordance with the guidelines issued under subsection 1.

(4) No person shall disclose any information concerning the result of an HIV test or related medical assessments, including the HIV or HIV antibody status or the sexual behaviour of a person, to any other person except

- (a) with the written consent of that person, or his legal administrator or legal guardian, as applicable;
- (b) to a medical practitioner, nursing officer, paramedical staff who is directly involved in the treatment or counselling of that person, where the HIV or AIDS status is clinically relevant;
- (c) for the purpose of an epidemiological study or research approved by the Permanent Secretary;
- (d) upon an order of a court where the information contained in the medical file is directly relevant to the proceedings before the court.

(5) Nothing in this section shall be construed as preventing the release of statistical or such other information that cannot reasonably be expected to lead to the identification of the person to whom it relates.

14. Syringe and needle exchange

(1) Subject to this section, an institution or non-governmental organisation may supply, as part of a therapy, syringes and needles to any person dependent on a dangerous drug.

(2) No institution or non-governmental organisation shall supply a new syringe or a new needle to any person unless the institution or non-governmental organisation has been prescribed under subsection 3.

(3) The Permanent Secretary may, after consultation with the Medical Council and Dental Council, and subject to the approval of the Commissioner of Police, prescribe medical institutions or non-governmental for the purposes of subsection 1.

(4) Where an institution or non-governmental organisation is satisfied that a person is dependent on a dangerous drug and requires the supply of new syringes or needles as part of a therapy, it may register that person according to the procedures established by it.

15. Disposal of syringe and needles

An institution or non-governmental organisation shall, pending their destruction and subject to any regulations made for the purposes of this section, store all used syringes or needles collected pursuant to section 15 in a container resistant to puncture and capable of being sealed or securely closed in such a way that its contents may not cause injury.

16. Possession of syringes and needles

A person who is in possession of a syringe or needle, in compliance with this Act, shall not, by reason only of that possession, be considered as having committed an offence under the Dangerous Drugs Act.

17. Evidence of certain communications

Notwithstanding any other enactment, no communication made by a person in undergoing an HIV test, any surgical or dental procedure, or any counselling, under this Act and relating to the sexual behaviour of any person shall be admissible as evidence in any civil or criminal proceedings.

18. Offences and penalties

(1) Any person who contravenes section 4(1), 6(1), 7(1), 12, 13(2), (3) or (4) or 14(2) shall commit an offence and shall, on conviction, be liable to fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding 12 months.

(2) Any person who contravenes section 15 shall commit an offence and shall, on conviction be liable to a fine not exceeding 100,000 rupees and to imprisonment not exceeding 5 years.

(3)(a) Any person who treats any other person or his relative

- (i) unfairly, unjustly, or less favourably than a third person would have been treated in comparable circumstances;
- (ii) with hatred, ridicule or contempt, on account of being, or being perceived as being, infected with HIV, shall commit an offence and shall on conviction be liable to a fine not exceeding 50,000 rupees.

(b) In paragraph a, "relative" means spouse, child, father, mother, brother, sister, grandparent, grandchild, uncle, aunt, nephew, niece and includes any person with whom the person concerned resides.

(4) No prosecution for an offence under subsection 2 or 3 shall be instituted except by, or with the consent of, the Director of Public Prosecutions.

19. Jurisdiction

Notwithstanding section 114 of the Courts Act and section 72 of the District and Intermediate Courts (Criminal Jurisdiction) Act a Magistrate shall have jurisdiction to try any offence under this Act or any subsidiary enactment made under this Act, and inflict such penalty as is provided for under this Act or any subsidiary enactment made under this Act.

20. Regulations

(1) The Minister may make such regulations as he thinks fit for the purposes of this Act.

(2) Any regulations made under subsection 1 may provide

- (a) for a code of conduct for institutions, medical practitioners, paramedical staff, and any other person involved in the protection and care of HIV-positive persons and any person involved in other activities that may give rise to a risk of infection by HIV;
- (b) that a person who contravenes them shall commit an offence and on conviction shall be liable to a fine not exceeding 25,000 rupees and to imprisonment not exceeding 6 months.

21. Commencement

(1) This Act shall come into operation on a date to be fixed by Proclamation.

(2) Different dates may be fixed for the coming into force of different provisions of this Act.

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

The HIV and AIDS (Prevention and Control) Bill to be submitted to the National Assembly was published for general information to the public in September 2007. Its full title is 'A Bill for An Act to provide for prevention, care and control of HIV and AIDS and for promotion of public health to persons living with HIV and AIDS; for appropriate treatment, where resources allow, counselling and care for persons living with or at risk of HIV and AIDS and for related matters'.

Excerpts

...

PART I – Preliminary provisions

1. Short title

This Act may be cited as the HIV and AIDS (Prevention and Control) Act 2007 and shall come into force on a date the Minister may, by Notice published in the *Gazette*, appoint.

2. Application

This Act shall apply to Mainland Tanzania.

3. Interpretation

In this Act unless the context otherwise requires

‘AIDS’ means Acquired Immunodeficiency Syndrome, which is a condition characterised by a combination of signs and symptoms, caused by HIV which attacks and weakens the body’s immune system, making the afflicted individual susceptible to other life-threatening infections;

‘AIDS Committee’ has the meaning ascribed to it under the Tanzania Commission for AIDS Act;

‘ARVs’ means Anti Retroviral Drugs;

‘CBO’ means a Community Based Organization;

‘Committee’ means the National HIV and AIDS Research Fellowship Committee established under section 36;

‘COSTECH’ means Commission for Science and Technology established by the Tanzania Commission for Science and Technology Act;

‘court’ means the High Court and courts subordinate thereto with exception to primary court;

‘FBO’ means a Faith Based Organisation;

‘health practitioner’ means any person trained to care for patients;

‘HIV negative’ means absence of HIV or HIV antibodies upon HIV testing;

‘HIV positive’ means presence of HIV infection as documented by the presence of HIV or HIV antibodies in the sample being tested;

‘HIV testing’ means any laboratory procedure done on an individual to determine the presence or absence of HIV infection;

‘HIV transmission’ means the transfer of HIV from one infected person to an uninfected person, most commonly through sexual intercourse, blood transfusion, sharing of intravenous needles, during pregnancy or breast feeding;

‘HIV and AIDS monitoring and evaluation framework’ means documentation and analysis of the number of HIV and AIDS infections and the pattern of its spread;

‘HIV and AIDS prevention and control’ means measures aimed at protecting non infected person from contracting HIV and minimising the impact of the condition of persons living with HIV;

‘Human Immuno-deficiency Virus (HIV)’ means the virus which causes AIDS;

‘informed consent’ means the voluntary agreement of a person to undergo or be subjected to a procedure based on full information, whether such agreement is written, conveyed verbally or indirectly expressed;

‘learning institutions’ includes primary and secondary schools, colleges, universities and other higher learning institutions;

‘local government authority’ means the local government authority established under the Local Government (District Authorities) Act and the Local Government (Urban Authorities) Act;

‘Minister’ means the Minister responsible for health;

‘Ministry’ means the ministry responsible for health;

‘NACP’ means National AIDS Control Programme, established within the Ministry;

‘NGO’ shall have the meaning ascribed to it under the Non-governmental Organisations Act;

‘NIMR’ means the National Institute for Medical Research Act;

‘positive prevention’ means the provision of public health promotion to persons living with HIV and AIDS.

‘Private Health Laboratory Board’ has the meaning ascribed to it under the Private Health Laboratories (Regulation) Act;

‘private health laboratory’ shall have the meaning ascribed to it under the Private Health Laboratories (Regulation) Act;

‘research incentives’ means compensation for time or other resources expended by a human subject participating or taking part in a clinical trial.

‘Secretary’ means the secretary of the Committee referred to under section 36;

‘sexual partner’ means a person involved in sex;

‘Stigma’ is an attitude of condescension or disrespect towards another person because one knows or suspect that person is infected with HIV, or because that person has close relationship with a person known or suspected to be infected with HIV;

‘stigmatise’ means

(a) to vilify, or to incite hatred, ridicule or contempt against a person or group of people living with HIV, by publication, distribution or dissemination to the public; or

(b) the making of any communication to the public, including any arctic or gesture, that is threatening, abusive, insulting, degrading, demeaning, defamatory, disrespectful, embarrassing, critical, provocative of offensive;

‘STIs’ means Sexually Transmitted Infections;

‘TACAIDS’ means the Tanzania Commission for AIDS established under the Tanzania Commission for AIDS Act.

PART II – General duties

4. General duties

(1) Every person, institution and organisation living, registered or operating in Tanzania shall, be under the general duty to

(a) promote public awareness on causes, modes of transmission, consequences and prevention and control of HIV and AIDS;

(b) reduce;

(i) the spread of HIV and AIDS;

(ii) prevalence of STIs in the population;

(iii) adverse effects of HIV and AIDS to AIDS orphans,

(c) protect rights of the orphans by;

(i) providing health care and social services;

(ii) prohibiting compulsory HIV testing unless provided for under this Act;

(iii) fighting stigma and discrimination;

(d) discourage negative traditions and usages which may enhance HIV and AIDS spread in the community;

(e) promote all traditions and usages which may reduce the transmission and prevalence of the infection in the community;

(f) increase access, care and support to persons living with HIV and AIDS from community or health care facilities.

(2) The Government, political, religious and traditional leaders shall

(a) integrate or prioritise on HIV and AIDS in their proceedings and public appearances;

(b) advocate against stigma and discrimination of people living with HIV and AIDS.

(3) Every person discharging a duty under subsection 1, and (2) shall be under obligation to consult or liaise with TACAIDS for purpose of ensuring that resources are evenly distributed within Tanzania in order to

(a) avoid concentration of such resources in one geographical area; and

(b) initiate pre-informed activities intended to prevent and control HIV and AIDS.

5. The Ministry to promote safety measures and precautions

(1) The Ministry shall promote utmost safety and universal precautions in invasive medical or non medical practices and procedures in order to reduce the risk of transmission of HIV.

6. Roles of sectors

(1) Every ministry, department, agency, local government authority, parastatal organisation, institution whether public or private, shall design and implement gender positive HIV and AIDS plans in their respective areas and such plans shall be mainstreamed and implemented into the activities of such sector.

(2) Every FBO shall undertake deliberate efforts in prevention, care and controlling HIV and AIDS through special plans and programmes in its activities.

(3) Civil societies and private organisations shall, in collaboration with the Government, design and implement plans and programmes aimed at or geared towards prevention, care of patients and control of HIV and AIDS in their respective areas.

(4) Every sector preparing a plan or programme under this section shall before implementation of such plan or programme, submit them to TACAIDS for coordination and advice.

PART III – Public education and programmes on HIV and AIDS

7. Public education and programmes on HIV and AIDS

It shall be the responsibility of the Ministry in consultation with the respective local government authority and other relevant stakeholders to formulate education programmes relating to prohibition of stigma and discrimination against persons living with HIV, taking care of patients and prevention of STI's.

8. Dissemination of HIV and AIDS information

(1) The Ministry, health practitioners, workers in the public and private sectors and NGOs, shall for the purpose of providing HIV and AIDS education to the public, disseminate information regarding HIV and AIDS to the public.

(2) Dissemination of HIV and AIDS education and information shall form part of the delivery of health care services by health practitioners and workers in the public and private sectors.

9. HIV and AIDS education in workplace

Every employer in consultation with the Ministry shall establish and coordinate a workplace programme on HIV and AIDS for employees under his control and such programme shall include provision of gender responsive HIV and AIDS education, distribution of condoms and support to people living with HIV and AIDS.

10. Training of health practitioners

The Ministry shall for the purpose of ensuring prevention and control of HIV and AIDS to the public, develop and conduct programmes to train health practitioners on universal precaution measures on HIV/AIDS and STIs and treatment procedures and such programmes shall, where resources allow, be adopted by health institutions.

11. Donation of tissues, organs, blood or blood products

(1) A person may on his own motion, volunteer to donate a tissue, organ, blood or blood products to the recognised laboratory or institution.

(2) No laboratory or institution shall accept a donation of tissue or organ, whether such donation is gratuitous or not, unless a sample from the donor has tested negative for HIV.

(3) No laboratory or institution shall transfuse blood or blood products whether such blood or blood products are donated gratuitously or not, unless a sample from that donation has tested negative for HIV.

(4) Any blood, blood product, tissue or organ which has been tested positive for HIV shall be disposed of immediately and properly.

(5) Any person who contravenes the provisions of this section commits an offence and upon conviction shall be liable

(a) in case of an individual to a fine not less than two hundred thousand shillings or to imprisonment for a term of not less than six months; or

(b) in case of a laboratory or an institution to a fine not less than five million shillings.

12. Surgical, dental and similar procedures

(1) Every health practitioner shall during surgical, dental and similar procedures have a duty to ensure that

(a) parenteral exposure (sharp objects) are handled with care during performance of any procedure;

(b) at all levels of health care, delivery services, and in case of accident, he uses the necessary tools such as gloves, goggles and gowns;

(c) he handles and disposes of used syringes and other material used in blood testing; and

(d) he handles and disposes of in an appropriate manner body fluids or wastes of persons known or believed to be infected with HIV.

(2) A person who is the owner, manager or the in charge of health care facility shall have a duty to ensure

(a) the provision of post exposure prophylaxis;

(b) the provision of necessary tools such as gloves, goggles and gowns;

(c) appropriate handling and disposition of used syringes, materials used in blood testing and body fluids or wastes of persons known or believed to be infected with HIV.

(3) A person who contravenes the provisions of this section commits an offence and upon conviction shall be liable to a fine of not less than five hundred thousand shillings.

PART IV – Testing and counselling

13. HIV testing

(1) For the purposes of facilitating HIV testing, every public health care facility and voluntary counselling and HIV testing centre recognised by the NACP shall be an HIV testing centre for the purposes of this Act.

(2) The Private Health Laboratory Board may, by Order published in the *Gazette*, accredit any private laboratory to be an HIV testing center.

(3) Every health practitioner performing or otherwise involved in the performance of an HIV test shall take all measures to ensure that

(a) the testing process is carried out promptly and efficiently; and
(b) the result of the HIV test is communicated in accordance with this Act.

(4) No person shall undergo HIV testing except in a center provided for under this Part.

(5) For the purposes of this section HIV testing centre includes any centre established in any place for the purpose of HIV testing.

14. Counselling

Any person who is the owner, manager or in charge of a testing centre shall ensure that there is a trained and authorised person to provide pre and post HIV test counselling to a person undergoing an HIV test, and where feasible, to any other person likely to be affected by the results.

15. Prohibition of compulsory HIV testing

(1) Every person residing in Tanzania may on his own motion volunteer to undergo HIV testing.

(2) A child or a person with inability to comprehend the result may undergo HIV testing after written consent of a parent or recognised guardian.

(3) A person shall not be compelled to undergo HIV testing.

(4) Without prejudice to the generality of subsection 3, no consent shall be required on HIV testing-

- (a) under an order of the court;
- (b) on the donor of human organs and tissues; and
- (c) to sexual offenders.

(5) Every pregnant woman and every person attending a health care facility shall be counselled and offered voluntary HIV testing.

(6) All health practitioners, traditional and alternative health practitioners, traditional birth attendants and any other attending patients shall be encouraged to undergo HIV testing.

(7) Any health practitioner who compels any person to undergo HIV testing or procures HIV testing to another person without the knowledge of that other person commits an offence.

(8) Without prejudice to the preceding subsections, a medical practitioner responsible for the treatment of a person may under take HIV test in respect of that person without the consent of the person if-

- (a) the person is unconscious and unable to give consent; and
- (b) the medical practitioner reasonably believes that such a test is clinically necessary or desirable in the interest of that person.

16. Test result

(1) The results of an HIV test shall be confidential and shall be released only to the person tested.

(2) Notwithstanding subsection 1, the results of an HIV test may be released to;

- (a) in the case of a child, his parent or recognised guardian;
- (b) in the case of a person with inability to comprehend the results, his spouse or his recognised guardian.
- (c) a spouse or a sexual partner of an HIV tested person; or
- (d) the court if applicable.

PART V – Confidentiality

17. Medical confidentiality

(1) All health practitioners, workers, employers, recruitment agencies, insurance companies, data recorders and other custodians of any medical records, files, data or test results shall observe confidentiality in the handling of all medical information and documents, particularly the identity and status of persons living with HIV.

18. Exceptions to confidentiality

(1) The medical confidentiality shall not be considered breached in

- (a) complying with reportorial requirements in conjunction with the monitoring and evaluation programmes;
- (b) informing other health practitioners directly involved or about to be in the treatment or care of a person living with HIV;
- (c) responding to an order of the Court over legal proceedings where the main issue is HIV status of an individual.

PART VI – Health and support services

19. Basic health services to persons living with HIV

(1) The Government shall where resources allow ensure that, every person living with and orphans are accorded with basic health services.

(2) Every CBO, private organisation and FBO dealing with HIV and AIDS matters shall in consultation with the local government authority in the area of its jurisdiction provide community based HIV and AIDS prevention and care services.

20. Programmes on survival, life skills and palliative services

(1) The Ministry shall in collaboration with other relevant ministries prepare programmes and conduct training for persons living with HIV on

- (a) their survival needs;

(b) life skills; and

(c) formation of support groups for the purpose of providing palliative services and care.

21. Prevention of transmission

(1) Any person who has knowledge of being infected with HIV after being tested shall

- (a) immediately inform his spouse or sexual partner of the fact; and
- (b) take all reasonable measures and precautions to prevent the transmission of HIV to others.

(2) The person referred to under subsection 1 shall inform his spouse or his sexual partner of the risk of becoming infected if he has unsafe sex with such person unless that other person knows that fact.

22. Prevention and control of STIs

The Ministry shall

- (a) ensure that STIs services are strengthened; and
- (b) create public awareness on STIs as far as it relates to transmission of HIV.

23. Condoms

(1) The Ministry shall quantify requirement of condoms in Tanzania by espousing different stakeholders, mobilising resources required for procurement of condoms generally with a view to ensure availability of condoms of standard quality in Tanzania.

(2) No condoms shall be manufactured or imported to Tanzania unless the condoms conform with the standards provided by the Tanzanian Bureau of Standards.

(3) Any person who contravenes the provisions of subsection 2 shall, on conviction be liable in case of-

- (a) an individual, to a fine of not less than ten million shillings or to imprisonment for a term not less than three years or to both; and
- (b) a body corporate, to a fine of not less than fifty million shillings.

24. Access to health care facilities

(1) A person being the owner, manager or in charge of a health care facility or medical insurance whether public or private shall facilitate access to health care services to persons living with HIV without discrimination on the basis of their status.

(2) The Ministry shall, where resources allow, take the necessary steps to ensure the availability of ARVs and other health care services and medicines to persons living with HIV and those exposed to risk of HIV infection.

25. Prevention of transmission from mother to child

(1) The Ministry shall regulate the care and treatment of HIV infected pregnant women, mothers infected with HIV while giving birth and measures to reduce HIV transmission from mother to child.

(2) In an endeavor to prevent the mother to child transmission of HIV

- (a) trained and authorised persons shall provide counselling services to HIV infected pregnant and breast feeding women;
- (b) health care facilities shall monitor, provide treatment and apply measures necessary to reduce HIV transmission from mother to child.

26. Post-exposure prophylaxis

A health practitioner who is exposed to or infected with HIV during the course of rendering health care services to a person living with HIV shall be entitled to

- (a) post exposure prophylaxis;
- (b) treatment or access to continuum of care in case of HIV diagnosis; and
- (c) compensation for any loss or pecuniary loss directly resulting from infection with HIV.

27. Misleading information or statement

(1) All statements or information regarding the cure of HIV and AIDS shall be subjected to scientific verification before they are announced.

(2) Publication of statements or information referred to under subsection 1 shall be attached with both evidence of pre- and post- cure HIV test results

(3) A person who makes or causes to be made any misleading statements or information regarding curing, preventing or controlling HIV and AIDS contrary to this section shall be liable on conviction to a fine of not less than one million shillings or to imprisonment for a term of not less than six months or to both.

PART VII – Stigma and discrimination**28. Prohibition of discriminatory laws and practice**

A person shall not formulate a policy, enact a law or act in a manner that discriminates directly or by its implication persons living with HIV and AIDS, orphans or their families.

29. Restriction of health practitioners to stigmatise or discriminate

Any health practitioner who deals with persons living with HIV and AIDS shall provide health services without any kind of stigma or discrimination.

30. Prohibition of other forms of discrimination

A person shall not

- (a) deny any person admission, participation into services or expel that other person from any institution;
- (b) deny or restrict any person to travel within or outside Tanzania;
- (c) deny any person employment opportunity;
- (d) deny or restrict any person to live anywhere; or
- (e) deny or restrict the right of any person to residence, on the grounds of the person's actual, perceived or suspected HIV and AIDS status.

31. Prohibition of stigma and discrimination

A person shall not stigmatise or discriminate in any manner any other person on the grounds of such other person's actual, perceived or suspected HIV and AIDS status.

32. Offences relating to stigma and discrimination

Any person who contravenes any provision under this part commits an offence and on conviction shall be liable to a fine of not less than two million shillings or to imprisonment for a term not exceeding one year or to both.

PART VIII – Rights and obligations of persons living with HIV**33. Rights and obligations of people living with HIV, orphans etc.**

(1) Any person living with HIV shall where the resources allow have

- (a) a right to the highest attainable standard of physical and mental health; and
- (b) a right to treatment of opportunistic infections.

(2) Any person living with HIV shall, subject to the provisions of subsection 1, have an obligation to

- (a) protect others from infection; and
- (b) share in scientific advancement and its benefits.

34. Access to education and basic health care services

(1) Every local government authority, shall design, formulate, establish and coordinate mechanisms and strategic plans for ensuring that the most vulnerable children within its respective area are afforded means to access education, basic health care and livelihood services.

(2) The Minister may, in consultation with the Minister responsible for local government, make regulations setting out criteria for indentifying the most vulnerable children referred to under subsection 1.

(3) For the purpose of this section, the term 'most vulnerable children' includes orphans.

35. Prohibition of misuse of aid by NGOs CBOs private organisations etc.

(1) Every NGO, CBO, FBO, Private Organisation and any person receiving aid and assistance for the purpose of providing preventive, treatment and care to persons living with HIV, widows, widowers or orphans shall ensure that the aid and assistance so received is used for that purpose.

(2) Any person who misuses any aid or assistance aimed at providing services to persons living with HIV, widows, widowers or orphans, commits an offence and shall be liable on conviction

(a) in case of an individual, to imprisonment for a term of not less than three years;

(b) in case of a body corporate, to a fine of not less than five million shillings and deregistration from the Register of NGOs, CBOs or FBOs, as the case may be.

PART IX – Establishment of a research committee**36. National HIV and AIDS Research Fellowship Committee**

(1) There shall be established a Committee to be known as the National HIV and AIDS Research Fellowship Committee.

(2) The Committee shall comprise of the following members

- (a) the Chairman;
- (b) one member from the National AIDS Control Programme;
- (c) one member from TACAIDS;
- (d) one member representing higher learning institutions;
- (e) one member representing the Attorney General;
- (f) one member representing private AIDS research bodies;
- (g) one member from NIMR
- (h) one member from COSTECH; and
- (i) one member from Muhimbili National Hospital

(3) All members referred to under subsection 2 shall be appointed by the Minister.

(4) The Director for Preventive Services in the Ministry shall be the Secretary to the Committee.

(5) The tenure of office, meetings and other procedural matters of the Committee shall be as set out in the Schedule to this Act.

37. Functions of the committee

(1) The Committee shall be responsible for

- (a) evaluating all proposals submitted for funding within the HIV and AIDS Research Fellowship Programme in respect to scientific quality, appropriateness as to priority areas of research and funding levels requested;
- (b) establishing the criteria for evaluating and funding the submitted proposals;
- (c) awarding best research proposals fellowships of at least ten million Tanzanian shillings and a maximum of fifty million Tanzanian shillings; and
- (d) advertising the fellowship programmes on an annual basis.

(2) The functions, activities and other expenses of the Committee shall be funded by the Ministry.

38. Ethics clearance

(1) All proposals seeking funding support from the Committee shall be required to submit evidence of having obtained ethical clearance of their proposals from the National Research Ethics Committee of the NIMR, COSTECH or other research ethics bodies established under any written laws.

(2) All research on HIV and AIDS involving local and multinational researchers shall require approval by the National HIV and AIDS Research Fellowship Committee.

39. Research by international teams

For the purpose of research conducted under this part every international research team shall include a national counterpart who shall be responsible for that study in Tanzania.

40. Research monitoring

(1) The Committee shall establish a mechanism for monitoring researches funded by the Committee by requiring a quarterly or six monthly report from persons awarded fellowships.

(2) After a research fellowship project has been completed, the research fellow shall be required to submit the final report of activities and budgeted expenditure to the Committee and copies of all publications originating from the funded project to NACP, TACAIDS and NIMR.

41. Vaccine trials and research on people

(1) The Ministry in collaboration with the relevant institutions may institute trials on HIV and AIDS vaccines, medicines and other related bio-products within the country, provided that such trials shall not endanger the health of persons undergoing such trials.

(2) A person shall not undertake HIV and AIDS related bio-medical research on another person or on any tissue of blood removed from such a person unless

- (a) there is informed consent of that other person; or
- (b) where that other person is a child, there is informed consent of a parent or legal guardian of the child.

(3) For the purpose of subsection 2, a person whose consent is sought to be obtained, shall be adequately informed of the aims, methods, anticipated benefits and potential hazards and discomforts of the research.

(4) The person who is the subject of the research shall be adequately provided with research incentives as far as ethical regulations are concerned.

42. Dissemination of research finding

(1) The public and private institutions shall maintain inventory of all ongoing and completed research projects on HIV and AIDS and TACAIDS shall compile and disseminate relevant research findings to the public.

(2) For the purpose of facilitating dissemination of research findings under this part, researchers shall translate or cause to be translated research findings into Kiswahili and English for public consumption.

PART X – Monitoring and evaluation

43. Monitoring

The Ministry shall establish a comprehensive system of monitoring mechanisms to determine the magnitude and progression of HIV infections and other matters relating to HIV and AIDS.

44. Reporting by health care facility

Every owner, manager or the person in charge of a health care facility shall adopt measures issued by the Ministry to ensure the reporting and confidentiality of any medical records and personal data relating to HIV and AIDS including all information which may be accessed from various data.

45. Diagnoses and reporting

(1) Every institution, hospital, laboratory, clinic and blood bank in the Regions and Districts shall be required to diagnose and report HIV and AIDS cases to the Ministry.

(2) The information referred to under subsection 1 shall be submitted to TACAIDS for inclusion in the HIV and AIDS Monitoring and Evaluation Framework.

PART XI – Offences and penalties

46. Offences relating to breach of confidentiality

(1) Any health practitioner or any person referred to under section 16 and 17 who

- (a) breaches medical confidentiality; or
- (b) unlawfully discloses information regarding HIV and AIDS status of any person, commits an offence, and on conviction shall be liable to a fine of not less than five hundred thousand shillings or to imprisonment for a term of not less than six months or to both.

47. Offences relating to spreading HIV

Any person who wilfully and intentionally transmits HIV to another person commits an offence, and upon conviction shall be liable to life imprisonment.

48. Offences relating to breach of safe practices HIV

Any person who wilfully breaches any provision relating to safe procedures and practices, commits an offence, and on conviction shall be liable to

- (a) in case of an individual, to a fine of not less than two hundred thousand shillings or to imprisonment for a term of not less than three months or both.
- (b) in the case of a health care facility, to a fine of not less than three million shillings.

49. Penalty for offence relating to obstruction

(1) It shall be an offence for any person to obstruct or prevent any activity related to implementation of provisions of this Act in any manner whatsoever.

(2) Any person convicted of an offence under this section, shall be liable to a fine not less than one hundred thousand shillings or to imprisonment for a term not exceeding three months or both.

50. General penalty

Any person, who commits any offence against the provisions of this Act shall be liable on conviction for every such offence except wherein any other section a specific penalty is provided to a fine of not less than two hundred thousand shillings or to imprisonment for a term not less than three months or to both such imprisonment and fine.

PART XII – Miscellaneous provisions

51. Complaints

(1) Any complaint against contravention of any provision of this Act may be lodged in writing to

- (a) the Secretary to the village, ward, district or urban AIDS Committees as the case may be;
- (b) the police station;
- (c) the owner, manager or person in charge of a health care facility concerned; or
- (d) the employer.

(2) Every complainant shall be required to give all necessary information relating to the complainant in question.

(3) The Minister may make regulations prescribing the mode of lodging complaints under this Act.

52. Regulations

The Minister may make regulations prescribing

- (a) circumstances under which a compulsory HIV testing may be conducted;
- (b) methods, programs, and coordination of distribution and use of ARVs;
- (c) the manner under which professional counselling shall be undertaken;
- (d) the conduct of HIV tests, informing of the results of HIV tests, reporting of HIV tests results and any other matter necessary or convenient in relation to HIV tests;

- (e) the preparation, maintenance and release of data relating to transmission, status of, and persons living with HIV and AIDS;
- (f) parenteral exposure (sharp instruments), syringes and other material used in blood testing and the manner of disposing them;
- (g) precautions to be taken by health practitioners against HIV transmission during surgical, dental, delivery services and any other similar procedures;
- (h) provisions of post exposure prophylaxis at all levels of health care services and necessary tools such as gloves, goggles and gowns to all health practitioners;
- (i) the manner of handling and disposing of body fluids and wastes of persons known or believed to have been infected with HIV;
- (j) manner in which vaccines and other trials are to be conducted;
- (k) circumstances under which a person may be regarded to make misleading statement to the public regarding the persons living with HIV, orphans and their families;
- (l) circumstances under which a person may be regarded to stigmatise and discriminate a person living with HIV, orphans and their families; and
- (m) anything which may be provided for the better carrying out of the objectives and purposes of this Act.

53. Prohibition of compulsion

Notwithstanding any provisions of this Act, no religious organisation or group shall be compelled in any manner to do or not to do anything which is against the belief of that organisation or group so long as such doing or, forbearance to do, does not contravene any provision of any written law.

54. Amendments of schedules

The Minister may, by order published in the *Gazette*, amend, vary or replace the Schedule to this Act.

...

Uganda: Human Immunodeficiency Virus Control Bill (2007)

The full title is of the Bill is 'A Bill for an Act to provide for the testing and controlling of Human Immunodeficiency Virus, the counselling of persons infected or living with Acquired Immunodeficiency Syndrome and for other related matters'. The Bill outlines the duty to protect oneself and others from HIV. It also deals with a spouse's right to refuse sexual intercourse on reasonable fear of HIV transmission and sets conditions for widow inheritance.

PART I – Preliminary

1. Objective

The objective of the Act is to provide for testing and counselling services to persons infected or living with Acquired Immunodeficiency syndrome.

2. Interpretation

In this Act, unless the context otherwise requires

“AIDS” means the medical condition known as the Acquired Immunodeficiency Syndrome, caused by the infected of an individual by the human immunodeficiency virus;

“Commission” means the Uganda AIDS Commission established under section;

“HIV” means the Human Immunodeficiency Virus the pathogenic organism responsible for AIDS.

“discordant” means a situation where one of the spouse is HIV positive and the other spouse is HIV negative in unsafe sexual relationship;

“medical practitioner” means a person registered and the Medical and Dental Practitioners Act (cap 272) to practice medicine, surgery or dentistry;

“other qualified officer” includes an allied health professional registered under the Allied Health Professionals Act (cap 268), nurse or midwife registered or enrolled under the Nurses and Midwives Act (cap 274) and a health work recognised by the laws of Uganda and the Ministry responsible for health.

“informed consent” means acceptance to take an HIV test after pre-test counselling, which acceptance is given freely without threat, coercion, duress, fraudulent means, representation or undue influence.

PART II – Prevention and control of AIDS

3. Duty to protect oneself and others from AIDS

Every person in Uganda has a duty to

- (a) contribute to the well-being of the community where he lives by promoting and encouraging an HIV/AIDS free community;
- (b) promote responsible parenthood which protects children from HIV infection;
- (c) protect oneself and others from being infected with HIV; and
- (d) assist and do everything possible to make a person having HIV cope with that situation.

4. Acts resulting into infection of another person an offence

A person who, directly or indirectly, omits to do or does any act which he knows or has reason to know or believe that it will result into the infection of another person with HIV commits an offence and is liable on conviction to a fine not exceeding twenty four currency points or to imprisonment not exceeding one year.

5. Denying sexual intercourse

A spouse may, where the other spouse refuses or is negligent to take precautions against HIV infection, deny that other spouse the right to sexual intercourse on reasonable fear that engaging in sexual intercourse is likely to infect the denying spouse with AIDS.

6. Sexual intercourse without consent

Where a person has sexual intercourse without the consent of the other spouse, and there is reasonable suspicion that the forcing spouse might be infected with HIV, the act shall create both a criminal and civil liability and in the case of

- (a) a criminal offence, the person who commits the offence is liable on conviction, to a fine not exceeding twenty four currency points or to imprisonment to a term not exceeding one year or to both.
- (b) a civil wrong, the complainant shall be entitled to a restriction order, suspension of conjugal rights or compensation as the court may determine.

7. Neglect of responsibility

A person legally responsible for the maintenance of a child, relative or other person shall be responsible for the welfare and for organising the treatment of that child or person if that child or person is infected with HIV and any person who neglects or refuses to carry out that responsibility commits an offence.

8. Widow inheritance and welfare of children

(1) No person shall inherit a widow or accept to be inherited as a widow under any customs, traditions or practices of the community before undertaking an HIV test of the parties involved.

(2) Where one of the parties taking a test under subsection 1 is found to be HIV positive, widow inheritance shall be effected only to the extent of responsibilities and no conjugal rights shall be attached to the inheritance.

(3) Whatever the results of the testing of the parties under this section, the welfare and support of the children and the widow shall be the responsibility of the person to whom the customs, traditions and practices of widow inheritance entrust them.

PART III – Testing for HIV

9. HIV testing services

- (1) Any public or privately owned hospital, clinic, maternity centre or health centre providing common health conditions, ante-natal care, family planning service or special or general treatment to patients shall offer HIV testing services to patients.
- (2) The identity of a person tested under subsection 1 shall be maintained only at the place where the sample for testing is drawn and shall not be disclosed or released to any person except in accordance with the law and medical standards of disclosing or releasing personal medical information.
- (3) The performance of a test shall be carried on by a medical practitioner, or other qualified officer

10. Voluntary HIV testing

- (1) A person may take a voluntary HIV test and the test results may be identified with that person if he gives his or her informed consent after discussion of the implications of the test with a medical practitioner or other qualified person during pre-test counselling.
- (2) A child or a person incapable of giving informed consent may be tested for HIV and the test results may be identified with that child or person, if his or her parent, guardian, caretaker or agent gives informed consent after discussion of the implications of the test with a medical practitioner or other qualified person during pre-test counselling.
- (3) The informed consent shall be in the form specified in form A of the Schedule to this Act.

11. Identified test results without consent

- (1) A medical practitioner or other qualified person may draw blood and secure identified test result for HIV/AIDS where
 - (a) the person to be tested is a child and has no parent, guardian or caretaker and the test is required for purposes of giving treatment to the child;
 - (b) the person to be tested is a child who appears to be symptomatic for HIV/AIDS and the parent, guardian or caretaker refuses to give the consent;
 - (c) the blood or bodily fluids of the person to be tested gets into dangerous contact with or exposure to another person in the course of that other person's employment or charitable action and the person to be tested refuses to give voluntary consent;
 - (d) in an emergency due to grave medical or psychiatric condition, it is not possible to obtain consent from the person to be tested or his or her parent, guardian, caretaker or agent;
- (2) No test shall be conducted under paragraph 1(c) unless the complainant has submitted an incident report to a medical practitioner within forty eight hours of the contact or exposure, identifying the person and stating the time, place and nature of the event leading to the contact or exposure and has submitted to HIV test within seventy two hours of the incident and tested negative.

12. Compulsory HIV test

- (1) The following persons shall be subjected to a compulsory HIV test
 - (a) a person convicted of drug abuse or being in possession of hypodermic instrument associated with drug abuse;
 - (b) a person convicted of sexual offence;
 - (c) a person convicted of an offence involving lewdness prostitution; and
 - (d) a pregnant woman during the first antenatal clinic visit or soon thereafter.
- (2) A person tested under this section shall be informed of the results of the test after discussion of the implications of the test with a medical practitioner or other qualified person.

13. Confidentiality of test results and counselling information

A medical practitioner or other qualified person who performs counselling or HIV test shall ensure that all information gathered

from the text or counselling of a person is kept confidential and the testing and counselling shall be conducted in an area where privacy and confidentiality are assured.

14. Report of test results

- (1) A medical practitioner and other qualified person who performs HIV tests shall report the test results to the tested person's medical practitioner or other qualified person who requested for the test.
- (2) The medical practitioner or other qualified person may enter HIV test results forwarded to him or her in the medical record of the patient as would be the case with any other diagnostic test.
- (3) The medical practitioner or qualified person to who a report is made under subsection 1 may notify the results of the test to
 - (a) Other health professional directly involved in the treatment and care of the person tested or to whom the person is referred for treatment;
 - (b) The parent, guardian, caretaker or agent of the child or person tested;
 - (c) Any third party with whom an HIV infected person is in close and continuous contact including but not limited to a spouse, if the nature of contact, in the opinion of the medical practitioner, poses a clear and present danger of HIV transmission to the third party, subject to subsection 4;
 - (d) Any person exposed to blood or body fluid of a person tested under paragraph 1(c) of section 5;
 - (e) The relevant court that requested for a test in case of a convicted person;
 - (f) The AIDS Commission.
- (4) No notice of results shall be given under paragraph 3(c) unless the medical practitioner or other qualified person has reason to believe that the person tested has not and will not inform the third party of the results of the test, in spite of the very strong encouragement from the medical practitioner or other qualified person.

15. Person tested to be notified on disclosure

The medical practitioner or other qualified person giving the results of HIV test to any person shall, except in the case of other professionals involved in the treatment or care of the person tested, inform the person tested of the disclosure giving

- (a) the nature and purpose of disclosure;
- (b) date of disclosure; and
- (c) the recipient of the information.

16. Organ, tissue, sperm or part of the body to be identified with test results

- (1) Any person donating any organ, tissue, sperm or part of his or her body for the treatment of another person or insemination of sperm shall provide blood for HIV testing and the results of the test shall be identified with the organ, tissue, sperm or part of the body donated.
- (2) Where the person donating an organ, tissue, sperm or part of a body provides proof of prior testing to the satisfaction of the relevant medical practitioner, the donor may not provide blood under subsection 1.

17. Efficiency to be ensured

A person who performs or is otherwise involved in the performance of an HIV test shall take all reasonable measures within his or her control to ensure that

- (a) the testing process is carried out promptly and efficiently; and
- (b) the results of the test are communicated promptly to the tested person, medical practitioner or other qualified person who requested for the test.

PART IV – Prevention of mother to child transmission

18. Testing as a prevention of mother to child transmission

(1) All pregnant women who are not confirmed to be living with HIV shall be tested under section 11 to determine their HIV status.

(2) A pregnant woman who tests HIV negative in the first test shall take a second or subsequent test after three months from the date of the first test.

(3) A pregnant woman who is HIV positive shall be entitled to safe and appropriate ARV regimens and routine medication to prevent transmission of HIV to the child.

19. Counselling of spouse of pregnant woman

A spouse of a pregnant woman tested for HIV under section 18 shall be entitled to pre-test counselling to help him take a decision on HIV testing.

20. Testing of the new born child

Every child born to a mother living with HIV shall, between ten and fourteen weeks of age, be tested for HIV and where necessary shall be given follow-up treatment, care and support.

PART V – Pre-test and post-test counselling

21. Professional counsellors

There shall be professional HIV/AIDS counsellors who shall be

- (a) qualified medical practitioners; or
- (b) persons who have completed an HIV counselling training programme approved by the AIDS Commission.

22. Persons entitled to counselling

Any person to be tested for HIV/AIDS under this Act is entitled to pre-test and post-test counselling.

23. Pre-test counselling

A professional counsellor shall give a person to be tested for HIV/AIDS pre-test counselling which shall include

- (a) information pertaining to the nature of HIV infection
- (b) the desirability of having an HIV test,
- (c) an explanation of the informed consent form,
- (d) client-centred information tailored to the behaviour, circumstances and special needs of the person to be tested,
- (e) personalised risk assessment,
- (f) possible results and how to handle the situation to reduce transmission,
- (g) such other relevant information as the counsellor may deem necessary.

24. Post-test counselling

(1) A professional counsellor shall give post-test counselling to a person getting negative HIV test results which shall include

- (a) the test results and the implication;
- (b) importance of further testing for persons with a high risk of infection;
- (c) continuing necessity of taking protective measures to avoid contracting AIDS.

(2) A professional counsellor shall give spot-test counselling to a person getting positive HIV test results which shall include

- (a) test results and the implication;
- (b) the infectious nature and types of the disease and measures to prevent transmission;
- (c) referral to medical and social services;
- (d) the importance of notifying his or her partner and other persons in close and continuous contact posing danger of infection;
- (e) continuing necessity of taking protective measures to avoid contracting other types of infection;
- (f) such other information as the counsellor may deem necessary.

25. Ongoing counselling

Any public or privately owned hospital, clinic or health centre providing common health conditions or special or general treatment to patients shall, after the post-test counselling, offer ongoing counselling sessions to a person whose test results are HIV positive to enable the person to effectively cope with the situation.

PART VI – Intentional creation of risk to others

26. Reasonable care to be taken

A person who is aware that he is infected with HIV shall take reasonable care to protect others from infection and as such shall

- (a) at all times, take reasonable measures and precautions to prevent the transmission of HIV to others;
- (b) use a condom or other reliable protective measures to protect his or her partners from infection with HIV during sexual intercourse;
- (c) inform any intended sexual partner or any person with whom a skin penetrative instrument is to be used, in advance of the sexual intercourse or sharing of the skin penetrative instrument, that he is infected with HIV.

27. Intentional transmission of HIV

(1) A person who intentionally transmits or attempts to transmit HIV to another person commits an offence of intentional transmission of HIV and shall be liable on conviction to two years imprisonment or to a fine not exceeding fifty currency points or to both.

(2) No person shall be convicted of an offence under subsection 1 if

- (a) the person alleged to have committed the offence was not aware of being infected with HIV at the time of committing the act which is the result of the complaint;
- (b) the other person was aware of the HIV status of the accused and the risk of infection and he voluntarily accepted the risk;
- (c) the alleged transmission or attempted transmission was through sexual intercourse and a condom or other reliable protective measure was used during penetration;
- (d) the other person was already infected with HIV at the time of the alleged transmission or attempted transmission.

28. Reckless behaviour causing risk of infection to others

(1) Where it is reasonably believed that a person

- (a) who is aware of being infected with HIV is behaving in such a way as to expose others to a significant risk of infection; and
- (b) is likely to continue that risky behaviour; and
- (c) has been counselled without success in achieving appropriate behaviour change; and
- (d) presents a real danger of infection to others, the chairperson of a local court may issue a written notice to that person.

(2) A notice under subsection 1 shall state

- (a) grounds upon which it is believed that the notice should be issued;
- (b) the nature of the risky behaviour of the person;
- (c) an order or direction to stop the behaviour;
- (d) any other order or direction to the person considered necessary to ensure change of behaviour; and
- (e) that breach of any order or direction shall be an offence.

(3) An offence committed under subsection 2(e) shall be deemed to be intentional transmission of HIV and the provisions of section 27 shall apply.

29. Exemption to creation of risk

The provisions in this Part shall not apply to any transmission of HIV by a mother to her child before, during or after the birth of the child.

PART VII – Discrimination of persons with HIV

30. Discrimination against persons with HIV

(1) A person, agency or organisation shall not discriminate against a person on the basis of positive HIV results or perception of a positive test in housing employment granting of credit public accommodation or in deliver of service.

(2) An HIV test shall not be required as a condition of employment by any person or body except where it is declared in writing by a medical practitioner, that the nature at the employment constitutes a danger to that person or a clear and great danger of transmission at HIV to other employees.

31. Exemption of insurance

(1) Any insurance company offering life insurance policy may require a person to be tested for HIV for purposes of determining the insurance premium.

(2) Any requirement for a test under subsection 1 shall be in writing and no testing shall be effected without the informed consent of the person or in case of a child, the informed consent of his or her parent, guardian or caretaker.

(3) Nothing in this section shall be construed to permit an insurance company to cancel or refuse to renew a life insurance policy that by its terms has not lapsed on the basis of a positive HIV test result.

PART VIII – Miscellaneous provisions

32. Information on counselling and reports confidential

(1) All information and reports pertaining to HIV counselling, testing and reporting under this Act shall be confidential and save as is provided under subsection 3 of section 7, shall not be disclosed to a third party without the written consent of the person to who the information or report relates.

(2) Any person who releases any information or report contrary to subsection 1 commits an offence and shall be liable on conviction to a fine not exceeding ... or to a term of imprisonment not exceeding two years or to both the fine and imprisonment.

33. Acquired information not to be disclosed

Any person who acquires any information in the course of his or her duty, that another person

- (a) is presumed to be HIV positive or has AIDS;
- (b) has been, is being or has refused to be tested; or
- (c) is related to or associated with, a person who is presumed to be HIV infected or who has AIDS;

shall take all reasonable steps to prevent disclosure of such information to any person who is not required to get that information.

34. Court or tribunal proceedings

Where in any proceedings before court or tribunal, it appears that the HIV status of any person may come into consideration, the court or tribunal may order that

- (a) the public or any particular person be excluded from the proceedings or any part of the proceedings;
- (b) only persons specified by the court or tribunal be present in the proceedings or any part of the proceedings; or
- (c) the publication of the proceedings, decision or report of the court or tribunal or any part thereof be prohibited.

35. Free counselling and testing centres

The Uganda AIDS commission may establish free HIV testing and counselling centres in all regions of Uganda as it may deem fit.

36. Laboratory analysis

(1) Any medical practitioner or other qualified officer who takes biological samples of specimens from persons in discordant relationships or from persons who tests positive initially and later

tests negative shall forward a sample to the Ministry of Health Laboratory through the Uganda AIDS Commission for analysis.

(2) The samples and specimens forwarded to the Ministry of Health laboratory shall not include names identified with them or any other information which would identify the person tested.

37. Regulations

The Uganda AIDS Commission may, in consultation with the Minister responsible for health, make regulations generally for the better carrying out of the provisions of this Act.

...

D2.2 Equality and non-discrimination

Angola: Law 8/04 on HIV and AIDS (2004)

See full text above under 'HIV specific laws', in particular section 5.

Burundi: Law 1/018 of 12 May 2005 on the legal protection of people infected with HIV and of people suffering from AIDS (2005)

See full text above under 'HIV specific laws', in particular articles 3, 22, 23, and 38.

Kenya: HIV and AIDS Prevention and Control Act 14 of 2006

See full text above under 'HIV specific laws', in particular sections 31 to 38.

Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)

See full text above under 'HIV specific laws', in particular articles 1, 2, 17, 28 to 34, 44 to 55 and 64.

Mauritius: HIV and AIDS Act 31 of 2006

See full text above under 'HIV specific laws', in particular section 3.

South Africa: Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

Enacted on 9 February 2000 and assented to by the President on 2 February 2002. It is intended to practically implement and enhance the effects of the equality clause of South Africa's Constitution. It provides specific directive principles on HIV/AIDS.

Excerpts

...

CHAPTER 1 – Definitions, objects, interpretation, guiding principles and application of Act

...

5. Application of Act

...

(3) This Act does not apply to any person to whom and to the extent to which the Employment Equity Act, 1998 (Act No 55 of 1998) applies.

CHAPTER 2 – Prevention, prohibition and elimination of unfair discrimination, hate speech and harassment

6. Prevention and general prohibition of unfair discrimination
Neither the State nor any person may unfairly discriminate against any person.

...

9. Prohibition of unfair discrimination on ground of disability
Subject to section 6, no person may unfairly discriminate against any person on the ground of disability, including

- (a) denying or removing from any person who has a disability, any supporting or enabling facility necessary for their functioning in society;
- (b) contravening the code of practice or regulations of the South African Bureau of Standards that govern environmental accessibility;
- (c) failing to eliminate obstacles that unfairly limit or restrict persons with disabilities from enjoying equal opportunities or failing to take steps to reasonably accommodate the needs of such persons.

CHAPTER 7 – Review of Act, short title and commencement

...

34. Directive principle on HIV/AIDS, nationality, socio-economic status and family responsibility and status

(1) In view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV status, socio-economic status, nationality, family responsibility and family status

(a) special consideration must be given to the inclusion of these grounds in paragraph a of the definition of “prohibited grounds” by the Minister

(b) the Equality Review Committee must, within one year, investigate and make the necessary recommendations to the Minister.

(2) Nothing in this section

(a) affects the ordinary jurisdiction of the courts to determine disputes that maybe resolved by the application of law on these grounds;

(b) prevents a complainant from instituting proceedings on any of these grounds in a court of law;

(c) prevents a court from making a determination that any of these grounds are grounds in terms of paragraph b of the definition of “prohibited grounds” or are included within one or more of the grounds listed in paragraph a of the definition of “prohibited grounds”.

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

Regulations on HIV/AIDS, employment and professional training

See full text above under ‘HIV specific laws’, in particular sections 28 to 32.

Uganda: Human Immunodeficiency Virus Control Bill (2007)

See full text above under ‘HIV specific laws’, in particular sections 30 and 31.

D2.3 Employment

Angola: Law no 8/04 on HIV and AIDS (2004)

See full text under ‘HIV specific laws’, in particular sections 7 to 11.

Angola: Regulations on HIV/AIDS, Employment, and Professional Training (Decree 43/03 of 4 July) (2003)

Adopted on 4 July 2003 and promulgated by the President of Angola on 20 April 2003. Its full name in Portuguese is *Regulamento sobre o HIV/SIDA, Emprego e Formação Profissional (Decreto nº43/03 de 4 Julho)*. Among other things, it expressly prohibits HIV testing in employment.

The infection by the Human Immunodeficiency Virus (HIV) and the development of the Acquired Immunodeficiency Syndrome (AIDS) constitute, in actual fact, one of the major health problems that society faces in respect of implementing legally protected social rights, namely the right to work, employment and professional training.

For this reason, we recognise the need to create regulation on HIV/AIDS, employment and professional training, in line with the recommendations by UNAIDS which establishes, defines and regulates the ways, the methods and behaviour to protect the employees, that must be observed by the employers in the workplace, by the centres of professional training, based on the respect for fundamental human rights and international decrees, namely, in ethical norms of health in the workplace, in professional training and in adoption of practices and attitudes of solidarity and respect towards the affected individuals.

In terms of the arrangements agreed to in section 112(d) and section 113, both sections from the Constitution, the government decrees the following

...

CHAPTER 1 – General considerations

Section 1: Purpose

The present regulation establishes compulsory rules for employers, employment professionals, and training institutes regarding the mechanisms for the protection of HIV positive citizens and those affected by HIV/AIDS in the workplace and professional training, as well as the promotion of preventive measures against the spread and dissemination of HIV/AIDS.

Section 2: Scope

The present regulation applies to State organs and institutions, central and local administration, public companies, mixed and private national, as well as foreign companies, cooperatives and also institutions of employment and professional training, irrespective of its size.

Section 3: Implementation

1. The implementation of the present regulation is secured by the organs of state that supersede public administration sectors and employment as well as public health.
2. It is specially the duty of the services linked to public health, in particular the *Programa Nacional De Luta Contra a SIDA* (National Programme for the Fight against AIDS), and the services of the General Inspection of Work and Employment and Professional Training to create the necessary activities to promote the present regulation.
3. Through the appropriate mechanisms cooperation and participation of social partners and organisations interested in the implementation of approved programmes, can be established.

Section 4: Definitions

The definitions which afford a better understanding of this regulation are attached to this document and form an integral part thereof.

CHAPTER 2 – Education, sensitisation and prevention

Section 5: Programmes

1. The entities referred to in section 3(1), in collaboration with the syndicate associations and respective employers must establish education and sensitisation programmes about HIV/AIDS incorporated to affect relatives close to the employees and trainees.
2. In the implementation of the above the following must be present
 - (a) prevention through education, information, sensitising of sexually transmitted diseases (STD) and HIV/AIDS.
 - (b) promotion, distribution of condoms and counselling.

CHAPTER 3 – Access to employment and professional training

Section 6: Access and control

1. It is not permitted under any circumstances to conduct an HIV test as a pre-requisite for admission for employment, neither is the forced control of HIV/AIDS in the workplace, unless at the request of the candidate or employee, expect for those cases where it is legally required.
2. Voluntary control of HIV/AIDS at the request of the employee must be conducted by properly qualified entities and credentialed by the national health services.

Section 7: Confidentiality

1. The employees, applicants, HIV/AIDS carriers are not obliged to disclose their status to the employers and those responsible for the institutions for employment and professional training or their representatives, except for those cases where it is legally required.
2. The information regarding the health status of the employee or trainees in relation to HIV/AIDS cannot be revealed without their consent, except in those cases where it is legally required.

CHAPTER 4 – Labour and training situation

Section 8: Labour and training situation

1. HIV status may not be a factor to take into account in decisions related to the dismissal and the promotion of employees or trainees; depending on their situation or professional training it shall be based on equal opportunity as defined by law to exercise a job or certain level of professional training.
2. The transfer of a HIV positive person from one position to another or from one centre of professional training to another shall be based on the need to best accommodate his or her physical condition based on his or her health status.
3. HIV status may not be a factor when considering professional training, techno-professional surpassing and qualifying of the citizen.
4. The employees and trainees infected with HIV shall maintain the labour or training tie for as long as they show that they are apt to carry the conditions embodied in the contract.
5. In the event of the clinical status aggravating and it being necessary to suspend the contract, the employers may not alter the remuneration terms for as long as there is still a tie with the institution, company or centre for professional training, and may only alter the rendering of services when death is imminent and duly attested to by competent medical entity.

Section 9: Security and health at the workplace

1. The employees and trainees infected with HIV/AIDS have the right to access to medical treatment without discrimination, on the terms and conditions established by the law relating to licenses for diseases.
2. Whenever medical conditions do not allow employees and trainees to continue exercising their normal activities or from progressing in their professional training, they must be offered alternative work or training, without jeopardising the benefits that flow from the contract.

Section 10: Social security

An HIV positive employee shall benefit from the same socio-economic rights guaranteed in the general laws for employees infected with tuberculosis, leprosy, stomach infections, cancer and severe mental illnesses.

Section 11: Professional benefits

1. The institutions for professional training and the associations that are willing must ensure that the employment benefits to the infected employees and trainees are not prejudiced, by giving them the necessary assistance.
2. The medical projects from companies and public institutions must not be discriminatory in relation to HIV/AIDS and must promote legal benefits to all employees and trainees irrespective of their clinical status.

Section 12: Counselling

Employers in collaboration with syndicate associations shall create methods of counselling that allow every employee to be aware of their rights, guarantees and other benefits, such as, medical assistance, life insurance and the many forms of social security.

CHAPTER 5 – Protection and guarantees

Section 13: Professional risks

Employers shall take preventive measures that promote the reduction of the risk of infection with HIV in the course of employment and provide the necessary information regarding the danger that results from negligence or failure to comply with the norms for the prevention of HIV/AIDS.

Section 14: Compensation

1. The employees infected with HIV during the course of their employment or during their professional training have the right to compensation or reparation in terms of the law.

2. Whenever it becomes inevitably necessary to transfer employees or trainees infected with HIV or suffering from AIDS, the employer has the duty to facilitate the process of relocating them with their families and persons under their care.

3. The employer shall secure the means of minimising the risk of infection, including access to information and condoms for employees whose occupation requires frequent travelling.

Section 15: Protection against *iniuria*

1. The HIV positive employee must be protected against stigmatisation and discrimination from work colleagues, employers or customers.

2. Stigmatisation and discrimination of employees infected with HIV or suffering from AIDS, constitutes a severe violation of the duty to respect established in sections 43 and 46 of the *Lei Geral do Trabalho* (General Labour Law).

3. The employers and institutions for professional training shall, in terms of the law, institute disciplinary sanctions on the perpetrators of the conducts referred to above.

Section 16: Violations

1. A violation of the present regulation by the employers and the representatives of the institutions for professional training is punishable by a fine from two to five times the minimum monthly salary offered by the company.

2. In cases where *dolus*, coercion or other fraudulent means are present, the fine may be aggravated up to 10 times the fine provided above without affecting the criminal proceedings.

Section 17: Application of the fines

1. The supervision, control and application of fines in terms of the present regulation are the responsibility of the *Inspecção Geral do Trabalho* (General Labour Inspection).

2. The funds produced from the fines for the transgression of the norms established by the present regulation will serve to aid HIV/AIDS policy coordinated by the Extended Programme for the Fight Against AIDS, which shall be distributed in the following proportions:

- (a) 50 per cent to the Central Government budget (aimed at *Programa Nacional de Luta contra SIDA*);
- (b) 20 per cent to the Health sector;
- (c) 20 per cent to Social Security;
- (d) 10 per cent to the General Labour Inspection.

Annexure

To which section 4 of the preceding regulation refers to (Definitions)

1. Regulation on HIV/AIDS, employment and professional training: a combination of norms relating to the protection of HIV-positive citizens in the workplace or professional training, health education directed at HIV-positive individuals with the objective of informing them about sexual practices aimed at reducing the risk of spreading HIV/AIDS in society.

2. Employment: the abstract social status conferred upon a national or foreign citizen for his or her professional activity to productive work and remuneration by another in public or private institutions linked to economic and social development.

3. Professional Training: the process through which youths and adults acquire and develop knowledge and general and specific professional skills, attitudes and practices directly linked to the exercise of a profession, which complements scholarly education in the field of permanent education and is aimed at integrating the individual in useful social life.

4. STD: sexually transmitted diseases.

5. Employee: any resident national or foreign individual person who voluntarily offers his or her professional activity to the service of an employer under his organisation or direction in return for remuneration.

6. Intern: any resident national or foreign individual person who is voluntarily obligatorily tied to a process of internship in a company, organ or institution for professional training.

7. Learner: every national or foreign citizen of active age who is legally tied to a process of methodical professional training, who has the goal of securing or developing their individual or collective ability and acquiring the necessary skills for the execution of a qualified profession, after having been conferred a grade of scholar equivalence which entails:

(a) Specific technical professional training which is observed by companies and institutions for employment and professional training recognised by the *Instituto Nacional de Emprego e Formação Profissional* (INEFOP).

(b) General training observed by official businesses belonging to companies or other public and private institutions.

8. Trainee: every national or foreign citizen of active age who is legally tied to a process of acquiring knowledge and general and specific professional skills which are directly linked to the exercise of a profession and aimed at best socially integrating the individual.

9. Workplace: the place where the employee regularly and permanently works.

Lesotho: Labour Code (Amendment) Act 5 of 2006

Enacted by the Parliament of Lesotho in 2006. It amends the Labour Code Order of 1992 to make provision for the protection of people living with HIV.

Excerpts

...

Insertion of new part

(1) The Labour Code 1992, (hereinafter referred to as "the principal law"), is amended by inserting the following new Part after section 235.

...

235 B: Information and education to employees on HIV and AIDS

(1) An employer shall

(a) in consultation with his employees or their organisations, design and implement education programmes in accordance with guidelines developed by the minister; and

(b) at his own cost, cause to be provided for the benefit of a person employed by him or her, and at a place and time during normal working hours as he may appoint, provide gender-sensitive education and information relating to

(i) acquisition, transmission and prevention of HIV and AIDS, and related communicable diseases;

(ii) promotion of safe sex and risk reduction measures in relation to sexually transmitted infections;

(iii) testing and counselling facilities for HIV and AIDS;

(iv) care, support and referrals; and

(v) rights of employees affected or infected with HIV and AIDS.

(2) Education and information to be provided in terms of subsection 1 shall be provided by a person who has knowledge, experience and expertise in matters relating to HIV and AIDS.

(3) The provision of education and information referred to in subsection 1 shall be at such intervals as the employer and his employees of their organisations may agree.

(4) An employer who refuses or otherwise fails to comply with the provisions of subsections 1, 2 and 3 commits an offence and is, on conviction, liable to a fine of not less than five thousand Maloti or five months imprisonment.

235 C: Testing

- (1) An employer shall not require a job applicant or an employee to undergo a direct or indirect HIV testing as a condition for employment, access to the employment, applications or training.
- (2) Subsection 1 shall not prevent medical testing of a person for fitness for work.
- (3) An employer who fails to comply with subsections 1 and 2 commits an offence and is, on conviction, liable to a fine not less than five thousand Maloti or five months imprisonment.

235 D: Confidentiality and non-disclosure

- (1) An employer shall not
 - (a) compel an employee or a job applicant to disclose his or her HIV status or that of any other person; or
 - (b) except with the written consent of the employee or job applicant to whom the information relates, disclose information relating to the HIV status of the employee or job applicant acquired by the employer in the course of his duties unless the information is required to be disclosed in terms of any other law.
- (2) An employer who fails to comply with the provisions of this section commits an offence and is, on conviction, liable to a fine of not less than five thousand Maloti or five months imprisonment.

235 E: Discrimination in employment

- (1) An employer shall not discriminate an employee on the basis of his or her HIV status in relation to the following
 - (a) promotion;
 - (b) transfer;
 - (c) training or other employee development programme;
 - (d) job status; and
 - (e) other terms and conditions of employment.
- (2) The positive HIV status of an employee or job applicant shall not in itself constitute lack of fitness to work.
- (3) An employer shall not discriminate a job applicant on the basis of his or her HIV status.
- (4) An employer who discriminates against his employee or job applicant on the ground stated in subsections 1, 2 and 3 commits an unfair labour practice.

235 F: Eligibility for employee benefits

- (1) The HIV status of an employee shall not affect his or her eligibility or that of his or her dependants for any occupational or other benefit schemes provided by the employer for his employees.
- (2) Where eligibility of a person for any occupational or other benefit scheme is conditional upon HIV testing, the conditions attaching to HIV status shall be the same as those applicable in respect of other life-threatening illness.
- (3) Where HIV testing is necessary in terms of subsection 2, the employer shall ensure that the employee undergoes appropriate pre-and post-HIV and AIDS counselling.
- (4) Where an employee undergoes an HIV testing or the purpose of subsection 2, the employer shall not be entitled to information concerning the HIV status of the concerned employee, unless the occupational or other benefit scheme concerned is operated by the employer.
- (5) An employer who fails to comply with the provisions of subsection 1 or 2 above commits an unfair labour practice.
- (6) An employer who fails to comply with the provisions of subsection 3 or 4 commits an offence and shall, on conviction be liable to a fine of not less than five thousand Maloti or five months imprisonment.

235 G: Termination of employment

- (1) An employer shall not terminate the employment of an employee solely on the ground of the employee's HIV status.
- (2) Where the employee becomes too ill as determined by a medical practitioner, to continue in employment, the provisions

of the principal law which deal with incapacity on grounds of ill health, shall apply.

- (3) Any action by the employer which contravenes the provisions of subsection 1, amounts to unfair dismissal

235 H: Risk assessment and management

- (1) Where a person is employed in an occupation or is required to provide services where there may be a risk of transmitting or acquiring HIV, the employer shall provide appropriate training, clear and accurate information and guidelines on minimising the transmission of HIV related communicable diseases.
- (2) The working conditions and procedures in relation to occupations referred to in subsection 1 shall be designed to ensure optimal precautions to prevent transmission of HIV and related communicable diseases to employees and members of the public.
- (3) An employer shall
 - (a) at his own cost and free of charge provide appropriate personal protective clothing to an employee referred to in subsection 1; and
 - (b) periodically review, for safety and efficacy, the use and condition of any equipment, devices, procedures, including first-aid procedures used or guidelines followed, in any occupation referred to in subsection 1.
- (4) An employer who fails to comply with the provisions of this section commits an offence and is, on conviction, liable to a fine of not less than five thousand Maloti or five months imprisonment.

235 I: Protection against victimisation

- (1) An employee shall not victimise or refuse to work with an employee or employer infected or affected or perceived to be infected or affected by HIV and AIDS.
- (2) An employer shall ensure that an employee who fails to comply with subsection 1 is subjected to a disciplinary action.
- (3) An employer who fails to comply with subsection 2 commits an offence and is, on conviction, liable to a fine not less than five thousand Maloti or five months imprisonment.

235 J: Care and support

- (1) An employer shall allow an employee an opportunity to seek medical attention of HIV and AIDS counselling from a service provider of the employee's choice.
- (2) An employer shall, in consultation with the employees or their organisations, determine the procedures to be followed in counselling or medical attendance by the employees.
- (3) Where HIV and AIDS counselling and care services exist at the workplace, the employer shall cause such to be provided for the benefit of the employees, and at such place and time during working hours as the need arises and at such times as may be agreed to by the employer and employees or their organisations.
- (4) Where HIV and AIDS counselling and care services exist at the workplace, the employer shall cause such to be provided for the benefit of the employees and at such place and time during working hours as the need arises and at such times as may be agreed to by the employer and employees or their organisation.
- (5) An employer who fails to comply with the provisions of this section commits an offence and shall, on conviction be liable to a fine of not more than five thousand Maloti or five months imprisonment.

235 K: Workplace HIV and AIDS policy

- (1) An employer shall, within three months of the coming into operation of this Act and in consultation with employees or their organisations develop and implement a workplace policy on HIV and AIDS aimed at
 - (a) prevention of new infections;
 - (b) protection of employees from discrimination and stigmatisation related to HIV and AIDS;
 - (c) provision of care and support for employees who are infected or affected by HIV and AIDS; and

(d) management of the impact of the HIV and AIDS epidemic in the organisation.

(2) An employer shall, periodically for a period not exceeding one year cause to be reviewed, the workplace policy on HIV and AIDS in consultation with his or her employees or their organisation.

(3) An employer who fails to comply with subsections 1 and 2 commits an offence and is, on conviction, liable to a fine of not less than five thousand Maloti or five months imprisonment.

...

Review of arbitration awards

5. The principal law is amended in section 228F by deleting words "Labour Appeal Court" wherever they appear and substituting the words "Labour Court".

Kenya: HIV and AIDS Prevention and Control Act 14 of 2006

See full text above under 'HIV specific laws', in particular sections 7, 13, and 31.

Madagascar: Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)

See full text under 'HIV specific laws', in particular articles 44 to 55.

Mauritius: Labour (Amendment) Act 1 of 2004

Among other things, this piece of legislation, assented to by the President of the Republic on 6 April 2004 and entered into force on 11 April 2004, amends the Labour Act to prohibit workplace harassment based on HIV status.

Excerpts

...

3. Section 2 of principal Act amended

Section 2 of the principal Act is amended by

(a) inserting in their proper alphabetical order, the following new definitions

"bullying" means any form of physical or psychological harassment;

"harassment" means any unwanted conduct, verbal, non-verbal, visual, psychological or physical, based on age, disability, HIV status, domestic circumstances, sex, sexual orientation, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority, birth or other status, that a reasonable person would have foreseen that a worker would be affected negatively in his or her dignity and includes sexual harassment;

...

5. New section 55A added to principal Act

The principal Act is amended by inserting immediately after section 55, the following new section

55A. Workplace violence

(1) Any person who

(a) assaults;

(b) verbally abuses, swears or insults;

(c) expresses the intention to cause harm, including bullying and threatening behaviour against;

(d) uses aggressive gesture indicating intimidation, contempt or disdain;

(e) harasses;

(f) by word or act, hinders, a worker, in the course of or as a result of, his work, shall commit an offence and shall, on conviction, be liable to a fine of not less than 10,000 rupees and not more than 75,000 rupees and to imprisonment for a term not exceeding 2 years.

...

Mauritius: Labour (Amendment) Act 1 of 2004

Mozambique: Law 5 of 2002

This law (in Portuguese, *Lei n°5/2002*) was adopted by the Parliament of Mozambique on 29 November 2001 and approved by the President on 5 February 2002. Among other things, it prohibits pre-employment HIV testing and dismissal based on HIV status. It also requires that employers provide employees with HIV education and advice.

Section 1: Definitions

For the purposes of this Act the following terms have the meaning hereby provided

AIDS (Acquired immunodeficiency syndrome) – group of infections caused by HIV, which attack and destroys certain cells in the body which are essential to the immune system;

HIV (Human Immunodeficiency Virus) – virus which transmits AIDS;

HIV positive person – individual infected by the human immunodeficiency virus – HIV;

Person with AIDS – HIV positive individual with clinical manifestations;

Employee – one who, in exchange for remuneration, is obliged to dedicate his intellectual activity or manual activity to another person, whether collective or singular, public or private, under such person's authority and direction;

Employer – one who employs another, whether in public administration, a public or private entity.

Section 2: Purpose

The present Act establishes the general principles aimed at guaranteeing that all employees and job applications may not be discriminated against in the workplace on the basis of being or suspected to be HIV positive or suffering from AIDS.

Section 3: Scope of application

The present Act applies, without any discrimination, to all employees and job applicants, in public administration and other public or private areas, including domestic workers.

Section 4: Prohibition on testing

It is prohibited to test employees or job applicants for HIV without their consent. It is prohibited to test employees or job applicants for HIV for the purpose of training courses or promotions.

Section 5: Privacy and confidentiality

Employees living with HIV enjoy the right to confidentiality regarding their condition of being HIV positive, in or outside of the workplace. Health care professionals, from the public service

or private sector, are obliged to maintain confidentiality regarding information about employees that are HIV positive.

Section 6: Consent of the employee

No employee may be obliged to inform his or her employer of his or her HIV positive or negative status. The employee may voluntarily request an HIV test, which must be done by a qualified place at an authorised health post.

Section 7: Equal opportunities

Employees shall enjoy worker's rights without any discrimination on any ground. The principle of right to equal opportunities with regard to merit and ability to exercise one's duty shall apply to all employees.

Section 8: Infection at the workplace

An employee who becomes infected with HIV in the workplace, within the course of his or her employment, has the right to guaranteed medical assistance and adequate medication in terms of the Employment Act and other relevant legislation, at the cost of the employer. The employer must guarantee adequate medical assistance approved by the National Health Services and medication available on the national market. Employers whose activities involve laboratory services, medical clinics, health sectors or other shall take necessary protective measures to avoid HIV transmission.

Section 9: Professional orientation

The employer has the duty to train and re-assign every worker infected with HIV or suffering from AIDS who is not capable of fulfilling his or her work duties.

Section 10: Medical assistance and medication

The employer has the duty to maintain medical assistance owed to the employee infected with HIV, according to the policy of psychosocial medical assistance and medication adopted for all employees and in light with the National System of Social Security.

Section 11: Absence and licences

Absence due to illness by an employee infected with HIV is deemed justifiable.

Section 12: Unfair dismissal

Every worker dismissed on the mere ground of his or her HIV positive status is deemed by the Employment Act to have been unfairly dismissed. The employee dismissed in terms of the above subsection is not only entitled to compensation but has to be reinstated.

Section 13: Compensation

Compensation is doubled if an employee is unfairly dismissed. Job applicants, who are not admitted for being HIV positive, are entitled to compensation equivalent to six months salary corresponding to the position applied for.

Section 14: Information service and counseling

Employers in conjunction with competent service providers shall make HIV/AIDS information, prevention and counseling services available at their workplaces.

Section 15: Risk of infection

Employees living with HIV shall abstain from behaviour which might put other employees at risk of contamination.

Section 16: Sanctions

Anyone who violates the provisions of section 4 of the present Act is liable to a fine equivalent to fifty minimum salaries. The fine imposed in the previous subsection is aggravated if it is a second violation or subsequent to this.

Anyone who violates the confidentiality provided for in sections 5 and 11 of this Act is liable to a fine equivalent to fifty minimum salaries, if a more severe penalty is inappropriate.

Anyone who violates subsection 1 of section 6 and the first part of section 11 of the present Act is liable to a fine equivalent to one hundred minimum salaries.

Anyone who violates section 7 of the present Act incurs a fine of one hundred and fifty minimum salaries.

Anyone who violates subsection 3 of section 8 of the present Act incurs a fine of fifty minimum salaries and the compulsory termination of his or her activities until necessary protection and precaution measures are undertaken.

Anyone who violates the subsection in section 15 incurs a fine equivalent to one hundred minimum salaries, if a more severe penalty is inappropriate.

Section 17: Destination of the fines

The following terms are attributed to fines resulting from the application of this Act

60 per cent to the state budget;

40 per cent to the department of information, counselling and fight against HIV/AIDS.

Namibia: Labour Act 15 of 2004

Adopted on 15 November 2004. Among other things, it prohibits HIV discrimination in the workplace.

Excerpts

...

5. Prohibition of discrimination and sexual harassment in employment

(1) For the purposes of this section

(b) "employment practice" includes

...

(i) access to vocational guidance, training and placement services;

(ii) access to employment and to a particular occupation or job, including

(aa) advertising;

(bb) recruitment procedures;

(cc) selection procedures;

(dd) appointments and the appointment process;

(ee) promotion, demotion, and transfer;

(ff) remuneration and other terms and conditions of employment;

(iii) access to and the provision of benefits, facilities and services;

(iv) security of tenure; or

(v) discipline, suspension or termination of employment;

...

(2) A person must not discriminate in any employment practice, directly or indirectly, against any individual on one or more of the following grounds

(a) race, colour, or ethnic origin;

(b) sex, marital status or family responsibilities;

(c) religion, creed or political opinion;

(d) social or economic status;

(e) degree of physical or mental disability;

(f) AIDS or HIV status; or

(g) previous, current or future pregnancy.

...

7. Disputes concerning fundamental rights and protections

- (1) Any party to a dispute may refer the dispute in writing to the Labour Commissioner if the dispute concerns
- (a) a matter within the scope of this Act and Chapter 3 of the Namibian Constitution; or
- (b) the application or interpretation of section 5 or 6.

CHAPTER 3 – Basic conditions of employment

Definitions relating to basic conditions of employment

...

(h) “sick leave cycle”

(i) means the period of 36 consecutive months’ employment with the same employer immediately following

(aa) an employee’s commencement of employment; or

(bb) the completion of the last sick leave cycle; and

(ii) includes any period, or combination of periods, not exceeding a total of 36 weeks, during which an employee is on annual leave, sick leave or any other absence from work on the instructions, or with the permission, of the employer.

...

PART D – Leave

24. Sick and compassionate leave

(1) During any sick leave cycle, an employee is entitled to sick leave as follows

(a) during the employee’s first 12 months of employment, one day’s sick leave for every 26 days worked; and

(b) thereafter

(i) not less than 30 working days, if the employee works not more than five days during a week;

(ii) not less than 36 working days, in the case of any other employee.

(2) Subject to subsection 3, on the employee’s agreed pay day, the employer must pay that employee an amount equal to that employee’s basic wage rate for each day’s sick leave.

(3) Despite subsection 2, an employer is not required to pay an employee for sick leave in any of the following circumstances:

(a) if the employee

(i) has been absent from work for more than two consecutive days; and

(ii) fails to produce a medical certificate by a medical practitioner;

(b) to the extent that the employee is entitled to payment in terms of the Employees’ Compensation Act, 1941 (Act No 30 of 1941), if the employee is absent from work during any period of incapacity arising from an accident or a scheduled disease;

(c) to the extent that the employee is entitled to payment in respect of that sick leave from a fund or organisation

(i) designated by the employee, and in respect of which the employer makes contributions at least equal to that made by the employee;

(ii) that guarantees the payment of sick leave; or

(d) to the extent that the employee is entitled to payment in respect of that sick leave under any other legislation.

(4) An employee is, during each period of 12 months that the employee is employed, entitled to five working days compassionate leave with fully paid remuneration.

(5) An employee is entitled to compassionate leave if there is a death or serious illness in the family.

(6) The Minister must prescribe the form and manner in which compassionate leave may be applied for by an employee and any other information which may be required to support the application.

...

PART F – Termination of employment

32. Unfair dismissal

(1) An employer must not, whether notice is given or not, dismiss an employee

(a) without a valid and fair reason

...

(b) without following

(i) the procedures set out in section 33, if the dismissal arises from a reason set out in section 33(1); or

(ii) subject to any code of good practice issued under section 135, a fair procedure, in any other case.

(2) It is unfair to dismiss an employee because that employee

(a) discloses information that the employee is entitled or required under any law to disclose to another person;

(b) fails or refuses to do anything that an employer must not lawfully permit or require an employee to do.

...

38. Employer duties to employees

(1) Every employer or person in charge of premises or place where employees are employed must, without charge to the employees

(a) provide a working environment that

(i) is safe;

(ii) is without risk to the health of employees; and

(iii) has adequate facilities and arrangements for the welfare of employees;

(b) provide and maintain plant, machinery and systems of work, and work processes, that are safe and without risk to the health of employees;

...

(d) provide employees with adequate personal protective clothing and equipment if reasonably necessary;

...

(i) take any other prescribed steps to ensure the safety, health and welfare of employees at work.

...

41. Employee’s right to leave dangerous place of work

(1) If an employee has reasonable cause to believe that, until effective measures have been taken, it is neither safe nor healthy to continue work in a place of work, that employee may leave that place.

South Africa: Occupational Health and Safety Act 85 of 1993

Assented to by the President on 23 June 1993 and entered into force on 1 January 1994. It includes provisions on occupational exposure to HIV. The Occupational Health and Safety Act gives employees the right to compensation for accidents and illnesses that they may contract in the course of their normal working activities.

Excerpts

...

7. Health and safety policy

(1) The chief inspector may direct

(a) any employer in writing; and

(b) any category of employers by notice in the *Gazette*, to prepare a written policy concerning the protection of the health and safety of his employees at work, including a description of his organisation on and the arrangements for carrying out and reviewing that policy.

(2) Any direction under subsection 1 shall be accompanied by guidelines concerning the contents of the policy concerned.

(3) An employer shall prominently display a copy of the policy referred to in subsection 1, signed by the chief executive officer, in the workplace where his employees normally report for service.

8. General duties of employers to their employees

(1) Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees

...

South Africa: Compensation for Occupational Injuries and Diseases Act 130 of 1993

Assented to by the President on 24 September 1993 and commenced on 1 March 1994. This Act has been amended to include provisions regarding HIV.

Excerpts

...

CHAPTER I – Interpretation of Act

1. Definitions

In this Act, unless the context indicates otherwise

'accident' means an accident arising out of and in the course of an employee's employment and resulting in a personal injury, illness or the death of the employee;

...

'compensation' means compensation in terms of this Act and, where applicable, medical aid or payment of the cost of such medical aid;

...

CHAPTER IV – Compensation for occupational injuries

22. Right of employee to compensation

(1) If an employee meets with an accident resulting in his or her disablement or death such employee or the dependants of such employee shall, subject to the provisions of this Act, be entitled to the benefits provided for and prescribed in this Act.

...

(4) For the purposes of this Act an accident shall be deemed to have arisen out of and in the course of the employment of an employee notwithstanding that the employee was at the time of the accident acting contrary to any law applicable to his employment or to any order by or on behalf of his employer, or that he was acting without any order of his employer, if the employee was, in the opinion of the Director-General, so acting for the purposes of or in the interests of or in connection with the business of his employer.

CHAPTER VIII – Medical aid

...

73. Medical expenses

(1) The Director-General or the employer individually liable or mutual association concerned, as the case may be, shall for a period of not more than two years from the date of an accident or the commencement of a disease referred to in section 65 (1) pay the reasonable cost incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.

(2) If, in the opinion of the Director-General, further medical aid in addition to that referred to in subsection 1 will reduce the

disablement from which the employee is suffering, he may pay the cost incurred in respect of such further aid or direct the employer individually liable or the mutual association concerned, as the case may be, to pay it.

South Africa: Labour Relations Act 66 of 1995

Assented to by the President on 26 November 1995 and entered into force on 11 November 1996. It prohibits dismissal on the mere basis of HIV or AIDS status.

Excerpts

...

CHAPTER 2 – Freedom of association and general protections

...

5. Protection of employees and persons seeking employment

(1) No person may discriminate against an employee for exercising any right conferred by this Act.

...

(2) Without limiting the general protection conferred by subsection 1, no person may do, or threaten to do, any of the following

...

(b) prevent an employer from exercising any right conferred by this Act or from participating in any proceedings in terms of this Act; or

(c) prejudice an employee or a person seeking employment because of past, present or anticipated.

...

(v) disclosure of information that the employee is lawfully entitled or required to give to another person;

...

CHAPTER 5 – Workplace forums

...

84. Specific matters for consultation

(5) Subject to any applicable occupational health and safety legislation, a representative trade union and an employer may agree

(a) that the employer must consult with the workplace forum with a view to initiating, developing, promoting, monitoring and reviewing measures to ensure health and safety at work;

(b) that a meeting between the workplace forum and the employer constitutes a meeting of a health and safety committee required to be established in the workplace by that legislation; and

(c) that one or more members of the workplace forum are health and safety representatives for the purposes of that legislation.

...

CHAPTER 8 – Unfair dismissal and unfair labour practice

...

185. Right not to be unfairly dismissed or subjected to unfair labour practice

Every employee has the right not to be

(a) unfairly dismissed; and

(b) subjected to unfair labour practice.

...

187. Automatically unfair dismissals

(1) A dismissal is automatically unfair if the employer, in dismissing the employee, acts contrary to section 5 or, if the reason for the dismissal is

...

(f) that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility.

South Africa: Basic Conditions of Employment Act 75 of 1997

Assented to by the President on 26 November 1997 and entered into force on 1 December 1998. Its provisions cover sick leave.

Excerpts

...

CHAPTER 3 – Leave

19. Application of this chapter

(1) This Chapter does not apply to an employee who works less than 24 hours a month for an employer.

(2) Unless an agreement provides otherwise, this Chapter does not apply to leave granted to an employee in excess of the employee's entitlement under this Chapter.

...

22. Sick leave

(1) In this Chapter, 'sick leave cycle' means the period of 36 months' employment with the same employer immediately following

- (a) an employee's commencement of employment; or
- (b) the completion of that employee's prior sick leave cycle.

(2) During every sick leave cycle, an employee is entitled to an amount of paid sick leave equal to the number of days the employee would normally work during a period of six weeks.

(3) Despite subsection 2, during the first six months of employment, an employee is entitled to one day's paid sick leave for every 26 days worked.

(4) During an employee's first sick leave cycle, an employer may reduce the employee's entitlement to sick leave in terms of subsection 2 by the number of days' sick leave taken in terms of subsection 3.

(5) Subject to section 23, an employer must pay an employee for a day's sick leave

- (a) the wage the employee would ordinarily have received for work on that day; and
- (b) on the employee's usual pay day.

(6) An agreement may reduce the pay to which an employee is entitled in respect of any day's absence in terms of this section if

- (a) the number of days of paid sick leave is increased at least commensurately with any reduction in the daily amount of sick pay; and

(b) the employee's entitlement to pay

(i) for any day's sick leave is at least 75 per cent of the wage payable to the employee for the ordinary hours the employee would have worked on that day; and

(ii) for sick leave over the sick leave cycle is at least equivalent to the employee's entitlement in terms of subsection 2.

23. Proof of incapacity

(1) An employer is not required to pay an employee in terms of section 22 if the employee has been absent from work for more than two consecutive days or on more than two occasions during an eight-week period and, on request by the employer, does not produce a medical certificate stating that the employee was unable to work for the duration of the employee's absence on account of sickness or injury.

South Africa: Employment Equity Act 55 of 1998

Assented to by the President on 12 October 1998 and entered into force on 9 August 1998. Its provisions deal specifically with HIV and AIDS in relation to employment.

Excerpts

...

Section 5: Elimination of unfair discrimination

Every employer must take steps to promote equal opportunity in the workplace by eliminating unfair discrimination in any employment policy or practice.

Section 6: Prohibition of unfair discrimination

(1) No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.

(2) It is not unfair discrimination to

- (a) take affirmative action measures consistent with the purpose of this Act; or
- (b) distinguish, exclude or prefer any person on the basis of an inherent requirement of a job.

(3) Harassment of an employee is a form of unfair discrimination and is prohibited on any one, or a combination of grounds of unfair discrimination listed in subsection 1.

Section 7

(1) Medical testing of an employee is prohibited, unless

- (a) Legislation permits or requires the testing;
- (b) It is justifiable in light of medical facts, employment conditions, social policy, the fair distribution of employee benefits, or the inherent requirements of the job.

(2) Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of section 50(4) of this Act.

...

Section 50

(4) If the Labour Court declares that the medical testing of an employee as contemplated in section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to

- (a) the provision of counselling;
- (b) the maintenance of confidentiality;
- (c) the period during which the authorisation for any testing applies; and
- (d) the category or categories of jobs or employees in respect of which the authorisation for testing applies.

South Africa: Public Service Regulations (2001)

These regulations have been amended several times and include amendments made in 2004 to provide for the rights of employees living with HIV.

PART VI – Working environment

A. Principles

The working environment should support effective and efficient service delivery while, as far as reasonably possible, taking employees' personal circumstances, including disability, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) and other health conditions into account.

B. Working hours

A head of department shall determine

- (a) the work week and daily hours of work for employees; and
- (b) the opening and closing times of places of work under his control, taking into account
 - (i) the needs of the public in the context of the department's service delivery improvement programme; and
 - (ii) the needs and circumstances of employees, including family obligations and transport arrangements.

...

D. Health and safety

A head of department shall establish and maintain a safe and healthy work environment for employees of the department.

E. HIV/AIDS and related diseases

E.1 Occupational exposure

A head of department shall

- (a) identify units or employees within the department that, due to the nature of their work, are at high risk of contracting HIV and other related diseases, and take reasonable steps to reduce the risk of occupational exposure to HIV and such diseases;
- (b) take all reasonable steps to facilitate timely access to voluntary counseling and testing and post-exposure *prophylaxis* in line with prevailing guidelines and protocols for employees who have been exposed to HIV as a result of an occupational incident; and
- (c) if the testing referred to in paragraph b indicates that an employee has become HIV-positive as a result of the occupational incident, ensure that the employee is assisted to apply for compensation in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993).

E.2 Non-discrimination

A head of department shall

- (a) ensure that no employee or prospective employee is unfairly discriminated against on the basis of his HIV status, or perceived HIV status, in any employment policy or practice; and
- (b) take appropriate measures to actively promote non-discrimination and to protect HIV-positive employees and employees perceived to be HIV-positive from discrimination.

E.3 HIV testing

A head of department shall

- (a) encourage voluntary counselling and testing for HIV and other related health conditions and, wherever possible, facilitate access to such services for employees in the department; and
- (b) ensure that no employee or prospective employee of the department is required to take a HIV test unless the Labour Court has declared such testing as justifiable in terms of the Employment Equity Act, 1998 (Act No 55 of 1998)

E.4 Confidentiality and disclosure

All employees shall treat information on an employee's HIV status as confidential and shall not disclose that information to any other person without the employee's written consent.

E.5 Health promotion programme

A head of department shall

- (a) introduce appropriate education, awareness and prevention programmes on HIV/AIDS and other sexually transmitted infections for the employees in the department and, where possible, their families, and as far as possible, integrate those programmes with programmes that promote the health and well-being of employees;
- (b) create mechanisms within the workplace to encourage openness, acceptance, care and support for HIV-positive employees. Such mechanisms should preferably form part of a comprehensive employee assistance programme or health promotion programme;
- (c) designate a member of the SMS with adequate skills, seniority and support to implement the provisions contained in regulation VI E within the department, and ensure that the member so designated is held accountable by means of his performance agreement for the implementation of the provisions;
- (d) allocate adequate human and financial resources to implement the provisions of regulation VI E, and, where appropriate, form partnerships with other departments, organisations and individuals who are able to assist with health promotion programmes;
- (e) establish a HIV/AIDS committee for the department with adequate representation and support from all relevant stakeholders, including trade union representatives, to facilitate the effectiveness of the provisions of regulation VI E; and
- (f) ensure that the health promotion programme includes an effective internal communication strategy.

F. Monitoring and evaluation

A head of department shall introduce appropriate measures for monitoring and evaluating the impact of the health promotion programme among the employees of the department.

PART VII – Procedures for appointment, promotions and termination of service

A. Principles

Employment practices shall ensure employment equity, fairness, efficiency and the achievement of a representative public service. Affirmative action shall be used to speed up the creation of a representative and equitable public service and to give practical support to those who have been previously disadvantaged by unfair discrimination to enable them to fulfil their maximum potential. Employment practices should maximise flexibility, minimise administrative burdens on both employer and employee, and generally prevent waste and inefficiency.

B. Conditions for appointment

B.1 General

An executing authority

...

- (d) shall determine the health requirements for incumbency of a post, in any case where it is in the requirements of the post;

...

C. Recruitment

C.1 Determination of requirements for employment

...

- (b) ensure that the requirements for employment do not discriminate against persons historically disadvantaged;

...

G. Termination of service

...

G.3 Ill-health

G.3.1 An executing authority may on the basis of medical evidence, consider the discharge of an employee in terms of section 17(2)(a) of the Act on account of ill-health. To this end, an executing authority may require an employee to undergo a medical examination by a registered physician.

G.3.2 A discharge on account of ill health shall occur with due regard to item 10 of schedule 8 to the Labour Relations Act.

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

See full text above under 'HIV specific laws', in particular sections 9 and 30.

Uganda: Human Immunodeficiency Virus Control Bill (2007)

See full text above under 'HIV specific laws', in particular section 30.

Zimbabwe: Statutory instrument 202 of 1998: Labour Relations (HIV and AIDS) Regulations

These regulations establish rights and responsibilities of both employers and employees in terms of prevention and management of HIV in the workplace.

Introduction

In September 1998, the Minister of Public Service Labour and Social Welfare enacted Statutory Instrument 202 of 1998, the Labour Relations (HIV and AIDS) Regulations. The regulations were introduced under the Labour Relations Act [Chapter 28:01]. They are also based on the provisions of the Constitution of Zimbabwe. As they are under the Labour Relations Act they currently cover only workers in the private sector and parastatals, but give an indication of the intention of the tripartite parties on what should apply across all sectors of employment.

The regulations are a product of the Intersectoral Committee on AIDS and Employment, chaired by the Ministry of Public Service, Labour and Social Welfare, and involving the Employers' Confederation of Zimbabwe, the Zimbabwe AIDS Co-ordination Programme and non-government organisations with expertise on HIV/AIDS. The drafting of the regulations involved three years of consultations and review of draft legal provisions by over 300 organisational representatives nationally. The legal provisions were adopted by the National Tripartite committee.

The regulations aim to ensure non-discrimination between individuals with HIV infection and those without; and between HIV/AIDS and other comparable life-threatening medical conditions.

In relation to employment, they establish that HIV-infection is an infection with a virus that by itself does not affect an employee's ability to perform the functions for which he will be or has been assigned in employment.

The law establishes rights and responsibilities of both employers and employees with regards to the prevention and management of HIV/AIDS and its employment consequences.

It is hereby notified that the Minister of Public Service, Labour and Social Welfare, in terms of, section 17 of the Labour

Relations Act [Chapter 28:01], has made the following regulations:

1. Title

These regulations may be cited as the Labour Relations (HIV and AIDS) Regulations, 1998.

2. Interpretation

In, these regulations

AIDS means Acquired Immunodeficiency Syndrome and includes the AIDS-related complex;

HIV means Human Immunodeficiency Virus;

Testing, in relation to HIV, includes:

- (a) any direct analysis of the blood or other body fluid of a person to determine the presence of HIV or antibodies to HIV; or
- (b) any direct method, other than the testing of blood or other body fluid, through which an inference is made, as to the presence of HIV.

Related communicable disease means any communicable disease whose transmission may be linked with HIV due to its transmission through body fluids or, whose risk of clinical disease may be increased due to the presence of HIV;

Medical practitioner means a person registered as a medical practitioner in terms of the Medical, Dental and Allied Professions Act [Chapter 27:08]

3. Education of employees on HIV and AIDS

(1) Every employer shall cause to be provided for the benefit of every person employed by him, and at such place and time during normal working hours as he may appoint, education and information relating to

- (a) the promotion of safe sex and risk-reducing measures in relation to sexually transmitted diseases; and
- (b) the acquiring and transmission of HIV; and
- (c) the prevention of the spread of HIV and AIDS; and
- (d) counselling facilities for HIV and AIDS patients.

(2) Education and information shall be provided in terms of subsection 1 by persons who have proven sound knowledge and expertise in matters relating to HIV and AIDS, and who are able to communicate information with consistency and accuracy.

(3) The design of the education programmes shall be in accordance with guidelines approved by the relevant employer and employee organisations, in consultation with the Ministry of Health and Child Welfare and any other organisation with expertise in HIV and AIDS-related matters.

(4) The provision of the education referred to in subsection 1 shall be at such intervals as the relevant employer and employee organisations may agree.

4. Medical testing on recruitment

(1) No employer shall require, whether directly or indirectly, any person to undergo any form of testing for HIV as a precondition to the offer of employment.

(2) Subsection 1 shall not prevent the medical testing of persons for fitness for work as a precondition to the offer of employment.

5. Testing of employees for HIV and confidentiality

(1) It shall not be compulsory for any employee to undergo, directly, any testing for HIV.

(2) No employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his or her employment, his or her HIV status.

(3) No person shall, except with the written consent of the employee to whom the information relates, disclose any information relating to the HIV status of any employee acquired by that person in the course of his or her duties unless the information is required to be disclosed in terms of any other law.

6. Job status and training

- (1) No employer shall terminate the employment of an employee on the grounds of that employee's HIV status alone.
- (2) No employee shall be prejudiced in relation to
- (a) promotion; or
 - (b) transfer; or
 - (c) subject to any other law to the contrary, any training or other employee development programme; or
 - (d) status; or
 - (e) in any other way be discriminated against on the grounds of his or her HIV status alone.

7. Eligibility for employee benefits

- (1) Subject to any other law to the contrary, the HIV status of an employee shall not affect his or her eligibility for any occupational or other benefit schemes provided for employees.
- (2) Where in terms of any law the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV test, the conditions attaching to HIV and AIDS shall be the same as those applicable in respect of comparable life-threatening illnesses.
- (3) Where any HIV testing is necessary in terms of subsection 2, the employer shall ensure that the employee undergoes appropriate pre- and post-HIV test counselling.
- (4) Where an employee who opts not to undergo an HIV testing for the purposes of subsection 2, no inferences concerning the HIV status of the employee may be drawn from such exercise by the employee of the option not to undergo the testing.
- (5) Where an employee undergoes an HIV testing for the purposes of subsection 2, the employer shall not, unless the occupational or other benefit scheme concerned is operated by the employer, be entitled to information concerning the HIV status of the employee concerned.

8. Sick and compassionate leave

Any employee suffering from HIV or AIDS shall be subject to the same conditions relating to sick leave as those applicable to any other employee in terms of the Act.

9.(1) Where a person is employed in an occupation or is required to provide services, where there may be a risk of transmitting or acquiring HIV or AIDS, the employer shall provide appropriate training, together with clear and accurate information and guidelines on minimising the hazards of the spread of HIV or AIDS and related communicable diseases.

(2) The working conditions and procedures in relation to occupations referred to in subsection 1 shall be designed to ensure optimal hygienic precautions to prevent the spread of HIV or AIDS and related communicable diseases to employees and members of the public

(3) Personal protective devices shall be issued, free of charge, by the employer to persons employed in occupations referred to subsection 1.

10. Copy of regulations for each employee

An employer shall provide every employee with a copy of these regulations.

11. Offences and penalty

Any person who contravenes any provision of these regulations shall be guilty of an offence and liable to a fine not exceeding five thousand dollars or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

D2.4 Right to health care

Angola: Law 8/04 on HIV and AIDS

See full text under 'HIV specific laws', in particular sections 1, 3, 5, 8, 10, 12, 22 and 27.

Burundi: Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005)

See full text under 'HIV specific laws' in particular articles 16 and 18.

Djibouti: Law 48 on the Orientation of Health Policy (1999)

This law articulates Djibouti's citizens rights regarding health.

Excerpts

...

1. Health is a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.

2. The nation proclaims the right to health for all. The safeguard of the right to health shall constitute an important responsibility of the state. It shall adopt the necessary principles and put in place the necessary means to carry out its responsibility.

3. Health-related public expenses: everyone shall contribute, within the limits of his resources, to the funding of these expenses. To this end, the state shall gradually put in place an expanded system of contribution by all beneficiaries. Such a system aims to recoup part of the costs of health. The measures necessary for the implementation of these provisions shall be defined by legislation and regulations.

...

13. Public, semi-public and private health institutions shall provide for the following

1) for in-patients and out-patients

- short-term care or care related to serious infections in their acute phase;

- continuous care as part of treatment or medical observation.

2) for in-patients, long term care for persons whose state of health requires continuous medical observation.

...

20. National programmes shall be drafted according to health priorities and issues specific to health. The activities formulated within national programmes shall be coordinated and integrated with the overall health strategy.

These national programmes shall address

...

AIDS

...

21. The treatment and prevention protocols included in the national programmes shall be applicable to persons and within the national territory.

...

25. The early screening of illnesses and disabilities as well as the prevention of the use of drugs, including tobacco in schools shall be given priority in schools.

26. The prevention of occupational illnesses as well as employment-related injuries shall be given priority at the workplace.

27. In sports, attention shall be on providing medical supervision of sportspersons as well as anti-doping measures.

...

30. The state has the duty to support and scientifically monitor traditional medicine.

31. The health policy related to traditional medicine aims to ensure

- 1) the collaboration between modern medicine and traditional medicine;
- 2) the improvement of patients' safety;
- 3) the promotion of traditional materia medica.

...

45. The funding mechanisms of public health services shall ensure equal access to care for all and equity with respect to the public sharing of health-related charges.

46. The health system relies on the mobilisation of all available resources. Pursuant to the provisions in article 41 above, the financial resources resulting from the financial contribution of users do not constitute substitute revenues, they shall only complement the state's budgetary allocations to health.

...

59. Citizens recognised as indigent in terms of the law shall be affiliated to a tier public payment through specific mechanisms as defined by law. The issuance of indigence cards will be in terms of conditions and modalities as defined by law.

...

82. Health and medical research shall aim at equipping the health system with means adapted to local and regional pathology and health problems. Health and medical research shall be applied and operational.

83. The research policy in terms of health shall be oriented towards applied and operational research, namely:

- The study of resistance in bacteriology, parasitology and entomology;
- All studies in public health needed for the definition of priorities in public health programmes;
- The study of resources in traditional materia medica and its scientific supervision.

...

86. Medication distributed on the territory of Djibouti, whether for free or at a fee, whether patented or generic drugs shall be granted an authorisation for commercialisation on the Djibouti market prior to distribution.

...

91. The supply and distribution of medications and medico-surgical equipments used within the public health service shall obey the rules on costs and standardisation; shall be adapted to each category of health institution in terms of quantity and quality and shall rely on quality and costs criteria on the national and international markets.

...

97. Blood transfusion shall be subject to regulations on control and safety as specified by laws.

...

103. The financial availability and accessibility of medication shall constitute the main priority of the national policy on public health.

104. The state shall promote activities geared towards the prevention of illnesses and the improvement of hygiene in

addition to improving the accessibility to medication with an aim of increasing the curative approach to health problems.

105. Consequently, the priorities of the health policy shall be oriented along the following

- treatment;
- prevention;
- public hygiene.

106. The state shall, in implementing the National Pharmaceutical Plan and pursuant to the health objectives defined in articles 85 and 103 above, facilitate the population's access to medication everywhere on the territory and at all facilities within financially bearable conditions even for the most disadvantaged users. The state shall empower itself to reach these objectives by implementing the measures provided in articles 86 to 92 above.

...

110. Prevention of illnesses shall rely on preventive medicine, protection of the mother's and the child's health and sanitary education.

111. Preventive medicine aims to increase the population's life expectancy through the reduction of morbidity and mortality caused by illnesses. It shall namely rely on the promotion of vaccination, epidemiological surveillance and the fight against endemic illnesses, early screening and treatment of illnesses.

112. The policy of preventive medicine shall ensure particularly the following actions

...

The prevention and fight against AIDS;

...

113. The compulsory notification/disclosure of illnesses targeted in article 112 above shall be conducted according to the conditions set in the regulations.

...

115: The protection of the health of the mother and the child is related to the promotion of preventive actions as well as health related information and education.

Kenya: HIV and AIDS Prevention and Control Act 14 of 2006

See full extract under section above on 'HIV specific laws', in particular sections 15 to 17, 19, and 36.

Madagascar: Law 2005-040 on the Fight against HIV/ AIDS and the Protection of Rights of People Living with HIV (2005)

See full text under 'HIV specific laws', in particular articles 5 to 16, 20, 21, 62 and 63.

Mauritius: HIV and AIDS Act 31 of 2006

See full extract under section above on 'HIV specific laws' in particular sections 5, 6, and 10.

South Africa: Medicines and Related Substances Control Amendment Acts 90 of 1997 and 59 of 2002

Adopted in 1997 and 2002 to amend the Medicines and Related Substances Act 101 of 1965. The Medicines and Related Substances Act 101 of 1965, as amended, now includes the following sections.

Excerpts

...

15.C Measures to ensure supply of more affordable medicines

The Minister may prescribe conditions for the supply of more affordable medicines in certain circumstances so as to protect the health of the public, and in particular may-

(a) notwithstanding anything to the contrary contained in the Patents Act, 1978 (Act 57 of 1978), determine that the rights with regard to any medicine under a patent granted in the Republic shall not extend to acts in respect of such medicine which has been put onto the market by the owner of the medicine, or with his or her consent;

(b) prescribe the conditions on which any medicine which is identical in composition, meets the same quality standard and is intended to have the same proprietary name as that of another medicine already registered in the Republic, but which is imported by a person other than the person who is the holder of the registration certificate of the medicine already registered and which originates from any site of manufacture of the original manufacturer as approved by the council in the prescribed manner, may be imported;

(c) prescribe the registration procedure for, as well as the use of, the medicine referred to in paragraph b.

...

22.F Generic substitution

(1) Subject to subsections 2, 3 and 4, a pharmacist or a person licensed in terms of section 22C(1) (a) shall

(a) inform all members of the public who visit the pharmacy or any other place where dispensing takes place, as the case may be, with a prescription for dispensing, of the benefits of the substitution for a branded medicine by an interchangeable multi-source medicine, and shall, in the case of a substitution, take reasonable steps to inform the person who prescribed the medicine of such substitution;

(b) dispense an interchangeable multi-source medicine instead of the medicine prescribed by a medical practitioner, dentist, practitioner, nurse or other person registered under the Health Professions Act, 1974, unless expressly forbidden by the patient to do so.

South Africa: Medical Schemes Act 131 of 1998

Assented to by the President on 20 November 1998 and entered into force on 23 February 1999. As amended, this text now includes the following sections.

Excerpts

...

CHAPTER 5 – Rules of medical scheme

29. Matters for which rules shall provide

(1) The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters

...

(u) If the members of a medical scheme who are members of that medical scheme by virtue of their employment by a particular employer terminate their membership of the said medical scheme with the object of obtaining membership of another medical scheme or of establishing a new medical scheme, such other or new medical scheme shall admit to membership, without a waiting period or the imposition of new restrictions on account of the state of his or her health or the health of any of his or her dependants, any member or a dependant of such first mentioned medical scheme who

- (i) is a person or persons contemplated in paragraph (s); or
- (ii) is a person or persons contemplated in paragraph (t).

(2) A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of

(a) failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules;

...

(3) A medical scheme shall not provide in its rules

(a) or the exclusion of any applicant or a dependant of an applicant, subject to the conditions as may be prescribed, from membership except for a restricted membership scheme as provided for in this Act;

(b) for the exclusion of any applicant or a dependant of an applicant who would otherwise be eligible for membership to a restricted membership scheme; and

(c) for the imposition of waiting periods other than as provided for in section 29(A).

29.A. Waiting periods

(1) A medical scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application

- (a) a general waiting period of up to three months; and
- (b) a condition-specific waiting period of up to 12 months.

(2) A medical scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application

(a) a condition-specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;

(b) in respect of any person contemplated in this subsection, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

(3) A medical scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

South Africa: National Health Act 61 of 2003

Assented to by the President on 18 July 2004 and entered into force on 2 May 2005.

Excerpts

...

CHAPTER 1 – Objects of act, responsibility for health and eligibility for free services

2. Objects of Act

The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by

- (a) establishing a national health system which
 - (i) encompasses public and private providers of health services; and
 - (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;
- (b) setting out the rights and duties of health care providers, health workers, health establishments and users; and
- (c) protecting, respecting, promoting and fulfilling the rights of
 - (i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;
 - (ii) the people of South Africa to an environment that is not harmful to their health or well-being;
 - (iii) children to basic nutrition and basic health care services contemplated in section 28(1) (c) of the Constitution; and
 - (iv) vulnerable groups such as women, children, older persons and persons with disabilities.

3. Responsibility for health

- (1) The Minister must, within the limits of available resources
 - (a) endeavour to protect, promote, improve and maintain the health of the population;
 - (b) promote the inclusion of health services in the socio-economic development plan of the Republic;
 - (c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
 - (d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and
 - (e) equitably prioritise the health services that the State can provide.
- (2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.

4. Eligibility for free health services in public health establishments

- (1) The Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.
- (2) In prescribing any condition contemplated in subsection 1, the Minister must have regard to
 - (a) the range of free health services currently available;
 - (b) the categories of persons already receiving free health services;

(c) the impact of any such condition on access to health services; and

(d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

(3) Subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide

(a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;

(b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; and

(c) women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act 92 of 1996), free termination of pregnancy services.

CHAPTER 2 – Rights and duties of users and health care personnel

5. Emergency treatment

A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.

6. User to have full knowledge

(1) Every health care provider must inform a user of

- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

(2) The health care provider concerned must, where possible, inform the user as contemplated in subsection 1 in a language that the user understands and in a manner which takes into account the user's level of literacy.

7. Consent of user

(1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless

(a) the user is unable to give informed consent and such consent is given by a person

(i) mandated by the user in writing to grant consent on his or her behalf; or

(ii) authorised to give such consent in terms of any law or court order;

(b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms of any law or a court order;

(d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or

(e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.

(2) A health care provider must take all reasonable steps to obtain the user's informed consent.

(3) For the purposes of this section 'informed consent' means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6.

8. Participation in decisions

- (1) A user has the right to participate in any decision affecting his or her personal health and treatment.
- (2)(a) If the informed consent required by section 7 is given by a person other than the user, such person must, if possible, consult the user before giving the required consent.
- (b) A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give the informed consent required by section 7.
- (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.

9. Health service without consent

- (1) Subject to any applicable law, where a user is admitted to a health establishment without his or her consent, the health establishment must notify the head of the provincial department in the province in which that health establishment is situated within 48 hours after the user was admitted of the user's admission and must submit such other information as may be prescribed.
- (2) If the 48-hour-period contemplated in subsection 1 expires on a Saturday, Sunday or public holiday, the health establishment must notify the head of the provincial department of the user's admission and must submit the other information contemplated in subsection 1 at any time before noon of the next day that is not a Saturday, Sunday or public holiday.
- (3) Subsection 1 does not apply if the user consents to the provision of any health service in that health establishment within 24 hours of admission.

10. Discharge reports

- (1) A health care provider must provide a user with a discharge report at the time of the discharge of the user from a health establishment containing such information as may be prescribed.
- (2) In prescribing the information contemplated in subsection 1, the Minister must have regard to
 - (a) the nature of the health service rendered;
 - (b) the prognosis for the user; and
 - (c) the need for follow-up treatment.
- (3) A discharge report provided to a user may be verbal in the case of an outpatient, but must be in writing in the case of an inpatient.

...

14. Confidentiality

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.
- (2) Subject to section 15, no person may disclose any information contemplated in subsection 1 unless:
 - (a) the user consents to that disclosure in writing;
 - (b) a court order or any law requires that disclosure; or
 - (c) non-disclosure of the information represents a serious threat to public health.

15. Access to health records

- (1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.
- (2) For the purpose of this section, 'personal information' means personal information as defined in section 1 of the Promotion of Access to Information Act, 2000 (Act 2 of 2000).

16. Access to health records by health care provider

- (1) A health care provider may examine a user's health records for the purposes of
 - (a) treatment with the authorisation of the user; and
 - (b) study, teaching or research with the authorisation of the user, head of the health establishment concerned and the relevant health research ethics committee.
- (2) If the study, teaching or research contemplated in subsection 1(b) reflects or obtains no information as to the identity of the user concerned, it is not necessary to obtain the authorisations contemplated in that subsection.

17. Protection of health records

- (1) The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.
 - (2) Any person who
 - (a) fails to perform a duty imposed on them in terms of subsection 1;
 - (b) falsifies any record by adding to or deleting or changing any information contained in that record;
 - (c) creates, changes or destroys a record without authority to do so;
 - (d) fails to create or change a record when properly required to do so;
 - (e) provides false information with the intent that it be included in a record;
 - (f) without authority, copies any part of a record;
 - (g) without authority, connects the personal identification elements of a user's record with any element of that record that concerns the user's condition, treatment or history;
 - (h) gains unauthorised access to a record or record-keeping system, including intercepting information being transmitted from one person, or one part of a record-keeping system, to another;
 - (i) without authority, connects any part of a computer or other electronic system on which records are kept to
 - (i) any other computer or other electronic system; or
 - (ii) any terminal or other installation connected to or forming part of any other computer or other electronic system;
 - (j) without authority, modifies or impairs the operation of
 - (i) any part of the operating system of a computer or other electronic system on which a user's records are kept; or
 - (ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a user's records are kept,
- commits an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both a fine and such imprisonment.

...

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

See full extract under section above on 'HIV specific laws'.

Uganda: Human Immunodeficiency Virus Control Bill (2007)

See full extract under section above on 'HIV specific laws' in particular sections 9, 18, 20, and 34.

Zimbabwe: Public Health Act 19 of 1924

The 1924 version of the Act refers to communicable and infectious diseases without expressly mentioning HIV/AIDS. However, in section 17 the ministers, by way of a statutory instrument, declare HIV/AIDS to be a communicable or infectious disease. The Act has been amended several times.

Excerpts

...

PART IV – Venereal diseases

...

47. Application of Part IV

This Part shall apply to all sexually transmitted diseases except such diseases as the Minister may specify by statutory instrument.

48. Duties of medical practitioners

(1) Every medical practitioner who attends or advises any patient in respect of any sexually transmitted disease with which the patient is infected shall

(a) direct the attention of the patient to the infectious nature of the disease and to the penalties prescribed by this Act for infecting any other person with such disease; and

(b) warn the patient against contracting marriage unless and until he has been cured of such disease or is free from such disease in a communicable form; and

(c) give to the patient such printed information relating to the treatment of sexually transmitted disease and to the duties and responsibilities of persons infected therewith as may be supplied to the medical practitioner by the Ministry.

(2) Every medical practitioner who knows or has reason to believe that any person is infected with a sexually transmitted disease in a communicable form and is not under treatment by a medical practitioner, or is not attending for medical treatment regularly and as prescribed by such medical practitioner, shall report the matter in writing to the medical officer of health of the local authority or to the Government medical officer.

(3) A medical practitioner who contravenes subsection 1 or 2 shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

...

50. Conveyance of infection an offence

Every person who, knowing that he is infected with a sexually transmitted disease, wilfully or by culpable negligence infects any other person therewith, or does or permits or suffers any act likely to lead to the infection of any other person with any such disease, shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

51. Detention in hospital of infected persons

(1) Where any person sentenced to imprisonment under this Act or any other law is infected with a sexually transmitted disease in a communicable form, he may, by order of the district administrator, be removed to a special hospital or place of accommodation provided and be detained under treatment therein until the expiry of his sentence; and the district administrator, on the representation of the Government medical officer or medical practitioner treating such person, and if satisfied that the public health cannot otherwise adequately be safeguarded, and that such person when released is unlikely to undergo treatment of a medical practitioner for such disease, may order that he be detained in such hospital or place either for a

specified period after the expiry of his or her sentence or until he is cured or free from the disease in a communicable form.

(2) Any person so detained in a hospital or other place of accommodation who escapes or attempts to escape therefrom shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

52. Medical examination of inhabitants in areas where sexually transmitted disease believed to be prevalent

Where the Minister, on a report by the Chief Health Officer, has reason to believe that sexually transmitted disease is prevalent amongst the residents in any premises or locality, he may issue an order requiring the examination by a medical practitioner of any person or of persons of any specified class or description residing therein. Any person who refuses to comply with such order or with any lawful instructions given thereunder, or who obstructs any medical practitioner or other duly authorised officer in the carrying out of such order, shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

...

54. Rights of persons detained in hospital

Any person detained in hospital under this Part shall be entitled to arrange, at his or her own expense, for his or her examination by any medical practitioner, and a report of such examination shall be furnished to the district administrator, who may thereupon cause to be made any further examination of such person which he may deem necessary. No person shall be detained in hospital under this Part who is not, or is no longer, infected with a sexually transmitted disease in a communicable form.

...

57. Contributions and facilities for diagnosis and treatment of sexually transmitted disease

The Minister, subject to regulations which he is hereby authorised to make, and which may deal with the procedure to be followed, the conditions to be complied with and any other matters necessary for the proper carrying out of this section, may

(a) provide in Government or other laboratories for the carrying out of bacteriological or other laboratory examinations for the purpose of ascertaining whether any person is infected with or is cured of any sexually transmitted disease, or is free from any such disease in a communicable form. Such examinations shall be free of charge;

(b) make provision for the free treatment and, where necessary, the accommodation and maintenance of persons infected with sexually transmitted disease. Such provision shall be made as far as practicable in connection with general or isolation hospitals or similar institutions by arrangement with the Minister or the hospital, local or other authority concerned;

(c) supply, free of charge, such remedies as may be specified from time to time in the *Gazette* for use in the treatment of persons infected with sexually transmitted disease who are treated as free patients at any public institution;

(d) refund to any local authority, or to two or more local authorities acting jointly, two-thirds of the net cost of any approved scheme for providing treatment, including maintenance and accommodation, where necessary, for persons who are infected with sexually transmitted disease;

(e) establish and maintain special accommodation for the maintenance and treatment of persons infected with sexually transmitted disease who are liable to detention;

(f) make grants-in-aid, subject to such conditions as the Minister may in each case fix and determine, to local authorities or other public bodies or voluntary societies or associations for the purpose of preventing the spread of or securing the proper treatment of persons infected with sexually transmitted disease.

D2.5 Property rights and inheritance

Botswana: Abolition of Marital Power Act 34 of 2004

This Act entered into force on 1 May 2005. Its full title is 'An Act to provide for the abolition of marital power, to amend the matrimonial property law of marriages, to provide for the domicile of married women, to provide for the domicile and guardianship of minor children and to provide for matters incidental thereto'. The Act provides for equal powers in community property of spouses who are married.

Excerpts

...

PART III – Provisions regarding marriages in community of property

...

7. Equal powers of spouses married in community of property

Subject to the provisions of this part, a husband and wife married in community of property

shall have equal capacity to

- (a) dispose of the assets of the joint estate;
- (b) contract debts for which the joint estate is liable; and
- (c) administer the joint estate.

8. Spouse's juristic act not subject to other spouse's consent

Subject to section 9, a spouse married in community of property may perform any juristic act with regard to the joint estate without the consent of the other spouse.

9. Acts requiring consent of spouse

A spouse married in community of property shall not without the written consent of the other spouse

- (a) alienate, mortgage, burden with a servitude or confer any other real right in any immovable property forming part of the joint estate;
- (b) enter into any contract for the alienation, mortgaging, burdening with a servitude or conferring of any other real right in immovable property forming part of the joint estate;
- (c) alienate, cede, or pledge any shares, stock, debenture, debenture bonds, insurance policies, mortgage bonds, deposits or any investment by or on behalf of the other spouse, forming part of the joint estate;
- (d) alienate, pledge or hypothecate any livestock, borehole, motor vehicle, jewellery, coins, stamps, paintings or other assets forming part of the joint estate;
- (e) alienate, pledge, hypothecate or otherwise burden any furniture or other effects of the common household forming part of the joint estate;
- (f) bind himself or herself as surety or enter into any loan or hypothecation agreement;
- (g) receive any money due or accruing to the other spouse or the joint estate by way of
 - (i) remuneration, earnings, bonus, allowance, royalty, pension or gratuity by virtue of the other spouse's employment, profession, trade, business or services rendered by the other spouse;
 - (ii) compensation for loss of any income contemplated in subparagraph i;
 - (iii) inheritance, legacy, donation, bursary, or prize left, bequeathed, made or awarded to the other spouse;
 - (iv) income derived from the separate property of the other spouse;

- (v) dividends or interest on or the proceeds of shares or investments in the name of the other spouse; or
- (vi) the proceeds of any insurance policy or annuity in favour of the other spouse;
- (h) deal with or dispose of moneys received under paragraph g; or
- (i) donate to another person any asset of the joint estate.

...

11. Acts not requiring other spouse's consent

A spouse married in community of property may without the consent of the other spouse

- (a) sell, cede or pledge listed securities on a stock exchange in order to buy other listed securities; and
- (b) perform acts required to be performed in the ordinary course of his or her profession, trade, occupation or business.

12. Want of consent and suspension of power of spouse

(1) A court may on application by a spouse married in community of property, grant the spouse leave to perform an act without the required consent under this part, where the court is satisfied that

- (a) in the case where the consent is withheld, such withholding is unreasonable; or
- (b) there is good reason to dispense with the consent.

(2) A court may on application by a spouse, suspend for a definite or indefinite period, any power that the other spouse may exercise under this part where the court is satisfied that it is essential for the protection of the interest of the applicant.

(3) A suspension under subsection 2 may be general or in relation to a particular act as the court may specify in the order.

...

PART IV – Provisions regarding marriages out of community of property

14. Liability for household necessities

(1) Spouses married out of community of property shall be jointly and severally liable to third parties for all debts incurred by either of them in respect of necessities for the joint household.

(2) A spouse married out of community of property has a right of recourse against the other spouse in so far as he has contributed more in respect of necessities for the joint household than for which he is liable.

15. Joint acquisition of property

(1) Where spouses married out of community of property acquire property jointly, Part III of this Act shall, in respect of the property, apply as if the marriage is in community of property.

(2) A spouse married out of community of property has a right of recourse against the other spouse in so far as he has contributed to the acquisition of property by that other.

...

Lesotho: Legal Capacity of Married Persons Act 9 of 2006

Enacted by Parliament on 2006 and published in the Government Gazette on 6 December 2006. It provides for the abolition of minority status of married women.

Excerpts

...

PART II – Repeal of marital power

3. Repeal of marital power

(1) Subject to the provisions of this Act with regard to the administration of a joint estate, the common law, customary law and any other marriage rules in terms of which a husband acquires the marital power over the person and property of his wife are repealed.

(2) The marital power which a husband has over the person and property of his wife before the commencement of this Act is repealed.

(3) The following restrictions which the marital power places on the legal capacity of a wife are removed

- (a) entering into a contract;
- (b) suing or being sued;
- (c) registering immovable property in her name;
- (d) acting as an executrix of a deceased's estate;
- (e) acting as a trustee of an estate;
- (f) acting as a director of a company;
- (g) binding herself as surety; and
- (h) performing any other act which was restricted by any law due to the marital power before the commencement of this Act.

(4) The repeal of the marital power under subsection 2 shall not affect the legal consequences of any act or omission made, or fact which existed before the commencement of this Act.

PART III – Marriage in community of property

4. The provisions of this part shall apply to a marriage in community of property, irrespective of the date on which the marriage was entered into.

5. Equal powers of spouses

Spouses married in community of property have equal capacity to do the following in consultation with one another

- (a) dispose of the assets of the joint estate;
- (b) contract debts of which the joint estate is liable; and
- (c) administer the joint estate.

6. Spouse's juristic acts

Subject to section 7, a spouse married in community of property may perform any act which arises by virtue of operation of law with regard to the joint estate without the consent of the other spouse.

...

Malawi: Deceased Estates (Wills, Inheritance and Protection) Bill (2004)

Drafted to replace the present Wills and Inheritance Act and the provisions of other subsidiary legislation. Among other things, this Bill protects the property rights of immediate family members by, in particular, criminalising property-grabbing.

Excerpts

...

PART V – Intestacy

...

17.(1) Upon intestacy the persons entitled to inherit the intestate property shall be the members of the immediate family and dependants of intestate the intestate and their shares shall be ascertained upon the following principles of fair distribution

...

(b) every spouse of the intestate shall be entitled to retain all the household belongings which belong to his household;

(c) if any property shall remain after paragraphs a and b have been complied with, the remaining property shall be divided between the surviving spouse or spouses and the children of the intestate;

(d) as between the surviving spouse or spouses and the children of the intestate their shares shall be determined in accordance with all the special circumstances including

(i) any wishes expressed by the intestate in the presence of reliable witnesses;

(ii) such assistance by way of education or other basic necessities any of the spouses or children may have received from the intestate during his lifetime; and

(iii) any contribution made by the spouse or child of the intestate to the value of any business or other property forming part of the estate of the intestate, and in this regard the surviving spouse shall be considered to have contributed to the business unless proof to the contrary is shown by or on behalf of the child, but in the absence of special circumstances the spouses and children shall, subject to subsection (3) be entitled to equal shares;

...

Namibia: Married Persons Equality Act 1 of 1996

Promulgated by the President on 20 May 1996, this Act abolishes the power of husbands over their wives and their property.

Excerpts

...

PART I – Abolition of marital power

2. Abolition of marital power

(1) Subject to the provisions of this Act with regard to the administration of a joint estate

(a) the common law rule in terms of which a husband acquires the marital power over the person and property of his wife is hereby repealed; and

(b) the marital power which any husband had over the person and property of his wife immediately before the commencement of this Act, is hereby abolished.

...

PART II – Provisions regarding marriages in community of property

5. Equal powers of spouses married in community of property

Subject to this Part, a husband and wife married in community of property have equal capacity

- (a) to dispose of the assets of the joint estate;
- (b) to contract debts for which the joint estate is liable; and
- (c) to administer the joint estate.

...

Namibia: Communal Land Reform Act 5 of 2002

Assented to by the President on 25 July 2002, this Act regulates, among others, inheritance rights with regard to customary land.

Excerpts

...

CHAPTER IV – Allocation of rights in respect of communal land

26. Duration of customary land right

(1) Subject to section 27, and unless the right is relinquished by the holder thereof, a customary land right allocated under this Act endures for the natural life of the person to whom it is allocated.

(2) Upon the death of the holder of a right referred to in subsection 1 such right reverts to the Chief or traditional authority for re-allocation forthwith

(a) to the surviving spouse of the deceased person, if such spouse consents to such allocation;

...

(3) If, after the allocation of a customary land right to a surviving spouse referred to in subsection 2, such spouse enters into a second or subsequent marriage, then, upon the death of such surviving spouse, the right in question reverts to the Chief or traditional authority for re-allocation of such right forthwith

(a) to the surviving spouse, if any, of such second or subsequent marriage, if he or she consents to such allocation;

...

D2.6 Customary practices

Eritrea: Female Circumcision Abolition Proclamation No158/2007

Published in the Government *Gazette* on 20 March 2007. The Proclamation abolishes female circumcision.

Whereas, female circumcision is a procedure that seriously endangers the health of women, causes them considerable pain and suffering and threatens their lives;

Whereas, this procedure violates women's basic human rights by depriving them of their physical and mental integrity, their right to freedom from violence and discrimination, and in the most extreme case, their life;

Whereas, the immediate or long-term harmful consequences of this procedure vary according to the type and custom of the procedure performed;

Whereas, its immediate consequences include severe pain, haemorrhage which can cause fainting or death, ulceration of the genital region and injury to adjacent tissues, urine retention and dangerous infection;

Whereas, its long-term consequences include recurrent infection of the urinary system, permanent infection of the fertility system, complications in childbirth (barrenness) and scar formation such as increasing abscess in the labia minor and, prevention of menstruation;

Whereas, it has been traditionally practised and is prevalent in Eritrea; and

Whereas, the Eritrean Government has decided to abolish this harmful procedure which violates women's rights;

Now, therefore, it is proclaimed as follows

Article 1. Short citation

This proclamation may be cited as "The Female Circumcision Abolition Proclamation No 158/2007"

Article 2. Definition

In this Proclamation, "female circumcision" means

(1) the excision of the prepuce with partial or total excision of the clitoris (clitoridectomy);

(2) the partial or total excision of the labia minora;

(3) the partial or total excision of the external genitalia (of the labia minora and the labia majora), including stitching;

(4) the stitching with thorns, straw, thread or by other means in order to connect the excision of the labia and the cutting of the vagina and the introduction of corrosive substances or herbs into the vagina for the purpose of narrowing it;

(5) symbolic practices that involve the nicking and pricking of the clitoris to release drops of blood; or

(6) engaging in any other form of female genital mutilation and/or cutting.

Article 3. Prohibition of female circumcision

Female Circumcision is hereby abolished.

Article 4. Punishment

(1) Whosoever performs female circumcision shall be punishable with imprisonment of two to three years and a fine of five to ten thousand (5,000.00 to 10,000.00) Nakfa. If female circumcision causes death, imprisonment shall be from five to ten years.

(2) Whosoever requests, incites or promotes female circumcision by providing tools or by any other means shall be punishable with imprisonment of six months to one year and a fine of three thousand (3,000.00) Nakfa.

(3) Where the person who performs female circumcision is a member of the medical professions, the penalty shall be aggravated and the court may suspend such an offender from practicing his profession for a maximum period of two years.

(4) Whosoever, knowing that female circumcision is to take place or has taken place, fails, without good cause, to warn or inform, as the case may be, the proper authorities promptly about it, shall be punishable with a fine of up to one thousand (1,000.00) Nakfa.

Article 5. Effective date

This Proclamation shall enter into force as of the date of its publication in the *Gazette* of Eritrean Laws.

Kenya: Children Act 8 of 2001

See text and background under 'Children's rights and protection of vulnerable groups', in particular article 14.

D2.7 Domestic violence

Lesotho: Legal Capacity of Married Persons Act 9 of 2006

See extract under 'Property rights and inheritance'.

Malawi: Protection against (Prevention of) Domestic Violence Act 5 of 2006

This Act was developed by the Ministry of Gender, Child Welfare and Community Services and was adopted by Parliament on 21 June 2006. The importance of the Domestic Violence Act is its broad applicability; it covers not only spousal relationships but also includes 'relations between family members' or financially dependent relations.

Excerpts

In this Act, unless the context otherwise requires

"domestic relationship", in relation to domestic violence, means the relationship between persons who are family members and share a household residence or are dependent on each other financially, and includes the relationship where

- (a) the applicant and the respondent are spouses;
- (b) a person has a child in common with the respondent and that person is being subjected or is likely to be subjected to domestic violence by the respondent;
- (c) one is a parent and the other is his child or dependent; and
- (d) the applicant and the respondent are or have been in a visiting relationship for a period exceeding twelve months;

"domestic violence" includes physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household, dependant or parent of a child of that household;

...

Namibia: Combating of Rape Act 8 of 2000

Adopted by parliament on 19 April 2000 and entered into force on 15 June 2000. Among other things, it provides for the criminalisation of marital rape.

Excerpts

...

2. Rape

(1) Any person (in this Act referred to as a perpetrator) who intentionally under coercive circumstances

- (a) commits or continues to commit a sexual act with another person; or
- (b) causes another person to commit a sexual act with the perpetrator or with a third person, shall be guilty of the offence of rape.

...

(3) No marriage or other relationship shall constitute a defence to a charge of rape under this Act.

3. Penalties

(1) Any person who is convicted of rape under this Act shall, subject to the provisions of subsections 2, 3 and 4, be liable

- (a) in the case of a first conviction

...

- (iii) where

...

- (dd) the convicted person is infected with any serious sexually-transmitted disease and at the time of the commission of the rape knows that he is so infected;

...

- (b) in the case of a second or subsequent conviction (whether previously convicted of rape under the common law or under this Act)

...

- (iii) where the rape in question or any other rape of which such person has previously been convicted was committed under any of the circumstances referred to in subparagraph (iii) of paragraph a, to imprisonment for a period of not less than forty-five years.

Namibia: Combating of Domestic Violence Act 4 of 2003

Promulgated by the President on 6 June 2003. This Act lists offences of 'domestic violence' and criminalises marital rape.

Excerpts

...

2. Definition of domestic violence

(1) For the purposes of this Act, "domestic violence", within the context of a domestic relationship, means engaging in any of the following acts or courses of conduct

...

- (b) sexual abuse, which includes
 - (i) forcing the complainant to engage in any sexual contact;
 - (ii) engaging in any sexual conduct that abuses, humiliates or degrades or otherwise violates the sexual integrity of the complainant;
 - (iii) exposing the complainant to sexual material which humiliates, degrades or violates the complainant's sexual integrity; or
 - (iv) engaging in such contact or conduct with another person with whom the complainant has emotional ties;

...

3. Definition of domestic relationship

(1) For the purposes of this Act a person is in a "domestic relationship" with another person if, subject to subsection 2

- (a) they are or were married to each other, including a marriage according to any law, custom or religion, or are or were engaged to be so married;
- (b) they, being of different sexes, live or have lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other;
- (c) they have, have had or are expecting a child together, excluding situations
 - (i) where the child is conceived as a result of rape; or
 - (ii) where the parties contributed gametes for artificial insemination, *in vitro* fertilisation or similar fertilisation techniques, but have no other relationship;
- (d) they are parent and biological or adoptive child;
- (e) they

- (i) are or were otherwise family members related by consanguinity, affinity or adoption, or stand in the place of such family members by virtue of foster arrangements; or
- (ii) would be family members related by affinity if the persons referred to in paragraph b were married to each other, and they have some connection of a domestic nature, including, but not limited to
- (aa) the sharing of a residence; or
- (bb) one of them being financially or otherwise dependant on the other; or
- (f) they, being of different sexes, are or were in an actual or a perceived intimate or romantic relationship.
- ...

Mauritius: Sex Discrimination Act 43 of 2002

Assented to by the President on 21 December 2002 and entered into force on 8 March 2003. It prohibits discrimination on the ground of sex in various instances.

Excerpts

...

PART II – Protection against unlawful discrimination

4. Definition and prohibited grounds of discrimination

- (1) For the purposes of this Act, a person discriminates against another person if the first-mentioned person makes, on any of the grounds specified in subsection 2, any distinction, exclusion or preference, the intent or effect of which is to nullify or impair equality of opportunity or treatment or employment
- (2) The grounds referred to in subsection 1 are
- (a) sex, marital status, pregnancy or family responsibility; or
- (b) a characteristic that generally appertains, or is imputed, to a person of the same sex or marital status as that other person, or to a person who is pregnant or has family responsibility.
- (3) Any act or omission or any practice or policy that directly or indirectly results in discrimination against a person on a ground referred to in subsection 2, is an act of discrimination regardless of whether the person responsible for the act or omission or the practice or policy, intended to discriminate and shall constitute an offence.
- ...

Mauritius: Protection from Domestic Violence (Amendment) Act 11 of 2004

Assented to by the President on 15 June 2004 and entered into force on 20 June 2004. It defines domestic violence and criminalises marital rape.

Excerpts

...

Section 2

“Domestic violence” includes any of the following acts committed by a person against his spouse, a child of his spouse or another person living under the same roof

...

- (d) compelling the spouse or the other person by force or threat to engage in any conduct or act, sexual or otherwise, from which the spouse or the other person has the right to abstain;

South Africa: Domestic Violence Act 116 of 1998

Assented to by the President on 20 November 1998 and entered into force on 15 December 1999. It includes broad provisions for domestic violence.

Excerpts

...

1. Definitions

In this Act, unless the context indicates otherwise “domestic violence” means,

- (a) physical abuse;
- (b) sexual abuse;
- (c) emotional, verbal and psychological abuse;
- (d) economic abuse;
- (e) intimidation;
- (f) harassment;
- (g) stalking;
- (h) damage to property;
- (i) entry into the complainant’s residence without consent, where the parties do not share the same residence; or
- (j) any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to, the safety. Health or wellbeing of the complainant;
- ...

Uganda: Domestic Relations Bill (2003)

This Bill is the product of a comprehensive study conducted by the Uganda Law Reform Commission. Its objectives include consolidating the law relating to marriage, separation and divorce and providing marital rights and duties. Among other things, the Bill deals with the age of marriage, consent to marriage and sexual rights, and the offences of adultery and marital rape. The Bill also prohibits widow inheritance.

Excerpts

...

PART III – Elements of marriage

14. A person shall not have the capacity to marry unless he has attained eighteen years of age.

15.(1) A marriage shall not be celebrated solemnised or contracted in Uganda without the consent of either party to the intended marriage.

...

16.(1) A man shall not marry a widow through the custom or practice of widow inheritance.

...

(3) Widow inheritance is prohibited.

...

PART IX – Matrimonial rights and obligations

60.(1) Spouses are entitled to equal rights to consortium in marriage.

(2) Notwithstanding subsection 1, a spouse may deny the other spouse the right to sexual intercourse on reasonable grounds, which may include

- (a) poor health;
- (b) after child birth;
- (c) after surgery;
- (d) during medical treatment or observation; or
- (e) reasonable fear that engaging in sexual intercourse is likely to cause physical or psychological injury or harm to the spouse denying the other spouse the right to sexual intercourse.

61. Where a person has sex with his spouse against the consent of the spouse, the act shall create both a criminal and civil liability, and in the case of

- (a) a criminal offence, a person who commits the offence is, on conviction, liable to a fine not exceeding twenty four currency points or to imprisonment not exceeding one year or both; and in addition, the Court may direct the person to pay to the spouse, compensation not exceeding thirty currency points; and
- (b) a civil wrong, shall give rise to a civil remedy such as a restricting order, suspension of conjugal rights or compensation as the Court may determine.

...

65.(1) Matrimonial property shall include

- (a) the matrimonial home or homes
- (b) household property in the matrimonial home or homes;
- (c) any other property either immovable or movable acquired during the subsistence of a marriage, deemed to be matrimonial property by express or implied agreement as construed through the conduct of the spouses; and
- (d) immovable property owned by either spouse, which provides the basic income for the family.

(2) Where immovable property has been ascertained as matrimonial property, if it is not already registered, it shall be registered in the names of the husband and wife; but where that property was registered in the name of one spouse, then notwithstanding any law to the contrary, it shall be deemed to be registered as matrimonial property.

(3) Any property held by a spouse as trust property whether acquired by way of inheritance or otherwise, shall not form part of matrimonial property.

(4) For the avoidance of doubt, the parties to a marriage may, by agreement entered before or during marriage, determine their property rights.

66.(1) Any matrimonial property, as defined by section 65, shall be owned in common by the spouses.

...

69. Where a spouse has acquired property before marriage or acquires property during the marriage and the property is not matrimonial property as defined under section 65, but the other spouse makes a contribution towards the improvement of that property, whether it is monetary or non-monetary, the spouse without an interest shall acquire a beneficial interest in the property equivalent to the contribution he has made.

70.(1) Where a man has more than one wife in a polygamous marriage, ownership in common of property between the husband and each particular wife shall be determined as follows

- (a) matrimonial property acquired by the man and the first wife shall be owned in common by the husband and the first wife if acquired before the man married the second wife.
- (b) any matrimonial property acquired after the man marries a second wife shall be regarded as owned in common by the man, the first wife and the second wife, and the same principle shall be applied to any other subsequent wife or wives.

(c) notwithstanding paragraph b of subsection 1, where it is clear either by agreement or through conduct of the parties that each wife has her separate matrimonial property, then she will own that matrimonial property in common with the husband without the participation of the other wives.

71. Subject to this Act, a spouse in any form of marriage recognised under this Act shall have the capacity to acquire his or her own separate property during the subsistence of the marriage.

72. No transaction shall be entered into in respect of any matrimonial property from which the family derives sustenance except with the written consent of the other spouse and dependent children as required by section 39 of the Land Act.

Zimbabwe: The Criminal Law (Codification and Reform) Act No 23 of 2004

This Act entered into force on 1 July 2006. It modified or repealed several pre-existing pieces of legislation including the Sexual Offences Act of 2001. The Criminal Law (Codification and Reform) Act excludes marriage as a defence to a charge of rape but creates a condition for the prosecution of that offence.

Excerpts

...

68. Unavailable defences to rape, aggravated indecent assault and indecent assault

It shall not be a defence to a charge of rape, aggravated indecent assault or indecent assault

(a) that the female person was the spouse of the accused person at the time of any sexual intercourse or other act that forms the subject of the charge

Provided that no prosecution shall be instituted against any husband for raping or indecently assaulting his wife in contravention of section sixty-six or sixty-seven unless the Attorney-General has authorised such a prosecution; or

(b) subject to sections six, seven and sixty-three, that the accused person was a male person below the age of fourteen years at the time of the sexual intercourse or other act that forms the subject of the charge.

...

D2.8 Children rights and protection of vulnerable groups

Djibouti: Law 48 on the Orientation of Health Policy

See extract under the section on 'right to health care', in particular articles 5, 115, and 116.

Kenya: Children's Act 8 of 2001

This Act of Parliament makes provision for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children. It also makes provision for the administration of children's institutions, gives effect to the principles of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

...

5. No child shall be subjected to discrimination on the ground of origin, sex, religion, creed, custom, language, opinion, conscience, colour, birth, social, political, economic or other status, race, disability, tribe, residence or local connection.

6.(1) A child shall have a right to live with and to be cared for by his or her parents.

(2) Subject to subsection 1, where the court or the Director determines in accordance with the law that it is in the best interests of the child to separate him from his or her parent, the best alternative care available shall be provided for the child.

(3) Where a child is separated from his or her family without the leave of the court, the Government shall provide assistance for reunification of the child with his or her family.

7.(1) Every child shall be entitled to education the provision of which shall be the responsibility of the Government and the parents.

(2) Every child shall be entitled to free basic education which shall be compulsory in accordance with article 28 of the United Nations Convention on the Rights of the Child.

...

9. Every child shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government.

13.(1) A child shall be entitled to protection from physical and psychological abuse, neglect and any other form of exploitation including sale, trafficking or abduction by any person.

(2) Any child who becomes the victim of abuse, in the terms of subsection 1, shall be accorded appropriate treatment and rehabilitation in accordance with such regulations as the Minister may make.

...

15. A child shall be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials.

...

19. Every child shall have the right to privacy subject to parental guidance.

20. Notwithstanding penalties contained in any other law, where any person wilfully or as a consequence of culpable negligence infringes any of the rights of a child as specified in sections 5 to 19 such person shall be liable upon summary conviction to a term of imprisonment not exceeding twelve months, or to a fine not exceeding fifty thousand shillings or to both such imprisonment and fine.

Madagascar: Law no 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005)

See full text under 'HIV specific laws', in particular articles 36 to 38 and 56 to 61.

Malawi: Child (Care, Protection and Justice) Bill (2003)

This Bill seeks to modernise the child justice system in Malawi by putting emphasis on the rehabilitation of child offenders and their reintegration into society. In addition, it seeks to improve the child care and protection system in Malawi.

...

CHAPTER I – Child care and protection by the family

...

94.(1) A parent or guardian shall not deprive a child of his or her welfare.

(2) Parent or guardian have responsibilities whether imposed by law or otherwise towards the child which include the responsibility to

(a) protect the child from neglect, discrimination, violence abuse, exploitation, oppression and exposure to physical, mental, social and moral hazards;

(b) provide proper guidance, care, assistance and maintenance for the child to ensure his or her survival and development, including in particular adequate diet, clothing, shelter and medical attention;

(c) ensure that during their temporary absence, the child shall be cared for by a competent person;

(d) exercise joint primary responsibility for raising their children;

except where the parent or guardian has forfeited or surrendered his or her rights and responsibilities in accordance with the law.

(3) A parent or guardian shall be responsible for the registration of the birth of his children.

(4) The fact that a parent or guardian has parental responsibility for a child shall not entitle him to act in any way which would be incompatible with any court order made in respect of the child.

(5) Subject to this Act, a person who does not have parental responsibility for a particular child but has care of the child may do what is reasonable in all the circumstances of the case for the purposes of safeguarding or promoting the child's welfare.

(6) Where it is more than one person that have parental responsibility for a child, each of them may act alone and without the other (or others) in meeting that responsibility; but nothing in this Chapter shall affect the operation of any law which requires the consent of more than one person in a matter affecting the child.

95. In the application of the provisions of this Act, and in any matter concerning a child, due regard shall be had to duties and responsibilities of the child to

(a) respect the parents, guardians, superiors and elders at all times and depending on the age of the child assist them in cases of need;

(b) serve the community by placing his physical and intellectual abilities at its service;

(c) preserve and strengthen social and national unity and character of Malawi;

(d) uphold the positive values of the community; and

(e) contribute towards the child's own development into being a useful member of the society,

but due regard shall be paid to the age and ability of the child and to such limitations as are contained in this Act.

96.(1) Where parents are not known or where parentage is disputed, the following persons may apply to a child justice court for an order to determine the parentage of a child

(a) the child;

(b) the parent of the child;

(c) the guardian of the child;

(d) a probation officer;

(e) a social welfare officer,

or any other interested person as the child justice court may deem fit.

(2) The application for parentage may be made

(a) before the child is born; or

(b) before a child is eighteen years of age or after the child has attained that age but with special leave of a child justice court or High Court

(3) For the purposes of succession and inheritance, the application for parentage shall be made within three years after the death of the father or mother of a child.

...

CHAPTER II – Children in need of care and protection

114.(1) A child is in need of care and protection if

(a) the child has been or there is substantial risk that the child will be physically, psychologically or emotionally injured or sexually abused by the parent or guardian or a member of the family or any other person;

(b) the child has been or there is substantial risk that the child will be physically injured or emotionally injured or sexually abused and the parent or guardian or any other person, knowing of such injury, risk or abuse or risk, has not protected or is unlikely to protect the child from such injury, risk or abuse;

(c) the parent or guardian of the child is unfit or has neglected, or is unable, to exercise proper supervision and control over the child and the child is falling into undesirable association;

(d) the parent or guardian of the child has neglected or is unwilling to provide for the child's adequate care, food, clothing, shelter, education and health;

(e) the child

(i) has no parent or guardian; or

(ii) has been abandoned by the parents or guardians and after reasonable inquiries the parents or guardians cannot be found, and no other suitable person is willing and able to care for the child;

(f) the child needs to be examined, investigated or treated for the purposes of restoring or preserving the child's health and if the parents or guardians neglects or refuse to have the child so examined, investigated or treated;

(g) the child behaves in a manner that is, or is likely to be, harmful to the child or to any other person and the parents or guardians are unable or unwilling to take necessary measures to remedy the situation or the remedial measures taken by the parents or guardians have failed and as a result the child cannot be controlled by his or her parents or guardians;

(h) there is such a conflict between the child and the parent(s) or guardians, or between the parents or guardians, that family relationships are seriously disrupted, thereby causing the child emotional injury;

(h) the child is in the custody of a person who has been convicted of committing an offence in connection with that child;

(i) the child frequents the company of immoral, vicious, or otherwise undesirable person or persons or is living in circumstances calculated to cause or induce the child's seduction, corruption or prostitution;

(j) the child is allowed to be on a street, premises or any place for the purpose of

(i) begging or receiving alms, whether or not there is any pretence of singing, playing, performing or offering anything for sale and as a result the child becomes a habitual beggar;

(ii) carrying out illegal hawking, illegal lotteries, gambling or other illegal activities detrimental to the health and welfare or retard the educational advancement of the child;

(k) the child cannot be controlled by his or her parent or guardian or the person in custody of the child;

(l) if the child is assessed by the Social Welfare Officer to be in need of care and protection.

(2) For the purposes of this Chapter, a child is

(a) physically injured if there is injury to any part of the child's body as a result of the non-accidental application of force or agent to the child's body that is evidenced by, among other things, a laceration, a concussion, an abrasion, a scar, a fracture or other bone injury, a dislocation, a sprain, a haemorrhaging, a

rupture, a burn, a scald, loss or alteration of consciousness or loss of hair or teeth;

(b) emotionally and psychologically injured if there is impairment of the child's mental or emotional functioning that is evidenced by, amongst other things, a mental or behavioural disorder, including anxiety, depression, withdrawal, aggression or delayed development;

(c) sexually abused if the child has taken part, whether as a participant or an observer, in any activity which is sexual in nature for the purposes of

(i) any pornographic or indecent material, photograph, recording, film, videotape or performance; or

(ii) sexual exploitation by any person for that person's the other person's sexual gratification or for commercial gain.

115. A police officer, social welfare officer, a chief or any member of the community, if satisfied on reasonable grounds that a child is in need of care and protection, may take the child and place him into his temporary custody or a place of safety.

...

117.(1) If a social welfare officer, police officer, chief or any member of the community is of the opinion that a child is in need of medical examination or treatment he may, instead of bringing the child before a child justice court present the child for medical care.

...

119. If the medical officer is of the opinion that hospitalisation of the child is necessary, he shall cause the child to be so hospitalised.

...

164. A local government authority shall keep a register of disabled children within its area of jurisdiction and give assistance to them whenever possible in order to enable those children grow up with dignity among other children and to develop their potential and self-reliance.

165. A local government authority shall provide accommodation for children within its area of jurisdiction who appear to the assembly to be in of the accommodation as a result of their being lost or abandoned or seeking refuge.

166. A local government authority shall make every effort, including publication through the mass media, to trace the parents or guardians of any lost or abandoned child or to return the child to the place where the child ordinarily resides; and, where the authority does not succeed, it shall refer the matter to a probation officer or social welfare officer or to the police.

...

169. A local government authority shall keep a register of children suffering from HIV/AIDS for the purposes of ensuring that

(a) they are not discriminated against on the basis of their status;

(b) they have equal access to health care services regardless of their status;

(c) they are provided with the necessary material support if required; and

(d) in conjunction with the District Social Welfare Officer, they are provided with substitute care in the form of

(i) care by relatives;

(ii) foster-care; or

(iii) adoption

(2) For the purposes of this section, children suffering from HIV/AIDS means children who are-

(a) infected by HIV;

(b) orphaned by AIDS

(c) vulnerable to HIV infection; or

(d) from infected families and facing increased financial, physical and emotional burdens.

CHAPTER VI – Protection of children from undesirable practices

170.(1) A person who, unlawfully takes, retains or conceals a child without the consent of the parent or without the consent of any other person who has lawful custody of the child commits an offence and shall be liable to imprisonment for ten years.

(2) For the purposes of this section, lawful custody may be conferred on a person by

- (a) the operation of any written law;
- (b) judicial or administrative decision; or
- (c) a lawful agreement.

171.(1) A person who takes part in any transaction the object or one of the objects of which is child trafficking commits an offence and shall be liable to imprisonment for life.

(2) For the purposes of this section, child trafficking means the recruitment, transaction, transfer, harbouring or receipt of a child for the purposes of exploitation.

172. No person shall subject a child to a social or customary practice that is harmful to the health or general development of the child.

173. No person shall

- (a) force a child into marriage;
- (b) force a child to be betrothed; or
- (c) subject a child to any dowry transaction.

174. No person shall

- (a) use a child as a pledge to obtain credit;
- (b) use a child as surety for a debt or mortgage; or
- (c) force a child into providing labour for the income of a parent, guardian or any other person.

175. A person who contravenes sections 172, 173 and 174 commits an offence and shall be liable to imprisonment for three years.

176.(1) If a social welfare officer has reasonable grounds to believe that a child

- (a) has been trafficked;
- (b) has been abducted;
- (c) has been subjected to a harmful cultural practice or any practice prohibited under sections 173 and 174; or
- (d) is being used for the purposes of prostitution or immoral practices, he may remove and temporarily place the child in a place of safety.

(2) A child who is temporarily placed in a place of safety, under this chapter shall be brought before a child justice court within forty-eight hours if it is practicable to do so.

(3) The child justice court may commit the child to a foster home or may place the child under the supervision of a social welfare officer until an inquiry into the circumstances of the case has been carried out and submitted to the child justice court by a social welfare officer.

(4) The social welfare officer shall complete the inquiry under subsection 3 and submit a report of the inquiry to the child justice court within one month from the date of placing the child into a place of safety.

(5) The child justice court may, after considering the report and if satisfied that the child is in need of protection and rehabilitation

- (a) commit the child to a foster home;
- (b) make an order placing the child under the supervision of a social welfare officer, for such period as the court thinks fit.
- (6) The child justice court may, in the best interests of the child, extend the period of the placement or the supervision, but such extension shall not go beyond the eighteenth birthday of the child.

(7) If the child justice court is not satisfied that the child is in need of protection or rehabilitation, it may order that the child be

returned to the custody of the parent, guardian or any other person who had custody of the child.

Mauritius: Child Protection (Amendment) Bill 36 of 2005

The purpose of this Bill is to amend the Child Protection Act to make better provision for the prevention, suppression and punishment of trafficking in children and to protect children generally.

Excerpts

...

13A. Child trafficking

(1) Any person who wilfully and unlawfully recruits, transports, transfers, harbours or receives a child for the purpose of exploitation shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding 15 years.

(2) Any person who wilfully and unlawfully recruits, transports, transfers, harbours or receives a child

(a) outside Mauritius for the purpose of exploitation in Mauritius; in Mauritius for the purpose of exploitation outside Mauritius, shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding 15 years.

...

(4)(a) Any person who takes part in any transaction the object or one of the objects of which is to transfer or confer, wholly or partly, temporarily or permanently, the possession, custody or control of a child in return for any valuable consideration shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding 15 years.

(b) Any person who, without lawful authority or reasonable excuse, harbours or has in his possession, custody or control of any child in respect of whom the temporary or permanent possession, custody or control has been transferred or conferred for valuable consideration by any other person in or outside Mauritius, shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding 15 years.

(5)(a) No press report of any court proceedings relating to an offence under this section shall include any particulars calculated to lead to the identification of any child who is the victim of that offence, nor shall any photograph or picture be published in any newspaper or broadcast as being or including a photograph or picture of that child.

(b) Any person who contravenes paragraph a shall commit an offence and shall, on conviction, be liable in respect of each offence to a fine not exceeding 100,000 rupees and to imprisonment for a term not exceeding one year.

(6) Part X of the Criminal Procedure Act and the Probation of Offenders Act shall not apply to a person liable to be sentenced under this section.

(7) In this section

‘exploitation’ includes the exploitation of the prostitution of children or other forms of sexual exploitation, forced labour or services, slavery or, practices similar to slavery, servitude or the removal of organs.

13B. Abandonment of child

(1) Any person who, for pecuniary gain or by gifts, promises, threats or abuse of authority, incites the parents of a child to abandon the child or a child to be born shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding eight years.

(2) Any person who, for pecuniary or other gain, acts as an intermediary between a person wishing to adopt a child and a parent willing to abandon a child or a child to be born, shall commit an offence and shall, on conviction, be liable to a fine not

exceeding 500,000 rupees and to penal servitude for a term not exceeding 15 years.

(3) Any person who exposes and abandons in a secluded spot any child, and any person who orders the child to be exposed, where such order has been executed, shall, for such act alone, be liable, on conviction, to a fine not exceeding 250,000 rupees and to imprisonment for a term not exceeding 5 years.

...

(6) Part X of the Criminal Procedure Act and the Probation of Offenders Act shall not apply to a person liable to be sentenced under this section.

13C. Abducting a child

(1) Any person who, by force or fraud, without the consent of the legal custodian

(a) takes away or causes to be taken away a child; or

(b) leads away, decoys, entices or causes to be led away, decoyed or enticed, a child out of the keeping of the custodian or from any place where the child has been placed or is with the consent of the custodian,

shall commit the offence of abduction, and shall, on conviction, be liable to penal servitude for a term not exceeding 12 years.

(2) Any person who unduly fails to present a child to the person who has the right to claim the child, shall commit an offence and shall, on conviction, be liable to a fine not exceeding 100,000 rupees and to imprisonment for a term not exceeding 2 years.

(3) In the case specified in subsection 1, where the abduction is committed without fraud or violence, the offender shall be liable to penal servitude for a term not exceeding eight years.

(4) Where an offender who has committed an offence under subsection 1 has civilly married the child whom he has so taken away, he shall not be prosecuted, except upon the complaint of the parties who have the right, under the Code Napoleon, of suing for the nullity of such marriage, and he shall not be convicted until after the nullity of the marriage has been pronounced.

(5) Part X of the Criminal Procedure Act and the Probation of Offenders Act shall not apply to a person liable to be sentenced under this section.

...

Rwanda: Law 27 of 2001 Relating to the Rights and Protection of the Child Against Violence

Promulgated on 28 April 2001. It covers a wide range of children's rights and criminalises forced marriage of a child below the age of twenty one.

Excerpts

...

CHAPTER 1 – Rights of the child

Article 1

For the purpose of this law, a child is anybody aged below eighteen (18) years with the exception of what is provided for in other laws.

Article 2

All the rights and their governing laws included in this law are to the benefit of all children. No article of this law modifies any articles of other existing laws that may provide more favourable rights and protection of the child against violence than those provided for by this law.

Article 3

Childcare organisations or families should fulfil conditions allowing them to ensure the children's welfare concerning

protection, health, and the number of adequately qualified workers. A Decree of the Minister having the Social Affairs in his attributions fixes the requirements in relation with the provision of the preceding paragraph of this article.

...

Article 8

Every orphan must have a guardian, an adoptive parent or be under the care of a specialised institution. The State is responsible for any child having neither a guardian nor an adoptive parent. Conditions to be fulfilled by child care institutions are determined by a decree issued by the Minister having the Social Affairs in his attributions.

Article 9

The child's interests must be taken into account before any decision concerning him/her is made. It is a right for the child to express his or her opinion on any matter regarding him/her. It is necessary to hear from the child prior to making any decision concerning him/her regarding administrative and judiciary matters whether directly or indirectly through his or her representative.

Article 10

The child has a right to education. Primary school education is compulsory and free in respect to the provisions of the law. The Ministry having Education in his attributions and the Minister having the Social Affairs in his attributions determine modalities according to which children with needy parents may gain access secondary and higher education. The District Council is responsible for the implementation of the provision included in the second paragraph of this article and decides appropriate measures to be taken against those acting contrary to the law.

...

Article 14

Depending on their possibilities, parents, guardians of children and any other person responsible for children must respect the rights of a child in terms of his or her welfare including good living conditions, health care and education so as to allow the child to develop physically, in his or her thinking ability, intellectually, culturally and in life in general. The Ministry having the Social Affairs in its attributions ensures those rights are respected. For those children with needy parents, the Ministry determines a programme meant to assist them.

...

Article 16

Adoption of any child should be done in the interest of the child. A decree of the Minister having Social Affairs in his or her attributions determines the mechanism to ensure a regular follow-up of the conditions of adopted children in the concerned families.

...

Article 20

No child should be subjected to torture, inhuman and degrading treatment.

...

Article 22

Necessary administrative, legal measures and those concerning social welfare and education must be taken in order to reinforce protection of the child against any kind of violence, psychological or physical brutality, abandonment, neglect, mistreatment, or exploitation. The Minister having Social Affairs in his attributions takes necessary measures to assist and support children who are victims of violence as well as to ensure that the perpetrators of violence are followed up by the relevant authorities.

...

CHAPTER 2 – A child's responsibilities

Article 24

The National Commission on Human Rights must set up specifications on how to follow-up the protection of the rights of the child.

...

CHAPTER 3 – Crimes against children and their penalties

Article 28

Any person who knowingly withholds from administrative authorities information about the crimes provided for in this chapter, shall be sentenced to imprisonment of between six months and five years and a fine of between twenty thousand and one hundred thousand francs or one of the two penalties.

...

SECTION 2 – Crimes of rape and use of a child for dehumanising acts

Article 33

In this law, any sexual relations with a child, whatever the means or methods used, are considered as rape.

Article 34

Anybody who rapes a child who is between fourteen years and eighteen years of age shall be sentenced to imprisonment of between twenty years and twenty-five years' and be fined between one hundred thousand and five hundred thousand francs. Any body who rapes a child aged below fourteen years of age shall sentenced to life imprisonment and be fined between one hundred thousand to two hundred thousand francs.

Article 35

If the rapist causes death to a child or infects him/her with an incurable disease, the rapist is sentenced to death.

Article 36

If the crime of raping a child is committed by a parent, a guardian, a government official, a religious leader, a security officer, a medical officer, an educational officer, a trainee or any one using his or her professional power over the child, this crime is punishable by life imprisonment and a fine of between one hundred thousand and two hundred thousand francs.

...

SECTION 3 – Crimes of engaging a child in fornication and prostitution

Article 38

Whoever attracts persuades or deceives a child to commit her/himself to prostitution or fornication, shall be sentenced to imprisonment of between three months and five years and pay a fine of between of ten thousand and one hundred thousand francs.

SECTION 4 – Crimes of child exploitation

Article 39

Whoever by his initiative or through someone else, leads, keeps or provides funds knowingly to support child prostitution shall be sentenced to imprisonment of between five years to ten years and pay a fine of between two hundred thousand and five hundred thousand francs.

Article 40

Anyone who benefits from prostitution of a child or knowingly is given and accepts assistance well aware that it is from a child's prostitution shall be sentenced to imprisonment of between two years and five years.

Whoever uses children or exploits them for night activities aimed at advertising prostitution or as interest arousing means in pornographic publications, shall be sentenced to imprisonment of between five years and twelve years and pay a fine of between two hundred thousand five hundred thousand francs.

Article 41

Whoever kidnaps, sells or leads children into slavery, shall be sentenced to imprisonment of between five years and life imprisonment and pay a fine of between two hundred thousand to five hundred thousand francs.

Article 42

Whoever gives illicit drugs to a child or uses him/her in illicit drugs or arms trafficking or in fraudulent practices, shall be sentenced to imprisonment of between five years and twenty five years and pay a fine of between one hundred thousand and five hundred thousand francs.

SECTION 5 – Crimes of neglecting and abandoning a child

Article 43

Any parent or guardian who abandons a child in an open place or uses someone else to do so and the child is found, shall be sentenced to imprisonment of between one year and five years and pay a fine of between twenty thousand and one hundred thousand francs.

Article 44

A parent or guardian who abandons a child in a hidden place or uses someone else to do so and the child is found, shall be sentenced to imprisonment of between five years and fifteen years and pay a fine of between fifty thousand and two hundred thousand francs.

Article 45

If the abandonment results in an incurable disability, the culprit shall serve a sentence of life imprisonment. If a child dies as a result of abandonment, the culprit shall be sentenced to death.

Article 46

Any parent, guardian of a child or child-care institution falling to give him/her the required protection against violence and necessary care, shall be sentenced to imprisonment of between six months and five years or pay a fine of between twenty thousand and one hundred thousand francs. Any parent, guardian or person in charge of a childcare institution that engages a child in delinquency, is given aid or benefits that are a result of from a child's delinquency, shall be sentenced to an imprisonment of between three months and five years or pay a fine of between ten thousand and one hundred thousand francs.

SECTION 6 – Crimes of giving a child for premature or forced marriage

Article 47

Any conjugal living-together of a boy and girl where one of the two or both of them are below the age provided for in the Preliminary Title of Book I of the Civil Code, is considered premature marriage. Forced marriage is any marriage of a girl/ boy of less than twenty one years and without his or her consent.

Article 48

Anybody who lives with or attempts to live with a child of less than eighteen years of age as a husband or wife, shall receive the same sentence as one who has committed child rape. In case that child is above eighteen years of age but less than twenty one, the person that lived with or attempted to live with the child contrary to article 47 of this law, shall be sentenced to imprisonment of between six months and two years and pay a fine of between fifty thousand and one hundred thousand francs.

Article 49

Anyone who will have played a role in child's premature or forced marriage shall be sentenced to imprisonment of between

six months and five years and pay a fine of between twenty thousand and one hundred thousand francs.

Article 50

In case the person who has played a role in a child's premature or forced marriage is a parent or guardian of that child, he shall be sentenced to imprisonment of between one year and five years and pay a fine of between forty thousand and one hundred thousand francs.

CHAPTER 4 – Miscellaneous and final provisions

...

Article 52

Withstanding article two, paragraph two of this law, all articles of previous laws contrary to this law are hereby abrogated.

...

South Africa: Children's Act 38 of 2005

Promulgated by the President on 8 April 2006. Part of the Act entered into force on 1 July 2007. The following excerpts highlight some of the relevant sections of the Act.

Excerpts

...

12. Social, cultural and religious practices

(1) Every child has the right not to be subjected to social, cultural and religious practices which are detrimental to his well-being.

(2) A child

(a) below the minimum age set by law for a valid marriage may not be given out in marriage or engagement; and
(b) above that minimum age may not be given out in marriage or engagement without his or her consent.

(3) Genital mutilation or the circumcision of female children is prohibited.

(4) Virginity testing of children under the age of 16 is prohibited.

(5) Virginity testing of children older than 16 may only be performed

(a) if the child has given consent to the testing in the prescribed manner;
(b) after proper counselling of the child; and
(c) in the manner prescribed.

(6) The results of a virginity test may not be disclosed without the consent of the child.

(7) The body of a child who has undergone virginity testing may not be marked.

(8) Circumcision of male children under the age of 16 is prohibited, except when

(a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
(b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.

(9) Circumcision of male children older than 16 may only be performed

(a) if the child has given consent to the circumcision in the prescribed manner;
(b) after proper counselling of the child; and
(c) in the manner prescribed.

(10) Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision.

13. Information on health care

(1) Every child has the right to

(a) have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction;

(b) have access to information regarding his or her health status;

(c) have access to information regarding the causes and treatment of his or her health status; and

(d) confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.

(2) Information provided to children in terms of this subsection must be relevant and must be in a format accessible to children, giving due consideration to the needs of disabled children.

...

CHAPTER 3 – Parental responsibilities and rights

PART 1 – Acquisition and loss of parental responsibilities and rights

18. Parental responsibilities and rights

(1) A person may have either full or specific parental responsibilities and rights in respect of a child.

(2) The parental responsibilities and rights that a person may have in respect of a child, include the responsibility and the right

(a) to care for the child;

(b) to maintain contact with the child;

(c) to act as guardian of the child; and

(d) to contribute to the maintenance of the child.

(3) Subject to subsections 4 and 5, a parent or other person who acts as guardian of a child must

(a) administer and safeguard the child's property and property interests;

(b) assist or represent the child in administrative, contractual and other legal matters; or

(c) give or refuse any consent required by law in respect of the child, including

(i) consent to the child's marriage;

(ii) consent to the child's adoption;

(iii) consent to the child's departure or removal from the Republic;

(iv) consent to the child's application for a passport; and

(v) consent to the alienation or encumbrance of any immovable property of the child.

...

PART 3 – Protective measures relating to health of children

130. HIV testing

(1) Subject to section 132, no child may be tested for HIV except when

(a) it is in the best interests of the child and consent has been given in terms of subsection 2; or

(b) the test is necessary in order to establish whether

(i) a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or

(ii) any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court.

(2) Consent for a HIV test on a child may be given by

- (a) the child, if the child is
 - (i) 12 years of age or older; or
 - (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (c) the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (d) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (e) the superintendent or person in charge of a hospital, if
 - (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and
 - (ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or
- (f) a children's court, if
 - (i) consent in terms of paragraph a, b, c or d is unreasonably withheld; or
 - (ii) the child or the parent or care-giver of the child is incapable of giving consent.

131. HIV testing for foster care or adoption purposes

If HIV-testing of a child is done for foster care or adoption purposes, the state must pay the cost of such tests where circumstances permit.

132. Counselling before and after HIV testing

- (1) A child may be tested for HIV only after proper counselling, by an appropriately trained person, of
 - (a) the child, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test; and
 - (b) the child's parent or care-giver, if the parent or care-giver has knowledge of the test.
- (2) Post-test counselling must be provided by an appropriately trained person to
 - (a) the child, if the child is of sufficient maturity to understand the implications of the result; and
 - (b) the child's parent or care-giver, if the parent or care-giver has knowledge of the test.

133. Confidentiality of information on HIV/AIDS status of children

- (1) No person may disclose the fact that a child is HIV positive without consent given in terms of subsection 2, except
 - (a) within the scope of that person's powers and duties in terms of this Act or any other law;
 - (b) when necessary for the purpose of carrying out the provisions of this Act;
 - (c) for the purpose of legal proceedings; or
 - (d) in terms of an order of a court.
- (2) Consent to disclose the fact that a child is HIV positive may be given by
 - (a) the child, if the child is
 - (i) 12 years of age or older; or
 - (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
 - (b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

- (c) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
- (d) the superintendent or person in charge of a hospital, if
 - (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and
 - (ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or
- (e) a children's court, if
 - (i) consent in terms of paragraph a, b, c or d is unreasonably withheld and disclosure is in the best interests of the child; or
 - (ii) the child or the parent or care-giver of the child is incapable of giving consent.

134. Access to contraceptives

- (1) No person may refuse
 - (a) to sell condoms to a child over the age of 12 years; or
 - (b) to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge.
- (2) Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or care-giver of the child if
 - (a) the child is at least 12 years of age;
 - (b) proper medical advice is given to the child; and
 - (c) a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.
- (3) A child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect, subject to section 105.

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

See full text under the section on 'HIV specific laws', in particular sections 25 and 34.

Uganda: Human Immunodeficiency Virus Control Bill (2007)

See full text under the section on 'HIV specific laws', in particular section 15.

Zambia: The Penal Code (Amendment) Act 15 of 2005

Assented to on 28 September this Act amends the Penal Code. The following sections focus on child protection issues.

Excerpts

...

136. Any person who unlawfully takes a child out of the custody or protection of the child's father, mother or other person having lawful care or charge of the child and against the will of such father, mother or other person, commits a felony and is liable,

upon conviction, to imprisonment for a term of not less than seven years and not exceeding ten years

...

137A.(1) Any person who practices sexual harassment in a workplace, institution of learning or elsewhere on a child commits a felony and is liable, upon conviction to imprisonment for a term of not less than three years and not exceeding fifteen years

...

(3) in this section, sexual harassment means

...

(d) sexual imposition using forceful behaviour or assault in an attempt to gain physical sexual contact.

138.(1) Any person who unlawfully and carnally knows any child commits a felony and is liable, upon conviction, to a term of imprisonment of not less than fifteen years and may be liable to imprisonment for life.

...

140. Any person who

(a) procures or attempts to procure any child or other person to have unlawful carnal knowledge either in Zambia or elsewhere, with any person or other persons for pornography, bestiality or any other purpose;

(b) procures or attempts to procure an child or other person to become either in Zambia or elsewhere, a common prostitute;

(c) procures or attempts to procure any child or person to leave Zambia with the intent that the child or person may become an inmate of or frequent a brothel elsewhere; or

(d) procures or attempts to procure any child or person to leave that child's or other person's usual place of abode in Zambia with intent that the child or other person may, for the purposes of prostitution, become an inmate of or frequent a brothel either in Zambia or elsewhere;

commits a felony and is liable, upon conviction, to imprisonment for a term of not less than twenty years and may be liable to imprisonment for life...

143. Any person who sells or traffics in a child or other person for any purpose or in any form commits an offence and is liable, upon conviction, to imprisonment for a term of not less than twenty years

Provided that where it is proved during the trial of the accused person that the sale or trafficking in a child or other person was for the purpose of causing that child or person to be unlawfully and carnally known by any other person, whether such carnal knowledge was intended to be with any particular person or generally, the person is liable, upon conviction, to imprisonment for life.

144.(1) Any person who detains any child or other person against that child or other person's will

(a) in or upon any premises with intent that the child or other person may be unlawfully and carnally known by any third person, whether particularly or generally or for rituals or any other purpose; or

(b) in any brothel;

commits a felony and is liable, upon conviction, to imprisonment for a term of not less than twenty years and may be liable to imprisonment for life.

...

157.(1) Any person who conducts or causes to be conducted a harmful cultural practice on a child commits a felony and is liable, upon conviction, to imprisonment for a term of not less than fifteen years and may be liable to imprisonment for life.

(2) in this section "harmful cultural practice" included sexual cleansing, female genital mutilation or an initiation ceremony that results in injury, the transmission of an infectious or life threatening disease or loss of life to a child but does not include circumcision on a male child.

The principal Act is amended by the repeal of section *one hundred and sixty-nine* and the substitution therefore of the following

169. Any person who being the

(a) parent;

(b) guardian: or

(c) person in charge;

of a child that is unable to provide for itself, refuses or wilfully neglects to provide, being able to do so, sufficient food, clothes, bedding or other necessities for such child, and thereby injures the health of such child, commits an offence and is liable, on conviction, to a fine not exceeding one hundred thousand penalty units or to imprisonment for a term not exceeding three years or to both.

...

D2.9 HIV and criminal law

Angola: Law 8/04 on HIV and AIDS (2004)

See full text under the section on 'HIV specific laws', in particular section 15.

Botswana: Penal Code (Amendment) Act 5 of 1998

This Amendment modified the Penal Code Act, which now includes the following provisions. For an interpretation of this Act, refer to the case law section.

Excerpts

...

Section 141. Definition of rape

Any person who has unlawful carnal knowledge of another person, or who causes the penetration of a sexual organ or instrument, of whatever nature, into the person of another for the purposes of sexual gratification, or who causes the penetration of another person's sexual organ into his person, without the consent of such other person, or with such person's consent if the consent is obtained by force or means of threats or intimidation of any kind, by fear of bodily harm, or by means of false pretences as to the nature of the act, or, in the case of a married person, by personating that person's spouse, is guilty of the offence termed rape.

Section 142. Punishment for rape

(1) Any person who is charged with the offence of rape shall

...

(ii) subject to subsections 2 and 4, upon conviction be sentenced to a minimum term of 10 years' imprisonment or to a maximum term of life imprisonment.

(2) Where an act of rape is attended by violence resulting in injury to the victim, the person convicted of the act of rape shall be sentenced to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with or without corporal punishment.

(3) Any person convicted of the offence of rape shall be required to undergo a HIV test before he is sentenced by the court.

(4) Any person who is convicted under subsection 1 or subsection 2 and whose test for the HIV under subsection 3 is positive shall be sentenced

(a) to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being HIV positive; or

(b) to a minimum term of 20 years imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being HIV positive.

...

Section 147. Defilement of person under 16 years

(1) Any person who unlawfully and carnally knows any person under the age of 16 years is guilty of an offence and on conviction shall be sentenced to a minimum term of 10 years, imprisonment or to a maximum term of life imprisonment.

(2) Any person convicted under subsection 1 shall be required to undergo a HIV test before he is sentenced by the court.

(3) Any person who is convicted under subsection 1 and whose test for the HIV under subsection (2) is positive shall on conviction be sentenced to a

(a) minimum term of 15 years' imprisonment and a maximum term of life imprisonment with or without corporal punishment, where it is proved that such person was unaware of being HIV positive; or

(b) minimum term of 20 years' imprisonment and a maximum term of life imprisonment with or without corporal punishment, where it is proved that on a balance of probabilities such person was aware of being HIV positive.

...

Section 184. Spreading infection

Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, is guilty of an offence.

Botswana: Public Health Act 44 of 1971

Enacted in 1971, the Public Health Act deals with disease prevention and controlling the spread of certain diseases. It also makes provisions for dealing with deliberate attempts to infect others with communicable diseases.

Excerpts

...

Section 11. Penalty for exposure of infected persons and things

(1) Any person who

(a) while suffering from any communicable disease wilfully exposes himself without proper precautions against spreading the said disease in any street, public place, shop or public conveyance;

(b) being in charge of any person so suffering so exposes or conveys such sufferer; or

(c) gives, lends, sells, transmits or exposes, without previous cleansing, any bedding, clothing, rags or other articles which have been exposed to infection from any such disease, shall be guilty of an offence:

Provided that proceedings under this section shall not be taken against persons conveying with proper precautions any bedding, clothing, rags or other articles for the purpose of having the same cleansed.

(2) For the purposes of this section, 'public conveyance' includes any railway coach, omnibus, motor car or any vehicle whatsoever or any aircraft, if the conveyance plies for hire or is used by members of the public.

Kenya: Sexual Offences Act 3 of 2006

This Act defines sexual offences. It also provides for the prevention and protection of all persons against harmful and unlawful sexual acts. The act criminalises the deliberate transmission of HIV.

Excerpts

...

6. Deliberate transmission of HIV or any other life threatening sexually transmitted disease

(1) Any person who, having actual knowledge that he is infected with HIV or any other life threatening sexually transmitted disease intentionally, knowingly and wilfully does anything or permits the doing of anything which he knows or ought to reasonably know

(a) will infect another person with HIV or any other life threatening sexually transmitted disease;

(b) is likely to lead to another person being infected with HIV or any other life threatening sexually transmitted disease;

(c) will infect another person with any other sexually transmitted disease,

shall be guilty of an offence, whether or not he is married to that other person, and shall be liable upon conviction to imprisonment for a term of not less fifteen years but which may be for life.

(2) Notwithstanding the provisions of any other law, where a person is charged with committing an offence under this section, the court may direct that an appropriate sample or samples be taken from the accused person, at such place and subject to such conditions as the court may direct, for the purpose of ascertaining whether or not he is infected with HIV or any other life threatening sexually transmitted disease.

(3) The sample or samples taken from an accused person in terms of subsection 2 shall be stored at an appropriate place until finalisation of the trial.

(4) The court shall, where the accused person is convicted, order that the sample or samples be tested for HIV or any other life threatening sexually transmitted disease and where the accused person is acquitted, order that the sample or samples be destroyed.

(5) Where a court has given directions under subsection 4, any medical practitioner or designated person shall, if so requested in writing by a police officer above the rank of a constable, take an appropriate sample or samples from the accused person concerned;

(6) An appropriate sample or samples taken in terms of subsection 5

(a) shall consist of blood, urine or other tissue or substance as may be determined by the medical practitioner or designated person concerned, in such quantity as is reasonably necessary for the purpose of determining whether or not the accused person is infected with HIV or any other life threatening sexually transmitted disease; and

(b) in the case a blood or tissue sample, shall be taken from a part of the accused person's body selected by the medical practitioner or designated person concerned in accordance with accepted medical practice.

(7) Without prejudice to any other defence or limitation that may be available under any law, no claim shall lie and no set-off shall operate against

(a) the State;

- (b) any Minister; or
 (c) any medical practitioner or designated persons,
 in respect of any detention, injury or loss caused by or in connection with the taking of an appropriate sample in terms of subsection 5, unless the taking was unreasonable or done in bad faith or the person who took the sample was culpably ignorant and negligent.
- (8) Any person who, without reasonable excuse, hinders or obstructs the taking of an appropriate sample in terms of subsection 5 shall be guilty of an offence of obstructing the cause of justice and shall on conviction be liable to imprisonment for a term of not less than five years or to a fine of not less fifty thousand shillings or to both.
- (9) Where a person is convicted of any offence under this Act and it is proved that at the time of the commission of the offence, the convicted person was infected with HIV or any other life threatening sexually transmitted disease whether or not he or she was aware of his or her infection, notwithstanding any other sentence in this Act, he shall be liable upon conviction to imprisonment for a term of not less than fifteen years but which may be enhanced to imprisonment for life.
- (10) For purposes of this section
- (a) the presence in a person's body of HIV antibodies or antigens, detected through an appropriate test or series of tests, shall be prima facie proof that the person concerned is infected with HIV; and
- (b) if it is proved that a person was infected with HIV after committing an offence referred to in this Act, it shall be presumed, unless the contrary is shown, that he was infected with HIV when the offence was committed.

Kenya: HIV and AIDS Prevention and Control Act 14 of 2006

See full text under 'HIV specific laws', in particular section 24.

Madagascar: Law no 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2006)

See full text under 'HIV specific laws', in particular article 67.

Namibia: Combating of Rape Act 8 of 2000

See extract and background information under 'domestic violence'.

South Africa: Criminal Procedure Second Amendment Act 85 of 1997

The act was assented to by the President on 26 November 1997. The act provides for an application of stricter bail measure. It also denies bail to a HIV positive defendant accused of rape unless exceptional circumstances are established.

Excerpts

...

58. Effect of bail

The effect of bail granted in terms of the succeeding provisions is that an accused who is in custody shall be released from custody upon payment of, or the furnishing of a guarantee to pay, the sum of money determined for his bail, and that he shall appear at the place and on the date and at the time appointed for his trial or to which the proceedings relating to the offence in respect of which the accused is released on bail are adjourned, and that the release shall, unless sooner terminated under the said provisions, endure until a verdict is given by a court in respect of the charge to which the offence in question relates, or, where sentence is not imposed forthwith after verdict and the court in question extends bail, until sentence is imposed: Provided that where a court convicts an accused of an offence contemplated in Schedule 5 or 6, the court shall, in considering the question whether the accused's bail should be extended, apply the provisions of section 60(11)(a) or (b), as the case may be, and the court shall take into account

(a) the fact that the accused has been convicted of that offence; and

(b) the likely sentence which the court might impose.

...

60. Bail application of accused in court

...

11A(a) If the attorney-general intends charging any person with an offence referred to in schedule 5 or 6 the attorney-general may, irrespective of what charge is noted on the charge sheet, at any time before such person pleads to the charge, issue a written confirmation to the effect that he intends to charge the accused with an offence referred to in schedule 5 or 6.

(b) The written confirmation shall be handed in at the court in question by the prosecutor as soon as possible after the issuing thereof and forms part of the record of that court.

(c) Whenever the question arises in a bail application or during bail proceedings whether any person is charged or is to be charged with an offence referred to in Schedule 5 or 6, a written confirmation issued by an attorney-general under paragraph a shall, upon its mere production at such application or proceedings, be prima facie proof of the charge to be brought against that person.

...

Addition of schedules 6 and 7 to Act 51 of 1977

10. The following schedules are hereby added to the principal Act

Rape

(a) when committed

...

(iv) by a person knowing that he has the Acquired Immunodeficiency Syndrome or the human immunodeficiency virus;

...

South Africa: Criminal Law Amendment Act 105 of 1997

This piece of legislation, amending the Criminal Law Act 51 of 1977, famous for repealing capital punishment in the country, was assented to by the President on 27 November 1997. It entered into force on 13 November 1998 and it was subsequently amended in 2000 and 2004.

Excerpts

...

PART I –

Rape –

(a) when committed

...

(iv) by a person, knowing that he has the Acquired Immunodeficiency Syndrome or the human immunodeficiency virus;

51. Minimum sentences for certain serious offences

(1) Notwithstanding any other law but subject to subsections 3 and 6, a High Court shall

(a) if it has convicted a person of an offence referred to in Part I of Schedule 2; or

(b) if the matter has been referred to it under section 52(1) for sentence after the person concerned has been convicted of an offence referred to in Part I of Schedule 2, sentence the person to imprisonment for life.

...

(3)(a) If any court referred to in subsection 1 or 2 is satisfied that substantial and compelling circumstances exist which justify the imposition of a lesser sentence than the sentence prescribed in those subsections, it shall enter those circumstances on the record of the proceedings and may thereupon impose such lesser sentence.

(b) If any court referred to in subsection 1 or 2 decides to impose a sentence prescribed in those subsections upon a child who was 16 years of age or older, but under the age of 18 years, at the time of the commission of the act which constituted the offence in question, it shall enter the reasons for its decision on the record of the proceedings.

(4) Any sentence contemplated in this section shall be calculated from the date of sentence.

(5) The operation of a sentence imposed in terms of this section shall not be suspended as contemplated in section 297(4) of the Criminal Procedure Act, 1977 (Act 51 of 1977).

(6) The provisions of this section shall not be applicable in respect of a child who was under the age of 16 years at the time of the commission of the act which constituted the offence in question.

(7) If in the application of this section the age of a child is placed in issue, the onus shall be on the State to prove the age of the child beyond reasonable doubt.

South Africa: Criminal Law (Sexual Offences and Related Matters) Amendment Bill (2006)

The Bill is commonly referred to as the Sexual Offences Bill. It has been debated since 1997. Initially the Bill included provisions criminalising the exposure to HIV when a person living with HIV engages in certain sexual acts without disclosing his or her status to his or her partner. However, these provisions were excluded from the final Bill adopted by the National Assembly on 22 May 2007.

Excerpts

...

CHAPTER 5 – Services for victims of sexual offences and compulsory HIV testing of alleged sex offenders

Part I: Definitions and services for victims of sexual offences

Definitions

27. For the purposes of this Chapter, and unless the context indicates otherwise

‘application’ means an application in terms of section 30 or 32;

‘body fluid’ means any body substance which may contain HIV or any other sexually transmissible infection, but does not include saliva, tears or perspiration;

‘body specimen’ means any body sample which can be tested to determine the presence or absence of HIV infection;

‘HIV’ means the Human Immunodeficiency Virus;

‘HIV test’ means any validated and medically recognised test for determining the presence or absence of HIV infection in a person;

‘interested person’ means any person who has a material interest in the well-being of a victim, including a spouse, same sex or heterosexual permanent life partner, parent, guardian, family member, care giver, curator, counsellor, medical practitioner, health service provider, social worker or teacher of such victim;

‘investigating officer’ means a member of the South African Police Service responsible for the investigation of an alleged sexual offence or any other offence or any member acting under his command;

‘medical practitioner’ means a person registered as a medical practitioner in terms of the Health Professions Act, 1974 (Act No 56 of 1974), and who, for purposes of section 33, is authorised to take body specimens as contemplated in this chapter;

‘nurse’ means a person registered as such in terms of any relevant legislation and who, for purposes of section 33, is authorised to take body specimens as contemplated in this Chapter;

‘offence’ means any offence, other than a sexual offence, in which the HIV status of the alleged offender may be relevant for purposes of investigation or prosecution

‘PEP’ means Post Exposure Prophylaxis;

‘sexual offence’ means a sexual offence in terms of this Act in which the victim may have been exposed to body fluids of the alleged offender; and

‘victim’ means any person alleging that a sexual offence has been perpetrated against him or her.

Services for victims relating to Post Exposure Prophylaxis and compulsory HIV testing of alleged sex offenders

28.(1) If a victim has been exposed to the risk of being infected with HIV as the result of a sexual offence having been committed against him or her, he may

(a) subject to subsection 2;

(i) receive PEP for HIV infection, at a public health establishment designated from time to time by the cabinet member responsible for health by notice in the *Gazette* for that purpose under section 29, at State expense and in accordance with the State’s prevailing treatment norms and protocols;

(ii) be given free medical advice surrounding the administering of PEP prior to the administering thereof; and

(iii) be supplied with a prescribed list, containing the names, addresses and contact particulars of accessible public health establishments contemplated in section 29(1)(a); and

b) subject to section 30, apply to a magistrate for an order that the alleged offender be tested for HIV, at State expense.

(2) Only a victim who

(a) lays a charge with the South African Police Service in respect of an alleged sexual offence; or

(b) reports an incident in respect of an alleged sexual offence in the prescribed manner at a designated health establishment contemplated in subsection 1(a)(i) within 72 hours after the alleged sexual offence took place, may receive the services contemplated in subsection 1(a).

(3) A victim contemplated in subsection 1 or an interested person must

(a) when or immediately after laying a charge with the South African Police Service or making a report in respect of the alleged sexual offence, in the prescribed manner, be informed by the police official to whom the charge is made or by a medical practitioner or a nurse to whom the incident is reported, as the case may be, of the

- (i) importance of obtaining PEP for HIV infection within 72 hours after the alleged sexual offence took place;
- (ii) need to obtain medical advice and assistance regarding the possibility of other sexually transmitted infections; and
- (iii) services referred to in subsection 1; and (b) in the case of an application contemplated in section 30, be handed a notice containing the prescribed information regarding the compulsory HIV testing of the alleged offender and have the contents thereof explained to him or her.

...

Part II: Application for compulsory HIV testing of alleged sex offender by victim

Application by victim or interested person for HIV testing of alleged sex offender

30.(1)(a) Within 90 days after the alleged commission of a sexual offence any victim or any interested person on behalf of a victim, may apply to a magistrate, in the prescribed form, for an order that

- (i) the alleged offender be tested for HIV and that the results thereof be disclosed to the victim or interested person, as the case may be, and to the alleged offender; or
 - (ii) the HIV test results in respect of the alleged offender, obtained on application by a police official as contemplated in section 32, be disclosed to the victim or interested person, as the case may be.
- (b) If the application is brought by an interested person, such application must be brought with the written consent of the victim, unless the victim is
- (i) under the age of 14 years;
 - (ii) a person who is mentally disabled;
 - (iii) unconscious;
 - (iv) a person in respect of whom a curator has been appointed in terms of an order of court; or
 - (v) a person whom the magistrate is satisfied is unable to provide the required consent.

(2)(a) Every application must-

- (i) state that a sexual offence was committed against the victim by the alleged offender;
- (ii) confirm that the alleged offence has been reported as contemplated in section 2(W);
- (iii) state that the victim may have been exposed to the risk of being infected with HIV as a result of the alleged sexual offence;
- (iv) if it is brought by an interested person, state the nature of the relationship between the interested person and the victim, and if the interested person is not the spouse, same sex or heterosexual permanent life partner or a parent of the victim, the reason why the application is being made by such interested person; and

(v) state that less than 90 days have elapsed from the date on which it is alleged that the offence in question took place.

(b) The matters referred to in paragraph a must be verified by the victim or the interested person, as the case may be, by affidavit or solemn declaration.

(3) The application must be made as soon as possible after a charge has been laid, and may be made before or after an arrest has been effected.

(4) The application must be handed to the investigating officer, who must, as soon as is reasonably practicable, submit the application to a magistrate of the magisterial district in which the sexual offence is alleged to have occurred.

Consideration of application by magistrate and issuing of order

31.(1) The magistrate must, as soon as is reasonably practicable, consider the application contemplated in section 30, in chambers and may call for such additional evidence as he deems fit, including oral evidence or evidence by affidavit, which must form part of the record of the proceedings.

(2)(a) For the purpose of the proceedings contemplated in subsection (1), the magistrate may consider evidence by or on behalf of the alleged offender if, to do so, will not give rise to any substantial delay.

(b) Evidence contemplated in paragraph a may be adduced in the absence of the victim, if the magistrate is of the opinion that it is in the best interests of the victim to do so.

(3) If the magistrate is satisfied that there is prima facie evidence that

(a) a sexual offence has been committed against the victim by the alleged offender

(b) the victim may have been exposed to the body fluids of the alleged offender: and

(c) no more than 90 calendar days have lapsed from the date on which it is alleged that the offence in question took place, the magistrate must

(i) in the case where the alleged offender has not been tested for HIV on application by a police official as contemplated in section 32, order that the alleged offender be tested for HIV in accordance with the State's prevailing norms and protocols, including where necessary

(aa) the collection from the alleged offender of two prescribed body specimens; and

(bb) the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection in the alleged offender, and that the HIV test results be disclosed in the prescribed manner to the victim or interested person, as the case may be, and to the alleged offender; or

(ii) in the case where the alleged offender has already been tested for HIV on application by a police official as contemplated in section 32, order that the HIV test results be disclosed in the prescribed manner to the victim or interested person, as the case may be.

(4) An order referred to in subsection 3 must be made in the prescribed manner and handed to the investigating officer.

(5) The investigating officer must, as soon as is reasonably practicable, after an application has been considered

(a) inform the victim or interested person, as the case may be, of the outcome of the application; and

(b) if an order has been granted in terms of subsection 3, inform the alleged offender thereof by handing to him or her a notice containing the information as prescribed and, if necessary, by explaining the contents of the notice.

Part III: Application for compulsory HIV testing of alleged sex offender by police official

Application by police official for HIV testing of alleged sex offender

32.(1) An investigating officer may, subject to subsection 2, for purposes of investigating a sexual offence or offence apply in the prescribed form to a magistrate of the magisterial district in which the sexual offence or offence is alleged to have occurred, in chambers, for an order that

(a) the alleged offender be tested for HIV, or

(b) the HIV test results in respect of the alleged offender, already obtained on application by a victim or any interested person on behalf of a victim as contemplated in section 30(1)(a)(i), be made available to the investigating officer or, where applicable, to a prosecutor who needs to know the results for purposes of the prosecution of the matter in question or any other court proceedings.

(2) An application contemplated in subsection 1 must

(a) set out the grounds, on the strength of information taken on oath or by way of solemn declaration, in which it is alleged that a sexual offence or offence was committed by the alleged offender; and

(b) be made after a charge has been laid, and may be made before or after an arrest has been effected, or after conviction.

(3) If the magistrate is satisfied that there is *prima facie* evidence that

(a) a sexual offence or offence has been committed by the offender; and (b) HIV testing would appear to be necessary for purposes of investigating or prosecuting the offence, the magistrate must, in the case of an application contemplated in subsection 1(a), order that the alleged offender be tested for HIV in accordance with the State's prevailing norms and protocols, including, where necessary

(i) the collection from the alleged offender of two prescribed body specimens; and

(ii) the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection in the alleged offender, and that the HIV test results be disclosed in the prescribed manner to the investigating officer or, where applicable, to a prosecutor who needs to know the results for purposes of the prosecution of the matter in question or any other court proceedings and to the alleged offender, if the results have not already been made available to such offender as contemplated in section 30(1)(a)(i).

(4) An order contemplated in subsection 3 must be made in the prescribed manner and handed to the investigating officer.

(5) The investigating officer must, as soon as is reasonably practicable, after an application has been granted in terms of subsection 3, inform the alleged offender by handing to him or her a notice containing the information as prescribed and, if necessary, by explaining the contents of the notice.

Part IV: Execution of orders for compulsory HIV testing and results of HIV tests

...

Use of results of HIV tests

34. The results of an HIV test, performed in terms of an order contemplated in sections 31(3) and 32(3), may only be used in the following circumstances:

(a) To inform a victim or an interested person whether or not the alleged offender in the case in question is infected with HIV with the view to

(i) reducing secondary trauma and empowering the victim to make informed medical, lifestyle and other personal decisions; or

(ii) using the test results as evidence in any ensuing civil proceedings as a result of the sexual offence in question; or

(b) to enable an investigating officer to gather information with the view to using it as evidence in criminal proceedings.

Part V: Miscellaneous

...

Confidentiality of outcome of application

36. The fact that an order for HIV testing of an alleged offender has been granted as contemplated in section 31 or section 32 may not be communicated to any person other than

(a) the victim or an interested person referred to in section 30;

(b) the alleged offender;

(c) the investigating officer and, where applicable, to

(i) a prosecutor; or

(ii) subject to section 35(2), any other person who needs to know the test results for purposes of any criminal investigations or proceedings or any civil proceedings; and

(d) the persons who are required to execute the order as contemplated in section.

Confidentiality of HIV test results obtained

37.(1) The results of the HIV tests performed on an alleged offender in terms of this Chapter may, subject to subsection 2, be communicated only to

(a) the victim or the interested person referred to in section 30;

(b) the alleged offender; and

(c) the investigating officer and, where applicable, to

(i) a prosecutor if the alleged offender is tested as contemplated in section 32; or (ii) any other person who needs to know the test results for purposes of any civil proceedings or an order of a court.

(2) A presiding officer, in any proceedings contemplated in this chapter or in any ensuing criminal or civil proceedings, may make any order he deems appropriate in order to give effect to this section, including the manner in which such results are to be kept confidential and the manner in which the court record in question is to be dealt with.

Offences and penalties

38.(1)(a) Any person who, with malicious intent lays a charge with the South African Police Service in respect of an alleged sexual offence and makes an application in terms of section 30(1), with the intention of ascertaining the HIV status of any person, is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding three years.

(b) Any person who with malicious intent or who in a grossly negligent manner discloses the results of any HIV tests in contravention of section 37, is guilty of an offence and is liable to a fine or to imprisonment for a period not exceeding three years.

(c) The institution of a prosecution for an offence referred to in paragraph a or b must be authorised in writing by the relevant Director of Public Prosecutions.

(2) An alleged offender who, in any manner whatsoever, fails or refuses to comply with or avoids compliance with, or deliberately frustrates any attempt to serve on himself or herself. An order of court that he be tested for HIV, is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding three years.

Regulations

39.(1) The Minister, after consultation with the cabinet members responsible for safety and security and health, may make regulations regarding

(a) any form required to be prescribed in terms of this Chapter;

(b) any matter necessary or required to be prescribed in terms of this Chapter; and

(c) any other matter the Minister deems to be necessary or expedient to achieve the objects of this Chapter.

(2) Any regulation made in terms of subsection 1 must be

(a) submitted to Parliament at least 30 days before publication in the *Gazette*; and

...

(6) made after consultation with the cabinet members responsible for safety and security and health, except for the matter prescribed in section 35, which must be made in consultation with the cabinet member responsible for safety and security.

Tanzania: HIV and AIDS (Prevention and Control) Bill (2007)

See full text under the section on 'HIV specific laws', in particular sections 21 and 47.

Uganda: Human Immunodeficiency Virus Control Bill (2007)

See full text under the section on 'HIV specific laws', in particular sections 4, 6, and 26 to 28.

Zimbabwe: The Criminal Law (Codification and Reform) Act No 23 of 2004

This Act criminalises in separate provisions the deliberate transmission of sexually transmitted diseases and the deliberate transmission of HIV.

Excerpts

...

78. Deliberate infection of another with a sexually transmitted disease

(1) In this section

'sexually-transmitted disease' includes syphilis, gonorrhea, herpes, and all other forms of sexually-transmitted diseases except, for the purposes of this section, HIV.

(2) Any person who

(a) knowing that he or she is suffering from a sexually transmitted disease; or

(b) realising that there is a real risk or possibility that he or she is suffering from a sexually transmitted disease;

intentionally infects any other person with the disease, or does anything or causes or permits anything to be done with the intention or realising that there is a real risk or possibility of infecting any other person with the disease, shall be guilty of deliberately infecting that other person with a sexually transmitted disease and liable to a fine up to or exceeding level fourteen or imprisonment for a period not exceeding five years or both.

(3) If it is proved in a prosecution for spreading a sexually transmitted disease that the person charged was suffering from a sexually transmitted disease at the time of the crime, it shall be presumed, unless the contrary is proved, that he or she knew or realised that there was a real risk or possibility that he or she was suffering from it.

(4) It shall be a defence to a charge under subsection (1) for the accused to prove that the other person concerned

(a) knew that the accused was suffering from a sexually transmitted disease; and

(b) consented to the act in question, appreciating the nature of the sexually-transmitted disease and the possibility of becoming infected with it.

Division D: Transmitting HIV deliberately or in the course of committing sexual crimes

79 Deliberate transmission of HIV

(1) Any person who

(a) knowing that he or she is infected with HIV; or

(b) realising that there is a real risk or possibility that he or she is infected with HIV;

intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realises involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person, and shall be liable to imprisonment for a period not exceeding twenty years.

(2) It shall be a defence to a charge under subsection (1) for the accused to prove that the other person concerned

(a) knew that the accused was infected with HIV; and

(b) consented to the act in question, appreciating the nature of HIV and the possibility of becoming infected with it.

80. Sentence for certain crimes where accused is infected with HIV

(1) Where a person is convicted of

(a) rape; or

(b) aggravated indecent assault; or

(c) sexual intercourse or performing an indecent act with a young person, involving any penetration of any part of his or her or another person's body that incurs a risk of transmission of HIV; and it is proved that, at the time of the commission of the crime, the convicted person was infected with HIV, whether or not he or she was aware of his or her infection, he or she shall be sentenced to imprisonment for a period of not less than ten years.

(2) For the purposes of this section

(a) the presence in a person's body of HIV antibodies or antigens, detected through an appropriate test, shall be prima facie proof that the person concerned is infected with HIV;

(b) if it is proved that a person was infected with HIV within thirty days after committing a crime referred to in those sections, it shall be presumed, unless the contrary is shown, that he or she was infected with HIV when he or she committed the crime.

...

D2.10 Legislation providing institutional mechanisms for HIV and AIDS

South Africa: North West Provincial Council on AIDS Act 5 of 2000

This Act provides for the establishment of a Provincial Council on AIDS for purposes of addressing the HIV epidemic in the province. It enables the Council to manage and to co-ordinate the response to HIV in the province.

Excerpts

...

3. Functions of the Council

(1) The functions of the Council shall be to

(a) advise the Government on HIV/AIDS/STI's and related matters;

(b) guide and monitor activities of District and local AIDS Council;

(c) monitor and coordinate implementation programmes and strategies of the Provincial multi-sectoral response to the epidemic;

(d) provide overall guidance on the implementation of the National HIV/AIDS/STI's strategic plan and other related matters;

(e) ensure periodic review of the Province's HIV/AIDS/STI's strategic plan and other related matters;

(f) mobilise resources for the implementation of HIV/AIDS programmes and strategies in the Province at community level; and

(g) recommend appropriate research around HIV/AIDS.

(2) In carrying out the objectives set out in (1) above, the PCA shall, where reasonably practically possible, involve all sectors of society in the

(a) implementation of response programmes and strategies for the prevention of HIV/AIDS; and

- (b) minimising of the impact of HIV/AIDS on the Province.

Tanzania: Tanzania Commission for AIDS Act 22 of 2001

This Act establishes the Tanzania Commission for AIDS, to provide for the prevention and control of AIDS, the Commission's composition, functions, objectives, co-ordination and other connected matters.

Excerpts

...

5. Functions and objectives of the Commission

(1) The functions of the Commission shall be as follows

- (a) to formulate policy guidelines for the response to HIV/AIDS epidemic and management of its consequences in Mainland Tanzania;
 - (b) to develop strategic framework for planning of all HIV/AIDS control programmes and activities within the overall national multisectoral strategy;
 - (c) to foster national and international linkages among all stakeholders through proper co-ordination of all HIV/AIDS prevention and control programmes and activities within the overall national multisectoral strategy;
 - (d) to mobilise, disburse, and monitor resources and ensure equitable distribution;
 - (e) to disseminate and share information on HIV/AIDS epidemic and its consequences in Tanzania on programmes for its prevention and control;
 - (f) to promote research, information sharing and documentation on HIV/AIDS prevention and control;
 - (g) to promote high level advocacy and education on HIV/AIDS;
 - (h) to monitor and evaluate all on going HIV/AIDS activities;
 - (i) to co-ordinate all activities related to the management of HIV/AIDS epidemic in Tanzania as per national multisectoral strategy;
 - (j) in collaboration with the relevant sector facilitate efforts to find a cure and to promote access to treatment and care and to develop vaccines;
 - (k) in collaboration with relevant sector to protect human and communal rights of people infected with and affected by HIV/AIDS;
 - (l) to promote positive living of people living with HIV;
 - (m) to advise the government on all matters relating to HIV/AIDS prevention and control in Tanzania Mainland;
 - (n) to identify obstacles to the implementation of HIV/AIDS prevention and control policies programmes and ensure the implementation and attainment of programmes, activities and targets;
 - (o) to supervise all activities related to the prevention and control of the HIV/AIDS epidemic and in particular regarding—
 - (i) health care and counselling of people living with HIV;
 - (ii) the welfare of the orphans and other survivors of people infected with HIV;
 - (iii) handling of social, economic, cultural and legal issues related to the AIDS epidemic; and
 - (p) in collaboration with relevant sectors, to perform such other activities and functions relating to the prevention and control of HIV/AIDS epidemic in Tanzania Mainland as the Commission may deem necessary.
- (2) Without prejudice to the generality of subsection 1 of this section, the Commission in performing its functions shall have the following objectives—
- (a) to develop strategic framework and national guidelines to support planning co-ordination and implementation of the national multi-sectoral response to HIV/AIDS at all levels;

(b) to develop and facilitate implementation of the national multi-sectoral strategy for mobilisation and utilisation of resources for HIV/AIDS;

(c) to develop and facilitate implementation of national multi-sectoral strategy for advocacy on HIV/AIDS epidemic;

(d) to establish and strengthen partnership for an expanded response among the stakeholders;

(e) to promote research on HIV/AIDS and foster linkage with research institutions;

(f) to establish and maintain multi-sectoral HIV/AIDS Information Management System and facilitate information dissemination;

(g) to develop effective mechanism for monitoring trends of the epidemic and for monitoring the impact of HIV/AIDS intervention worldwide; and

(h) to establish and sustainably maintain an efficient and effective management capacity at the Commission.

...

PART IV – AIDS committees

13. Establishment of AIDS Committees

(1) For the purpose of smooth implementation of the Commissions functions and objectives there shall be established in accordance with this Act, AIDS Committees at every local government level, Ministry or other sectors to co-ordinate and implement AIDS activities of the Commission.

(2) The composition of AIDS Committees to be established under this section shall be in accordance with the guidelines issued by the Commission from time to time.

14. Reports by Committees

It shall be the duty of every AIDS Committee established in accordance with the provisions of this Part to prepare quarterly and annual performance reports and present them to the Commission.

PART V – Financial provisions

15. Funds of the Commission

Sources of funds of the Commission shall be as follows

- (a) such amounts as may be appropriated by Parliament;
- (b) such sums as may be payable to the Commission by way of donation gifts, grants, loans or bequests;
- (c) such sums as may in any manner become payable to or vested in the Commission or acquired in the course of performing its functions under the Act; and
- (d) any other lawful source of funding.

...

National AIDS Council of Zimbabwe Act 26 of 1999

This Act provides for the establishment of the National AIDS Council of Zimbabwe. It sets the structure, functions and powers of the National AIDS Council of Zimbabwe. The Act also provides for measures to combat the spread of HIV and the promotion, co-ordination and implementation of attendant programmes and measures.

Excerpts

...

PART II – National AIDS Council of Zimbabwe and Board of Council

3. Establishment of National AIDS Council of Zimbabwe

There is hereby established a council, to be known as the National AIDS Council of Zimbabwe, which shall be a body corporate capable of suing and being sued in its corporate name and, subject to this Act, of doing anything that bodies corporate may do by law.

4. Functions and powers of Council

(1) Subject to this Act, the functions of the Council shall be

- (a) to ensure the development of strategies
 - (i) to combat HIV and AIDS; and
 - (ii) to control and ameliorate the effects of the HIV and AIDS epidemic; and to promote and co-ordinate the application of such strategies and policies; and
- (b) to mobilise and manage resources, whether financial or otherwise, in support of a national response to HIV and AIDS; and
- (c) to enhance the capacity of the various sectors of the community to respond to the HIV and AIDS epidemic and to co-ordinate their responses; and
- (d) to encourage the provision of facilities to treat and care for persons infected with HIV and their dependants; and
- (e) to monitor and evaluate the effectiveness of the strategies and policies referred to in paragraph a and, generally, the national response to HIV and AIDS; and
- (f) to promote and co-ordinate research into HIV and AIDS and to ensure the effective dissemination and application of the results of such research; and
- (g) to disseminate, and to encourage the dissemination of, information on all aspects of HIV and AIDS; and
- (h) to submit regular reports to the President, through the Minister, concerning the HIV and AIDS epidemic; and
- (i) to exercise any other function that may be conferred on the Council by or in terms of this Act or any other enactment; and
- (j) generally, to do all things which, in the Board's opinion, are necessary or appropriate to combat HIV and AIDS and to ameliorate the effects of those diseases.

(2) For the better exercise of its functions, the Council shall have power, subject to this Act, to do or cause to be done, either by itself or through its agents, all or any of the things specified in the Schedule, either absolutely or conditionally and either solely or jointly with others.

...

PART IV – Financial provisions

25. Funds of Council

The funds of the Council shall consist of

- (a) any moneys that may be payable to the Council from moneys appropriated for the purpose by Act of Parliament; and
- (b) fees and charges raised for services and facilities provided and other things done by the Council; and
- (c) donations, which may be accepted with the approval of the Minister; and
- (d) loans, which may be raised with the approval of the Minister and the Minister responsible for finance; and
- (e) any other moneys that may vest in or accrue to the Council, whether in the course of its operations or otherwise.

...

PART V – General provisions

32. Provincial branches and committees

(1) The Board shall ensure that, so far as is practicable, a branch of the Council is established in each province of Zimbabwe.

(2) For each provincial branch established in terms of subsection 1 there shall be a committee consisting of such number of

persons, appointed by the Board, as the Board may determine in each case.

(3) The members of a provincial branch committee referred to in subsection 2 shall hold office for such period and subject to such terms and conditions, including remuneration and allowances, as the Board may determine.

(4) Subject to the direction and control of the Board, every provincial branch committee referred to in subsection 2 shall exercise within its province such of the Council's functions as the Board may delegate to it.

(5) Section twelve shall apply, *mutatis mutandis*, to the procedure to be followed at meetings of provincial branch committees referred to in subsection 2 and, in respect of any matter that is not provided for in that section, shall be as determined by the Board.

...

D3 Policies and other similar documents

Malawi: National HIV/AIDS policy (2003)

The objectives of the National HIV/AIDS Policy are to prevent the further spread of HIV and to mitigate the impact of HIV on the socio-economic status of individuals, families, communities and the nation.

Excerpts

1.5 Guiding principles

This policy shall be guided by, governed by and based on the following principles:

- Political leadership and commitment

Strong political leadership and commitment at all levels is essential for a sustained and effective response to HIV/AIDS.

- Multisectoral approach and partnerships

An effective response to HIV/AIDS requires the active involvement of all sectors of society. Thus, a multisectoral approach is required that includes partnerships, consultations and coordination with all stakeholders, particularly PLWAs, in the design, implementation, review, monitoring and evaluation of the national response to HIV/AIDS.

- Public health approach

A public health approach reduces the risk of transmission by intensive mass education on modes of transmission and ways to reduce risk, widespread and vigorous use of barrier methods, antibody testing, beneficial disclosure or notification of partners, prevention of mother-to-child transmission (PMTCT) services, and medical treatment and management of infected individuals.

- Promotion and protection of human rights

International human rights law and the Constitution of Malawi guarantee the right to equal protection before the law and freedom from discrimination on grounds, singly or in combination, of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status. Discrimination on any of these grounds is not only inherently wrong but also creates and sustains conditions leading to vulnerability to HIV infection and to receiving inadequate treatment, care and support once infected.

Groups suffering from discrimination which makes them vulnerable to HIV/AIDS include women and young girls, orphans, widows and widowers, children and young people, the poor, sex workers, prisoners, mobile populations, persons engaged in same-sex relationships, people with disabilities and PLWAs.

An effective response to the epidemic requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled—in particular, in gender relations among women, men, girls and boys.

- The greater involvement of PLWAs

The greater involvement of PLWAs at all levels is crucial for an effective response to HIV/AIDS.

- Good governance, transparency and accountability

An effective national response to the epidemic requires government to provide leadership, good governance, transparency and accountability to effectively mobilise resources—including, but not limited to, financial resources—and to prudently manage resources at all levels and in all sectors.

- Scientific and evidence-based research

It is essential that the national response to HIV/AIDS be based on sound, current, empirically-based research. As aspects of the

epidemic continually change and as scientific, medical and programmatic knowledge of the worldwide pandemic progresses, our understanding of the HIV/AIDS epidemic and how best to respond to it must likewise evolve.

CHAPTER 3 – Promotion of HIV/AIDS prevention, treatment, care and support

...

3.2 Prevention

HIV prevention strategies include the provision of information and education, condoms, sterile injection equipment, voluntary counselling and testing (VCT), antiretroviral (ARV) medicines (eg, to prevent mother-to-child transmission or to provide post-exposure prophylaxis [PEP]) and, once developed, safe and effective microbicides and vaccines.

3.2.1 Information, education and communication (IEC) for behaviour change

3.2.1.1 Rationale

To tackle the HIV/AIDS epidemic, people must have the ability to adopt risk-reducing behaviour and to make full use of existing opportunities to cope with HIV infection and AIDS. Targeted information delivered within a culturally sensitive context can help to increase awareness and knowledge and to overcome stigma, discrimination, myths, beliefs and prejudices associated with HIV/AIDS and sexuality. Mass media, supported by interpersonal communication, are vital channels to reach the largest number of people with accurate, targeted and relevant messages.

In addition to information and knowledge, adopting and sustaining new behaviour also requires motivation and support, a forum to practice the new behaviour, and an enabling environment in which this new behaviour can take place and be sustained.

3.2.1.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that all people have equal access to culturally sound and age-appropriate formal and nonformal HIV/AIDS information and education programmes, which shall include free and accurate information regarding mother-to-child transmission, breastfeeding, treatment, nutrition, change of lifestyle, safer sex and the importance of respect for and nondiscrimination against PLWAs.
- support development of adequate, accessible, sound and effective HIV/AIDS information and education programmes by and for vulnerable populations and shall actively involve such populations in the design and implementation of these programmes.
- ensure that behaviour change interventions are guided by the evidence-based needs of the target populations and existing evidence on potential opportunities for and barriers to behaviour change.
- ensure that behaviour change interventions aim at a transition from general awareness to knowledge of one's serostatus and, ultimately, to knowing how to protect oneself and others.
- integrate and promote sound, age-appropriate life skills education, including sexual and reproductive health education and HIV/AIDS information and education, at all levels of formal and nonformal education.
- ensure that life skills education is integrated into school curricula as a subject in which students are regularly assessed.
- support programmes that strengthen the role of parents and guardians in shaping positive attitudes and healthy behaviours of children and young people with regard to sexuality and gender roles in the context of HIV/AIDS and other STIs.
- ensure greater involvement of PLWAs in the design and implementation of HIV/AIDS information and education

programmes, as well as activities aimed at influencing and sustaining behaviour change.

- promote abstinence and/or delay of first sexual experience for the youth and mutual faithfulness among adult sexual partners.

3.2.2 HIV testing

3.2.2.1 Voluntary HIV counselling and testing

3.2.2.1.1 Rationale

VCT is an essential component on the continuum of prevention, treatment, care and support for PLWAs. Through pre- and post-test counselling carried out in a supportive environment, a person undergoing voluntary HIV counseling and testing is motivated towards positive behaviour change. VCT provides an opportunity for a person to ascertain HIV status, and if infected with HIV, to prevent both transmission to others and reinfection. It also offers an opportunity to access care and support programmes, including prophylaxis and treatment of opportunistic infections, access to antiretroviral therapy (ART) and access to PMTCT programmes.

To be effective, VCT services must be of good quality, accessible, affordable and totally confidential. Uptake can be improved when VCT services are organised to take into consideration the special needs of men, women, girls and boys as well as the social status of clients. Since young people between the ages of 13 and 24 are particularly vulnerable to HIV infection, it is crucial that VCT services be designed to accommodate their special needs as well as those of other vulnerable groups, and be widely available. Observations in Malawi and elsewhere have shown that same-day-results VCT services attract high uptake.

3.2.2.1.2 Policy statements

Government, through the NAC, undertakes to do the following

- promote and provide high quality, cost-effective, totally confidential and accessible VCT services countrywide, in particular, youth-friendly services and services that are adequate and accessible to other vulnerable groups.
- ensure that
 - VCT shall only be carried out with informed consent of the person seeking testing, who is provided with adequate information about the nature of an HIV test, including the potential implications of a positive or negative result, in order to make an informed decision as to whether to take the test or not.
 - Children aged 13 or over shall be entitled to access VCT without the consent of a guardian or other adult.
 - VCT shall either be confidential or anonymous. Where it is anonymous, VCT service providers shall not provide written test results to people seeking testing except with the consent of such people for referral to other HIV/AIDS-related services.
 - The results of any HIV test shall not be disclosed to a third party without the consent of the person seeking testing, except as may be provided in this Policy.
- promote and encourage couple-counselling and partner-disclosure of HIV test results.
- ensure that VCT services are staffed by adequate numbers of trained counsellors.
- coordinate and ensure the links between VCT services and other HIV/AIDS-related services to provide a continuum of prevention, treatment, care, support and impact mitigation.

3.2.2.2 Diagnostic testing

3.2.2.2.1 Rationale

Experience has shown that people fearing HIV infection have difficulty making an informed decision to have an HIV test. The fact that a patient presents voluntarily with a health problem allows the assumption that he would be grateful to be guided by a qualified health care worker in diagnosis and management. In such instances and where HIV infection is suspected, HIV testing should be part of the diagnostic process. As with all tests, the patient has the right to refuse the test.

3.2.2.2.2 Policy Statements

Government, through the NAC, undertakes to do the following

- ensure that adequate facilities and staff for HIV diagnostic testing are available in all health facilities, hospitals and clinics, with the right for the patient to opt out.
- permit testing without consent for diagnosis of an unconscious patient in the absence of a parent or guardian, where the same is necessary for purposes of optimal treatment.

3.2.2.3 Routine testing

3.2.2.3.1 Rationale

Routine testing is necessary for tracking HIV/AIDS, informing the nation on the progression of the epidemic and ensuring the safety of blood and blood products. Routine testing is also vital for the prevention of HIV transmission from mother to child.

3.2.2.3.2 Policy statements

Government, through the NAC, undertakes to do the following

- permit HIV testing without consent in the following circumstances
 - Sample screening of pregnant women through anonymous unlinked testing for surveillance.
 - Testing of blood, body fluids and other body tissues for transfusion and transplants.
- ensure that HIV testing is routinely offered to all pregnant women attending antenatal clinics unless they specifically choose to decline.

3.2.2.4 National security forces

3.2.2.4.1 Rationale

For national security reasons, it is important that the Army, Police, Prisons and Immigration be permitted to carry out HIV testing as part of their pre-recruitment and periodic general medical assessment of staff for purposes of establishing fitness.

3.2.2.4.2 Policy statement

Government, through the NAC, undertakes to do the following

- permit HIV testing in the Army, Police, Prisons and Immigration as part of a broader assessment of fitness for work.

3.2.2.5 Beneficial disclosure

3.2.2.5.1 Rationale

Refusal to notify sexual partners of one's positive serostatus can result in the onward transmission of HIV, therefore HIV post-test counselling programmes should involve strong professional efforts to encourage, persuade and support HIV-positive persons to notify their partners. In exceptional cases where a properly counselled HIV-positive person refuses to disclose his or her status to sexual partners, it is important that the health care provider be permitted to notify those partners without the consent of the source client.

3.2.2.5.2 Policy statements

Government, through the NAC, undertakes to do the following

- promote voluntary disclosure of his or her HIV serostatus by a PLWA to his or her sexual partner.
- ensure that voluntary disclosure of HIV status by the infected person to his or her sexual partner is explained and encouraged during counselling.
- ensure that professional and lay counsellors are trained on how to advise and assist PLWAs on how best to disclose their HIV serostatus to their partner.
- develop appropriate and explicit guidelines outlining how, when and to whom beneficial disclosure by a health care worker may be made, in accordance with UNAIDS and the Office of the United Nations High Commissioner for Human Rights.

3.2.3 Condoms for HIV prevention

3.2.3.1 Rationale

Male and female condoms can prevent both unwanted pregnancies and STIs, including HIV. To be effective, condoms must be of good quality, and properly and consistently used. Providing women with support to participate fully in the decision to use a condom during every sexual encounter and involving men to promote condom use will enhance more consistent condom use.

3.2.3.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that affordable male and female condoms and other barrier methods of good quality are made available to all those who need them, in particular, to prisoners.
- promote the proper use and disposal of both the male and the female condom and other barrier methods to prevent HIV and STI transmission.
- promote the implementation of programmes aimed at providing women with support to participate fully in decision-making regarding the use of condoms.
- periodically review and revise fiscal and other measures to ensure equitable access to and affordability of socially-marketed condoms.

3.2.4 Prevention of Mother-to-Child Transmission (PMTCT)

3.2.4.1 Rationale

HIV can be transmitted from a mother to her child during pregnancy, during delivery, and through breast milk. The desire of HIV-infected couples to have a child must therefore be balanced with the possibility of having an HIV-infected baby who has a high risk of dying in early childhood, after suffering extended periods of illness.

In addition, the death of a parent, especially the mother, drastically reduces the baby's chances of survival, regardless of the baby's HIV serostatus. It is important, therefore, that interventions address treatment for parents, in addition to PMTCT, so as to minimise orphanhood and improve the chances of child survival.

3.2.4.2 Policy statements

Government, through the NAC, undertakes to do the following

- promote VCT for couples planning to have a child, and early attendance at an antenatal clinic.
- ensure that HIV testing is routinely offered to all pregnant women attending antenatal clinics unless they specifically choose to decline.
- ensure the availability of quality infrastructure, skilled staff and supplies for maternal and child health (MCH) care, and proper management of MCH services to increase women's access to PMTCT interventions.
- provide accurate and accessible information on PMTCT and infant feeding options to all pregnant women and their partners.
- provide access to affordable antiretroviral treatment (ART) to prevent HIV transmission from mother to child. PMTCT programmes shall also provide treatment, care and support for both parents.
- provide an enabling environment for women to participate in PMTCT or other preventive care or support programmes without the consent of their husbands, sexual partners or family.
- ensure baby-friendly hospital initiatives to support HIV-positive lactating mothers who choose to exclusively breastfeed for six months.
- ensure that women who act as wet nurses are encouraged to undergo VCT prior to breastfeeding and are discouraged from breastfeeding if they are HIV-positive.

3.2.5 Treatment of Sexually Transmitted Infections (STIs)

3.2.5.1 Rationale

STIs significantly increase the risk of HIV infection and their effective control has been shown to decrease the risk of HIV transmission. Women are particularly vulnerable to STIs because of biological and sociocultural factors.

3.2.5.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that every person has access to appropriate, nondiscriminatory, comprehensive, confidential and client-friendly sexual and reproductive health services, including syndromic STI management and care in accordance with existing reproductive health policies.
- ensure that partner referrals are encouraged during the management of STIs.
- ensure that STI services are appropriate for and accessible to women, young people and other vulnerable groups.
- ensure that health care workers at all levels are adequately trained in syndromic STI management.
- encourage HIV testing among STI clients.

3.2.6 Blood and tissue safety

3.2.6.1 Rationale

Transfusion of infected blood and transplants of infected tissue lead to the transmission of blood-borne diseases, including HIV, hepatitis and syphilis. It is essential that blood transfusion and tissue transplant services ensure safety at the time of donation, during storage and during transfusion and/or transplant.

3.2.6.2 Policy statements

Government, through the NAC, undertakes to do the following

- establish efficient and effective blood transfusion services that include safe and reliable blood banking and transfusion.
- ensure that all blood and tissue products are screened for HIV.
- ensure the constant availability of trained personnel and safe blood and tissue supplies at all secondary and tertiary health care institutions.

3.2.7 Universal precautions

3.2.7.1 Rationale

Universal precautions for infection control include the use of gloves and appropriate cleaning techniques when dealing with open wounds and blood spills, and the safe disposal of needles and medical waste. Failure to observe these can increase the risk of accidental exposure to blood-borne infections, including HIV. A high prevalence of HIV/AIDS in the general population exacerbates the risk of accidental exposure to HIV infection through needlestick injuries and other contact with blood and blood products in health care, workplace and other settings.

3.2.7.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that health care providers, home-based care providers, traditional healers and traditional birth attendants (TBAs) are adequately trained in the application of universal precautions and are provided with the equipment necessary to implement these precautions in the course of their work.
- promote adherence to universal precautions to reduce the risk of HIV infection through accidental exposure to HIV and shall ensure that appropriate and accessible information on the application of such precautions is widely disseminated.

3.2.8 Clean injecting materials and skin-piercing instruments

3.2.8.1 Rationale

Unsterilised dental, surgical and cosmetic instruments and equipment pose a risk of HIV transmission. A similar risk is posed by the use of unsterilised skin piercing and/or cutting

instruments, for example, for cultural practices such as scarification and circumcision. Use of disposable materials and proper sterilisation of reusable materials can reduce the risk of HIV infection.

3.2.8.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure the availability of adequate disposable materials as well as sterilising equipment for nondisposable materials at all health care facilities.
- ensure that adequate facilities are provided for the appropriate disposal and removal of used disposable materials at all health care facilities.
- ensure the dissemination of appropriate information on the dangers associated with the use of unsterilised skin-piercing materials.
- ensure that guidelines for the use and disposal of disposable materials and the sterilisation of nondisposable materials are regularly updated and communicated to all health care facilities.
- ensure that traditional healers, TBAs and traditional initiation counsellors use sterile skin-piercing materials.

3.2.9 Post-exposure Prophylaxis (PEP)

3.2.9.1 Rationale

If initiated within 72 hours of suspected exposure to HIV, PEP (short-term antiretroviral treatment) can reduce the risk of HIV infection. Accidental exposure to HIV infection can occur in institutional, workplace and home care settings and in situations involving trauma, such as rape.

3.2.9.2 Policy statement

Government, through the NAC, undertakes to do the following

- ensure access to affordable short-term ARV prophylaxis for people who have experienced occupational exposure to HIV, as well as for victims of rape.

3.3 Treatment, care and support

Comprehensive treatment, care and support include the provision of ART and other medicines; diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections (OI) and other conditions; good nutrition; social, spiritual and psychological support; and family or community home-based care.

3.3.1 Rationale

HIV infection results in serious medical, emotional, psychological, social and economic consequences for the affected individual and family. There is no known cure for HIV infection, but ART can prolong and improve the quality and length of life of PLWAs. Use of ART significantly reduces viral load, arrests immune destruction and may render the infected person less infectious. Boosting the immunity also reduces the occurrence of OIs.

In addition, most OIs associated with HIV infection can be treated with affordable drugs; others can be prevented or delayed through drug prophylaxis. Proper nutrition and psychosocial support, including support counselling, as well as community home-based care (CHBC), can help to improve the quality of life of a PLWA.

3.3.2 Policy statements

Government, through the NAC, undertakes to do the following

- progressively provide access to affordable, high quality ART and prophylaxis to prevent OIs, but only to individuals who have tested HIV-positive and are medically deemed to be in need of this drug therapy.
- ensure the active participation of PLWAs and vulnerable groups in the design, development and implementation of a national plan for the progressive realisation of universal access to treatment.
- ensure that every person has access to accurate information regarding HIV treatment options and shall promote widespread treatment literacy campaigns, with access to

information on where and how to access treatment, care and support.

- promote the delivery of quality CHBC as an essential component on the continuum of care for PLWAs.
- ensure that the prescription and sale of ART drugs is adequately regulated to guarantee quality control and to reduce the risk of drug resistance developing through inappropriate use of the drugs.
- ensure that health care workers are adequately trained in the use and management of ART as well as in the treatment of OIs.
- promote the establishment of effective referral and discharge plans by the providers of HIV/AIDS-related services as an integral part of the continuum of care.
- ensure that the national Essential Drug List is regularly updated to incorporate essential drugs for HIV/AIDS treatment in accordance with the World Health Organisation Essential Drugs List.
- ensure that management of drugs and medical supplies, including procurement, storage and distribution of essential and ARV drugs, is constantly monitored and improved as necessary.
- ensure that treatment of HIV/AIDS-related infections is provided according to the Essential Health Package.

CHAPTER 4 – Protection, participation and empowerment of people living with HIV

4.1 Rationale

In its Declaration of Commitment on HIV/AIDS, the United Nations General Assembly noted that the realisation of human rights and fundamental freedoms for all, especially PLWAs, is an essential component of an effective response to HIV/AIDS. Discrimination against PLWAs violates their rights and is counterproductive to HIV/AIDS efforts in that it threatens voluntary disclosure of HIV serostatus, thus increasing vulnerability to HIV infection. However, PLWAs also have a responsibility to respect and protect the rights and health of others. Therefore, active participation of PLWAs in the design and implementation of HIV/AIDS programmes is integral to national efforts.

4.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that the human rights and dignity of those affected and infected by HIV/AIDS are respected, protected and upheld in a conducive legal, political, economic, social and cultural environment.
- ensure the effective participation of PLWAs in all decision-making on the design, implementation, monitoring and evaluation of HIV/AIDS-related policies and programmes.
- ensure that PLWAs are not discriminated against in access to health care and related services and that respect for privacy and confidentiality are upheld.
- ensure that HIV/AIDS, whether suspected or actual, is not used as a reason for denying access to social services, including health care, education, religious services, or employment.
- ensure that sector policy-makers, including those in labour, corporate and social service sectors, put in place sectoral policies that effectively address discrimination on the basis of HIV/AIDS and take steps to effectively eliminate stigma and discrimination in their institutions and in the implementation of their sectoral mandates.
- ensure that PLWAs whose rights have been infringed have access to independent, speedy and effective legal and/or administrative procedures for seeking redress.
- establish mechanisms and services at family, community or national levels to protect those who choose to disclose their HIV serostatus, as well as their families and communities.
- ensure that orphans living with HIV are not discriminated against in access to health care; in education; or in access to fostering, adoption or placement in institutions.

- ensure that PLWAs are aware of and take responsibility for protecting themselves from reinfection and protecting others from infection.

CHAPTER 5 – Protection, participation and empowerment of vulnerable populations

5.1 Introduction

Vulnerable populations include women, children, orphans, widows, widowers, young people, the poor, persons engaged in transactional sex (sex in exchange for cash or in-kind benefit), prisoners, mobile populations, persons engaged in same-sex relations and people with disabilities. These people, who are often underprivileged socially, culturally, economically or legally, may be less able to fully access education, health care, social services and means of HIV prevention; to enforce HIV prevention options; and to access needed treatment, care and support. They are thus more vulnerable to the risks of HIV infection and suffer disproportionately from the economic and social consequences of HIV/AIDS.

5.2 Women and girls

5.2.1 Rationale

Woman and girls are frequently socially, culturally, economically and legally vulnerable. Socio-culturally, in particular, they are taught to be subservient to men and boys, so are much more vulnerable to physical abuse, including sexual abuse. Economically, they generally have lower levels of education, so have less access to highly-paid employment, meaning they are less likely to be able to avoid abusive situations. Often, women and girls are less aware of their human rights.

5.2.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that women and girls, regardless of marital status, have equal access to appropriate, sound HIV-related information and education programmes, means of prevention and health services (i.e. woman-specific and youth-friendly sexual and reproductive health services for all women of reproductive age, including women living with HIV).
- protect the rights of women to have control over and to decide responsibly, free of discrimination or coercive violence, on matters related to their sexuality, including sexual and reproductive health.
- ensure that women and girls are protected against violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.
- ensure women's legal rights and equality within the family, in matters such as divorce, inheritance, child custody, property and employment rights, recognising, in particular, the right to equal remuneration of men and women for work of equal value, equal access to responsible positions, measures to reduce conflicts between professional and family responsibilities, and protection against sexual harassment in the workplace.
- ensure that women enjoy equal access to the benefits of scientific and technological progress so as to minimise the risk of HIV infection.
- develop and implement gender-sensitive HIV/AIDS care programmes that ensure continuity of care among hospital, clinic, community care, family or household, and hospice.
- ensure that young girls and boys, both in and out of school, have access to life skills education which addresses unequal gender relations, to enable them to protect themselves from HIV infection or live positively with HIV/AIDS if they are already infected.

5.3 Orphans

5.3.1 Rationale

Orphans are generally underprivileged, but AIDS orphans are particularly vulnerable. The older child(ren) may have had to

nurse one or both parents through numerous periods of illness prior to death, thus preventing them from attending school and/or helping cultivate the land. At the same time, the youngest orphan(s) within a family may also be HIV-positive. Furthermore, whatever financial resources were available when the parents were healthy may well have been used up for drugs and funeral expenses, leaving the children with nothing to fall back on. Many AIDS orphans are now dependent on elderly grandparents, but others have no one to turn to, so in both cases they are disempowered.

5.3.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that communities and extended families caring for orphans are assisted and empowered with resources, services and skills to help them cope with the extra burden.
- ensure that orphans are not denied access to primary education, whether by virtue of their inability to pay, their age or their gender.
- put in place mechanisms for the registration of births and deaths at a local level, including by chiefs, to facilitate and inform the monitoring of and planning for the orphan situation.
- ensure that child-headed households are supported, in order to safeguard the best interests of children.
- put in place mechanisms to ensure the protection of inherited property of orphans until they attain the age of majority.

5.4 Widows and widowers

5.4.1 Rationale

All those who lose their spouse, but particularly women, are vulnerable to exploitation at their time of greatest grief. At this time, they often forget their rights, if they were already aware of them. Culturally, they may be expected to perform ceremonies which expose themselves or others to HIV/AIDS (see Chapter 6). Economically, they have lost a source of support.

5.4.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that communities, especially women and the elderly, have access to accurate and comprehensive information, both about laws protecting the legal rights of a surviving spouse to inherit property and about ways to enforce these rights.
- ensure that victims of property grabbing and custody disputes have access to affordable legal support services to enforce their rights.

5.5 Children and young people

5.5.1 Rationale

Children and young people are socially and culturally disadvantaged because they cannot make their voice heard if they are being exploited or abused. The power relations in school settings may make them particularly vulnerable.

5.5.1 Policy statements

Government, through the NAC, undertakes to do the following

- strengthen and enforce existing legislation to protect children and young people against any type of abuse or exploitation.
- ensure that children and young people have access to youth-friendly sexual and reproductive health information and education, including HIV/AIDS and STI information, appropriate to their age and needs, to equip them with knowledge and skills to protect themselves, in particular from HIV and other STIs.
- incorporate life skills education, including reproductive and sexual health education, into the school curricula as a subject in which students are regularly assessed (cf. Chapter 3). Peer education will be one of the possible modes of teaching.
- ensure that similar life skills education, including reproductive and sexual health education, is made accessible to out-of-school youth to protect themselves, in particular

from HIV and other STIs. Peer education will be one of the modes of teaching.

- ensure that all counsellors, including career, traditional and faith-based counsellors, are trained to offer counselling to youth on ways of delaying sex, protecting themselves from unwanted pregnancies, and preventing infection and/or reinfection with HIV and other STIs.
- ensure that traditional initiation counsellors incorporate sound, appropriate sexual and reproductive health education into traditional and cultural rites of passage and/or initiation processes.
- in partnership with institutions offering education and youth services, provide multi-purpose youth centres to ensure the well-being and development of young men and women, while at the same time protecting them from HIV and other STIs.
- ensure that all educational institutions have appropriate systems and safeguards in place that are enforced to prevent sexual abuse, harassment, or exploitation of students by peers or education sector employees. These safeguards shall prohibit education sector employees from engaging in sexual relations with students.

5.6 The Poor

5.6.1 Rationale

Anyone who is so poor that he cannot meet the basic needs for food, clothing and shelter is vulnerable to exploitation by others merely because of his efforts to survive. Poor people sometimes find themselves engaging in behaviours they know can be detrimental to their health because they have no alternative source of income.

5.6.1 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that HIV/AIDS prevention services are accessible to the poor, in terms of physical location, cost and the appropriateness of information and interventions.
- ensure that essential health care, treatment and support for HIV/AIDS and opportunistic infections is accessible to the poor, in accordance with the Essential Health Package and the PRSP.
- promote effective partnership with non-governmental and private health providers who offer essential HIV/AIDS care and support to the poor and hard-to-reach populations.
- ensure that mechanisms and national guidelines are developed for the delivery of ART. These mechanisms and guidelines shall not hinder access by the poor and people in remote places.
- engage civil society, particularly organisations that serve or represent the poor, in designing, implementing and monitoring the national response to HIV/AIDS.
- ensure that HIV/AIDS prevention is mainstreamed into strategies and programmes to reduce poverty.
- allocate an increasing proportion of its resources to specifically target HIV/AIDS under the PRSP.

5.7 People engaged in transactional sex

5.7.1 Rationale

Very often, people who engage in transactional sex do so because they perceive that they have no alternative if they wish to survive (cf. 5.6 above). They are particularly vulnerable economically.

5.7.1 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that people engaged in transactional sex have access to confidential and respectful health care, particularly sexual and reproductive health services, female and male condoms, and treatment and care of sex workers who are living with HIV.
- ensure that young women and men who are approaching adulthood, and who are engaged in transactional sex, are supported through multi-disciplinary interventions with life skills and sexuality education, so that they may make

informed decisions about their lives, particularly how to prevent HIV infection.

- ensure that people engaged in transactional sex (including commercial sex workers and their clients) are aware of and take responsibility for protecting themselves and their sexual partners.

5.8 Prisoners

5.8.1 Rationale

Prisoners are particularly vulnerable to exploitative and abusive sexual relations because of the environment in which they are living. They, therefore, need to be empowered to make informed decisions in the same way as other vulnerable groups.

5.8.1 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that prisoners are not subjected to mandatory testing, nor quarantined, segregated, or isolated on the basis of HIV/AIDS status.
- ensure that all prisoners (and prison staff, as appropriate) have access to HIV-related prevention information, education, VCT, means of prevention (including condoms), treatment (including ART), care and support.
- ensure that prison authorities take all necessary measures, including adequate staffing, effective surveillance, and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion by fellow prisoners and by warders. Juveniles shall be segregated from adult prisoners to protect them from abuse.
- ensure that prisoners who have been victims of rape, sexual violence or coercion have timely access to PEP, as well as effective complaint mechanisms and procedures and the option to request separation from other prisoners for their own protection.

5.9 Mobile populations

5.9.1 Rationale

Mobile populations, especially refugees, are often vulnerable to social, cultural, economic and legal discrimination precisely because of their mobility.

5.9.1 Policy statements

Government, through the NAC, undertakes to do the following

- identify, address and reduce the vulnerability to HIV/AIDS of all mobile groups, including modification of their living and working conditions.
- collaborate with regional institutions, such as the Southern African Development Community and the International Organisation on Migration, in developing regional responses to HIV/AIDS that are rights-based and meet public health imperatives.
- ensure that the rights of refugees in Malawi are respected, protected and upheld, including their rights with respect to HIV prevention, treatment, care and support.

5.10 People engaged in same-sex sexual relations

5.10.1 Rationale

People who engage in same-sex sexual relations are socially and culturally vulnerable to prevailing attitudes. If they are not accorded access to HIV/AIDS prevention education, treatment, care and support, they may endanger others as a result of their ignorance.

5.10.1 Policy statement

Government, through the NAC, undertakes to do the following

- put in place mechanisms to ensure that HIV and STI prevention, treatment, care and support can be accessed by all without discrimination, including people engaged in same-sex sexual relations.

5.11 People with disabilities

5.11.1 Rationale

People with disabilities are disadvantaged because they frequently have little, if any, access to formal education, and often also experience lack of opportunities for informal education. Without education, they become more vulnerable to abuse, whether physical, psychological, or sexual.

5.11.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that HIV-related prevention information, education, treatment, care and support strategies are tailor-made for and accessible to people with disabilities.
- ensure that all decision-making fora and structures provide for the full and active participation of people with disabilities.
- ensure that all responses to HIV/AIDS consider the implications for people with disabilities and plan for more effective responses based on models of national and international best practice.

CHAPTER 6 – Traditional and religious practices and services

6.1 Customary practices

6.1.1 Rationale

Some customary practices increase the risk of HIV infection. Among these are polygamy, extramarital sexual relations, marital rape, first aid to snakebite victims, ear piercing and tattooing (mphini), and traditional practices such as widow- and widower-inheritance (chokolo), death cleansing (kupita kufa), forced sex for young girls coming of age (fisi), newborn cleansing (kutenga mwana), circumcision (jando or mdulidwe), ablation of dead bodies, consensual adultery for childless couples (fisi), wife and husband exchange (chimwanamaye) and temporary husband replacement (mbulo).

6.1.2 Policy statements

Government, through the NAC, undertakes to do the following

- in partnership with civil society, including traditional and religious leaders, promote and encourage monogamous marriages and fidelity within any type of marriage, to prevent HIV and other STIs.
- promote correct and consistent use of condoms in marital sex where there is real or perceived risk of HIV infection and other STIs.
- ensure that support services are available for spouses who assert their rights to safer sex with their partners and are abused or thrown out of the home.
- ensure that traditional and religious leaders sensitise their communities to the dangers of, and discourage, customary widow- and widower-inheritance practices.
- ensure that men and women are empowered to make independent and informed decisions and choices regarding widow- and widower-inheritance to reduce the risk of HIV transmission.
- in partnership with civil society, religious and traditional leaders, promote VCT for men and women who willingly choose to practice widow- and widower-inheritance.
- ensure the provision of support services and access to PEP for people who reject the practice of widow- and widower-inheritance and are victimised as a result.
- in partnership with civil society including religious leaders, sensitise traditional leaders and their subjects on the dangers of customary practices such as death cleansing (kupita kufa), forced sex for young girls coming of age (fisi or kuchotsa fumbi), newborn cleansing (kutenga mwana), consensual adultery for childless couples (fisi), wife- and husband-exchange (chimwanamaye), temporary husband replacement (mbulo), and sucking of blood (to help

snakebite victims), all of which practices may lead to HIV infection.

- ensure that traditional leaders stop or modify unsafe customary practices to make them safer in order to prevent HIV transmission, or promote alternative customary practices which do not place people at risk of HIV infection.
- in partnership with civil society, traditional and religious leaders, sensitise childless couples and HIV positive partners on available options, such as fostering, adoption and medical treatment.
- ensure that risky practices like circumcision, tattooing and ear piercing are done safely to prevent HIV infection.

6.2 Traditional healers and traditional birth attendants

6.2.1 Rationale

The majority of Malawians rely on traditional healers and TBAs for many of their health care needs. It is thus imperative to include these health workers in the fight against HIV/AIDS.

6.2.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that traditional healers and TBAs have access to and training in HIV-related prevention information and education, as well as care and support for PLWAs.
- in partnership with civil society, traditional and religious leaders and traditional healers, sensitise communities on the role of traditional healers and TBAs in the context of HIV/AIDS.
- in partnership with civil society, traditional and religious leaders, sensitise and discourage traditional healers from making false claims about HIV/AIDS cures and prescribing practices that increase the risk of HIV infection.

6.3 Religious practices and services

6.3.1 Rationale

Religious groups have an important role to play in promoting behaviours that reduce the risk of HIV infection, such as abstinence before and faithfulness within marriage, and the use of VCT prior to marriage and during marriage reconciliations (after divorce or separation). These groups can also provide care and support for PLWAs. However, certain religious practices, such as refusal to seek medical care and treatment or belief in miracle cures, increase vulnerability to HIV infection.

6.3.2 Policy statements

Government, through the NAC, undertakes to do the following

- work closely with religious leaders to facilitate the provision of accurate HIV-related prevention information and education, as well as care and support for PLWAs.
- sensitise religious leaders to HIV/AIDS and discourage them from making false claims of miracle HIV/AIDS cures.

CHAPTER 7 – Responding to HIV/AIDS in the workplace

7.1 Rationale

The impact of HIV/AIDS in the workplace is increasingly being felt. Among other factors, absenteeism and death result in low productivity, premature payment of employee benefits and low workplace morale. Discrimination against PLWAs has also been perpetuated through practices such as pre-employment HIV testing, dismissal as a result of being HIV-positive and the denial of employee benefits if known to be infected.

One of the most effective ways of reducing and managing the impact of HIV/AIDS in the workplace is through implementation of an HIV/AIDS policy and a prevention, treatment, care and support programme.

7.2 Policy statements

Government, through the NAC, undertakes to do the following

- ensure that all public and private sector workplaces shall develop and implement an HIV/AIDS workplace policy and an HIV prevention, treatment, care and support programme.
- ensure that all public and private sector workplace policies provide that
- No employer shall require any person, whether directly or indirectly, to undergo testing for HIV as a precondition for employment. The criterion for employment shall be fitness to do the job for which employment is sought. No person shall be denied employment solely on the basis of HIV serostatus.
- No employee shall be compelled to disclose his or her HIV serostatus to the employer or other employees. Where an employee chooses to voluntarily disclose his or her HIV serostatus to the employer or to another employee, such information shall not be disclosed to others without that employee's express written consent.
- No employer shall terminate the employment of an employee solely on the grounds of HIV serostatus or family responsibilities relating to HIV/AIDS.
- Employees living with HIV shall continue working in their current employment for as long as they are medically fit to do so. When, on medical grounds, they cannot continue with normal employment, verifiable efforts shall be made to offer them alternative employment or accommodate them without prejudice to their benefits.
- ensure that all public and private sector employees and employers understand that
- where an employee becomes too ill to perform any work, an employer may terminate his or her employment for reasons of incapacity in accordance with the procedures set out in the law.
- an employee living with HIV shall not be unfairly discriminated against or in any way prejudiced within the employment relationship or within any employment policies or practices.
- the HIV serostatus of an employee shall not affect his or her eligibility for any occupational insurance or other benefit schemes provided for employees by an employer. Where in terms of any law the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV test, the conditions attaching to HIV/AIDS shall be the same as those applicable in respect of comparable life-threatening illnesses.
- an employee living with or affected by HIV/AIDS shall be subject to the same conditions relating to sick or compassionate leave as those applicable to any other employee in terms of the law or of the conditions of service applicable.
- both employers and employees shall be proactive in safeguarding their health and that of their families by actively participating in HIV/AIDS programmes and sharing the lessons learnt in their homes and communities.

Namibia: National Code on HIV/AIDS in Employment (2000)

The National Code on HIV/AIDS in Employment was approved by the Cabinet and adopted by the National Assembly in 2002. The Code is based on the principles set forth in the Constitution of Namibia, the SADC Code on HIV/AIDS and Employment and is subject to the Labour Act (Act No 6 of 1992). The Code is informed by sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals.

Excerpts

...

Preamble

With the world-wide marked increase in number of persons infected with the Human Immunodeficiency Virus (HIV) and

suffering from Acquired Immunodeficiency Syndrome (AIDS) mainly in the economically active part of the population, the 20 to 50 year age group, the employers, employees and their organisations show a high level of anxiety in regard to the impact of the pandemic on the work environment.

Loss of employment and individual income, loss of employees without adequate availability of replacement, and a subsequent decline in production and national income can pose a severe and detrimental effect on the social and economic stability and the growth of a country.

In response to the AIDS pandemic and its volatile and dynamic nature, the Ministry of Labour in conjunction with the Ministry of Health and Social Services and with the wide tripartite consultation through the Labour Advisory Council has formulated the National Code HIV/AIDS and Employment for HIV prevention and control. These policies and guidelines address most of major issues related notably to the prevention of new infections as well as to the provisions of optimal care.

Aims

This National Code is aiming to provide all employers and employees and their organisations with the information required to introduce and sustain basic, uniform practices in regard to the relevant relations between employers and employees, employees inter se, and the state and employers and employees.

They outline the basic requirements for the promotion and maintenance of proper and consistent employment relationship and social security in regard to HIV-infection and AIDS in the work environment.

More favourable conditions may be laid down in registered collective agreements between employers or their organisations and trade unions.

The conditions laid down in such agreements are enforceable as stipulated in the Labour Act 1992 (6 of 1992).

...

Screening for HIV

(1) The "Official HIV and AIDS Policies and Guidelines of the Republic of Namibia" (see Appendix 5.2), are explicit on indications for screening and testing. Section 4.1.2, subsections 4.1.2.1 through 4.1.2.3, state that

(a) with the exception of mandatory screening of blood and other tissue and organ donors, differential diagnosis in a patient, assessment of potential risks to patients of specific interventions such as immunosuppressive therapy, after accidental exposure and gathering epidemiological data to monitor the spread of HIV, there is no justification for the systematic screening of groups, or indiscriminate testing of individuals;

(b) determination of an individual's HIV status should not be a pre-requisite of entry into work, continuation of work, transfer, promotion prospects or training opportunities;

(c) principally, any direct testing or any indirect means that oblige individuals to declare their HIV status as a condition of employment is discouraged. The only medical criterion for recruitment should be fitness to work.

As an employer, the Government of Namibia will not require such test and will see to it that all other sectors of employment do likewise.

(2) Therefore, compulsory routine pre-employment and follow-up screening for HIV as part of the assessment of fitness to work vocational training or any other training is unnecessary and should not be required, since:

(a) HIV-infection by itself does not affect an employee's ability to perform the functions for which he will be or has been employed;

(b) HIV with commonly applied testing methods can only be detected after a period between 3 to 6 months post infection;

(c) an infected person cannot transmit infection to co-workers casually.

(3) Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions

related to the assessments of risk behaviour should be considered in the same context as subsection 2 and must not be required.

(4)(a) Participation in pre-employment and follow-up HIV-testing requested by the employer for insurance purpose should be left to the discretion of the applicant/ employee.

(b) Should the applicant or employee refuse the HIV-test, this should not by itself deny employment or continuation of employment.

(5) The participation in certain benefit schemes provided by the employer under the conditions of prior HIV-testing should be left to the discretion of the applicant or employee.

Voluntary testing however should be promoted in general and specially for workers at risk under the condition that pre-and post-counseling, confidentiality and non-discrimination is guaranteed.

Guiding fundamental principles

In line with WHO/ILO recommendations the following fundamental principles should be applied to workers with HIV-infection and AIDS.

(1) Workers with HIV-infection who are medically fit for work should be treated the same way as other workers. They should be enabled to contribute their creativity and productivity in a supportive occupational setting.

(2) Workers with AIDS should be treated the same as other workers with a serious, chronic and terminal illness.

(3) Confidentiality regarding all medical information, including HIV and AIDS status, must be maintained at all times. This applies also to health professionals under contract with the employer.

(4) Employees affected by or believed to be affected by HIV or AIDS must be guaranteed protection from stigmatisation and discrimination by co-workers employers or clients.

Adherence to this fundamental principle could be best achieved by providing adequate information and education about HIV and AIDS to all parties concerned for better mutual understanding.

Informing the employer

(1) It is generally considered unreasonable; that an employee keeps the employer informed of his health status in detail. Therefore, there should be no obligation on the employee to inform the employer regarding his HIV and AIDS status, if it is not constituting a health threat in the work situation.

(2) If the health of an employee deteriorates to the extent that he becomes unable to partially or fully perform his work, there is a duty upon the employee to inform the employer of this impairment. The extent of the impairment should then be confirmed by means of a medical certificate of fitness, to be paid by the employer.

Continuity of employment

(1) HIV infection is not a reason for terminating employment since HIV-infection by itself does not limit fitness to work.

In Namibia, the dismissal of an employee merely because of their HIV-positive status, would be regarded as an unfair dismissal, if at the stage of dismissal he was physically fit and capable of performing his duties, and possibly going to remain that way for and indefinite period.

(2) Where the employee is incapable of carrying out the functions for which he was employed especially for an unreasonable length of time, the common law regards the contract as having become impossible which may lead to the termination of the contract.

The employer may end the contract by giving due notice. However, persons with HIV-related illness should be able to work as long as they are medically declared fit. If medically indicated and certified, alternative work arrangements or workplaces should be facilitated.

Alternative working arrangements

Employees, suffering from HIV-infection may request a transfer to workplace offering reasonable alternative working arrangements where work environment related hazards could aggravate the HIV status. It should be left to the discretion of the infected person to apply for changes in the work arrangement and to disclose his HIV status.

However, every employee working in a environment, that could increase the risk to develop AIDS or transmit the virus, should be informed by the employer about this risk and should be encouraged to assess his HIV status.

Requests for transfer by known HIV carriers should be processed by the employer without undue delay in view of the specific nature of the infection.

Benefits

All HIV infected employees, including agricultural and domestic workers and seafarers, should be entitled to the same work related remuneration, allowances, social security and insurance benefits as all other employees.

Transmission of HIV in the workplace

Preventative measures

(1) Infection with the human immunodeficiency virus in the course of employment is transmitted in the same way as any other infection by a blood-transmitted virus, for instance such as hepatitis B, haemorrhagic fever or cytomegaly. It can be prevented through the consistent adherence of universal infection control methods.

Therefore, there is at present no sound justification for mandatory HIV testing or screening of health workers patients at hospitals, and clinics, including antenatal clinics.

(2) Certain circumstances may justify the exclusion of some health workers from the duty of caring for HIV-infected patients in order to protect the patient or to protect themselves. They include medical conditions such as a compromised immune status, the presence of infections such as herpes simplex, varicella-zoster and extensive skin lesions.

(3) It shall be the obligation of the employer to provide any employee in an occupation, where there may be a risk of acquiring and transmitting an infectious disease, including HIV-infection, clear and accurate information non the hazards, adequate training to minimise the hazards and personal protective devices/measures, free of charge to the employee.

People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

(4) Relevant policies and strategies in regard to communicable diseases, including HIV and AIDS, should be formulated, implemented, monitored and reviewed on a periodic basis by the employer in co-operation with the workers and their organisations.

(5) In consideration of occupational first-aid attendants, first aid procedures and first aid kits are to be reviewed and revised on a periodic basis to ensure optimal hygienic precautions against infectious diseases, including HIV.

Every employee has the obligation to adhere to the principles of universal precautions, which include preventative measures provided and implemented by the employer in order to minimise as far as possible the risk to acquire or transmit communicable diseases, including HIV in the workplace.

Compensation for employees at occupation risk

1. An employee, at risk to acquire HIV in the workplace and infected accidentally during or in the course of his work, is entitled to 'Employee's Compensation Act,' (Act 30 of 1941) or comparable private insurance bearers.

In nearly all cases of occupational HIV infection, the virus was transmitted by accidental injuries with contaminated articles.

Therefore a health professional not previously infected by HIV, who for example injured or pricked him/herself with a sharp object, or where patients, blood or body fluids came into contact with mucous membranes of the health professional, should report the incident immediately to the supervisor as an injury on duty. The supervisor then must immediately document the incident in writing according to prescribed procedures relating to occupational accidents.

The health worker, if so indicated, should then undergo immediately an HIV test, including a confirmatory test, to document that he was not an HIV carrier at the time of the accident.

In case of a negative test result of the health worker and a positive HIV test of the patient, the health worker should undergo a second test after 6 months. The second test is required to establish if the accident resulted in a transmission of HIV as commonly applied testing methods can only detect the infection after a period between 3 to 6 months post infection.

The patient/person whose blood/body fluids caused the contamination or contaminated the object causing an injury, should be obliged to undergo relevant tests after having received appropriated counselling.

Should the health worker's second HIV test be positive, the incident and the test results have to be reported to the Employee's Compensation Commission National Code on HIV/AIDS and Employment.

South Africa: National HIV/AIDS Strategic Plan 2007-2011 (2007)

The National Strategic Plan (NSP) seeks to provide continued guidance to all government departments and sectors of civil society and build on work done in the past decade. The primary aim of the NSP is to reduce the rate of new HIV infections by 50 per cent by 2011. The NSP also seeks to reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80 per cent of all HIV positive people and their families by 2011.

Excerpts

...

7. Purpose of the Strategic Plan 2007-2011

The NSP 2007-2011 is designed to guide South Africa's response to HIV & AIDS & STIs control in the next five years. This strategy document draws on lessons learned in responding to HIV and AIDS in the last decade. The NSP builds on existing strengths and successes, considers the policy and legal environment, developments in scientific evidence, international practices, estimated needs for treatment and current coverage rates, demonstrable capacities, projects potential achievements by 2011, is informed by resources available, and looks at innovative ways to address areas of weakness, and sets ambitious targets to meet the broad aims the national response to HIV and AIDS and STIs. Linked to this plan is a Framework for Monitoring and Evaluation.

Practically the new NSP seeks to strengthen and improve the efficiency of existing services and infrastructure and introduce additional interventions based on recent advances in knowledge.

The two main goals of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa are to provide comprehensive care and treatment for people living with HIV and AIDS and to facilitate the strengthening of the national health system. The NSP 2007-2011, however, is not a plan for the health sector alone. Instead, it seeks to be relevant to all agencies working on HIV and AIDS in South Africa, within and outside the government. The underlying basic premise is the recognition that no single sector, ministry, department or organisation can by itself be held responsible for the control of HIV and AIDS.

It is envisaged that all government departments and sectors of civil society will use this plan as a basis to develop their own HIV and AIDS strategic and operational plans to achieve a focussed, coherent, country-wide approach to fighting HIV and AIDS. It will be used as a basis for engagement with national and international partners on matters that pertain to HIV and AIDS. Where there are policy gaps, these will be addressed and financial and other resources will be mobilised accordingly. This alignment and harmonisation of efforts will also enable consistent and effective monitoring and evaluation of the national response to HIV and AIDS, which will enable further revision and improvement of interventions.

8. Guiding principles

The principles guiding the implementation of the NSP 2007-2011 are in keeping with the imperatives of the Constitution, those outlined in the Comprehensive Plan, and *Batho Pele*. These Principles are

- Supportive leadership: The NSP should be driven by South Africa's political leadership with the support of leaders from all sectors.
- Leadership role of government: The effective implementation of the NSP and the attainment of its goals depends on government leadership in resource allocation, policy development, and effective coordination of all programmes and interventions.
- Greater Involvement of people living with HIV: There must be meaningful involvement of people living with HIV in all aspects of the national response.
- Young people (aged 15-24) as a priority group for HIV prevention: The trend of the HIV epidemic can be reversed if young people are informed and empowered to change their behaviour and reduce their risk. In all interventions there must be a special plan on reaching young people and consciously involving them in activities.
- Effective Communication: Clear and ongoing communication is an essential tool for the attainment of the aims of the plan.
- Effective partnerships: All sectors of government and all stakeholders of civil society shall be involved in the AIDS response.
- Promoting social change and cohesion: The national movement on moral regeneration and values promotion shall be enhanced to support sustainable behavioural change.
- Tackling inequality and poverty: The NSP affirms government's programmes and measures to ensure progressive realisation of rights to education, health care services and social security all people of South Africa. HIV and AIDS interventions will be implemented in a way that complements and strengthens other developmental programmes.
- Promoting equality for women and girls: The NSP recognises the particularly vulnerable position of women and girls to HIV, AIDS and its social impact. It commits to prioritising interventions focussing on the causes of gender inequality, and the horrific impact that HIV has on many women and girls.
- Protecting and respecting children: The impact of HIV on the rights of children is enormous. Respect for the best interests of the child dictates that children's rights and needs must be at the forefront of all interventions for HIV prevention, treatment and support.
- Recognising Diversity: The NSP recognises the special needs and diversity of disability rights as human rights and recognises disability as a social and developmental issue.
- Challenging stigma: The stigma against people living with HIV undermines dignity and hinders an effective response to HIV and AIDS. The NSP is committed to ending all stigma by creating knowledge and competence about HIV especially within our communities.
- Ensuring equality and non-discrimination against marginalised groups: The NSP is committed to challenging discrimination against groups of people who are marginalised, including people with disabilities, orphans,

refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men, intravenous drug users, and older persons. All these groups have a right to equal access to interventions for HIV prevention, treatment and support.

- **Personal Responsibility:** Every person in South Africa has a responsibility to protect themselves and others from HIV infection, to know their HIV status and seek appropriate care and support.
- **Building Community Leadership:** Programmes shall be informed and owned by communities and their leaders.
- **Using scientific evidence:** The interventions outlined in the NSP shall, wherever possible, be evidence-informed.
- **Strengthening care systems:** Strengthening of health and social systems, and organisational capacity of NGOs, FBOs and CBOs, is central to effective implementation.
- **Accessibility:** All essential commodities including prevention technologies, medicines, diagnostics tools, nutritional and food supplements, shall be made affordable and accessible.
- **Monitoring progress:** All interventions shall be subject to monitoring and evaluation. A budget of between 4 per cent and 7 per cent of the total HIV and AIDS budget should be dedicated to M&E.
- **Financial sustainability:** No credible, evidence-based, costed HIV and AIDS and STI sector plan should go unfunded. There should be predictable and sustainable financial resources for the implementation of all interventions. Additional resources from development partners shall be harmonised to align with policies, priorities and fund programme and financial gaps.

9. The HIV & AIDS and STI Strategic Plan for South Africa (NSP 2007-2011)

The primary aims of the NSP are to

- Reduce the rate of new HIV infections by 50 per cent.
- Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to an appropriate package of treatment, care and support to 80 per cent of all people diagnosed with HIV.

In particular young people in the age group 15-24 should be a focus of all the interventions, especially for behaviour change based prevention.

The interventions that are needed to reach the aims of the NSP are structured according to the following four key priority areas

- Prevention;
- Treatment, care and support;
- Monitoring, research and surveillance; and
- Human and rights and access to justice.

The executive summary section outlines the key priority areas, the goals and the identified specific objectives. The section that follows focuses in more detail on the interventions that will be pursued in the next 5 years towards the attainment of these objectives. However it needs to be understood that these priority areas are a continuum in the response to HIV and AIDS.

Priority area 1: Prevention

The target is to reduce the national HIV incidence rate by 50 per cent by 2011. Identifying and keeping HIV negative people negative is the most effective and sustainable intervention in the AIDS response. (The unavailability of incidence measures is a cause for uncertainty regarding the reliability of monitoring targets in this regard. Monitoring incidence will be informed by modelling work for some time in the NSP period.)

It is thought that as much as 85 per cent of the South African HIV epidemic is caused by heterosexual spread. Vertical transmission from mother to child and, less frequently, transmission associated with blood products account for the rest of the infections. The HIV epidemic is complex and diverse that although not fully understood, is known to be driven by many behavioural, social, and biological factors that both exacerbate and/or facilitate the spread of HIV. It is unlikely that the society will be able to keep up with the demand for health and social

services unless there is a significant slowing down in the incidence of newly infected individuals. This situation underscores the central role and importance of HIV prevention.

Priority area 2: Treatment, care and support

The target is to provide an appropriate package of treatment, care and support services to 80 per cent of people living with HIV and their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.

Key to meeting these targets are

- Establishing a national culture in which all people in South Africa regularly seek voluntary testing and counselling for HIV.
- Strengthening the health and other systems so as to create the conditions for universal access to a comprehensive package of treatment for HIV, including antiretroviral therapy, and the integration of HIV and TB care.
- Drawing on and disseminate the growing body of experience and innovation in care, treatment and support strategies across the country, in both public and private sectors.
- Focussing on specific issues and groups: the prevention-of-mother-to-child transmission, the care of children and HIV infected pregnant women, and wellness management of people before they become eligible for ART
- Ensure the effective implementation of policies and strategies to mitigate the impacts of HIV, in particular orphans and vulnerable children, youth headed households, and on the health and educational system as well as support to older people

Priority area 3: Research, monitoring and surveillance

The NSP 2007-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool. National, provincial and district level indicators to monitor inputs, process, outputs, outcomes and impact will be used to assess collective effort. It is recommended that a sustainable budget of between 4 per cent – 7 per cent of the total HIV and AIDS budget is dedicated for the Monitoring and Evaluation of the NSP in line with international trends.

Priority area 4: Human rights and access to justice

HIV and AIDS is a human rights issue. A major objective of the NSP is to create a social environment that encourages many more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support. Respect for and the promotion of human rights must be integral to all the priority interventions of the NSP. In addition, active and ongoing campaigns that promote, protect, enforce and monitor human rights must be linked to every intervention and mounted at district, provincial and national level. The NSP identifies a range of activities to improve access to justice, in order that people can challenge human rights violations immediately and directly. It sets out issues for law reform in order to create a legal framework that uniformly assists HIV prevention, treatment, research and surveillance.

Youth as a specific target group

Young people are not only the key to South Africa's future, but also the key to whether we meet the goals of the NSP. A key message of the NSP is that one of our greatest challenges is to influence and change the behaviour of young people, particularly those under 24, in order to try to reduce HIV infection in the age group that is most at risk. If this strategy is successful, behaviour change will need to be sustained and monitored as people get older. Also, access to youth-friendly services in clinics and multipurpose centres is key to getting young people involved in HIV and AIDS prevention treatment care and support programmes. The NSP outlines some critical youth specific interventions.

South Africa: National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in further Education and Training (1999)

The policy was published on the 10 August 1999 by the Ministry of Education in terms of section 3(4) of the National Education Policy Act, No 27 of 1996. The policy's aim is to prevent the spread of HIV infection, to reduce stigma and discrimination, develop knowledge, skills, values and attitudes in order to protect learners and educators from HIV infection and to support people infected and affected by HIV.

Excerpts

3. Non-discrimination and equality with regard to learners, students and educators with HIV

3.1 No learner, student or educator with HIV may be unfairly discriminated against directly or indirectly. Educators should be alert to unfair accusations against any person suspected to have HIV/AIDS.

3.2 Learners, students, educators and other staff with HIV should be treated in a just, humane and life-affirming way.

3.3 Any special measures in respect of a learner, student or educator with HIV should be fair and justifiable in the light of medical facts, established legal rules and principles; ethical guidelines; the best interest of the learner, student and educator with HIV; school or institution conditions; and the best interest of other learners, students and educators.

3.4 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996.

4. HIV testing and the admission of learners to a school and students to an institution, or the appointment of educators

4.1 No learner or student may be denied admission to or continued attendance at a school or an institution on account of his or her HIV status or perceived HIV status.

4.2 No educator may be denied the right to be appointed in a post, to teach or to be promoted on account of his or her HIV status or perceived HIV status. HIV status may not be a reason for dismissal of an educator, nor for refusing to conclude, or continue, or renew an educator's employment contract, nor to treat him or her in any unfair discriminatory manner.

4.3. There is no medical justification for routine testing of learners, students or educators for evidence of HIV infection. The testing of learners or students for HIV as a prerequisite for admission to, or continued attendance at school or institution, to determine the incidence of HIV/AIDS at schools or institutions, is prohibited. The testing of educators for HIV as a prerequisite for appointment or continued service is prohibited.

5. Attendance at schools and institutions by learners or students with HIV

5.1 Learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

5.2 Learners and students with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to do so effectively.

5.3 Learners of compulsory school-going age with HIV, who are unable to benefit from attendance at school or home education, may be granted exemption from attendance in terms of section 4(1) of the South African Schools Act, 1996, by the Head of Department, after consultation with the principal, the parent and the medical practitioner where possible.

5.4 If and when learners and students with HIV become incapacitated through illness, the school or institution should make work available to them for study at home and should support continued learning where possible. Parents should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of section 51 of the South African Schools Act, 1996, or provide older learners with distance education.

5.5 Learners and students who cannot be accommodated in this way or who develop HIV/AIDS-related behavioural problems or neurological damage, should be accommodated, as far as is practically possible, within the education system in special schools or specialised residential institutions for learners with special education needs. Educators in these institutions must be empowered to take care of and support HIV-positive learners. However, placement in special schools should not be used as an excuse to remove HIV-positive learners from mainstream schools.

6. Disclosure of HIV/AIDS-related information and confidentiality

6.1 No learner or student (or parent on behalf of a learner or student), or educator, is compelled to disclose his or her HIV status to the school or institution or employer. (In cases where the medical condition diagnosed is the HIV/AIDS disease, the regulations relating to communicable diseases and the notification of notifiable medical conditions Health Act, 1977 only require the person performing the diagnosis to inform the immediate family members and the persons giving care to the person and, in cases of HIV/AIDS-related death, the persons responsible for the preparation of the body of the deceased.)

6.2 Voluntary disclosure of a learner's, student's or educator's HIV status to the appropriate authority should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated. In terms of section 39 of the Child Care Act, 1983 (Act No 74 of 1983), any learner or student above the age of 14 years with HIV, or if the learner is younger than 14 years, his or her parent, is free to disclose such information voluntarily.

6.3 A holistic programme for life-skills and HIV/AIDS education should encourage disclosure. In the event of voluntary disclosure, it may be in the best interests of a learner or student with HIV if a member of the staff of the school or institution directly involved with the care of the learner or student, is informed of his or her HIV status. An educator may disclose his or her HIV status to the principal of the school or institution.

6.4 Any person to whom any information about the medical condition of a learner, student or educator with HIV has been divulged, must keep this information confidential.

6.5 Unauthorised disclosure of HIV/AIDS-related information could give rise to legal liability.

6.6 No employer can require an applicant for a job to undergo an HIV test before he is considered for employment. An employee cannot be dismissed, retrenched or refused a job simply because he is HIV positive.

7. A safe-school and institution environment

7.1 The MEC should make provision for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment. Universal precautions include the following

7.1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) should therefore be treated as potentially infectious.

- (a) Blood, especially in large spills such as from nosebleeds, and old blood or blood stains, should be handled with extreme caution.
- (b) Skin exposed accidentally to blood should be washed immediately with soap and running water.
- (c) All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or other antiseptics.
- (d) If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.
- (e) Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.
- (f) Disposable bags and incinerators must be made available to dispose of sanitary wear.

7.1.2 All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.

7.1.3 Cleansing and washing should always be done with running water and not in containers of water. Where running tap water is not available, containers should be used to pour water over the area to be cleansed. Schools without running water should keep a supply, eg in a 25-litre drum, on hand specifically for use in emergencies. This water can be kept fresh for a long period of time by adding a disinfectant, such as Milton, to it.

7.1.4 All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes, open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, eg a towel.

7.1.5 If a surface has been contaminated with body fluids and excretions which could be stained or contaminated with blood (for instance tears, saliva, mucus, phlegm, urine, vomit, faeces and pus), that surface should be cleaned with running water and fresh, clean household bleach (1:10 solution), and paper or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags.

7.1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to an appropriate disposal firm. Tissues and toilet paper can readily be flushed down a toilet.

7.1.7 If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution for at least one hour before drying and re-using.

7.1.8 Needles and syringes should not be re-used, but should be safely disposed of.

7.2 All schools and institutions should train learners, students, educators and staff in first aid, and have available and maintain at least two first aid kits, each of which should contain the following

- (a) two large and two medium pairs of disposable latex gloves;
- (b) two large and two medium pairs of household rubber gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate);
- (c) absorbent material, waterproof plasters, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids.
- (d) protective eye wear; and
- (e) a protective face mask to cover nose and mouth.

7.3 Universal precautions are in essence barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described in 7.2, such as

- (a) unbroken plastic bags on hands where latex or rubber gloves are not available;
- (b) common household bleach for use as disinfectant, diluted one part bleach to ten parts water (1:10 solution) made up as needed.
- (c) spectacles; and
- (d) a scarf.

7.4 Each classroom or other teaching area should preferably have a pair of latex or household rubber gloves.

7.5 Latex or household rubber gloves should be available at every sports event and should also be carried by the playground supervisor.

7.6 First-aid kits and appropriate cleaning equipment should be stored in one or more selected rooms in the school or institution and should be accessible at all times, also by the playground supervisor.

7.7 Used items should be dealt with as indicated in paragraphs 7.1.6 and 7.1.7.

7.8 The contents of the first-aid kits, or the availability of other suitable barriers, should be checked each week against a contents list by a designated staff member of the school or institution. Expired and depleted items should be replaced immediately.

7.9 A fully equipped first-aid kit should be available at all school or institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events.

7.10 All learners, students, educators and other staff members, including sports coaches, should be given appropriate information and training on HIV transmission, the handling and use of first-aid kits, the application of universal precautions and the importance of adherence universal precautions.

7.10.1 Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.

7.10.2 Learners, especially those in pre-primary and primary schools, and students should be instructed never to touch the blood, open wounds, sores, breaks in the skin, grazes and open skin lesions of others, nor to handle emergencies such as nosebleeds, cuts and scrapes of friends on their own. They should be taught to call for the assistance of an educator or other staff member immediately.

7.10.3 Learners and students should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be kept covered completely with waterproof dressings or plasters at all times, not only when they occur in the school or institution environment.

7.11 All cleaning staff, learners, students, educators and parents should be informed about the universal precautions that will be adhered to at a school or an institution.

7.12 A copy of this policy must be kept in the media centre of each school or institution.

8. Prevention of HIV transmission during play and sport

8.1 The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.

8.1.1 The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners, students and educators are exposed to infected blood.

8.1.2 Certain contact sports may represent an increased risk of HIV transmission.

8.2 Adequate wound management, in the form of the application of universal precautions, is essential to contain the risk of HIV transmission during contact play and contact sport.

8.2.1 No learner, student or educator may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.

8.2.2 If bleeding occurs during contact play or contact sport, the injured player should be removed from the playground or sports field immediately and treated appropriately as described in paragraphs 7.1.1 to 7.1.4. Only then may the player resume playing and only for as long as any open wound, sore, break in

the skin, graze or open skin lesion remains completely and securely covered.

8.2.3 Blood-stained clothes must be changed.

8.2.4 The same precautions should be applied to injured educators, staff members and injured spectators.

8.3 A fully equipped first-aid kit should be available wherever contact play or contact sport takes place.

8.4 Sports participants, including coaches, with HIV should seek medical counselling before participation in sport, in order to assess risks to their own health as well as the risk of HIV transmission to other participants.

8.5 Staff members acting as sports administrators, managers and coaches should ensure the availability of first-aid kits and the adherence to universal precautions in the event of bleeding during participation in sport.

8.6 Staff members acting as sports administrators, managers and coaches have special opportunities for meaningful education of sports participants with respect to HIV/AIDS. They should encourage sports participants to seek medical and other appropriate counselling where appropriate.

9. Education on HIV/AIDS

9.1 A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

9.2 Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students, and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners. This should include the following

9.2.1 providing information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission;

9.2.2 inculcating from an early age onwards basic first-aid principles, including how to deal with bleeding with the necessary safety precautions;

9.2.3 emphasising the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV, and empowering learners to deal with these situations;

9.2.4 encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines;

9.2.5 teaching learners and students how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes around HIV/AIDS;

9.2.6 cultivating an enabling environment and a culture of non-discrimination towards persons with HIV/AIDS; and

9.2.7 providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

9.3 Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.

9.4 Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educator and imparters of values at home.

9.5 Educators may not have sexual relations with learners or students. Should this happen, the matter has to be handled in terms of the Employment of Educators Act, 1998.

9.6 If learners, students or educators are infected with HIV, they should be informed that they can still lead normal, healthy lives for many years by taking care of their health.

10. Duties and responsibilities of learners, students, educators and parents

10.1 All learners, students and educators should respect the rights of other learners, students and educators.

10.2 The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.

10.3 The ultimate responsibility for the behaviour of a learner or a student rests with his or her parents. Parents of all learners and students

10.3.1 are expected to require learners or students to observe all rules aimed at preventing behaviour which may create a risk of HIV transmission; and

10.3.2 are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

10.4 It is recommended that a learner, student or educator with HIV/AIDS and his or her parent, in the case of learners or students, should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognised significant health risk to others. If such a risk is established, the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of other learners, students, educators and staff members.

10.5 Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

11. Refusal to study with or teach a learner or a student with HIV/AIDS, or to work with or be taught by an educator with HIV/AIDS

11.1 Refusal to study with a learner or student, or to work with or be taught by an educator or other staff member with, or perceived to have HIV/AIDS, should be pre-empted by providing accurate and understandable information on HIV/AIDS to all educators, staff members, learners, students and their parents.

11.2 Learners and students who refuse to study with a fellow learner or student or be taught by an educator or educators and staff who refuse to work with a fellow educator or staff member or to teach or interact with a learner or student with or perceived to have HIV/AIDS and are concerned that they themselves will be infected, should be counselled.

11.3 The situation should be resolved by the principal and educators in accordance with the principles contained in this policy, the code of conduct for learners, or the code of professional ethics for educators. Should the matter not be resolved through counselling and mediation, disciplinary steps may be taken.

12. School and institutional implementation plans

12.1 Within the terms of its functions under the South African Schools Act, 1996, the Further Education and Training Act, 1998, or any applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the national policy.

12.2 A provincial education policy for HIV/AIDS, based on the national policy, can serve as a guideline for governing bodies when compiling an implementation plan.

12.3 Major role players in the wider school or institution community (for example religious and traditional leaders, representatives of the medical or health care professions or traditional healers) should be involved in developing an implementation plan on HIV/AIDS for the school or institution.

12.4 Within the basic principles laid down in this national policy, the school or institution implementation plan on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves. Consultation on the school or institution implementation plan

could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances.

...

14. Implementation of this National Policy on HIV/AIDS

14.1 The Director-General of Education and the Heads of provincial departments of education are responsible for the implementation of this policy, in accordance with their responsibilities in terms of the Constitution of the Republic of South Africa, 1996, and any applicable law. Every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department's HIV/AIDS programme, to advise Management regarding programme implementation and progress, and to create a supportive and nondiscriminatory environment.

14.2 The principal or the head of a hostel is responsible for the practical implementation of this policy at school, institutional or hostel level, and for maintaining an adequate standard of safety according to this policy.

14.3 It is recommended that a school governing body or the council of an institution should take all reasonable measures within its means to supplement the resources supplied by the State in order to ensure the availability at the school or institution of adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.

14.4 Strict adherence to universal precautions under all circumstances (including play and sports activities) is advised, as the State will be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school or institution.

...

South Africa: Human Rights and Ethical Guidelines on HIV: A Manual for Medical Practitioners of South Africa (2001)

Published by the South African Medical Association's Human Rights, Law and Ethics Unit in November 2001. It addresses the need to harmonise the rights and interests of individuals and groups in their various capacities. In particular, it provides guidance to doctors dealing with issues relating to human rights and ethical duties concerning testing, counselling, and confidentiality when treating HIV-positive patients.

Excerpts

...

2. Pre-testing counselling

...

[The] South African Medical Association believes that having a person merely sign a form or reading leaflet before an HIV test does not constitute pre-test counselling.

Pre-test counselling should include the following aspects

- What an HIV test is and the purpose of the test
- How long a test takes and what is actually done (drawing blood, et cetera)
- The need for a test in the particular circumstances, for example in the preoperative setting, the effect the results may have on treatment and the patient's future health care, et cetera
- The advantages and disadvantages of taking the test and of knowing one's HIV status
- The meaning of a negative result and the need for or possibility of a second test

- The necessity for lifestyle changes and coping with such changes
- Assessment of personal risk of HIV infection
- Strategies to reduce risk
- Coping with a positive result emotionally, including divulging one's status
- Where support services are and how to access them, and
- Sufficient space and opportunity to make an informed decision about taking the test

...

3. Testing for HIV

...

In principle, a person may only be tested at his or her own request. However, SAMA encourages medical practitioners to urge their patients to undergo HIV testing for the purpose of good patient care. A person may otherwise only be tested if it is authorised by legislation or by court order ...

The following have to be considered if an HIV test is to be performed

- Check for legislative provisions that may prohibit or regulate HIV testing, for example in schools, prisons, in the workplace, for medical aid purposes, insurance policy purposes, et cetera.
- Is the test needed for medical reasons (clinically indicated)? Has this been explained to the patient as part of pre-test and should be wary of testing exclusively for HIV where there could be grounds for performing other tests as well.
- Has pre-testing counselling been done?
- Is the patient informed about the virus, the test window period, et cetera?
- Have all of the principles of informed consent been addressed?
- Has the patient consented in writing to the test?
- Is the confidentiality of the fact that the test is to be undertaken guaranteed?

...

In terms of the Employment Equity Act of 1998, medical practitioners may not test (prospective) employees at the request of employers. In general, the same principle applies, i.e. no medical testing without the employee's free and informed consent.

...

4. Informed consent

...

It has long been part of South African law that a patient must provide informed consent for all medical treatment (diagnostic or therapeutic) performed on him/her (*Stoffberg v Elliot*, 1912). Basically, informed consent means that sufficient information is provided to enable the patient to make an informed decision, and that the patient actually understands the information and implications of acting on that information. Informed consent relates to a person's right to human dignity and autonomy. The medical practitioner has the duty to obtain the consent, as s/he is in a position to answer questions and provide further details.

The following are elements of informed consent

Consent must be voluntary and without constraint

In the case of an HIV test, consent should preferably be written, although consent may be implied

- Consent must not conflict with good morals or the Constitution
- The patient must be capable of consenting
- The patient must give the consent personally, unless proxy consent is applicable
- The patient should know why the medical practitioner needs the results of the test

- There should be sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results, et cetera.
- The patient must understand the situation clearly. As such, there may be a need for an interpreter, or at least an awareness that the patient may not actually understand everything; arrangements should be made to assist the process of understanding.

...

5. Post-test counselling

...

The duty to do post-test counselling falls on the practitioner who commissioned the test. This duty can not be dispensed with by referring a patient to a counselling service, although these services and support groups may be helpful for the patient after the post-test counselling.

...

Post-testing counselling should also take place where a patient tested negative. Important aspects such as the window-period, a second test two months later, lifestyle changes or how to stay negative, should form an integral part of post-test counselling in this context.

...

6. Confidentiality

...

Patient confidentiality is one of the cornerstones of the medical profession. It ensures that a patient divulges all the information relevant to his or her health care to the practitioner, thereby ensuring the best appropriate health care. Apart from the ethical rule on confidentiality, the South African Constitution protects the right to privacy and confidentiality...

A patient's HIV status may only be disclosed to a person or group if that patient consents to it being made known to that person or group of persons, for example the team of health care workers.

...

Informing sexual partners is an extremely complicated issue, and depends on whether a legal- or an ethical view is taken of the issue. Medical practitioners should be aware of the fact that their decisions in this regard may be measured against the Constitution and/or the relevant ethical guidelines ...

Consideration should be given to the following in this regard:

- During pre- and post-test counselling patients should be told of the need to disclose their HIV status to their partner(s) and how they should protect their partners in this regard.
- The first line of action should be to persuade the patient to consent to disclosure or to self disclose.
- The patient should be encouraged to be responsible in terms of his or her behaviour so as to prevent others from becoming infected. The patient should be made aware that penalties may result in cases of irresponsible (negligent or culpable) conduct.
- If the patient is unwilling, the medical practitioner may offer, with the patient's consent, to speak with both parties as a matter of good health care to the patient and the partner.
- If the patient is still unwilling, the medical practitioner may choose to disclose the patient's HIV status only if all the following conditions are met:

(a) The sexual partner should be a known and identified person. A general suspicion that a number of unidentified people may be at risk is not sufficient.

(b) The sexual partner should be at risk of being infected. This means that the patient has refused to take the necessary precautions and it is clear to the medical practitioner that the patient is posing a risk to the sexual partner. The medical practitioner may be required in court to show that he was acting on substantial information and not on suspicion. There should not be any other way to protect the partner or spouse.

(c) The patient should be informed beforehand that the medical practitioner is intending to breach his duty to maintain confidentiality. It may be wise to tell the patient of this intention and allow the patient a specified period of time to tell the partner him/herself.

- Only now may the medical practitioner disclose the HIV status to the partner. Pre-test counselling and/or referral of the person to a facility providing counselling and support should be offered. Remarks in passing about the partner-patient's HIV status are not sufficient and unethical.
- Where the patient firmly believes that this disclosure to a partner will put his or her life at risk, the medical practitioner's primary duty is to protect the life of the patient and act in his or her best interest. In some countries people living with HIV are persecuted. SAMA recommends that the patient's HIV status is *not* disclosed to the partner in these circumstances.

...

7. Access to treatment and clinical independence

...

SAMA Human rights, Law and Ethics Committee Resolutions

1. The Committee affirms its strong support for the right of medical practitioners to clinical independence and autonomy. This includes the right to treat patients without undue influence, pressure or victimisation from employers or government institutions. Medical practitioners are under an ethical duty to act in the best interests of their patients, who form an exceptionally vulnerable group in South African society. The Committee also supports the right of patients to receive necessary treatment, always with their informed consent.

2. The Committee supports the right of all pregnant women who are HIV-positive to receive the best available treatment that has been proven to reduce mother-to-child transmission. SAMA urges the government to make an unequivocal statement that women who are pregnant and HIV-positive, who have received the necessary counselling and have given their informed consent, will not be denied that treatment.

No medical practitioner may refuse to treat a patient who is HIV-positive solely on the basis of that person's HIV status. A medical practitioner may also not refuse normal standards of treatment to a patient based on the patient's HIV status. A medical practitioner may also not, by failing to fill out required forms for, for example social assistance grants et cetera., hinder a patient's right of access to treatment ...

HIV and prisons

Apart from the ordinary right such as human dignity and physical integrity, the Constitution, contains a set of rights applicable to arrested, accused and detained persons. One of the crucial elements is the right to medical treatment. Medical treatment includes voluntary HIV testing and counselling.

...

Medical practitioners working in correctional facilities should also be aware of the fact that segregation of prisoners based on their HIV status is likely to be unconstitutional (unless they have AIDS and suffer from an infectious disease such as TB).

...

D4 Case law of Eastern and Southern African national courts

D4.1 HIV-related discrimination

Hoffmann v South African Airways 2001 (1) SA 1 (SACC 2000)

In this case, the Constitutional Court of South Africa determined that the appellant's constitutional right to equality was violated when South African Airways refused to employ him on the basis of his HIV-positive status.

Excerpts

...

Introduction

[1] This appeal concerns the constitutionality of South African Airways' (SAA) practice of refusing to employ as cabin attendants people who are living with the Human Immunodeficiency Virus (HIV). Two questions fall to be answered: first, is such a practice inconsistent with any provision of the Bill of Rights; and second, if so, what is the appropriate relief in this case?

[2] Mr Hoffmann, the appellant, is living with HIV. He was refused employment as a cabin attendant by SAA because of his HIV-positive status. He unsuccessfully challenged the constitutionality of the refusal to employ him in the Witwatersrand High Court (the High Court) on various constitutional grounds. The High Court issued a positive certificate and this Court granted him leave to appeal directly to it.

...

Facts

[5] In September 1996 the appellant applied for employment as a cabin attendant with SAA. He went through a four-stage selection process comprising a pre-screening interview, psychometric tests, a formal interview and a final screening process involving role-play. At the end of the selection process the appellant, together with 11 others, was found to be a suitable candidate for employment. This decision, however, was subject to a pre-employment medical examination, which included a blood test for HIV/AIDS. The medical examination found him to be clinically fit and thus suitable for employment. However, the blood test showed that he was HIV positive. As a result, the medical report was altered to read that the appellant was 'HIV positive' and therefore 'unsuitable'. He was subsequently informed that he could not be employed as a cabin attendant in view of his HIV-positive status. All this was common cause. In the course of his argument, Mr Cohen, who, together with Mr Sibeko, appeared for SAA, raised an issue as to whether HIV-positive status was the sole reason for refusing to employ the appellant.

[7] SAA denied the charge. It asserted that the exclusion of the appellant from employment had been dictated by its employment practice, which required the exclusion from employment as cabin attendant of all persons who were HIV positive. SAA justified this practice on safety, medical and operational grounds. In particular, SAA said that its flight crew had to be fit for worldwide duty. In the course of their duties they are required to fly to yellow fever endemic countries. To fly to these countries they must be vaccinated against yellow fever in accordance with guidelines issued by the National Department of Health. Persons who are HIV positive may react negatively to this vaccine and may, therefore, not take it. If they do not take it, however, they run the risk not only of contracting yellow fever, but also of transmitting it to others, including passengers. It added that people who are HIV positive are also prone to contracting opportunistic diseases. There is a risk, therefore, that they may contract these diseases and transmit them to others. If they are ill

with these opportunistic diseases, they will not be able to perform the emergency and safety procedures that they are required to perform in the course of their duties as cabin attendants. SAA emphasised that its practice was directed at detecting all kinds of disability that make an individual unsuitable for employment as flight crew. In this regard it pointed out that it had a similar practice that excluded from employment as cabin crew individuals with other disabilities, such as epilepsy, impaired vision and deafness. SAA added that the life expectancy of people who are HIV positive was too short to warrant the costs of training them. It also pointed out that other major airlines utilised similar practices.

Applicable law

[22] The relevant provisions of the equality clause, contained in section 9 of the Constitution, provide:

(1) Everyone is equal before the law and has the right to equal protection and benefit of the law ...

(3) The State may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth ...

(5) Discrimination on one or more of the grounds listed in subsection 3 is unfair unless it is established that the discrimination is fair.

Application of law to facts

[23] Transnet is a statutory body, under the control of the state, which has public powers and performs public functions in the public interest. It was common cause that SAA is a business unit of Transnet. As such, it is an organ of state and is bound by the provisions of the Bill of Rights in terms of section 8(1), read with section 239, of the Constitution. It is, therefore, expressly prohibited from discriminating unfairly.

[27] At the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. The determining factor regarding the unfairness of the discrimination is its impact on the person discriminated against. Relevant considerations in this regard include the position of the victim of the discrimination in society, the purpose sought to be achieved by the discrimination, the extent to which the rights or interests of the victim of the discrimination have been affected and whether the discrimination has impaired the human dignity of the victim.

[28] The appellant is living with HIV. People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV-positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV-positive people still persist. In view of the prevailing prejudice against HIV-positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason they enjoy special protection in our law.

[29] There can be no doubt that SAA discriminated against the appellant because of his HIV status. Neither the purpose of the discrimination nor the objective medical evidence justifies such discrimination.

[30]SAA refused to employ the appellant, saying that he was unfit for worldwide duty because of his HIV status. But, on its own medical evidence, not all persons living with HIV cannot be vaccinated against yellow fever or are prone to contracting infectious diseases. It is only those persons whose infection has reached the stage of immunosuppression and whose CD4+ count has dropped below 350 cells per microlitre of blood. Therefore, the considerations that dictated its practice as advanced in the High Court did not apply to all persons who are living with HIV. Its practice, therefore, judged and treated all persons who are living with HIV on the same basis. It judged all of them to be unfit for employment as cabin attendants on the basis of assumptions that are true only for an identifiable group of people who are living with HIV. On SAA's own evidence, the appellant could have been at the asymptomatic stage of infection. Yet, because the appellant happened to have been HIV positive, he was automatically excluded from employment as a cabin attendant.

[37] Prejudice can never justify unfair discrimination. This country has recently emerged from institutionalised prejudice. Our law reports are replete with cases in which prejudice was taken into consideration in denying the rights that we now take for granted. Our constitutional democracy has ushered in a new era it is an era characterised by respect for human dignity for all human beings. In this era, prejudice and stereotyping have no place. Indeed, if as a nation we are to achieve the goal of equality that we have fashioned in our Constitution, we must never tolerate prejudice, either directly or indirectly. SAA, as a state organ that has a constitutional duty to uphold the Constitution, may not avoid its constitutional duty by bowing to prejudice and stereotyping.

Finding

[41] I conclude, therefore, that the refusal by SAA to employ the appellant as a cabin attendant because he was HIV positive violated his right to equality guaranteed by section 9 of the Constitution.

Remedy

[53] In these circumstances, instatement should be denied only in circumstances where considerations of fairness and justice, for example, dictate otherwise. There may well be other considerations too that make instatement inappropriate, such as where it would not be practical to give effect to it.

[54] Here, there was no suggestion that it would either be unfair or unjust were SAA to be ordered to employ the appellant as a cabin attendant. Nor was it suggested that it would not be practical to do so. On the contrary, Mr Cohen assured us that it would not be impractical to employ the appellant as a cabin attendant. Nor does the medical condition of the appellant render him unsuitable for employment as a cabin attendant. The appellant is currently receiving combination therapy, which should result in the complete suppression of the replication of the virus and lead to a marked improvement in his CD4+ count. On 19 June 2000 he was medically examined and his blood sample was taken. He was found to be asymptomatic and his CD4+ count was 469 cells per microlitre of blood. He describes his prognosis as excellent. He is able to be vaccinated against yellow fever and is not prone to opportunistic infections.

[55] It was contended that an order of instatement would open the floodgates for other people who are living with HIV and who were previously denied employment by SAA. However, what the appropriate relief would be in this case cannot be made to depend on other cases that may or may not be instituted. What constitutes appropriate relief depends on the facts of each case. The relief to be granted in those other cases will have to be determined in the light of their facts.

[56] In the light of the foregoing, the appropriate order is one of instatement.

Nanditume v Minister of Defence (2002) AHRLR 119 (NaLC 2000)

The Namibian Labour Court found that HIV status alone could not be a reasonable ground for exclusion from the Namibian Defence Force (NDF). When conducting an HIV test, the military must also conduct additional tests to assess whether HIV-positive individuals are fit and healthy for participation in the NDF.

Excerpts

...

[2] The issue raised in this application is whether the exclusion on the grounds of HIV status alone of a prospective applicant for enlistment in the Namibian Defence Force (hereafter NDF) constitutes unfair discrimination as contemplated in section 107 of the Labour Act (Act 6, 1992).

...

[14] In many countries of Africa, [AIDS] has reached epidemic proportions; these include Namibia and the Republic of South Africa, as well as their neighbours. It poses an economic and financial threat to those African states with fragile economies.

[15] It is a disease which, relatively, has only recently been identified. It is transmitted in only a few ways but largely by a mother who is infected with the disease transmitting it at birth to her baby and predominantly through sexual intimacy between two persons one of whom is infected. It is not transferred via toilet seats or swimming pools or the sharing of food utensils or touching infected persons, nor is it transmitted in urine, faeces or sweat from the body nor in saliva.

[16] Because of the origins of the disease, the way it is transmitted, and its rampant magnitude, ignorance and prejudice have shrouded all aspects of the disease including its treatment and control.

[17] Since time immemorial the world has had visitations of plagues and epidemics. But never before has the world been able to face a plague or giant epidemic with the scientific technology which is available today. Never before have commerce and industry rallied to the side of medical research and never before has there been such a concentrated effort in the social and educational fields to control this plague and, if possible, eliminate it. In the same vein, certain states have legislated or issued guidelines for the implementation of policies to combat the disease or to ameliorate the suffering of those who have it. The United Nations has also made pronouncement in respect thereof.

[18] In Namibia, the National Defence Force and the Police Force are not excluded from the operation of the Labour Act 1992, the state being regarded as the employer. On 3 April 1998 and in *Government Gazette* no 1835, Namibia issued 'Guidelines for the Implementation of a National Code on HIV/AIDS in Employment'.

[19] These guidelines are therefore applicable to the NDF but they are only guidelines, and do not have the force of law.

[20] Clause 6(2)(1) of the 'Guidelines' provides:

Job access:

There should be neither direct nor indirect pre-employment tests for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV.

Clause 6(5) provides:

HIV testing or training:

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical condition.

Clause 6(6)(2) provides:

Employees with HIV-related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions.

Clause 6(6)(3) provides that HIV-infected employees should work under normal conditions so long as they are fit to do so and if they can no longer do so, they should be offered alternative employment 'without prejudice to their benefits'.

[21] While the foregoing guidelines may well be implemented in certain instances, in others they could be economically impossible. As far as the military is concerned section 65(2) of the Defence Act (Act 44 of 1957) requires recruits to undergo a medical examination.

[22] Mr Negonga lists some of the diseases for which recruits are examined. Any medical examination of a recruit must be fully carried out. In the light of what has been said above, if the test is to ascertain whether a recruit is fit for military service, an HIV test only will not achieve this purpose. In addition to the HIV test, there must be a CD4 count test and a viral load test. If the military does not and will not do these latter two tests then the HIV test should also be abandoned. It will not achieve the purpose for which medical examinations are held.

[23] In the supporting affidavit to his notice of motion the applicant said that he had been a former plan combatant and a member of SWAPO's National Liberation Struggle in exile from 1976 to 1989, and while in exile had undergone military training at Thobias Hainyeko Training Centre. In September 1996, he sought enlistment in the Namibian Defence Force. On 11 September 1996 applicant went to the Oshakati State Hospital, where blood was taken for the purposes of an HIV test. The results of the test were sent to the Okahandja base of the NDF. On 26 September 1996, at the Okahandja base, applicant was informed by Dr Shaenda, a medical officer in the NDF, that he had tested positive, and that because he was HIV positive, he would not be accepted by the NDF.

[24] In his affidavit applicant asserted that, except for being HIV positive, he was in sound health, and in proof thereof he annexed to his affidavit a medical report made and signed by a district surgeon or medical officer of the state. From this it appears that applicant was at that date in good and sound health. It is apparent from this comprehensive medical report that applicant had a thorough clinical examination. At the foot of this medical report, the following question is posed to the doctor:

Do you consider that the applicant is in good health and free from any physical or mental defect, disease, or infirmity which should be likely to interfere with the proper performance of duty as a 'Government Service Official in any part of South West Africa?' (For South West Africa read Namibia.)

To this question, the medical officer replied in the affirmative and signed and dated the medical report 31 October 1996, that is, approximately one month after the applicant, to the knowledge of respondent, had tested positive for HIV.

[25] It is therefore abundantly clear that the sole and only ground for refusing to enlist the applicant as a member of the NDF was because he was HIV positive and that he was, nevertheless, at that time fit and able to perform the usual duties and functions in the NDF.

[26] It is furthermore relevant to observe that it was respondent's doctor, acting in the course and scope of his duties, who certified that applicant was in sound and good health and capable of performing his duties anywhere in Namibia.

[27] Applicant avers in his supporting affidavit that the conduct of the NDF in refusing to enlist him solely on the basis of his HIV status constitutes discrimination in an unfair manner as contemplated by section 107 of the Labour Act, given his ability and capacity to do the duties as an NDF member. In the alternative, applicant says he was discriminated against on the impermissible ground of disability, by the respondent in conflict with section 107 of the Act.

[28] At this stage, it is necessary to consider the provisions of section 107 of the Labour Act, as far as it is relevant hereto. Section 107(1) provides:

Subject to the provisions of section 106 and subsection 2 of this section, if, upon an application made to the Labour Court in accordance with the provisions of part IV by any person, the Labour Court is satisfied (a) that any person has discriminated

or is about to discriminate in an unfair manner or is so discriminating against him on the grounds of his ... disability, in relation to his employment ... the Labour Court may – (i) issue an order in terms of which such person is ordered – (aa) in the case of continuing acts of unfair discrimination ... to discontinue any such acts as may be specified ... (bb) to perform or to refrain from performing any act specified ... (ii) make any such other order as the circumstance may require.

...

[31] It is common cause that there are military personnel in the NDF who are HIV positive. When the NDF was established there was no testing for HIV and personnel who were HIV positive may have been recruited. Furthermore, Mr Negonga says in his affidavit that 'military personnel are a population group notably at risk for developing and transmitting sexually transmitted diseases (STD) including HIV'.

[32] Consequently, certain personnel may well have acquired HIV subsequent to enlistment. Mr Negonga does not state how many HIV-positive persons are in the NDF, but it appears from his own affidavit that the numbers are not small. Mr Negonga sets out in considerable detail the humane way persons who suffer from HIV and AIDS are treated in the military. He says that when a member of the NDF is diagnosed as HIV positive or with AIDS, the NDF accepts responsibility and follows a 'policy of non-discrimination as far as possible'. It disciplines persons who discriminate against HIV/AIDS personnel and where necessary deploys infected personnel to other positions 'where they run less risk of the process accelerating' but, this, he says, means 'rearranging personnel in the NDF. Such people are permitted to attend clinics and they receive "immune boosters" and hospitalisation if necessary. They and their families receive counselling.' It is apparent therefore from the affidavit of Mr Negonga that the NDF has a large number of personnel who are infected with HIV/AIDS and that the NDF is geared to cope with these. The NDF is therefore complying with the clauses 6(6)(2) and 6(6)(3) of the Guidelines for Implementation of a National Code for HIV/AIDS and is to be commended for doing that.

[33] The applicant annexed to his supporting affidavit a reference from the Secretary General of Swapo which relates and confirms that the applicant was in the party's National Liberation Struggle from 1976 to 1989 and that he underwent military training at Thobias Hainyeko Training Centre. The Secretary recommends him as an 'employee'. If this is read with the medical report of 31 October 1996 that he is fit to do duty anywhere in Namibia, the refusal to enlist him constitutes discrimination particularly as there are in the ranks of the NDF persons who are HIV positive and in some of these persons the disease has progressed to the extent that the persons concerned have been 'deployed to other positions where they run less risk of the process accelerating'.

[34] Furthermore, the cost factor does not arise. The 'Guidelines' enjoin employers to pay for medication and, according to Mr Negonga, if the necessity for medical treatment arises the machinery for doing so is already in place.

[35] Apparently because of the large numbers of persons in the military who are HIV positive, Dr Clive Evian, who was called by respondent to testify, conceded that an HIV test not followed by a CD4 and viral load test before enlistment cannot be justified on the basis of keeping 'the military an aids-free workplace'.

[36] The case for applicant in this regard was considerably strengthened when Major Maiba, testifying for respondent, said that personnel in the military, although it is a high risk environment, are not tested for HIV once they have enlisted. This applies even if they are selected to leave Namibia for peacekeeping operations in other countries in breach of a specific request made by the United Nations.

[37] By reason of the foregoing, I find that the exclusion of applicant from the military, solely because he was found to be HIV positive, constituted in September 1996, discrimination in an unfair manner, in breach of section 107 of the Labour Act.

[38] The act of unfair discrimination occurred in September 1996, that is approximately four years ago. I repeat what I have said previously. The medical experts who testified agreed that an HIV-positive person can be as fit and as healthy as any other

normal person in similar circumstances, but as that person's CD4 count decreases and the viral load increases, such person's well-being progressively deteriorates. Clinically, as soon as the CD4 drops below 200 such person is said to suffer from AIDS. A combination of these two indicators can serve as a prognosis as to the time period that will elapse before a person will suffer from AIDS proper. The two medical experts were in agreement that a person with a CD4 count below 200 and a viral load in excess of 100 000 would probably be incapable of participating in the strenuous and exacting work as required in the fighting units of the military. Common sense tells one that the different departments or divisions or categories or branches of the military have different degrees of stress, physical and mental, and this is confirmed by Mr Negonga in his affidavit where he says HIV-positive personnel are transferred to such departments. Major Maiba says at present no one is allocated to a particular department or activity when such person enlists. This only happens, he says, after everyone has done his basic training. The Major says this basic training is strenuous. Both medical experts were of the opinion that a person who contracts HIV is fit and healthy for several years and that the training routine would not be to his detriment. Dr Steinberg in fact said that regular exercise would be to such persons' benefit. This, however, depends on the progress of the 'disease' in later years. It is therefore essential that the date when the HIV virus is contracted be established as accurately and as soon as possible. In this regard the cooperation and good faith of the recruit is essential. A comprehensive and proper test after basic training will enable the military authorities to place an HIV-infected person in a suitable department of the NDF.

[39] In the instant case, the applicant was not frank with the court. He was diagnosed in September 1996 as being HIV positive, but he did not inform the court when he thought he may have contracted the condition. If he had contracted it four or five years prior to September 1996, to grant an order that respondent enlist him now could be saddling the respondent with a recruit who could not do the basic training nor any of the duties which may arise in the military. Applicant must therefore be prepared to subject himself to the CD4 test and to the viral load test.

[40] The order of the court therefore is:

- (1) Respondent shall enlist applicant in the NDF should applicant re-apply for enlistment, provided the applicant's CD4 count is not below 200 and his viral load is not above 100 000.
- (2) The medical examination to which respondent is obliged to subject applicants shall include an HIV test together with a CD4 count test and a viral load test and no person may be excluded from enlistment into the NDF solely on the basis of such person's HIV status where such person is otherwise fit and healthy unless such person's CD4 count is below 200 and his viral load is above 100 000.

Diau v Botswana Building Society (BBS) 2003 (2)
BLR 409 (BwIC)

The Botswana Industrial Court ordered the reinstatement of an employee who had been dismissed by the Botswana Building Society for refusing to undergo an HIV test. The dismissal was found to be an unconstitutional violation of the employee's right to liberty and right not to be subjected to inhuman and degrading treatment.

Excerpts

...

Facts

...

The applicant was employed by the respondent as a security assistant in terms of a letter dated 18 February 2002. She commenced her employment on 25 February 2002. Her employment was however conditional on her undergoing a probationary period of six months and passing a full medical examination in terms of her letter of employment. By letter dated

27 August 2002 the respondent wrote to the applicant advising her that as part of the employment examination she was to submit a certified document of her HIV status. The respondent refused to undergo an HIV test and in response was told that she would not be confirmed in the respondent's service. She was eventually dismissed in October 2002. ... It was argued for the applicant that the instruction to undergo an HIV test was unreasonable and the applicant was entitled to disobey it. Furthermore, the conduct of the respondent in instructing the applicant to undergo an HIV test and subsequently not confirming her after she refused to oblige ... constituted degrading treatment as contemplated by s 7(1) of the Constitution of Botswana.

...

Applicable law

...

It would appear to me that Botswana National Policy on HIV/AIDS, is consistent with the World Health Organisation, SADC Code of Good Practice on HIV/AIDS and Employment (1997); HIV/AIDS and Human Rights: International Guidelines, United Nations (1998), ILO guidelines on HIV/AIDS in the workplace, to the extent that it encourages voluntary testing and or discourages compulsory pre- and post employment testing as part of the assessment of fitness to work because such an approach is unnecessary, in addition to promoting stigmatisation.

In my considered view the National HIV/AIDS Policy augments rather than detracts from the constitution, to the extent that the constitution entrenches the right to equality, human dignity, liberty and the right to privacy. It is not law. It therefore does not impose any direct legal obligations. However, to the extent that its provisions are consistent with the values espoused by the constitution, breach of its provisions may, in an appropriate case, constitute evidence of breach of constitutional provisions. In essence, the National HIV/AIDS Policy is a very progressive document in that it seeks to eliminate HIV/AIDS related unfair discrimination, promote equality and fairness especially at the workplace and more fundamentally, gives effect to Botswana's international obligations.

The elimination of unfair discrimination and the promotion of non-discrimination are the key objectives of the national HIV/AIDS policy. In my view, the National HIV/AIDS Policy is based and or is consistent with the national and international legal framework for eliminating unfair discrimination and the promotion of equality at the workplace. This framework, in the circumstances of our country, where there is no statutory regulation of matters to do with HIV/AIDS and employment, must of necessity begin with the constitution. It also embraces, relevant international instruments, including United Nations (UN) Human Rights Treaties, International Labour Organisation (ILO) and appropriate regional and sub regional instruments. The constitution as the supreme law is immensely relevant when interrogating issues of HIV/AIDS at the workplace to the extent that it guarantees that every person is entitled to equality before the law, equal protection of the law and human dignity and also to the extent to which it prohibits unfair discrimination.

...

The right not to be subjected to inhuman and degrading treatment.

The right to dignity permeates the entire bill of rights in our constitution, it is an intrinsic part of the right to life, broadly construed, for the denial of the right to dignity would denude the right to life of its effective content and meaningfulness. Section 7(1) of the constitution in so far as it prohibits inhuman and degrading treatment, is protective of the right to dignity.

Section 7(1) bears quoting in full:

7.(1) No person shall be subjected to torture or to inhuman or degrading punishment or other treatment ...

The Right to Liberty

The right to liberty finds protection in section 3 of the constitution. The relevant portion bears quoting in full. It provides:

3. Whereas every person in Botswana is entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, place of origin, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interests to each and all of the following, namely:

(a) Life, liberty, security of the person and the protection of the law;

...

Application of law to facts

...

In liberal moral philosophy human dignity is considered to be what gives a person their intrinsic worth as human beings, consequently every human being must be treated worthy of respect. It is the right to dignity that lays the foundation for the right to equality and all other rights that human beings possess.

In my mind the right to dignity requires us to respect that an individual is the master of his own body and or destiny and that he is free to resist any potential violation to his privacy or bodily integrity.

To punish an individual for refusing to agree to a violation of her privacy or bodily integrity is demeaning, undignified, degrading and disrespectful to the intrinsic worth of being human.

Punishing the applicant for refusing an invasion of her right to privacy and bodily integrity is inconsistent with human dignity. This is particularly so in the context of HIV/AIDS where even the remotest suspicion of being HIV/AIDS can breed intense prejudice, ostracisation and stigmatisation. This is the context within which one must analyse the right to dignity in this case. The symbolic effect of punishing an employee for refusing to undergo an HIV test is to say that all those who refuse to undergo an HIV test are not competent to be employed - they should lose their jobs and by extension be condemned to unemployment - a form of economic death for simply saying, as a human being, I have decided not to test for HIV/AIDS.

Having regard to the supreme importance of the right to dignity, I believe that it is proper that when a decision under challenge is the one that has deprived or threatens to deprive an applicant of his livelihood such a decision calls for the most anxious scrutiny. This is so because, as I have said earlier, even the remotest suspicion that someone who has refused to undergo an HIV test, may have done so because he may be fearful that he is HIV positive may give birth to prejudice and vulnerability. Prejudice to that category of people may be no different from those who are HIV positive ...

Speaking for myself, I think that it would be offensive to modern thinking and the values espoused by our Constitution, to tolerate any practice whose effect is to undermine, directly or indirectly the values of our Constitution, which values also inform our national vision, and directly contradicts national efforts at tackling stigma and prejudice.

It is incompetent to force people to undergo HIV testing. People must be encouraged to test voluntarily through persuasion and education. After all, common sense dictates that it is prudent for people to know their status so that if positive they can take treatment at the earliest opportunity. Compelling people to undergo HIV test is inhuman and degrading in addition to being counter productive. In this case the applicant paid the highest price for refusing to undergo the HIV test: deprivation of livelihood by losing her job.

Viewed from this angle the conclusion that the respondent conduct was inhuman and degrading is inescapable.

The choices imposed upon the applicant in this case were most unfair. She had to choose between protecting her employment (by undergoing the test) and in the process lose the fundamental private right of choosing whether or not to test or insist on her right to choose and lose employment.

I take it that human rights matter most during periods of crisis, a period when the weak and marginalised are particularly vulnerable. HIV/AIDS is an epidemic that has brought a crisis of immense proportions. This calls for heightened vigilance to any

conduct that infringes the baseline right - the right to dignity. In my mind, the respondent by dismissing the applicant for refusal to undergo an HIV test amounted to an assault on the applicant's *dignitas* by which I mean that 'valued and serene condition in her social or individual life which is violated when she is, either publicly or privately subjected by another to offensive and degrading treatment, or when she is exposed to ill-will, ridicule, disesteem or contempt' (per Gardiner AJA, in *Minister of Posts and Telegraphs v Rasool* 1934 AD 167).

Having regard to the stigma, paranoia, prejudice and ignorance that surrounds HIV/AIDS, the conduct of the respondent in the circumstances of this case qualifies as inhuman and degrading treatment as contemplated by section 7(1) of the constitution. What is more, the directive of the respondent instructing the applicant to go for an HIV test, does not appear to be alive to the internationally recognised requirement for counseling before one can go for such a test. My conclusion that the conduct of the respondent amounted to inhuman and degrading treatment derives from the premise that the human body is inviolable and respect for it is a fundamental element of human dignity and freedom. Compromise these rights the society to which we aspire - the one promised by the constitution - of human dignity becomes illusory. Expressed positively, the content of the right to dignity encompasses the freedom of individuals to rebuff attempts at subjecting their bodies to any treatment or test, without being punished for exercising such freedom or right. This explains why the National HIV/AIDS Policy and a number of international legal instruments encourage voluntary testing where the person to be tested, must not just consent, but must give informed consent, meaning that before the person who is tested may give consent he must be made to fully appreciate the consequences and implications of his consent. Informed consent is premised on the view that the person to be tested is the master of his own life and body. In the premises it should follow that the ultimate decision whether or not to test lies with him or her, not the employer, not even the medical doctor. The purpose of informed consent is to honour a person's right to self determination and freedom of choice.

I believe it to be my sacred duty to give section 7(1) of the constitution a broad and generous meaning in order to safeguard and secure the fundamental rights and freedoms of the individual...

The basic theme in the discourse of human rights which we in the judiciary must address is how we can convert the promise of our constitution into reality. In my mind a proper application of the constitution can serve as a potent source of a sober critique of the existing arrangements and or practices that serve, often unwittingly, to promote stigma and prejudice about HIV/AIDS at the workplace. It is up to the judiciary to clarify, the content, context, and location of any rights and duties that are conferred by the constitution. The Bill of Rights provisions must be safeguarded from possible attempts to narrow their scope unduly or to circumvent altogether the obligation they engender.

The constitutional provisions in our Bill of Rights are couched in elastic terms in order to enable an interpretation that is dynamic. In the context of the reality of HIV/AIDS afflicting our society, rampant ignorance of the syndrome, the consequent problems of stigma and prejudice, it is imperative for the courts to interpret the constitutional provisions purposefully, as far as the language permits, and in a manner consistent with the contemporary norms, aspirations, expectations and the sensitivities of the people of Botswana as expressed in the constitution, and further having regard to the emerging consensus of values in civilised international community which Botswana share.

...

In effect the respondent in this case is saying to the applicant 'Agree to test for HIV/AIDS and keep your job; or maintain your right to make the inherently personal decision of whether or not to have an HIV test and lose the employment opportunity.' In my view the very fact of this irrational demand, it being wholly unrelated to the inherent requirement of the job, is a veritable assault on the applicant's right to liberty and human dignity.

It is not just a threat to her right to liberty it is an actual violation of that right, for she has already suffered the consequences of her

right to liberty, through the respondent's refusal to confirm her, effectively dismissing her. In my view the foregoing analysis and authorities, adequately disposes of the central question earlier posed. For the reasons I have given, the post employment HIV test requirement imposed by the respondent is susceptible to constitutional scrutiny.

I am of the conclusive view that the HIV test requirement, coupled with the dismissal, consequent upon exercising the right not to consent to testing infringes the applicant's right to liberty.

Finding

In all the circumstances of this case, this court takes the view that because of the appalling and or disgraceful manner in which the respondent treated the applicant an appropriate order would be one of reinstatement plus an order of compensation.

In the circumstances the court makes the following determination:

1. The termination of the contract of employment of the applicant was unlawful and or wrongful for want of procedural and substantive fairness.

...

3. That the conduct of the respondent of terminating the applicant's contract of employment for refusing to undergo an HIV test, as instructed, was an unjustifiable violation of the applicant's right to liberty as contemplated by section 3(a) of the Constitution of Botswana, as well as section 7(1) which outlaws inhuman and or degrading treatment.

...

Remedy

...

The applicant earned P900 per month at the time of her dismissal. In fairness, I think the appropriate award for compensation should be an amount equivalent to her four months salary, namely P3 600.

The court wants to make it clear that the amount to be awarded to the applicant is compensation and not salary and therefore the full amount, without any deductions should be paid to the applicant.

...

Jimson v Botswana Building Society (2005) AHRLR 3 (BwIC 2003)

This case involves an employee whose probationary employment was terminated as a result of a positive HIV test. The Botswana Industrial Court ruled that the termination of the employee's contract was both substantively and procedurally unfair. Of particular note in this case is the Court's exhortation to the legislature to address the issue of compulsory HIV testing.

Excerpts

...

Facts

[1] The applicant, Rapula Jimson, was offered and accepted employment by the respondent, Botswana Building Society. The Botswana Building Society letter of 20 June 2002 which offered the employment made the appointment subject to six months probationary period; 48 hours notice of termination during probation; passing a medical examination by a doctor chosen and paid for by the Society.

[2] On successful completion of probationary period the applicant would be appointed to the permanent and pensionable service of the society and be required to join the membership of the Staff Pension Fund.

[3] For purposes of medical examination the applicant was 'issued with the enclosed medical examination form to be

completed by the medical doctor referred to.' Nineteen days later on 9 July 2002 the applicant received another letter from the respondent...

Further pre-employment medical examination

Further to the pre-employment medical examination that has been conducted on you, you are advised that there is still a requirement for you to undergo an HIV test, as a condition for employment with the society.

[4] The applicant complied but apparently the doctor chosen by the Society declined to conduct the HIV test because she was not convinced that the test was voluntary. The applicant then approached another doctor and had the test done at his own expense. The results of the test were sent directly to the respondent showed that the applicant was HIV positive. On 27 August 2002 the respondent wrote a letter to the applicant informing him that 'your probationary employment with the society will be terminated with effect from 31 August 2002.' Copy of the results of the test was enclosed.

...

Substantive fairness

[9] The approach taken by this Court in dismissal cases is that notwithstanding the provisions of sections 18 and 19 of the Employment Act (cap 47:01) and taking into account the provisions of section 20(2), a contract of employment for an unspecified period of time should not be terminated unless *just cause* can be shown. This is also consistent with the ILO Convention article 4 which provides:

The employment of a worker shall not be terminated unless there is a valid reason for such termination connected with the capacity or conduct of the worker or based on the operational requirements of the undertaking, establishment or service.

[10] For purposes of this part of the judgment the issue boiled down to:

(a) Whether the letter of June 20 and the attached medical form included HIV test, and,

(b) Whether the Respondent was entitled to terminate the Applicant's employment because of his HIV status.

[11] Currently there is no legislation governing the employment of HIV positive persons. I shall deal with the procedural aspects of the complaints later under the appropriate heading.

...

[15] It was not disputed that the medical form explained above represented what may be termed, a standard form, for purposes of employment. The applicant did not raise any objection to going through the tests as specified in the form. It was also admitted in court by the respondent's representatives that the tests specified in the form were done and there was no negative recommendation.

[16] The medical form does not tell the doctor the minimum state of health required of an applicant for a positive recommendation. I shall assume therefore that the matter is left to the doctor to give an expert opinion on the applicant's state of health and suitability for employment, no doubt taking into account the import of the last two questions on the applicant's general state of health. In view of the absence of objection to the test as specified in the medical test form, I shall assume that the result would still have been accepted even if it had been negative. However unfortunately the matter did not end there.

...

[18] The Court does not agree that the form provided for HIV test. If until June 2002 no one was tested for HIV on the basis of that form, there is no reason why it could be treated as prescribing HIV testing. It was admitted in Court that a particular doctor who did the medical examination, had been used by the respondent in the past. Not only did the doctor not consider the tests listed to include HIV but she also didn't include it in the tests. The respondent did not, at that time, say to the applicant that the doctor omitted the HIV test. Instead it made it clear that the test was *additional* by stating, that 'further to the pre-employment medical examination that has been conducted on you, you are advised that there is still a requirement for you to

undergo an HIV test, as a condition for employment with the Society.' In any case, having supplied the applicant with a detailed questionnaire on his health dealing with many ailments from 'spitting blood' through venereal disease, discharge from the ears, to minor ailments such as sore throat, it must be assumed on the basis of the principle, *inclusio unius est exclusio alterius*, (the inclusion of one is the exclusion of another) that HIV test which was not mentioned was not part of the test ordered. Admittedly the questionnaire included the question 'Any disease or illness not above mentioned'. That was part of the standard form and never resulted in HIV test before. HIV is such a prominent subject that I do not believe it could have been dealt with in that indirect and casual manner. In any case nothing in the conduct of the respondent suggests that the questionnaire was intended to cover subjects such as HIV. There is not even any reference to blood test in the form. The test clearly focused on general physical fitness. That is the purpose of paragraph 9 of the medical form. Being HIV positive does not *per se* imply physical unfitness. It depends on the stage of the virus. (See *Hoffman v SA Airways* (2000) 21 ILJ 891 at 899).

[19] It is a well established National Policy in this country that 'Pre-employment HIV testing as part of the assessment of fitness to work is unnecessary, and should not be carried out.' (P 12, para 6(2) of the Botswana National Policy on HIV/AIDS).

[20] The National Policy is clearly based on the World Health Organisation and ILO guidelines on HIV/AIDS in the workplace of 1990 which provide that pre-employment HIV/AIDS screening as part of the assessment of fitness is unnecessary and should not be required. The SADC code on HIV/AIDS and employment also states that there should be no direct or indirect pre-employment HIV test. (See *Hoffman v SA Airways* (2000) 21 ILJ 891 at 908). With all these policy codes including that of the World Health Organisation, there is no way any doctor would adopt a casual approach to HIV testing without risking accusation of breach of the Hippocratic oath. The doctor to whom the applicant was sent not only did not test for HIV but even after the respondent wrote a specific letter on HIV test, she still refused on ethical grounds as she was not satisfied as to the applicant's un coerced consent.

...

[22] The applicant accepted the offer of employment on the basis of the letter of 20 June 2002. He complied with the conditions of the offer relating to the passing of a medical examination. He passed the prescribed test and therefore satisfied the conditions set from the medical point of view. Did the applicant's compliance with the demands of the letter of 9 July amount to the applicant's consent to the variation of the contract already concluded? Was the applicant made aware that the requirement for additional medical test was introducing new terms to the contract already concluded?

...

[24] On the other hand the respondent cannot be classed as unskilled or even semi-skilled. It had all the skilled manpower to conduct its business. Yet it took advantage of an unskilled employee by making a variation of the conditions of a contract entered into look like a continuation of the original medical examination.

...

[28] In view of the foregoing authorities and court decisions on the duties and responsibilities of the Industrial Court, can this court *fairly* enforce the effect what the applicant correctly determined 'the compulsory post-employment HIV testing' which was turned into a precondition for employment contrary to the offer that had already been accepted? Does it matter that the applicant complied? All these questions must be answered in the negative. The respondent's unlawful unilateral alteration of a contract entered into, which alteration unfairly affected the applicant's employment opportunities and work security and jeopardised or prejudiced his social welfare, is not one that this Court can give blessing to. To do so would be to act contrary to the rules of fairness or equity. We would be administering injustice not justice. Compliance with a compulsory instruction by an unskilled and uninformed worker desperate for employment is not the type of consent that can form a proper

basis for a defense by the respondent to the applicant's claim. Compulsion and consent are mutually exclusive concepts. It is clear from statutory intervention in the private relations between employers and employees and the introduction of concepts such as *just cause*, *good cause* and *lawful termination* (see sections 20(2), 33(1)(d), 120(1) & (2) and 17 respectively of the Employment Act) in the place of to common law *laissez-faire* policy that it was clearly intended to mitigate the harsh realities of unequal contracting.

[29] The Court finds therefore that the compulsory post-employment HIV testing ordered by the respondent was in breach of the contract of employment entered into between the applicant and the respondent. Therefore the termination of the applicant's contract because of an HIV testing in breach of his contractual rights was substantively unfair as having been tainted by the unfairness of the test.

[30] The conclusion reached also answers the question put to the Court whether the *dismissal* on the basis of positive HIV status constituted a just cause in terms of section 2(2) of the Employment. The answer is that the dismissal of the applicant was substantively unfair. The Applicant having passed the medical examination he was required to go through, the deal was done. He was now in the same position as any other employee serving probation whose admission into the permanent and pensionable service could only be thwarted by poor performance or misconduct. The introduction of the HIV test at that stage amounted to discriminatory treatment, as it was not applied to other employees. Evidence was given by respondent's witness that existing employees who are found to be HIV positive are not dismissed but counseled. The applicant was exactly in that position. He should have been given the same treatment.

Is pre-employment testing of HIV permissible?

...

[32] I have already stated that there is no statutory provision regulating the employment of HIV infected applicants. I have also referred to the existing National Policy on HIV/AIDS. This policy simply provides that: 'Pre-employment HIV testing as part of the assessment of fitness to work is unnecessary and should not be carried out.'

[33] In the South African case of *Hoffman v SA Airways* (2000) 21 ILJ (CC) 2357 the Constitutional Court of South Africa ruled that the refusal by SAA to employ the appellant as a cabin attendant because he was HIV positive violated his right to equality guaranteed by the Constitution. Counsel for the respondent relied on the ruling of the Witwatersrand Local Division on the same case which favoured the employer while the applicant's representative relied on the decision of the Constitutional Court on appeal which favoured the employee.

[34] Section 9 of the South African Constitution provides: '(1) The state may not unfairly discriminate directly or indirectly against anyone ...'. Section 15 of the Botswana constitution provides that:

- (1) ... No law shall make any provision that is discriminatory either of itself or in its effect.
- (2) ... No person shall be treated in a discriminatory manner by any person acting by virtue of any written law of in the performance of the functions of any public office or public authority.

[35] Two points need to be made about these constitutional provisions. First these are matters of public law as opposed to private law.

...

The second point is that both provisions forbid discrimination by public authorities including the making and enforcing such laws by such authorities. It is because of the nature of the constitutional provisions of the South African Constitution that Ngcobo J in laying the foundation for ruling that SAA acted unconstitutionally stated:

Transnet is a statutory body, under the control of the state, which has public powers and performs public functions in the public interest. It was common cause that SAA is a business unit of Transnet. As such, it is an organ of state and is bound by the Bill

of Rights in terms of s 8(1), read with 239 of the Constitution. It is therefore, expressly prohibited from discriminating unfairly.

[36] The Botswana constitution also forbids the making of discriminatory laws (no doubt by the state) and the discriminatory treatment of persons acting in pursuance of any written law or 'in the performance of the functions of any public office or any public authority.' See also the definition of public office in section 127(1) of the Constitution.

...

[38] It is clear that both the South African and the Indian courts based their decisions on the fact that they were dealing with the state or state organs. This is consistent with the wording of constitutions on bills of rights. The bills of rights protect the individual against the state or state power. This is public law as contradistinguished from private law which regulates dealings between private individuals including private legal persons. The wording of the National Policy on HIV/AIDS is wide and imperative enough to create the impression that it applies to all and sundry. It is binding on the respondent? The respondent is not a statutory body or a parastatal. It is not a state organ but a private commercial entity. The government is merely a shareholder just as it is a shareholder in other private commercial entities.

[39] The Botswana National Policy on HIV/AIDS is a government policy produced and approved by the said government in 1998. It is a binding policy on the government and state organs. The power to 'make laws for the peace, order and good government of Botswana' is vested only in Parliament. In the absence of specific delegated powers of legislation with respect to particular subjects, the government would not have power to legislate. Nowhere does the policy claim to have statutory authority. In any case, sub-legislation is effected by way of statutory instruments and not by way of policy. Therefore however worded paragraph 6(2) of the policy may be, it remains a policy carrying only persuasive authority. It is not binding on the Botswana Building Society.

[40] In another policy document, Botswana National Strategic Framework for HIV/AIDS 2002 – 2003 of 29 November 2002, one of the national objectives is stated as: 'To develop and implement laws, regulations and measures to eliminate stigma and discrimination against PLWH.'

[41] In an apparent acknowledgement of the fact that so far only persuasion through policies is in place, the preamble, under the heading 'HIV/AIDS and employment', states:

The government as an employer, as well a private sector and parastatal organisations, will have to manage staff affected by HIV/AIDS and *make decisions regarding recruitment, deployment, training, payment of terminal benefits, retirement due to ill-health et cetera* (emphasis added).

[42] The Botswana Building Society made a decision with regard to the recruitment of people living with HIV. In the absence of any legal stipulation forbidding the making of that policy, this Court cannot assume the role of a lawmaker.

[43] However the Court, as a court of equity, would be remiss if it did not comment on the moral force of the applicant's case on the simple issue of mandatory HIV testing for prospective employees with consequent rejection simply because of an applicant's HIV status.

...

[45] ... [I]t is time for the government to 'develop and implement laws and regulations ... to eliminate the stigma and discrimination against PLWH' as promised. The applicant lost his employment because of an indiscriminate policy of the employer who took advantage of the absence of restraining legislative instruments. It was not that at that point in time the applicant was found to be incapacitated but simply because he was HIV positive. This is not the type of prejudice that can be left to the courts to tackle. The courts can only fill the gaps, clear doubt or give meaning where there is lack of clarity. But they cannot create a new law outlawing the testing for a particular disease simply because policy would wish it to be so. The Court is not unmindful of the provisions of section 13(5) of the Trade

Disputes Act (cap 48:02) which permits the Court to take into consideration 'any terms and conditions of employment that may, from time to time, be issued by the government.' That does not give the Court the power to turn policy into law.

[46] I stated earlier that the respondent's tests included infection of the throat. It is not clear whether the applicant would have been disqualified if he had a sore throat. An infected throat will not necessarily incapacitate a worker just as being HIV positive will not necessarily incapacitate a worker. The only reason a court would outlaw testing for HIV and not for throat infection would be in response to government policy. This is not the way courts of law and even those vested with equity jurisdiction, are supposed to operate. Courts have to apply the *law* not *policy*. The two operate at different levels. It is instructive that the policy maker after categorically stating that there should be no pre-employment HIV testing, four years later in another policy document left it to employers to 'make decisions regarding recruitment' of people living with HIV.

[47] The conclusion the Court arrives at is that it is for the state to decide whether it wants to stop HIV testing in the workplace in which case it would introduce legislation to that effect.

...

Remedy

...

[59] Although the Court ruled that the National Policy had no force of law, it has been observed also that it has persuasive moral force. The applicant received the most unfair treatment that can be meted out to an HIV sufferer by a commercial entity depending for its survival on the patronage of members of the public. The applicant is a member of that public.

...

[66] In consequence of the foregoing the Court makes the following determination:

The termination of the contract of employment of the applicant was substantively unfair

The said termination was also procedurally unfair.

The National Policy on HIV/AIDS has no force of law but has a strong moral persuasive force. It is therefore not legally binding on the Respondent which has the right to 'make (its) decisions regarding recruitment.'

The respondent is hereby ordered to pay the applicant compensation for substantive and procedural unfairness in the amount of P 9240 being the equivalent of six months' monetary wages for the applicant at the time of termination. (P 1540 x 6). No other compensation is due for the alleged remainder of the probationary period.

The respondent is also ordered to pay the costs of HIV testing, as conceded, in the amount of P 159.50.

...

Lemo v Northern Air Maintenance (Pty) Ltd 2004 (2) BLR 317 (IC)

The applicant was dismissed from his job a day after disclosing his HIV-positive status to his employer. The applicant brought the matter before the Botswana Industrial Court seeking relief in the form of compensation and reinstatement. Relying, among others, on the persuasive value of international conventions, the Court significantly held that the dismissal of an employee on the sole account of his HIV status is tantamount to a violation of his right to dignity.

Excerpts

...

Facts

...

The applicant was employed by the respondent as a trainee aircraft engineer on 8 September 1998. His salary whilst so employed was P1 297.60 per month. As part of his duties, he was to undertake aircraft maintenance and service under the supervision of a qualified aircraft engineer. It is common cause that the applicant was to be eligible for further training after four years in employment with the respondent which was to be tenable in 2002. The applicant was however not sent for further training as initially planned and or agreed as it was thought prudent that he should recuperate first, before embarking on the training.

There is sufficient evidence to indicate that between the period 1999 and 2003, the applicant's health deteriorated badly with the result that, the applicant, having exhausted up all his annual leave and paid sick leave entitlement, obtained unpaid leave on several occasions.

...

A close scrutiny of the documents filed of record, including medical certificates certifying the applicant to be unfit for duty, revealed that the applicant for the period 1999 to 2004 was persistently and intermittently on sick leave and therefore absent from duty.

It is this poor attendance record that brought things to a head culminating in a meeting between the applicant and management on 28 January 2004, at which meeting the respondent suggested that the applicant must consult a private medical doctor, ostensibly to assess his fitness to work. The applicant refused to consult a private doctor because he thought the medical personnel at Maun General Hospital was best suited to attend to his illness as they were familiar with its history.

The respondent's technical liaison officer Ms Catherine Marsh explained that she preferred the applicant to be attended by a private medical practitioner because she needed to know whether the applicant was fit to perform his duties, adding that the problem with Maun General Hospital was that they did not regard her as 'family' and therefore not entitled to know the situation of the applicant. No serious attempts were made to resolve these differences with the result that no assessment was ever made as to the applicant's fitness to continue working. It is not clear why the respondent could not trust Maun General Hospital to do the assessment.

From Ms Marsh's evidence it would appear that her primary concern was not necessarily to have a qualified medical practitioner do the assessment, but wanted a medical practitioner who could regard her as 'family' and share with her the medical status of the applicant.

On 29 January 2004, the applicant disclosed to the respondent that he was HIV/AIDS positive. The applicant testified that he did not disclose his status earlier because he was afraid that if he did so he would be prejudiced. He said the respondent's administrator, now technical liaison officer, Ms Catherine Marsh used to ridicule him that he may be HIV positive. This was before he knew his status.

Ms Catherine Marsh in her evidence indicated that there was a stage where she suspected that the applicant, given his deteriorating health, could well be HIV positive and consequently encouraged him to go for an HIV test.

On 30 January 2004, the respondent wrote a letter terminating the applicant's contract of employment. In terms of the aforesaid letter the reason for terminating the applicant's services was because of his 'continual poor attendance over the last three years'.

...

The applicant protested his dismissal at the district labour office, complaining that he was dismissed from the employ of the respondent because he had disclosed that he was HIV positive. The district labour office held that the applicant's dismissal was unfair and recommended that the applicant be paid compensation equivalent to his salary for three months which amounted to P3 892.80.

The applicant says that although he accepted the aforesaid payment, he was unhappy with the decision of the district labour office.

...

Findings

Substantive fairness

The undisputed facts of this case point to a persistent pattern of absenteeism, mostly, if not wholly, authorised, over a three year period. The applicant, in consequence of his poor health, exhausting his annual and sick leave days per annum and having to obtain unpaid leave, often for months, in order to obtain medical assistance. This was clearly not a case of misconduct. It was a case of persistent, but intermittent absence because of ill-health. The respondent, it must be said, demonstrated the highest level of compassion and care, as it cooperated throughout the three years to ensure that the applicant got the medical attention he needed, to the extent that it even allowed him (applicant) to go on unpaid leave for months and suggesting, at one point, that the applicant consult a private doctor at its expense.

Given that the respondent tolerated the applicant's absenteeism for about three years, the question that arises is what triggered the dismissal of the applicant. The respondent's evidence is that a meeting between the applicant and respondent was held on 28 January 2004 at which meeting the respondent expressed concern about the applicant's continued absenteeism. At the said meeting the respondent suggested that the applicant consult a private medical practitioner. The applicant expressed its preference for Maun General Hospital doctors. There is no evidence to indicate that at this stage the respondent was contemplating dismissing the applicant. The applicant was not warned at that meeting that his job was in jeopardy. Yet following his refusal to consult the private medical practitioner as suggested by the respondent, the respondent allegedly took a decision to dismiss him.

There is no evidence that he was even informed on 28 January 2004 that a decision had been taken to dismiss him. As far as he was concerned he was on seven days sick leave and was still in the employ of the respondent.

On the evidence the decision to dismiss the applicant was substantively unfair because there was no valid reason for his dismissal. This is so for any or all of the four reasons herein stated. Firstly, the applicant's absence from work for the last three years as reflected in the letter dismissing him was, mostly, if not wholly, authorised by the respondent. That his absence for the last three years was mostly, if not wholly authorised by the respondent, was accepted by learned counsel for the respondent during her final submissions.

Secondly, learned counsel for the respondent conceded in her final submissions that the applicant's refusal to submit to medical examination as suggested by the respondent contributed to the decision to dismiss him. That surely cannot be a valid reason. The applicant, on the evidence did not refuse to have his fitness assessed, he just did not think it prudent to consult a private medical practitioner, when there are doctor(s) at Maun General Hospital who are and were familiar with his illness.

Thirdly, there is no evidence that as at 28 January 2004, the applicant was incapacitated on account of ill-health to perform his duties. Even assuming that it is true that the applicant was dismissed on 28 January 2004, there is no evidence to suggest that there was a valid reason for so doing.

Fourthly, the respondent by not taking action against the applicant for the last three years waived its right to take action and or condoned the applicant's conduct, at least for the preceding three years before 28 January 2004.

...

This court has decided a number of cases involving HIV/AIDS at the workplace. Whilst the circumstances and facts of those cases differ, the golden thread that runs throughout the judgments is that it is incompetent to dismiss an employee solely on the grounds that such an employee is HIV positive. (*Diau v Botswana Building Society* [2003] 2 BLR 409, IC.) (See also

Jimson v Botswana Building Society (IC 35/03), unreported and *Monare v Botswana Ash (Pty) Ltd* (supra).

It is my considered view that where an employee has become ill, and has in consequence been not reporting for duty for a cumulatively long period of time, whether such illness is a result of HIV/AIDS or any other illness, and is in consequence unable to perform his duties, the normal rules as to termination of services for inability to perform the job apply. As I see it, even in the case of progressive incapacitation, the employee cannot be dismissed without first being given a fair enquiry, at which the nature of the incapacity; the cause of the incapacity; the likelihood of recovery; improvement or recurrence; the period of absence; its effect on the employer's operations; and the employee's length of service, to mention only some of the critical factors are considered.

Where an employee is HIV positive, employers should refrain from any discriminatory practices towards an HIV/AIDS positive employee, and should view the employee in the same way as it would any other employee suffering from a life threatening illness. This is so because as a general rule an HIV positive employee may for years, even decades, experience no interference with his or her capacity for service in fulfilment of the demands of his job. This is particularly so in this era where anti-retroviral drugs are readily available.

To exclude an HIV/AIDS positive employee from employment through dismissal solely because he is HIV positive and without having established that he is incapacitated, as in this case, lacks a rational foundation and is unfair.

The view I hold is that once an employee is dismissed because he is HIV positive, as in this case, the constitution is immediately implicated, in particular s 7(1) which prohibits inhuman and degrading treatment. This is so because to dismiss an employee because he is HIV positive is a violation of his right to dignity.

The value of dignity as a core value of our constitution cannot be overemphasised. Recognising the right to dignity is an acknowledgement of the intrinsic worth of a human being. It is therefore plainly impermissible to dismiss an employee because he is HIV positive, when such a status has not been shown to incapacitate him. The era of routine dismissals because an employee is HIV positive, if ever there was, is now past. It is offensive to modern thinking and must not be tolerated. The courts, need to assert and enforce this right, so as to inform the future, and invest in our legal and constitutional order the intrinsic worth of all human beings.

In the context of an individual, human dignity means having a sense of self-respect and self-worth. It is concerned with physical and psychological integrity. Human dignity is harmed by unfair treatment or discrimination based on personal traits or circumstances which have no relationship to individual capacities.

This court, being a court of equity, is entitled to have regard to international principles on rights at work. The International Labour Organisation Declaration on Fundamental Principles and Rights at Work, adopted in June 1998 reaffirms the constitutional principle of the elimination of discrimination at the workplace.

There can be no doubt in my mind that the values of human dignity and elimination of discrimination are the very essence of our constitution. The current approach to issues of HIV/AIDS at the workplace is that it is incompetent to dismiss an employee solely because he or she is HIV positive. This position is correctly articulated, by Jane Hodges et al, in their publication entitled *An Outline of Recent Developments Concerning Equality Issues in Employment for Labour Court Judges and Assessors* (1997) at p 28 as follows:

To sum up the current international approach, it appears that HIV infection is not a valid ground for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as they are medically fit for available and appropriate work. For example the ILO Termination of Employment Convention, 1982 (No. D 758) requires that there must be a valid and fair reason 'connected with the capacity or conduct of the worker' for a disciplinary dismissal. Given the fact that HIV is impossible to transmit through casual contact, the mere fact that a worker has HIV is not a rational basis for discriminatory treatment or for

termination of services. Enterprises should not have policies which invoke discriminatory practices towards an HIV-positive employee. They should view the worker concerned in exactly the same way as they would view any other employee suffering from a life-threatening illness.

The above quote is based on the International Labour Organisation Code of Practice on HIV/AIDS. The above code, although not having a force of law, is persuasive in so far it is consistent with Botswana's international obligations, (see Convention no 111 (Discrimination, Employment and Occupation Convention, 1958), which Botswana has ratified).

...

Procedural fairness

...

In this case, the applicant was not consulted and or engaged to show cause why, given, his persistent absenteeism on account of ill health, he should not be dismissed. This much the respondent does not dispute in its evidence. From the peculiar circumstances of this case the respondent ought to have explained fully to the applicant why it was that what had been accepted for the past three years could no longer be accepted; and should have held a proper discussion with the applicant, and if required, members of the workers committee, as to whether and to what extent his post should be adapted. In my view the discussion of 28 January 2004 fell far short of this. Clearly, the respondent acted unfairly in not permitting the applicant that opportunity.

It follows therefore that the applicant's dismissal was procedurally unfair.

Remedies

In its statement of case the applicant seeks compensation for back pay and reinstatement.

...

Section 19(1) makes it clear that reinstatement is a discretionary remedy. It can only be considered where the termination was found to be unlawful or motivated on the grounds of sex, trade union membership, trade union activity, the lodging of a complaint or a grievance, or religious, tribal or political affiliation, or where the employment relationship has not irrevocably broken down. (See *Hirschfeld v Express Cartage Botswana (Pty) Ltd* (IC 67/96), unreported.)

The Industrial Court's discretion, though wide, must be exercised within certain limits. The employee's employment opportunities and work security, the unfair disruption of the employer's business and the harmful effect on the employment relationship are some of the considerations within which the discretion is to be exercised. The above limits amount to a system of checks and balances which the court weighs up before making a decision.

It has also been held to be too disruptive to reinstate employees on the ground that their positions have been filled. (See the case of *Maine and Others v African Cables* 1985 (6) ILJ 234 (IC) at p 245.) In this case evidence has been led to indicate that the position of the applicant has been filled. It would, in the circumstances, not be appropriate to accede to the prayer of reinstatement.

Another factor the courts have taken into account as having a possible disruptive effect is whether or not an order of reinstatement would undermine management authority. (See *FIHIA and Others v Pest Control Tvl (Pty) Ltd* 1984 (5) ILJ 165 (IC) at p 169.) It has not been suggested in this case that an order of reinstatement will undermine management authority and I do not think there is any basis whatsoever for so saying. Whether or not the relationship between the employee and the employer has irretrievably broken down is also an important factor to take into consideration.

The above factor is, of course, the same as that which is often advanced by our ordinary courts when they decide against ordering specific performance of employment contracts. The court generally examines the circumstances of each case in deciding whether or not reinstatement would be appropriate. In this case no evidence has been led on whether the relationship between has irretrievably broken-down or not. On a balance, we

are persuaded that to reinstate the applicant may be disruptive. Accordingly, the court holds the view that reinstatement would not be an appropriate relief.

In our view the applicant is entitled to compensation for the dismissal, which we have held is procedurally and substantively unfair.

...

D4.2 Access to HIV-related treatment

***Mangani v Register Trustees of Malamulo Hospital* (1991) High Court of Malawi**

The case involved a patient claiming damages against the defendant for negligence. The issue of HIV was addressed in relation to the doctor's act of negligence. The High Court of Malawi found held that doctors have a moral duty not only to save but also to prolong life including that of people with AIDS related-illnesses.

Excerpts

...

Facts

According to her evidence the plaintiff was admitted to Malamulo Hospital at Makwasa in the Thyolo District on 2nd November 1988. She complained of having sores in her mouth and pain on the throat causing difficulties in swallowing. She complained also of pain in her legs. Although she went to the hospital to be treated as an out patient, she was advised to be admitted because on the examination it was found that her blood pressure was very high. She was put on a drip on account of the condition of her throat which could make tablets difficult to swallow.

...

On the morning of 6 November 1988, at about 4 am the plaintiff woke up from her bed in order to visit the wash room. While she was in the wash room she began to bleed from the nose and became rather dizzy. She walked from the washroom to the desk where the Medical Assistant on night duty was sitting. She stated that she went to the Medical Assistant in order to seek help as she was still bleeding from the nose and getting dizzy, unfortunately the Medical Assistant on night duty was having his nap and could not hear the plaintiff's entreaties. It would appear that before she could get any assistance from the medical assistant, the plaintiff passed out and could not remember what immediately happened to her next.

...

On the following morning the plaintiff complained of the injury to her right ankle and about her fall to doctor Hayton but she was told words to the effect that the pain would cease in due course. On 11 November 1988 she was discharged from the hospital but was told to return to the hospital on 17 November 1988 in order to obtain the results of the lost of her blood. Apparently a sample of her blood had been taken for examination.

When the plaintiff went to the hospital on 17 November 1988, she complained again to Dr. Hayton about the injury to her right ankle. On Dr. Hayton's instructions, the ankle was X-rayed and when the doctor examined the X-rays, he told the plaintiff that she sustained no fracture but was severely injured. He prescribed no treatment for the injury but only gave her two weeks bed rest. He also gave the plaintiff a letter in a sealed envelope and told the plaintiff to take that letter to any doctor to who she might wish to go for further treatment. The letter was addressed to "TO WHOM IT MAY CONCERN". At a later day, the plaintiff opened the envelope and read the letter.

...

The pain in the plaintiff's right ankle did not subside even after the recommended two weeks bed rest. After several months she went to the Queen Elizabeth Hospital where she was under the care of Dr Blair. Her ankle was X-rayed again and the doctor informed her that she had a ruptured deltoid ligament. Different types of treatment were prescribed starting from pressure bandage to plaster of paris and the P.O.P was used for periods ranging from four weeks to six weeks. In September 1989, Dr Blair prepared a medical report which showed that the injury to the ankle was permanent and that the ligament could not be repaired and that the injury sustained would continue to cause her pain for the rest of her life.

...

The last witness for the plaintiff was Mr. Chester Alhed Dimba. He is a senior Orthopaedic Clinical Officer at Queen Elizabeth Central Hospital. He worked under Dr. Blair. He stated that the plaintiff came to the hospital complaining of pain in her right ankle ... He treated her, of course under Dr Blair's supervision ... Mr Dimba also told the court that had treatment to the ligament started immediately after the injury had been sustained, it would have been possible for the ligament to be repaired and heal properly. He stressed that the plaintiff came for treatment long after the injury had been sustained and that the ligament had been kept unattended for a long time after it had been torn and that was why it was not possible to repair it.

...

I am satisfied that the hospital authorities did not allow the plaintiff's guardian to sleep near her in the ward. I find therefore that the hospital owed the patient a duty to look after her as and when she needed assistance. The Medical Assistant on night duty was sleeping when he was expected to be attending to the patients. This was negligence and the defendants are vicariously responsible for this negligence. I also find this negligence was the cause of the plaintiff's fall causing injury to her ankle.

...

I find Dr. Hayton's conduct to have constituted negligence because he was a doctor from whom medical knowledge is presumed. It was stated in *R v Bateman* 1925 94 791.

'If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in understanding the treatment. If he accepts the responsibility and undertakes the treatment accordingly he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment'.

It is may be assumed that Dr. Hayton's medical knowledge was not in any way inferior, the question may be asked as to why, having seen that the plaintiff had suffered a torn ligament, he decided not to treat her professionally but only advised her simply to take a rest.

...

I repeat that there is not direct evidence on this point but from what can be gathered from the circumstantial evidence available the inescapable conclusion is that it was the view of Dr. Hayton that the patient was an HIV reactive victim and that it would be a waste of medicine and time to give medicine to such patient who is fated to die in any event ... If this was his view, then it must be deplored in no uncertain terms as being both unethical and unprofessional. Doctors who take the Hippocratic Oath before being conferred with dignity and title of "Doctor" have a moral duty not only to save but also to prolong life. Even an AIDS victim is owed such duty from his doctors. The power to end life is vested only in God the Almighty.

Finding

In conclusion, I find as proved that the defendants, having refused the plaintiff's request to have her guardian attend to her during the night, failed to provide the necessary care to ensure that the plaintiff who was under their care was safe. I also find as proved that the defendants were negligent for failing to provide treatment and care to the plaintiff when it was clear to them that

the plaintiff had sustained a serious injury while she was under their care.

Remedy

...

In all the circumstances of the case, I consider that an overall award of K75,000 would be reasonable and this is the amount which the court awards. The defendant will also be condemned in the cost of this action.

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

In this case, the South African Constitutional Court interpreted the right to access to health care as provided under the Constitution. Giving effect to that right, the Constitutional Court ordered the government to modify its programme for the prevention of mother-to-child transmission of HIV in order to ensure that nevirapine, an antiretroviral drug, is widely available in the public health sector.

Excerpts

...

Introduction

[2] This appeal is directed at reversing orders made in a high court against government because of perceived shortcomings in its response to an aspect of the HIV/AIDS challenge. The court found that government had not reasonably addressed the need to reduce the risk of HIV-positive mothers transmitting the disease to their babies at birth. More specifically the finding was that government had acted unreasonably in (a) refusing to make an antiretroviral drug called nevirapine available in the public health sector where the attending doctor considered it medically indicated and (b) not setting out a timeframe for a national programme to prevent mother-to-child transmission of HIV.

[3] The case started as an application in the High Court in Pretoria on 21 August 2001. The applicants were a number of associations and members of civil society concerned with the treatment of people living with HIV and with the prevention of new infections. In this judgment they are referred to collectively as “the applicants”. The principal actor among them was the Treatment Action Campaign (TAC). The respondents were the national Minister of Health and the respective members of the executive councils (MECs) responsible for health in all provinces save the Western Cape. They are referred to collectively as “the government” or “government”.

[4] Government, as part of a formidable array of responses to the pandemic, devised a programme to deal with mother-to-child transmission of HIV at birth and identified nevirapine as its drug of choice for this purpose. The programme imposes restrictions on the availability of nevirapine in the public health sector. This is where the first of two main issues in the case arose. The applicants contended that these restrictions are unreasonable when measured against the Constitution, which commands the state and all its organs to give effect to the rights guaranteed by the Bill of Rights.

...

At issue here is the right given to everyone to have access to public health care services and the right of children to be afforded special protection. These rights are expressed in the following terms in the Bill of Rights:

27(1) Everyone has the right to have access to –

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

...

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

...

28(1) Every child has the right –

...

(c) to basic nutrition, shelter, basic health care services and social services.

[5] The second main issue also arises out of the provisions of sections 27 and 28 of the Constitution. It is whether government is constitutionally obliged and had to be ordered forthwith to plan and implement an effective, comprehensive and progressive programme for the prevention of mother-to-child transmission of HIV throughout the country.

...

[25] The question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are. The question is whether the applicants have shown that the measures adopted by the government to provide access to health care services for HIV-positive mothers and their newborn babies fall short of its obligations under the Constitution.

Minimum core

[36] The state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflict our society. The courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in section 1. As the Bill of Rights indicates, their function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable. As this Court said in *Grootboom*, “[i]t is necessary to recognise that a wide range of possible measures could be adopted by the State to meet its obligations”.

Government policy on the prevention of mother-to-child transmission of HIV

[41] Following the 13th International Conference on HIV/AIDS held in Durban in July 2000, government took a decision to implement a programme for the prevention of mother-to-child transmission of HIV. This programme entailed the provision of voluntary HIV counselling and testing to pregnant women, the provision of nevirapine and the offer of formula feed to HIV-positive mothers who chose this option of feeding. The implementation of this programme was to be confined to selected sites in each province for a period of two years. As pointed out earlier, these pilot sites were to be used primarily to evaluate the use of nevirapine, monitoring and evaluating its impact on the health status of the children affected as well as the feasibility of such an intervention on a countrywide basis. Information gathered from these sites was to be used in developing a national policy for the extension of this programme to other public facilities outside the pilot sites. Nevirapine was not to be made available to public facilities outside the pilot sites.

[42] This programme was to be implemented in accordance with the Protocol for providing a comprehensive package of care for the prevention of mother to child transmission of HIV in South Africa, draft version 4 of which was adopted in April 2001. This protocol made provision for a comprehensive package of care for the prevention of mother-to-child transmission of HIV. It was based on two propositions: first, the acceptance that there is enough scientific evidence confirming the efficacy of various antiretroviral drugs for reducing the transmission of HIV from mother to child; and second, that there is a need to assess the operational challenges inherent in the introduction of an antiretroviral regimen for the reduction of mother-to-child transmission of HIV in South Africa in both rural and urban settings. The protocol recognised that appropriately trained staff is a prerequisite for the successful implementation of any programme. To this end, provision was made in the protocol for the development of materials for the required training of staff, including training in counselling, testing for HIV, the medical and obstetric interventions necessary to reduce mother-to-child transmission at the time of birth and other related matters.

[43] The protocol contemplated that the programme would be introduced at two sites, one rural and one urban, in each of the provinces. A full package of care would be available at these sites and the progress made by the infants receiving the treatment would be carefully monitored for a period of two years.

The applicants' contentions

[44] It is the applicants' case that the measures adopted by government to provide access to health care services to HIV-positive pregnant women were deficient in two material respects: first, because they prohibited the administration of nevirapine at public hospitals and clinics outside the research and training sites; and second, because they failed to implement a comprehensive programme for the prevention of mother-to-child transmission of HIV.

[47] The applicants' contentions raise two questions, namely, is the policy of confining the supply of nevirapine reasonable in the circumstances; and does government have a comprehensive policy for the prevention of mother-to-child transmission of HIV.

The policy confining nevirapine to the research and training sites

[48] In deciding on the policy to confine nevirapine to the research and training sites, the cost of the drug itself was not a factor.

...

[49] The costs that are of concern to the government are therefore the costs of providing the infrastructure for counselling and testing, of providing formula feed, vitamins and an antibiotic drug and of monitoring, during bottle-feeding, the mothers and children who have received nevirapine. These costs are relevant to the comprehensive programme to be established at the research and training sites. They are not, however, relevant to the provision of a single dose of nevirapine to both mother and child at the time of birth.

[50] The implementation of a comprehensive programme to combat mother-to-child transmission of HIV, such as that provided at the research and training sites, is no doubt the ideal. The real dispute between the parties on this aspect of the case is not, however, whether this optimum was feasible but whether it was reasonable to exclude the use of nevirapine for the treatment of mother-to-child transmission at those public hospitals and clinics where testing and counselling are available and where the administration of nevirapine is medically indicated.

...

[55] Related to this was a submission raised in argument that from a public health point of view, there is a need to determine the costs of providing the breastmilk substitute, the supplementary package and the necessary counselling and monitoring. Without knowing the full extent of these costs and the efficacy of the treatment, it would be unwise for government to commit itself to a wide-ranging programme for treating mother-to-child transmission that might prove to be neither efficacious nor sustainable.

[56] We deal with each of these issues in turn.

[57] First, the concern about efficacy. It is clear from the evidence that the provision of nevirapine will save the lives of a significant number of infants even if it is administered without the full package and support services that are available at the research and training sites. Mother-to-child transmission of HIV can take place during pregnancy, at birth and as a result of breastfeeding. The programme in issue in this case is concerned with transmission at or before birth. Although there is no dispute about the efficacy of nevirapine in materially reducing the likelihood of transmission at birth, the efficacy of the drug as a means of combating mother-to-child transmission of HIV is nevertheless challenged. How this comes about requires some discussion.

...

[64] It is this that lies at the heart of government policy. There are obviously good reasons from the public health point of view to monitor the efficacy of the "full package" provided at the research and training sites and determine whether the costs involved are warranted by the efficacy of the treatment. There is a need to determine whether bottle-feeding will be implemented in practice when such advice is given and whether it will be implemented in a way that proves to be more effective than breastfeeding, bearing in mind the cultural problems associated

with bottle-feeding, the absence of clean water in certain parts of the country and the fact that breastfeeding provides immunity from other hazards that infants growing up in poor households without access to adequate nutrition and sanitation are likely to encounter. However, this is not a reason for not allowing the administration of nevirapine elsewhere in the public health system when there is the capacity to administer it and its use is medically indicated.

Considerations relevant to reasonableness

[67] The policy of confining nevirapine to research and training sites fails to address the needs of mothers and their newborn children who do not have access to these sites. It fails to distinguish between the evaluation of programmes for reducing mother-to-child transmission and the need to provide access to health care services required by those who do not have access to the sites.

...

[69] The applicants do not suggest that nevirapine should be administered indiscriminately to mothers and babies throughout the public sector. They accept that the drug should be administered only to mothers who are shown to be HIV-positive and that it should not be administered unless it is medically indicated and, where necessary, counselling is available to the mother to enable her to take an informed decision as to whether or not to accept the treatment recommended. Those conditions form part of the order made by the High Court.

[70] In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences.

[71] The cost of nevirapine for preventing mother-to-child transmission is not an issue in the present proceedings. It is admittedly within the resources of the state. The relief claimed by the applicants on this aspect of the policy, and the order made by the High Court in that regard, contemplate that nevirapine will only be administered for the prevention of mother-to-child transmission at those hospitals and clinics where testing and counselling facilities are already in place. Therefore this aspect of the claim and the orders made will not attract any significant additional costs.

[72] In evaluating government's policy, regard must be had to the fact that this case is concerned with newborn babies whose lives might be saved by the administration of nevirapine to mother and child at the time of birth. The safety and efficacy of nevirapine for this purpose have been established and the drug is being provided by government itself to mothers and babies at the pilot sites in every province.

[73] The administration of nevirapine is a simple procedure. Where counselling and testing facilities exist, the administration of nevirapine is well within the available resources of the state and, in such circumstances, the provision of a single dose of nevirapine to mother and child where medically indicated is a simple, cheap and potentially lifesaving medical intervention.

Children's rights

[74] There is another consideration that is material. This case is concerned with newborn children. Sections 28(1)(b) and (c) of the Constitution provide that

[e]very child has the right –

...

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

(c) to basic nutrition, shelter, basic health care services and social services.

[78] The provision of a single dose of nevirapine to mother and child for the purpose of protecting the child against the transmission of HIV is, as far as the children are concerned, essential. Their needs are "most urgent" and their inability to have access to nevirapine profoundly affects their ability to enjoy

all rights to which they are entitled. Their rights are “most in peril” as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to nevirapine.

[79] The state is obliged to ensure that children are accorded the protection contemplated by section 28 that arises when the implementation of the right to parental or family care is lacking. Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the state to make health care services available to them.

Evaluation of the policy to limit nevirapine to research and training sites

[80] Government policy was an inflexible one that denied mothers and their newborn children at public hospitals and clinics outside the research and training sites the opportunity of receiving a single dose of nevirapine at the time of the birth of the child. A potentially lifesaving drug was on offer and where testing and counselling facilities were available it could have been administered within the available resources of the state without any known harm to mother or child. In the circumstances we agree with the finding of the High Court that the policy of government in so far as it confines the use of nevirapine to hospitals and clinics which are research and training sites constitutes a breach of the state’s obligations under section 27(2) read with section 27(1)(a) of the Constitution.

[81] Implicit in this finding is that a policy of waiting for a protracted period before taking a decision on the use of nevirapine beyond the research and training sites is also not reasonable within the meaning of section 27(2) of the Constitution.

...

Testing and counseling

[90] The evidence shows that at the time of the commencement of these proceedings there was in place a comprehensive policy for testing and counselling of HIV-positive pregnant women. The policy was not, however, implemented uniformly. Professor Schneider’s research is the only evidence on record concerning the extent of the testing and counselling facilities at fixed clinics 3[9] in the provinces. She refers to a number of studies – particularly two surveys conducted by the Health Systems Trust in 1998 and 2000.

...

Summary of the relevant evidence

[92] To sum up, the position when the application was launched was this. Two research and training sites had been selected at hospitals in each province to use nevirapine for the prevention of mother-to-child transmission of HIV. These research and training sites were linked to access points at satellite clinics. There were approximately 160 access points. (During the course of the proceedings these had increased to over 200.) At the project hospitals and satellite clinics a full package for the treatment of mother-to-child transmission was to be available. This included testing, counselling, nevirapine if medically indicated, the provision of formula feed as a substitute for breastfeeding, aftercare including the provision of vitamins and antibiotics, and monitoring of the progress of the children. At all other public hospitals and clinics nevirapine would not be available. There was, however, to be a programme for testing and counselling, including counselling on matters related to breastfeeding. Formula feed was available at some hospitals and clinics but it was not a requirement of the programme to combat mother-to-child transmission outside the research and training sites that it be made available to HIV-positive mothers of newborn babies who would like to avoid breastfeeding but cannot afford the formula feed. Although the programme envisaged the progressive establishment of testing and counselling facilities at all hospitals and clinics, progress had been slow in certain parts of the country, particularly in clinics in the Northern Province, Mpumalanga, the Eastern Cape and KwaZulu-Natal. The bulk of the rural population lives in these

provinces where millions of people are still without access to clean water or adequate sanitation.

Findings concerning government’s programme

[93] In the present case this Court has the duty to determine whether the measures taken in respect of the prevention of mother-to-child transmission of HIV are reasonable. We know that throughout the country health services are overextended. HIV/AIDS is but one of many illnesses that require attention. It is, however, the greatest threat to public health in our country. As the government’s HIV/AIDS & STD strategic plan for South Africa 2000–2005 states:

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy.

[94] We are also conscious of the daunting problems confronting government as a result of the pandemic. And besides the pandemic, the state faces huge demands in relation to access to education, land, housing, health care, food, water and social security. These are the socio-economic rights entrenched in the Constitution, and the state is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them. In the light of our history this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the state by the Constitution.

[95] The rigidity of government’s approach when these proceedings commenced affected its policy as a whole. If, as we have held, it was not reasonable to restrict the use of nevirapine to the research and training sites, the policy as a whole will have to be reviewed. Hospitals and clinics that have testing and counselling facilities should be able to prescribe nevirapine where that is medically indicated. The training of counsellors ought now to include training for counselling on the use of nevirapine. As previously indicated, this is not a complex task and it should not be difficult to equip existing counsellors with the necessary additional knowledge. In addition, government will need to take reasonable measures to extend the testing and counselling facilities to hospitals and clinics throughout the public health sector beyond the test sites to facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

The powers of the courts

...

[122] In the present case we have identified aspects of government policy that are inconsistent with the Constitution. The decision not to make nevirapine available at hospitals and clinics other than the research and training sites is central to the entire policy. Once that restriction is removed, government will be able to devise and implement a more comprehensive policy that will give access to health care services to HIV-positive mothers and their newborn children, and will include the administration of nevirapine where that is appropriate. The policy as reformulated must meet the constitutional requirement of providing reasonable measures within available resources for the progressive realisation of the rights of such women and newborn children. This may also require, where that is necessary, that counsellors at places other than at the research and training sites be trained in counselling for the use of nevirapine. We will formulate a declaration to address these issues.

Relief

[125] It is essential that there be a concerted national effort to combat the HIV/AIDS pandemic. The government has committed itself to such an effort. We have held that its policy fails to meet constitutional standards because it excludes those who could reasonably be included where such treatment is medically indicated to combat mother-to-child transmission of HIV. That does not mean that everyone can immediately claim access to such treatment, although the ideal, as Dr Ntsaluba says, is to achieve that goal. Every effort must, however, be made to do so as soon as reasonably possible. The increases in the budget to which we have referred will facilitate this.

[126] We consider it important that all sectors of the community, in particular civil society, should co-operate in the steps taken to achieve this goal. In our view that will be facilitated by spelling out the steps necessary to comply with the Constitution.

[127] We will do this on the basis of the policy that government has adopted as the best means of combating mother-to-child transmission of HIV, which is to make use of nevirapine for this purpose. Government must retain the right to adapt the policy, consistent with its constitutional obligations, should it consider it appropriate to do so. The order that we make has regard to this.

...

[130] The anxiety of the applicants to have the government move as expeditiously as possible in taking measures to reduce the transmission of HIV from mother to child is understandable. One is dealing here with a deadly disease. Once a drug that has the potential to reduce mother-to-child transmission is available, it is desirable that it be made available without delay to those who urgently need it.

[131] We do not underestimate the nature and extent of the problem facing government in its fight to combat HIV/AIDS and, in particular, to reduce the transmission of HIV from mother to child. We also understand the need to exercise caution when dealing with a potent and a relatively unknown drug. But the nature of the problem is such that it demands urgent attention. Nevirapine is a potentially lifesaving drug. Its safety and efficacy have been established. There is a need to assess operational challenges for the best possible use of nevirapine on a comprehensive scale to reduce the risk of mother-to-child transmission of HIV. There is an additional need to monitor issues relevant to the safety and efficacy of and resistance to the use of nevirapine for this purpose. There is, however, also a pressing need to ensure that where possible loss of life is prevented in the meantime.

Orders

[135] We accordingly make the following orders:

...

2. It is declared that:

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

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

(c) The policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs a and b in that:

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

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

3. Government is ordered without delay to:

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

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

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

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

D4.3 HIV prevention and care in prison

Van Biljon and Others v Minister of Correctional Services and Others 1997 (4) SA 441 (C) (SAHC 1997 C)

The Department of Correctional Services failed to prove that it could not afford to provide antiretroviral medication to the applicants, who were HIV positive prisoners. The Cape High Court (South Africa) concluded that the provision of such therapy was part of the prisoners' constitutional right to adequate medical treatment.

Excerpts

...

Facts

[1] The four applicants are inmates of the Pollsmoor Prison on the outskirts of Cape Town. The first and second respondents are, respectively, the Minister and the Commissioner of Correctional Services. The third respondent is the Commander of Pollsmoor Prison and the fourth respondent is the Minister of Health and Welfare of the Province of the Western Cape.

[2] Applicants all suffer from Human Immunodeficiency Viral infection or, as it has become commonly known, they have been diagnosed as HIV positive. According to their amended notice of motion they, inter alia, seek declaratory orders in the following terms:

...

4. Declaring that the right to adequate medical treatment of the applicants and the prisoners infected with HIV, who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500/ml, entitles them to have prescribed and to receive at State expense appropriate anti-viral medication, including but not limited to AZT, ddI, 3tC or ddC individually or in combination.'

...

Applicable law

[5] The matter squarely raises some of the problems related to HIV and AIDS in prisons which have attracted international research and debate.

[6] To at least one of the questions raised in this matter, the Constitution of the Republic of South Africa ('the Constitution') provides a clear and final answer, more particularly in s 35(2) thereof which provides that:

(2) Everyone who is detained, including every sentenced prisoner, has the right -

...

(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at State expense, of adequate accommodation, nutrition, reading material and medical treatment.

Application of law to facts

...

[8] The only real dispute between the parties, therefore, revolves around the issues that arise from the declarator sought in para 4 of the notice of motion, namely whether applicants and other HIV infected prisoners - who have reached the symptomatic

stage of the disease and whose CD4 counts are less than 500/ml - are entitled to receive the anti-viral treatment mentioned in that paragraph, at State expense.

...

[23] From the answering affidavits filed on behalf of respondents, it is apparent that the increasing number of HIV infected prisoners has led to investigations and reports by several working groups. On the basis of these reports, the Department of Correctional Services has formulated management strategy documents for the handling of prisoners who are HIV positive. From these management strategy documents which are annexed to respondents' papers, it appears, however, that they are predominantly concerned with the prevention of prison officials and other prisoners contracting AIDS, rather than with the medical treatment of HIV prisoners.

[25] From the affidavit of Dr Wood, it appears that the policy of provincial hospitals regarding the prescription of anti-viral drugs at State expense is, firstly, that only AZT monotherapy is provided; secondly, that the only HIV patients who can be considered for AZT treatment are essentially those with a CD4 count of less than 200 and whose condition - as I understand the policy - has developed to full-blown AIDS; and, thirdly, that in order to qualify for AZT treatment at State expense, the patient must still have a CD4 count of more than 50/ml.

...

[31] As stated at the outset, the issue between the parties is whether applicants and other HIV prisoners, who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500/ml, are entitled to have prescribed to them and to receive at State expense the anti-viral therapy described in para 4 of the notice of motion. As appears from the foregoing, the determination of this issue requires an answer to two separate questions. The first question is whether applicants and other HIV prisoners who fall within the stated category are entitled to have such anti-viral therapy prescribed for them on medical grounds. The second question is whether applicants and other prisoners who are entitled to have anti-viral therapy prescribed for them on medical grounds are entitled to receive such therapy at State expense.

[33] The question whether applicants and other HIV patients who fall within the stated category are entitled to a prescription of a particular combination of anti-viral drugs on medical grounds is a medical question. The answer to this question by applicants' medical experts is that the anti-viral medication contended for by applicants should be prescribed for all prisoners who have reached the symptomatic stage of the HIV virus and whose CD4 counts are less than 500/ml. This view appears to find general support internationally. Dr Wood's answer to the question is, however, somewhat different. In his opinion, there are patients who fall into the stated category for whom the said anti-viral drugs should not be prescribed. As was decided by the American Supreme Court, 'the Court is not empowered to delve into the intricacies of modern medicine'. Mr Seligson's answer to Dr Wood, namely that he stands alone against an overwhelming majority, involves a head count which I am not prepared to undertake.

[34] Moreover, a declarator in the terms sought by applicants would, in my view, dictate to medical doctors when they must prescribe anti-viral treatment. Mr Seligson submitted that the order sought by applicants would leave the medical practitioner with a discretion as to what anti-viral medication he deems appropriate. That may be so. The fact remains, however, that it would compel the doctor to prescribe some form of anti-viral medication. For reasons that are, in my view, obvious, it is not the function of this Court to make an order of that nature.

...

[38] This brings me to the question whether first and second applicants are entitled to be provided - at State expense - with the anti-viral therapy which has been prescribed for them on medical grounds. For the sake of convenience, I will henceforth refer to first and second applicants as 'applicants'.

[39] With regard to this question, Mr Scholtz referred to two decisions by American Courts that failure by the prison

authorities to provide HIV positive prisoners with AZT does not amount to an infringement of the prisoners' constitutional rights. Having regard to the reasons for these judgments, it is, however, apparent that the conclusion arrived at in these two cases is of very limited assistance for at least two reasons. The first reason is that both cases involved the treatment of HIV prisoners in 1989. At that time it was found that the plaintiff-prisoners were asserting a right to an experimental and novel form of treatment. In the present case, the medical consensus is that the anti-viral therapy prescribed for applicants can no longer be regarded as experimental. On the contrary, it is internationally recognised as 'state of the art' treatment for HIV patients in applicants' condition.

[40] The second reason why these two American cases are of limited assistance is that they were dictated by the 'deliberate indifference test' which was adopted by the United States Supreme Court in *Estelle v Gamble* in giving effect to the Eighth Amendment prohibition against cruel and unusual punishment. According to this test, a failure by prison authorities to provide medical treatment will only amount to cruel and unusual punishment - as envisaged by the Eighth Amendment - if the prison authorities are shown to have been deliberately indifferent to the prisoners' medical needs. In short - unlike our Constitution - the American Constitution does not contain a provision in terms whereof a prisoner's right to adequate medical treatment is specifically entrenched. This obvious difference must also be borne in mind in considering other decisions of the American Courts, including those in which it was held that federal and state governments have a constitutional obligation to provide 'minimally adequate' medical care or 'reasonable medical assistance' to those whom they are punishing by incarceration.

...

[42] At common law it has been held repeatedly that prisoners retain all basic rights not temporarily taken away or necessarily inconsistent with being prisoners. As long ago as 1912, Innes J dealt as follows with a contention on behalf of the prison authorities that a prisoner may only claim such rights as the prison regulations confer:

(T)he directly opposite view is surely the correct one. They were entitled to all their personal rights and personal dignity not temporarily taken away by law, or necessarily inconsistent with the circumstances in which they had been placed.'

This principle was restated by Corbett JA in *Goldberg and Others v Minister of Prisons and Others* when he explained that, although there are infringements which incarceration necessarily makes on a prisoner's rights, 'there is a substantial residuum of basic rights which he cannot be denied.

...

[49] In principle, I agree with Mr Seligson's submission that lack of funds cannot be an answer to a prisoner's constitutional claim to adequate medical treatment. Therefore, once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that form of medical treatment and it would be no defence for the prison authorities that they cannot afford to provide that form of medical treatment. I do not, however, agree with the proposition that financial conditions or budgetary constraints are irrelevant in the present context. What is 'adequate medical treatment' cannot be determined in vacuo. In determining what is 'adequate', regard must be had to, inter alia, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as 'sufficient' or 'adequate medical treatment'. After all, as was pointed out by Mr Scholtz, s 35(2)(e) of the Constitution does not provide for 'optimal medical treatment' or 'the best available medical treatment', but only for 'adequate medical treatment'.

...

[52] With reference to, inter alia, accommodation, nutrition and medical care, the Constitution itself draws a distinction between prisoners and people outside prison. In terms of s 35(2)(e), prisoners have a fundamental right to adequate accommodation,

nutrition and medical care, and Mr Scholtz submitted that, as far as medical care is concerned, this is a distinction without any real difference. What is guaranteed to prisoners, he argued, is 'adequate medical care' and not 'optimal medical care' or 'the best available medical care'. What is good enough for people outside prison, Mr Scholtz submitted, must be good enough for prisoners. According to Mr Scholtz's argument, such medical treatment as is afforded outside prison must, therefore, per se be regarded as 'adequate medical care'. I do not believe that this submission can be accepted as a principle of general application. What is true for medical treatment must also be true, for example, for accommodation. Acceptance of the principle contended for by Mr Scholtz would, therefore, mean that the State is not obliged - in terms of s 35(2)(e) - to provide better accommodation for prisoners than that which is provided for people outside. It is an unfortunate fact of life, however, that there are many people in this country whose accommodation cannot be described as adequate by any standard. What is provided for people outside can therefore be no absolute standard for what is adequate for prisoners.

[53] With reference to the position at common law, Mr Scholtz submitted that if the same standard of care and treatment is provided for prisoners attending State institutions, they would be retaining the residuum of rights which survive incarceration. I do not believe that this is so. Unlike persons who are free, prisoners have no access to other resources to assist them in gaining access to medical treatment. It is true that some HIV positive prisoners will, upon release, be dependent on the State for medical treatment. On the other hand, there are prisoners, like first applicant, who may well be able, upon their release, to earn an income which will enable them to afford anti-viral treatment or who will receive charitable assistance from their employers. As far as the latter category of prisoners is concerned, an inroad would be made upon their personal liberties if they were to be refused access to anti-viral treatment. Since such inroad cannot be described as a necessary consequence of incarceration, I do not believe that the refusal to provide these prisoners with anti-viral medication is consistent with the principles of our common law. In saying that I obviously do not intend to suggest that the standard of medical treatment for any particular prisoner should be determined by what he could afford outside prison. What I am saying, is that the standard of medical treatment for prisoners in general cannot be determined by the lowest common denominator of the poorest prisoner on the basis that he could afford no better treatment outside.

[54] As far as HIV prisoners are concerned, there is another factor which should, in my view, be borne in mind, namely that they are more exposed to opportunistic viruses than HIV sufferers who are not in prison. It is applicants' case that tuberculosis and pneumonia are prevalent in prison. Although respondents deny the prevalence of these particular opportunistic infections, they do admit that the overcrowded conditions in which prisoners are accommodated exacerbates the vulnerability of HIV prisoners to opportunistic infections. Even if it is, therefore, accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve the immune systems than that which the State provides for HIV patients outside.

...

[57] With regard to possible financial constraints, there is the further consideration of a cost-saving raised by applicants' experts to which respondents have, in my view, not given a conclusive answer. As appears from the foregoing, it is contended by applicants' experts, on the basis of international research, that the administration of anti-viral therapy at an early stage is cost-effective in that the treating of opportunistic infections is significantly reduced. It is true that respondents' medical expert, Dr Wood, does not agree with the results of the international research. It is also true, as was submitted by Mr Scholtz, that this dispute between medical experts cannot be

determined on motion papers. It does, however, stand to reason that the postponement of the costly treatment for opportunistic infections must result in some cost-saving, even if such saving does not exceed the cost of prophylactic anti-viral treatment, as appears to be suggested by the results of international research. From respondents' papers, it appears that they have disregarded the possibility of any cost-saving through anti-viral treatment.

...

[60] Applicants have, therefore, established, in my view, that anti-viral therapy is at present the only prophylactic. The benefits of this treatment - in the form of extended life expectancy and enhanced quality of life - are such that this treatment must be provided for the unfortunate sufferers of HIV infection if at all affordable. As I have already stated, respondents have failed to make out a case that the Department of Correctional Services cannot afford to provide HIV I infected prisoners in the stated category with the combination anti-viral therapy claimed by applicants. In these circumstances, I believe that the medical treatment claimed by applicants must be regarded as no more than the 'adequate medical treatment' to which they are entitled in terms of s 35(2)(e) of the Constitution. It follows that the failure to provide applicants with this treatment amounts to an infringement of applicants' constitutional rights.

Remedy

[61] ... What I therefore propose to order is that first and second applicants be provided with such anti-viral therapy as had already been prescribed for them on medical grounds and only for as long as this treatment is so prescribed.

...

Stanfield v Minister of Correctional Services and Others 2004 (4) SA 43 (C) (SAHC 2003)

This case deals with an inmate who applied for parole on medical grounds after being diagnosed with terminal cancer. The Department of Correctional Services rejected the application. The Cape High Court (South Africa) reversed the Department's decision, affirming the inmate's constitutional right to conditions of detention that are consistent with human dignity. Although this case does not directly deal with care for persons living with HIV, the Court did address how its decision could affect the population of prisoners living with HIV.

Excerpts

...

[128] Despite the huge increase in the prevalence of HIV/AIDS and other terminal diseases in our prisons, only the tiniest percentage of prisoners suffering from such diseases were released on medical grounds during 2002. I associate myself fully with the call by Inspecting Judge J Fagan that the release of terminally ill prisoners should receive far more attention, if not priority attention, than is the case at the present time. The alternative is grotesque: untold numbers of prisoners dying in prisons in the most inhuman and undignified way. Even the worst of convicted criminals should be entitled to a humane and dignified death.

...

[132] The applicant is fully entitled to spend the remaining portion of his life ensconced in his own home in the consolatory embrace of his family. When the time comes for him to pass on, he must be able to do so peacefully and in accordance with his inherent right to human dignity.

...

The appellant was accused of fraud and sentenced. She appealed to the South African Supreme Court of Appeal for lesser sentence due to her AIDS status. The court decided on a sentence of imprisonment equal to the time spent in prison subsequent to the date on which the appellant had been sentenced by the magistrate and held that the appellant could not undergo any further period of imprisonment.

Excerpts

...

Facts

[5] The accused was represented at her trial and her legal representative presented the following facts from the side-bar (the appellant did not testify): The appellant was 26 years old and was the mother of a 7-year old daughter who had been placed in the father's custody. She was a first offender. The appellant completed matric and had been in several jobs after that. When she committed the offences in question she had been unemployed. The appellant perpetrated the fraud of which she had been convicted by paying for goods with cheques from chequebooks obtained by false pretences. She committed the offences in concert with others.

...

[1] The appellant pleaded guilty to and was convicted of 99 counts of fraud in the Bellville Magistrates' Court. On 30 July 2001 she was sentenced to 60 days' imprisonment on each count, of which 40 days' imprisonment was suspended on condition that she was not convicted of fraud or theft or any attempt thereto committed during the period of suspension. The cumulative total sentence amounted to 16 years and 3 months' imprisonment. The unsuspended term of imprisonment amounted to 5 years, 5 months and 2 days.

[2] The appellant served part of her sentence but was released on bail pending her appeal to the Cape High Court. That appeal was dismissed (per Hlophe JP and Franks AJ). The court below granted leave to appeal that decision and further extended bail pending the outcome of the present appeal.

[3] Before us the appellant applied to have evidence by way of affidavits admitted on appeal. The affidavits reveal that the appellant discovered, after she was sentenced, that she had contracted the Human Immunodeficiency Virus (HIV), which had caused her to develop full-blown Acquired Immunodeficiency Syndrome (AIDS). As a result her life expectancy has been drastically reduced. She and the doctors treating her describe the treatment she is receiving which is not available to her in prison. This evidence is set out in greater detail later in this judgment. The state did not oppose the admission of the evidence and, for reasons that will become apparent, it was admitted on appeal.

[4] The following are the appellant's grounds of appeal:

(a) The magistrate did not supply reasons for the sentence imposed by him and the Cape High Court was therefore not at liberty to deal with the question of sentence as though it has been properly imposed;

(b) The appellant's legal representative before the court below did not properly present her case on appeal and she could therefore not be considered to have had a fair appeal as envisaged by the Constitution;

(c) The appellant's HIV/AIDS status entitled her to a lesser sentence.

[7] That then was the sum total of the material available to the magistrate in respect of sentencing. The magistrate supplied no reasons for the sentence imposed by him. Reasons were not requested and the court below proceeded without the benefit of the magistrate's reasons.

[8] The appellant's former legal representative did not apply to have the evidence referred to in para [3] admitted in the court below. It appears that all that he did was to make a submission (encompassed in three very brief paragraphs in heads of argument) that the appellant's HIV status entitled her to a lesser sentence as any sentence of imprisonment imposed would affect her more harshly than it would a healthy person.

[9] At this stage it is necessary to set out in some detail the evidence presented to us: On applying for bail pending the present appeal, the appellant described how, without the proper treatment for AIDS, she would die within a few months - even with treatment, her life expectancy has been drastically reduced. She described further how, in a government-sponsored initiative, she is receiving antiretroviral treatment at Groote Schuur hospital in Cape Town.

Whilst awaiting trial in prison she contracted tuberculosis very quickly because she had been HIV positive. The treatment received at the hospital was not available in prison. The appellant contracted shingles and thrush flowing from her AIDS condition. She described in her affidavit how her diet in prison and a lack of the range of necessary vitamins are not conducive to combating her present condition. Whilst in prison the appellant became sicker. In her words: 'My immune system crashed.' Her exposure to opportunistic infections in prison increases the risk to her health.

...

[11] The doctors treating the appellant at Groote Schuur confirm that her return to prison will have a serious impact on her health and that, without proper treatment, she will die prematurely. They confirm the effectiveness of highly active antiretroviral therapy in the treatment of AIDS. The head of the prison in which the appellant served part of her sentence confirmed by way of a letter that nevirapine, a vital antiretroviral drug in the fight against AIDS, is unavailable in any prison.

[12] The following is the essential part of a very brief judgment in the court below:

The appellant who pleaded guilty knew exactly what she was doing. When she is in prison she will still be entitled to receive her treatment. No case has been made out or no suggestion has been made that she has been deprived of treatment for her HIV status by relevant authorities. I am not aware of any good authority for the view that if someone is HIV positive, he may get away with murder. In my view the sentence fits the crime. She was very lucky to get this kind of sentence for the crimes she committed. I would dismiss the appeal against sentence as being altogether without merit.

...

[15] As stated earlier, the appellant's legal representative in the court below appeared to have contented himself with a submission from the Bar that the appellant's AIDS status entitled her to a lesser sentence. He did not consider it necessary to request the magistrate prior to the hearing in the court below to supply reasons for the sentence imposed. Neither did the court below.

Finding

[16] In my view, the court below erred: first, in not considering that it was necessary to call on the magistrate to supply reasons for the sentence imposed; and, second, in failing to appreciate that, on the new issue raised, it did not have sufficient evidential material or an adequate notice of appeal before it.

[17] Whilst it is correct that any illness does not *per se* entitle a convicted person to escape imprisonment, the facts presented to us by the appellant and the issue raised before the court below comprise matter forming part of the totality of the circumstances of a convicted person that ought to be considered in order to do justice both to the person to be sentenced and to society. See *S v Berliner* 1967 (2) 193 (A) at 199F-G and *S v C* 1996 (2) SACR 503 (T) at 511g-h. This Court has for decades emphasised the importance of the individualisation of sentence. See in this regard *S v Blank* 1995 (1) SACR 62 (A) at 70f-71c.

[18] In *S v Cloete* 1995 (1) SACR 367 (W) and *S v C*, supra, it was held that a court, in considering an appropriate sentence, may take into account a convicted person's ill-health and how it

may relate to the effect of a contemplated sentence. Thus, for example, a particular sentence may be rendered more burdensome by reason of an offender's state of health.

[19] In respect of treatment that may or may not be available in particular prisons, an appropriate order - after an investigation of all the facts - may address the needs of the person to be sentenced.

[20] In the present case, where a pertinent issue was raised on appeal, it ought rightly to have been considered and explored further. Ideally the matter ought to be remitted to the magistrate for a reconsideration of the appropriate sentence. However, the circumstances in the present case are such as to warrant an expeditious decision. We have all the necessary facts at our disposal and given the history of the matter and the misdirections alluded to, we are at large in deciding an appropriate sentence.

[21] The appellant was arrested on 19 July 2000 and remained in custody until she was sentenced on 30 July 2001. She remained in prison until 24 November 2003 when she was released on bail pending the outcome of her appeal in the court below. The appellant thus spent slightly more than 40 months in detention. Having regard to all the factors referred to above, including the fact that the appellant may die soon, and considering the seriousness of the offence, the interests of the appellant and of society, I agree with the submission by counsel for the State and the appellant that further imprisonment is unwarranted. In my view, a sentence of imprisonment equal to the time spent in prison subsequent to the date on which the appellant had been sentenced by the magistrate is an appropriate one.

Remedy

[22] The following order is made:

The appeal is upheld. The sentence imposed by the trial court is set aside and the following sentence is substituted:

The accused is sentenced to imprisonment for a period of two years, three months and 25 days.

The substituted sentence is antedated to 30 July 2001.

[23] The effect of the substituted sentence is that the appellant is not to undergo any further period of imprisonment.

...

EN and Others v Government of the RSA and Others 2007 (1) BCLR 84 (SAHC Durban 2005)

The Durban High Court (South Africa) held that the Westville Correctional Centre must allow all HIV-positive prisoners who meet certain criteria to access antiretroviral treatment. This ruling is in accordance with South Africa's Constitution, the Correctional Services Act, the National Health Act, and the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment.

Excerpts

...

Facts

[1] The First to the Fifteenth Applicants were at the launch of these proceedings, all serving prison sentences in the Medium B Section at the Westville Correctional Centre (WCC). The Sixteenth Applicant is the Treatment Action Campaign (TAC), a duly registered section 21 not for profit company.

...

The Government of the Republic of South Africa, nominally cited as the First Respondent, is the umbrella body of the various National and Provincial Governments responsible for the health and care of incarcerated persons. The Second, Third, Fourth, Fifth and Sixth Respondents are all cited in their official capacities as representatives of those State departments.

The First to the Fifteenth Applicants act in their personal capacities as persons infected by the HIV/AIDS virus and also in the interest of all prisoners with HIV/AIDS who need or will need to access antiretroviral (ARV) treatment as fellow inmates at the WCC. They also, as the Sixteenth applicant does act in the public interest for the purposes of securing the effective enforcement on Constitutional rights. The Sixteenth Applicant also acts in the interest of its members who include persons with HIV/AIDS.

...

[4] The main relief claimed as set out in paragraphs 3, 4 and 5 of the Notice of Motion reads as follows:

3. That the respondents are hereby ordered with immediate effect to remove the restrictions that prevent the First to the Fifteenth Applicants, and any and all other similarly situated prisoners at Westville Correctional Centre, who meet the criteria as set out in the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, from accessing antiretroviral treatments at an accredited public health facility.

4. That the respondents be and are hereby ordered with immediate effect to provide antiretroviral treatment in accordance with the foresaid Operational Plan, to the First to Fifteenth Applicants, and any and all other similarly situated prisoners at Westville Correctional Centre, at an accredited public health facility; ...

Applicable law

[8] It is common cause that the Respondents are legally and constitutionally bound to provide adequate medical treatment to prisoners who need it.

Section 35(2)(e) of the Constitution provides:

Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision at State expense, of adequate accommodation, nutrition, reading material and medical treatment.

It is also common cause that the Applicants have a right to ARV treatment.

...

[13] It is not disputed that the Operational Plan was put in place by the Cabinet of the First Respondent on the 19th of November 2003 and contains a comprehensive strategy for the management of HIV/AIDS, the care and treatment of patients living with HIV described as a "National Pandemic." The Operational Plan recognises the critical role of ARV medicines in the treatment of the virus and the need to make it progressively available especially to those less fortunate than others in the private sector who can afford it and to whom it is readily available. Importantly, the Operational Plan acknowledges that patients with a CD 4 count of below 200 need to commence ARV treatment as well as those patients who present with certain particularly serious illnesses designated as World Health Organisation (WHO) Stage IV illnesses. In the case of the latter illnesses, ARV treatment should commence regardless of the CD 4 count. It is accepted that the lower the CD 4 count the higher the risk of AIDS and consequently more the urgency for treatment. It is further recognised that an important precondition before starting ARV treatment is a patient's readiness and commitment to adhere to the treatment over the long term. This assessment is tasked to the Multidisciplinary Team.

The National Antiretroviral Treatment 'Guidelines':

[14] The guideline was published by the National Department of Health in 2004 and deals, inter alia, with patient selection criteria and 'psycho-social considerations' which are expressly stated to be non-exclusionary criteria. It is to be noted that the only instance contemplated in the Guidelines where treatment will not commence is when a patient is found not to meet the readiness criteria. The suitability and readiness for the initiation of treatment is taken by a Multidisciplinary Team at the applicable ARV treatment centre. It is to be further noted that not all hospitals or clinics are accredited centres. Only those designated as such can initiate treatment. Relevant for present purposes is that the guidelines list the following criteria for ARV initiation in Adults, Adolescents and Pregnant Woman: CD 4 <200 cells/mm

irrespective of stage, or WHO stage IV AIDS defining illness, irrespective of CD 4 count, or Patient expresses willingness and readiness to take ARV adherently.

Multi-Disciplinary Team

[15] The Multi –Disciplinary Team as described by the Respondents is a team which consists of doctors, social workers, nutritionists, professional nurses et cetera. They assess social support of the patient and his readiness to take the ARV treatment. The first decision to treat the patient with ARV 's at an accredited site is taken by this team.

...

[21] The Respondents do not dispute their obligation both in terms of the Constitution and in terms of section 12 of the Correctional Services Act No 111 of 1998 –the relevant part of which reads as follows:

(1) The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every prisoner to lead a health life.

(2)(a) every prisoner has a right to adequate medical treatment.

...

(4)(a) every prisoner should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his health.

...

Section 21(2)(b)(iv) of the National Health Act 61 of 2003 provides:

The Director-General [of Health] must, in accordance with the national health policy, issue and promote health services for convicted persons awaiting trial ...

Application of law to facts

[18] ... My understanding of the relief claimed, and what the applicants seek to do, is to remove impediments and to fast track the procedures because it is a matter of urgency that the First to Fifteenth Applicants and other similarly situated prisoners be assessed for ARV treatment in accordance with the Operational Plan and Guidelines. ... My understanding is that what the applicants seek to do is to avoid unnecessary delays in treatment of prisoners because such delays, especially in the context of their incarceration and vulnerability, compromise their already serious health status, which ... are "*a matter of life and death*." Justification that the matter is a "life and death one" is to be seen from an examination of Dr Venter's evidence and annexure "AMG 19" attached to the founding affidavit which shows that the Applicants are seriously ill. All fifteen applicants have CD 4 cell counts of below 200. Eight have CD 4 cell counts of below 100 and of these, five Applicants have CD 4 cell counts of below 50.

[19] It is not disputed that Venter was one of a group of expert clinicians who contributed to the development of the ARV Treatment Guidelines for the public sector that was adopted by the Government in March 2004. He says that people with CD 4 counts of below 200 cells/ml are by definition severely ill and require immediate assessment for ARV treatment. He qualifies this by saying that this is not a rigid requirement and would depend on other circumstances of the particular patient, for example, whether the patient is showing symptoms of opportunistic infections and the CD 4 cell count. What he makes clear is that they need to be immediately assessed. He comes to the conclusion that if ARV medicines are not made available to offenders at WCC immediately, many of them will suffer irreparable harm and in all likelihood premature death.

...

[23] ...What is significant ... is that apart from the Fourteenth Applicant for whom some tests were done in June 2005, there is not a single mention of anything being done for any of the other Applicants, by reference to month or date between November 2004, March, April and August 2005 up to October 2005, when the ALP showed an interest in the matter, or until the 12th of April 2006 when this application was launched.

... It has always been, as I perceive it, that the Respondents have delayed without good cause in circumstances where life and

death mattered. The parties may not be too apart right now, but as I see it intervention by this Court is called to ensure that the Respondents urgently comply with their constitutional and statutory obligations not only to the first fifteen Applicants ... but also to similarly situated prisoners.

[27] ... Now, it does not seem to me that the steps taken by WCC are in the least bit adequate. The plan envisaged by them is patently unworkable unless other designated sites are accessed immediately. There is no commitment by the Respondents to adhere to any workable or rational time frames ... More pertinent to this application we hear of no commitment on the part of the Respondents committing themselves to time frames in respect of those other, similarly situated prisoners. There is a deafening silence on this issue. This is perhaps understandable because they deny that the fifteen Applicants have *locus standi* to represent other prisoners in a class action.

[29] I am acutely conscious, speaking from my own experience, that when sentencing a prisoner to a long term of imprisonment, that his prospects of emerging from prison alive is seriously compromised because of the HIV/AIDS pandemic. I believe that that thought would also engage most of my colleagues in this division ...

[30] ... In the context of the factual position about which much has already been said, I am in full agreement with the Applicants' contentions as articulated by their counsel in her heads of argument that the Respondents' implementation of the laws and policies is unreasonable in that:

(a) it is inflexible;

(b) it is characterised by unjustified and unexplained delay, and

(c) some of the steps taken by the Respondents after the institution of these proceedings, in particular the manner in which the appointments were set up, are irrational.

Finding

[31] ... On the facts of this case, I come to the conclusion that the treatment and medical care afforded to the First to the Fifteenth Applicants and other similarly situated prisoners at WCC is neither adequate nor reasonable in the circumstances. The Respondents have, I find, fallen short of their constitutional and legislative obligations to the Applicants. Had steps been taken as early as November 2004 in the case of one Applicant or in March, April or August 2005 in the case of the others, the current serious impasse could well have been avoided.

...

Remedy

[35] I accordingly make the following order:

1. That the Respondents are hereby ordered with immediate effect to remove the restrictions that prevent the First, Second, Third, Fifth, Sixth, Seventh, Ninth, Tenth, Eleventh, Twelfth and Fifteenth Applicants, and all other similarly situated prisoners at Westville Correctional Centre who meet the criteria as set out in the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa from accessing Anti-Retroviral Treatment at an accredited public health facility.

2. That the Respondents be and are hereby ordered with immediate effect to provide Anti-Retroviral Treatment in accordance with the aforesaid Operational Plan to the First, Second, Third, Fifth, Sixth, Seventh, Ninth, Tenth, Eleventh, Twelfth and Fifteenth Applicants and all other similarly situated prisoners at Westville Correctional Centre at an accredited public health facility;

...

The High Court (South Africa) set aside the Department of Correctional Services' decision not to release the applicant on medical parole. The Court held that further incarceration of the applicant, who was suffering from AIDS-related illnesses, would not serve any of the general purposes of imprisonment.

Excerpts

...

Facts

The applicant is 32 years of age. He was convicted in the Transvaal Provincial Division of the High Court, sitting in Pietersburg, on the following crimes and sentenced as follows:

Murder: Life imprisonment.
Assault with intent to do grievous bodily harm: Ten years' imprisonment.
Robbery: 15 years' imprisonment.
Theft: 15 years' imprisonment.
Possession of unlicensed firearm: Eight years' imprisonment.
Possession of ammunition: 15 years' imprisonment.

...

The applicant was sentenced on 20 March 2002. On 22 September 2003, the applicant was diagnosed as being HIV positive. And he was admitted at Baviaanspoort Maximum Correctional Centre, on 17 December 2004, after he had been transferred from the Kutama-Sinthumule Correctional Centre.

On 19 May 2005, his CD4 count was 189, on 9 September CD4 count was 143, indicating a decline, because on 10 November 2005, his CD4 count was 96. He states further that he was infected with tuberculosis and diarrhoea, and suffers from vomiting.

On 3 September 2005, his condition deteriorated, and as a result, he was admitted at the medium hospital, at Baviaanspoort. He had also complained of dizziness and lack of energy.

Chest x-rays and a CT scan was conducted, which identified a lesion in his lung. At the time of the launching of this application the applicant suffered severe pains and disabilities, as a result of which he is unable to bathe himself and get to the toilet by himself. He is wheel-chair bound.

He further avers that he does not receive proper medical care and adequate pain control system. He is unable to receive anti-retroviral treatment, alleging that same are not available in the prison. He cannot combine anti-retro viral with any tuberculosis treatment, because he has been informed that the side effects can be fatal.

On 5 October 2005, a medical parole board was constituted and it recommended that the applicant be placed on medical parole. The applicant has annexed to his founding papers, annexures SM1, SM2 and SM3, relating to his health, by a medical doctor and a chief professional nurse, respectively.

...

It details the deteriorating health of the applicant, and refers extensively to the various treatments given to the applicant and the comments of the doctors.

The applicant avers that it is quite clear, from annexure SM1 and SM2 and SM3, that he is dying. On 14 November 2005, his attorney of record had applied to the regional commissioner of correctional services, in Gauteng, through annexure SM8, on medical grounds, which application was declined despite the recommendations by a medical officer and the medical board.

He states that his release was declined because the commissioner wanted a second opinion which may be ready by 5 January 2006. He further avers, very interestingly, and importantly, on page fifty, paragraph 8.27 of the founding affidavit, by saying:

No second opinion is going to change the fact that I am currently dying of AIDS. And my health is steadily worsening,

and as of 10 November 2005, my CD count was 96. As previously stated, in May this year it was 189, in September 143, and in October 138.

...

Applicable laws

The Correctional Services Act 8 of 1959, section 69 thereof, and Act 111 of 1998, section 79, are to the same effect, and read as follows:

A prisoner serving any sentence in a prison:

(a) who suffers from dangerous infectious or contagious disease, or

(b) whose placement on parole is expedient on the grounds of his physical condition, or in the case of a woman, her advanced pregnancy, may at any time, on the recommendation of the medical officer, be placed on parole by the commission, provided that a prisoner sentenced to imprisonment for life, shall not be placed on parole, without the consent of the Minister.

Application of law to facts

... In these particular circumstances of the applicant, it is clear from all medical reports, the recommendations of the parole board, and the averments by the applicant, that he suffers from a terminal disease, which has no cure to date.

The physical condition of the applicant, is undoubtedly, what it is depicted to be, and it is expedient to qualify him to meet the requirements of placement, as this is also met by the recommendations of the medical officer.

Finding

In my view, there is nothing in the Act, which requires the first respondent, to base his decision on a second opinion, of any medical officer. For the purposes of the relevant section of the Act, the applicant is entitled to release on medical grounds. The applicant, in his own words, is dying of AIDS.

The purposes of punishment by imprisonment, or otherwise to a convicted person, are: 'Two deter, prevent, reform, and retribute the offender and would-be offenders'.

In the circumstances, one is at pains to ask the following: is the continued incarceration of the applicant serving any purpose in terms of imprisonment; if the applicant is released in terms of the Act, is he going to enjoy life at his home when in his own words, he is a spent-force? The answer is No. It is clear and lucid that the applicant has been convicted of very serious crimes, and that by law, he is required to serve his sentences lest a wrong message be sent out to the community, that when you are sick, you will be released to go home and continue to enjoy life, as if nothing had happened.

But this is not the case with the applicant. There is no good life for him outside prison when his health is deteriorating daily. 5 January 2006, may be too long a period to wait for the second opinion, of pending results. The sooner he leaves prison, in terms of the act, will serve him, his relatives and the community well. In this way the applicant will be accorded his right to security and control over his body (see section 12(2)(b) of the constitution).

The applicant has averred that he is dying of AIDS. To deny him a release under medical parole, is to deny him his dignity and respect, which he requires to enforce by being allowed to go home and complete his life there ...

...

It is my view, that refusing to release the applicant, who has complied with the requirements of the Act, amounts to an infringement of section 33(1) of the constitution.

Mercy is a hallmark of a civilised and democratic country. The applicant in the circumstances that he finds himself in, requires to be treated with mercy, within the precincts of the law.

Remedy

In conclusion, therefore, I find that the refusal to release the applicant on medical parole, is unjust, unlawful, unreasonable, and procedurally unfair

...

D4.4 HIV, AIDS and family law

***Midwa v Midwa* 2000 (2) EA 453 (CAK 2000)**

The Court of Appeal of Kenya stayed an execution order of the Superior Court that would have encouraged the stigmatisation of, and discrimination against, people living with HIV.

Excerpts

...

[1] This is an application under Rule 5(2)(b) of the Court of Appeal Rules seeking an order for a stay of execution of the order of the superior court (Rawal J) dated 6 June 2000, by which order the applicant, the wife in the petition, was expelled from the matrimonial home and consigned into the servants quarter euphemistically labelled an outhouse pending the hearing and determination of the intended appeal.

[2] Though this is a peculiar case and one of its rare kind to reach this Court, we are somehow perturbed by the manner in which the learned Judge approached it. In the process she ignored the medical condition of the wife and the tender age of the children of the marriage and consequently made certain orders which plainly cry loudly for justice.

[3] The parties are husband and wife. They solemnised their marriage under the African Christian Marriage and Divorce Act at the All Saints' Cathedral, Nairobi, on 10 February 1990. The husband works with Total Kenya Ltd while the wife is an officer with the National Bank of Kenya. They are blessed with two sons, now aged 7 and 10. The marriage appears to have been reasonably happy until in or about December 1996 when the wife tested HIV positive. The medical status of the husband has so far not been revealed.

[4] On 24 January 2000, the husband petitioned for divorce on the grounds of cruelty; the particulars thereof being given as that the wife having tested HIV positive was endangering the life of the husband.

...

[5] Under the Matrimonial Causes Act (Chapter 152) Laws of Kenya only impotence, insanity and infectious venereal diseases are recognised as grounds of petition for divorce and for decree of nullity.

[6] Ms Abida Ali for the wife, submits that the servants quarter is unfurnished, unpainted and incomplete. It has only a simple bed and a cooker. The wife is denied access and enjoyment of the matrimonial home and yet her salary is deducted every month in payment of the mortgage taken for its construction. She contended that it was totally unjustified for the learned Judge to confine the wife there in her present predicament.

[7] As for the children, Ms Ali argues that there do not exist any exceptional circumstances so as to justify giving their custody to the father. She contended that to separate them from their mother will make them suffer psychologically and emotionally thereby causing them irreparable loss and damage.

[8] We have no hesitation in holding that the intended appeal is arguable and not frivolous. The ruling of the learned Judge, on its face, smacks of insensitivity and total inconsideration of the facts presented before her. It is not denied that the wife is 50 per cent holder of the entire property and that her salary services the mortgage. It is traumatising and dehumanising to order her to live in the servants quarter of her own house. We agree with Ms Ali that in such conditions her health is likely to be adversely affected.

[9] It is trite law that, *prima facie*, other things being equal, children of tender age should be with their mother, and where a court gives the custody of a child of tender age to the father it is incumbent on it to make sure that there really are sufficient reasons to exclude the *prima facie* rule. See *Re S* (an infant)

[1958] 1 All ER 783 at 786 and 787 and *Karanu v Karanu* [1975] EA 18. The learned Judge, in our view, did not correctly direct herself on the principle that in cases of custody of the children the paramount consideration is their welfare. Moreover, as the record shows, there were no exceptional circumstances shown to justify depriving the mother of her natural right to have her children with her.

[10] The husband in countering the application maintains that he cannot live together with his wife under the same roof as she poses a grave risk to his life. We sympathise. The wife is still working and servicing the mortgage. She avers that she is still strong and healthy despite the fact that she was diagnosed HIV positive about five years ago. Until the Court decrees otherwise the husband should not desert his wife. Presently it would be morally wrong.

[11] If anything is done to upset and alter the state of health of the wife, substantial harm may be occasioned and the intended appeal will be rendered nugatory.

[12] We allow the application and grant a stay of execution. We order that the wife be put back in the matrimonial home forthwith. ...

***Dindi v Dindi and Kamaloni* (2004) Supreme Court of Zambia**

This case deals with property rights and HIV. The appellant is married to the first respondent in a polygamous marriage. The respondent accommodated all his wives in separate homes on a property to which he had a title. In 1997, the respondent was diagnosed HIV positive and was put on antiretroviral drugs. To supplement his income, he sold three of his vehicles and disclosed his illness to his six wives. At a later stage he was not able to sustain buying the necessary drugs and decided to sell the house. The other wives agreed but the appellant was against the idea of selling the house. Despite her opposition, the respondent sold the house to the second respondent and made arrangements for his family to move to a flat he had rented. The appellant lodged a caveat on the property claiming an estate or interest as beneficiary of the plot. This created problems for the second respondent from registering the contract of sale and obtaining title deeds. In 2002, the second respondent lodged a case against the first respondent claiming vacant possession of the property she had bought through her father. She obtained a judgement in her favour and a writ of possession was issued. The appellant issued ex-parte summons to stay execution of writ of possession but it was discharged. The appellant then appealed to a judge in the High Court in Chambers. The judge at the High Court upheld the Deputy Registrar's decision in dismissing the appellant's summons for stay execution of possession.

Excerpts

...

We have carefully considered the facts and submissions made before us. The case brings to the fore a serious test of the vows at marriage: "for better for worse", "in sickness and in health" et cetera. We recognise that the marriage was contracted under Tonga Customary law. The marriage is still existing. The property in question is registered in the first respondent's name and is the owner. There is no evidence that the appellant contributed to its construction ... For the sketch plan, one would see that this was "Dindi" Compound. No authority to subdivide was obtained ...

A beneficiary owner, according to Osborn's Concise Law Dictionary, is a person who enjoys or who is entitled to the benefit of the property. So as a beneficiary, the appellant must prove that the property is held by trustees or in Trust. From the undisputed facts, the property in question is a matrimonial home so that any act affecting this property as to the dealings of the property between the appellant and the first respondent is a matrimonial matter and as such it has to be dealt with as provided under section 11(1) of the High Court, Cap 27 to this extent, we agree with Counsel for the appellant that the law applicable in

Zambia has to be in substantial conformity with the law and practice for the time being in force in England. But this is not the end of the matter. The appellant has to show special or peculiar interest of her own in the matrimonial property.

For the appellant, on her behalf, it has been argued that the first respondent had intended by December 1991 to subdivide the property and share it amongst his wives. This, it has been submitted, was a clear intention to dispose the property as a gift to the appellant. There is no evidence or suggestion that she in anyway contributed to the purchase or construction of this matrimonial home. It is the court's duty to determine whether the conduct of the parties clearly showed there was intent to dispose interest of the property to the appellant. The case of *Burns v Burns* is very instructive in ascertaining the intention of the parties... On the facts of the case, the court ruled that the appellant had not established her interest. In the present case, we are being asked to infer from the first respondents conduct of writing to the Livingstone District Council for permission to subdivide as a clear intention that he wanted to pass on the benefit to the appellant. This is not enough. The application was made in December 1991 and nothing happened. The appellant herself did nothing until March 2001 when the first respondent was not in a state of "health" but "sickness" that the appellant wanted to claim her right. We think it is a heartless move. She can not stand by her sick husband and consent to the sale of the house to enable him buy life prolonging drugs as her friends have done. She instead surreptitiously lodged a Caveat on the property on which she has spent nothing. We are satisfied that even under the English Law she has not established any right so as to amount to be a beneficial owner. On the facts of this case, we are satisfied that the learned appellant judge correctly held that the appellant had no right over the property.

Remedy

This appeal is dismissed. It follows that the stay of execution of writ of possession falls away. The Registrar of Lands and Deeds is ordered to cancel the caveat to allow the second respondent get her title deeds.

...

D4.5 HIV and confidentiality

Van Vuuren and Another NNO v Kruger 1993 (4) SA 842 (SAA)

The plaintiff alleged that his right to privacy was violated when a medical practitioner disclosed his HIV-positive status to a colleague. In its decision, the South African Appellate Division (the predecessor of the Supreme Court of Appeal) emphasised the importance of doctor-patient confidentiality and considered that the stress caused by the disclosure could have hastened the onset of AIDS for the plaintiff.

Excerpts

...

Introduction

This is an appeal against a judgment of Levy AJ in the Witwatersrand Local Division in which he dismissed a claim for damages for the alleged breach of the plaintiff's right to privacy. The appellants are the executors of the estate of the plaintiff, Mr McGeary, who died, during the course of the trial, of an AIDS-related disease. The respondent, a general medical practitioner of Brakpan, was the first defendant. The second defendant was the owner of a medical testing laboratory in the same town, but the claim against him was withdrawn shortly before the trial.

...

Facts

The factual background to the plaintiff's claim can be shortly summarised. He lived in a homosexual relationship with one Van Vuuren in Brakpan. It appears that they were fairly well-known residents of that town and that the nature of their relationship was either generally known or surmised. During the beginning of 1990 they began a business venture in and moved to Nylstroom. They had, however, retained some links with Brakpan. During that period the plaintiff applied for life insurance cover from Liberty Life Insurance Company. The company required a medical report, including a report on the plaintiff's HIV status (ie whether the plaintiff was infected with the human immunodeficiency virus). The first defendant had been the plaintiff's general medical practitioner since 1983 and the plaintiff nominated him to prepare the medical report. For purposes of an HIV blood test a sample was drawn on 27 March 1990 at the second defendant's laboratory. The result was positive and the second defendant informed the first defendant accordingly. The first defendant in consequence arranged an appointment with the plaintiff in order to consult with him on the outcome. That took place on 10 April 1990. The plaintiff was extremely upset and distressed. He was also concerned about a possible leak and raised the issue with the first defendant, who promised to respect his wish to keep it confidential. The following day during the course of a game of golf with Dr Van Heerden, also a general medical practitioner, and Dr Vos, a dentist, the first defendant disclosed the plaintiff's condition to them. The plaintiff and these three doctors moved in the same social circle in Brakpan; the plaintiff was engaged in business venture with Van Heerden's wife; Vos had in the past been the plaintiff's dentist; and the first defendant's ex-wife and her parents were on friendly terms with Van Vuuren. Van Heerden, in due course, informed his wife. Whether Vos informed his was not established in evidence, but all assumed that he had. The news spread and the plaintiff became aware of this fact.

...

The plaintiff ... instituted proceedings against the two defendants in October 1990 ...

The plaintiff's case against the first defendant was pleaded in these terms: the first defendant had been his general medical practitioner; in consequence he owed him a duty of confidentiality regarding any knowledge of the plaintiff's medical and physical condition which might have come to his notice; he became aware of the plaintiff's HIV status; it was a term of the agreement which established the doctor-patient relationship that the first defendant and his staff would treat this information in a professional and confidential manner; in breach of the agreement and in breach of his professional duties the first defendant 'wrongfully and unlawfully' disclosed the test results to third parties; in consequence the plaintiff had suffered an invasion of, and had been injured in, his rights of personality and his right to privacy. Sentimental (ie non-pecuniary) damages of R50 000 were initially claimed, but the amount was increased to R250 000 during the course of the trial.

...

Applicable law

As far as the public disclosure of private medical facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2 370 years ago, is still in use. It requires of the medical practitioner 'to keep silence' about information acquired in his professional capacity relating to a patient, 'counting such things to be as sacred secrets'.

...

According to the rules of the SA Medical and Dental Council ('the Council') it amounts to unprofessional conduct to reveal 'any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient' ...

The reason for the rule is twofold. On the one hand it protects the privacy of the patient. On the other it performs a public interest function. This was recognised in *X v Y and Others* [1988] ... where Rose J said:

In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients "will not come forward if doctors are going to squeal on them".

Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care ...

A similar view was expressed by the Supreme Court of New Jersey in *Hague v Williams* [1962] ...

A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled.

The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law ... As far as present-day law is concerned, the legal nature of the duty is accepted as axiomatic ... However, the right of the patient and the duty of the doctor are not absolute but relative ... One is, as always, weighing up conflicting interests and ... a doctor may be justified in disclosing his knowledge 'where his obligations to society would be of greater weight than his obligations to the individual' because '(t)he action of injury is one which *pro publica utilitate exercetur*' ...

Application of law to facts

The objective facts that are of relevance in assessing whether the disclosure was justified, are these:

1. The HIV-infection and AIDS-related illnesses are considered by many to be the major health threat of our day. In a paper by the head of the AIDS Centre at the SA Institute for Medical Research, Mrs Christie (who testified for the plaintiff) gave the following graphic description:

'It is a modern day scourge which has already claimed the lives of thousands of people worldwide. The World Health Organisation estimates that between five to ten million people are infected with the AIDS virus and that there will be an exponential increase in the number of AIDS cases in the next few years. In the absence of a cure or vaccine, the only way to stop the spread of this deadly disease is by prevention of infection in the first place. This is clearly the task of education which is the only current tool available to combat the AIDS epidemic.

Although the concept of "education for prevention" is not new, it takes on special significance in the context of AIDS. For one thing, there is widespread ignorance and subsequent fear of the disease. The public is afraid of AIDS and the media has also helped to reinforce existing fear through sensationalist and sometimes inaccurate coverage on the topic. This is largely detrimental to society because it is a well-documented psychological fact that fear arousal is not conducive to learning or promoting behavioural change. In fact, fear elicits denial so that people tend to block out what they hear or see. Another difficulty in promoting socially responsible behaviour is that AIDS deals with so many taboo subjects, including: sex, blood, death, promiscuity, prostitution, abortion, homosexuality, drug use, et cetera. These taboos makes AIDS an uncomfortable subject to deal with and creates impediments in the learning process.'

...

3. Even though the virus is highly infective, it is far less infectious than many other common viruses and can only be transmitted through exchange of certain body fluids, viz semen, vaginal fluids and blood. The mode of spread of the infection generally follows well-defined routes, namely unprotected sexual intercourse, the injection of infected blood, the infection of an unborn foetus whilst in the womb and, in exceptional cases, the infection of a newborn baby through the medium of breast milk.

4. Not a single case of occupationally acquired HIV has been confirmed in South Africa. Although health care workers are therefore at risk, the risk is small and arises only if through an invasive procedure infected blood enters the worker's blood stream.

5. There are many pathogens that are more infectious than HIV, such as hepatitis B, and a medical practitioner must, in the course of his ordinary practice, take steps to prevent their spread. Some of them are usually sufficient to prevent the spread of HIV in a professional context.

6. There is a reported instance in the USA of a dentist who infected one or more of his patients but that was through the use of instruments which he had used on himself in somewhat extraordinary circumstances. But his own HIV-infection was not occupationally acquired.

7. Reference has already been made to the Council's rule 16 which is of general application. In addition, the Council formulated a guideline in 1989 ... in connection with HIV in these terms:

The health care professions are fully aware of the general rules governing confidentiality. Council is confident that if doctors fully discuss with patients the need for other health care professionals to know of their condition, in order to offer them optimal treatment and also to take precautions when dealing with them, the reasonable person of sound mind will not withhold his consent regarding divulgence to other health care workers. If having considered the matter carefully in the light of such counselling, the patient still refuses to have other health care workers informed, the patient should be told that the doctor is duty bound to divulge this information to other health care workers concerned with the patient. All persons receiving such information must of course consider themselves under the same general obligation of confidentiality as the doctor principally responsible for the patient's care.

If it were found that an act or omission on the part of a medical practitioner or dentist had led to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the practitioner concerned.

An important aspect of it is that the patient has to be informed of the doctor's obligation to make a disclosure. That gives the patient the opportunity to say why it is in fact not necessary - something that the plaintiff was denied. The first defendant not only did not seek to obtain the plaintiff's consent to a disclosure; to the contrary, he promised not to divulge the information.

...

10. There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others, which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

11. Section 45 of the Health Act 63 of 1977 empowered the Minister of Health to declare any medical condition to be a notifiable medical condition, presumably in order to promote public health. Diseases that have been declared in terms of this provision include cholera, leprosy, malaria, measles, poliomyelitis, tuberculosis and viral hepatitis. HIV-infection or AIDS-related diseases are, on the other hand, not notifiable diseases.

12. Dr Van Heerden had treated the plaintiff once only. That was in January 1990, during the first defendant's absence. He diagnosed, as mentioned, an oral fungal infection. It was a minor problem which, he said, would normally respond promptly to appropriate treatment. There was no evidence of an intrusive procedure having been performed or of any risk having been created.

13. The plaintiff had consulted Dr Vos in his professional capacity prior to and during September 1987 but not since. There is no evidence of the nature of any procedure carried out by Vos on the plaintiff, whether of a risky nature or not.

...

In determining whether the first defendant had a social or moral duty to make the disclosure and whether Van Heerden and Vos had a reciprocal social or moral right to receive it, the standard of the reasonable man applies. With that in mind, I am of the view that he had no such duty to transfer, nor did Van Heerden and Vos have the right to receive, the information.

At the risk of repetition, and in summary, I see the matter in this light: AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even more pronounced because of the express undertaking by the first defendant. Vos and Van Heerden had not, objectively speaking, been at risk and there was no reason to assume that they had to fear a prospective exposure. As Levy AJ stated, the real danger to the practitioner lies with the patient whose HIV condition had not been established or (due to the incubation period) cannot yet be determined ...

Finding

...

In consequence I conclude that the communication to Vos and Van Heerden was unreasonable and therefore unjustified and wrongful.

Remedy

...

[T]he right of privacy is a valuable right and the award must reflect that fact. Aggravating factors include the fact that a professional relationship was abused notwithstanding an express undertaking to the contrary. So, too, the breach created the risk of further dissemination by others. The evidence also established that the publication of a person's HIV condition increases mental stress and that the plaintiff was seriously distressed by the disclosure. And stress hastens the onset of AIDS - something which may have occurred in this instance. On the other hand, the disclosure was limited to two medical men who, it was reasonable to assume, would have dealt with the information with some circumspection. The nature of the plaintiff's condition was in any event such that it would inevitably have become known at some stage. He had, to an extent, already severed his links with Brakpan. There is no evidence that his friends ostracised or avoided him; it was rather a case of his having chosen to withdraw from society, something he would probably in any event have done. In the light of all this I believe that R5 000 will be a just award.

NM and Others v Smith and Others (Freedom of Expression Institute as Amicus Curiae) 2007 (5) SA 250 (CC)

The names of three women living with HIV were published in a book without their consent. According to the South African Constitutional Court, this disclosure violated the women's constitutional rights to privacy and dignity and infringed on their right to keep their HIV status confidential.

Excerpts

...

Introduction

[1] In March 2002 a biography of Ms Patricia de Lille entitled *Patricia de Lille* and authored by Ms Charlene Smith was published by New Africa Books (Pty) Ltd. The names of three women who are HIV positive were disclosed. They alleged that their names had been published in the book without their prior consent having been obtained. The three women claimed that their rights to privacy, dignity and psychological integrity had been violated. A sequel to that publication was an action for damages in the Johannesburg High Court. The High Court dismissed with costs the action against Ms Smith and Ms de Lille.

[2] This is an application for leave to appeal against the judgment and order of Schwartzman J in the High Court which was handed down on 13 May 2005 and an amended costs order handed down on 19 May 2005.

...

Facts

[4] The first to third applicants are NM, SM and LH respectively. They are unemployed, adult women who live in informal settlements in and around Atteridgeville, Pretoria. Their identities are undisclosed as they are HIV positive and wish to prevent further publication of their identities and HIV status.

...

[6] In August 1999, Dr Marietta Botes, head of the Immunology Clinic in the Medical Faculty of the University of Pretoria (the University), recruited volunteers to participate in clinical trials, known as the FTC 302 trials, directed at determining the efficiency of a combination of drugs that could decrease a patient's HIV level. The volunteers, including the applicants, were required to sign a consent form indicating that they had been informed of the nature, benefits, side effects and the risks of the clinical trials. The trials were conducted at the Kalafong Hospital, Pretoria and ended in 2001.

...

[8] Soon after the start of the clinical trials, concerns were raised by the participants, including the applicants, regarding illnesses and fatalities on the trials. The gravity of the complaints was noted. On 5 April 2000, the Minister of Health made a statement to Parliament regarding the effects of the drugs and called for a report from the Medicines Control Council, which found that a causal association between the drugs and the deaths was probable. As a consequence the Medicines Control Council halted any further recruitment of study projects while full reports were being compiled on all the serious adverse effects, including the deaths.

...

[10] On 28 March 2000, the second respondent met with members of the support group. The participants complained that, amongst others, the consent form was never properly explained to them and that Dr Botes was unsympathetic to complaints about the side effects of the drugs, which she attributed to the disease and not to the drugs themselves.

...

[15] In the period September to November 2001 Ms Charlene Smith (the first respondent) was commissioned by the publisher to write a biography of Ms de Lille. The book was to include a chapter on Ms de Lille's work in campaigning for the rights of those living with HIV. During the trial, Ms Smith stated that although she had the Strauss Report, she did not have the annexures to it which contained the terms of the consent forms signed by the applicants. The consent forms did not permit full public disclosure of the identity of the three applicants and the fact that they are living with HIV, but only permitted limited disclosure for the purposes of the University's investigation. She stated that there was nothing in the report nor in the covering letter sent to Ms de Lille that suggested the report was confidential and pointed to the fact that the report had been circulated to two journalists. She confirmed in evidence that she knew that the annexures contained the terms of the consents of the three applicants. She also acknowledged that she knew that media ethics would require her ordinarily not to disclose a person's HIV/AIDS status without his consent. She also stated that she had tried to obtain the annexures to the report from Professor Grove, but that he did not return her calls and she gave up trying to obtain the annexures. She also stated that though she originally made attempts to meet the three women, she did not succeed in these attempts either.

...

[19] Approximately six months after the application for the interdict, the applicants sued the respondents for damages. They claimed: (a) a private apology from the respondents; (b) the removal or excision of their names from all unsold copies of the book; (c) payment by the respondents of the sum of R200 000 to each of the applicants, and (d) costs of suit. A pre-trial conference was held on 4 February 2005, but it appears that nothing was resolved there. The trial commenced before the High Court. The applicants applied for and obtained an order to

prevent the disclosure of their identities. Judgment was given on 13 May 2005. The applicants appealed to the High Court for leave to appeal to the Supreme Court of Appeal.

[20] On 22 August 2005, the High Court refused leave to appeal to the Supreme Court of Appeal. On 29 November 2005, the Supreme Court of Appeal dismissed with costs an application for leave to appeal without giving reasons.

...

[23] In their plea and in the trial the respondents admitted publication of the names and HIV status of the applicants but denied that the publication was intentional or negligent. More specifically, they pleaded that the HIV status of the applicants was not a private fact at the time of the publication of the book. Furthermore, the respondents pleaded that the publication of the HIV status of the applicants was not unlawful because earlier the applicants had given their consent to their names being included in the Strauss Report which was undertaken at the instance of the University.

[24] In the alternative the respondents pleaded that it was reasonable for any reader of the Strauss Report to assume that the necessary consent had been obtained since nothing in the report indicated that it was confidential. There was accordingly no malice on the part of the respondents in publishing the names of the applicants and their HIV status. The publication of the names would give authenticity to the book.

...

[26] The applicants did not accept the offer within the time stipulated in the rules and so the trial proceeded as scheduled and lasted for some 10 days. Judgment followed shortly thereafter, and the matter was decided partly in favour of the applicants and partly in favour of the respondents. It is against that judgment that the applicants now approach this Court on appeal, an earlier appeal to the Supreme Court of Appeal having been dismissed without reasons being furnished.

Application of law to facts

[29] The applicants approached this Court with the view to vindicate their constitutional rights to privacy, dignity and psychological integrity which, they allege, have been violated by the respondents. Their claim is, however, based on the *actio iniuriarum* and, therefore, falls to be determined in terms of the *actio iniuriarum*.

...

[33] Privacy encompasses the right of a person to live his life as he pleases. In *Bernstein and Others v Bester NNO and Others* this Court stated:

A very high level of protection is given to the individual's intimate personal sphere of life and the maintenance of its basic preconditions and there is a final untouchable sphere of human freedom that is beyond interference from any public authority. So much so that, in regard to this most intimate core of privacy, no justifiable limitation thereof can take place. But this most intimate core is narrowly construed. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere; the individual's activities then acquire a social dimension and the right of privacy in this context becomes subject to limitation.

[34] Private facts have been defined as those matters the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private.

...

[39] In my view, when they made their application for the interdict in their names, they were not thereby saying their names should be published in a book having a wide circulation throughout South Africa, which would be the position since the second applicant is a national figure. Similarly by attending the various inquiries they were not giving blanket consent to the publication of their status.

[41] Individuals value the privacy of confidential medical information because of the vast number of people who could have access to the information and the potential harmful effects

that may result from disclosure. The lack of respect for private medical information and its subsequent disclosure may result in fear jeopardising an individual's right to make certain fundamental choices that he has a right to make. There is therefore a strong privacy interest in maintaining confidentiality.

[43] As a result, it is imperative and necessary that all private and confidential medical information should receive protection against unauthorised disclosure. The involved parties should weigh the need for access against the privacy interest in every instance and not only when there is an implication of another fundamental right, in this case the right to freedom of expression.

[44] The assumption that others are allowed access to private medical information once it has left the hands of authorised physicians and other personnel involved in the facilitation of medical care, is fundamentally flawed. It fails to take into account an individual's desire to control information about him or herself and to keep it confidential from others. It does not follow that an individual automatically consents to or expects the release of information to others outside the administration of health care. As appears from what has gone on before there is nothing on the record to suggest that the applicants' HIV status had become a matter of public knowledge.

...

[46] The High Court held that the first and second respondent were not liable for any damage suffered at the time of publication of the book. I disagree with this finding of the High Court. The first respondent did not sufficiently pursue her efforts to establish if the necessary consents had been obtained, despite having ample time to do so. More importantly she could have used pseudonyms instead of the real names of the applicants. The use of pseudonyms would not have rendered the book less authentic. The same position applies to the second respondent.

[47] I am, therefore, persuaded that the publication by the respondents of the HIV status of the applicants' constituted a wrongful publication of a private fact and so the applicants' right to privacy was breached by the respondents. The need for access to medical information must also serve a compelling public interest.

Dignity

[47] It is trite that the *actio iniuriarum* under the common law protects both dignity and privacy under the concept of dignitas. There is nothing shameful about suffering from HIV/AIDS. HIV is a disease like any other; however the social construction and stigma associated with the disease make fear, ignorance and discrimination the key pillars that continue to hinder progress in its prevention and treatment. These pessimistic perceptions persist to fuel prejudice towards people living with HIV. Living with HIV should not be viewed as a violation of one's dignity. Rather, an acceptance that HIV/AIDS should be treated like any other disease would help to destigmatise negative perceptions and pave the right channels to encourage positive change in the lives of those afflicted with HIV/AIDS, as well as in the treatment of the disease. It is, however, an affront to the infected person's dignity for another person to disclose details about that other person's HIV status or any other private medical information without his consent.

...

[50] If human dignity is regarded as foundational in our Constitution, a corollary thereto must be that it must be jealously guarded and protected ...

[51] In *S v Makwanyane and Another* this Court observed as follows:

Respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution.

...

[53] The indignity experienced by the applicants as a result of the disclosure of their names, seems to have been treated lightly by

the court a quo. The case of the applicants was reduced to a malady that had befallen 'lesser men or women'. They were regarded as poor, uneducated, coming from an insignificant informal settlement and their plight disclosed in the book was not likely to spread far beyond the community where they resided. There was, in my view, a total disregard for the circumstances of the applicants and the fact that because of their disadvantaged circumstances their case should have been treated with more than ordinary sensitivity.

[54] I therefore conclude that by the disclosure of the applicants' HIV status the respondents violated the dignity and the psychological integrity of the applicants and that nowhere can it be shown that the disclosure was in the public interest.

...

[64] Looking at the aforesaid conduct of the respondents and despite their denial of having acted *animo iniuriandi* and their further contention that they acted reasonably, I am satisfied that the respondents were certainly aware that the applicants had not given their consent or at least foresaw the possibility that the consent had not been given to the disclosure. As seasoned campaigners in the field of HIV/AIDS the respondents knew well of the wrongfulness of their conduct and that the disclosure of private facts was likely to invade the privacy rights of the applicants.

[65] I can come to no other conclusion but that the respondents have not rebutted the presumption that the disclosure of private facts was done with the intention to harm the applicants. Therefore the respondents had the requisite *animus iniuriandi*. Their position is exacerbated by their attitude that they wanted the book to have authenticity and credibility by publishing the names of the applicants. The defence of the respondents must accordingly fail.

Freedom of expression

[67] It was suggested by the respondents and the amicus that if the media were to be held liable for negligent disclosure of private facts they would have an additional burden which would frustrate the right of freedom of expression. The amicus contended that it was neither necessary nor desirable for the common law to be developed to include negligence as a ground of fault under the *animus iniuriarum*. It submitted that such an approach would unjustifiably limit the ambit of the right of freedom of expression and would have a 'chilling effect' on the freedom of expression in South Africa.

...

[69] In light of the fact that this judgment is not extending the common law definition of intention to include negligence in relation to the publication of private medical facts, there will be no 'chilling effect' on freedom of expression in South Africa and there is no need to pursue this issue any further.

Assessment of quantum of damages

...

[77] In assessing damages courts have in the past considered a range of factors arising from the circumstances and facts of the case: the nature and extent of the invasion or violation of privacy; malice on the part of the respondent; rank or social standing of the parties; the absence or nature of the apology; the nature and extent of the publication; and the general conduct of the respondent. The greater the violation of the privacy, the greater the need to protect the applicants and the greater the award of damages.

...

[81] The respondents clearly violated the dignity and privacy enjoyed by the applicants and are therefore liable to compensate the applicants in damages. Due to the gravity of the violations, I would consider a higher award reasonable in these circumstances.

[82] Accordingly, I consider a fair assessment of the damage suffered by the applicants at R35 000 for each applicant.

...

Order

[90] In the circumstances I make the following order:

1. The application for leave to appeal is granted;
2. The order in the court a quo is set aside;
3. The following order is made:

The respondents shall pay to each applicant the sum of R35 000 inclusive of the amount of damages awarded against the third defendant in the High Court as compensation for damage jointly and severally;

...

The names of the applicants shall be deleted from all unsold copies of the book *Patricia de Lille* by Charlene Smith;

...

D4.6 HIV and testing

C v Minister of Correctional Services 1996 (4) SA 292 (T)

The High Court (South Africa) found that the Johannesburg Prison did not comply with the national strategy regulating HIV and AIDS in prisons. The prison's deviation from the norm of informed consent and the lack of pre-test counselling led the court to award damages to the plaintiff.

Excerpts

...

Facts

During September 1993, and while the plaintiff was a prisoner in the custody of the defendant at the Johannesburg Prison, a blood sample was taken from the plaintiff which was later subjected to a test for the HIV virus. On the day in question the plaintiff was a member of a group of prisoners standing in a row in a passage in a hospital when he had been informed, together with the other prisoners, by K, a sergeant in the Department of Correctional Services employed as a medical health aid and as a nurse, that the blood test was for HIV and other transmissible sexual illnesses and that he had the right to refuse to undergo the test. This information was repeated to the plaintiff by K in the closed consulting room where the blood was taken, and in the presence of W, a prisoner assisting K with the drawing of blood. The plaintiff was accordingly fully aware that the test was, *inter alia*, for the HIV virus and that he had the right to refuse to be tested when he consented to undergo the test. The Department of Correctional Services had adopted the concept that informed consent was a prerequisite for testing prisoners and had specified what norms were applicable. This informed-consent policy as determined by the department had already been in operation by March 1993. In terms of those norms prisoners who had been involved in high-risk behaviour (prior to imprisonment the plaintiff had been involved in homosexual relationships which placed him in the high-risk category) had to receive pre- and post-test counselling by a competent member and the prisoner's informed consent had to be obtained prior to the HIV test being administered.

Pre-test counselling entailed informing the prisoner of the meaning of HIV infection; the manner of transmission of the disease; the nature of the test and that consent was required; the social, psychological and legal implications of the test; what was expected if the result of the test proved positive; and the prisoner had to be granted time to consider the information before consenting to the test being administered. In the event of a positive blood test post-test counselling required that psychologists, social workers and nursing staff be at hand to support the prisoner and to provide advice so that the result could be accepted. At the time that K took the blood sample of the plaintiff for the HIV test he had been unaware of the norm of

informed consent adopted by his department. The plaintiff, who was subsequently advised that he had tested positive for HIV, instituted an action for damages in a Provincial Division against the defendant on the grounds of alleged wrongful invasion of his right to privacy.

Applicable law

...

Members of the medical profession and others who have studied and worked with people who have tested HIV positive and with AIDS sufferers have developed a norm or recommended minimum requirement necessary for informed consent in respect of a person who may undergo such a blood test. Because of the devastation which a positive result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive result. These requirements have become almost universal in the Republic of South Africa.

...

[T]he Department of Correctional Services has itself adopted the concept that informed consent is a prerequisite for testing prisoners and has specified what the norms are. They are in accord with the views and suggestions of all major contributors in this country. The official brochure and policy of the defendant's department is set out in a document appearing in the bundle bearing the title: 'Management Strategy: AIDS in Prisons.'

Paragraph 2.2 reads as follows:

Possible HIV infected persons: Once a person has been exposed to HIV (by high-risk behaviour) he can contract the HIV infection. For a period of three weeks to six months, blood tests can be negative and this person will show no signs or symptoms of the disease. This is known as the window period. During this period an infected person can pass on the virus to another person. For this reason the person is considered to be HIV infected and must be treated in the same manner as a positive HIV infected person.

Paragraph 5 provides:

Pre- and post-test counselling to prisoners who are or were involved in high-risk behaviour prior to admission:

All individuals who are identified as being involved in high-risk behaviour should be counselled. Pre- and post-test counselling is of the utmost importance and should be done by a competent member (see Counselling to Prisoners point 14).

Informed consent must be obtained from a prisoner prior to an HIV antibody test being administered. If the prisoner refuses permission for the tests to be done, it must be brought under (*sic*) the attention of the medical officer.

The relevant paragraph, or as it is here called 'point 14', reads as follows:

14. Counselling to Prisoners

14.1 Pre-test: potentially HIV infected persons

A prisoner may experience anxiety if he believes he may be HIV infected. The purpose of pre-test counselling is to ensure that the prisoner is aware of: what HIV infection means, and is prepared for the progress of the infection; the manner of transmission of the disease and that high-risk behaviour must be avoided; the nature of the test and that his consent is required before the test can be administered; the social, psychological and legal implications of the test; and what is to be expected should the result of the test prove positive.

- The prisoner must be persuaded to avoid high-risk behaviour should the test be negative. The prisoner must also receive information to avoid the spreading of the disease if he is HIV infected.

- With the above information the prisoner could more readily give his permission for the test to be administered. However, the prisoner must be granted time to consider the information before he gives his permission for the test to be administered.

- Should the blood tests return a positive result the prisoner may be less shocked if he received pre-test counselling.

14.2 Post-test counselling: negative blood test result

Should the blood test return a negative result, the prisoner will most likely feel relieved and happy. This is a crucial time during which to inform the prisoner:

- that he must understand that prior to the test he was engaged in high-risk behaviour, and that his behaviour has to change;

- that a second test will have to be administered after three months to ensure that the result remains negative. The virus can be inactive for three months while tests are negative. This is known as the window period. During this time spreading of the infection can take place while the infected person is not aware of his infection.

- That he may need the help of a psychologist or social worker to help him/her to change his behaviour.

14.3 Post-test counselling: positive blood test results

Comprehensive counselling to prisoners who are informed that their blood tests have proved positive is vitally important. Whereas some prisoners will be relieved to know that they are HIV-infected, others will be shocked to realise that they are infected. Psychologists, social workers and nursing staff should be at hand to support the prisoner and to provide advice so that the result can be accepted. Counselling must therefore be geared towards:

- helping the prisoner to accept the result;

- giving the prisoner guidance as regards breaking the news to relatives;

- giving advice as to the persons to whom the prisoner should disclose his condition;

- conveying the implications of any further pregnancies;

- convincing the prisoner that he can carry on with a normal life, as they are only HIV-infected and do not as yet have AIDS; signs and symptoms can take up to 10 years to manifest themselves; and

- convincing the prisoner to avoid high-risk behaviour, thus preventing the further spreading of the disease.

...

This then is the norm for informed consent adopted by the department itself.

...

Application of law to facts

...

Informed consent, as determined by the department itself, was already in operation in March 1993, five and a half months before the plaintiff was tested. No reason has been advanced why the Johannesburg Prison was not made aware of these norms before 1994 or, if they were, why Sergeant Kinnear was not made aware thereof. The fact is that Sergeant Kinnear did not apply them. ... The norm was laid down by the department and, as a prisoner, the plaintiff was entitled to the right of informed consent as determined by the department which controlled his incarceration in prison. It was not granted to him and it is obvious to what extent the consent obtained fell short of the informed consent laid down by the department itself.

Counsel for the defendant submitted that the deviation from the norm laid down by the department was minimal and not wrongful. That, however, depends on the circumstances and I refer to the following facts:

1. The first information about the test, its object and the right to refuse to submit to the test was communicated to the plaintiff as a member of a group of prisoners standing in a row in a passage. There was no privacy and little time to reflect.

2. No information on the right to refuse was communicated to each prisoner individually prior to his entering the consulting room.

3. What was repeated to each one of them in the consulting room was not said by anyone trained in counselling; it was also not said to each of them privately but in the presence of a co-prisoner, De Waal.

4. No reasonable time for consideration and reflection was accorded to each prisoner in the consulting room before he was asked whether he consented to the test.

Finding

In these circumstances the deviation from the accepted norm of informed consent, including the fact that there was no

precounselling, was of such a degree that the deviation, in my view, was material and wrongful.

Remedy

...

Had he received the pretest counselling postulated for informed consent, the emotional blow would, on the probabilities, have been diminished. That must be weighed against the fact that, as an intelligent person, he did *de facto* consent when he was told what the test was for and that he had a choice whether to subject himself to that test or not. Also to be weighed are the circumstances under which the plaintiff was asked to consent, to which I have referred.

I also take into account that, according to Lieutenant Warren, post-test counselling appears to have been successful.

Counsel for the plaintiff, in my view, correctly conceded that the plaintiff is entitled to not much more than nominal damages if the defence version of the facts is true.

...

In all the circumstances I consider an award of R1 000 adequate.

Thebe v Mbewe t/a Checkpoint Laboratory Services 2000 JOL 7142 (ZS)

The plaintiff had a routine blood test for insurance purposes. The test, carried out in the defendant's laboratory, showed positive results for HIV. The plaintiff immediately went for further tests, both with her own doctor and at the insistence of the insurer. The results of both were negative. She claimed damages for the shock and suffering caused to her by the defendant's negligence. The Zimbabwe Supreme Court held that the defendant was negligent in the collecting and labelling of the blood sample. The court also held that the trauma suffered by the plaintiff was transitory and there was no evidence that she needed counselling or psychiatric care. On these grounds, the Court found that a small sum could be justified as damages.

Excerpts

...

Introduction

The appellant ("Thebe") issued summons in the High Court against the respondent ("Mbewe") for damages in the sum of \$150 000,00 together with costs of suit. This was in relation to an HIV test carried out at Mbewe's laboratory (Checkpoint Laboratory Services). The Court *a quo* found Mbewe liable and awarded Thebe damages in the sum of \$2 000 and costs on the Magistrate's Court scale. Thebe appeals against the quantum of damages awarded and the order of costs. It was submitted on her behalf that she should have at least been awarded damages in the region of \$30 000,00 and that the costs should have been on the High Court scale.

It was, on the other hand, submitted on behalf of Mbewe that the Court *a quo*'s award and order of costs was proper in the circumstances. Mbewe also counter-appealed against the court's finding of liability on the matter. He submitted that the court erred in finding that there was negligence on his part.

The counter-appeal is also opposed by Thebe.

Facts

The facts in the matter are that Thebe was sent to Mbewe's laboratory for the purposes of an HIV test to be carried out upon her by her insurance company (First Mutual Life Assurance Company ("the insurance company")) because her insurance policy for over \$100 000,00 had lapsed. On 22 October 1997 a blood sample was taken by an employee of Mbewe, one Steve Chibukwe ("Chibukwe"). The insurance company was given the results on 27 October 1997 which were to the result that Thebe was positive.

The results were communicated to Thebe by the insurance company on 28 October 1997. She went to her own doctor about the matter on the same day and he referred her to Clinical Laboratories for a further blood test to be carried out upon her. This was done and on 29 October 1997 the blood test report she was given indicated:

Blood test for HIV:

WELLCOZYNE (MUREX): Non-reactive

ROCHE: Non-reactive.

Subsequently that same blood sample was used to carry out what is known as a western blot test and the result, which was communicated to Thebe on 17 November 1997, was that there were no bands seen. All the above indicated that the results for the blood test were negative. On 27 November 1997 Thebe was once again asked by the insurance company to undergo a further HIV test. This time she was sent to Cimas Medical Laboratories. A test was carried out on the same day and the report released on the same day. The Elisa test which was carried out indicated:

ELISA test for HIV

GENELAVIA mixt: negative

Bioteest: negative.

This therefore indicated that the blood test was also negative. This information was communicated to the insurance company in December 1997.

Thebe alleged that Mbewe was negligent in that he did not attach to the results of his tests a letter to the insurance company to the effect that Thebe should undergo a further test. In her view, this omission had the effect of leaving his result as conclusive. She further alleged that Mbewe conducted his test negligently, or alternatively that he, an experienced doctor, left the conducting of the tests to his inexperienced assistant who did not perform the tests properly. She also alleged that as a result of the negligence she suffered damages in the form of mental trauma and contumelia which resulted in her seeking counselling. She quantified her damages as being in the sum of \$150 000,00.

Mbewe denied the allegation of negligence. In his plea he stated that the person who carried out the tests was a qualified technician, Chibukwe. He himself never had any contact with Thebe. He also stated that his technician performed two different Elisa tests on the blood sample he got on the day in question and that they came out with a positive result. He further stated that after receiving the letter of demand he carried out a western blot test on the blood sample which remained from the first test and that this also came out positive. He also stated that he did not know how Thebe received the results but that the results were sent to a Dr Shabudin of the insurance company marked confidential and not to be disclosed to the client (Thebe). Mbewe denied that Thebe suffered damages as alleged and challenged her to prove her damages.

...

Thebe goes on to state that as soon as she was told the said information she felt dizzy and was speechless. According to her, it came to her as if someone had given her a death sentence. She became suicidal. When she later tried to explain the situation to her friends they distanced themselves from her. Some two days later she went to see her doctor, Dr Browne, who sent her to Clinical Laboratories. As indicated above, they came out with the negative results. And, as also indicated above, a further HIV test was carried out by Cimas Medical Laboratories at the request of Dr Shabudin on 27 November 1997 and it again came out negative.

...

On what possible explanation there could be for the different results, Professor Marson's response was that there could be errors in the initial collection, labelling and interpretation by the reader. Professor Marson thereafter explained to the court how the HIV tests were carried out and that they all had to be done in accordance with the guidelines issued by the World Health Organisation as well as the National AIDS Co-ordinating Project ("the guidelines"). He also stated that on all blood samples for HIV tests two samples must be tested. It was also Professor Marson's evidence that the western blot test was an exceptional test because it was very expensive and would probably be done

with a fresh sample of blood. On his opinion about the test carried out at Mbewe's laboratory and the two subsequent ones, his reply was that Mbewe's test was not consistent with the other two tests and that this indicated to him that there was an error in labelling in Mbewe's laboratory's tests.

...

Mbewe gave evidence for the defence. He testified that Thebe's blood sample was taken and labelled by Chibukwe. He is a qualified laboratory technician with two or three years' experience. Chibukwe thereafter carried out the Elisa tests. These tests gave a positive result. He then informed the insurance company of the results. Thebe later telephoned for the results but was told that the insurance company would get the results.

...

Mbewe also stated that, after receiving a letter of demand, he carried out another test from the remainder of Thebe's blood sample and that that again tested positive. On the difference between his results and those two subsequent tests carried out by two laboratories his reply was that he was suspicious as to how blood was extracted in connection with the subsequent tests. He denied that there was negligence in the manner the test was carried out in his laboratory.

Under cross-examination Mbewe confirmed that he did not extract the blood sample from Thebe. He, however, agreed that he owed a duty of care to make sure that things were done properly in the testing of Thebe's blood samples. He stated that he would be calling Chibukwe, who carried out the test, to give evidence in the matter. Mbewe also indicated that he disagreed with Professor Marson's evidence on the guidelines and on the question as to whether there was an error in the manner the test was carried out – collection and labelling of the blood.

...

The learned trial judge preferred the evidence of Professor Marson on the testing of blood samples to that of Mbewe. In particular he accepted that there must have been an error in labelling at Mbewe's laboratory. He also was of the view, and also in agreement with Professor Marson, that a reasonable professional technician in the position of Mbewe or Chibukwe, when dealing with a low risk person such as Thebe, should, as indicated in the guidelines, have asked Thebe to provide another blood sample so that another test could be carried out once the first test proved positive.

In the result, the learned trial judge found Mbewe negligent on the ground that before sending out the results of Thebe's test to the insurance company he should have first asked her for another blood sample and carried out another test. This, according to the learned trial judge, was because Thebe was a low risk person.

On quantum, the learned trial judge was of the view that the amount being sought by Thebe was exorbitant. His view was that the trauma Thebe suffered could not be other than transitory. This was because, firstly, she was at the time the positive result was communicated to her aware that in January 1997 a similar test resulted in a negative result. Under the circumstances, this should have caused her to doubt the result of Mbewe's laboratory's test. Secondly, some two days later another test resulted in a negative result.

I will deal firstly with the issue of liability. In this connection Mr Dondo, for Mbewe, firstly submitted that the learned trial judge erred in finding that Mbewe was negligent in that he failed to treat Thebe as a low risk person, in which case he should not have sent her results to the insurance company before conducting another test with a fresh sample of blood from her in accordance with the guidelines. Mr Dondo argued firstly that the guidelines – which were not produced in either court – did not apply to the situation he was in. Thebe was not his client or patient. She was the insurance company's client. His client was the insurance company and he owed a duty of care to it. His instructions from his client were simply to carry out the test on Thebe and send the results to it. There were no instructions to carry out a second test in the event the results were positive. This is evidenced by the insurance company's form which requested the test. The situation might have been different if Thebe had been his client or patient. I agree with Mr Dondo's argument on this. He had no

instructions to carry out another test in the event the result was positive. In my view, the obligation to have the second test carried out is on the insurance company who eventually did just that.

Mr Dondo's second argument was that even if it could be said that there was an obligation to carry out a second test in accordance with the guidelines this would only come into play on knowledge that Thebe was a low risk person. He argued that in this case there was no way he would have known that, because Thebe was a person simply sent to him by the insurance company. He carried out tests on all persons who were referred to him by insurance companies and other persons. There was no way he could judge as to whether they were high or low risk persons. He would not know their social or medical histories. I again agree with Mr Dondo's argument and disagree with Mr Mazonde's counter-argument that Mbewe ought to have been aware that Thebe was a low risk person because she had been sent to him by an insurance company and because the insurance policy she wanted renewed was over \$100 000,00. It does not follow that persons in that category are low risk. As a result, I agree that Mbewe should not have been found negligent because of sending the results to the insurance company before conducting a second test on Thebe.

However, the second ground of negligence generally found by the Court *a quo* or eventually adopted in this Court by Mr Mazonde, which was to the effect that Mbewe was negligent in the collecting and labelling of Thebe's blood sample, was, in my view, proper. In this connection, the learned trial judge relied on the evidence of Professor Marson and the two subsequent tests.

Mbewe's insistence in his assertion that his tests were correct, as evidenced by the second test he later carried out on the remainder of the same blood sample, reinforces, when account is taken of the two subsequent results, the probability that there must have been an error in the collection and labelling of the blood. Mbewe's account was also dented by his failure to call Chibukwe to give evidence. He would have told the court the circumstances surrounding the collection and labelling of Thebe's blood sample, the testing of the sample and the reading of the result. An allegation by Mbewe that the collection of blood samples in the two subsequent tests must have been suspicious or faulty was never persisted in and no evidence was proffered to substantiate it. Further, the two laboratories who carried out the tests independently of each other had good reputations and appear to be used by many medical institutions in the country. In any event, the probabilities favour the finding that there must have been an error in Mbewe's laboratory and that in the circumstances there was liability.

Mr Dondo submitted that an error of the nature alleged in this case does not amount to negligence to be visited with damages because it had not been proved that Mbewe's laboratory's actions or inaction fell below the standard expected of a professional in the same position. He cited Jackson and Powell's Professional Negligence 2 ed at page 291 6.11 where the learned authors say:

Whether he is sued in contract or tort, the medical practitioner is not obliged to achieve success in every case that he treats. His duty, like that of other professional men, is to exercise reasonable skill and care ...

And in *Hauck v Hooper* (1835) 7 C & P 81 Tindall CJ said:

A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge in his profession. If from some accident, or some variation in the frame of a particular individual, an injury happens, it is *not* a fault of the medical man (my emphasis).

And further Denning LJ said, directing the jury in *Hatcher v Black*, *The Times*, 2 July 1954, as part of the summing up (including the passage quoted), and it is also set out by Lord Denning in *The Discipline of Law* (Butterworths 1979) page 242–244 as follows:

You must not, therefore, find him negligent simply because something happens to go wrong; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgment. You should only find him guilty of

negligence when he falls short of a standard of a reasonably skilled medical man, in short, when he is deserving of censure – for negligence in a medical man is deserving of censure (my emphasis).

In the first instance, Chibukwe was not called to give evidence and it is therefore not known what diligence he applied in extracting and labelling Thebe's blood sample and the testing itself. Secondly, the error alleged is, in my view, a very basic procedure which a professional technician is expected to follow, and cannot be said to be an "inherent risk" in an exercise of this nature. It also cannot be said to have consisted of "an error of judgment" or of some "accident or variation in the frame of a particular individual" or that some complication ensued in the exercise. In my view, the cases cited by Mr Dondo do not apply in the present situation. Here, the allegation is that Mbewe's laboratory erred in the most fundamental aspect of blood testing – collecting and labelling the blood sample. A professional technician, in my view, is expected to comply with that. In failing to do that he failed to exercise the due skill and care required of him and he deserves censure.

Finding

I therefore consider that the finding that Mbewe was negligent in the matter was proper.

On quantum I am again of the view that the learned trial judge's finding is unassailable. In the first place, I agree with Mr Dondo's submission that the assessment of damages is left to the discretion of the trial judge and that an appeal court will be reluctant to interfere unless there is a misdirection found. There is no misdirection alleged here. Secondly, I agree that the cases cited by both counsel in the matter are not of much assistance. This is virgin territory. Thirdly, I agree with the view that the trauma Thebe must have suffered was transitory as reasoned by the learned trial judge. Further, no evidence was adduced to indicate that Thebe went for counselling or that she sought medical or psychiatric attention for her condition. There was also no evidence to substantiate the allegation that her family and friends shunned her after she informed them of the results of the first test. Surely she would have also informed them of the results of the much earlier case to the contrary and the fact that she was undergoing further tests to check the correctness of Mbewe's laboratory's finding.

Remedies

In the circumstances, I am not inclined to interfere with the award by the learned trial judge.

On the question of costs in the Court *a quo*, I am, however, of the view that the learned trial judge should have awarded Thebe costs on the High Court scale. This is because, in my view, this is virgin territory. Matters concerning HIV/AIDS are high profile issues which are presently of the highest concern to the country and indeed the world. It was therefore incumbent upon a superior court, such as the High Court, to make the first pronouncement on the matter. Thebe should not therefore have been punished for bringing the matter in the High Court even though I agree that her claim for \$150 000,00 was exorbitant.

In the result, both the appeal and cross-appeal are dismissed with costs. The order of the Court *a quo* is, however, amended by the deletion of the words 'at the Magistrate's Court Scale'.

Joy Mining Machinery v National Union of Metal Workers of South Africa and Others 2002 (23) ILJ 391 (SALC 2002)

Joy Mining Machinery applied to the South African Labour Court for permission to conduct HIV testing among its staff in order to plan an effective HIV and AIDS prevention strategy and evaluate its training and awareness programme. Because the proposed testing was to be voluntary and anonymous and was not to be used for discriminatory purposes, the court granted the application.

...

Excerpts

Facts

[4] Joy Mining Machinery carries on business nationally as a manufacturer, supplier and service provider in respect of machinery to the mining industry. Joy Mining employs about 800 employees. Joy Mining, with the support of the representative union and most non-union employees, wishes to test its employees for HIV in order to determine the incidence of the disease amongst its staff so as to be better able to deal with the pandemic. It has applied for an order in terms of section 7(2) of the Employment Equity Act 55 of 1998 (EEA).

Applicable law

[5] Section 7(2) of the EEA [Employment Equity Act 55 of 1998] reads:

Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court in terms of section 50(4) of this Act.

[6] The powers which a court may exercise should it be satisfied that testing for HIV be permitted are set out in section 50(4) of the EEA. This section reads as follows:

If the Labour Court declares that the medical testing of an employee as contemplated in section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to:

- (a) the provision of counselling;
- (b) the maintenance of confidentiality;
- (c) the period during which the authorisation for any testing applies; and
- (d) the category or categories of jobs or employees in respect of which the authorisation for testing applies.

[10] The glossary to the code provides some guidance on what the testing for HIV entails. It provides:

Taking a medical test to determine a person's HIV status. This may include written or verbal questions inquiring about previous HIV tests; questions related to the assessment of "risk behaviour" (for example questions regarding sexual practices, the G number of sexual partners or sexual orientation); and any other indirect methods designed to ascertain an employee's or job applicant's HIV status.

[11] Section 1 of the EEA defines 'medical testing' as including any test, question, enquiry or other means designed to H ascertain, or which has the effect of enabling the employer to ascertain, whether an employee has any medical condition. Medical testing itself is the subjection of the employee to one or more medical tests. These tests may take the form of X-rays, ultrasonography, audiometry, eye tests, lung function, ECG, tests for sensitisation and cytology ... The test for HIV, more properly a procedure, may be administered in various ways. The procedure may be non-invasive, eg the employee providing the opportunity for a smear of saliva to be taken. Or it may be invasive, eg involve the drawing of blood. Usually a test will require the cooperation of the employee.

[12] An employer who wishes to test its employees to determine their HIV status must apply to the Labour Court for permission. Ordinarily this requires the employer to serve a notice of motion and supporting affidavits on the affected employees and their union or representative. The court has a discretion to grant an order or issue a rule nisi calling on the respondents to show cause why an order should not be granted.

[13] The court must determine whether the proposed testing for HIV status is justifiable.

...

[15] In the context of the EEA 'justifiability' will be informed by the statute including the objects of the Act and guidelines for interpreting the Act. The purpose of the EEA is to achieve equity in the workplace by:

- (a) promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination; and
- (b) implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups, in order to ensure their equitable representation in all

occupational categories and levels in the workforce. See section 3 of the EEA.

[16] The EEA must be interpreted:

- (a) in compliance with the Constitution;
- (b) so as to give effect to its purpose;
- (c) taking into account any relevant code of good practice issued in terms of this Act or any other employment law; and
- (d) in compliance with the international law obligations of the Republic, in particular those contained in the International Labour Organisation Convention 111 concerning Discrimination in Respect of Employment and Occupation. See section 4 of the EEA.

[17] Section 7(2) of the EEA does not provide any guidance about when it would be justifiable. But section 7(1)(b), which deals with medical testing generally, sets out the factors which must be present or at least considered in deciding whether a medical test is justifiable. The test must be justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of the job ...

[18] Section 54(1)(a) of the EEA permits the Minister of Labour to issue any code of good practice. A Code of Good Practice: Key Aspects of HIV/AIDS and Employment was published on 1 December 2000. Clause 7 deals with HIV testing, confidentiality and disclosure. It reads:

7. HIV Testing, Confidentiality and Disclosure

7.1 HIV Testing

7.1.1 No employer may require an employee, or an applicant for employment to undertake an HIV test in order to ascertain that employee's HIV status. As provided for in the Employment Equity Act, employers may approach the Labour Court to obtain authorisation for testing.

7.1.2 Whether s 7(2) of the Employment Equity Act prevents an employer-provided health service supplying a test to an employee who requests a test, depends on whether the Labour Court would accept that an employee can knowingly agree to waive the protection in the section. This issue has not yet been decided by the courts.

7.1.3 In implementing the sections below, it is recommended that parties take note of the position set out in item 7.1.2.

7.1.4 Authorised testing

Employers must approach the Labour Court for authorisation in, amongst others, the following circumstances:

- (i) during an application for employment;
- (ii) as a condition of employment;
- (iii) during procedures related to termination of employment;
- (iv) as an eligibility requirement for training or staff development programmes; and
- (v) as an access requirement to obtain employee benefits.

7.1.5 Permissible testing

(a) An employer may provide testing to an employee who has requested a test in the following circumstances:

- (i) as part of a health care service provided in the workplace;
- (ii) in the event of an occupational accident carrying a risk of exposure to blood or other body fluids;
- (iii) for the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids.

(b) Furthermore, such testing may only take place within the following defined conditions:

- (i) at the initiative of an employee;
- (ii) within a health care worker and employee-patient relationship;
- (iii) with informed consent and pre- and post-test counselling, as defined by the Department of Health's National Policy on Testing for HIV; and
- (iv) with strict procedures relating to confidentiality of an employee's HIV status as described in clause 7.2 of this code.

7.1.6 All testing, including both authorised and permissible testing, should be conducted in accordance with the Department of Health's National Policy on Testing for HIV issued in terms of the National Policy For Health Act 116 of 1990.

7.1.7 Informed consent means that the individual has been provided with information, understands it and based on this has agreed to undertake the HIV test. It implies that the individual

understands what the test is, why it is necessary, the benefits, risks, alternatives and any possible social implications of the outcome.

7.1.8 Anonymous, unlinked surveillance or epidemiological HIV testing in the workplace may occur provided it is undertaken in accordance with ethical and legal principles regarding such research. Where such research is done, the information obtained may not be used to unfairly discriminate against individuals or groups of persons. Testing will not be considered anonymous if there is a reasonable possibility that a person's HIV status can be deduced from the results.'

Application of law to facts

[3] HIV (and AIDS) is a pandemic. The International Labour Organisation estimates that by 2020 the labour force in South Africa will be 17 per cent smaller than it was in 2000. See the report prepared for the 88th ILO Conference. The report also mentions that AIDS-related illnesses and deaths of workers will affect employers by increasing costs and reducing revenues. Employers will be required to spend more on health care, burial, training and recruitment of replacement employees. There will be a reduction in revenues due to absenteeism related to illness, attendance at funerals, time spent on caring for the ill and training of replacements. The advent of HIV/AIDS has brought with it a new manifestation of discrimination, namely unfair discrimination on the grounds of the HIV/AIDS status of a person including employees.

...

[22] In my opinion the Labour Court, in determining whether the testing of employees for their HIV status is justifiable, will take the following considerations into account, insofar as they are applicable to the factual circumstances of the case:

- the prohibition on unfair discrimination;
- the need for HIV testing;
- the purpose of the test;
- the medical facts;
- employment conditions;
- social policy;
- the fair distribution of employee benefits;
- the inherent requirements of the job;
- the category or categories of jobs or employees concerned.

[23] The court will also so wish to be informed about the following which does not go to justifiability but which is also relevant to arriving at a proper decision:

- the attitude of the employees;
- whether the test is intended to be voluntary or compulsory;
- the financing of the test;
- preparations for the test, i.e. whether the employees are able to give their informed consent;
- pre-test counselling;
- the nature of the proposed test and procedure;
- post-testing counselling.

[24] The need to test for HIV must be shown. Where sufficient data is available from other sources there may not be a need to test a specific workforce for their HIV status. Joy Mining has attempted to gauge the extent of the HIV problem at its workplace by commissioning an HIV prevalence study based on the demographic groups at its workplace. This study was later found to be unhelpful as it did not reflect Joy Mining's experience of the incidence of HIV/AIDS. Joy Mining then decided that it would be more helpful to establish the exact HIV prevalence existing at its workplace itself in order to be in a better position to evaluate its training and awareness programme as well as being able to formulate future plans based on a more accurate prevalence study.

...

[25] An employer needs to know the extent of HIV infection among its workforce in order:

- (a) To be proactive regards prevention of employees becoming infected with HIV.

Joy Mining has engaged since or during 1997, in an effort to deal with the AIDS crisis facing South Africa. To this end Joy Mining implemented various programmes dealing with education and awareness campaigns. Joy Mining also distributed condoms and provided for the treatment of sexually transmitted diseases (STDs) at its on-site clinics.

(b) To treat at a minimum, the symptoms of the disease.

In the case of Joy Mining it has on-site clinics which treat sexually transmitted diseases.

No specific information was supplied as to the treatment, if any, envisaged for HIV-infected employees (or dependants) but details cannot be realistically expected until a survey has been conducted.

(c) To plan for contingencies and other eventualities.

Joy Mining wishes to be in a position to formulate a strategy to deal with the incidence of HIV in its workplace. Clearly there are a number of aspects of its employment practices which may require adaptation. These may include the fair distribution of employee benefits, medical aid and the training of replacement labour.

...

[26] Joy Mining has been instrumental in preparing its employees for HIV testing. As envisioned by the Code of Good Practice on Preparation, Implementation and Monitoring of Employment Equity Plans, consultation took place between all relevant stakeholders at several meetings. The meetings also dealt with the benefits associated with knowing the prevalence of HIV within the company in order to face the crisis rather than being unprepared for it. The first meeting took place on 21 August 2001, at which Dr Clive Evian of the AIDS Management & Support Company, held a representation covering, inter alia, the benefits of knowing the prevalence of HIV within the company. The presentation was attended by all shop stewards, all human resources staff, the factory director, as well as Mr Johan Maritz, as the senior management representative.

The meetings also dealt with the benefits associated with knowing the prevalence of HIV within the company in order to face the crisis rather than being unprepared. The shop stewards reported to the human resources department on 9 November 2001 that their members supported the survey. The only concern raised by the unions was that there would be pressure within departments to participate in the survey. The applicant addressed this concern by stating that the employees could either participate as they came on-site or in the clinics situated on-site. This would prevent anyone being able to ascertain whether a specific employee had participated in the survey or not.

Subsequently further presentations were held during working hours to inform all employees of the survey as well as the reasons for the survey. These presentations were held at the Steeldale and Wadeville plants on 21 September 2001. All employees were encouraged to attend these presentations.

In order to further inform all non-unionised employees of the survey and to ascertain their support Joy Mining attached a memo to all employees pay-slips during the week of 9 October 2001. 45 per cent of employees handed in their letters detailing whether or not they were in favour of the survey. 98 per cent of those who responded were in favour of the survey.

...

[27] Joy Mining has made it plain in the prelude to this application and in the application itself, that participation is voluntary and no one will be forced to participate. Joy Mining, however, told its employees:

It is, however, important that you participate as the information will be more reliable and valuable if more people participate. It would be best if all the employees took part in the survey...

These results, because of the anonymous nature of their collection, cannot inform the company who is infected. Only the percentage of people who are affected will be known. The numbers in each job category are large enough so as to ensure absolute anonymity. Joy Mining has invited employee representatives to send observers to the collection points to make

sure that participation is voluntary and that the specimens are all anonymous. Employees are to be notified of where these collection points will be. At each point the nursing sister will ask the employee who presents whether he wishes to participate and will check that the employee agrees to participate. If the employee refuses to participate, the employee will not be forced to do so and no further action will be taken. The nurses who collect the saliva specimens are independent and are not employed by Joy Mining. They work for Dr Clive Evian of AIDS Management and Support, who is a registered medical specialist.

...

[28] There will be no need for post-testing counselling in this case. Employees who wish to know whether they are HIV positive will be required to arrange for their own tests. They will be advised where to obtain assistance should they wish to have a private test.

...

[29] The confidentiality and anonymity of the employees must, in this case, be safeguarded at the time of testing. The proposed procedure will ensure this. The employees will not be asked for their names. An employee who declines to take the test may be asked:

Should you disagree to participate:

- The nurse may ask your age and job grade/category.
- You can choose to give this information or refuse if you do not want to.
- No further action will be taken.

Finding

[1] ... It is ordered that:

1. The non-compliance with rule 7 of the Rules for the Conduct of Proceedings in the Labour Court be condoned.
2. Applicant be authorised and permitted, in terms of section 7(2) of the Employment Equity Act 55 of 1998 (the Act), to perform the ELISA HIV test ... on the following conditions:
 - 2.1 that the testing shall be voluntary;
 - 2.2 that the test to be used is the ELISA saliva test;
 - 2.3 that the tests are to be done on an anonymous basis, ie the employees participating in the survey will be asked to supply a saliva sample, as well as their age and job category. At no time will the participating employees be asked their name, nor will such information be recorded on the sample;
- ...
- 2.5 that the employees have been advised that they may request a private test which will enable them to know their own HIV status but this will not form part of the survey nor will such testing be done by the applicant or on its behalf;
- ...
- 2.7 that the applicant may not at any time discriminate against HIV positive employees should it become aware of such status;
- 2.8 that the testing at all times only be done with the consent of the employee and would not be requested as a condition of employment, promotion and/or any other benefits;
- 2.9 that the intention of the testing shall be to find out what per centage of employees at the applicant is HIV infected in order to assist the applicant to plan an effective HIV/AIDS prevention strategy;
- 2.10 that the testing will not be a job requirement;
- 2.11 that no prejudicial inference will be drawn from a refusal to submit to testing nor will the applicant be aware of which employees have undergone testing. The applicant will only be informed of the per centage of employees who have participated and the per centage of employees within the various age groups and job bands who have tested positive.
3. This order, together with a notice that every employee may decline to take the test without being subjected to any prejudice on that account, is to be placed at all entrances to the testing area and on all company notice-boards.

...

Irvin and Johnson Ltd v Trawler and Line Fishing Union and Others 2003 (4) BLLR 379 (SALC)

The South African Labour Court determined that section 7(2) of the Employment Equity Act of 1998, which prohibits medical testing, applies only to compulsory, involuntary testing. The court held that voluntary, anonymous testing in the workplace should be encouraged, not impeded.

Excerpts

...

Introduction

[1] The applicant, which employs more than 1 100 workers in its trawling division, wishes to arrange for the voluntary and anonymous HIV testing of these employees. It seeks an order declaring that the testing in question does not fall within the ambit of section 7(2) of the Employment Equity Act 55 of 1998 ("the Act"). In the alternative, the applicant seeks an order that the testing is justifiable as contemplated in section 7(2), subject to certain conditions set out in the notice of motion.

...

[4] The applicant believes that it requires information on HIV prevalence in its workforce to assess the potential impact of HIV/AIDS on the workforce; to enable the applicant to engage in appropriate manpower planning so as to minimise the impact of HIV/AIDS mortalities and HIV/AIDS-related conditions on its operation; to enable it to put in place adequate support structures to cater for the needs of employees living with HIV; and to facilitate the effective implementation of proactive steps to prevent employees from becoming infected with HIV/AIDS.

[5] The applicant has already instituted various HIV/AIDS education and awareness programmes, the objectives of which are: to educate employees about HIV/AIDS; to offer psychological support to employees; to dispel myths and unfounded fears about HIV/AIDS; to encourage employees to go for voluntary testing; and to help employees to make necessary lifestyle changes. The applicant has drafted and implemented an AIDS policy. It has established HIV/AIDS committees to monitor the implementation of the policy. The applicant has arranged for the supply of condoms to its employees from dispensers located at the workplace. It offers counselling to employees living with HIV, and has also organised various presentations and concerts of an educational nature. The applicant has an equity committee which has fully endorsed the applicant's HIV/AIDS programmes.

...

[8] An employee who volunteers for HIV testing will be required to sign a form confirming that he has consented to the test and indemnifying the independent agency, the pathologists and the applicant against any claim arising from the test. This form will be completed by the employee with the assistance of an Isibindi counsellor. The employee's name would appear on the form and would thus be known to the Isibindi counsellor. The employee is informed of this fact and may decline to proceed with the testing. The applicant will have no access to these forms, which are retained by the independent agency.

...

[11] The only information which the applicant will obtain concerns the age and job category of the various employees who have been tested. This information will be used for statistical purposes ...

Applicable law

[12] Section 7(1) of the Act prohibits "medical testing" unless legislation permits or requires the testing or unless "it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job". Section 7(2) reads as follows:

Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court in terms of section 50(4) of this Act.

[13] Section 50(4) provides as follows:

If the Labour Court declares that the medical testing of an employee as contemplated in section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to:

- (a) the provision of counselling;
- (b) the maintenance of confidentiality;
- (c) the period during which the authorisation for any testing applies; and
- (d) the category or categories of jobs or employees in respect of which the authorisation for testing applies.

Application of law to facts

[18] Section 7 forms part of a chapter dealing with the prohibition of unfair discrimination. One of the main purposes of the Act is to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination (see section 2(a)). In this context, the purpose of section 7 seems to me to be clear. An employer should not unfairly discriminate against an employee on the basis that the latter suffers from some or other medical condition. One of the ways of reducing the likelihood of such discrimination is to limit the circumstances in which an employer may ascertain the employee's medical condition through testing.

[19] Where employees are tested in such a way that the employer is unable to identify which employees are suffering from the medical condition in question, the risk of discrimination based on medical condition is absent. It would thus not be surprising to find, and would not be in conflict with the broad purpose of the Act, that anonymous testing should fall outside the ambit of section 7. I believe there is support in the language of the Act for this view.

...

[23] Accordingly, when section 7(2) prohibits the "testing" of an employee to determine that employee's HIV status, what it is prohibiting is a test which is designed to enable, or which will have the effect of enabling, the employer to ascertain the HIV status of an employee. And it is clear from the language of section 7(2) itself that the testing will be prohibited only if the employer is thereby enabled to determine the HIV status of a particular employee (the expression used is "that employee's HIV status").

[24] The foregoing view is based on the language of the Act itself, interpreted in the light of the purpose of the legislation. However, it is a view which is supported, I think, by clause 7.1.8 of the Code of Good Practice: Key Aspects of HIV/AIDS and Employment issued under section 54(1)(a) of the Act. This clause is quoted in paragraph 18 of Landman J's judgment in the Joy Mining case (*supra*). As the learned judge observed in paragraph 21 of his judgment, clause 7.1.8 of the Code appears to permit anonymous testing (ie without the need for an order from this Court). Section 3(c) of the Act states that the Act must be interpreted taking into account any relevant code of good practice issued in terms of the Act.

...

[26] In the present case the testing does not have as its purpose to enable the applicant to ascertain the HIV status of any identifiable employees. Will this nevertheless be its effect? During argument I expressed to Mr Loxton (who appeared for the applicant) a concern that in certain of the job categories in the 16 to 25 age group the numbers were very small. In response, he stated that the applicant was willing to combine persons in the 16 to 35 age range in a single group for statistical purposes or alternatively to eliminate the distinction between shore-based and seagoing staff for purposes of receiving information on the age group 16 to 25. It seems to me that either of these adjustments would be sufficient to eliminate any reasonable possibility that an individual's HIV status could be deduced from the statistical information.

...

[28] I should explain what I mean by compulsory and voluntary testing. Compulsory testing is not limited to the case of taking a sample from an employee by physical force. In the absence of consent, such conduct would amount to an assault, and it would not require any statutory provision in order to render it unlawful. By compulsory testing is meant, in this context, the imposition by the employer of a requirement that employees (or prospective employees – see section 9 of the Act) submit to testing on the pain of some or other sanction or disadvantage if they refuse consent. This is to be contrasted with voluntary testing, where it is entirely up to the employee to decide whether he wishes to be tested and where no disadvantage attaches to a decision by the employee not to submit to testing.

[29] In considering the permissibility of voluntary testing, it is perhaps appropriate to observe that the avoidance of discrimination against those infected with HIV is not likely to be best served by encouraging a climate of secrecy. It is one thing to protect employees against compulsory testing. It is quite another thing to place obstacles in the way of voluntary testing. Clause 15.2 of the Code to which I have referred recommends that every workplace works towards developing and implementing a workplace HIV/AIDS programme, and it is recommended that the programme should, inter alia, encourage voluntary testing. The programme should also “create an environment that is conducive to openness, disclosure and acceptance amongst all staff”. Clause 7.2 of the Code, while acknowledging an employee’s right to privacy, states that mechanisms should be created “to encourage openness, acceptance and support” for employers and employees who voluntarily disclose their HIV status within the workplace.

[30] If section 7(2) were interpreted as applying to voluntary testing, it would mean that although voluntary testing is regarded in the Code as something to be encouraged, an employer would not (without the expense of a court application) be entitled to assist in the attainment of this objective by making its own testing facilities available to its staff.

...

[33] There is thus good reason to conclude that the legislature did not intend section 7 to apply to voluntary testing. This is a view which in my opinion is fortified by a consideration of the consequences which attach to a violation of section 7. Medical testing is not itself an act of discrimination. Section 7 is a pre-emptive measure designed to reduce the risk of discrimination on the grounds of a medical condition. Section 10, which deals with disputes concerning Chapter II of the Act, appears only to make provision for the referral to the CCMA of disputes concerning alleged unfair discrimination. (Section 10(2) requires the referral to be made within six months after the act or omission allegedly constituting unfair discrimination.) If the dispute remains unresolved it may be referred to the Labour Court (section 10(6)(a)). In terms of section 50(2) this Court may order compensation or damages for unfair discrimination, but there is no jurisdiction to make such an award merely because a person has been medically tested. In terms of section 50(1)(g) the Labour Court can impose fines in accordance with Schedule 1 for contraventions of certain provisions of the Act, but section 7 is not one of them. A contravention of section 7 is not stated by the Act to be a criminal offence.

[34] It thus appears that a dispute concerning medical testing cannot be referred to the CCMA nor can a contravention of section 7 be visited with a fine or an order for damages or compensation. What then is the consequence of a violation or threatened violation of section 7. Where testing is compulsory and is not objectively justifiable (under section 7(1)) or, in the case of HIV testing, has not been authorised by this Court (under section 7(2)), an employee would be entitled to approach this Court for an order declaring that the compulsory testing is prohibited and interdicting same. Where, on the other hand, the testing is voluntary, it is difficult to see what remedy would either be required or be possible. A person who does not wish to be tested and who is not required to undergo testing would have no need for the protection of a declaratory order and an interdict. A person who volunteers for testing would in the nature of things not seek redress. If such an employee were later to regret that he had volunteered for testing, I doubt whether he would have any

ground for approaching the court, given that he volunteered for the testing. If future testing remained voluntary he would require no ongoing protection. And as I have said, the Act does not appear to impose any penalty for a past infraction of section 7 per se, so that no effective order could be made at the instance of such an employee.

[35] In short, it seems to me that there are no circumstances in which voluntary medical testing could ever be the subject of legal proceedings or legal redress. This being so, it strikes me as most improbable that voluntary testing was intended to be within the ambit of section 7.

Findings

[36] I thus find that section 7 as a whole applies only to compulsory testing (in the sense described above) and does not apply to voluntary testing. Provided testing is truly voluntary, I do not believe it matters whether the initiative for testing comes from the employer or the employees. I imagine that in many instances the initiative might come from the employer, in the sense that the employer would establish medical facilities and convey to employees that these facilities are available for any members of staff wishing to take advantage thereof.

...

[42] I thus conclude that the anonymous and voluntary testing which the applicant wishes to arrange for its employees does not fall within the ambit of section 7(2) and that the applicant does not require the authority of this Court before allowing its employees to be tested. If this conclusion had been reached solely on the basis of the anonymous nature of the testing, some slight adjustment might have been required to the manner in which statistical information is reported to the applicant. However, in the light of the view I have reached on the issue of voluntary testing, it seems to me that such an adjustment is not obligatory.

[43] Since the applicant is, in my view, entitled to the declaratory order sought in paragraph 1 of the notice of motion, it is not necessary to consider the question of justifiability under section 50(4).

...

VRM v Health Professions Council of SA and Others 2003 JOL 11944 (T)

The appellant was a patient of the third respondent (a medical practitioner) during her pregnancy. The appellant alleged, among others, that the third respondent conducted an HIV test without her consent and without pre- and post- test counselling. She also alleged that the third respondent failed to take necessary measures to reduce the risk of mother-to-child transmission. The appellant lodged a complaint against the third respondent before the Committee of Preliminary Inquiry of the Health Professions Council of South Africa which found that there had been no improper or disgraceful conduct on the part of the third respondent. The appellant then brought the matter to the High Court (South Africa) but was dismissed on the ground that the ‘allegation of irregular and unreasonable conduct remains a mere allegation, and is not substantiated.’ She appealed against this judgement before the full bench of the High Court (South Africa) which set aside the decision of the first judge and ordered that the disputed facts be resolved by means of an inquiry.

Excerpts

...

Introduction

[1] The appellant appeals against the dismissal of her application, by the court a quo for the review and setting aside of a decision of the second respondent, the Committee of Preliminary Inquiry of the first respondent, and the adoption thereof by the first respondent, the Health Professions Council of South Africa. The appeal comes before this court with leave of

the court a quo. The decision under attack was a finding by the second respondent that the conduct of the third respondent, a medical doctor, cannot be said to have been improper or disgraceful. A recommendation by the second respondent that no further action be taken against the third respondent was adopted by the first respondent.

[2] The appellant wants the court not only to set aside the aforesaid decision but in addition to direct the first respondent to refer her complaint to a disciplinary committee. The committee is to be appointed to hold an enquiry into the question whether, on the strength of the allegations made by the appellant, the third respondent is not guilty of improper or disgraceful conduct.

Facts

[3] The complaint of the appellant was set out in a letter dated 9 July 1999. It reads:

...

24. Our client requests that an investigation be initiated into the conduct of Dr Labuschagne and that Dr Labuschagne provides clarity on the following issues

- Why Dr Labuschagne conducted an HIV test without the consent of our client and without providing pre or post test counselling;

- Why Dr Labuschagne did not disclose client's HIV status at the consultation during March when both our client and her husband raised the concern of the statement received from Drs Buisson and Partners;

- Why Dr Labuschagne did not advise our client on measures to take to reduce the risk of mother to child HIV transmission during birth after he had knowledge of her HIV status;

- Why Dr Labuschagne did not perform the Caesarian Section immediately after our client's waters broke to further reduce the risk of mother to child HIV transmission.

- At the time of registering the death of the still birth, Dr Labuschagne listed in section G of the Notification or Register of Death or Still Birth Form that the HIV status of the baby was the cause of death;

- When did Dr Labuschagne perform an HIV test on her baby and what type of test;

- And if Dr Labuschagne performed an HIV test on her baby he did so without her consent;

- That Dr Labuschagne informed her husband of her HIV status without her consent and did this without advising our client and her husband to go for counselling;

- Our client seeks further clarity as to whether Dr Labuschagne had any intentions of informing our client of her HIV status if the baby had lived;

- Why Dr Labuschagne abused her medical aid by doing a test and not informing our client of the type of test being performed, yet our client's medical aid is liable for treatment to which our client did not consent to nor had any knowledge of.

25. Our client submits that Dr Labuschagne acted unethically and illegally and requests that your offices start investigations into his conduct immediately.

[4] The third respondent replied to each allegation in the letter of complaint of the appellant. The gist of his reply came to the following:

(a) That he asked and obtained her consent to take a blood sample and to have it tested also to determine her HIV status.

(b) That he was aware thereof that she was HIV positive when her husband and she enquired, during March 1999, about the meaning of 'HIV Elisa' but that as she was one month away from delivery he thought it in her best interests, from a psychological point of view, not to inform her of her status then. He states that he attempted 'to sidestep' the question by explaining to them in medical terms that 'HIV Elisa' indicated an infection and that AIDS may be a result thereof.

(c) He denied that he stated that the account had nothing to do with AIDS and that he would follow it up with Drs Buisson and Partners.

(d) He denied that her water broke on 2 April but stated that he caused it to break in an attempt to get the patient to go into normal labour. He refers to the hospital report which indicates that the membrane was intact. He states that when he broke the water there was a very offensive discharge. It seems as if, after

the caesarian section, he formed the opinion that it was the result of an intra uterine infection which may have caused the still birth.

(e) He denied that he asked to see her husband and says that after he had informed her of her status he asked her whether she would tell her husband or whether he was to do it. He says that she asked him to do it and that he subsequently did so.

(f) He denied that he had told the complainant that the baby was also HIV positive. He denied that he performed any HIV testing on the baby. What he told her was that its death was probably caused by its mother's HIV status and intra uterine infection. He explained that the reference to HIV on the death certificate was a reference to the mother's HIV status.

(g) He explained that he considered it to be heartless and cruel to inform a woman pregnant with her first child one month before its birth that she was HIV positive. At that stage such information could not change anything. In any event statistics show that only one half of children born HIV negative convert to HIV positive.

(h) He pointed out that there were no facilities for pre- or post-natal test counselling at the Louis Trichardt hospital. Nor did there exist protocols regarding measures to reduce the risk of mother-to-child transmission.

(i) He also denied that there was any risk of mother-to-child transmission.

[5] By way of a letter dated 7 October 1999 the appellant provided the appellant's attorney with a copy of the third respondent's explanation. The appellant's attorney reacted by way of a letter dated 29 October 1999 in which she stated that she would revert on the issues in contention. That never happened. In the letter it was pointed out, however, that the third respondent, on his own showing, had not obtained the appellant's informed consent and that he was not conversant with current medical knowledge concerning the reduction of mother-to-child transmission.

[6] In a letter dated 14 April 2000 the appellant's attorney was informed that the Committee of Preliminary Inquiry of the first respondent had found that there had been no improper or disgraceful conduct on the part of the third respondent. At the request of the appellant's attorney the reasons for the finding were supplied in a letter dated 21 February 2001...

[7] In the application, which was launched on 31 October 2001, the appellant reiterated the facts stated in her letter of complaint with the exception that she conceded that her husband had been informed of her HIV status with her consent. Her husband was subsequently tested for HIV and the test was negative. These circumstances led to a separation between her and her husband. She denied that there were no facilities for pre and post-natal counselling in Louis Trichardt. Such facilities were available at the government primary health clinic.

...

[9] It appears from the so-called SAMDC guidelines, that have been of effect since 1992, that routine or universal testing of patients is considered to be unjustifiable and undesirable. It is stated that a patient should only be tested for HIV infection if he gives informed consent, which must include a verbal discussion between the doctor and the patient, a clear understanding by the patient of the purpose of the test, the advantages and disadvantages of testing for the patient, and addressing the psychological impact of a positive test with post test counselling.

[10] The affidavit of Mr Brouard sets out what counselling should precede and follow HIV testing. In the case of pre-test counselling time should also be allowed for deliberation. He expressed the opinion that the appellant had not been counselled properly and that she was emotionally unprepared for the test.

[11] Dr McIntyre gave a detailed account of the prevalence of mother-to-child transmission of HIV and the measures to reduce it, like feeding options, vitamin supplementation, the management of labour, and the use of anti-retroviral treatment.

[12] The main grounds on which the appellant relied are.

(a) that the second respondent misdirected itself in accepting the version of the third respondent regarding the question of whether she had consented to HIV testing in spite of the existence of a dispute of fact;

(b) that the second respondent ignored the fact that on the version of the third respondent he had not obtained her informed consent;

(c) that the second respondent erroneously accepted that there 'was a lack of facilities for proper pre- and post- HIV testing in the hospital'.

...

[15] Mr Marcus SC, who, with Ms Grenfell, appeared for the appellant, argued that the first respondent was under a statutory duty to act on complaints of improper or disgraceful conduct if a prima facie case of such conduct had been disclosed. He contended that in this regard the first respondent failed to appreciate its statutory duties. He referred to section 15A(g) and (h) and section 41 of the Health Professions Act 56 of 1974 (the Act) and to the case of *Veriava*, supra, at 310J–311E. He submitted that the finding in *Korff v Health Professions Council of South Africa* 2000 (1) SA 1171 (T) at 1178D that the first respondent was not an organ of State must be considered to have been wrongly decided in the light of decisions of the Constitutional Court in cases like *National Gambling Board v Premier, KwaZulu-Natal and others* 2002 (2) SA 715 (CC), *Independent Electoral Commission v Langeberg Municipality* 2001 (3) SA 925 (CC) and *Islamic Unity Convention v Independent Broadcasting Authority and others* 2002 (4) SA 294 (CC). Then he argued that even the undisputed facts –disclosed a prima facie case of improper and disgraceful conduct in that the third respondent had failed to obtain the appellant's informed consent, that he had failed to conduct pre- and post-test counselling, or had failed to refer the appellant for such counselling and that he had failed to counsel the appellant on the prevention of mother to child transmission of HIV. In respect of informed consent he referred the court to *Castell v De Greef* 1994 (4) SA 408 (C) at 425H–I and *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 300G–J.

[16] Mr Nthai, who appeared for the first and second respondents, conceded that the first respondent was an organ of State as defined in section 23 of the Constitution of the Republic of South Africa Act 108 of 1996 (the Constitution). He argued that the second respondent furnished sufficient reasons for its decision and that a court would not lightly interfere with the decision. The second respondent accepted the third respondent's explanation and there was a rational connection between the decision and the facts on which it was based. He referred to the regulations governing the matter and pointed out that the regulations published in Government Notice R2303 of 28 September 1990 were applicable. In particular he referred to regulation 7 which entitled Committee of Preliminary Inquiry not to direct an enquiry if a complaint, even if substantiated does not constitute improper or disgraceful conduct. With reliance on the case of *Veriava*, supra, he submitted that the correct test was not whether disputes of fact existed, but whether prima facie evidence of improper or disgraceful conduct had been presented. He pointed out that the Committee of Preliminary Inquiry was a peer committee and submitted that it, having regard to the complaint and the explanation, had found that there was no prima facie case against the third respondent. To the extent that the third respondent deviated from the guidelines, he submitted that they were not intended to be followed slavishly. He pointed out that the Promotion of Administrative Justice Act 3 of 2000 had not come into effect when the second respondent's decision was taken and that the matter had to be decided in terms of section 33(1) of the Constitution. He submitted that the court should be slow to substitute its opinion regarding the propriety of professional conduct for that of an expert body. In this regard he referred to *Thuketana v Health Professions Council of South Africa* [2002] 4 All SA 493 (T) at 504E–505C.

[17] It is essential for the purpose of this appeal to define the parameters of the discretion vested in the Committee of Preliminary Inquiry to direct an inquiry or to decline to do so. What needs to be addressed in particular is the approach to be adopted in the case of a dispute of fact and the weight to be accorded to the explanation furnished by a respondent.

[18] In the *Veriava* case, supra, the court held, in effect, that if there was prima facie evidence of conduct amounting to improper or disgraceful conduct, an inquiry had to be directed

(see page 311G–H). It found that the only function of the Committee of Preliminary Inquiry was to determine whether the evidence furnished in support of the complaint, disclosed prima facie evidence of improper or disgraceful conduct (see page 307J–310B). It pointed out that the committee had no power to hear evidence under oath to determine whether the evidence available in fact substantiated the complaint (see page 310C–D).

...

[20] It would seem that the deletion of the duty to direct an inquiry if there is prima facie evidence of misconduct must have had the effect of extending the discretion of the Committee of Preliminary Inquiry. The question is whether it would have had the effect of broadening the discretion of the committee to the extent where it could resolve factual disputes without having recourse to evidence under oath. Such an effect would be startling and out of keeping with the function of a Committee of Preliminary Inquiry. It does have to act as a sieve so as to eliminate complaints without substance lest the council be burdened unnecessarily and practitioners be subject to complaints that cannot be sustained. But it is not its function to adjudicate complaints that raise disputes of fact, unless the complaint, accepting it to be true, in itself does not, in the view of the Committee of Preliminary Inquiry, constitute improper or disgraceful conduct.

[21] It is so that the regulations require that the respondent be given an opportunity to give an explanation. One must assume that the Committee of Preliminary Inquiry is obliged to take the explanation into account. The committee may also cause a further investigation to be made and thus obtain information not necessarily emanating from the complainant or the respondent (see regulation 6).

[22] The question is what weight is to be accorded to the explanation of a respondent and how disputes of facts are to be approached. Obviously where the respondent provides explanations in areas where the complainant only made inferences, it would be proper to accept the explanation of the respondent. It should also be proper for the committee to accept the explanation of the practitioner in the face of contrary allegations of the complainant where there is evidence to support the version of the practitioner such as bed records, hospital records, test results, signed consent forms, and the like. It would obviously at this stage be permissible for the committee to have regard to what may strictly be hearsay evidence. Any evidence of an objective nature or from an independent source may be taken into account to determine whether the complaint has substance.

[23] The exposition of the discretion of the Committee of Preliminary Inquiry set out in paragraph 22 above goes beyond what was held to be its limited function in the *Veriava* case, supra, at 310F. Although the court there said that no discretion is exercised by the Committee of Preliminary Inquiry it is clear even on the reasoning of the court that the Committee of Preliminary Inquiry must have had a discretion to determine, for the purposes of regulation 6 (now 7), whether a complaint, even if substantiated, disclosed evidence of misconduct. That involves a value judgment for the purpose of which the committee must apply the expertise of which it is possessed. As has been stated above, the regulations have been amended since the judgment in the *Veriava* case had been given and one must accept that it was done with the intention of giving the Committee of Preliminary Inquiry a greater discretion.

[24] Where there is a fundamental dispute of fact the Committee of Preliminary Inquiry has no means of resolving it. It finds itself in much the same position as a court confronted with a dispute of fact in motion proceedings. If the complaint, on the face of it, discloses improper conduct, the only way of resolving the dispute of fact is to direct an inquiry. That is also the proper approach, bearing in mind the function of a Committee of Preliminary Inquiry and what was said in *Veriava's* case, supra, at 311B–F.

Finding

[25] In this matter there was a fundamental dispute about whether the third respondent had informed the appellant that the blood taken from her would be tested for HIV. It was never suggested that it would have been proper for the third respondent

to have taken the appellant's blood for that purpose without informing her of the purpose of the test. If such a view had been tenable, it would have been possible for the second respondent to decline to direct an inquiry with reliance on regulation 7. It is clear therefore that the second respondent on a vital dispute of fact accepted the third respondent's version and rejected that of the appellant. In doing that it misconceived its powers and overstepped the bounds of its discretion. For that reason its decision should be reviewed and set aside.

[26] It was argued that if it was not competent for the second respondent to decide the factual dispute about consent, the matter should be referred back to it so that it could reconsider the matter. Technically it is correct that it is still open for the second respondent to consider the complaint for the purposes of regulation 7, that is to establish whether the complaint, even if substantiated, does not disclose improper conduct. It is also true that the second respondent is peculiarly equipped to make such an assessment. In the circumstances of this case it is, however, not appropriate to follow such a course. If the second respondent had been of the view that the complaint, even if substantiated, did not disclose evidence of misconduct, it could have declined to direct an inquiry in the first place on that ground. Then there is the dispute about whether the third respondent had told the appellant about the purpose of the test. It seems inevitable that that dispute must be resolved and it can only be resolved by means of an inquiry.

[27] In the circumstances the appeal must succeed and relief should be granted in terms of paragraph 2 and 3 of the notice of motion. In view of this conclusion it is unnecessary, also inadvisable, for this Court to make any pronouncement on all the arguments to the effect that on the undisputed facts the third respondent was in any event guilty of improper or disgraceful conduct.

Remedies

[28] In the result the following order is made:

(a) the appeal succeeds with costs which costs will include the costs attendant upon employment of two counsel.

(b) The order of the court *a quo* is set aside and the following order is substituted for it:

'An order is granted in terms of prayers 2, 3 and 4 of the notice of motion.'

D4.7 HIV and the law of delict (tort)

Venter v Nel 1997 (4) SA 1014 (SAHC D)

The plaintiff sought damages from a previous partner who had infected her with HIV. In assessing the appropriate amount of damages, the Durban High Court (South Africa) considered the plaintiff's past and future medical expenses, as well as the physical stress and psychological trauma that the plaintiff endured as a result of her infection.

Excerpts

...

The plaintiff in this action claims the amount of R466 031,86. Her cause of action, as stated in the particulars of claim is, in broad outline, that the defendant, a businessman who resides in the Durban area, infected her with HIV. This occurred when the parties had sexual intercourse, one with the other, in August or September 1995.

...

I am asked simply to fix a figure for damages and, in doing so, I stress that, the matter being undefended, the inquiry is inevitably not as detailed as would otherwise be the case.

The plaintiff's claim falls under three main heads. The first is for past medical expenses and the schedule, annexure A, has been handed in and it demonstrates that the plaintiff's costs of medication to date amount to R19 399,06. I propose to allow that sum.

The second is for future medical expenses, the amount claimed is R195 000. These expenses are based on the evidence, in the main, of Dr Clark, who has given the present costs of the present medication. There are other forms of medication, far more costly, and these figures may well change in the future. Any assessment for future medical expenses involves two principal factors, namely the estimated amount of the annual expenditure and the duration of such expenses. That is to say the plaintiff's expectation of life - how much is it estimated she will have to pay per year and for how long is it estimated that she will have to pay these amounts. As indicated by Dr Clark, the matter of expectation is by no means clear. In the worst case, it would be estimated at five to seven years and in the best case it could be virtually a normal expectation. Much depends on the treatment the patient receives.

In the nature of things, it seems to me that the annual expenses will increase, not only on account of the inflationary tendencies to which we have had to become accustomed, but also I think allowance must be made for the plaintiff's condition becoming more serious and requiring more expensive drugs more frequently. The figure I arrive at is inevitably an estimate. It is an amount of money which, if put away now, will see the plaintiff through for the rest of her life. At present the expenses are R19 000 per year. I do not propose to indulge in any actuarial calculation, discounting future expenses at some arbitrary rate of interest. It seems to me that the discounting procedure is more or less offset by the inevitable rise in costs of these things and, as I say, the probable necessity of having more expensive drugs more often. In my judgment, justice would be done if I were to allow a figure of R150 000 under this head.

The third is for general damages. Here I have heard the evidence of the plaintiff herself, of Mrs Towell and, as I say, Dr Clark. They all touch on the matter of general damages which, as I have said, involve the possibility of a reduction in life expectancy, psychological stress, contumelia and pain and suffering. I do not propose to recapitulate all the evidence that I have heard. My impression of the plaintiff is that she is a well-adjusted person. She is now aged 34. She appears to have come to terms with her condition but, at the same time, there were hints in the evidence of other witnesses that there were times when the stress and inevitable fear of the unknown took its toll on the plaintiff. She has been seen on occasions to be tearful. It is obviously an extremely serious matter for her. It strikes at the very heart of her life. At times she must experience feelings of helplessness and hopelessness. She is aware of the adverse effect that this condition has on her general relationship with all others. That is with family and friends and people at work. All the more is this adverse effect evident when in the realms of her sex life. The anguish must be gross. It is so, as Dr Clark pointed out, that it is mostly of a psychological and social character but, nevertheless, it is a form of suffering for which the plaintiff must be adequately compensated. Dr Clark was of the opinion that the initial episode of encephalitis and meningitis were, more probably than not, caused by the HIV condition. That, in itself, was a most unpleasant and relatively protracted episode in her life and was severely disabling. Now, as I say, she is left with HIV, with the various possible progressions mentioned by Dr Clark.

What I have said so far is just a very broad outline of some of the evidence that I have heard this afternoon. I see this as an extremely serious case. I see her condition as one which calls for extremely high damages under the head of general damages, as claimed. It is so that money can never put plaintiffs back in the position in which they were before they suffered their particular disability, but the Court must do its best to put a monetary figure on the plaintiff's disability, the effect that it has on her day-to-day life, the possible reduction in her life expectation and, I think, most important of all is the factor that I have already mentioned, that is the fear of the unknown. No one can foresee exactly what will happen. It ranges from the worst case to the best case and it is this uncertainty which is ever-present in her life and which is a matter which must cause great distress. It must cause her a great

deal of stress and, inevitably, a great deal of fear. Doing the best I can, it seems to me that a figure of R175 000 would be appropriate in this case.

I therefore refer to the particulars of claim and under para 8, award under 8.1 the amount claimed, 8.2 the amount of R150 000 and I take 8.4, 8.5 and 8.6 together and award R175 000, giving a figure of R344 399,06.

...

D4.8 HIV and the criminal law

***Republic v Cidreck* 1995 MLR 695 (High Court of Malawi 1994)**

The case deals with the enhancement of rape sentences in the context of the HIV epidemic in Malawi. The Malawi High Court rejected the argument that rape sentences should be enhanced on the sole basis of the current HIV epidemic. The court held that rape sentences should only be enhanced if there is proof that the victim has thereby contracted HIV or that the rapist is HIV-positive.

Excerpts

...

Introduction

The accused was charged with rape contrary to section 1333 of the Penal Code and was sentenced to 18 months' imprisonment with hard labour. The case has been set down to consider enhancing sentence which appears to be inordinately low.

Facts

The accused was 18 years and the victim was 16 years at the material time. These two youngsters were pupils at the same school. On 24 August 1994 the victim had gone to visit a friend and on her way back she saw the accused running after her. He grabbed and pulled her down to the ground and forcibly had sexual intercourse with her. After satisfying his sexual lust he ran away. The victim reported the matter to her grandmother and eventually to the police. The accused was arrested. His evidence was that he had sexual intercourse with the victim with her consent. He alleges that they were lovers. The lower court rejected his evidence. There was ample evidence that that sexual intercourse was done against the wishes of the victim ...

...

Mr Assani submitted that the offence is serious especially that the dignity of the woman was being interfered with without her consent. Furthermore, that the AIDS scourge put the victims of such offences at risk. He referred the court to the cases of *Rep v Jackson* Conf Case No 116 of 1994 (unreported) where a sentence of two years was enhanced to four years' imprisonment with hard labour and *Rep v Machilika* Conf Case No 736 of 1992 (unreported) where both the accused and victim were pupils and 24 months' imprisonment with hard labour was confirmed.

...

Finding

I agree that the offence which the accused committed is very serious. Society requires protection of the law through a meaningful penal process in our courts. Therefore there is real need to meet our appropriate sentences. The sentence of 18 months does not sufficiently punish the accused although he is a first offender. He must learn and appreciate that what he did was wrong so that in future he shall refrain from such mischief. The argument that the sentence should be enhanced because there is now the AIDS epidemic in our society is unacceptable. The position has been clearly put in several local cases that the sentence should be enhanced if there is proof that the victim has

thereby contracted the virus which causes the disease or that the rapist is HIV positive. No such evidence is available here.

Remedy

The aggravating factors outweigh the mitigating factors. Consequently I set aside the sentence of 18 months' imprisonment with hard labour and in its place impose a stiffer sentence of 36 months' imprisonment with hard labour.

***Makuto v The State* 2000 (2) BLR 130 (CA)**

The Penal Code (Amendment) Act 5 of 1998 (an extract of this Act is available under 'D 2.9 HIV and criminal law') provides that all persons found guilty of rape must undergo an HIV test prior to sentencing. If the test is positive, offenders are subject to higher minimum sentences. The Botswana Court of Appeal found that this procedure was constitutional, as long as it could be shown that the offender was HIV-positive at the time the offence was committed. The Court held that although the procedure was discriminatory, it was justified in order to help combat the spread of HIV in Botswana.

Excerpts

...

Facts

This appeal is against a conviction and sentence for rape. The appellant was charged with the offence and was duly tried and convicted by the Magistrate's Court sitting at Jwaneng. In accordance with the amendment in section 142(2) of the Penal Code ... which was effected by section 3 of the Penal Code (Amendment) Act, 1998 ... the appellant was 'required to undergo a HIV test' before sentence. The appellant on this test proved positive. The 1998 Act provided new penalties for persons convicted of rape. A person convicted of rape which was not attended by violence where, upon the HIV test, he was found not to have the HIV syndrome was made liable by the amended section 142(1)(ii) to a minimum sentence of 10 years' imprisonment. If, on the other hand, the convicted person tested positive to HIV, then according to the amended section 142(4) the following sentencing provisions applied, ie:

Any person who is convicted under subsection 1 or subsection 2 and whose test for the HIV under subsection 3 is positive shall be sentenced

(a) to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being HIV positive; or

(b) to a minimum term of 20 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being HIV positive.

... The High Court judge after consideration of the matter sentenced the appellant to 16 years' imprisonment with two strokes of the light cane.

The appellant personally noted an appeal against the conviction and sentence on several grounds ... The second ground raises a constitutional issue. It states that the provisions of section 142(4) of the Penal Code as amended by section 3 of the Penal Code (Amendment) Act 1998 are discriminatory and unjust in so far as they provide stiffer penalties for a person convicted of rape who is found to be HIV positive. Further, counsel submits that the section is ultra vires the Constitution because it offends against the spirit of the Constitution, particularly section 15. Thirdly, counsel claims in the alternative that section 142(4) of the Penal Code as amended by the 1998 Act is unjust and unfair in so far as it presumes that the convicted person who, after trial and conviction, tests HIV positive must have transmitted the virus to the victim and therefore must be harshly punished.

Applicable law

I take the constitutional point first. That point covers both the second and the alternative grounds of appeal argued by the appellant. In support of the submission that section 142(4) as amended was ultra vires the Constitution, counsel for the appellant referred to section 15 of the Constitution. Subsections 1 and 2 of that section provide that:

(1) Subject to the provisions of subsections 4, 5 and 7 of this section, no law shall make any provision that is discriminatory either of itself or in its effect.

(2) Subject to the provisions of subsections 6, 7 and 8 of this section, no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority.

...

Section 15(1), the very provision which proscribes legislation "that is discriminatory either of itself or in its effect," subjects that proscription to three other subsections of that section. One of these is subsection 4 of which paragraph e is relevant to this case. It provides that:

(4) Subsection 1 of this section shall not apply to any law so far as that law makes provision ...

(e) whereby persons of any such description as is mentioned in subsection 3 of this section may be subjected to any disability or restriction or may be accorded any privilege or advantage which, having regard to its nature and to special circumstances pertaining to those persons or to persons of any other such description, is reasonably justifiable in a democratic society.

...

Application of law to facts

...

Freedom from discrimination only on account of being a member of an identifiable and recognised group or class is guaranteed by the Constitution. That freedom has to be liberally interpreted. Indeed, the fact of including in the groups of those likely to be affected by discrimination persons afflicted by disease or disability is a result of such liberal interpretation. But that freedom is not absolute. It is curtailed in section 15(4)(e) by the exception which recognises the power of Parliament to restrict this freedom from discrimination by the enactment of a law, which, "having regard to its nature and to special circumstances pertaining to those persons or to persons of any other such description, is reasonably justifiable in a democratic society."

AIDS is the modern scourge of the world ... It is a pestilence the effect of which, in the areas that it has struck, has been devastating. The general effect on the persons it has afflicted is certain exposure to infections, and malignancies, rapid emaciation of the body and a severely shortened life expectancy. The accepted view of experts in this sphere of medicine and science is that AIDS is caused by HIV. The respondent in this case has narrated to us a history of the development of AIDS in this country, and the background of the amendment passed by Parliament, the provisions of which are objected to by the appellant in this appeal. In my view, it is unnecessary to repeat this narrative. It is sufficient to say that judicial notice ought to be taken of the fact that Botswana is one of the countries which has been afflicted by the disease to such an alarming extent that it has been described as having assumed pandemic proportions. According to counsel for the respondent, as high a percentage as 20 per cent of its people have the HIV syndrome. By any measure, any government faced with such a grave and sombre situation involving the survival of its people has an urgent duty to act to contain or, at least, to ameliorate the suffering of its people. These, according to counsel, and we have no reason to doubt her, are the circumstances which moved Parliament to enact the Penal Code (Amendment) Act of 1998, with its enhanced penalties.

As provisions of that enactment are challenged on the ground that they abridge the freedom from discrimination of persons who after conviction are found to test HIV positive, the issues for consideration are, in the first place, whether the provisions are discriminatory; and if so, whether such provisions can or cannot be permitted to prevail on the ground of being laws which,

having regard to their nature and to special circumstances pertaining to persons with the HIV syndrome, are reasonably justifiable in a democratic society.

The first consideration, whether or not the amendment unlawfully curtails the freedom of persons with the HIV syndrome is easy to dispose of. For the exception in section 15(4)(e) to apply, it must be shown that there has in fact been a discrimination. In so far as the amendment treats such persons differently in punishment from the rest of men without that syndrome who commit the same act of rape, it is discriminatory. But that is not the end of the matter. Having accepted that the law is discriminatory, we come to the next question, whether the law enacted is or is not reasonably justifiable in a democratic society. Rape by itself is a very serious offence with such traumatic consequences for the victim that in the effort to combat it, Parliament has before the disputed amendment made a change to the punishment of those found guilty of it. As far back as 1982, the Penal Code (Amendment) Act in section 1 made corporal punishment compulsory for the offences of rape and attempted rape. That in itself gave an indication of the seriousness with which Parliament then regarded the incidence of the offences. To add to the victim's trauma of rape the anxiety of possible contagion of AIDS and the actual contraction of the disease must be a tragedy beyond endurance. In the face of the gravity of the crisis which has overtaken the people, Parliament it is clear, formed the view that it would be imprudent and irresponsible if it did not act; and that one method of meeting the crisis that it chose was to provide enhanced minimum sentences for persons who committed rape and were found to be HIV positive.

...

The examination for the HIV syndrome takes place after conviction, not before. Crisply stated, the bone of contention between the parties is that the appellant submits that the interpretation, which made a person without the syndrome before the rape liable to undergo the enhanced penalty, is discriminatory and therefore unconstitutional. The respondent, on the other hand, says that Parliament, having regard to its right and power to enact laws for the governance of the people, had enacted that even if the law results in a person not having the syndrome before the act of rape being liable to the enhanced penalty, that was what was necessary to face the crisis confronting the people, and cannot be unconstitutional.

A court should be slow to declare an Act of Parliament, as the representative of the collective will of the people, unconstitutional. It should not, however, fear to do so if that is the only conclusion it could come to after a serious consideration of the challenged enactment and an examination of all sides of the question. If an interpretation can be given which saves the enactment from being declared unconstitutional, the court must adopt that interpretation. That said, I must add that in this case, I do think that the submission made by counsel for the State is not acceptable in its entirety. As I said earlier, on the face of the amendment, it must be admitted in terms of section 15 of the Constitution that it discriminates against the group of men who are found to have the HIV syndrome upon conviction for rape. But I do not think that Parliament intended to apply the enhanced penalty provisions to persons who before the act of rape did not have the HIV syndrome. As far as I can see, the broader interpretation advocated by the respondent has been given some credibility only because the amendment chose to require the testing for HIV to be done after conviction. We asked counsel why this was so. Her explanation, given without conviction, was that this was because to do so before conviction would infringe the accused's person's rights. I do not know which rights of the accused person counsel was referring to. But it is not unknown for medical examination of persons arrested for offences to take place upon arrest and before a trial if the results of the examination would affect any part of the trial proceedings. And if that had been done in this case, it would probably have distinguished those offenders who had the syndrome before the act from those who did not. The report on the test done after conviction would have to state whether or not the accused had the syndrome before he committed the offence.

A law enacted for the purpose of providing an enhanced punishment for an offence which takes into account

circumstances which occur after and which are unconnected with the commission of that offence cannot be considered a law for the punishment of that offence. Neither can it be considered to deter people from the commission of that offence. It is neither just nor necessary for the prevention of the offence because it bears no relationship with the crime which the law seeks to punish. If I were to accede to the argument on this point by counsel for the respondent, namely, that it matters not when the HIV syndrome was contracted, and that once the convicted person is found after conviction to have HIV, he was liable to the enhanced punishment imposed by the amendment, I would have to hold further that such legislation offends against the constitutional freedom from discrimination conferred by section 15(1). It offends the Constitution because it is too broad and discriminatory; and it exceeds any measure which can be described as reasonably necessary for the legislature to take in combating the threat to the nation's health, serious though it be. And in so far as it exceeds what is reasonably necessary to meet the situation posed, the discrimination cannot be justified under section 15(4). Having regard to the fact that the HIV syndrome can be acquired through means other than sexual contact, the possibility of the convicted person surrendering to it in the course of the rape from the victim, or after the offence of rape was committed, cannot be excluded.

If a law can be interpreted either in a manner which leads to a declaration that it is unconstitutional, or in a manner which presumes its constitutional validity, a court is bound to adopt the alternative which leads to the upholding of its constitutional validity. Section 142(4)(a) merely says that, "Any person who is convicted [of rape, et cetera] and whose test for the HIV ... is positive shall be sentenced to a minimum term of 15 years' imprisonment." The section does not expressly deal with the time when HIV positive status was acquired. That has given the respondent the opportunity to argue that it does not matter if the status was acquired after the rape. Having regard to the fact that the punishment was decreed for the offence of rape, it would be extraordinary that a reading of the provision should be adopted which covers HIV status acquired in the course of the rape from the victim or after the offence for which the punishment was prescribed. The status must, to make sense, be related to, and affecting the offender when he commits the rape; it would, therefore have to be in existence at the time of the offence. Otherwise it would appear as if Parliament intended to impose such a severe minimum sentence on persons not for the rape committed, but simply because they had HIV. That cannot be right and cannot be the intention of Parliament. In my view, the broad interpretation sought by the respondent is unacceptable. It is only by the interpretation which limits the enhanced penalty to the person having the HIV syndrome at the time of the act of rape that the provision can be justified as within the constitutional limits of Parliament to enact.

...

Finding

In the event, I conclude that section 142(4)(a) of the Penal Code as amended by section 3 of the Penal Code (Amendment) Act (No 5 of 1998) is not unconstitutional as contended by the appellant. Read in the sense that the convicted person must have the HIV syndrome at the time of the act of rape, whether he was aware of it or not, I think the legislation is reasonably necessary in a democratic society, as Botswana is, to abridge the freedom from discrimination provision of the Constitution, in order to combat the spread of the HIV/AIDS pandemic which has afflicted the nation; and to deter the increasing incidence of rape. If an offender commits rape and it turns out that he is HIV positive at the time of the offence, he is liable to the enhanced punishment. Naturally, if he was aware that he was HIV positive at that time, he would qualify for the enhanced punishment in terms of section 142(4)(b) of the Penal Code. It matters not whether he is aware at the time he commits the offence or not. Sufficient notice has been given by Parliament of this result for every male within the jurisdiction to know that he is liable to this penalty if, having the virus, he violates a woman. He cannot therefore complain that he is being prejudiced by the consequences of his own intended act of which he was not aware.

...

As it was not shown that the appellant had the HIV syndrome at the time the offence of rape was committed, the precondition for the imposition of the minimum sentence of 15 years' imprisonment by section 142(4)(a) as amended has not been established. Accordingly the sentence of 16 years' imprisonment and two strokes of the light cane is hereby set aside ...

Remedy

... The minimum sentence of 10 years for rape under section 142(1)(i) of the Penal Code as amended, however, applies.

Lejony v The State 2000 (2) BLR 145 (BwCA)

In accordance with section 147(2) of the Penal Code of Botswana, as amended by the Penal Code (Amendment) Act 5 of 1998 (an extract of this Act is available under 'D 2.9 HIV and criminal law') a person convicted of defilement is required to undergo HIV testing before sentencing. The appellant tested positive to HIV but there was no evidence confirming that he had HIV at the time he committed the offence. The Botswana Court of Appeal dismissed the appeal on the ground that the accused must be shown to have been HIV positive at the time of the offence and not merely at the time of the test after conviction.

Excerpts

...

Facts

Ontshabetshe Lejony was tried and convicted of defilement of a female under 16 years of age contrary to section 147(1) of the Penal Code (Cap. 08:01), as amended by section 8 of the Penal Code (Amendment) Act, 1998 (Act No 5 of 1998). The conviction was recorded by the magistrate's court at Francistown on 2 August 1999. Under the amended section 147(2) any person convicted of such offence shall be required to undergo a HIV test. Where the test is positive, the convicted person is liable, under section 147(3)(a) of the amended Act to a minimum sentence of 15 years' imprisonment, with or without corporal punishment, if proved that he was unaware that he was HIV positive. Lejony tested positive. There was no evidence that he was aware at any time before the test that he was HIV positive. The magistrate, whose sentencing power did not extend to imposing a penalty of 15 years' imprisonment, committed Lejony to the High Court under section 296 of the Criminal Procedure and Evidence Act (Cap. 08:02) for sentence. The case thereupon came before Mosojane J. In a considered judgment in *State v Lejony* [2000] 1 B.L.R. 326, Mosojane J came to the conclusion that he was not entitled to impose the minimum penalty of 15 years' imprisonment. This conclusion was based in the first place, on the fact that the document certifying that Lejony was HIV positive, did not state whether Lejony had the HIV syndrome at the time he committed the offence; and secondly, on the reasoning which was embodied in two passages of his judgment. It reads as follow at p. 329F:

It seems to me clear without any room for doubt at all that the legislature intended to punish those people who were HIV positive but were unaware of their status at the time when they committed the offence and not everybody who was found with the disease after conviction regardless of whether or not they carried the disease when they committed the offence. To punish them simply because they were found to be HIV positive after conviction would be absurd and the language of the subsection permits no such construction in my judgment.

That led to the observation he later made, at p. 330H, that:

Finally, I wish to remark that the possibility exists in this case, as always it will, that the accused got his HIV status, if he has it, from his victim. The law does not say that he should be punished for that. He would however be punished if he was HIV positive though unaware of it when he committed the offence. This is what I understand the law to be saying. Therefore, in the view that I have taken, unless a court is satisfied that the convicted person was HIV positive though unaware of it at the

time of committing the offence it has no right to punish him under subsection 3(a) of section 147 of the Penal Code.

Accordingly, the learned judge imposed the minimum sentence prescribed by section 147(1) of the Penal Code, as amended, for defilement of a female by a person who did not have the HIV syndrome, that is, 10 years' imprisonment.

The State disagrees with this interpretation of section 147(3)(a), and has appealed against it to this court...

Taking the appeal by the State first, the grounds filed were no less than seven. They were as follows:

1. The High Court judge erred by placing or determining the HIV status of an accused person at the time of the commission of the offence, when the Act refers to the status of the accused after conviction.
2. The Honourable judge erred when he made an assumption that because the complainant had been sexually active, the possibility of accused person being infected with the HIV virus by complainant could not be ruled out.

...

Finding

They all revolve round the single issue arising from the interpretation placed by Mosojane J on the amendment to section 147 of the Penal Code, in so far as he concluded that the accused must be shown to have had the HIV syndrome at the time of the offence, and not merely at the time of the test after conviction ...

The arguments canvassed on this question were exactly the same as this court considered in *Makuto v The State*, reported at p. 130, ante, which judgment was given today. In that case, counsel for the appellant relied on the decision of Mosojane J in this case. We expressly approved of the reasoning of Mosojane J. In this case, I think we should apply the reasoning of this court in the *Makuto* case. I think on that account, the submission of the State that this court should adopt the broad interpretation which makes the person convicted for the offence liable of rape or defilement to the enhanced punishment of 15 years, whether he had the HIV syndrome at the time of the offence or not, must be rejected.

Remedy

The decision of Mosojane J in this case was right and I would as a result, dismiss the appeal of the State.

...

Nqubi v The State (Practice direction) 2001 (1) BLR 154 (BwCA)

The case involved the defilement of a 9-year-old child. The court applied the same reasoning as in the *Makuto* case (above), that a minimum sentence of 15 years is only applicable upon proof that the convicted was HIV-positive at the time of the offence. The Botswana Court of Appeal indicated that caution is required in admissibility of documentary evidence.

Excerpts

...

Introduction

This appeal is restricted to sentence. After argument on appeal a sentence of 10 years' imprisonment was substituted for the 15 years imposed by the court *a quo*. These are the reasons we undertook to furnish for so doing.

Facts

The appellant was tried in a magistrate's court on a charge of rape. The complainant was a nine year old girl. He was found guilty, not of rape but of defilement of a girl under the age of 16 years in terms of section 147(1) of the Penal Code (Cap. 08:01) as amended by the Penal Code (Amendment) Act, 1998 (Act 5 of 1998). In compliance with section 147(2), the magistrate ordered

that the appellant undergo a HIV test to determine his status in this regard. On receipt of the result of this test the magistrate recorded that:

The court has the misfortune to inform the Accused that following a compulsory HIV test ... the results are now ready and they show that the Accused is HIV positive.

The magistrate was under the impression that a mandatory sentence of 15 years had to be imposed.

Application of law to facts

The matter was referred to the High Court for sentence in terms of section 295 of the Criminal Procedure and Evidence Act (Cap. 08:02). When the case came before Mwaikasu J the learned judge, having determined that the conviction was in order, observed that "the medical test for HIV/AIDS ... turned out to be positive." The evidence adduced in that court was that the appellant was unaware of this infection at the time he committed the offence, assuming that it was present at that stage. The court accepted this. It, however, considered that a sentence of 15 years' imprisonment was mandatory in terms of section 147(3)(a). In doing so the decision of this court in the matter between *Makuto v The State* was overlooked. In this case the court was concerned with a rape conviction and the correct sentence to be imposed having regard to the provisions of section 142(4) of the Penal Code as amended. This subsection provides for a minimum sentence of 15 years on proof that the convicted accused is HIV positive. The question raised, and calling for decision as a constitutional issue, was whether the section applies in the absence of proof that the offender was HIV positive at the time the offence was committed. The relevant passage in the judgment (at p. 141 D to E) reads as follows:

As it was not shown that the appellant had the HIV syndrome at the time of the offence of rape was committed, the precondition for the imposition of the minimum of 15 years' imprisonment by section 142(4) (a) as amended has not been established.

This conclusion applies a fortiori in the case of a person convicted, as in this case, of a contravention of section 147(1). Thus the court was not obliged to impose the sentence of 15 years and erred in doing so. Counsel before us acknowledged this, and agreed that a substituted sentence of imprisonment for 10 years would be an appropriate one.

Finding

In conclusion I must draw attention to an evidential feature of this case. As I have indicated, according to the record both the magistrate and the learned judge simply told the appellant that according to a medical report he was HIV positive. This is not the first case in which such a finding is dealt with in this manner that overlooks the requirements for the admissibility of documentary evidence. The medical report may be produced and placed on record as an exhibit with the consent of the accused who admits its correctness. Failing such consent and admission, the person responsible for the report must be called as a witness. This matter has been raised with the Chief Justice, and he agrees that the necessary steps are to be taken by the Registrar of the High Court to inform all prosecutors and judicial officers accordingly.

Remedy

For these reasons the appeal succeeded to the extent that the period of imprisonment was reduced from 15 years to 10 years. These remarks relating to the admissibility of proof of HIV status must be drawn to the attention of all judicial officers.

S v Nzara 2001 JOL 8529 (ZHC)

This case was related to sodomy acts committed by the accused on a four-year-old child. Upon conviction, the case was referred to the Zimbabwe High Court for sentencing. The court indicated that sodomising a minor child with the knowledge that one is infected by a sexually transmissible disease and possibly by HIV, is a much more serious offence. The accused was sentenced to 20 years imprisonment.

Excerpts

...

Introduction

The accused was charged with the crime of sodomy. It was alleged that between 15 and 17 of December 1999 at a house in Glen-Norah, the accused unlawfully and intentionally and against the order of nature had sexual intercourse per anum with one Z, a minor aged four-and-half years on diverse occasions. He pleaded not guilty and after a long trial, he was found guilty of the crime charged and he was referred to the High Court for sentence.

I am satisfied that the conviction was in order and the referral of the matter to the High Court for sentence was also in order.

It is significant that the issue of the accused's HIV status arose when, during the trial, the accused asked if the child had a sexually transmitted disease similar to the one he was suffering from. This prompted the magistrate with the accused's consent and the consent of the minor child's parents to order that the accused and the minor child both be examined or tested for the HIV/AIDS virus. The accused person confirmed in court that he was indeed examined. Blood samples were taken from him and they were analysed. The results of the tests were that the accused was found to be HIV positive and the minor child was also found to be HIV positive.

In sentencing the accused, I need to highlight one feature of this case for the benefit of society at large. The accused was employed on odd jobs by the minor child's parents at their rural home in Chiweshe communal area. The accused visited the minor child's parents' home in Harare from Chiweshe in order to discuss matters connected with the tasks he was performing for them. From the evidence on record he had a view to being asked to do more work for them. He stayed at their home for three days and was asked to do some work in the garden for which he was paid \$100,00. During the three days on which he stayed at their home, he slept on the same bed and in the same blanket with the minor child. It was during the night or nights that he sodomised the minor child.

In my view, parents should be jealously protective of their minor children. They should not expose them to persons, relatives or otherwise trusted visitors, without the absolute necessity to do so. It was as a result of the parents' baseless trust in one of their casual workers that resulted in this tragedy. Sodomising a minor child is a serious offence which is akin to rape. But sodomising a minor child with the knowledge that one is infected by a sexually transmitted disease and possibly by HIV/AIDS, is a much more serious offence.

From what transpired during the trial, the accused was aware that he had a sexually transmitted disease. He must have been aware that he was also possibly HIV positive. Because of the illness which he suffered and of which he was aware, he would have had every reason to believe that he was infected with the HIV/AIDS virus. It is proved in this case that at the time of the offence the accused was indeed HIV positive because the minor child was tested HIV positive on examination.

The accused was 22 years old and he is now 24 years old. He is single. He has submitted in mitigation that he looks after his grandparents and his young brothers and sisters who are

dependent on him. He has asked the court to exercise leniency in his favour. The accused committed a most grievous offence against a young child who he was entrusted to sleep with in the same bed. He abused both the trust bestowed on him and betrayed the minor child's parents' trust in him in a most painful manner. His moral blameworthiness is therefore very very high indeed.

The courts must impose a punishment which is retributive in nature. Retributive because with the absence of a cure for HIV/AIDS, the accused has procured that the minor child will not only suffer during whatever remains of his natural life, but also that he will eventually die from HIV/AIDS.

Finding

Sodomy is a distasteful offence. It is an offence of deeper malignity than rape (see *State v Kampher* 1997 (2) SACR 418 (C)). Children are entitled to the protection of their right to dignity and integrity of the person. Courts have a duty to send a clear message to sodomists and potential sodomists and to the community in general that they are determined to protect the dignity and integrity of young children and no mercy must be shown to those who seek to invade young children's rights. In my view, the accused represents a danger to society sufficiently serious to warrant his detention for a very very long period.

Remedy

In assessing the appropriate sentence, I have taken into account the fact that the accused himself is HIV positive. He is therefore a sick man but in sentencing him and having to balance the interest of society and the absolute necessity to protect young children from child abusers, I consider that the following sentence is justified.

I therefore sentence the accused to 20 years' imprisonment.

Attorney General's Reference: In re: The State v Marapo 2002 (2) BLR 26 (BwCA 2002)

The case dealt with the issue of unconstitutionality of section 142(1)(i) of the Penal Code, which restricts bail to persons charged of rape. The Botswana Court of Appeal indicated that depriving a person of his or her liberty does not reduce incidence of HIV. The Court decided that the section referred to is unconstitutional.

Excerpts

...

Facts

The issue for decision by the court in this matter is whether s 142(1)(i) of the Penal Code ... which provides that any person who is charged with the offence of rape shall not be entitled to be admitted to bail, is unconstitutional or not.

The respondent, Moatlhodi Marapo, was arrested on 27 September 2000 and charged with rape. In terms of s 142(1)(i) of the Penal Code, he was not entitled to bail pending his trial. On 9 February 2001 he brought an application in the High Court in Francistown ... for an order declaring s 142(1)(i) *ultra vires* section 5(3)(b) of the Constitution ...

...

Applicable law

...

Section 142(1)(i) of the Penal Code, as amended, provides thus:

- (1) any person who is charged with the offence of rape shall -
- (i) not be entitled to be granted bail.

Section 5(3)(b) of the Constitution, which is alleged to be contravened by section 142(1)(i) reads as follows:

- Any person who is arrested or detained -

(a) ...

(b) upon reasonable suspicion of his having committed, or being about to commit, a criminal offence under the law in force in Botswana, and who is not released, shall be brought as soon as is reasonably practicable before a court; and if any person arrested or detained as mentioned in paragraph b of this subsection is not tried within a reasonable time, then, without prejudice to any further proceedings that may be brought against him, he shall be released either unconditionally or upon reasonable conditions, including in particular such conditions as are reasonably necessary to ensure that he B appears at a later date for trial or for proceedings preliminary to trial.

Application of law to facts

...

It is beyond my comprehension how depriving a person of his liberty merely because he is alleged to have committed rape - not, it must be stressed, because he is found guilty of it - can in any way reduce the crime rate, including rape or serve to contain or restrict the incidence of HIV/AIDS. After all, not all persons who commit rape are infected with HIV/AIDS. It may be thought that knowing that no bail will be granted if a person is charged with rape will have a deterrent effect, persuading those who may be so minded to desist from pursuing their intentions. That, however, it would seem, was the ostensible purpose in the enactment of the section 142(1)(i), (2), (3), (4) and (5) by s 3 of Act 5 of 1998 containing, as they do, harsh and severe mandatory punishments for rape, particularly for those persons who are HIV positive and especially if they are aware of it. I cannot conceive that making the fact that a person who may be alleged to have committed rape not entitled to bail can operate in any manner as a deterrent.

Faced with the difficulties that I have just set out, Mrs Dambe [counsel for the Attorney General] submitted that, in any event, the enactment of section 142(1)(i) by the legislature was an expression of public concern about the crime situation in the country.

If I am wrong in my views and that the public interest may in some way be served by section 142(1)(i) or if it may represent an expression of concern about the crime situation, sight must not be lost of the fundamental right enshrined in section 3 of the Constitution of personal liberty. It is one of the most basic of human rights in a democratic society and its deprivation or curtailment must occur only within the most narrow of confines ... As stated by Kentridge JA in *Attorney-General v Moagi*...

Constitutional rights conferred without express limitation should not be cut down by reading implicit restrictions into them, so as to bring them into line with the common law.

Such rights are jealously guarded and the development, extension and preservation of them are cornerstones of the intellectual processes of democracies throughout the world and are embodied in the laws and judicial pronouncements of such countries as the United States, the United Kingdom, the many members of the European Community and neighbours of Botswana, such as South Africa. This trend has been particularly marked in the sphere of those rights personal to the individual and especially the right to personal liberty. This court as far back as 1992 has recognised that Botswana is one of the countries in Africa where liberal democracy has taken root ... and international human rights norms should receive expression in the constitutional guarantees of this country. The court is accordingly required to balance the concept of the public interest against the right of personal freedom and to determine the precedence of the F one in relation to the other by reference to the mores of the community and by using an assessment based on proportionality ...

It is notorious ... that the trend nowadays - and it has been so for a considerable time - is that basic human rights are nurtured, promoted and protected in all liberal democracies. Having stated that, the denial of entitlement to bail of a person who is only alleged to have committed rape to satisfy the public interest that serious crime should be confined, does not, in my view, weigh up against the infringement of that person's right of personal freedom and his deprivation of it on the mere allegation of his having committed the offence. It must be remembered that, even

where a person is charged with the grave offences of murder and treason, he may be admitted to bail ... It is therefore incongruous, to say the least, that a person accused of rape may not be so admitted ...

...

Finding

...

Adopting a purposive construction to the Constitution therefore and applying a value judgment to the proportional assessment of the public interest, on the one hand, and the right of personal liberty, on the other, I find that section 142(1)(i) of the Penal Code offends against the provisions of section 5(3)(b) of the Botswana Constitution and that the denial of bail where a person is alleged to have committed the offence of rape is not in the public interest

...

Remedy

...

The following order is therefore made:

(1) Section 142(1)(i) of the Penal Code as introduced by 3 of Act 5 of 1998 is declared *ultra vires* the Constitution of Botswana and is struck down.

...

Snoti v S 2007 JOL 19383 (SAHC E)

The appellant had raped a nine-year-old girl with whom he shared a bedroom. He was sentenced to life imprisonment. Apart from the age of the complainant, another aggravating factor had been that the appellant knew he was HIV positive and knew it. After several medical tests conducted on the complainant after the rape it had been established that the appellant had not transmitted HIV to the complainant. The court was not persuaded that the fortuitous circumstance of the complainant's HIV negative status had any bearing on the appellant's moral blameworthiness. The appeal against the sentence was dismissed by the Eastern Cape High Court (South Africa).

Excerpts

...

Introduction

This is an appeal to the Full Bench of this Division against a sentence of life imprisonment imposed by Jones J upon appellant pursuant to a conviction of rape in the South East Cape Local Division. Appellant, a 29 year old man, was charged as accused one with the rape of complainant, a nine-year-old girl. One Eunice Weziwe Cingi Makana, a woman, appeared as accused two, charged with being an accomplice to the aforesaid rape. She was eventually acquitted on this charge.

Facts

It appears from the evidence of complainant that she, appellant and accused two shared a bedroom at the house of one Sis Nomabaca, complainant's paternal aunt. On the night of 3 November 2004 complainant was sent to buy some home made liquor for appellant. On her return with the liquor she was called by accused two who whispered to her that appellant loved her and that she should go and sleep with him on his mattress. I interpose to mention that accused two in her evidence denied having said this to complainant. Although Jones J was satisfied as to the credibility of the complainant he considered that, in the absence of any corroboratory evidence, it would be dangerous to convict accused two on the single evidence of a child witness, hence her acquittal.

Be that as it may, complainant stated that she obeyed accused two and went to appellant where he was lying on his mattress.

Appellant undressed her proceeded to rape her. When he penetrated her vagina she 'jumped' and screamed because of what she described as being terrible pain. Appellant then closed her mouth with one hand and slapped her on the thigh with the other hand. When he was finished he gave her R600 which she told him she did not want. Accused two then 'borrowed' it. The following morning complainant reported the incident to her grandmother. Complainant was thereafter taken for a medical examination to Dr Mazibuko who recorded her findings on form J88 (exhibit C). Dr Mazibuko also testified at the trial. Her findings and evidence were summarised by Jones J as follows:

...

As regards the personal circumstances of appellant he is, as I have said, 29 years of age, and was at the time of the incident unemployed. Although he had a previous conviction for dishonesty he was treated by Jones J as a first offender. During 2000 he was diagnosed as being HIV positive.

In coming to the conclusion that no substantial and compelling circumstances existed which justified the imposition of a lesser sentence than the minimum sentence of life imprisonment prescribed by section 51 of Act 105 of 1977 the learned Judge took into account as aggravating features two factors in particular. Firstly, that complainant was a helpless little girl aged nine years who had been given a place to sleep in appellant's room where she was supposed to be safe. Instead of protecting her appellant raped her in the presence of an adult woman. Secondly, the fact that at the time of the incident appellant was, to his knowledge, HIV positive. In this regard the learned Judge stated as follows:

...

After having granted leave to appeal against the sentence imposed upon appellant by him Jones J furnished a report in terms of section 320 of Act 51 of 1977. In such report he stated that he had inadvertently not referred to a significant item of information on sentence given to him from the bar during the course of argument in mitigation namely, that subsequent to the rape the complainant had been medically examined at regular intervals to establish whether or not she had been infected with HIV. The result of the testing was that she had not been so infected and that it can now be accepted that appellant did not transmit the virus to her. The learned Judge stated that this objective fact might have a bearing on whether or not a sentence of life imprisonment should have been imposed.

In his judgment on sentence the learned Judge emphasised, correctly with respect, that the rape of a small child such as complainant is always an extremely serious matter, even in the absence of serious injury and despite there being no evidence of permanent psychological after-effects. This is all the more so where the perpetrator is a man in a position of trust vis à vis the complainant. I agree further with the learned Judge that the fact that appellant was aware that he was HIV positive at the time that he committed the offence places this case within the worst category of rape cases (compare *S v Mahomotsa* 2002 (2) SACR 435 (SCA) at 443f-h).

Finding

Ms Theron, who appeared for appellant, emphasised the fact that complainant had not been infected. I am not persuaded that this fortuitous circumstance has any bearing on appellant's moral blameworthiness. His conduct in raping a nine-year-old child entrusted to his care whilst knowing of his HIV status, was reprehensible in the extreme.

Remedy

In my view the learned trial Judge correctly found that in the light of the aggravating factors present in the case no substantial and compelling circumstances existed justifying a lesser sentence than that of life imprisonment.

Accordingly the appeal against sentence is dismissed.

...

D4.9 HIV and the right to expression

South African Human Rights Commission v SABC & Another (SABCT 2003)

The complaint concerned a broadcast disclosing the identity of a minor, as well as his HIV positive status, without masking the minor's face or digitally fragmenting his image. The Broadcasting Complaints Tribunal of South Africa held that, since there was a compelling societal interest that the AIDS pandemic be communicated to the public, and since the parents had granted their permission, the broadcasters had not contravened the Code.

Excerpts

...

Introduction

[1] The South African Human Rights Commission (HRC) is, in terms of article 1 of the Human Rights Commission Act 54 of 1994, enjoined to investigate complaints of alleged human rights violations when a complainant has either a direct interest or when the alleged human rights violation is a matter in the public interest. This complaint is lodged by the SAHRC in the interest of a minor, as the Human Rights Commission contends that this matter concerning the publication of the identity and image of the minor and his HIV/AIDS status is in the public interest.

Facts

[2] The HRC contends that the respondents had, on 7 March 2003, flighted news broadcasts disclosing that the minor had contracted HIV/AIDS as a result of a blood transfusion administered to him at Pretoria Academic Hospital during an operation. The news broadcast further exposed the identity of the minor without masking his face or digitally fragmenting the identity of the minor. Thus the argument is advanced that the minor's constitutional rights to privacy and dignity were infringed.

[3] The HRC contends that the respondents could have achieved their objective less intrusively by not revealing and exposing the identity, name and image of the minor; the respondents by their broadcast are said to have violated the dignity and privacy of the minor, conducted the broadcast unreasonably, and failed to promote and protect 'the best interest of the child'. Further, that the respondents violated the rights of the child to dignity and privacy; that they contravened section 10 and section 14 of the Constitution Act 108 of 1996. The HRC submits that the respondents' failure to protect the identity of the minor was not in his best interest as envisaged in terms of section 28(2) of the Constitution. The HRC states that the respondents contravened clause 38 of the Code. Clause 38 provides as follows:

Insofar as both news and comment are concerned, broadcasting licensees shall exercise exceptional care and consideration in matters involving the private lives and private concerns of individuals, bearing in mind that the right to privacy may be overridden by a legitimate public interest.

[4] The respondents' response is that the minor's parents approached them to publicise and to offer assistance for their financial plight in having to provide medical assistance for the child amounting to R900,00 per month. Further, the parents sought legal assistance in their efforts to sue the Pretoria Academic Hospital. The parents initially approached the print media – "Beeld" newspaper in particular – which published the minor's story as well as photographs disclosing the minor's name, where he lived, where he was schooled, his family and community relationships.

[5] As a result of the respondents exposé, the minor's parents received legal assistance from Legal Aid and funds for the minor's medical expenses. The respondents argued that their broadcasts were flighted with the intention of promoting the best interest of the child and that the news report was broadcast with

the requisite concern and sensitivity. The respondents further argued that the newsworthiness of the report was such that the public interest superseded the right to privacy of the minor, in view of the fact that HIV/Aids is a matter of national concern and that the broadcast exposed the inadequacies in the national health system.

[6] The respondents contend further that they were authorised to broadcast the news item and interview with the minor and his parents by virtue of the fact that the minor's parents had signed a waiver granting the respondents the right to reveal the name of the minor and also the fact that he is HIV positive as a result of a blood transfusion.

[7] The complainant contends that the minor and his parents could not have appreciated the legal implications of signing a waiver authorising the respondents to disclose the name of the minor and display his face on national television, thus publicising his HIV status to his community and schoolmates. Doing so, the argument ran, induced trauma and stress to the minor's life, since the broadcasts had stigmatised his rights of personality.

[8] The Tribunal viewed the news broadcasts, and listened to the interview, and is of the opinion that the minor's parents had the locus standi to freely and voluntarily exercise their parental authority and legal guardianship by signing the waiver. Further, the Tribunal is of the view that the minor's parents fully appreciated what a waiver of rights entailed and the consequences thereof, since legal advice was proffered to them before such waiver was signed. The Tribunal's view is that the news broadcast and interview were reasonably and sensitively conducted, without sensationalism or exploitation of, or violation of, the interest of the minor.

...

[10] The Tribunal is not convinced that the respondents infringed the minor's constitutional rights to dignity and privacy, as the declared government policy in combating HIV/AIDS is to embrace the sufferers and those who are infected, to create empathy and understanding in society for them, and not to ostracise the infected but rather to accord them dignity as members of society,

Finding

[11] Even if we accept that there was an infringement of the child's rights to dignity or privacy, we believe that the invasion was justified in terms of section 36 of the Constitution. The matter was treated with due sensitivity and there was a compelling societal interest which justified the invasion of privacy. The child was alleged to have been an innocent victim and it was in the public interest to disclose this to the viewers. The constitutional right of the broadcasters concerned to inform the public, and the right of the public to be informed even through disclosure of the identity of the child, weighs more than the right of the child to privacy in these circumstances, where consent was given by the parents. Had there not been permission by the parents, the outcome of this case might have been different. Since that situation is not before us, however, we decline to express an opinion on such a hypothetical case.

The complaint is dismissed.

...

Allen v SAFM (SABCT 2006)

The case was related to a complaint against a talk-show aired on South Africa FM (SAFM). The complainant submitted that the show was one-sided and the information was inaccurate. The Tribunal decided that the respondent did not contravene clause 36 of the Broadcasting Complaints Commission of South Africa (BCCSA) Code. The Tribunal held that due to the nature of the show it is not always possible for broadcasters to have two guests with opposing views on the same programme. It further indicated that there is inherent balance in the programme due to the fact that the listening public can phone in and express their views.

Excerpts

...

Facts

[1] During the Vuyo Mbuli Talk Show on SAFM at about 10am on 23 March 2006 the presenter had as his guest for about one hour Dr Clive Gray who represented the National Institute for Communicable Diseases. This body is a partner in a research programme together with the Centre for HIV/AIDS Vaccine Immunology (CHAVI). As is usual with such talk shows, the telephone lines were opened and listeners were invited to air their views, which a few did. During the discussions the public was invited to volunteer for vaccine testing with which the Centre was involved. The way in which the programme was presented, created the impression with the complainant that the show was one-sided and she lodged a complaint with the BCCSA. At the hearing it was agreed between all the parties that there is no need for the Tribunal to listen to the programme as it was common cause that Dr Gray was the only guest on the show. It was agreed that the matter of balance in presenting the programme would be argued and that the Tribunal would give judgment on this matter only.

[2] The complaint reads as follows:

First complaint:

Complaint against Vuyo Mbuli Show, SABC SAFM 10am to 1am on 23 March 2006. I wish to lay a formal complaint against the above radio talk show, regarding the one hour exposure given to the Centre of HIV/AIDS Vaccine Immunology (CHAVI) on the basis that it was one-sided, no attempt was made to present alternate opinion; as a result inaccurate, misleading and false facts including false scientific facts were presented as cast in stone and were left unchallenged by the presenter. I request that the radio station be instructed to present a programme of similar duration representing alternate scientific views.

Second complaint:

Complaint against Vuyo Mbuli Show, SABC SAFM 10am to 11am on 23 March 2006. I wish to append an additional complaint to the one above as follows: Complaint against SABC – editor-in-chief for non-compliance with the SABC code in matter pertaining to microbiology. There is abundant evidence that the editorial board of the SABC is not applying its code. I restrict myself to matters relating to HIV/AIDS. However, the field in which it is embedded – microbiology, impacts so many spheres of our existence that the SABC deficiency in the HIV/AIDS field is merely a symptom of far wider problem.

...

[3] The SABC responded as follows:

In respect of the above complaint, I enclose a copy of the programme segment on CD. Our comments are as follows. The complainant is a well known AIDS dissident who, to our understanding, usually challenges the portrayal of any conventional and generally accepted scientific evidence. The discussion on The Vuyo Mbuli Show was not intended to be a debate on the issues of differing scientific viewpoints regarding HIV/AIDS. It was, rather, a discussion on a joint International Research Initiative that involves as one of the partners in the initiative the Centre for HIV/AIDS Vaccine Immunology (CHAVI). The guest in the studio, Dr Clive Gray was

representing the National Institute for Communicable Diseases, which is also involved in the research initiative. The suggestion that this was a “one-sided” show with “no attempt to present alternate opinion” is rejected on the basis that from the outset of the programme the lines were open for listeners to call in and contribute to the discussion. In fact some nine callers were taken on air and they posed questions and made comments.

...

[4] I shall start with the complainant's second complaint, the one headed “complaint against SABC editor-in-chief for non-compliance with the SABC code in matter pertaining to microbiology”. It is not within the jurisdiction of the BCCSA to adjudicate on complaints like non-compliance with the SABC code. We do not apply the SABC code, only the Code of Conduct signed by the majority of broadcasters in South Africa, including the SABC. The complaint apparently flowed out of the first one, which is a complaint against a specific programme. This falls within our jurisdiction and I shall deal with it next.

Applicable laws

[5] The clause in the Code of Conduct, applicable to the facts of this case, is 36 which determines the following:

In presenting a programme in which controversial issues of public importance are discussed, a licensee shall make reasonable efforts to fairly present opposing points of view either in the same programme or in a subsequent programme forming part of the same series of programmes presented within a reasonable period of time of the original broadcast and within substantially the same time slot.

Application of law to facts

There is no doubt that the whole matter of HIV and AIDS is a controversial issue of public importance. There is still debate on whether AIDS is caused by the HIV virus and what the best treatment for the syndrome is. There are various opposing views, politically, scientifically, socio-economically, et cetera on this matter that have resulted in acrimonious debate and even litigation. There is definitely no agreement in our society on the most effective and efficient way in which the disease should be treated.

[6] The programme complained of is not the first and will surely not be the final one on which this topic is discussed. The respondent has presented this topic on different kinds of programmes too. The present one is labeled a talk show. Mostly, in this type of programme, one guest is invited to the studio. The guest is allowed to put forward his viewpoints and then the opportunity is given to the listening public to phone in and to agree or disagree with the guest and give their own viewpoints. In programmes like this one, the Tribunal of the BCCSA has in the past made its conviction very clear. One example is the judgment in the case of *N Dinur, D Mankowitz and EMTSA v M-Net*, Case number: 11/2002 where the Tribunal said:

“Our reaction is, accordingly, to tread with utter care when opinion is expressed – even opinion which is based on erroneous assumption or error. The well-known approach of Holmes J in *Abrams v The United States* 250 US 616 (1919) that unjustified opinion should rather be left for the market place of ideas to counter it, also carries special weight in the opinion of the Commission.

... [T]he nature of freedom of expression is that we should not, and cannot, stop people from disseminating their ideas, how unacceptable it may be. Let it be tested in the market place of ideas and let the listeners decide for themselves. There are limits to the freedom of expression where the expression amounts to propaganda for war, advocacy of hatred based on race, religion, et cetera, but the limits to this freedom have not been transgressed in this instance” (see section 16(3) of the Constitution of the Republic of South Africa).

The same can be said of the programme in question. The applicability of section 16 of the Constitution was not debated because the complainant did not aver that what was said on the programme amounted to hate speech, and rightly so.

[7] It is conceded that the “market place of ideas” consists, inter alia, of radio and television. This is where the debate should rage. The respondent says it does; the complainant says, as far as HIV and AIDS are concerned, not enough and not in a balanced way.

The complainant, in one of her communications to the representative of the respondent dated 8 September 2005, says:

It was one of the no more than ten occasions where a person skeptical of the HIV causes AIDS paradigm has been accorded time at the SABC since October 1999 when Thabo Mbeki first raised his concerns.

It has often been said in this Tribunal that it is not possible to determine with mathematical precision how many times for and how many times against a viewpoint the broadcaster should allow participants to air their views.

[8] Many of the broadcasters have talk shows or phone-in programmes. The usual format is to invite a guest to present one perspective. A discussion follows and then the listeners are invited to phone in and to engage in debate with the guest. This is an excellent opportunity to get down to the gist of things and also an example where “unjustified opinion” is left for “the market place of ideas” to counter it.

[9] We realise that, due to the nature of talk shows or phone-in programmes and the time constraints on these programmes, it is not always possible for broadcasters to have two guests with opposing views on the same programme. I think there is inherent balance in the programme due to the fact that the listening public can phone in. This is part of the “market place of ideas”. Anyone is free to phone in and to challenge what the guest or another listener has said. We were assured at the hearing that the respondent does not keep a list of “banned listeners” whose calls are blocked on such occasions, as was averred. The problem, of course, is that the broadcaster has no control over the viewpoints of those listeners who do phone in. If all callers agree with the guest's opinion, one can easily come to the conclusion that there was no balance. This, in our view, is not the answer to the question whether clause 36 has been contravened. The overriding principle is that a “market place of ideas” has been created by the broadcaster where everyone is free to air his opinion. If, in a particular programme of this nature, it appears that balance was not obtained because of the reaction, or lack thereof, of the callers, the principle of the ‘market place of ideas’ still remains and the broadcaster cannot be censured for this.

Finding

[10] We have been assured by the representative of the respondent that the broadcaster has invited people of different viewpoints on HIV and AIDS to air their views on this and other programmes in the past. We have no reason not to believe him. This, coupled with the fact that talk shows or phone-in programmes are inherently programmes where balance could be obtained, brings us to the conclusion that the respondent did not contravene clause 36 of the Code.

The complaint is therefore not upheld.

De Vos v Talk Radio 702 (SABAT 2006)

The respondent's talk-show host had invited, on his programme, a woman who believed in an alternative cure for HIV and AIDS. The woman claimed that eating garlic and lemons could wash toxins out of the body and AIDS patients would become healthy within five days. Upholding the decision of the first tribunal, the Broadcasting Appeal Tribunal of South Africa held that it is highly unlikely that reasonable listeners will simply jump to new conclusions upon hearing one person's views on a lemon and garlic ‘cure’ for AIDS. Accordingly, the appeal was dismissed.

Excerpts

...

Introduction

[1] A Tribunal dismissed a complaint lodged by the applicant. The complaint concerned a call-in programme in which references were made to an alternative treatment (involving

lemons and garlic) for people living with AIDS. An appeal was allowed by the Chairperson of the Tribunal and the appeal was heard in Cape Town where the complainant lives.

Facts

On Wednesday, 28 September 2005 between 10am and 11am the host of the Tim Modise Network interviewed one Tina van der Maas on Radio 702 and 567 Cape Talk in a show entitled, 'Effectiveness of Diet to Improve Immune System'. Listeners were also allowed to call in to the show. In the interview by Mr Modise, Ms Van der Mass claimed that by eating garlic and lemons, people living with HIV and AIDS could wash the toxins out of their bodies and that even 'very sick' AIDS patients would become healthy within 5 days to a week after going on her diet. Mr Modise asked polite questions and entertained many calls from interested listeners who seemed to believe Ms Van der Mass and wanted to find out more about her diet. When a certain Dr Geffen phoned in from Cape Town and called Ms Van der Mass a 'charlatan', Mr Modise allowed Ms Van der Mass to respond without comment. At no stage did Mr Modise indicate that he agreed with Dr Geffen or that Ms Van der Mass might be a charlatan and a complete fraud. The views of Ms Van der Mass were presented as medical information or facts provided for the benefit of listeners.

Taken as a whole and given the context of the ongoing obfuscation and confusion in South Africa around the HIV/AIDS pandemic and the uses of anti-retroviral drugs to manage the disease, the programme suggested that Mr Modise found Ms Van der Mass's theories credible and believable and no more than further medical information about the treatment of HIV/AIDS. It sent out a message that lemons and garlic was a credible – no, indeed a preferable – remedy for the scourge of HIV/AIDS. Many HIV positive listeners to the programme – especially poor, and less informed listeners – could have been persuaded that garlic and lemon should be taken instead of other scientifically proven drugs (including anti-retroviral drugs) to combat the HI virus.

The original complaint claimed that the programme contravened section 34 of the BCCSA Code in that it constituted the presentation of 'news', while the 'facts' presented were demonstrably false and dangerous. The Tribunal found that the programme did not constitute 'news'. The correct approach, according to the Tribunal, is to deal with this programme in terms of section 36.1 of the BCCSA Code of Conduct.

Grounds for appeal

The basis for the appeal is, in essence two-fold. First I contend that in general the judgment by the Tribunal failed to interpret the Code with reference to the Constitutional values as enshrined in the Bill of Rights and as interpreted by the Constitutional Court. Second, I contend that because of the said failure the judgment of the Tribunal specifically misconstrued the meaning of section 34 of the Code and, alternatively, also of section 36 of the Code.

Constitutional context

The Code of the BCCSA explicitly calls for its interpretation within the context of the guarantee of free expression as set out in section 16 and qualified by section 36 of the Constitution.

It is therefore imperative to have regard to the jurisprudence of the Constitutional Court when interpreting the Code. It is my contention that the judgment of the Tribunal fails to do so.

The Constitutional Court has stated on several occasions that the right to freedom of expression is 'one of a web of mutually supporting rights' in the Constitution.

At the same time, the Court has reiterated that expression has the potential to impair the exercise and enjoyment of other rights which, would include the right to human dignity, the right to life, the right not to be subjected to medical or scientific experiments without informed consent, and the right of access to health care.

Most pertinently the court has stated that 'freedom of expression cannot be said automatically to trump' other rights such as the right to dignity and that freedom of expression 'does not enjoy superior status in our law'.

The right must be balanced against other rights in order to give effect to the values enshrined in the Constitution. This means when interpreting the BCCSA Code, the Tribunal should take cognisance of the way in which expression can fundamentally erode the enjoyment of other rights and should interpret the provisions of the Code to give effect to this insight. Section 7 of the Code endorses this approach and requires the Tribunal to weigh up the right to free expression against other rights when interpreting the Code. I contend that the Tribunal failed to do so in this judgment.

In determining which kinds of expression are more worthy of respect and thus what kinds of speech are of significant public importance, the Tribunal should also have regard for the aims of freedom of expression as set out by the Constitutional Court. Any purposive interpretation of the Code – the kind of interpretation endorsed by the Constitutional Court – requires one to identify the actual purpose of the provision to be interpreted or applied. The Constitutional Court has identified several aims of guaranteeing freedom of expression and opinion in section 16 of the Constitution, naming three interrelated goals of this right namely: (a) it has an instrumental function in guaranteeing democracy; (b) it recognises and protects moral agency of individuals to make up their own minds about controversial matters; (c) it provides for an open market place of ideas in which even controversial ideas could be tested through vigorous debate and exchange of opinion to seek the truth of any matter.

A purposive approach to the interpretation of the BCCSA Code would require the Tribunal to interpret its provisions to more vigorously protect the kinds of speech encompassed by the above goals of free expression. This, I contend, the Tribunal failed to do. I contend the provisions of the Code must be interpreted with reference to the principles set out above. I now turn to the interpretation of the Code itself.

Can the programme be identified as 'news'?

In my original complaint I contended that the programme did not constitute fair comment, nor a legitimate presentation of controversial matters of public importance and must therefore be judged as a news programme and dealt with in terms of section 34 of the Code, which requires that news be presented 'truthfully, accurately and fairly'. The Code also states that news should 'be presented in the correct context and in a fair manner, without intentional or negligent departure from the facts'. This would include 'distortion, exaggeration or misrepresentation', 'material omissions' and 'summarisation'. The Tribunal found that the discussion could not be typified as news and rejected my claim. I contend that this was incorrect, that the programme did not constitute 'fair comment' as per section 35 of the Code, nor 'controversial issues of public importance', but news.

Ms Van der Mass presented material purported to be scientific and/or medical evidence of how to treat HIV infection. It was presented as fact, not as opinion. It was presented as uncontroversial information, not as a controversial issue of public importance. When information is presented as medical or scientific facts the programme in which such information is presented constitutes, in my contention, a news programme.

The host dealt with the guest in a respectful manner and did not challenge the information presented as fact. If the host had indicated to the audience that the guest's views were controversial or questionable and that he was only giving her a platform to stir debate and if he had invited another guest with opposing views, the programme might conceivably have been classified as one dealing with 'controversial issues of public importance'. His failure to do so, created the impression that mere factual information was being provided. A programme in which mere factual information is purportedly provided must be seen as a news programme.

...

Mr Modise was therefore at best grossly negligent in allowing Ms Van der Maas a platform to present her information in a way that would give it legitimacy. By doing so he allowed distorted and untrue facts to be presented as credible and acceptable. This is clearly in contravention of section 34 of the BCCSA Code.

...

The Tribunal failed to define what constitutes ‘controversial issues of public importance’, seemingly assuming that all controversial issues would automatically also constitute issues of public importance. The Tribunal thus erred in two distinct ways:

It is a well established principle of legal interpretation that when interpreting legal documents it should be assumed that there are no superfluous words contained in that document. When the Code thus speaks of ‘controversial issues of public importance’, the content of a programme will only fall under it if the content is both controversial and of public importance. The Tribunal argued that because this is a controversial issue about which there has been no agreement in society, it necessarily mean that it is also an issue of public importance. This would suggest that all controversial issues are of public importance but this cannot be the case because it would lead to absurd results. For example, in South Africa many people believe that having sex with a virgin or with a child will cure HIV infection. This is an extremely controversial issue about which many people have argued heatedly. But surely, no one would say it is of public importance to allow a person on a radio talk show to explain exactly how one will get cured by having sex with a child and also explaining how to go about it. Some forms of expression such as the expression in the example above, while controversial, serve no public purpose because one of the possible consequences of such expression would be to encourage men to go out and have sex with children. It thus cannot be of any public importance to allow such speech. I contend that the speech of Ms Van der Maas although controversial is also not dealing with issues of public importance. The question is how to determine what speech is of public importance.

...

However, within the Constitutional context, some forms of expression will not constitute expression of public importance. Those kinds of speech would include speech that is patently false while also being (sic) having the serious potential to fundamentally impairing the enjoyment of other rights. As both the Constitutional Court and section 7 of the BCCSA Code acknowledge, the right to freedom of expression must be weighed against other rights. Where speech of little or no public value (because it does not contribute to enhancement of democracy; does not contribute to individual agency; and does not contribute to a search for the truth or at least a truth) severely limit the enjoyment of other rights, such speech cannot be said to be speech of public importance.

It is my contention that if the statements by Ms Van der Maas are measured against the test set out in the previous paragraph, it must be clear that her speech is not of any public importance. This is, first, because her contribution is demonstrably false. It is well-established scientific and medical fact that people living with HIV can prolong their lives significantly by going on a regimen of anti-retroviral drugs. This fact has also been accepted by South Africa's Constitutional Court.

However, there is no evidence that Ms Van der Maas's ‘cure’ for HIV/AIDS is effective and no person of any scientific or medical stature and no medical journal has ever endorsed this quackery. All available medical and scientific evidence show that if people follow the advice of Ms Van der Maas they will die, but if they follow the advice of accepted medical and scientific consensus – a consensus endorsed by the Constitutional Court – and go on a regimen of ARV's, they have an excellent chance of prolonging their lives by decades. Her statement is therefore false. Second, the statements have the potential to severely limit the enjoyment of other rights, most notably the right to life and the right of access to health care. If believed, the statements will induce some people not to make use of life-saving ARV drugs, but to go on a diet of garlic and lemon juice. This will result in their needless untimely death. This is an extreme case where the right to free expression will/has the potential to obliterate the right to life, unless the right to free expression is curbed. The Tribunal erred in failing to grasp this fact. Its decision chooses free expression over life. This is Constitutionally untenable. It is also an interpretation of the Code that falls foul of section 7 of the Code and of the need to interpret the Code purposively and with reference to the Constitution.

The programme provided a platform for views of no public importance in a context in which views were offered as fact, when, indeed the views were false and potentially deadly. It is inconceivable that the Code could have been intended to allow such speech in a broadcast. The respondent might contend that because politically (but not medically) the question of how to treat HIV infection has become controversial, the speech must be deemed political speech that should be allowed because it forms part of one of the aims of freedom of expression, namely to enhance democracy. This would be an ingenious but fallacious argument. It is in the interest of democracy to allow almost all speech of a political nature, but even here there must be limits. Speech that is demonstrably false and that has the serious potential to cause irrevocable and harm of severe nature – and in this case death – can never be said to enhance democracy. To allow a traditional leader, for example, to advocate that men should have sex with children to cure them of HIV, will be to allow a form of political speech, but it will in no way contribute to or guarantee democracy. On the contrary, it will undermine some of the very values that our democracy is based on, namely human dignity, bodily integrity and the right to life. I contend the speech under consideration has the same characteristics and cannot be said to allow for an enhancement or guarantor of democracy.

In the alternative: the required balance was not struck

...

Section 36(1) states that a broadcaster ‘shall make reasonable efforts to fairly present opposing points of view either in the same programme or in subsequent programmes ...’. The crux of the matter is to determine whether ‘reasonable efforts’ were made to provide opposing views. Whether efforts have been reasonable must, once again, be determined purposively with reference to the values of the Constitution. The specific context relating to the nature of the speech and the possible effect of letting the speech go unchallenged should be taken into account.

The context in this case is one in which false and controversial statements about the alternative treatment of HIV infection was presented in a programme as medical/scientific facts. All available medical evidence points to the fact that if this advice is followed, the advice dispensed on the programme would lead to the death of those listeners who follow it, while alternative care in the form of ARV treatment would have substantially prolonged the life of the said listeners. In this context, and given the balance that needs to be struck between the right to life and the right to freedom of expression, I contend that it was profoundly unreasonable – even irresponsible – to provide Ms Van der Maas with a platform without including an alternative opinion in the same programme. Not all people who would have listened to Ms Van der Maas would have listened to the follow-up programme. For such listeners there would have been no corrective to the false and deadly advice of the guest.

...

Conclusion

I therefore wish to appeal against the decision of the Tribunal on the grounds set out above and contend that the broadcast in question contravened the Constitution and also the BCCSA Code:

I request that the BCCSA make the following orders: Finding that the broadcast on 28 September 2005 between 10am and 11am on the Tim Modise Show on Radio 702 and Cape Talk, constituting an interview with Tina van der Maas contravened the BCCSA Code as well as the Constitution.

Ordering the two Radio stations to broadcast a public apology. The apology should include information that:

the message put out by Ms Van der Maas is scientifically unproven and that almost all medical doctors reject her advice as dangerous;

that although nutrition is important when managing HIV, without anti-retroviral drugs almost all HIV positive individuals will die.

Order Radio 702 and Cape Talk 567 to pay fines of R200 000 each.

...

[4] The Appeal Tribunal agrees with the first Tribunal that the Tim Modise show is not 'news' (section 34), but is clearly billed and marketed as a 'talk show', which falls under clauses 35 and/or 36 of the Broadcasting Code. Within this context, the lack of challenge by the talk show host is not acquiescence, nor can his respect for the views of his guests and callers be construed as acceptance of their views.

[5] Alternatively, the appellant claims that if it is decided that the broadcast is covered by clause 36 (controversial issues of public importance), a guest with opposing views should have been included in the same programme, and that a correction one week later was insufficient. This Appeal Tribunal finds that the licensee frequently had only one guest per show, and that they did in fact broadcast a show one week later in which a guest with differing views was given the opportunity to expound these. One week is considered by the tribunal to be a 'reasonable period of time (from) the original broadcast' as provided in the Broadcasting Code. The time period was such that callers to the second programme referred to the first. In both instances, callers of opposing views were given the space to express these. The appellant had the opportunity to express his views in this programme but chose not to phone in.

[6] The appellant claims that the original Tribunal failed to interpret the constitutional 'right to life' appropriately in terms of the Broadcasting Code of Conduct. The assumption that the programme will automatically lead to loss of life is tenuous, since few adults are likely to take the opinions expressed on a talk show as medical advice.

...

Finding

[8] The conclusion reached by this Tribunal is accordingly that the conclusion reached by the first Tribunal is not 'clearly wrong' in terms of the Broadcasting Code. In fact, the Tribunal will go further than it is required to do by the Appeal Procedural Rules and state that it believes that the conclusion reached was correct. Problematic issues may not be ignored by a broadcaster simply because a few listeners might not understand the programme in its broader context. Even those who might not have understood the programme in context would know that AIDS cannot be treated or cured without proper advice and that one cannot simply go along with the view of one person as broadcast on a radio talk show. The Tribunal holds that it is highly unlikely that reasonable listeners will simply jump to new conclusions upon hearing one person's views on a lemon and garlic 'cure' for AIDS. The programme must be judged as a whole and with due consideration being given to the subsequent related programme. The Appeal Tribunal cannot fault the conclusions reached by the first Tribunal.

The appeal is dismissed.

E LEGISLATION POLICIES AND CASE LAW FROM OTHER REGIONS

- E1 Legislation
- E2 Policies and other similar documents
- E3 Case law

E1 Legislation

E1.1 HIV specific laws

Benin: Law No 2003-04 relating to Sexual and Reproductive Health (2003)

Adopted by the National Assembly at its session of 24 January 2003. The law provides for full access to reproductive health services without discrimination. It also deals with HIV and recognises special treatment for persons who declare their HIV status.

Excerpts

...

Article 2: The right to reproductive health is universal

All individuals are equal in rights and dignity in terms of health and reproduction. The right to reproductive health is a universal right, fundamentally guaranteed to all human beings, during the entire course of his life, in every situation and in every place. No individual shall be denied this right of which he shall benefit without any discrimination based on age, sex, wealth, religion, ethnicity, marital status.

...

Article 7: The right to non-discrimination

Patients are entitled to receive full reproductive health treatment without discrimination based on sex, marital status, sanitary status or any other status, ethnic group, religion, age or the ability to pay.

...

Article 8: Confidentiality

No information concerning a patient's or any public service user's health may be disclosed without his due authorisation. Moreover, a patient has the right to be informed of information related to his health at the possession of the health service provider. Health service providers shall not withhold any information against the will of patients.

...

Article 10: Duties and responsibilities

The state, local organisations, community groups and other moral persons, via their representatives, shall ensure the safety, promotion and protection of the right of any human being to reproductive health. They shall actively seek to improve communication between men and women so that they may better understand their common responsibilities and become equal partners in their public and private lives.

Every couple, every individual has the obligation to contribute to the safety and harmony of the family, to the protection and promotion of the welfare of children, of his partner, of the elderly and of any other person close to him or her.

CHAPTER 4 – Contraception, voluntary interruption of pregnancy, rights of persons affected by STDs/AIDS and criminal justice.

...

Article 18: Persons living with sexually transmissible diseases and HIV/AIDS

Any person infected with a sexually transmissible disease (STD), and by HIV/AIDS in particular, shall enjoy without any discrimination his civil, political and social (housing, education, employment, health, social protection et cetera.) rights. Any such person has the right to benefit from particular assistance, basic health, treatment and be ensured that the confidentiality in his relationships with the socio-sanitary personnel is guaranteed.

Persons suffering from AIDS or infected by HIV, and who declare it, shall benefit from a particular assistance in terms of psycho-social support, counselling and other services, and receive appropriate medical care.

A decree taken by the Council of Ministers shall specify the conditions and modalities of this special treatment.

...

Article 19: Criminal justice

The following acts shall be considered violations of the rights to sexual and reproductive health and shall be punishable in conformity with the criminal laws of the State:

- all forms of sexual violence of which women and children are generally the victims,
- female genital mutilations and paedophilia,
- voluntary transmission of HIV
- exploitation, in all its forms, of the forced prostitution of women and children; forced marriages

Benin: Law No 2005-31 relating to the Prevention, Care and Control of HIV/AIDS in the Republic of Benin (2005)

The law was enacted by the Benin National Assembly in 2005. The law guarantees civil, political and social rights without discrimination against people suffering from a Sexually Transmitted Infection (STI) or living with HIV.

Excerpts

...

PRELIMINARY TITLE – General provisions

Article 1: Definitions of terms and concepts

HIV: Human Immunodeficiency Virus responsible for the infection. There exist two types of serological status [positive and negative] and several sub-types.

AIDS: Acquired Immunodeficiency Syndrome. This is the final stage of the disease characterised by the appearance of opportunistic infections and the increase of the viral mass.

PLWH: Person Living With HIV;

Person affected by HIV: Any person who has a close relative (father, mother, child, partner) who died because of HIV or who has HIV;

STIs: Sexually Transmissible Infections which represent the main entranceway of HIV in the [human] organism;

ARVs: Antiretrovirals which act upon the various stages of viral replication;

Socio-sanitary structures: Health centres, counselling and outreach centres, public, private, associative, religious or for-profit psycho-social care centres;

Care of PLWHs: Provision of medical (consultations, medicine, ARV treatment, minimum set of medical exams), psycho-social and nutritional services;

Particular assistance: medical, psycho-social and nutritional services graciously offered to very poor PLWH;

Incapables: Persons suffering from mental failure (because of senility or for pathological reasons ...) or afflicted with physical incapacity (sick who absolutely need assistance to meet their basic needs);

Socio-sanitary service provider: person, grouping, or public, semi-public or private structure which delivers socio-sanitary services;

Persons at high-risk: any person who is at high risk of transmission of HIV (professional sex workers, men who have sex with men and injecting drug users);

Vulnerable Persons: children, women, and all other persons who qualify as incapables;

Designated Persons: physical or moral persons legally authorised to deliver medical certificates and any other administrative documents certifying the health status of a PLWH;

Employer: Any person or organisation employing workers under written or oral contracts that establish the rights and duties of the Parties, in accordance with legislation and national practice. The Government, the civil service, public and private corporations and particulars can be considered employers.

Special arrangement: A modification of working conditions or of the workplace that is reasonably achievable and that enables a PLWH to have access to a job, to work and to obtain promotions.

HIV/AIDS counselling: Communication technique which consists in informing the patient on HIV/AIDS, the origin of the contamination, the means for testing, treatment, prevention and the consequences on partners before and after the test.

Gender: This is the recognition of the difference between men and women without implying a difference in treatment.

TITLE II – The Right to information and treatment

Article 2

Any person who is afflicted by a Sexually Transmissible Infection (STI) or living with HIV shall enjoy without any discrimination his civil, political and social (housing, education, employment, health, social protection, et cetera.) rights.

Any such person has the right to benefit from particular assistance, basic health, treatment and a warrant of confidentiality in his relationships with socio-sanitary personnel.

Those persons infected by HIV or suffering from AIDS, and who declare it, benefit from a particular assistance in terms of counselling, psycho-social support, in nutritional, medical and material terms, and receive medical care, in conformity with existing norms and procedures.

This particular assistance in terms of counselling, psychosocial support and in nutritional, medical and material terms must be given by the person's family, the State and its deconcentrated and decentralised structures, civil society, communities and any person in a position to provide such assistance.

Article 3

Any HIV test shall be conducted with the free and informed consent of the person to be tested and accompanied by pre and post-test HIV/AIDS counselling. For a minor or a person afflicted with incapacity, the consent of the legal guardian may be required.

Article 4

A doctor who finds out that a person is infected with HIV or suffers from AIDS has the obligation to inform the patient but shall not under any circumstance divulge this information [to

other people]. Notwithstanding, the statistics must be transmitted to the Ministry in charge of health.

The doctor's language shall respect the human dignity of the patient and shall not display any rejection of the patient. He shall be sensitive to questions of gender, be precise and understandable.

Any person who tested positive to HIV has the obligation to inform his partner, with the support of a counsellor if necessary.

The partner(s), on the basis of their free and informed consent, shall be subjected to an HIV test and if found positive, shall receive the necessary information, prevention counselling and appropriate care.

The medical staff shall ensure that the elements of information and exchange were properly understood.

Article 5

Any person infected or affected by HIV has the right to confidentiality and to respect of his privacy. These rights can only be restricted under exceptional circumstances.

Article 6

The doctor or any other person who because of his professional status possesses information on the serological status of a patient, shall not divulge such information to other persons without the consent of the patient, except in the following cases:

- case of extreme necessity;
- patient not being able to give his consent;
- HIV positive person whose behaviour may endanger the health of others;
- minors and incapables

Article 7

The doctor shall in the case of criminal proceedings and by court order share the results of the HIV test of a patient with the court.

TITLE III – The impact of AIDS on individuals, society and the world

Article 8

Any person suffering from AIDS or infected with HIV shall be given the possibility to disclose his status to the socio-sanitary services.

In the event of explicit disclosure of their own HIV positive status to the above-mentioned structures, persons suffering from AIDS or infected with HIV shall benefit from a particular assistance.

Such disclosure shall be thoroughly ascertained by a doctor.

Children whose parents or legal guardians have passed away because of AIDS shall benefit from a medical assistance and psycho-social help from the community, the State and its deconcentrated and decentralised structures.

To this end, a special Fund is created for the fight against AIDS and assistance to people affected by AIDS.

A decree taken by the Council of Ministers shall specify how this Fund will be created and how it will operate.

Article 9

Persons suffering from AIDS or infected by HIV shall receive all appropriate medical care as specified in article 18 of Law 2003-04 of 3 March 2003 on sexual and reproductive health.

Article 10

Any person having reached the specific legal age required, shall enter into marriage with his free and full consent. During the prenuptial medical examination, HIV testing shall be offered to the to-be-betrothed.

TITLE IV – Medical ethics

Article 11

The health agent who has accepted to provide care to a person living with HIV shall:

- personally, or with the help of qualified third-persons, deliver all medical care in his power and all medical care that is necessary in the particular circumstance;
- always act with rigour, empathy and consideration for the patient

Article 12

The health agent who is called upon in an emergency situation to assist a minor or an incapable adult living with HIV has the obligation to provide the required care to the patient even if he was unable to get the consent of the legal guardian in due time.

Article 13

The State shall take all the necessary steps to make the medical monitoring of persons at high risk for HIV – sex workers, homosexuals, injecting drug users – compulsory and encourage voluntary HIV testing.

TITLE V – AIDS in the workplace

Article 14

An employer, whether in the public, the semi-public or the private sector, may not ask a candidate for a job to undergo an HIV test or include HIV tests in entrance tests/exams

Article 15

The refusal to accept a candidate at an entrance test/exam or for a job because of his HIV positive status is a violation of the law.

Article 16

Dismissing a worker because of his HIV positive status is unlawful.

Article 17

The State and its deconcentrated structures as well as private or semi-public structures shall encourage via measures, donations and subsidies, families and welcoming structures to receive orphans and children rendered vulnerable by AIDS.

Article 18

All workplace attitudes or regulations which discriminate or stigmatise a worker because of his HIV status, such as the refusal to grant promotions, the refusal to provide opportunities for internships or other ways of acquiring experience, the denial of social protection, are forbidden.

Article 19

When an employee infected with HIV may not continue his usual occupations in the workplace for health reasons, the employer is required to establish a special arrangement enabling the worker to continue his work as long as possible, in accordance with existing regulations.

Article 20

All employers in the public, semi-private and private sectors are requested to define and implement a workplace policy for the prevention of STIs/HIV/AIDS and care of PLWH.

Article 21

Any socio-sanitary agent infected with HIV in the course of his employment shall benefit from medical and social care.

TITLE VI – AIDS and medical insurance

Article 22

Insurance providers shall not subject access to insurance schemes to an HIV test.

TITLE VII – Provisions relating to criminal law

Article 23

The violation by any health agent of the ethical rules set out in Title IV of the present law shall be punished according to criminal law provisions.

In the event of a repetition of the offence, the offender shall be suspended from exercising his profession for at least five years.

Whoever contravenes the afro provision shall be punished to one to three years of imprisonment and a fine of two hundred thousand to one million CFA Francs, or one of these two punishments.

Article 24

Any person who through his profession possesses confidential information related to the HIV/AIDS status of a patient and who finds himself guilty of divulging this information will be dealt with according to criminal law provisions relating to the illegal sharing of confidential information.

This sentence can be aggravated if this illegal sharing of confidential information caused:

- divorce;
- loss of employment and/or material goods;
- suicide.

Article 25

Any health agent who contravenes the provisions of article 12 of the present law shall be punished to three months to one to three years' imprisonment and a fine of two hundred thousand to five hundred thousand CFA francs, or of one these two sentences only.

The offender may be suspended for a period which cannot exceed six to twelve months.

In the event of a violation committed in a private socio-sanitary structure or medical analysis structure, the structure may be denied the right to operate for a period not exceeding twelve months.

Article 26

The violation of the provisions in articles 14, 15 and 16 of the present Law shall be punished by a fine of two hundred thousand to one million CFA Francs, notwithstanding any civil actions.

In the event of repetition of the offence, the sentences shall be doubled.

Article 27

Any person who is aware of his own HIV positive status and who knowingly engages in unprotected sex with a partner without informing the latter of his HIV status, even if the latter is also HIV-positive, shall be punished to five to ten years of imprisonment and a fine of one million to five million CFA Francs.

Article 28

Laboratories or similar institutions shall not accept or keep blood, tissue or organs if the sample of blood, tissue or organ has not been ascertained HIV-negative.

Article 29

Whoever voluntarily gives, via any possible way, HIV-positive blood to a person shall be punished to lifetime imprisonment.

If the act was committed because of neglect, imprudence, carelessness or non-respect of the rules, the offender shall be punished to one to five years of imprisonment.

Article 30

Any person who is aware of his HIV positive status and who, by violence, constraint or surprise, engage in unprotected sex of any nature with any person shall be punished to five to twenty years of imprisonment and a fine of three million to ten million CFA Francs.

If the act was committed under threat by one or several persons, by a (legitimate, natural or adoptive) relative, or by a person who

abused the authority of his functions on a vulnerable person, on an incapable or a minor, the punishment shall be lifetime imprisonment.

Article 31

Undertaking biomedical research on a person infected with HIV without having obtained the informed and explicit consent of that person or his legal guardian shall be punished by two to five years of imprisonment and a fine of five million to twenty million CFA Francs.

The same punishments are applicable if the biomedical research was practised under circumstances in which the consent was withdrawn.

Article 32

Any person who exposes or abandons, or makes someone expose or abandon in a solitary place a child or an incapable adult suffering from AIDS shall, for this act alone, be punished to one to three years' imprisonment and a fine of fifty thousand to two hundred thousand CFA Francs, or one of these two punishments only.

Article 33

The following persons shall be punished to six months to two years of imprisonment and a fine of one hundred thousand to one million CFA Francs, or to one of these two punishments only:

- A father or mother who abandons the family home for more than two months on account of HIV-positive status, thus not fulfilling his moral and material obligations;
- A husband or wife who abandons his partner on account of HIV-positive status;
- A father, mother or legal guardian who voluntarily abandons his child whom he knows is HIV-positive.

Article 34

Whoever counterfeits, falsifies or tampers with medical certificates or other documents relating to HIV/AIDS delivered by the relevant personnel shall be punished to five to twenty years of imprisonment and a fine of three million to ten million CFA Francs.

The same punishments shall be applied to persons who knowingly used such counterfeit or falsified documents.

Any such attempt shall be prosecuted the same way as the actual act.

Article 35

Any violation to the provisions of articles 24 and 25 exposes the offender to a fine of five hundred thousand CFA Francs to a million CFA Francs.

In the event of repetition of the offence, the fine shall be doubled ...

Cambodia: Law on the Prevention and Control of HIV/AIDS (2002)

Enacted by the National Assembly on 14 June, 2002 at its 8th plenary session of the 2nd legislature, and entirely approved, in its form and legal concepts by the Senate on the 10th July, 2002 at its 7th plenary session of the 1st legislature. The law emphasises educational programmes for women and the provision of HIV and AIDS-related information to tourists and travellers.

Excerpts

...

CHAPTER I – General provisions

Article 1

This Law has the objective to determine measures for the prevention and control of the spread of HIV/AIDS in the Kingdom of Cambodia.

Article 2

AIDS is a communicable disease caused by the HIV virus, which is recognised as having spread no territorial, social, political, and economic boundaries, and there is no known cure. The epidemic has serious impact on social security, stability, and socio-economic development; which requires a multisectoral response to be undertaken by the State in order to:

1. Promote nationwide public awareness, through extensive IEC activities and mass campaigns, about the fact of HIV/AIDS such as modes of transmission, consequences, means of prevention and control of the spread of the disease.
2. Prohibit all kinds of discrimination against those persons suspected or known to be infected with or affected by HIV/AIDS;
3. Promote the universal precaution on those methodologies and practices, which carry the risk of HIV transmission.
4. Appropriately address all determinants which drive the HIV/AIDS epidemic
5. Promote potential role of PLWA for their greater involvement by disclosing information and sharing their own experiences to the public.
6. Mainstream HIV/AIDS prevention and control programs, and make it priority in the national development plan.

CHAPTER II – Education and information dissemination

Article 3

The State shall stimulate some practices as hereunder:

1. Integrate the knowledge on HIV/AIDS in subjects taught in schools. This subject shall include the causes, modes of transmission, means of prevention, consequences of the HIV/AIDS and fact about STDs, especially focusing on the life skills in accordance with promoting social value through introduction into the curriculum of all educational establishments including non-formal education systems.
2. Organise workshops and trainings of trainers on HIV/AIDS prevention and control for teachers and other instructors who will be assigned to teach on the subject.
3. Mobilise communities, associations, and organisations for their involvement in the design and implementation of HIV/AIDS education and information dissemination programs.

Article 4

The State shall make HIV/AIDS education as part of the delivery of health services through health care workers and personnel. Knowledge and capability of these health care workers and personnel shall be enhanced through additional trainings to include skills for proper information dissemination and education on HIV/AIDS.

The education and information dissemination on HIV/AIDS and additional training are also the duty of health care providers in the private sector in contribution to the overall prevention and control of HIV/AIDS.

The additional enhancement shall include discussion on issues of the code of conduct and ethics related to HIV/AIDS, especially maintaining confidentiality and respect to the individual's right.

Article 5

The State shall organise the dissemination of information and art performance programs for HIV/AIDS education through all media channels with free of charge, in order to raise the public awareness.

This information dissemination has to be done with appropriate methodologies and circumstance to ensure its effectiveness.

Article 6

The State shall organise special educational programs on HIV/AIDS targeting teen age girls and women-headed-household to address role of women in the society and gender issues.

Article 7

The State shall develop IEC materials on HIV/AIDS for tourists and travellers in transit at the international port of entry and exit. These IEC materials shall be printed in Khmer and in other languages as necessary.

Article 8

The State shall provide information, HIV/AIDS educational materials or organise workshops for all Cambodian workers, diplomatic officials, and civil servants, on the causes, modes of transmission, means for prevention, and the consequences of the HIV/AIDS, before their departures for overseas assignment.

Article 9

All institutions, enterprises, and handiworks, shall cooperate with the National AIDS Authority to organise the education programs on HIV/AIDS at the workplace, and shall include the topics on maintaining of confidentiality and attitude toward the infected employees and workers.

Beside the education on HIV/AIDS, all institutions, enterprises, and handiworks shall develop plans according to their mandate to contribute to the prevention and control of HIV/AIDS.

Article 10

The State shall mobilise individual citizen, families, organisations, monks, religious groups, and most vulnerable groups to participate in conducting an educational and information activities on HIV/AIDS at all levels throughout the Kingdom of Cambodia.

Article 11

All prophylactic devices offered for sale or given, as donation shall be attached with appropriate information printed in Khmer and in other languages as necessary, and contains literature on the proper use of those devices and its efficacy against HIV/AIDS infection.

Article 12

All propagandas or commercial advertisements of misinformation on the treatment and mean of prevention of HIV/AIDS that is contrary to the measures set by the National AIDS Authority and medical and scientific basis shall be strictly prohibited.

CHAPTER III – Safe practices and procedures

Article 13

All practices and procedures shall be complied with the guidelines of the National AIDS Authority.

The National AIDS Authority shall consult with and coordinate for the Ministry of Health and relevant specialised institutions to determine and disseminate guidelines on universal precautions against HIV/AIDS transmission, especially during the normal surgical, cosmetic surgical, dental, embalming, tattooing or other similar procedures.

...

Article 18

Any practice or acts of those who are HIV positive, which have the intention to transmit HIV to other people, shall be strictly prohibited.

CHAPTER IV – Testing and counseling

Article 19

All HIV tests shall be done with voluntary and informed consent from the individual. For those who are minor, a written informed consent shall be obtained from his legal guardian.

In case that such written consent could not be obtained from the legal guardian of the minor, and the test is considered to provide most interest to the individual, the test still can be performed only with an informed consent from the individual.

The State shall be in charge of the mentally incapacitated individual.

Article 20

It is strictly prohibited to any compulsory HIV testing undertaken to indicate pre or post conditions for employment, admission to educational institutions, as well as for the exercise of freedom of abode, travelling, and the provision of medical services or other services.

Article 21

The compulsory HIV testing shall be allowed in case of court order only.

Article 22

All HIV testing shall be performed anonymously. The Ministry of Health shall provide a mechanism for anonymous HIV testing, and shall guarantee the anonymity and medical confidentiality during the process of this test.

...

Article 24

All testing centres shall provide pre-test and post-test counselling services for those who request HIV testing. The counsellors shall be sufficiently competent in conformity with a determined standards set by the Ministry of Health.

...

CHAPTER V – Health and support services

Article 26

The State shall ensure that all persons with HIV shall receive primary health care services with free of charge in all public health networks, and encourage the participation from the private sector.

Article 27

The State shall mobilise the participation of the citizens, families, organisations, monks, religious groups and the most vulnerable groups to provide treatment, care and supports to those living with HIV all over the Kingdom of Cambodia.

Article 28

The state shall pay attention to providing the vocational training for improved livelihood and self-help activities to the persons with HIV. Persons infected with HIV shall have the right to the full participation in all vocational training programs for better livelihood and self-help.

Article 29

The State shall promote the prevention and control of sexually transmitted diseases (STD), which contributes to preventing the spread of HIV/AIDS.

CHAPTER VI – Monitoring

Article 30

The State shall establish a comprehensive HIV/AIDS monitoring program to monitor the magnitude of vulnerabilities of population, pattern of sexual behaviour and the trend of the HIV/AIDS epidemic.

This program will be monitored and evaluated for its adequacy, effectiveness and continuity of the HIV/AIDS prevention and control programs in the country.

...

CHAPTER VII – Confidentiality

Article 33

The confidentiality of all persons living with HIV shall be maintained. All health professionals, workers, employers, recruitment agencies, insurance companies, data encoders, custodians of medical records related to HIV/AIDS, and those who have the relevant duties shall be instructed to pay attention to the maintenance of confidentiality in handling medical information, especially the identity and personal status of persons with HIV.

Article 34

The medical confidentiality shall be breached in the following cases:

- (a) When complying with the requirement of HIV/AIDS monitoring program, as provided in article 30 of this law,
- (b) When informing health workers directly or indirectly involved in the treatment or care to the persons with HIV,
- (c) When responding to an order issued by the court related to the main problems concerning the HIV status of individuals. The confidential medical records shall be properly sealed by the custodian, after being thoroughly checked by the responsible person, hand delivered, and opened officially and confidentially by the judge in front of the legal proceeding.

Article 35

All HIV testing results shall be released to the following persons:

- (a) The person who voluntarily requests HIV testing;
- (b) A legal guardian of a minor, who has been tested for HIV;
- (c) A person authorised to receive such testing results in conjunction with HIV/AIDS monitoring program as provided in the article 30 of this law; and
- (d) The requirement of the court, as provided as point C in article 34 of this law.

CHAPTER VIII – Discrimination acts and policies

Article 36

Discrimination in any form at pre and post employment, including hiring, promotion and assignment, living in society based on the actual, perceived or suspected HIV status of an individual or his family members is strictly prohibited. Any termination from working based on the actual, perceived or suspected HIV status of individual or his family members is deemed unlawful.

Article 37

No educational institution shall refuse admission or expel, discipline, isolate or exclude from gaining benefits or receiving services to a student on the basis of the actual, perceived or suspected HIV positive status of that student or his family members.

Article 38

A person living with HIV shall have full right to the freedom of abode and travel.

No person shall be quarantined, place in isolation or refused abode, accompany or expulsion due to the actual, perceived or suspected HIV status of that person or his family members.

Article 39

Discrimination against any person with HIV in seeking public position is prohibited.

The right to seek elective and appointive public position shall not be refused to a person based on the actual, perceived or suspected HIV status of that person or his family members.

Article 40

Discrimination against person with HIV in accessing to all credits or loans services including health, accident and life

insurance, upon such concerned person who meets all technical criteria as other uninfected citizens, is strictly prohibited.

Article 41

Discrimination against person with HIV in the hospitals and health institutions is strictly prohibited.

No person shall be denied to receive public and private health care services or be charged with higher fee on the basis of the actual, perceived or suspected HIV positive status of the person or his family members.

Article 42

The person with HIV shall have the same rights as of the normal citizens as stated in the chapter 3 of the Constitution of the Kingdom Cambodia.

...

CHAPTER X – Penalties

Article 48

Any person who violates the article 12 of this law shall be punished with a penalty of fine of five hundred thousand to one million Riels, and with a penalties of imprisonment for one month to one year, plus revocation of his relevant professional licenses. In case of repeated offences, the punishment shall be double. For civil servants, administrative sanctions shall be added.

Article 49

Any person who violates the article 13, 14 or 15 of this law shall be punished with a penalty of fine of five hundred thousand to one million Riels, and with a penalties of imprisonment for six months to one year. In case of repeated offences, the punishment shall be double. This is without prejudice to reconstitute civil liability and revoked relevant professional license. For civil servants, administrative sanctions shall be added.

Article 50

Any person, who violates the article 18 of this law, shall be punished to imprisonment for ten to fifteen years.

Article 51

Any person who violates the article 23, 31 or 33 of this law, shall be punished with a penalty of fine of fifty thousand to two hundred thousand Riels, and with a penalty of imprisonment for one month to six months. In case of repeated offences, the punishment shall be double. For civil servants, administrative sanctions shall be added.

Article 52

Any person who violates the article 36, 37, 38, 39, 40 or 41 of this law, shall be punished with a penalty of fine of one hundred thousand to one million Riels, and with a penalty of imprisonment for one month to six months. In case of repeated offences, the punishment shall be double. For civil servants, administrative sanctions shall be added.

CHAPTER XI – Final provision

Article 53

Any provision, which is contrary to this law, shall be here by abrogated.

Kazakhstan: Law of 5 October 1994 on the Prevention of AIDS

This law protects aliens and stateless persons against compulsory HIV testing and provides free supplies of medicines and reimbursement of travel expenses. It also provides allowances for children below 16 years if infected by HIV or suffering from AIDS. The law also allows for compulsory HIV testing if there are 'sufficient grounds' indicating HIV infection.

...

3. Centres for the prevention and control of AIDS

Republic, provincial, and municipal centres for the prevention and control of AIDS means establishments providing specialised preventive and therapeutic care of a particular type, involving a combination of therapeutic, diagnostic, prophylactic, and epidemic control measures, the aim being to assure the early detection and treatment of AIDS and the prevention of its spread.

...

5. The right of citizens of the Republic of Kazakhstan, aliens, and stateless persons to undergo medical testing for AIDS

Citizens of the Republic of Kazakhstan, aliens, and stateless persons residing or present on the territory of the Republic shall have the right to a voluntary, confidential, anonymous medical test in State health establishments, with a view to detecting infection by the human immunodeficiency virus.

6. Obligation of citizens of the Republic of Kazakhstan, aliens, and stateless persons to undergo medical testing for AIDS

Citizens of the Republic of Kazakhstan, aliens, and stateless persons shall be obliged to undergo medical testing should there exist sufficient grounds for presuming that they may be infected by the human immunodeficiency virus.

The principles and procedures for directing citizens for testing, and their treatment, shall be regulated by the Law of the Republic of Kazakhstan on the protection of the health of the population in the Republic of Kazakhstan.

Staff members of diplomatic, representational, and consular services of foreign States and other persons enjoying diplomatic privileges and immunities on the territory of the Republic of Kazakhstan may be tested for infection by the human immunodeficiency virus only with their consent. The Ministry of Health of the Republic of Kazakhstan shall reach prior agreement with the Ministry of Foreign Affairs of the Republic of Kazakhstan on proposals as to the need for such persons to undergo testing.

HIV-infected persons must be informed in writing on their condition by the health establishments that established the fact that they are infected. Such persons shall be required to comply with measures for the prevention of the spread of infection, established by the Ministry of Health of the Republic of Kazakhstan.

Aliens residing on the territory of the Republic who refuse to undergo testing or prophylactic surveillance, or who are infected by HIV or suffering from AIDS, shall be expelled beyond the borders of the Republic.

An alien whose husband or wife is a citizen of the Republic of Kazakhstan shall not be subject to expulsion.

7. Social protection of persons infected by the human immunodeficiency virus

Citizens of the Republic of Kazakhstan and stateless persons who are infected by HIV shall have the right to free supplies of medicaments and outpatient and inpatient care in State health establishments, as well as to reimbursement of expenses incurred by their travel to and from the place of treatment, these expenses being covered by the health establishments at their place of residence.

Children under 16 years of age who are infected by HIV or are suffering from AIDS shall be eligible for a monthly State allowance, amounting to 80 per cent of the minimum wage.

If one of the parents is obliged to interrupt his work contract in order to take care of a child under 16 years of age who is infected by HIV or suffering from AIDS, he shall be entitled to retain his seniority without a break.

Children and young persons who are infected by HIV or suffering from AIDS shall have the right to be educated in a school establishment or in another educational establishment.

Dismissal, refusal of employment, and refusal of admission to an establishment for pre-school children or to an educational establishment, restrictions on other legitimate rights and interests of persons infected by HIV or suffering from AIDS, as well as restrictions on rights in the field of housing or other fields, in respect of the relatives and close associates of the above-mentioned persons, shall be prohibited.

8. Measures for the prevention of AIDS infection related to specific persons and professions

Medical and pharmaceutical personnel and workers in the service sector, who are infected by HIV, shall be liable to removal from their service functions, and transferred to other work.

HIV-infected persons may not be donors of blood, tissues, or organs.

9. Liability for infection by HIV

In the event that a person who is aware that he is infected knowingly exposes another person to a risk of HIV infection, or infects that person, the person responsible shall incur liability in accordance with the legislation in force.

10. Liability of persons for negligence in the fulfilment of their professional duties

Medical personnel and other persons working in the service sector who are guilty of negligence in the fulfilment of their professional duties, such as to entail HIV infection of other persons, shall incur liability in accordance with the established legislation.

11. Preservation of medical confidentiality

Medical personnel and other persons who become aware, in the performance of their professional duties, of information on persons who are infected by HIV or suffering from AIDS, shall be required to maintain confidentiality, protected by the Law, in respect of this information.

12. AIDS as an occupational disease

HIV infection of medical and pharmaceutical personnel, as well as the staff of medical research institutes and workers in the service sector, while performing their service and professional duties, shall be classified as an occupational disease.

13. Insurance of medical and other personnel against the risk of occupational infection by HIV and AIDS

Medical and other personnel who, in the performance of their functions, are liable to contract AIDS of occupational origin shall be required to take out compulsory State insurance. In the event of infection, disease, incapacity, or death due to AIDS, the persons concerned shall receive a lump-sum allowance, in accordance with the Law of the Republic of Kazakhstan on labour protection.

The right to the above-mentioned allowance shall also apply to persons infected by HIV or suffering from AIDS as a consequence of duties performed in an inappropriate manner by medical personnel and service workers in the service sector.

14. Benefits granted to medical personnel concerned with the prevention and treatment of AIDS

Medical personnel and service and technical personnel working in centres for the prevention and control of AIDS, other health establishments, agencies, or medical and research institutes, who are directly involved in the prevention, treatment and diagnosis of, and research on, AIDS, shall have the right to a shortened six-hour working day, extra paid leave of 24 working days' duration, and a supplementary indemnity for professional risk amounting to 60 per cent of the established salary.

...

Papua New Guinea: HIV/AIDS Management and Prevention Act 4 of 2003

The Act was adopted by the National Parliament on 2 July 2003. It gives effect to the basic rights recognised in the Constitution of Papua New Guinea. It provides detailed definitions of terms and procedures, and protects the privacy of individuals. Wilful transmission of HIV is prohibited but consent is accepted as defence to a charge of an offence of wilful transmission.

Excerpts

...

Being an Act to give effect to the Basic Rights acknowledged in the Preamble to the Constitution, in particular the rights and freedoms of

- (a) life, liberty, security of the person and the protection of the law; and
- (b) freedom from inhuman treatment; and
- (c) conscience, of expression, of information and of assembly and association; and
- (d) employment and freedom of movement; and
- (e) protection for the privacy of homes and other property, in providing for
- (f) the prevention of the spread of HIV/AIDS; and
- (g) the management of the lives and protection from discriminatory practices of people living with HIV and of people who are affected by or believed to have HIV/AIDS; and
- (h) the protection of public health, and for related purposes,

PART I – Preliminary

1. Compliance with constitutional requirements

(1) This Act, to the extent that it regulates or restricts a right or freedom referred to in Subdivision III.3.C (Qualified rights) of the Constitution, namely

- (a) the right to freedom from arbitrary search and entry conferred by section 44; and
- (b) the right to freedom of expression conferred by section 46; and
- (c) the right to privacy conferred by section 49; and
- (d) the right to freedom of information conferred by section 51; and
- (e) the right to freedom of movement conferred by section 52, of the Constitution, is a law that is made for the purpose of giving effect to the public interest in public safety, public welfare and public health, and in order to protect the rights and freedoms of others.

...

3. Application of other Acts

(1) HIV infections and AIDS are not

- (a) infectious or venereal diseases for the purposes of the Public Health Act (chapter 226); or
 - (b) quarantinable diseases for the purposes of the Quarantine Act (chapter 234).
- (2) HIV/AIDS awareness materials are not
- (a) obscene or indecent matter for the purposes of section 228 of the Criminal Code (chapter 262); or
 - (b) indecent articles or other matter for the purposes of sections 25 and 25A of the Summary Offences Act (chapter 264); or
 - (c) objectionable publications or declared publications subject to classification under Part V of the Classification of Publication (Censorship) Act 1989; or
 - (d) prohibited imports for the purposes of the Customs Act (Chapter 101); or

(e) prohibited statements or advertisements under

- (i) Section 140 of the Public Health Act (Chapter 226); or
- (ii) Section 31 of the Medicines and Cosmetics Act 1999.

(3) Condoms and condom lubricant are not

(a) obscene or indecent objects or things for the purposes of section 228 of the Criminal Code (chapter 262); or

(b) indecent articles for the purposes of sections 25 and 25A of the Summary Offences Act (chapter 264).

(4) Where a provision of any other Act is inconsistent with a provision of this Act in relation to matters for which provision is made in this section, this Act prevails to the extent of that inconsistency.

4. Act binds the State

(4) This Act binds the State.

PART II – Discrimination and other unlawful acts

...

6. Unlawful discrimination

(1) Subject to subsections 2 and 3 and section 8, it is unlawful to discriminate against a person to the detriment of that person on the grounds that the person is infected or affected by HIV/AIDS.

(2) Subsection 1 does not prevent the taking of any action which is for the special benefit, assistance, welfare, protection or advancement of any person or group of a kind referred to in that subsection.

(3) Notwithstanding subsection 1, it is not unlawful to discriminate against a person on the ground of infection by HIV or having AIDS if the discrimination is no more detrimental than discrimination on the ground of having another life-threatening medical condition.

(4) For the purposes of subsection 1, where

- (a) an act of discrimination is done for two or more reasons; and
 - (b) one of the reasons is a ground set out in subsection 1, whether or not it is the dominant or a substantial reason for doing the act,
- the act is presumed to have been done for that reason.

7. Situations of discrimination

In particular, and without limiting the generality of section 6, an act of unlawful discrimination may take place

- (a) in relation to employment and contract work, in
 - (i) the arrangements an employer or contracting principal makes for the purpose of determining who should be offered employment or contract work; or
 - (ii) the terms on which an employer or principal offers employment or contract work; or
 - (iii) the refusal or deliberate omission by an employer or principal to offer employment or contract work; or
 - (iv) the way an employer affords access to opportunities for promotion, transfer or training, or to any other benefits, services or facilities, or in the refusal or deliberate omission to afford access to them; or
- (v) dismissal from employment or termination of contract work; or
- (vi) the subjecting of a person to any other detriment in relation to employment or contract work; and
- (b) in relation to partnerships, in
 - (i) determining who should be invited to become a partner; or
 - (ii) the terms and conditions on which the partnership is offered; or
 - (iii) the denial or limitation of access to any benefit arising from being a partner in the partnership; or
 - (iv) expulsion from the partnership; or
 - (v) the subjecting of the partner to any other detriment in relation to membership of the partnership; and

- (c) in relation to industrial and professional organisations, clubs, sporting associations and other associations, in
 - (i) the terms of admission to membership or qualification; or
 - (ii) the refusal or deliberate omission to accept applications for membership or qualification; or
 - (iii) the way access is afforded to any benefit, service or facility, or the refusal or deliberate omission to afford access to them; or
 - (iv) deprivation of membership or qualification or variation of the terms of membership or qualification; or
 - (v) the subjecting of a person to any other detriment in relation to admission or membership; and
- (d) in relation to education and training, in
 - (i) refusal or failure of an education institution to accept an application for admission as a student; or
 - (ii) the terms or conditions on which an education institution is prepared to admit a student; or
 - (iii) denial or limitation of access to any benefit, service or facility provided by an education institution; or
 - (iv) segregation within or expulsion from an education institution; or
 - (v) the subjecting of a person to any other detriment in relation to education or training; and
- (e) in relation to detainees and persons in custody, in
 - (i) the application of detention, restriction or segregation procedures or conditions; or
 - (ii) the provision of and access to health facilities and care; or
 - (iii) the subjecting of a detainee to any other detriment in relation to detention or custody; and
- (f) in relation to the provision of accommodation, including rental, hotel and guesthouse accommodation, in
 - (i) the refusal or deliberate omission to accept applications for or to provide accommodation; or
 - (ii) the terms or conditions on which or the manner in which the accommodation is provided; or
 - (iii) eviction from the accommodation; or
 - (iv) the subjecting of a person to any other detriment in relation to the provision of accommodation; or
- (g) in relation to surveillance or research related to HIV/AIDS, whether or not that is the primary purpose of the surveillance or research, in
 - (i) the selection of subjects for surveillance or research; or
 - (ii) the access to benefits of the research or surveillance; or
 - (iii) the maintenance of confidentiality of personal information acquired for, during or from the surveillance or research; and
- (h) subject to section 8, in relation to the provision of or access to goods, services or public facilities, in
 - (i) the refusal to provide goods, services or public facilities; or
 - (ii) the terms or conditions on which or the manner in which the goods, services or public facilities are provided; or
 - (iii) the withdrawal or curtailment of goods, services or public facilities; or
 - (iv) the subjecting of a person to any other detriment in relation to provision of or access to goods, services or public facilities.

...

9. Unlawful screening

- (1) Subject to section 14(4), it is unlawful to require or coerce
 - (a) a person seeking or applying for
 - (i) employment or contract work; or
 - (ii) acceptance in a partnership; or
 - (iii) membership of an industrial or professional organisation, club sporting association or other association; or
 - (iv) admission to an education institution; or
 - (v) accommodation including rental, hotel and guesthouse accommodation; or

- (vi) the provision of or access to goods, services or public facilities; or
- (vii) adoption or marriage; or
- (viii) entry into, residence in or citizenship of the country; or
- (b) a person who is
 - (i) a contract worker or employee, or
 - (ii) a partner, or
 - (iii) a member of an industrial or professional organisation, club, sporting association or other association; or
 - (iv) a student in an education institution; or
 - (v) in accommodation; or
 - (vi) being provided with goods, services or facilities; or
- (c) a detainee or person in custody, to undergo an HIV test, produce proof that he is not infected with HIV or answer any questions the answer to which may tend to show that he is a person of a kind referred to in section 6(1), except in accordance with this Act.

(2) A consent, written or otherwise, by a person of a kind referred to in subsection (1) to the provision of a medical service or to the performance of a general medical review does not constitute consent to an HIV test.

10. Unlawful stigmatisation

- (1) Subject to subsection 2, it is unlawful to stigmatise a person on the ground that the person is infected or affected by HIV/AIDS.
- (2) Subsection 1 does not apply to
 - (a) a fair report of an act of stigmatisation referred to in subsection 1; or
 - (b) the communication, dissemination, distribution or publication of any matter that is subject to a defence of absolute privilege in proceedings under the Defamation Act (chapter 293); or
 - (c) a public act, done reasonably, in good faith and not actuated by ill-will to the person stigmatised, for academic, artistic, scientific, research or religious discussion or instruction purposes or for other purposes in the public interest, including discussion or debate about and expositions of any act or matter.

11. Access to means of protection.

- (1) It is unlawful to deny a person access, without reasonable excuse, to a means of protection from infection of himself or another by HIV.
- (2) Proof of a reasonable excuse in subsection 1 is on the person alleged to be denying the access.
- (3) In particular, and without limiting the generality of subsection 1, 'means of protection' includes:
 - (a) HIV/AIDS awareness materials; and
 - (b) condoms, condom lubricant and any other means of prevention of HIV transmission; and
 - (c) exclusive personal use of skin penetrative instruments, including razors, needles and syringes; and
 - (d) means of disinfecting skin penetrative instruments.

PART III – Testing, counselling, reporting and confidentiality

Division 1 – Preliminary

12. Interpretation of Part III

...

- (2) Pre-test information, in relation to an HIV test, includes information about
 - (a) the nature of HIV and of AIDS; and
 - (b) the nature and purpose of an HIV test; and
 - (c) the testing process and the probable time-frame for obtaining test results; and
 - (d) the legal and social consequences, including the possibility of notifying sexual partners, of

- (i) having an HIV test; and
- (ii) being infected with HIV; and
- (e) the ways to prevent transmission of HIV.
- (3) Post-test support, in relation to an HIV test, includes
 - (a) where the HIV test result is negative—information about
 - (i) the nature of HIV and of AIDS; and
 - (ii) the effects of the window period and the desirability of repeating the test after a specified time; and
 - (iii) the ways to prevent infection by HIV; or
 - (b) where the HIV test result is positive, information about
 - (i) the nature of HIV and of AIDS; and
 - (ii) the legal and social issues associated with HIV and AIDS; and
 - (iii) the ways to prevent transmission of HIV; and
 - (iv) the treatment available (if any) to mitigate the effects of infection; and
 - (v) the care available, together with any necessary referral to an appropriate care service; and
 - (vi) the desirability of informing the tested person's sexual partner or partners, and the action that may be taken under section 20 in the event of failure or refusal by the tested person to inform the sexual partner or partners; and
 - (vii) any other matter relevant to the personal circumstances of the tested person.

Division 2. Testing and reporting

...

14. Testing

- (1) It is unlawful for any person
 - (a) not being a medical practitioner or authorised person, to request an HIV test; or
 - (b) to perform an HIV test except on the request of a medical practitioner or authorised person.
- (2) Subject to subsection 4 and section 23(4), it is unlawful to request an HIV test except
 - (a) with the voluntary informed consent of the person to be tested; or
 - (b) where the person to be tested is aged 12 years or less and is, in the opinion of the person providing the pre-test information, not capable of understanding the meaning and consequences of an HIV test—with the voluntary informed consent of a parent or guardian of the person; or
 - (c) subject to subsection 3, where the person to be tested has a disability which, in the opinion of the person providing the pre-test information, renders the person incapable of giving consent, with the voluntary informed consent, in order, of
 - (i) a guardian of the person; or
 - (ii) a partner of the person; or
 - (iii) a parent of the person; or
 - (iv) a child aged 18 years or more of the person; or
 - (d) where a person is required to undergo an HIV test in accordance with section 23, or the blood, tissue or an organ of a person is required to be tested, under this Act or any other law.
- (3) The voluntary informed consent required under subsection 2(c) shall be obtained in the following manner:
 - (a) the consent of the person in the categories referred to in subsection 2(c)(i), (ii), (iii) and (iv) shall be sought in the order of those Paragraphs;
 - (b) if that person refuses consent, no further request for consent shall be sought;
 - (c) where there is no person in a category or the person cannot, after reasonable inquiry, be found—a request may be made to the person in the next category.
- (4) Notwithstanding subsection 2 or section 9, a medical practitioner responsible for the care and treatment of a person may request an HIV test in respect of that person without the consent required by subsection 1 where

- (a) the person is unconscious or otherwise unable to give consent; and
- (b) the medical practitioner believes that the test is clinically necessary or desirable
 - (i) in the interests of that person; and
 - (ii) for the purposes of treatment of that person.

15. Test results

...

- (3) It is unlawful for a person who has requested an HIV test to divulge information about the result of that test except
 - (a) to the person who has been tested; or
 - (b) where another person gave the voluntary informed consent to the test, in accordance with section 14(2)(b) or (c), to that person; or
 - (c) with the consent of the person who gave the voluntary informed consent, to a person who is directly involved in providing care to, or treatment or counselling of, the person tested, where the information is required in connection with providing the care, treatment or counselling; or
 - (d) by order of a court; or
 - (e) in accordance with section 16.
- (4) It is unlawful to inform a person of the result, either negative or positive, of an HIV test without also offering post-test support.

...

Division 3. Confidentiality and disclosure

18. Confidentiality of information

- (1) Subject to subsection 2, section 19(3) and section 20, a person who
 - (a) while providing, or being associated in the course of his duties whether paid or unpaid with the provision of, an HIV testing, treatment, care, counselling, or associated health care service; or
 - (b) while acting or assisting in the administration of this Act; or
 - (c) while present in any room or place where a matter is being investigated, inquired into or heard under this Act; or
 - (d) while acting in his professional capacity as a clergyman of a church or other religious leader of any religious denomination; or
 - (e) while conducting surveillance or research, acquires information that another person, whether dead or alive
 - (f) is, or is presumed to be, infected by HIV or has, or is presumed to have, AIDS; or
 - (g) has been, is being, is seeking or has refused to be tested for HIV; or
 - (h) is related to or associated with a person who is, or is presumed to be, infected by HIV or has, or is presumed to have, AIDS,
 shall take all reasonable steps to prevent disclosure of the information to any other person.
- (2) The information referred to in subsection 1 may be disclosed
 - (a) with the consent of the person to whom it relates, in accordance with the terms of that consent; or
 - (b) where the person to whom the information relates is aged 12 years or less and consent to testing of that person has been given by a parent or guardian in under section 14(2)(b) with the consent of that parent or guardian; or
 - (c) by order of a court or person acting judicially or otherwise empowered to examine witnesses, where the information is directly relevant to proceedings in the court or before the person; or
 - (d) where the information is statistical only or cannot otherwise reasonably be expected to lead to the identification of the person to whom it relates; or
 - (e) to the extent authorised by this Act or any other law.

19. Privacy of proceedings

(1) Where, in any proceedings before a court or tribunal, it appears that information of a kind referred to in section 18(1) is proposed to be given, the court or tribunal

(a) shall, if requested by the person to whom the information relates; or

(b) may, where it considers that because of the social, psychological or economic consequences to the person to whom the information relates, the information should not be publicly disclosed, make all or any of the following orders:

(c) that all or any persons be excluded from the room or place in which the proceedings or any part of the proceedings are being conducted;

(d) that only persons specified by it may be present during the whole or any part of the proceedings;

(e) that the publication of a report of the whole or any part of the proceedings be prohibited.

(2) Subject to subsection 3, it is unlawful to print or publish, except on the written authority of the Director

(a) a report of any proceedings or matter heard in camera or in private under subsection 1 or Part V; or

(b) a report contrary to subsection 1(e).

(3) subsection 2 does not apply to the printing or publishing of

(a) any pleading, transcript of evidence or other document for use in connection with any judicial proceedings, or to the communication of the contents of any such pleading, transcript or document to a person concerned in the proceedings; or

(b) a notice or report under the directions of a court or judge; or

(c) any matter in a separate volume or part of a bona fide series of law reports that does not form part of any other publication and consists solely of reports of proceedings in courts; or

(d) a report of any conclusions, recommendations and suggestions of the Ombudsman Commission; or

(e) any matter in a publication of a technical character *bona fide* intended for circulation among members of the legal or medical profession.

20. Partner notification

(1) Notwithstanding section 18, a person providing a treatment, care or counselling service to a person infected with HIV may notify a sexual partner of the person that the person is infected with HIV where

(a) the notifying person is requested by the infected person to do so; or

(b) in the opinion of the notifying person

(i) counselling of the infected person has failed to achieve appropriate behavioural change; and

(ii) the infected person has refused to notify, or consent to the notification of, the sexual partner; and

(iii) there is a real risk of transmission of HIV by the infected person to the sexual partner; or

(c) the infected person is

(i) dead, unconscious or otherwise unable to give consent; and

(ii) unlikely to regain consciousness or the ability to give consent; and

(iii) in the opinion of the notifying person, there is or was a real risk of transmission of HIV by the infected person to the sexual partner.

(2) A notification under subsection 1 shall be made in such a manner as to conceal, so far as is possible, the identity of the infected person from the sexual partner.

(3) Where a person has been notified under subsection 1, the notifying person shall offer appropriate counselling.

21. Unlawful disclosure

It is unlawful to disclose information of a kind referred to in section 18(1) contrary to this Division.

PART IV – Persons creating a risk to others

22. Mother to child transmission

Nothing in this Part applies to the transmission of HIV by a woman to her child, either before, during or after the birth of the child.

23. Intentional transmission

(1) The intentional transmission or attempted transmission of HIV to another person is

(a) an assault or attempted assault, as the case may be, occasioning bodily harm within the meaning of section 340; and

(b) where death has occurred — an act of unlawful killing within the meaning of section 298, of the Criminal Code (chapter 262).

(2) Section 297 of the Criminal Code (chapter 262) shall not apply in a prosecution under subsection 1(b).

(3) It is a defence to a charge of an offence relating to the intentional or attempted transmission of HIV to another person that

(a) the other person was aware of the risk of infection by HIV and voluntarily accepted that risk; or

(b) the other person was already infected with HIV; or

(c) where the transmission or attempted transmission is alleged to have occurred by sexual intercourse

(i) a condom or other effective means of prevention of HIV transmission was used during penetration; or

(ii) the accused person was not aware of being infected with HIV.

(4) A court may, in any proceedings under this section, order either or both of the following:

(a) that an HIV test be performed on the accused;

(b) that the court be informed of any information regarding the HIV status of the accused.

(5) In making an order under subsection 4, the court may make any ancillary order it considers necessary or desirable, and in particular, orders relating to

(a) the provision of counselling to the accused; and

(b) the release or suppression of the results of any test performed or of any information obtained.

24. Reasonable care

A person who is, and is aware of being, infected with HIV shall

(a) take all reasonable measures and precautions to prevent the transmission of HIV to others, including the use of a condom or other effective means of protection from infection during sexual intercourse; and

(b) inform any intended sexual partner or any person with whom a skin penetrative instrument is to be shared, in advance of the sexual intercourse or sharing of the skin penetrative instrument, that he is infected with HIV,

and the taking of those measures and precautions and the giving of that information shall constitute the taking of reasonable care within the meaning of section 286 of the Criminal Code (chapter 262).

25. Reckless behaviour causing risk of infection

(1) Where the Director believes, on reasonable grounds, that a person

(a) is and is aware of being infected with HIV; and

(b) has behaved in such a way as to expose others to a significant risk of infection; and

(c) is likely to continue that behaviour in future; and

(d) has been counselled without success in achieving appropriate behaviour change; and

(e) presents a real danger of infection to others, the Director may issue a written notice to the person.

(2) A notice under subsection 1 shall state:

- (a) the grounds upon which the Director believes that it should be issued; and
 - (b) the reasons why the person should not continue the behaviour referred to in paragraph a; and
 - (c) a direction that the person should not continue that behaviour, or should commence to behave in a specified manner; and
 - (d) any other matters or directions that the Director considers are necessary or convenient to ensure an appropriate change of behaviour; and
 - (e) that breach of a direction in the notice is an unlawful act, and may be dealt with according to this Act.
- (3) A notice under subsection 1 may be delivered to the person to whom it is directed by
- (a) delivering a sealed copy of the notice to the person personally or, if the person cannot be found, by leaving it at the person's last known place of residence with some other person apparently residing at that place and apparently not less than 16 years of age; or
 - (b) delivering a sealed copy of the notice to another person who is known to be providing treatment, care or counselling to the person to whom the notice is directed.
- (4) Failure to comply with a notice under subsection 2 is unlawful.

PART V – Dealing with unlawful acts

26. Interpretation of part V

In this part

‘action’ means a complaint, application or other process by which a proceeding or investigation is commenced under this part;

‘Court’ means the national court or a district court.

27. Unlawful acts

- (1) An unlawful act under this Act
 - (a) is a discriminatory practice within the meaning of
 - (i) Section 219(1)(c) of the Constitution; and
 - (ii) the Organic Law on the Ombudsman Commission; and
 - (b) is professional misconduct under the Medical Registration Act (chapter 398) and the Lawyers Act 1986; and
 - (c) is a disciplinary offence under the Public Services (Management) Act 1995, the Police Act 1988, the Correctional Service Act 1995 and the Defence Act (chapter 74); and
 - (d) may be the subject of an action under section 28; and
 - (e) is an offence to which the penalty is
 - (i) in the case of a corporation, a fine not exceeding K10,000.00; and
 - (ii) in the case of a natural person, a fine not exceeding K5,000.00 or imprisonment for a term not exceeding three years, or both.
- (2) Action in respect of an unlawful act may be taken in accordance with any paragraph of subsection 1 by any person who has an interest in the unlawful act complained of, or in the case of a person who is, in the opinion of the court, unable fully and freely to exercise his right under this section, by a person acting on his behalf, whether or not by his authority.
- (3) Action in respect of an unlawful act may be taken in accordance with any paragraph of subsection 1 notwithstanding either or both of the following:
 - (a) that the person the object of the unlawful act has died, whether the death occurred before or after the occurrence of the act;
 - (b) subject to section 29, that action has been or is being taken in accordance with any other paragraph of subsection 1.

...

PART VI – Miscellaneous

...

33. Evidence of certain communications

(1) Any communication relating to the sexual behaviour of a person made by another person undergoing an HIV test, a surgical or dental procedure or counselling under this Act is not admissible in any proceedings under

- (a) Section 210 or 212 of the Criminal Code (chapter 262); or
- (b) Section 55 or 56 of the Summary Offences Act (chapter 264).

(2) Any communication made by a woman who is and is aware that she is infected with HIV relating to the procurement of her miscarriage is not admissible in any proceedings under section 225 of the Criminal Code (chapter 262).

...

Philippines: AIDS Prevention and Control Act of 1998

Enacted in 1998, this Act prescribes measures for the prevention and control of HIV and AIDS in the Philippines by instituting a nationwide HIV-related information and educational program, establishing a comprehensive HIV and AIDS monitoring system, and strengthening the Philippine National AIDS Council.

Excerpts

...

2. Declaration of policies

Acquired Immunodeficiency Syndrome (AIDS) is a disease that recognises no territorial, social, political and economic boundaries for which there is no known cure. The gravity of the AIDS threat demands strong State action today, thus:

- (a) The State shall promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV/AIDS through a comprehensive nationwide educational and information campaign organised and conducted by the State. Such campaigns shall promote value formation and employ scientifically proven approaches, focus on the family as a basic social unit, and be carried out in all schools and training centres, workplaces, and communities. This program shall involve affected individuals and groups, including people living with HIV.
- (b) The State shall extend to every person suspected or known to be infected with HIV/AIDS full protection of his human rights and civil liberties. Towards this end:
 - (1) compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act;
 - (2) the right to privacy of individuals with HIV shall be guaranteed;
 - (3) discrimination, in all its forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical to individual and national interest; and
 - (4) provision of basic health and social services for individuals with HIV shall be assured.
- (c) The State shall promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission.
- (d) The State shall positively address and seek to eradicate conditions that aggravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalisation, drug abuse and ignorance.
- (e) The State shall recognise the potential role of affected individuals in propagating vital information and educational messages about HIV/AIDS and shall utilise their experience to warn the public about the disease.

ARTICLE I – Education and information

4. HIV/AIDS education in schools

The Department of Education, Culture and Sports (DECS), the Commission on Higher Education (CHED), and the Technical Education and skills Development Authority (TESDA), utilising official information provided by the Department of Health, shall integrate instruction on the causes, modes of transmission and ways of preventing HIV/AIDS and other sexually transmitted diseases in subjects taught in public and private schools at intermediate grades, secondary and tertiary levels, including non-formal and indigenous learning systems: provided, that if the integration of HIV/AIDS education is not appropriate or feasible, the DECS and TESDA shall design special modules on HIV/AIDS prevention and control: provided, further, that it shall not be used as an excuse to propagate birth control or the sale or distribution of birth control devices: provided, finally, that it does not utilise sexually explicit materials.

Flexibility in the formulation and adoption of appropriate course content, scope, and methodology in each educational level or group shall be allowed after consultations with parent-teachers-community associations, private school associations, school officials, and other interest groups. As such, no instruction shall be offered to minors without adequate prior consultation with parents who must agree to the thrust and content of the instruction materials.

All teachers and instructors of said HIV/AIDS courses shall be required to undergo a seminar or training on HIV/AIDS prevention and control to be supervised by DECS, CHED and TESDA, in coordination with the Department of Health (DOH), before they are allowed to teach on the subject.

5. HIV/AIDS information as a health service

HIV/AIDS education and information dissemination shall form part of the delivery of health services by health practitioners, workers and personnel. The knowledge and capabilities of all public health workers shall be enhanced to include skills for proper information dissemination and education on HIV/AIDS. It shall likewise be considered a civic duty of health providers in the private sector to make available to the public such information necessary to control the spread of HIV/AIDS and to correct common misconceptions about this disease. The training or health workers shall include discussions on HIV-related ethical issues such as confidentiality, informed consent and the duty to provide treatment.

6. HIV/AIDS education in the workplace

All government and private employees, workers, managers, and supervisors, including members of the Armed Forces of the Philippines (AFP) and the Philippine National Police (PNP), shall be provided with the standardised basic information and instruction on HIV/AIDS which shall include topics on confidentiality in the workplace and attitude towards infected employees and workers. In collaboration with the Department of Health (DOH), the Secretary of the Department of Labor and Employment (DOLE) shall oversee the anti-HIV/AIDS campaign in all private companies while the Armed Forces Chief of Staff and the Director General of the PNP shall oversee the implementation of this Sec.

7. HIV/AIDS education for Filipinos going abroad

The State shall ensure that all overseas Filipino workers and diplomatic, military, trade, and labor officials and personnel to be assigned overseas shall undergo or attend a seminar on the cause, prevention and consequences of HIV/AIDS before certification for overseas assignment. The Department of Labor and Employment or the Department of Foreign Affairs, the Department of Tourism and the Department of Justice through the Bureau of Immigration, as the case may be, in collaboration with the Department of Health (DOH), shall oversee the implementation of this Section.

8. Information campaign for tourists and transients

Informational aids or materials on the cause, modes of transmission, prevention, and consequences of HIV infection shall be adequately provided at all international ports of entry and exit. The Department of Tourism, the Department of Foreign Affairs, the Department of Justice through the Bureau of Immigration, in collaboration with the Department of Health (DOH), shall oversee the implementation of this Act.

9. HIV/AIDS education in communities

Local government units, in collaboration with the Department of Health (DOH), shall conduct an educational and information campaign on HIV/AIDS. The provincial governor, city or municipal mayor and the barangay captain shall coordinate such campaign among concerned government agencies, non-government organisations and church-based groups.

10. Information on prophylactics

Appropriate information shall be attached to or provided with every prophylactic offered for sale or given as a donation. Such information shall be legibly printed in English and Filipino, and contain literature on the proper use of the prophylactic device or agent, its efficacy against HIV and STD infection, as well as the importance of sexual abstinence and mutual fidelity.

11. Penalties for misleading information

Misinformation on HIV/AIDS prevention and control through false and misleading advertising and claims in any of the tri-media or the promotional marketing of drugs, devices, agents or procedures without prior approval from the Department of Health and the Bureau of Food and Drugs and the requisite medical and scientific basis, including markings and indications in drugs and devices or agents, purporting to be a cure or a fail-safe prophylactic for HIV infection is punishable with a penalty of imprisonment for two months to two years, without prejudice to the imposition of administrative sanctions such as fines and suspension or revocation of professional or business license.

ARTICLE III – Testing, screening and counselling

15. Consent as a requisite for HIV testing

No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. Lawful consent to HIV testing of a donated human body, organ, tissue, or blood shall be considered as having been given when

- (a) a person volunteers or freely agrees to donate his blood, organ, or tissue for transfusion, transplantation, or research;
- (b) a person has executed a legacy in accordance with section 3 of Republic Act 7170, also known as the 'Organ Donation Act of 1991';
- (c) a donation is executed in accordance with section 4 of Republic Act 7170.

16. Prohibitions on compulsory HIV testing

Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the country, or the right to travel, the provision of medical service or any other kind of service, or the continued enjoyment of said undertakings shall be deemed unlawful.

17. Exception to the prohibition on compulsory testing

Compulsory HIV testing may be allowed only in the following instances

- (a) When a person is charged with any of the crimes punishable under articles 264 and 266 as amended by Republic Act 8353, 335 and 338 of Republic Act 3815, otherwise known as the 'Revised Penal Code' or under Republic Act 7659;

- (b) When the determination of the HIV status is necessary to resolve the relevant issues under Executive Order No 309, otherwise known as the 'Family Code of the Philippines'; and
- (c) When complying with the provisions of Republic Act 7170, otherwise known as the 'Organ Donation Act' and Republic Act 7719, otherwise known as the 'National Blood Services Act'.

...

20. Pre-test and post-test counselling

All testing centers, clinics, or laboratories which perform any HIV test shall be required to provide and conduct free pre-test counselling and post-test counselling for persons who avail of their HIV testing services. However, such counselling services must be provided only by persons who meet the standards set by the DOH.

...

ARTICLE IV – Health and support services

22. Hospital-based services

Persons with HIV/AIDS shall be afforded basic health services in all government hospitals, without prejudice to optimum medical care which may be provided by special AIDS wards and hospitals.

...

ARTICLE VI – Confidentiality

30. Medical confidentiality

All health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of any medical record, file, data, or test results are directed to strictly observe confidentiality in the handling of all medical information, particularly the identity and status of persons with HIV.

31. Exceptions to the mandate of confidentiality

Medical confidentiality shall not be considered breached in the following cases

- (a) when complying with reportorial requirements in conjunction with the AIDSWATCH programs provided in section 27 of this Act;
- (b) when informing other health workers directly involved or about to be involved in the treatment or care of a person with HIV: provided, that such treatment or care carry the risk of HIV transmission; provided, further, that such workers shall be obliged to maintain the shared medical confidentiality;
- (c) when responding to a subpoena duces tecum and subpoena ad testificandum issued by a Court with jurisdiction over a legal proceeding where the main issue is the HIV status of an individual: provided, that the confidential medical record shall be properly sealed by its lawful custodian after being double-checked for accuracy by the head of the office or department, hand delivered, and personally opened by the judge: provided, further, that the judicial proceedings be held in executive session.

32. Release of HIV test results

All results of HIV testing shall be confidential and shall be released only to the following persons

- (a) the person who submitted himself/herself to such test;
- (b) either parent of a minor child who has been tested;
- (c) a legal guardian in the case of insane persons or orphans;
- (d) a person authorised to receive such results in conjunction with the AIDSWATCH program as provided in section 27 of this Act;
- (e) a justice of the Court of Appeals or the Supreme Court, as provided under subsection c of this Act and in accordance with the provision of section 16 hereof.

33. Penalties for violations of confidentiality

Any violation of medical confidentiality as provided in section 30 and 32 of this Act shall suffer the penalty of imprisonment for six months to four years, without prejudice to administrative

sanctions such as fines and suspension or revocation of the violator's license to practice his profession, as well as the cancellation or withdrawal of the license to operate any business entity and the accreditation of hospitals, laboratories or clinics.

34. Disclosure to sexual partner

Any person with HIV is obliged to disclose his HIV status and health condition to his spouse or sexual partner at the earliest opportune time.

ARTICLE VII – Discriminatory acts and policies

35. Discrimination in the workplace

Discrimination in any form from pre-employment to post-employment, including hiring, promotion or assignment, based on the actual, perceived or suspected HIV status of an individual is prohibited. Termination from work on the sole basis of actual, perceived or suspected HIV status is deemed unlawful.

36. Discrimination in schools

No educational institution shall refuse admission or expel, discipline, segregate, deny participation, benefits or services to a student or prospective student on the basis of his actual, perceived or suspected HIV status.

37. Restrictions on travel and habitation

The freedom of abode, lodging and travel of a person with HIV shall not be abridged. No person shall be quarantined, placed in isolation, or refused lawful entry into or deported from Philippine territory on account of his actual, perceived or suspected HIV status.

38. Inhibition from public service

The right to seek an elective or appointive public office shall not be denied to a person with HIV.

39. Exclusion from credit and insurance services

All credit and loan services, including health, accident and life insurance shall not be denied to a person on the basis of his actual, perceived or suspected HIV status: provided, that the person with HIV has not concealed or misrepresented the fact to the insurance company upon application. Extension and continuation of credit and loan shall likewise not be denied solely on the basis of said health condition.

40. Discrimination in hospitals and health institutions

No person shall be denied health care service or be charged with a higher fee on account of actual, perceived or suspected HIV status.

41. Denial of burial services

A deceased person who had AIDS or who was known, suspected or perceived to be HIV-positive shall not be denied any kind of decent burial services.

42. Penalties for discriminatory acts and policies

All discriminatory acts and policies referred to in this Act shall be punishable with a penalty of imprisonment for six months to four years and a fine not exceeding Ten thousand pesos. In addition, licenses or permits of schools, hospitals and other institutions found guilty of committing discriminatory acts and policies described in this Act shall be revoked.

ARTICLE VIII – The Philippine National AIDS Council

43. Establishment

The Philippine National AIDS Council (PNAC) created by virtue of Executive Order 39 dated 3 December 1992 shall be reconstituted and strengthened to enable the Council to oversee an integrated and comprehensive approach to HIV/AIDS prevention and control in the Philippines. It shall be attached to the Department of Health.

44. Functions

The Council shall be the central advisory, planning and policy-making body for the comprehensive and integrated HIV/AIDS

prevention and control program in the Philippines. The Council shall perform the following functions

(a) Secure from government agencies concerned recommendations on how their respective agencies could operationalise specific provisions of this Act. The Council shall integrate and coordinate such recommendations and issue implementing rules and regulations of this Act. The Council shall likewise ensure that there is adequate coverage of the following

(1) The institution of a nationwide HIV/AIDS information and education program;

(2) The establishment of a comprehensive HIV/AIDS monitoring system;

(3) The issuance of guidelines on medical and other practices and procedures that carry the risk of HIV transmission;

(4) The provision of accessible and affordable HIV testing and counselling services to those who are in need of it;

(5) The provision of acceptable health and support services for persons with HIV/AIDS in hospitals and in communities;

(6) The protection and promotion of the rights of individuals with HIV; and

(7) The strict observance of medical confidentiality.

(b) Monitor the implementation of the rules and regulations of this Act, issue or cause the issuance of orders or make recommendations to the implementing agencies as the Council considers appropriate;

(c) Develop a comprehensive long-term national HIV/AIDS prevention and control program and monitor its implementation;

(d) Coordinate the activities of and strengthen working relationships between government and non-government agencies involved in the campaign against HIV/AIDS;

(e) Coordinate and cooperate with foreign and international organisations regarding data collection, research and treatment modalities concerning HIV/AIDS; and

(f) Evaluate the adequacy of and make recommendations regarding the utilisation of national resources for the prevention and control of HIV/AIDS in the Philippines.

...

47. Creation of Special HIV/AIDS Prevention and Control Service

There shall be created in the Department of Health a Special HIV/AIDS Prevention and Control Service staffed by qualified medical specialists and support staff with permanent appointment and supported with an adequate yearly budget. It shall implement programs on HIV/AIDS prevention and control. In addition, it shall also serve as the secretariat of the Council.

...

ARTICLE IX – Miscellaneous provisions

...

51. Repealing clause

All laws, presidential decrees, executive orders and their implementing rules inconsistent with the provisions of this Act are hereby repealed, amended or modified accordingly.

...

United States of America: State of New Jersey – An act concerning testing of Pregnant Women and Newborns for Human Immunodeficiency Virus (2007)

The Act was introduced to the Senate and General Assembly of the State of New Jersey on 14 May 2007. It requires health care providers to test pregnant women for HIV as part of routine prenatal care, unless the woman refuses testing, and by also requiring HIV testing of all newborns. The Act has come under strong criticism from human rights groups arguing that it infringes on the right to autonomy of pregnant women.

1. Section 1 of P.L.1995, c.174 (C.26:5C-15) is amended to read as follows

1. As used in this Act

‘AIDS’ means Acquired Immunodeficiency Syndrome as defined by the Centres for Disease Control and Prevention of the United States Public Health Service.

‘Commissioner’ means the Commissioner of Health and Senior Services.

‘Department’ means the Department of Health and Senior Services.

‘HIV’ means the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

2. Section 2 of P.L.1995, clause 174 (C.26:5C-16) is amended to read as follows

2. It is the policy of this State that testing of all pregnant women for HIV shall be part of routine prenatal care; and, in the absence of a specific written objection to the testing by the pregnant woman, all pregnant women shall be tested for HIV as early as possible in their pregnancy, and again during the third trimester of their pregnancy.

(a)(1) A physician or other health care practitioner who is the primary caregiver for a pregnant woman [or a woman who seeks treatment within four weeks of giving birth,] shall, in accordance with guidelines developed by the commissioner, provide the woman with information about HIV and AIDS, and also inform the woman of the benefits of being tested for HIV [and present her with the option of being tested] as early as possible in the course of her pregnancy and a second time during the third trimester, the medical treatment available to treat HIV infection if diagnosed early, and the reduced rate of transmission of HIV to a fetus if an HIV-infected pregnant woman receives treatment for HIV.

The physician or other health care practitioner shall also advise the woman that HIV testing is recommended for all pregnant women both early in their pregnancy and during the third trimester, and that she will receive HIV tests as part of the routine panel of prenatal tests unless she specifically refuses to be tested for HIV.

The woman shall, on a form and in a manner prescribed by the commissioner, acknowledge receipt of the information and [indicate her preference regarding testing], when applicable, indicate her refusal to be tested. A woman shall not be denied appropriate prenatal or other medical care because she [decides not] refuses to be tested for HIV.

(2) A pregnant woman, who presents herself for delivery and has not been tested for HIV during the course of her pregnancy, shall be given the information and counselling specified in paragraph 1 of this subsection as soon as may be medically appropriate and, unless she refuses in writing after receiving that information and counselling, shall be tested for HIV as soon as may be medically appropriate.

(b) The commissioner shall establish guidelines regarding notification to a woman whose test result is positive, and to provide, to the maximum extent possible, for counseling about the significance of the test result.

(c) Information about a woman which is obtained pursuant to this section shall be held confidential in accordance with the provisions of P.L.1989, clause 303 (C.26:5C-5 et seq.).

(cf: P.L.1995, clause 174, section 2)

3. Section 6 of P.L.1995, clause 174 (C.26:5C-20) is amended to read as follows

6. The commissioner, pursuant to the ‘Administrative Procedure Act,’ P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effect this act. The regulations shall be consistent with the latest recommendations for HIV testing of pregnant women prepared by the United States Centres for Disease Control and Prevention.

(cf: P.L.1995, clause 174, section 6)

4. (New section)(a) The Commissioner of Health and Senior Services shall require each birthing facility in the State to administer to every newborn in its care a test for human immunodeficiency virus (HIV).

(b) The commissioner shall establish a comprehensive program for the testing of newborns for the presence of HIV, which shall include, but not be limited to, procedures for the administration of HIV testing, counselling of the newborn's mother, tracking the newborn, disclosure of HIV test results to the mother, facility compliance reviews, and educational activities related to the HIV testing.

(c) The provisions of this section shall not apply to a newborn whose parents object to the test as being in conflict with their religious tenets and practices. The parents shall provide the health care facility with a written statement of the objection, and the statement shall be included in the newborn's medical record.

(d) As used in this section, 'birthing facility' means an inpatient or ambulatory health care facility licensed by the Department of Health and Senior Services that provides birthing and newborn care services.

(e) The Commissioner of Health and Senior Services shall adopt rules and regulations, pursuant to the Administrative Procedure Act, P.L.1968, clause 410 (C.52:14B-1 et seq.), necessary to carry out the purposes of this section.

5. This Act shall take effect on the 180th day after enactment but the commissioner may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this Act.

E1.2 Equality and non-discrimination

Canadian Human Rights Act (1977)

Passed by the Parliament of Canada in 1977, this statute ensures equal opportunity to individuals who may be victims of discriminatory practices based on a set of prohibited grounds such as gender, disability, sexual orientation or religion.

Excerpts

...

5. Denial of good, service, facility or accommodation

It is a discriminatory practice in the provision of goods, services, facilities or accommodation customarily available to the general public

(a) to deny, or to deny access to, any such good, service, facility or accommodation to any individual, or

(b) to differentiate adversely in relation to any individual, on a prohibited ground of discrimination.

...

7. Employment

It is a discriminatory practice, directly or indirectly,

(a) to refuse to employ or continue to employ any individual, or

(b) in the course of employment, to differentiate adversely in relation to an employee, on a prohibited ground of discrimination.

...

E1.3 Employment

The Bahamas: Bahamas Employment Act 27 of 2001

Enacted in 2001 by the Parliament of Bahamas and entered into force on 1 January 2002. This Act, among other things, prohibits discrimination against an employee on the basis of his HIV status.

Excerpts

...

6. Non-discrimination and equal pay for equal work

No employer or person acting on behalf of an employer shall discriminate against an employee or applicant for employment on the basis of race, creed, sex, marital status, political opinion, age or HIV/AIDS by

(a) refusing to offer employment to an applicant for employment or not affording the employee access to opportunities for promotion, training or other benefits, or by dismissing or subjecting the employee to other detriment solely because of his race, creed, sex, marital status, political opinion, age or HIV/AIDS;

(b) paying him at a rate of pay less than the rate of pay of another employee, for substantially the same kind of work or for work of equal value performed in the same establishment, the performance of which requires substantially the same skill, effort and responsibility and which is performed under similar working conditions except where such payment is made pursuant to seniority, merit, earnings by quantity or quality of production or a differential based on any factor other than race, creed, sex, marital status, political opinion, age or HIV/AIDS;

(c) pre-screening for HIV status

Provided that this section does not affect any other law or contract term which stipulates a retirement age.

...

E2 Policies and other similar documents

Australia's National HIV/AIDS Strategy (2005-2008) (2005)

The HIV/AIDS Strategy of Australia attempts to deal with new features of the epidemic. Its goal is to reduce HIV transmission and to minimise the personal and social impacts of HIV. Its overall objectives are to reduce the number of new infections; to improve the health and well being of people living with HIV; to reduce HIV related discrimination; and to develop and strengthen links with other related national strategies.

Excerpts

...

4. Guiding principles for this strategy

The principles informing this Strategy are those that have underpinned the effectiveness of Australia's response to HIV/AIDS in all previous national strategies. Continued adherence to these principles is essential to support achievement of the Strategy's two overarching goals of eliminating the transmission of HIV and minimising the personal and social impacts of HIV/AIDS. These guiding principles are

- leadership;
- the HIV/AIDS partnership;
- the centrality of PLWH;
- an enabling environment;
- non-partisan response; and
- health promotion and harm minimisation.

In 2001, Australia endorsed the UN General Assembly Declaration of Commitment on HIV/AIDS (United Nations General Assembly, 2001). The six principles highlighted in this Strategy will support Australia in meeting the commitments expressed in the declaration that are of particular relevance to Australia's national response.

The complexity of HIV/AIDS medicine, the sensitivity of the personal and social issues involved, and the constantly changing medical and social dimensions of the disease create the potential for HIV/AIDS policy and programs to be characterised by conflict rather than consensus, and for strategic momentum to be lost as a result.

The principles underlying this Strategy are intended to provide a framework for collaborative consensus building, through which conflict can be resolved productively by focusing on common goals, a shared commitment to evidence-based policy and programming, and role delineation based on strategic planning. The principles also facilitate increased policy and program reach and enable policies and programs to adapt effectively to changing social and policy contexts.

4.1 Leadership

...

Leadership was a focus at the 15th International AIDS Conference in Bangkok in 2004. The leadership program and the Leadership Statement that was issued supported the assurances stated in the UN General Assembly Declaration of Commitment, and hold governments, communities and international organisations accountable for the implementation of HIV-related programs. Concern was voiced in the Leadership Statement that the worldwide response to the epidemic so far has not been effective and that some of the response to date has been motivated by value judgements. The Australian Government supports the commitment to actions based on evidence.

An important aspect of leadership in Australia's response to HIV/AIDS has been non-partisan support for the provision of appropriate prevention information, education and treatment, care and support. The re-establishment of the Parliamentary

Liaison Group will also contribute to successful leadership by the Australian Government. In evaluating this Strategy, leadership will be monitored and outcomes documented to ensure effectiveness and accountability.

4.2 The HIV/AIDS partnership

The UN General Assembly Declaration of Commitment commits governments to multi-sectoral responses involving partnerships with civil society and the full participation of people living with HIV and AIDS as well as affected communities. It recognises that the involvement of affected communities is vital to the successful design and delivery of effective prevention and education messages on HIV/AIDS, and that it is necessary to support organisations and partners to be actively involved in addressing the epidemic facing so many communities.

This Strategy will strengthen the partnership approach that has characterised Australia's response to HIV/AIDS. Partnership continues to be at the core of the national strategic response. The HIV/AIDS partnership

- has contributed to a focused approach in which the expertise of different sectors has been effectively combined;
- is a valuable, cooperative effort between all levels of government, community organisations, PLWH and affected communities, and the medical and scientific communities; and
- is based on a commitment to consultation and joint decision-making in all aspects of the response.

...

This Strategy accords a priority to strengthening partnerships between governments and the community-based organisations representing PLWH, gay and other homosexually active men, drug users, sex workers and Aboriginal and Torres Strait Islander populations. This Strategy emphasises the involvement of these communities in decision-making and policy formulation.

4.3 Centrality of PLWH

This Strategy recognises the overriding importance of the participation of PLWH in policy and program development, implementation, monitoring and evaluation. This participation is necessary for the effectiveness of responses, because it ensures that policies and programs are informed by the experiences of PLWH, are responsive to need, and take adequate account of the full range of personal and community effects of policy directions.

The involvement of PLWH and affected communities in shaping policies and programs has been critical to the success of Australia's national HIV/AIDS response. To ensure continued community engagement in the national HIV/AIDS strategy, PLWH must be placed at the centre of the national response and be supported in providing a leadership role that guides and supports the national response.

This Strategy also recognises that sustaining the involvement and leadership of PLWH in the national response requires the provision of ongoing support to individuals and these organisations representing PLWH. This Strategy recognises the importance of this role's continuing.

...

4.4 An enabling environment

The success of the national strategy is dependent on sustaining a supportive social, legal and policy environment that encourages PLWH and affected communities to

- support and promote education and prevention;
- respond to education;
- access voluntary testing and treatment services; and
- participate effectively in all levels of the response.

This requires ongoing scrutiny of the impact of policies across government on PLWH and affected communities including in areas such as mental health, welfare, housing, human rights, criminal justice, housing and income support.

The UN General Assembly Declaration of Commitment on HIV/AIDS requires governments to

- eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, PLWH and members of vulnerable groups; and
- develop strategies to combat stigma and social exclusion connected with the epidemic.

This Strategy gives priority to the development of approaches to reduce stigma and discrimination experienced by PLWH in Australia, aimed particularly at improving their access to clinical care and health services. Programs to highlight and challenge discrimination will continue to be supported, as well as efforts in individual and systemic advocacy and access to effective complaint systems.

Policies and laws of governments at all levels should be reviewed to ensure that all areas support improved health outcomes and that they combat and resolve, rather than compound, stigma, discrimination and social exclusion.

...

There is a need for nationally consistent guidelines for the management of people who knowingly place others at risk of infection. Most States and Territories have legislation that allows for people to be managed either through Health Department processes or through the courts under a Crimes Act. This Strategy supports an approach that emphasises counselling and community management rather than immediate criminal processes and calls for the States and Territories to develop a common approach in this area. The National Public Health Partnership has developed a legislative tool on this topic, Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk.

4.5 Non-partisan response

Non-partisan support has been important to the success of Australia's response to HIV/AIDS to date. It involves support for pragmatic social policy and for innovative interventions that effect sustainable behaviour change among more marginalised groups in society.

This approach will continue throughout the term of this Strategy, primarily through the reestablishment of the Parliamentary Liaison Group (PLG). HIV/AIDS in Australia is a health issue and HIV-related policy responses – for example, the work done with marginalised communities and the delivery of targeted HIV/AIDS prevention messages – should be handled in a non-partisan way.

4.6 Health promotion and harm minimisation

Health promotion

The UN General Assembly Declaration of Commitment commits governments to strengthening national strategies through participatory approaches that promote the health of communities, and to supporting efforts to prevent and minimise harm related to drug use.

Australia's approach to HIV/AIDS will continue to be set within the overall framework of the Ottawa Charter for Health Promotion (World Health Organisation, 1986). The charter defines health promotion as the process of enabling people to increase control over, and thereby improve, their health.

Health promotion includes disease prevention, education, social mobilisation and advocacy as well as an emphasis on a complete state of wellbeing. Health promotion acknowledges that vulnerabilities can be influenced only by a holistic approach addressing the total experience, not just individual behaviour(s).

The Ottawa Charter requires health promotion action to be taken on five fronts

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- re-orienting health services.

At the heart of this process is the empowerment of communities to take action to improve health and welfare. The Australian

Government supports Australia's previous approaches to prevention and health maintenance in the context of HIV/AIDS.

HIV/AIDS health promotion includes strategies that enable people to increase their control of conditions affecting HIV/AIDS. Such health promotion encompasses working on a range of levels including: interpersonal, group, organisational and societal, addressing any HIV/AIDS issue, from primary prevention to treatment and social policy.

Health promotion activities for PLWH should address the contextual realities of living with treatments, aim to maintain emotional wellbeing, develop necessary skills in self care, develop understanding and awareness of the networks and systems of clinical and community support, and, as suggested by the Ottawa Charter, those areas of life skills for PLWH that relate to broader areas of work, socialisation and wellbeing. Such activities should also respond to the specific needs of all target populations such as Aboriginal and Torres Strait Islander communities and people from CALD backgrounds living with HIV.

The Australian Government acknowledges the centrality of PLWH in all aspects of HIV/AIDS health promotion and acknowledges the previous success and continued value of health promotion models such as peer education and community development, and the important role community-based organisations and affected communities have played in their implementation.

Harm minimisation

Harm reduction has been and will continue to be the basis of Australia's public health response to the transmission of HIV and other blood borne viruses through injecting drug use. It is one of three elements that make up the principle of harm minimisation that is the basis of Australia's approach to drug use, as recognised by the National Drug Strategy—supply reduction, demand reduction and harm reduction. Harm reduction encompasses a variety of strategies, including needle and syringe programs, peer education about safer drug use practices and drug treatment programs.

The Australian Government does not support or encourage drug use and, in conjunction with law enforcement agencies in the States and Territories, is working to reduce drug-related harm. However, it is acknowledged that this behaviour occurs and that damaging consequences can result. Public health measures should be designed to reduce the harm that drug use can cause, both to individuals and to the community. The objective of this approach is to reduce the transmission of disease, and so reduce the personal and social impact and the loss of quality of life caused by ill health.

The principle of harm minimisation supports access to any necessary and proven technologies to help achieve this, such as new and safer injecting equipment (through needle and syringe programs), condoms, and any other interventions shown to be effective in preventing HIV transmission. The success of Australia's NSPs has greatly limited the potential impact of HIV/AIDS.

Similarly, condoms have been repeatedly demonstrated to be the cheapest, most readily accessible, safe and practical way to prevent sexual transmission of HIV and some other STIs.

5. Priority areas for action

Some of the main priorities to emerge from the reviews and the Government's response to the reviews for the next three years have been identified as follows

- continuing to develop a targeted prevention education and health promotion program for HIV/AIDS, in consultation with organisations representing PLWH and other community-based organisations;
- improving the health of PLWH by increasing the effectiveness of new treatments, improved
- targeting of treatments and increased availability of clinical information;
- responding to changing care and support needs;
- reviewing the HIV testing policy;

- further development of the surveillance system for HIV/AIDS; and
- providing a clearer direction for HIV/AIDS research.

Priority target groups

The following groups have been identified as priorities for prevention education and health promotion initiatives under this Strategy. These groups are not mutually exclusive.

Gay and other homosexually active men

Most people living with or at risk of HIV infection in Australia are gay or other homosexually active men, and in view of this, this Strategy maintains the direction of previous strategies in recognising this group as the highest priority for health promotion. Gay and other homosexually active men have borne the greatest burden of the HIV/AIDS epidemic in Australia. In 2003, transmission of HIV continued to be mainly through sexual contact between men, and more than 85 per cent of newly acquired HIV infections between 1999 and 2003 were reported to be the result of this mode of transmission. The effectiveness of peer-based responses to HIV/AIDS has been clearly demonstrated in gay communities. The challenge for this Strategy will be to maintain and reinforce the safe behaviour message among gay and other homosexually active men in the broader context of health promotion and the changing nature of Australia's gay community. It should also respond to the cultural diversity of gay and other homosexually active men including Aboriginal and Torres Strait Islander gay men, transgender people, Sistergirls, and gay and other homosexually active men from CALD backgrounds.

PLWH

PLWH have played an important and effective role in the implementation of previous national HIV/AIDS strategies, and the beneficial roles played by PLWH in health promotion, treatment, research, and care and support initiatives are the best evidence of the value of this group in the national response. With the number of PLWH in Australia continuing to grow, the response to HIV/AIDS in Australia needs to recognise that PLWH are crucial to providing insight into effective and meaningful social and clinical interventions. Health promotion efforts for PLWH should focus on initiatives relating to broader health education and improved quality of life as well as on treatments and health maintenance initiatives. These efforts should also respond to the specific needs of all priority populations such as Aboriginal and Torres Strait Islander people and people from CALD backgrounds living with HIV.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are recognised as a priority group under this Strategy, both in terms of prevention and education, and care and support, as there are particular issues arising for HIV-positive Aboriginal and Torres Strait Islander people within their communities. These include high levels of concern about stigma and discrimination, particularly in smaller and remote communities, which lead to fears of disclosure and heightened secrecy.

HIV/AIDS continues to pose a serious threat to Aboriginal and Torres Strait Islander people and the potential for a rapid-spreading generalised epidemic in this population remains, sustained by high rates of STIs occurring in Aboriginal and Torres Strait Islander communities. The nature of the epidemic in Aboriginal and Torres Strait Islander communities is different to that in the non-Aboriginal and Torres Strait Islander population. This difference includes lower numbers of infections through male homosexual contact, and higher numbers through heterosexual contact. A higher proportion of cases are attributed to injecting drug use. While the overall number of Aboriginal and Torres Strait Islander people living with HIV and AIDS is small, the diagnoses more than doubled between 1999 and 2003.

In addressing these challenges, this Strategy recognises the needs of children and other family members affected by HIV/AIDS and identifies some of the associated problems of isolation, lack of appropriate services and the need to travel to reach services.

...

People who inject drugs

HIV/AIDS prevention among people who inject drugs has, to date, been very successful in Australia's response to HIV/AIDS. These HIV/AIDS prevention efforts have not just been in the provision of new injecting equipment through needle and syringe programs but also through peer education on safer injecting practices, blood awareness, safe sex practices, drug treatment options including pharmacotherapy treatment and harm reduction strategies.

However, the need to improve access to clinical care and to reduce the level of discrimination experienced by injecting drug users within the health care system still exists. It is also important to provide additional support for the group of people who inject drugs who may have difficulty adhering to complex treatment regimens. These issues should be addressed through community education, training programs for health care workers and the development of systematic approaches at local levels.

...

People in custodial settings, including young people in detention

In the correctional environment, there are often systemic and other impediments to best-practice prevention and standards of care. These problems are exacerbated by higher levels of co-infection with HIV and hepatitis C in this population. This group is a target for priority action in this Strategy due to the risk of a rise in HIV/AIDS among people in correctional facilities as well as the increased risk of transmission by inmates on their return to the community. The high levels of needle sharing, the availability of drugs and the rate of transfer of inmates between and within custodial settings increases the risk of a rise in HIV among people in correctional facilities. Prevention and education on safe sex and safe injecting practices should be central elements of any effort to reduce and prevent the spread of HIV/AIDS in custodial settings. The physical and mental health needs of young people in custodial settings should also be taken into account when considering education and service provision in custodial settings.

Sex workers

There is a relatively low prevalence of HIV/AIDS among Australian sex workers, and there has been no recorded case of HIV transmission in a sex industry setting in Australia. Sex workers are able to negotiate high levels of condom use in their work and voluntary testing has also been an effective component of the response to HIV/AIDS.

The potential for an increase in HIV/AIDS in this priority group remains. Implementation of the Scarlet Alliance National Training Project has provided some national support and opportunities to sex worker peer educators to extend and receive accreditation for their skills. However, the high turn over of staff in this industry remains a challenge to peer education.

Additionally, prevention efforts are often affected by resource constraints and sex industry legislation, including legislation around anti-discrimination, occupational health and safety and privacy. The different regulatory frameworks that govern sex work in Australia have the potential to have an effect on trends in HIV infections. Sex workers working in the regulated industry have a much increased capacity to negotiate condom use and other safer behaviours as opposed to those working in less safe, unregulated settings.

People from priority culturally and linguistically diverse (CALD) backgrounds

People from CALD backgrounds constitute a growing component of HIV/AIDS in Australia. Within this population there is considerable diversity in terms of culture and language and also in terms of risk behaviours as this population includes gay and other homosexually active men, heterosexual men, women and injecting drug users.

People from CALD backgrounds are more likely to have a late diagnosis of HIV/AIDS and associated poorer health outcomes. There are also complexities in care and support arising from cultural and linguistic issues and their impact on health literacy, social disadvantage and social isolation.

Nigeria: National Policy on HIV/AIDS (2003)

The overall goal of this HIV/AIDS policy is to control the spread of HIV in Nigeria, and to mitigate its impact to the point where it is no longer of public health, social and economic concern. The main target of the HIV/AIDS policy is to achieve at least a 25 per cent reduction in HIV incidence among adults.

Excerpts

PART II – Goals, objectives and targets

Guiding principles

The government and people of Nigeria affirm that

- The National Policy on HIV/AIDS is complementary to all existing national policies related to the development and corporate existence of the country;
- The Policy shall be based on the principles of human rights, social justice and equity;
- The various governments of the federation acknowledge their responsibility to provide Nigerians with adequate information to take responsibility for, and safeguard their health and well-being.
- The various governments of Nigeria acknowledge their responsibility to provide for the health and well being of the people, which shall be fulfilled by the provision of adequate health and social services.
- The nation will adopt strategies that are cost effective, practical, socially acceptable, and scientifically sound to ensure that the HIV/AIDS epidemic is brought under control.

PART III – Policies and strategies

The following policies and strategies to achieve them are founded on the above stated principles and objectives. Structurally, the policies focus on five strategic components

1. Prevention of HIV/AIDS
2. Law and Ethics
3. Care and Support
4. Communication
5. Program Management and Development

Prevention of HIV/AIDS

Unprotected, penetrative sexual intercourse is the most common mode of transmission of HIV in the Nigeria. Other modes of infection of include mother-to-child transmission, transmission through blood and blood products, the sharing of sharp instruments including hypodermic needles, and the use of unsterilised tattoo and grooming equipment. Nigeria recognises these modes of transmission and their relative importance in the spread of HIV. Accordingly, the Federal Government of Nigeria policy and strategy will be directed towards reducing the risk of transmission through

- Promotion of safer sexual behaviour
- Appropriate Use of Condoms
- Prevention of HIV/AIDS Transmission through Blood and Blood Products
- Voluntary counselling and testing
- Prevention of mother-to-child transmission

- Early diagnosis and effective treatment of Sexually Transmitted
- Infections
- Adolescents and Youth focused interventions

Law, human rights and ethics

Law

The lack of appropriate, HIV-relevant legislation affects the ability of persons living with HIV to live positively and persons susceptible or vulnerable to the disease from being able to protect themselves from the disease. In recognition that this lack adversely affects the nation's ability to reduce the spread of HIV/AIDS and mitigate its impact, the government of Nigeria commits itself to reviewing existing legislation and enacting appropriate new laws in the following areas.

- HIV/AIDS legislation in the workplace: Protection of worker's rights on the job for those infected
- HIV/AIDS legislation in the workplace: Protection of worker's on the job from being infected as a result of their work;
- Legislation on legal rights and property ownership of persons infected and affected by HIV/AIDS;
- Legislation to improve access to legal services, and care and support for persons infected and affected by HIV/AIDS;
- Legislation to protect the rights of victims of sexual violence;
- The establishment and codification of the nation's HIV/AIDS response structure.
- The codification of HIV relevant legislation

Ethics and Human Rights

The government recognises the stigma and discrimination facing people infected and affected by HIV/AIDS and realises that the promotion and protection of human rights for all Nigerians can reduce the negative effects associated with the epidemic; therefore the Federal Government of Nigeria affirms the following:

- Persons living with or affected by HIV shall not be discriminated against on the basis of their health status with respect to education, training, employment, housing, travel, access to health care and other social amenities and citizenship rights;
- The denial of appropriate care and support for persons living with HIV is an abuse of their human rights, unethical and illegal;
- All persons shall respect the right to privacy and confidentiality of people living with HIV and shall not disseminate information on the HIV status of individuals without the individual's consent, or that of the individual's family when the individual is incapable of giving such consent;
- Where the dissemination of information is medically indicated, information being imparted shall be assigned the strictest measures of confidentiality on a strictly enforced 'need-to-know' basis;
- HIV and STI testing shall not be included as part of a routine medical examination without the knowledge and prior consent of the client.
- Mandatory HIV testing without consent is illegal except in the case of a person charged with any sexual offence that could involve risk of HIV
- Confidential pre- and post-test counselling services shall be made available to tested individuals and, if requested by an individual, to his family in all places where individuals are tested and/or notified of HIV test results.
- Insurance of any kind shall not be revoked or affected by an individual's change in his health status following the issuance of an insurance policy;
- The Government of Nigeria shall monitor human rights abuses and develop enforcement mechanisms for redress;

Communication

The various governments of Nigeria realise that public support is essential to the success of the policy's goals and objectives, as the programme must compete with other national priorities for resources; is contingent upon policy reforms; and upon attitudinal and behaviour changes in the general public, high risk groups, health care providers and the various sectors of the country.

A comprehensive information, education and communication (IEC) system is central to the nation's efforts to prevent the spread of HIV/AIDS and mitigate its impact. The communication strategies will focus on the main area of need: IEC and Public Enlightenment.

...

Care and support

Nigeria recognises its responsibility to provide access to health care for all its citizens. Given that no effective curative therapy currently exists presently for AIDS, effective management of the condition must include an emphasis on compassion and support for the persons infected and affected by HIV/AIDS. The effects of the HIV/AIDS epidemic go beyond health and affects the ability of persons infected and affected to live productively therefore support is needed. The objectives for the strategies for care and support are to provide accessible, affordable and sustainable quality care for those infected by HIV/AIDS and also to provide them and those affected by HIV/AIDS with the ability to live positively in spite of their condition.

Clinical Management

- All health workers and care givers shall receive the appropriate level of training in the modes of transmission and management of HIV/AIDS related conditions, and also be trained in the counselling associated with an HIV/AIDS.
- No health care institution or health care worker shall refuse to provide treatment to AIDS patients or those with HIV infection.

...

- The government will develop appropriate guidelines for the adequate nutrition of persons living with and affected by HIV/AIDS, and the babies borne to persons living with HIV.

Home-Based Care

- Appropriate mechanisms will be put in place to increase the availability of home based care.

...

Opportunistic Infections (OI)

...

- Nigeria shall ensure nationwide access and availability to cost-effective drugs for the prevention and treatment of the most common opportunistic infections;

...

Anti-retroviral Therapy

The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, including the provision of antiretroviral medication (ARV)

- Cost-effective and affordable care shall be made accessible to all people living with HIV-related illnesses, including access to anti-retroviral therapy;
- The use of ARV shall be under medical supervision and shall be governed by established effective guidelines. These will be updated regularly with the results of research.
- A cost-effective drug list for the management of HIV/AIDS shall be developed and incorporated into Nigeria's essential drug list;
- Sale of ARVs shall be provided solely under strict medical supervision;

...

Support for the Infected

- The government of Nigeria shall guarantee and enforce equal access of every Nigerian citizen to employment, housing, health, education, and social services regardless of HIV status;
- The government of Nigeria shall facilitate efforts in support of micro-credit schemes and other economic initiatives designed to eradicate poverty and provide a financial safety net for PLWHs;
- The government of Nigeria shall actively facilitate and support community-level efforts designed to provide a social safety net for PLWHs.

Support for the people affected by HIV/AIDS including orphan and vulnerable children care.

The government at all three tiers commit themselves to facilitating and promoting community initiatives to sustain the necessary level of care for Nigeria's children who are affected or infected by HIV/AIDS.

...

West and Central Africa: Law # of 2004 on HIV/AIDS Prevention and Control

This model law is the outcome of a project initiated and funded by USAID in collaboration with various organisations including the Forum of African and Arab Parliamentarians for Population and Development and the Economic Community of West African States Parliament. It aims at providing countries in the West and Central African Regions with an opportunity to enact laws that reflect a strong commitment by political decision makers to respond to the epidemic. It was adopted at a regional workshop held in September 2004. This model law has attracted criticism from human rights organisations for introducing coercive measures such as compulsory disclosure of HIV status and the criminalisation of non-intentional transmission of HIV.

Article 1. Definition of terms

In accordance with the law, the terms and expressions used in the first article of this convention shall be understood as follows, unless otherwise defined by the context:

Acquired Immunodeficiency Syndrome AIDS: a condition characterised by a combination of signs and symptoms caused by HIV, which attacks and weakens the body's immune system, exposing the affected individual to other potentially fatal infections.

Anonymous Screening Test: a sensitive procedure whereby the individual tested does not reveal his true identity. An identification number or symbol is used to replace the person's name, thus allowing the laboratory conducting the test and the person undergoing the test to match the results of the analysis with the identification number or symbol

Compulsory Screening Test: HIV screening test imposed on a person without his consent or with his vitiated consent obtained through the use of force, intimidation or any form of extortion.

Contact Tracing: a method used to trace and care for the sexual partner of a person who has been diagnosed as suffering from a sexually transmitted disease.

Human Immunodeficiency Virus (HIV): The virus that causes AIDS.

HIV/AIDS Monitoring: documentation and analysis of the number of HIV/AIDS infections

HIV/AIDS Prevention and Control: measures aimed at preventing non-infected persons from contracting the disease and minimise the impact of the disease on PLWH.

HIV Positive: result of a screening test revealing the presence of HIV or HIV antibodies in the person tested.

HIV Negative: the absence of HIV or HIV antibodies in persons tested.

HIV Screening Test: A laboratory test conducted on an individual to determine the presence or the absence of HIV infection.

HIV Transmission: infection of a person by another who is already infected. Infection usually occurs through sexual intercourse, blood transfusion or the sharing of intravenous needles, skin-piercing instruments or through mother-to-child transmission.

Willful Transmission: transmission of HIV through any means by a person with full knowledge of his HIV/AIDS status to another person.

HIV Risk Behaviour: frequent participation of a person in activities that increase the risk of transmission or acquisition of HIV.

Free and Informed Consent: a voluntary agreement of a person who accepts to undergo a procedure based on complete information, whether this agreement is written, verbal or implied.

Medical Confidentiality: a relationship of trust existing or which should exist between a patient in general and PLWH in particular and his doctor or any health agent, paramedical staff, health worker, laboratories, pharmacies or people of similar status, as well as any person whose professional or official prerogatives allows him/her to have access to such information.

Persons Living with HIV: a person, whose screening test, directly or indirectly, reveals that he is infected by HIV.

Pre-test Counselling: information given to a person on the biomedical, social and behavioural aspects of HIV/AIDS and on the results of the test as well as the counseling needed before he undergoes the screening test.

Post-test Counselling: information given to a person who has undergone an HIV screening test as well as counselling when he is given the results of the test.

Prophylaxis: any agent or instrument, which serves to prevent the disease.

Voluntary HIV Test: refers to an individual who, after a pre-test counselling, willingly undergoes a screening test.

PLWH: persons living with HIV.

Public Media Broadcast: Radio broadcasting, TV, cinema, the press, posters, exhibits, hand bills, flyers, other written documents or pictures of any kind; speeches, songs and generally any information aimed at reaching the public.

CHAPTER I – Education and information

Article 2. Education and information on HIV/AIDS in schools

Based on official data provided by the Ministries of Health, the Ministries of Education, Youth, Sports and Culture shall integrate programs on the causes, modes of transmission and prevention of HIV/AIDS and sexually transmitted infections in the curriculum of the basic, secondary and tertiary levels of public and private schools and in the traditional school system.

If for any reason, the integration of these programs into the curricula is considered inappropriate, the aforementioned ministries shall develop special teaching modules on HIV/AIDS prevention and control.

The content of the teaching modules, its formulation, the methodology used and its adoption shall be adapted to each level of instruction, after consultation with Parent-Teacher associations, associations of private schools and community groups, traditional and religious leaders, PLWH, and related groups.

It is strictly forbidden to teach courses such as the one provided for in this article to minors without prior consultation with parents whose approval is required both for the content and the materials used for such courses.

Prior to the authorisation to teach lessons on HIV/AIDS, teachers, instructors and any other person involved in programs and teaching modules provided for in the first and second

paragraphs of this article shall be trained on HIV/AIDS prevention and control, under the supervision of the Ministry of Health.

Article 3. Information on HIV/AIDS as a health service

Education and information on HIV/AIDS must form part of the health services administered by doctors and health personnel. The knowledge and capacity of employees to appropriately disseminate information and education on HIV/AIDS shall be improved.

Doctors working in the private and public sector shall made available to their patients, information needed for controlling the spread of HIV/AIDS and those which help counteract pre-conceived ideas on the disease.

The Training of health personnels shall include discussions on issues related to ethics within the context of HIV/AIDS, confidentiality, informed consent and obligation to provide treatment.

Article 4. Sensitisation of HIV/AIDS in the workplace

All employees of the public and private sector, formal or informal, whatever their position in the hierarchy, members of the armed forces and security services shall receive a standardised basic training in HIV/AIDS, which will include themes on confidentiality at the workplace and behaviour towards workers infected or affected by HIV/AIDS.

The National AIDS Commission in collaboration with the Ministry of health, civil society and labour organisations shall launch awareness campaigns in all enterprises (both public and private) while the directorates of the security services including the armed forces shall be responsible for the enforcement of the provisions in the preceding paragraph of this article in their respective structures.

Article 5. Education on HIV/AIDS within communities

The National AIDS Commission in collaboration with the Ministry of Health, government services, municipal assemblies and civil societies, shall launch an education and information campaign on HIV/AIDS.

Local authorities and other decentralised institutions of government shall coordinate this campaign, which will involve the various government bodies, NGOs as well as traditional and religious associations.

Article 6. Education of nationals working abroad on HIV/AIDS

The government shall train all its personnel appointed to work abroad on the causes, prevention and the effect of HIV/AIDS prior to official confirmation of their appointment.

The Ministries of Health in collaboration with the Ministries of Employment, Foreign Affairs, Tourism, Justice and Immigration shall be responsible for enforcing the provisions of the preceding paragraph of this article.

The Ministry of Transport will include in its test for the issuance of driving licenses for public transport, knowledge of transmission modes, prevention and the consequences of HIV/AIDS.

Sailors shall not be allowed to embark on fishing or passenger boats, except on provision of a document issued by the port authorities and testifying that they have received training in the causes, prevention and consequences of HIV/AIDS.

Airline companies shall train all their technical and commercial flight personnel in the causes, prevention and consequences of HIV/AIDS.

Article 7. Information for tourists and passengers in transit

Information material on the causes, modes of transmission, prevention and consequences of HIV infection shall be provided in the appropriate manner at all international entry and exit points and major tourist sites.

The Ministry of Health in collaboration with the National AIDS Commission and the Ministries of Tourism, Foreign Affairs,

Justice and Immigration shall be in charge of enforcing the provisions of the preceding paragraph of this article.

Article 8. Information in prisons

Information material on the causes, modes of transmission, prevention and consequences of HIV infection shall be provided in the most appropriate way at all Prison and detention institutions.

The Ministries of Justice and Health shall be responsible for enforcing the provisions of the preceding paragraph of this article.

Article 9. Information on drugs

Appropriate information shall be clearly written on the packaging of all drugs intended for sale or free distribution.

Information contained in the preceding paragraph of this article shall be printed in one of the widely spoken languages in the country. They shall contain information on the appropriate use of the device or agent, its effectiveness against the HIV infection and sexually transmitted diseases.

The Ministry of Health or its accredited agency shall ensure the quality and efficacy of all drugs brought into the country prior to their sale and consumption.

Article 10. Dissemination of erroneous or false information on HIV

Any person found guilty of dissemination of information on HIV/AIDS prevention using erroneous and false publicity and solicitations through whatever means of communication, and the commercial promotion of drugs, materials, agents and procedures without any medical and scientific basis and without the prior authorisation of the Ministry of Health or its accredited agencies, as well as inscriptions and indications on the packaging of drugs, materials or agents that are intended to cure HIV/AIDS or protect against the disease, is punishable by a term of imprisonment not exceeding xxxx to xxxx months/year or to a fine not exceeding xxxxxx francs.

CHAPTER II – Secure practices and procedures

Article 11. Requirements related to blood, tissues or organ donation

All human blood, blood related products, tissues and organs to be donated shall be tested for HIV. Laboratories or related institutions are not allowed to accept for use or keep donated blood, tissues and organs, unless the sample of the donor's blood, tissue or organ has tested HIV negative.

The beneficiary of donated blood, tissues or organs may demand a second test prior to blood transfusion or transplantation of the tissues or organs into him or her.

Blood, tissues and organs infected with the HIV shall be immediately disposed of in a safe manner.

Article 12. Guidelines concerning surgical interventions and other related procedures

The Ministry of Health shall take the necessary measures to guarantee that precautions are taken to avoid HIV transmission during surgical intervention, dental care, embalming, tattooing and other related procedures.

The Ministry of Health must also develop general guidelines and regulations for the handling and disposal of bodies and body parts of persons known or suspected of being HIV positive who died.

The necessary protective equipment, i.e. gloves, protective glasses and coats shall be made available to all doctors and other health procedures in particular those taking care of AIDS patients.

The implementation of the above provisions in this article shall be fixed by decree.

Article 13. Sanctions for risky practices and procedures

Any person who through clumsiness, negligence, carelessness, recklessness or non-compliance with the regulations and the

protection guidelines certified in the preceding article infects another with HIV, shall be guilty of intentionally infecting another person with HIV in the fulfillment of his profession, and shall be sentenced to imprisonment for a period not exceeding 12 months.

When the offence is committed in a hospital institution or private clinic, the license of the institution shall be suspended for a period not exceeding 12 months.

CHAPTER III – Traditional medicine

Article 14. Commission on traditional medicine

A Commission on Traditional Medicine shall be established and be responsible for the registration, accreditation and suspension of traditional medicine practitioners in the country.

The composition of the commission, its roles and functions and the conditions of issuance, suspension and withdrawal of traditional medicine practitioners' licence shall be established by decree.

Article 15. Practice of traditional medicine

All traditional medicine practitioners shall be required to register with the Commission as stated in article 14 prior to being issued with an operating license authorising them to practice, sell or advertise their products.

The Commission shall make regulations regarding the licensing of the operations of all traditional medicine practitioners. Traditional medicine who violate this provision shall be sanctioned by a imprisonment for a period not exceeding xxxx months/year or a fine not exceeding xxxxx.

Article 16. Public media broadcasting

The dissemination of information relative to the control and prevention of HIV/AIDS through advertisement, solicitation, or whatever means, and the marketing of medical products, equipment, agents and procedures, without the prior authorisation of the traditional medicine commission, and the indication that the above stated items can cure or protect against HIV/AIDS, shall be punished by an imprisonment of a period ranging from xxxx to xxxx months/year.

The broadcasting institution, which helped in disseminating such information, shall be liable to a fine ranging between 500 000 CFA to 2 000 000 CFA francs.

CHAPTER IV – Voluntary counselling and testing (VCT)

Article 17. Consent to undergo an HIV test

No one shall be compelled to undergo an HIV test without his written consent. Such consent must be free and informed and written. It shall be required of the person concerned if he is of age or by his parent or guardians if the person is a minor or is mentally challenged.

The Government shall take all the necessary measures to ensure the provision of VCT services and encourage their use by all individuals at a high risk of HIV infection.

In the event of donations of organs, cells or blood, the consent to undergo an HIV test is legally assumed when a person willingly or freely agrees to give his blood, organ or cell for transfusion, transplant or research.

Article 18. Prohibition of the requirement to undergo an HIV test

HIV testing shall not be a requirement for the following: securing a job, admission to school or universities, access to accommodation, right to entry/residence in a country, or as a precondition to travel, access to medical care or any other services.

The state shall encourage future spouses to undergo screening tests prior to marriage.

This prohibition however is revoked in the following cases:

(a) where a person is indicted for infecting or attempting to infect another person with HIV by whatever means;

- (b) where a person is indicted for rape;
- (c) where the determination of the HIV status is necessary to solve a matrimonial conflict;
- (d) in cases anticipated in article 17 paragraphs 3 of the present law.

Article 19. Testing centres and voluntary testing

The government shall develop a system of anonymous HIV screening which shall guarantee anonymity and medical confidentiality when undertaking such tests.

In order to carry out operations, all centres, hospitals, clinics and laboratories providing HIV testing services shall be required to obtain authorisation from the relevant government departments of health.

All centres, clinics or laboratories, carrying out an HIV test, shall provide pre and post test counselling to the clients to whom VCT is being offered. However, counselling services shall only be provided by trained personnel who meet the standards of the health departments.

The Ministry of Health shall build the HIV testing capacities of hospitals, clinics, and laboratories and other testing centres by providing training to personnel providing such services.

CHAPTER V – Health and counselling services

Article 20. Services in the health centres

Persons living with HIV shall receive basic health care in all institutions (private and public) including optional medical care provided in the hospitals and institutions specialised in the treatment of AIDS.

Article 21. Communities services

Specialised government institutions in collaboration with NGOs, persons living with HIV and groups that are highly exposed to the risk of HIV infection shall undertake preventive activities as well as psychosocial responsibility within the communities.

Article 22. Outreach and training of PLWH

PLWH Groups shall be provided with adequate training programs, the objective of which shall be towards self-reliance and mutual self-assistance.

No one has the right to deny access to the full participation of persons living with HIV in outreach activities and self-help programs designed to further their training capacities by virtue of their HIV/AIDS status.

Article 23. Treatment of sexually transmitted diseases

The Ministry of Health in collaboration with relevant government agencies, NGOs, and the private and the traditional sector shall take all necessary steps to strengthen the preventive measures, care, and control of sexually transmissible infections to fight against the spread of HIV infection.

CHAPTER VI – Confidentiality

Article 24. Medical confidentiality

The medical and other support staff in health facilities, employment agencies, insurance companies, computer operators or all other persons having access to patient medical records or the identity or HIV status of persons living with HIV are bound by professional ethics not to disclose such information.

Public or private health institutions shall guarantee the confidentiality of the medical, financial or administrative information it has on hospitalised PLWH. Access to confidential medical information can only be authorised by the PLWH, except in legal cases carried out under required legal norms without violating the anonymity guaranteed by the law.

However, the medical confidentiality referred to in the preceding paragraph of the present article will not be considered to have been violated:

- When the authorities of a health institution comply with the epidemiological requirements specified by the public health code.

- When the health personnel directly or indirectly involved in the treatment or care of a PLWH is informed; in such a case, the person will bear the responsibility of the professional secret.
- When the health personnel is called to testify upon the request of a court of competent jurisdiction in the case of a lawsuit in which the determination of HIV/AIDS is an important element in the case. In such a case, the testimony shall be made in writing in a sealed envelope and shall only be accessibly by the competent legal authority.

Article 25. HIV test results

All HIV/AIDS screening test results shall be confidential and will only be handed to the following people:

- The person who took the test;
- One or either of parent of a tested under aged child;
- The parent or guardian in the case of a mentally challenged person or an orphan; and
- The legal authority which legally requested the test.

Article 26. Revelation to spouses and sexual partners

Any person who has been tested positive for HIV is bound to reveal his HIV status to his spouse or regular sexual partner as soon as possible provided that the period does not exceed six full weeks, starting from the date he was notified of his HIV status.

Care service providers shall provide all the necessary psychological support to facilitate the disclosure of the HIV test result to his spouse or sexual partners. The hospital institution must ensure that this announcement is made and done in such a way as to take into account possible communication and comprehension problems of the patient and his spouse or sexual partners.

If the person whose HIV status has just been determined does not proceed to voluntary revelation as provided for in the preceding paragraph within the prescribed period, the doctor or any other qualified paramedical official of the hospital or health institution concerned after having informed the person whose HIV status is known, can proceed to disclose the information to the spouse or sexual partners, without infringing on the provisions relating to medical confidentiality provided for by existing laws.

Article 27. Disclosure to minors, and the mentally and physically challenged

A child shall be entitled to information regarding his HIV/AIDS status, laboratory results and necessary actions with respect to his state of health, according to his age and capacity to understand the information. The doctor or paramedical staff shall ensure that the disclosure is made using means that are appropriately adapted to facilitate acceptance and understanding of their status.

The doctors or paramedical staff shall take the same measure in making the disclosure to the minor's schoolteacher, parents or any other person involved in his education/training or care.

Physically and/or mentally challenged persons shall benefit from appropriate information. The doctor or paramedical staff having access to his test result shall disclose the status of the mentally challenged person to the family and to his care-givers using appropriate measures to facilitate understanding and acceptance.

The persons mentioned in the preceding paragraph are obliged to maintain confidentiality. However, for legitimate and exceptional reasons, a minor or physically and/or mentally challenged person who is HIV positive may be left uninformed of his status as long as the doctor or paramedical staff deem it necessary and as long as this situation does not create any risk for the minor, physically and/or mentally challenged person and for other persons.

Article 28. Sanctions for violating confidentiality

The violations of the provisions of articles 26 and 27 of the present law by all moral and physical persons shall be sanctioned by an imprisonment not exceeding xxxx months or a fine not exceeding xxxx years.

In addition, the court may order the suspension or withdrawal of the person's professional license or the operating permit of the

facility if it is established that the hospital/laboratory or clinic is also involved.

CHAPTER VII – Discriminatory acts

Article 29. Discrimination at workplaces

Discrimination under any form against a person whose HIV status is real or suspected, with respect to hiring, promotion, dismissal and retirement is strictly forbidden.

Consequently any dismissal of an employee based on a real or suspected HIV status is illegal.

Article 30. Discrimination in school and educational institutions

No educational or training institution shall refuse enrolment or other educational services or expel a student, pupil, trainee or applicant on the basis of his real, or suspected HIV status.

Article 31. Violation of the right to travel and accommodation

No one shall interfere in any form with the right to travel or to accommodation based on one's real or suspected HIV status.

No person shall be quarantined, isolated, or barred from entry into a country or deported on the basis of his real or suspected HIV status.

Article 32. Access to public or elected office

No one shall be deprived of his right to an elected or appointed public office or admission to a public function on the basis of his real or suspected HIV status.

Article 33. Access to credit and insurance services

No one shall be denied access to credit, loans and insurance services on the basis of his real or suspected HIV status so long as the person has not hidden his HIV status from the insurance company.

The continuation or extension of the credit and insurance policy shall not be denied solely on the basis of the HIV status of the individual.

Article 34. Discrimination in hospitals and health institutions

No one shall be denied access to services in hospitals or private or public health institutions nor will any one receive a bill which is higher than normal because of his HIV status.

Article 35. Sanction against discriminatory acts

Any discriminatory act anticipated in Chapter VII of the present law shall be sanctioned with a term of imprisonment ranging from xxxx to xxxx or the withdrawal of the license.

E3 Case law

E3.1 HIV and AIDS related discrimination

Canada (Attorney General) v Thwaites (TD) (1994) FC (3rd) 38

In this case, the Attorney General of Canada applied for judicial review of a Human Rights Tribunal decision that determined that Thwaites—a naval electronics sensor operator in the Canadian Armed Forces (CAF) who had filed a complaint against the CAF, alleging that ‘it discriminated against him by terminating his employment and by restricting his duties and opportunities because of his disability, i.e. because he was “HIV positive”’—was justified in his complaint. The Tribunal awarded Thwaites CAN\$147 015 for past and future loss of wages under subsection 53(2) of the Canadian Human Rights Act; \$5,000 for special compensation under subsection 53(3) of the Act, plus interest from the date of the complaint; reasonable costs of his counsel including the cost of actuarial services. The Court studied the application and held that it be dismissed.

This case is interesting because it sheds light on the requirements established in Canada for employers (and the military is no exception) with regards to people living with HIV. In particular, it acknowledges that providing accommodation for employees living with HIV ‘may add some risks and make matters somewhat more burdensome for employers but this is a small price to pay for the higher value that society has placed on equal opportunity’.

Mr X v Hospital Z (1998) Supreme Court of India (1998) 85 SCC 296

This case involves a person living with HIV who was about to marry a woman who did not know his status. The respondent disclosed his status to the woman and the marriage was cancelled. The Supreme Court of India held that the woman had the right to be informed and the respondent was not liable for violating the rule of confidentiality or the right to privacy.

Excerpts

...

Judgment

[1] Infringement of ‘Suspended Right to marry’ cannot be legally compensated by damages either in Torts or common law, is our answer to the problem raised in this appeal which is based on the peculiar facts of its own.

Facts

[3] One who was ailing from a disease which was provisionally diagnosed as aortic aneurism was advised to go to the ‘Z’ Hospital at Madras and the appellant was directed by the government of Nagaland to accompany the said patient to Madras for treatment. For the treatment of the above disease, he was posted for surgery on May 31, 1995 which, however, was cancelled due to shortage of blood. On June 1, 1995 the appellant and the driver were asked to donate blood for the latter. Their blood samples were taken and the result showed that the appellant’s blood group was A positive. On the next date, namely, on June 2, 1995, he was operated for Aortic Anuerism and remained in the Hospital till 10 June 1995 when he was discharged.

[4] In August 1995 the appellant proposed marriage to one Ms ‘Y’ which was accepted and the marriage was proposed to be held on December 12, 1995. But the marriage was called off on the ground of blood test conducted at the respondents’ hospital in which the appellant was found to be HIV positive ...

Since the marriage had been settled but was subsequently called off, several people including the members of the appellant’s family and persons belonging to his community became aware of

the appellant’s HIV positive status. This resulted in severe criticism of the appellant and he was ostracised by the community. The appellant left Kohima (Nagaland) around November 26, 1995 and started working and residing at Madras.

[5] The appellant then approached the National Consumer Disputes Redressal Commission for damages against the respondents, on the ground that the information which was required to be kept secret under Medical ethics was disclosed illegally and, therefore, the respondents were liable to pay damages. The Commission dismissed the Petition as also the application for interim relief summarily by order dated 3rd July 1998 on the ground that the appellant may seek his remedy in the civil court.

[6] Learned counsel for the appellant has vehemently contended that the principle of ‘duty of care’, as applicable to persons in medical profession, includes the duty to maintain confidentiality and since this duty was violated by the respondents, they are liable in damages to the appellant.

...

[11] Here, in this country, there is the Indian Medical Council Act, which controls the medical education and regulates the professional conduct.

[12] It is true that in the doctor-patient relationship, the most important aspect is the doctor’s duty of maintaining secrecy. A doctor cannot disclose to a person any information regarding his patient which he has gathered in the course of treatment nor can the doctor disclose to anyone else the mode of treatment or the advice given by him to the patient.

[13] It is contended that the doctor’s duty to maintain secrecy has a correlative right vested in the patient that whatever has come to the knowledge of the Doctor would not be divulged and it is this right which is being enforced through these proceedings.

...

[17] The General Medical Council of Great Britain in its guidance of HIV infection and AIDS has provided as under:

Where diagnosis has been made by a specialist and the patient after appropriate counselling still refuses permission for the general practitioner to be informed of the result, that request for privacy should be respected. The only exception would be when failure to disclose would put the health of the health care team at serious risk. All people receiving such information must consider themselves to be under the same obligations of confidentiality as the doctor principally responsible for the patient’s care. Occasionally the doctor may wish to disclose a diagnosis to a third party other than a health care professional. The Council think that the only ground for this are when there is a serious and identifiable risk to a specific person, who, if not so informed would be exposed to infection ... A doctor may consider it a duty to ensure that any sexual partner is informed regardless of the patient’s own wishes.

Thus, the Code of Medical Ethics also carves out an exception to the rule of confidentiality and permits the disclosure in the circumstances enumerate above under which public interest would override the duty of confidentiality, particularly where there is an immediate or future health risk to others.

[18] The argument of the learned counsel for the appellant, therefore, that the respondents were under a duty to maintain confidentiality on account of the Code of Medical Ethics formulated by the Indian Medical Council cannot be accepted as the proposed marriage carried with it the health risk to an identifiable person who had to be protected from being infected with the communicable disease from which the appellant suffered. The right to confidentiality, if any, vested in the appellant was not enforceable in the present situation.

[19] Learned Counsel for the appellant then contended that the appellant’s right of privacy has been infringed by the respondents by disclosing that the appellant was HIV positive and, therefore, they are liable in damages.

...

[25] The emphasis, therefore, in practically all systems of marriage is on a healthy body with moral ethics. Once the law provides the ‘venereal disease’ as a ground for divorce to either husband or wife, such a person who was suffering from the disease, even prior to the marriage cannot be said to have any right to marry so long as he is not fully cured of the disease. If the

disease, with which he was suffering, would constitute a valid ground for divorce, was concealed by him and he entered into marital ties with a woman who did not know that the person with whom she was being married was suffering from a virulent venereal disease, that person must be injected from entering into marital ties so as to prevent him from spoiling the health and consequently, the life of an innocent woman.

[28] Sections 269 and 270 of the Indian Penal Code ... spell out two separate and distinct offences by providing that if a person, negligently or unlawfully, does an act which he knew was likely to spread, the infection of a disease, dangerous to life, to another person, then, the former would be guilty of an offence, punishable with imprisonment for the term indicated therein. Therefore, if a person suffering from the dreadful disease 'AIDS', knowingly marries a woman and thereby transmits infection to that woman, he would be guilty of offences indicated in sections 269 and 270 of the Indian Penal Code.

[31] Ms 'Y', with whom the marriage of this appellant was settled, was saved in time by the disclosure of the vital information that the appellant was HIV-positive. The disease, which is communicable, would have been positively communicated to her immediately on the consummating of marriage. As a human being Ms 'Y' must also enjoy, as she, obviously, is entitled to, all the Human Rights available to any other human being. This is apart from, and, in addition to, the fundamental rights available to her under article 21, which, as we have seen, guarantees 'Right to Life' to every citizen of this country. This right would positively include the right to be told that a person, with whom she was proposed to be married, was the victim of a deadly disease, which was sexually communicable. Since 'Right to Life' includes right to lead a healthy life so as to enjoy all faculties of the human body in their prime condition, the respondents, by their disclosure that the appellant was HIV-positive, cannot be said to have, in any way, either violated the rule of confidentiality or the right of privacy. Moreover, where there is a clash of two fundamental rights, as in the instant case, namely, the appellant's right to privacy as part of right to life and Ms 'Y' right to lead a healthy life which is her fundamental right under article 21, the right which would advance the public morality or public interest, would alone be enforced through the process of court, for the reason that moral considerations cannot be kept at bay and the judges are not expected to sit as mute structures of clay, in the hall, known as court room, but have to be sensitive, 'in the sense that they must keep their fingers firmly upon the pulse of the accepted morality of the day.'

**A, C & Others v Union of India & Others High Court of
Judicature at Bombay [Mumbai] Writ Petition
No 1322 of 1999**

The petitioners asked the court to declare that a person living with HIV has the right to marry and not to be subjected to criminal prosecution under the Indian Penal Code. The Bombay High Court dismissed the petition on the ground that it was more appropriate that the matter be dealt with directly by the Supreme Court.

Excerpts

...

[1] In the above matter, we heard all the learned Counsel for various parties at length. The Petitioner No 1 who is a female and Petitioner No 2 who is a male, both of whom have been diagnosed as HIV positive, are desirous of getting married and may like to get married in future. Both of them have filed this Writ Petition, seeking clarifications in the light of the Supreme Court judgment, in *Mr X v Hospital Z* (1998) 8 SCC 296. Wherein the Supreme Court has held that the person's right to get married is suspended, during the period when a person is HIV positive. Similarly, the Supreme Court has also held that if a person who suffers from HIV positive were to marry, he may be guilty of an offence punishable under sections 269 and 270 of the Indian Penal Code.

[2] The learned Counsel for the Petitioners has broadly submitted as under; firstly, according to the learned Counsel for the Petitioners the right to marry is recognised as a basic human right. In this behalf he has referred to the various International Covenants which have recognised the right to marry and found a family as a fundamental human right. He has relied upon article 16 of the Universal Declaration of Human Rights which states that the men and women of full age, without any limitation due to race, nationality and religion have a right to marry and to found a family. The learned Counsel for the Petitioners has also relied upon article 23 of the International Covenant on Civil and Political Rights which states that the family is the natural and fundamental group unit of society and is entitled to protection by Society and the State. He submits that the right of men and women of marriageable age to marry and found a family shall be recognised. The learned Counsel for the Petitioners has also relied upon article 8 of the European Convention on Human Rights and its Five Protocols which states that everyone has a right to respect for his private and family life, his home and his correspondence, and that there shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interest of national security, public safety, the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of rights and freedoms of others. Further, the learned Counsel for the Petitioners has relied upon article 12 of the European Convention on Human Rights and its Five Protocols which states that the men and women of marriageable age have a right to marry and to found a family according to the national law governing the exercise of their rights. He also referred to the United Kingdom Declaration of Rights of People with HIV and AIDS which states that all the citizens of the UK including people living with HIV are also accorded with the right to marry and found a family. Thereafter, the learned Counsel for the Petitioner has referred to the International Covenant on Economic, Social and Cultural Rights, of which article 10 states that the widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of the society, particularly for its establishment and while it is responsible for the care and education of dependent children.

[3] It is the submission of the learned Counsel for the Petitioners that the right to marry is recognised as a fundamental right. He submits that in various foreign Countries notably the United States of America has also recognised the right to marry as a constitutionally protected fundamental right ...

[4] The learned Counsel for the Petitioners has further submitted that the right to marry has been recognised as a fundamental right by the Supreme Court of India under article 19 and 21 of the Constitution of India ...

[5] It is the submission of the learned Counsel for the Petitioners that the right to marry envisaged under article 21 of the Constitution of India, can only be abridged or terminated by a valid law enacted by a competent legislature. He has further submitted that this fundamental right to marry can only be abridged or suspended by a valid law or under article 359 when an emergency is declared.

[6] The learned Counsel for the Petitioners further submits that the various matrimonial laws do not ban or prohibit marriage on account of a communicable venereal diseases. He further states that the HIV positive can be termed as a communicable venereal disease. He has made a reference of section 13(I) (v) of the Hindu Marriage Act, 1955 section 32 of the Paris Marriage Act, 1936, section 2(vi) of the Dissolution of Muslim Marriages Act, 1939 and section 27(f) of the Special Marriage Act, 1954 and submitted that the venereal disease is a ground for dissolution of marriage.

[7] The learned Counsel for the Petitioners has submitted that the HIV positive does not render the marriage void or voidable. In this behalf he has made a reference of section 5 and 11 of the Hindu Marriage Act, 1955, section 18 and 19 of the Indian Divorce Act, section 3 of the Parsi Marriage Act, 1936. Muslim Personal Law, section 4 and 24 of the Special Marriage Act 1956, and contended that there cannot be a ban on a marriage with a

HIV positive person or a person suffering from a communicable venereal disease.

...

[9] According to the learned Counsel for the Petitioners, for a valid marriage in law, there is an obligation on a person to disclose his HIV-positive status to his prospective spouse before marriage. He submitted that the discordant Couples (only one of the spouse is HIV-positive) can lead a happy married life and can resort to safe penetrative sex by consistent and correct use of condoms which would reduce the risk of HIV transmission from 0.01 per cent to 0.001 per cent or to practically zero. He further submits that the discordant couple can bear HIV-negative children. According to him where the wife is HIV-positive the risk of transmission of HIV from mother to child during the pregnancy is 33 per cent and such a risk can be reduced to 2 per cent by medical intervention. And where the husband is HIV-positive the sperm-washing technique may be used to make the sperms free of HIV. He further submits that the discordant couple may decide not to have any child of their own and may instead decide to adopt a child.

[10] He has also submitted that the Supreme Court does not deal with marriage of an HIV positive person to another (positive or negative) after disclosure of HIV status and consent in that it is full, free and informed consent ...

[11] The learned Counsel for the Petitioners has referred to article 21 of the Constitution of India and has submitted that the right to privacy must encompass and protect the personal intimacies of home, family, the marriage, motherland, procreation and child rearing. He has submitted that a common law there is no right conferred on an unborn child. The unborn child is not considered to be a legal person and does not have any legal rights until 'born alive' ...

[12] The learned Counsel for the Petitioners has further referred to Medical Termination of Pregnancy Act, 1971. He has submitted that the termination of pregnancy can be lawful if it is done within 12 weeks of the pregnancy on the opinion of one doctor, or between 12 and 20 weeks of the pregnancy on the opinion of two doctors that the continuance of pregnancy will involve a risk to the life of the pregnant women or that the continuance of pregnancy will be of grave injury to her physical or mental health or if there is a substantial risk that if the child were born it would suffer from such a physical and mental abnormalities as to be seriously disabled. He has further submitted that the risk of HIV transmission to the unborn child is about 33 per cent and can be reduced substantially by appropriate and timely medical intervention.

[13] The learned Counsel for the Petitioners has submitted that if a person intentionally, unlawfully and negligently does any act whereby there is a substantial risk of transmitting a disease dangerous to life (like HIV) to another person, then such a person is said to be committing a criminal offence. He referred to section 269 of the Indian Penal Code which provides that whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished. Thereafter, he referred to section 270 of the Indian Penal Code which provides that whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished.

[14] According to the learned counsel for the Petitioners the use of condoms, or safer sex methods would amount to the exercise of reasonable care and precaution to guard against the injury of another, and would not amount to negligence. He has submitted that the consent is the primary factor. According to him, having consensual, protected sexual intercourse, after full disclosure of HIV positive status to the sexual partner, such an act of intercourse would not be a criminal offence amounting to hurt, grievous hurt, murder or assault. He has further submitted that in a consensual marital setting, wherein full disclosure of the HIV status of the infected partners made to the other, and the mode of transmission of the disease are known and explained to the partner, the application of sections 269 and 270 of the Indian Penal Code would not be appropriate.

[15] It is the submission of the learned Counsel for the Petitioners that, to prohibit persons living with HIV positive to

marry, and by criminalising the act of sexual intercourse (which would be protected or safer) would only drive the disease underground and people will not test themselves for HIV. According to learned Counsel what is required is a counselling protocol to be followed and persons infected and affected to be made aware of the ways of transmission of the disease and how to take precautions against the spread of the disease. He has further submitted that, in spite of counselling, if an HIV positive person has non-counselling unprotected sex with another, whereby the sexual partner is at a substantial risk of acquiring the disease, it would be an offence under the penal code and would cast a criminal liability on the wrong doer.

[16] The learned Additional Solicitor General for India has submitted that so long as the person is not cured of the communicable venereal disease or impotence, the right to marry cannot be enforced through a Court of Law and shall be treated to be a suspended right, as has been categorically held by the Supreme Court in the case of *Mr X v Hospital Z* (1998) 8 SCC 296. The learned Additional Solicitor General for India further referred to sections 269 and 270 of the Indian Penal Code and has submitted that these sections impose a duty upon the Appellant (an HIV positive person) not to marry as the marriage would have the effect of spreading the infection of his own disease, which obviously is dangerous to life, of the women whom he marries, apart from being an offence. He has submitted that, in the aforesaid judgment, the Honorable Supreme Court has held that the sex with them or the possibility thereof has to be avoided as otherwise they would infect and communicate the dreadful disease to others.

[17] He fairly conceded that the right to marry may well be regarded as a part of the right to life under article 21 of the Constitution of India because marriage and procreation are essential facets of the right to life, however, at the same time, the right of life is not absolute and the enjoyment of all components of that right is subject to procedure established by law. He has submitted that the Hindu Marriage Act and other cognate provisions of personal law impose restrictions upon the right to marry and regulate various aspects of marriage, and that these regulatory provisions are in furtherance of the undoubted regulatory power of the State to regulate marriage and its incidence, and therefore no one can possess an unrestricted right to marry.

...

[19] According to the learned Additional Solicitor General for India, the proposition urged on behalf of the Petitioners that an HIV positive individual would have the right to marry subject only to disclosure of the HIV status to a prospective spouse, would be too broad to merit acceptance. According to him, such a consent as an attribute may have relevance to a society with high levels of literacy, education and one that is individualistic. He has submitted that in our society the court has to be mindful of that position of women in society and the peculiar disabilities faced by women, and that the regard will have to be had to the impact of such social circumstances like poverty, illiteracy and socio economic pressures which operate upon women. According to him the mere requirement of consent is not sufficient to protect against the exploitation of women. The sexual exploitation of women, occasioned due to the socio economic handicaps faced by women among other causes, makes women as a class extremely vulnerable to the transmission of HIV infection. He has submitted that the transmission of the HIV virus is not gender neutral and the law has to be cognisant of the special need to protect the rights of women, particularly the preservation of their health. According to him, it would not be adequate to allow an HIV positive person to say that 'I told my prospective spouse that I am HIV positive', and that cannot constitute an end of his responsibility.

[20] The learned Additional Solicitor General for India, has further submitted that, the Court may have to take notice of the fact that women are increasingly becoming the focus of the transmission of AIDS. The groups of women in our society have been faced with the danger of becoming carriers of the HIV virus, the infection being transferred from their own husbands, and that is likely to be particularly so in the case of groups of migrant men workers who contract the disease in large cities and thereafter pass it on to their spouses in the rural areas.

Consequently, according to him, in considering the nature of the problem, due importance has to be given to the role and position of women in our society. While referring to section 375 of the Penal Code which expressly lays down that the sexual intercourse by a man with his wife shall not constitute rape, he has submitted that the limitations of consent are apparent in the marital context from the existing provisions of our law, and that being the position, it is clear that section 375 does not contemplate any further consent apart from consent to marriage ... He has submitted that the aforesaid section 375 of the Penal Code, as it stands, does not protect a married women from an unwanted assertion of sexual desire by the husband. He is of the opinion that the law must recognise the need to protect the women from and against the practice of unprotected sex, particularly in the context of the transmission of HIV virus. According to him, the Court, in the present case, is in the realm of policy wherein numerous rights of different segments of the population have to be balanced, and that the said exercise can appropriately be performed only by the legislature. He has submitted that the right to public health is itself a fundamental right under article 21 of the Constitution of India, and that the conflicting rights are required to be balanced while taking into consideration the rights of HIV-positive men versus the rights of women in general to public health; the right and duty of the State to protect the public health; the right of the state in so far as potential life and the right of the unborn child is concerned ...

[21] The learned Additional Solicitor General has further submitted that it would be too broad a proposition in Constitutional law for an individual to assert that he should have an unrestricted right to marry another though such individual is conscious of the fact that the consequence of the marriage may be the passing on of the HIV infection which one of the two proposing to join in wedlock suffers from. The necessary consequence of contracting the HIV virus is death, though the period taken for the illness to grow into a fully manifested disease may vary from case to case. He has made a reference of the case of *Gian Kaur v State of Punjab* 1996 volume 2 SCC 648, in which the Honorable Supreme Court has held that the positive right, the right to life, does not necessarily include a negative right not to live or to decide to end life ...

[22] The learned Additional Solicitor General for India has further submitted that, despite medical treatment, there is a substantial risk that a child born to a married couple one of whom is HIV positive, will be HIV positive. He has submitted that the State has a vital interest in potential life ... He has also made a reference of the Hindu Succession Act, 1956 and the Medical Termination of Pregnancy Act, 1971 which recognise the position and rights of the unborn child, and thus the State has the concern so far as the public health is concerned.

...

[24] Ms Flavia Agnes, the Intervenor in this case, has submitted that the right to marry and right to life as envisaged under article 21 of the Constitution of India, is subject to reasonable restrictions. She has submitted that the observation of the Honourable Supreme Court in *Mr X v Hospital Z* that while a person is afflicted with HIV/AIDS, can be construed as reasonable restrictions upon the right of marriage. She has stated that the law is already laid down that where the legislature has failed to introduce necessary legislation to protect the right of women and children, the courts have a duty to intervene and protect the right of vulnerable sections through judicial interventions. According to her, while the HIV/AIDS afflicted persons face discrimination at workplace and within the health care system and also face social stigma, the men with HIV/AIDS afflictions continue to enjoy a privileged position vis-a-vis their wives in the Indian setting and neglect to exercise due care and caution to avoid risk to life and health of their wives and children. She is of the opinion that in order to control the spread of disease within the domestic sphere which remains a grossly neglected area of public health policy in India, there is a need of protective public health policies. She is of the opinion that this Court may declare that the communication of HIV/AIDS affliction through the negligence or callousness may be deemed as a matrimonial offence. According to her, in view of the alarming rate at which the disease has spread into the domestic sphere, this Court should issue a direction to all the agencies providing counselling and

health care to HIV/AIDS patients that they are under a moral and legal obligations to reveal the HIV/AIDS status of their clients to the spouse and counsel the couple together about the implications of unprotected sex with such persons. She is of the opinion that, in the event the Court permits marriages between the afflicted persons, the scope of such a permission be narrowed down to two afflicted persons, and that the marriage between the un afflicted person and afflicted person may be permitted only after an application to this effect is made and the Court has the opportunity to ascertain the consent of the un afflicted spouse to such a marriage.

...

[35] The learned Counsel for the Petitioners has also made a reference of International Human Rights obligations and HIV/AIDS. He has stated that the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. According to him, the prevention of the transmission of HIV can be done through effective intervention methods rather than suspending or taking away the fundamental rights of persons affected. He is of the opinion that the prevention interventions like as widespread prevention information, education and health services to men and women on how to protect themselves through safer sex, inside and outside marriage, the provision of counselling and voluntary testing for those concerned about their HIV status and prevention interventions targeted to groups whose behaviour put them at higher risk of infection, are more effective. According to him the social structure in traditional societies where women have a subordinate position, information, education and communication are the main solutions to deal with the problem rather than suspending or taking away fundamental rights of human beings. According to him, suspending or taking away rights does not prevent the spread of the disease.

[36] The learned Counsel for the Petitioners has further submitted that, as per the International Guidelines on HIV/AIDS with respect to women, children and other vulnerable groups, the States should, in collaboration with, and through the community, promote a supportive and enabling environment for women and children and other vulnerable groups by addressing them inequalities through community dialogue, specially designed social and health services and support to community, and thus, the women and children can be protected by empowering them and spreading information and knowledge of the disease, rather than suspending their fundamental rights.

[37] Thereafter, the learned Counsel for the Petitioners has submitted that the transmitted that the transmission of HIV can be effectively prevented through Condom usage. According to him consistent and correct use of condoms is highly effective in preventing the transmission of the disease.

[38] While giving example of Thailand, the learned Counsel for the Petitioners has further submitted than in Thailand they have developed and implemented the most effective HIV/AIDS education programmes, resulting in an outstanding 77 per cent reduction in the rate of STDs the last five years. They had a 100 per cent condom usage program among the new army recruits in the north which was successful in reducing HIV and other STDs. A National AIDS campaign was launched by the government to educate all Thai citizens. The media used was the radio and the television to provide hourly messages on HIV/AIDS and prevention. They had created programs for distribution of condoms et cetera. For effective prevention of the spread of the disease. He has further submitted that in India the Sonagachi Project in West Bengal has aimed at preventing the spread of the disease by effective condom usage and empowering sex workers, which has been successful in preventing the spread of HIV and STDs by condom usage. According to him the condom program in the Country is gaining ground as per the National AIDS Control Organisation Country Scenario 1997 to 1998. The social marketing and commercial sales of condoms is increasing and on the rise over the years. Improved quality of condoms are available all over the country and the unlubricated ones are being phased out.

...

[39] The learned Counsel for the Petitioners has submitted that the HIV is not the only communicable disease that is 'dangerous to life'. According to him the other communicable diseases like cholera, malaria, Filariasis, tuberculosis and Hepatitis B are also 'dangerous to life' as they are the major cause of deaths in the Country. He is of the opinion that to control a disease and prevent it from spreading further, the state has to act quickly and effectively. According to him it is the responsibility of the State to spread information, educate people about the disease and about the precautions to be taken to prevent themselves from getting infected. He has submitted that the prevention of the spread of a disease 'dangerous to life' like HIV/AIDS can and should be done only by information, education and communication, and not by taking away or suspending the fundamental rights of the human beings.

[40] It is submitted by the learned Counsel for the Petitioners that the transmission of HIV to the spouse during the subsistence of the marriage is not an offence covered by sections 269/270 of the Indian Penal Code. According to him, the aforesaid sections 269 and 270 deal with negligently or malignantly transmitting the disease dangerous to life to another person, however, in a consensual marital situation wherein the spouse is fully aware of the ways in which the disease is transmitted, the spouse is consenting to marry an HIV positive person, or any person with a disease 'dangerous to life' would not be exposing themselves to a criminal act and it could not be said that the couple is committing a criminal offence under the Indian Penal Code. According to him a consensual marital situation with full knowledge and free and informed consent is different from a non-marital situation especially where there is no knowledge and/or full free and informed consent. Therefore, according to him, in consensual marital situation it cannot be said that the consenting married couple is committing an offence under sections 269 or 270 of the Indian Penal Code. He has submitted that under the various matrimonial laws, the venereal disease is a ground for divorce and not an offence under the Act. According to him even impotency and epilepsy render the marriage void or voidable but they do not prohibit a person suffering from such impotency from marrying, not does it make such an act a criminal offence.

[41] Thereafter, the learned Counsel for the Petitioners has submitted that the right to bear children is also a fundamental right under the bundle of rights under article 21 of the Constitution ... He has submitted that the right to bear children can only be restricted by a constitutionally valid statute, and therefore, except by such a statutory law, a woman cannot be prevented from bearing children. Such a right of a woman to bear children cannot be abridged. While referring to the Medical Termination of Pregnancy Act which gives the discretion to a woman to abort the child on the opinion of the medical practitioners, in a situation where the unborn child is likely to be born with defects or where there is substantial danger to the mother or the child, the learned Counsel for the Petitioners has submitted that it does not however prevent the woman from bearing a child. As such, it is the submission of the learned Counsel that no authority including this Court can take away the fundamental right of a woman to bear children in the absence of a valid statute.

[42] Thereafter, the learned Counsel for the Petitioners has submitted that, transmission of HIV from mother to child can be substantially reduced by adequate and effective medical interventions. By giving example of Wadia and Nair Hospitals in Mumbai, he has stated that such medical interventions have proved to be successful and have reduced the risk of transmission of HIV to the child in the womb and after birth. He has stated that new drugs eg Nevirapine introduced in Uganda and some other African Countries et cetera are rapidly being introduced which seem to be more effective in reducing the risk of transmission of HIV from mother to child.

[43] He has submitted that in fact it is the state's duty to ensure that adequate medical facilities are made available to ensure that the child born is healthy and the mother is educated about the pregnancy and how to prevent the child from getting infections and disease that could be fatal and lead to the death of the child. He has stated that in the HIV scenario, the mother should be

given the option and must be informed that transmission of HIV to the child can be prevented by medical intervention and such medical intervention should be made easily available by the State. As such, the learned Counsel has submitted that, because of State's inability, the fundamental rights of the individuals cannot be abridged.

[44] It is the submission of the learned Counsel for the Petitioners that the disease is spreading from rural to urban areas largely because of a floating population of the Country. According to him it is incorrect to say that HIV positive men are knowingly and purposefully marrying innocent women and infecting them with the disease. He has submitted that as the said disease is asymptomatic for about eight to ten years the persons who are HIV positive are unaware about their HIV positive status, and therefore, they may transmit the said disease to their partner or spouse unknowingly. He has submitted that once a person is aware of his HIV status, thereafter, he takes adequate precautions not to spread it to the spouse or partners. He is of the opinion that it is incorrect to assume that the persons infected may spread the said disease to the spouse knowingly and maliciously. According to him what needs to be done is to give information to the people about the disease and encourage persons who have had high risk behaviour to test themselves, and such a testing can be done at anonymous unlinked testing centres where full confidentiality of the persons HIV status is kept. Lastly the learned Counsel for the Petitioners has submitted that the object of preventing the spread of the disease cannot be achieved by taking away or suspending the fundamental rights of the human beings, however, it can be achieved through imparting information, educating people about the said disease and by the effective communication.

[45] We are of the considered view that for the clarifications and declarations sought in this Petition, the Petitioners ought to approach the Supreme Court and all the more when now Supreme Court itself is seized of the matter.

[46] Hence, we are not inclined to interfere in this matter and the Rule stands discharged. We must also record our appreciation that all the learned Counsel who appeared in the above matter had taken great pains with a good deal of research.

E3.2 Access to HIV and AIDS related treatment

Jorge Odir Miranda Cortez et al v El Salvador (2001) Inter-American Commission on Human Rights

The petitioners alleged that the Government of El Salvador had violated their rights under the American Convention on Human Rights by failing to provide antiretroviral therapy necessary to prevent death and improve quality of life. The Inter-American Commission on Human Rights granted the interim order requesting that the government provide antiretroviral medications and other necessary medical care to the 27 petitioners pending the determination of the merits of their complaint (which was, at the time, also pending before the Supreme Court of El Salvador).

Excerpts

Summary

[1] On January 24, 2000, the Inter-American Commission on Human Rights (hereinafter 'the Inter-American Commission' or 'the IACHR') received a petition filed by Carlos Rafael Urquilla Bonilla of the Foundation for Studies for the Application of Law, FESPAD ('the petitioners'), alleging international liability on the part of the Republic of El Salvador ('the state') with respect to Jorge Odir Miranda Cortez and 26 other persons who are carriers of the Human Immunodeficiency Virus/Acquired Immunodeficiency Virus ('HIV/AIDS') and are members of the Atlacatl Association. The petitioners allege that the acts reported constitute a violation of several provisions of the American

Convention on Human Rights (hereinafter 'the American Convention'): the right to life (article 4); humane treatment (article 5); equal protection before the law (article 24); judicial protection (article 25); and economic, social, and cultural rights (article 26), in accordance with the general obligation set forth in article 1(1) and the duty set forth in article 2 of the aforementioned international instrument. They also allege violation of article 10 of the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights ('Protocol of San Salvador'), as well as other provisions consistent with the American Declaration on the Rights and Duties of Man ('the American Declaration') and other human rights instruments. In light of the gravity and urgency of the situation, the petitioners requested precautionary measures on behalf of the 27 persons mentioned above, which were granted by the IACHR when it began processing of the case.

[2] The petition alleges that the State violated the right to life, health, and well being of the alleged victims in this case, inasmuch as it has not provided them with the triple therapy medication needed to prevent them from dying and to improve their quality of life. The petitioners maintain that the situation of these persons, which they also attribute to negligence on the part of the State, constitutes cruel, inhumane, and degrading treatment. They further allege that the Salvadoran Social Security Institute (ISSS) has discriminated against Mr. Jorge Odir Miranda Cortez and the alleged victims because they are carriers of HIV/AIDS. In April 1999, the petitioners instituted amparo proceedings in the Constitutional Division of the Supreme Court of El Salvador, claiming violation of the rights outlined in their petition to the Inter-American Commission. The petitioners assert that the delay on the part of this Salvadoran legal entity is unreasonable and constitutes an additional violation of the right to a fair trial and judicial protection, and provides grounds for invoking the exception to the exhaustion of domestic remedies set forth in article 46(2)(c) of the American Convention.

Processing by the Commission

[7] The comments of the petitioners were received on March 21, 2000. On March 24, 2000, the Inter-American Commission requested from the petitioners the names of the alleged victims involved in this case who had died since processing of the case began, and specific information regarding precautionary measures. On April 3, 2000, the petitioners submitted this information and reiterated their request that the IACHR take the matter to the Inter-American Court in order to request provisional measures. On April 7, 2000, they sent another communication containing the same request.

[8] The Inter-American Commission contacted the State on April 20, 2000 in order to transmit the comments of the petitioners and to request additional information regarding compliance with the precautionary measures granted in this case. In its response of April 28, the State informed the IACHR of the actions taken by the Salvadoran authorities to address the claims of the alleged victims related to care. The State submitted additional information in this regard on May 4, 2000.

...

[19] On November 24, 2000, the petitioners submitted correspondence in which they once again asked the Inter-American Commission to declare that the Salvadoran State had failed to comply with the precautionary measures and to seek provisional measures from the Inter-American Court. On December 6, 2000, they submitted additional correspondence to that effect. On that same date, the State submitted a communication providing a summary of the activities conducted in order to comply with the precautionary measures and containing comments on the merits of the petition.

[20] At its 109th special session, the IACHR decided not to grant the request for provisional measures. In making this decision, the Inter-American Commission considered the information received from both parties, and evaluated the different actions taken by the Salvadoran State to provide medical treatment not only to the members of the Atlacatl Association but also to other persons infected with HIV/AIDS in

that country. These actions had continued even after expiration of the deadline for precautionary measures on August 29, 2000.

[21] On December 12, 2000, the Inter-American Commission forwarded the pertinent parts of the most recent communications from the petitioners together with a request for information from the Salvadoran State regarding the medical care and treatment provided to the 24 surviving persons identified in this case. On January 19, 2001, the Salvadoran State requested an extension of the deadline for its response to several cases, including this one, because of the national emergency in that country. A 30-day extension was granted on January 24, 2001.

[23] The Salvadoran State forwarded the information requested by the IACHR on February 22, 2001. In its correspondence, it indicated that 'to date, anti-retroviral medication has been provided to 11 of the 24 persons included in Case 12.249' and explained that this medication is available to the other persons identified in the case, subject to the appropriate medical evaluation. In addition, the State reported that it had expanded provision of the medication to other persons not included in this case.

Positions of the parties

The petitioners

[25] With regard to the alleged violation of the right of the persons listed in this report to humane treatment, the petitioners allege that 'the State, because of its negligent acts, can also place or allow a group of persons to be placed in cruel, inhumane, or degrading conditions.' The petitioners' position is that persons who live with HIV/AIDS are in 'a vulnerable situation that exposes them to death' which is 'clearly a cruel, inhumane, or degrading situation.'

[27] The petitioners maintain that the alleged victims were discriminated against and stigmatised because they are infected with HIV/AIDS. They allege, among other things, that the bed linen of seropositive patients was separated from the bed linen of other patients and placed in a red bag that they were given drinking glasses with special markings, and the nursing staff shunned them and treated them differently from the other patients.

The State

[31] In a subsequent communication, the Salvadoran State disputes the merits of the case and asserts that no violation occurred in this case. The State further disputes the allegations of discriminatory treatment of seropositive patients in El Salvador. It maintains, in that regard, that hospitals follow general rules regarding disease prevention and control, as well as the guidelines adopted by the World Health Organisation on the classification of hospital solid waste from infectious and contagious diseases such as AIDS and hepatitis B and C.

Analysis

[48] The IACHR is aware of the fact that the people of El Salvador are in the midst of a very difficult period brought on by a series of natural disasters, which has placed enormous demands on the health authorities and officials. In that context, the Inter-American Commission appreciates the efforts of the Salvadoran authorities to address the needs of persons infected with HIV/AIDS in that country. The supply of anti-retroviral medications has been steadily increasing in recent months, and the State has announced that it will continue to adopt the measures necessary in that regard.

Conclusion

1. Declare this case admissible with respect to alleged violation of the rights protected under articles 2, 24, 25, 26 of the American Convention.
2. Inform the parties of this decision.
3. Continue analysis of the merits of the case, and
4. Publish this decision and include it in its Annual Report to the OAS General Assembly.

AIDS Access Foundation et al v Bristol Myers-Squibb Company and Department of Intellectual Property (ThCIPITC 2002)

The judgment by the Thailand Central Intellectual Property and International Trade Court confirms that patients, whose health and lives depend on medicines that they cannot afford, have legal grounds to sue and challenge the legality of pharmaceutical patents.

Excerpts

...

The patent owner's exclusive right is legally empowered to prevent third parties not having the patentee's consent from any act of exploiting his invention. In view of everyday life consumers, a substantial difference between general products or inventions and medicines may be perceived as the former are slightly optional means while the latter prove to be basic essentials for survival. On this account, greater importance of human life safeguard and health care should be stressed prior to any property rights, as assured internationally through the Declaration on the TRIPS Agreement and Public Health adopted on 14 November 2001 by the Ministerial Conference of the World Trade Organisation (WTO), Fourth Session at Doha, the State of Qatar, affirming that 'the [TRIPS] Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all'. With respect to such principles as aforesaid, any interested parties or parties injured by a grant of patent for one's medicine are deemed to include not only the producers or traders of rival pharmaceutical products but also the patients or parties in need of such patentable pharmaceuticals.

Under section 3 of the Patent Act B.E. 2522 (1979), a patentable invention with regard to product is defined as any discovery or creation considered to constitute a new product. A patentable pharmaceutical, especially a patentable pharmaceutical composition or formula is, therefore, required to be novel and any dosing unit is regarded as the substance of such pharmaceutical invention. Under section 17 of the Patent Act B.E. 2522 (1979), an application for a patent shall contain certain particulars including a description of the invention (the 'description') and a claim or claims. As the patent applicant is required to disclose the description to the public in return for the exclusive right to be lawfully conferred on the patent applicant by society, most details of technical information and knowledge with regard to the invention should be publicly disseminated. The scope or subject-matter of an invention for which the patent applicant seeks statutory protection is defined by a claim or claims. As a prime test to determine whether any patent is found infringed or not, the claim or claims must be clear and concise. Accordingly, both the description and the claim or claims are deemed the utmost importance to any patent application. The scope of an invention as defined by a claim or claims for which the patent applicant seeks statutory protection shall be supported by, comply with, and not extend beyond, the disclosed description. Under section 20 of the Patent Act B.E. 2522 (1979), a patent application may not be amended by the patentee in such a way that it contains subject-matter which extends beyond the substance of the invention. In terms of such provision, the substance of an invention means both the description required to benefit society and a claim or claims defining the scope or subject-matter of the right or profit for which the patentee seeks statutory protection. A mixture of both units must be taken into consideration. Only single aspect is deemed insufficient. A phrase 'from about 5 to 100 milligram per dosing unit' which is crossed off the original claims is held to alter the substance of the claims because such unlimited quantity per dosing unit in pharmaceutical composition as conferred upon the patentee denotes an extended protection beyond the scope stated in the initial claims. As a result, the scope or subject-matter for which the patentee seeks protection under the amended claims is extended beyond that disclosed in the description. To delete the

aforesaid phrase from the original claims is held prohibitive due to extending the substance of that invention.

The Patent Act B.E. 2522 (1979) provides only for the surrender, revocation, and partial cancellation of a patent, without any provision regarding amendment to the claims. Nonetheless, legal consequences of revocation or partial cancellation of a patent are apparently graver than those of amendment to the claims: (1) the protection conferred on the patentee becomes promptly extinct when the patent is revoked; and (2) the protected subject-matter within the scope of the invention is limited to the remaining effective claims available after the claims are cancelled in part. Accordingly, an amendment to the claims is deemed more beneficial than the revocation or partial cancellation of a patent. Where no statutory provision for amendment to claims is explicitly prohibited, the plaintiffs are entitled to amend the defendant's patent by filing an application for restoration of the original phrase 'from about 5 to 100 milligram per dosing unit' to be included back to claims 1 and 2 as existed previously.

E3.3 HIV prevention and care in prison

Prisoners A-XX Inclusive v State of New South Wales (1995) Supreme Court of New South Wales

This case involves prison inmates demanding a change of policy in relation to condom use in prison. The Supreme Court of New South Wales upheld the ruling of the court of first instance which allows the supply and use of condoms in New South Wales prison. It, however, indicated that the claim had to be redrafted so as to be brought solely on behalf of the four aggrieved plaintiffs, rather than as a class action on behalf of the larger group of prisoners.

Excerpts

...

[1] Fifty persons who are inmates of New South Wales prisons and described as 'Prisoners A XX Inclusive', by leave of the Court, appeal from a decision of Dunford J of 5 October 1994. The appellants began the proceedings by a statement of claim which was, at first instance, amended in some minor respects. In summary the appellants sought relief designed to ensure they would have access to condoms while in gaol ...

Public law

[3] In para 12 of the statement of claim the appellants alleged that 'the decision of the Commissioner of Corrective Services and the New South Wales Department of Corrective Services not to supply or permit the possession or use of condoms by male prisoners was an improper exercise of power in that it was so unreasonable that no reasonable person could have so exercised the power and was exercised taking into account irrelevant considerations and without taking into account or giving no weight to relevant considerations.' In paragraph 13 the appellants alleged that they apprehended that they might contract HIV or hepatitis while in prison which illness might be caused or contributed to by, inter alia, 'the decisions of the Commissioner of Corrective Services and the Director General of the department of Corrective Services referred to in paragraph 12.'

...

[6] In paragraphs 2 to 11 of the statement of claim the appellants alleged a breach of the duty the Department of Corrective Services owed to take reasonable care for the safety of prisoners in its care. In paragraph 14 (a) and (b) the appellants asked for *quia timet* injunctions, both prohibitory and mandatory.

[7] Dunford J distinguished between relief sought on the basis of the published policy of the Department not to allow condoms and relief sought based on the refusal to give individual prisoners access to condoms. His Honour accepted that if the failure to take a certain action constituted a breach of duty to an individual to take reasonable care, the defendant could not excuse itself by claiming a policy decision had been made that such action would

not be taken; *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 469 and *Parramatta City Council v Lutz* (1988) 12 NSWLR 293. He held that, if the appellants amended their particulars to allege the refusal of requests made by individual prisoners for access to condoms, the statement of claim would not be objectionable.

...

[10] However, depending on the evidence adduced at the final hearing of the proceedings, individual prisoners might be entitled to injunctive or other relief if they could show that the refusal of the Department to permit them to use condoms constituted a breach of the duty of care it owed to them. Such proceedings taken by fifty plaintiffs in the one action would be unwieldy and unmanageable. Not more than four of the appellants should continue with the proceedings.

Conclusions

[39] In my opinion the appeal fails. What remains to be done is for the appellants to apply in the Common Law Division to amend their statement of claim in a way which accords with Dunford J's orders and the conclusions I have reached. The amendments will include those necessary to raise their contention based on *Wednesbury* principles.

R v Secretary of State for Home Department Ex Parte Glen Fielding (1999) EWHC Admin 641

The applicant, a homosexual man, was refused access to condoms while incarcerated in a correctional facility. He challenged the Home Department's policy limiting access to condoms in prisons. Although the England and Wales High Court found that 'the real issue is one of health' it upheld the Home Department's policy which provides that condoms would only be available upon a prison doctor's prescription.

Excerpts

...

Facts

[1] In June 1996, the applicant was sentenced to four and a half years imprisonment. He is a practising homosexual who enjoys both active and passive penetrative sex. He is at present at liberty, but on licence. Whilst in Littlehey prison, a prison run by the Prison Service, he asked for, but was refused, condoms. He was informed, in terms to which I shall return in detail later, that to provide him with condoms would be contrary to the policy of the Prison Service. Sometime later, he was moved to Blakenhurst prison, which is managed by a private company, where he was able to obtain condoms from the prison authorities without difficulty. In these proceedings, he seeks to challenge the policy of the Prison Service as irrational. Despite the fact that the applicant is now at liberty, the respondent does not seek to argue that the applicant has no sufficient interest to maintain these proceedings. It is accepted that, because he is on licence, he remains at risk of being recalled to an institution at which the policy, will, unless altered in the meantime, be applied.

...

Findings

[10] Taking these documents together, it is clear that the policy of the Prison Service, as explained to the applicant's solicitors, was that the Prison Service did not wish to be seen in any way to encourage homosexual activity in prison, and that as a result condoms were not made available freely for purchase or otherwise by inmates, but that it was recognised that such activity did occur, which required the Prison Service to take appropriate steps for the protection of the health of the inmates by encouraging prison medical officers to prescribe condoms where they perceived a health risk, particularly a risk of HIV to exist. This view is confirmed by Doctor Longfield, the Director of Health care of the Prison Service, who in his affidavit of the 26th January 1999 said as follows:

...

(2) The facts of custody and the need to maintain good order and discipline mean that it would be inappropriate for prisons to take action which might be seen to encourage overt sexual behaviour by prisoners. However, it is recognised that sex in prisons is an occasional reality which carries with it public health risks. Consequently, condoms are made available to prisoners through the Health care Centre where the doctor can form a judgment about the risks to the prisoner and others and provide prophylactics and advice as appropriate.

(3) The Prison Service has always viewed the prescribing of condoms to prisoners from the perspective of protecting public health by preventing the spread of HIV and other communicable diseases amongst prisoners, and to the wider community when prisoners are released.

(4) Guidance on the provision of condoms was given to prison doctors in the form of a Dear Doctor Letter (DDL), issued in August 1995. It was believed at the time that the issuing of a DDL was the most appropriate method of promulgating what is, essentially, professional guidance to Prison doctors. The guidance contained in the DDL applies equally to all prisons regardless of whether they are publicly or privately run establishments. The letter encourages prison doctors to prescribe condoms for individual prisoners if, in their clinical judgment, there is a known risk of HIV infection as a result of unsafe sexual behaviour. This was intended to include not only cases where one (or both) of the prisoners was known to have HIV but also *any prisoner* (original emphasis) taking part in unsafe sex. This guidance has become the de facto Prison Service policy and is generally referred to as such.

[11] But Doctor Longfield's affidavit goes on to accept that there have been problems about ensuring consistency of approach across the Prison Service, and in particular across the whole spectrum of prisons, both those run by the Prison Service, and those run privately. He further accepts that the memorandum from Doctor Rupasinghe would appear to be an example of the way in which the policy may have been misinterpreted. It is clear to me from the tone of his memorandum that Doctor Rupasinghe was applying the policy in a significantly more restrictive way than a fair reading of the Dear Doctor Letter justified. Indeed therein may lie the real vice in the present case.

[12] However, Mr Daniel on behalf of the Applicant argues that this case is not simply about the misapplication of a lawful policy. He asserts that the policy, as acknowledged by Doctor Longfield, is irrational. His argument is simple and straightforward. He says that it is accepted by all responsible medical authorities that unprotected penetrative sex carries with it the risk of HIV. There is no way of determining at any one time, save in a wholly stable sexual relationship between those who can be shown not to be carrying HIV, whether one or other party to the intercourse may not be carrying HIV and therefore capable of transmitting it to the other. It follows that if a homosexual prison inmate presents himself to the authorities requesting condoms, the only inference that can be properly be drawn is that he is intending to have penetrative sex, which will by definition carry with it the risk of the spread of HIV and that therefore no question of the clinical judgment of a doctor arises. The exercise of discretion explicit in the Dear Doctor Letter is therefore either a fiction, or an unjustified interference with a homosexual's ability to obtain the means to ensure safe sex.

[13] As far as the latter argument is concerned, Mr Daniel bases it upon the proposition that any interference with an inmate's ability to have safe sex is an interference with his right under Article 8(1) of the European Convention on Human Rights to respect for his private life. Mr Daniel acknowledges that he is not yet entitled to rely directly upon the convention. But nonetheless he argues that the fact that the applicant is entitled to respect under the Convention for his sexual orientation, and its practical consequences, is a material matter in determining the extent to which it could said to be rational to interfere to any extent with that right. I accept that in principle. It should, however, be noted that the right which the applicant asserts is as to his ability to express his sexuality by way of penetrative sex safely. Unlike the majority of those who lose their liberty, imprisonment does not prevent him from expressing his sexuality at all. This underlines that which seems to me to be at the root of this case. The issue, as Doctor Longfield sets out clearly in his affidavit, is how best to protect the health of prisoners, and the population at large, from the spread of HIV

and other communicable diseases, in the context of the particular security, welfare and policy considerations applicable to prisons.

[14] There is an attractive simplicity in Mr Daniel's argument, namely that a homosexual who asks for condoms is asserting that he intends to engage in unsafe sex as to which the only prophylactic is a condom, which he should therefore be given without there being any question of clinical judgment or discretion. However, I consider that the Prison Service is entitled to take the view that it should not be seen to encourage homosexual activity in prison. That might be the message which would be given to the prison population, and the public at large, if condoms were available on demand. That is a matter of judgment for the Prison Service. Further, condoms have uses other than those for which they were designed; it seems to me to be reasonable for the Prison Service to consider it necessary for that reason that some control should be exercised. Given that the view that has been taken is not irrational, the question is whether or not the mechanism which has been chosen to control the supply of condoms is itself irrational. I have already indicated that it seems to me that the real issue is one of health, as identified by Doctor Longfield. In these circumstances, it does not seem to me to be irrational to leave the decision to the prison medical officer. He is the one who can judge whether or not a request for a condom is made for genuine health reasons. This may require investigation, which is more appropriately carried out by a doctor. The mere fact that a person asserts that he wants a condom does not mean that he is a genuine homosexual, nor does it mean that he is necessarily intending to engage in penetrative or other dangerous sexual activity, nor does it necessarily mean that he is in truth a consenting party to whatever activity is anticipated.

[15] For these reasons, it seems to me that the policy is lawful. In the result, it seems to me that whenever a prison medical officer is satisfied that a request for condoms is from a genuine homosexual who is intent on indulging in what would otherwise be unsafe sex, he should prescribe condoms. I would like to think that so long as the Prison Service continues to take the view that there should be the control inherent in the policy, the policy itself might be reformulated so as to make clear what the limits of the prison medical officers discretion should be, so as to avoid the sort of misunderstanding or misinterpretation which is clearly evident in Doctor Rupasinghe's memorandum. It follows that, although the particular decision to refuse to supply condoms about which the applicant complains was wrong, it was wrong because the policy was misinterpreted, not because the policy itself was unlawful. This application is refused.

...

***Odafe and Others v Attorney-General and Others*
(2004) AHRLR (NgHC 2004)**

The applicants were inmates awaiting trial. They alleged that their constitutional rights were violated because they were continuously detained without trial. They also argued that they were segregated and discriminated against and did not receive proper medical care because of their HIV status. The Nigerian High Court decided that the state has a responsibility to provide medical treatment to all prison inmates and relocate the applicants to a hospital.

Excerpts

...

Facts

[14] The applicants are awaiting trial inmates currently at Kirikiri Medium Prison in Lagos detained on the orders of some magistrate in Lagos for various offences ranging from armed robbery and murder. Whilst applicants were in detention they were diagnosed and tested positive to HIV/AIDS. Exhibit LK1 is the medical report ... and applicants averred in the affidavit that they are discriminated against because of their ailment.

Application of law to facts

[15] On whether awaiting trial accused persons have a legal right to seek redress, section 46(1) of the 1999 Constitution provides that '[a]ny person who alleges that any of the provisions of this chapter (four) has been, is being or is likely to be contravened in any state in relation to him may apply to a High Court having jurisdiction in that area for redress'.

[16] The word 'any person' I respectfully hold means that anybody without any distinction has a legal right to enforce the provisions of chapter 4.

[17] It is settled law that a prisoner on death row has rights enforceable under the Constitution. This was the legal position in the case of *Peter Nemi v State* 1996 6 NWLR pt 452 at 42. Equally, it is my respectful view that the Constitution, having stipulated that an accused awaiting trial is presumed innocent until proven guilty, the accused also enjoys similar enforceable rights under the provision of section 46(1) of the Constitution.

[18] It is also pertinent to note at this stage that the evidence before the Court in exhibit LK1 reflects that the first applicant has been awaiting trial for three years eleven months, the second applicant for four years eight months, the third applicant for two years four months whilst the fourth applicant (reported dead) three years eight months. These reports are as of 2002 when the report was signed. Clearly the applicants have respectfully been awaiting trial for a period of not less than two years. The 1999 Constitution, in safeguarding the rights to personal liberty of every person, provide under section 35(1)(c) and subsection 4 that any person arrested and detained upon reasonable suspicion of having committed an offence shall be arraigned before a court of law within a reasonable time and if not tried within two months from date of arrest or detention shall be released on bail unconditionally or upon such conditions as are reasonably necessary. Reasonable time was defined as a period of two days or such reasonable time as may be considered by court.

[19] Furthermore under section 36(1) of the Constitution a person shall be entitled to a fair hearing within a reasonable time by a court.

[20] It is indisputable that applicants have been awaiting trial for an unreasonable period without trial. This is condemnable and the blame will go the first respondent, the chief legal officer in the country.

[21] Therefore the Constitution recognises that accused persons detained awaiting trial has a right of access to court by virtue of the provision of section 36(1) and section 35(1)(c) and (4) and section 46(1) of the Constitution.

[22] Furthermore the appellate Court has ruled in *Peter Nemi v State supra* that a prisoner on death row still has rights enforceable under the Constitution. I therefore respectfully hold that the present applicants awaiting trial are conferred with rights under the Constitution and article 7 of the African Charter on Human and Peoples' Rights Cap 10 to seek redress of court for any infraction of those rights.

[23] Mr Fapohunda submitted that the continuous detention of the applicants without trial in their physical disabled state amounts to torture, whilst the refusal of treatment and discrimination by prison officials and inmates amount to discrimination. I have earlier on condemned the fact that applicants have been awaiting trial for the period of not less than two years. Whether they are confirmed as HIV/AIDS patients or not, every detained accused is entitled to a fair hearing.

[24] Obviously in the instant case applicants were diagnosed with HIV/AIDS whilst in detention.

[25] Further, whether applicants are arraigned before a court or not each have a right under sections 7 and 8 of the Prisons Act Cap 366 to be treated for any serious illness once certified and the medical officer recommends his removal to a hospital. Exhibit LK1 issued by Dr Nebo Kingsley, the medical officer in prisons, has a list of 11 inmates awaiting trial and their special conditions.

[26] The prison officials having been placed on sufficient notice by the contents of that document (exhibit LK1) are under a duty to [observe] the conditions set out in section 8 for removal of sick prisoners to hospital. The second and third respondents, though they were served did not appear nor [did they] file a counter affidavit to contradict the facts averred. I therefore deem

the facts averred in the affidavit as correct. Consequently I hold the second and third respondents have not taken legal step to that effect.

[27] On whether HIV/AIDS is a serious illness to fall within the provisions of section 8 of the Prison Act, it is my respectful view that AIDS is an understatement to use the word serious. This is because it is deadly. In the South African case of *Minister of Health and Others v Treatment Action Campaign and Others* [(2002) AHRLR 189 (SACC 2002)] the Constitutional Court of South Africa described HIV/AIDS as one of the many illness that requires attention and that it is the greatest threat to public health in their country.

[28] The government HIV/AIDS & STD strategic plan for South Africa 2000 to 2005 in the same report had this to say:

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS had claimed millions of lives, inflicting pain and grief, causing fear and uncertainty and threatening the economy.

[29] So presented clearly applicants who have been so diagnosed, as HIV/AIDS are afraid and also sick from the prognosis of the virus. Because of lack of sufficient awareness it is yet to be generally appreciated how contagious the virus is and the level of contact required before a person will contract the illness. It is therefore not strange nor am I surprised that the prisons officials are discriminating against the applicants from the averments in the affidavit which has not been contradicted.

[30] However, the right to freedom from discrimination as enshrined in section 42(1) of the Constitution did not cover discrimination by reason of illness, virus or disease. For emphasis I produce section 42(1): 'A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not by reason only that he is such a person ...'

[31] Therefore from the above category specified, applicants cannot invoke section 42(1) on the contention that they have a right to exercise under that section. The concept of torture has been succinctly described by the appellate Court in *Uzoukwu v Ezeonu supra* to include mental or psychological trauma.

[32] Justice Nasir in the same case defined torture to include mental agony whilst inhuman treatment means any barbarous act or acting without feeling for the suffering of the other.

[33] Justice Niki Tibi JCA observed that torture could mean mental torture where the person's mental orientation is disturbed so that he cannot think and do things rationally as a rational human being. Applying this definition to the present case it is my respectful view that an average person diagnosed with HIV/AIDS ... will be greatly disturbed and will live in perpetual fear of the enemy attack. The second and third respondents are under a duty to provide medical help for applicants. Article 16 of African Charter Cap 10 which is part of our law recognises that fact and has so enshrined that '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health'.

[34] Article 16(2) places a duty on the state to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. All the respondents are federal agents of this country and are under a duty to provide medical treatment for the applicants.

[35] I therefore hold that the state having failed to provide medical treatment for the applicants who are diagnosed as HIV/AIDS carriers, their continuous detention without medical treatment amounts to torture.

[36] I have already held that the respondents failed to comply with the provisions of section 8(1) and (3) of the Prisons Act and article 16 of the African Charter ...

[37] The applicants ... have a right to life; however, the fact is that the applicants are in the custody of the second to fourth respondents awaiting trial and suffering from illness. The second to fourth respondents are under a duty to provide medical attention for them; failure to do so is non-compliance of the provisions of section 8 of the Prison Act and article 16 of the African Charter on Human and Peoples' Rights. The nature and detailed consequences of the virus are not placed before the Court for me to arrive at the conclusion that the non-compliance is an infringement of their right to life. In other words, that if

treatment is provided they will live, if not provided they will die. This is for an expert in the medical area concerned to tell the Court and there is no expert evidence before me. From the foregoing I conclude as follows: The government of this country has incorporated the African Charter on Human and Peoples' Rights Cap 10 as part of the law of the country. The Court of Appeal in *Ubani v Director SSS* 1999 11 NWLR pt 129 held that African Charter is applicable in this country. The Charter entrenched the socio-economic rights of a person.

Findings

[38] The Court is enjoined to ensure the observation of these rights. A dispute concerning socio-economic rights such as the right to medical attention requires the Court to evaluate state policy and give judgment consistent with the Constitution. I therefore appreciate the fact that the economic cost of embarking on medical provision is quite high. However, the statutes have to be complied with and the state has a responsibility to all the inmates in prison, regardless of the offence involved, as in the instant case where the state has wronged the applicants by not arraigning them for trial before a competent court within a reasonable time and they have been in custody for not less than two years suffering from an illness. They cannot help themselves even if they wanted to because they are detained and cannot consult their doctor.

Relief

[39] I therefore declare as prayed in [prayers for] relief 1 2, 3 and in respect of 4 I order the authorities to comply with the provision of section 8 of the Prison Act and relocate the applicants after the precondition has been complied with, to a hospital in accordance with section 8 of the Prison Act.

[40] I award N100 000 costs in favour of the applicants.

E3.4 HIV and disability

Bragdon v Abbott 1998 (107) F 3d 934 (USSC 1998)

The respondent (a person living with HIV) brought a suit against the appellant under the Americans with Disabilities Act (ADA), alleging discrimination on the basis of her disability. The trial court and the Appellate Court decided in her favour. The United States Supreme Court remanded the case to the Court of Appeal to determine whether the Supreme Court's analysis of some of the studies cited by the parties would alter its conclusion that the appellant presented neither objective evidence nor a triable issue of fact on the question of risk.

Excerpts

...

Introduction

We address in this case the application of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 327, 42 U.S.C. § 12101 et seq., to persons infected with the human immunodeficiency virus (HIV). We granted *certiorari* to review, first, whether HIV infection is a disability under the ADA when the infection has not yet progressed to the so-called symptomatic phase; and, second, whether the Court of Appeals, in affirming a grant of summary judgment, cited sufficient material in the record to determine, as a matter of law, that respondent's infection with HIV posed no direct threat to the health and safety of her treating dentist.

Facts

Respondent Sidney Abbott has been infected with HIV since 1986. When the incidents we recite occurred, her infection had not manifested its most serious symptoms. On September 16, 1994, she went to the office of petitioner Randon Bragdon in Bangor, Maine, for a dental appointment. She disclosed her HIV

infection on the patient registration form. Petitioner completed a dental examination, discovered a cavity, and informed respondent of his policy against filling cavities of HIV-infected patients. He offered to perform the work at a hospital with no added fee for his services, though respondent would be responsible for the cost of using the hospital's facilities. Respondent declined.

Respondent sued petitioner under state law and §302 of the ADA, 104 Stat. 355, 42 U.S.C. § 12182 alleging discrimination on the basis of her disability. The state law claims are not before us. Section 302 of the ADA provides:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who ... operates a place of public accommodation. §12182(a).

The term 'public accommodation' is defined to include the 'professional office of a health care provider.' §12181(7)(F).

A later subsection qualifies the mandate not to discriminate. It provides:

Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. §12182(b)(3).

Application of law to facts

We first review the ruling that respondent's HIV infection constituted a disability under the ADA. The statute defines disability as:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such impairment. §12102(2).

We hold respondent's HIV infection was a disability under subsection A of the definitional section of the statute. In light of this conclusion, we need not consider the applicability of subsections B or C.

Our consideration of subsection A of the definition proceeds in three steps. First, we consider whether respondent's HIV infection was a physical impairment. Second, we identify the life activity upon which respondent relies (reproduction and child bearing) and determine whether it constitutes a major life activity under the ADA. Third, tying the two statutory phrases together, we ask whether the impairment substantially limited the major life activity. In construing the statute, we are informed by interpretations of parallel definitions in previous statutes and the views of various administrative agencies which have faced this interpretive question.

The ADA's definition of disability is drawn almost verbatim from the definition of 'handicapped individual' included in the Rehabilitation Act of 1973, 29 U.S.C. § 706(8)(B) (1988 ed.), and the definition of 'handicap' contained in the Fair Housing Amendments Act of 1988, 42 U.S.C. § 3602(h)(1) (1988 ed.). Congress' repetition of a well-established term carries the implication that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations.

...

The directive requires us to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act.

The first step in the inquiry under subsection A requires us to determine whether respondent's condition constituted a physical impairment. The Department of Health, Education and Welfare (HEW) issued the first regulations interpreting the Rehabilitation Act in 1977 ... The HEW regulations, which appear without change in the current regulations issued by the Department of Health and Human Services, define 'physical or mental impairment' to mean:

- (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs;

cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or

- (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. 45 CFR § 84.3(j)(2)(i) (1997).

In issuing these regulations, HEW decided against including a list of disorders constituting physical or mental impairments, out of concern that any specific enumeration might not be comprehensive ...

HIV infection is not included in the list of specific disorders constituting physical impairments, in part because HIV was not identified as the cause of AIDS until 1983 ... HIV infection does fall well within the general definition set forth by the regulations, however.

...

In light of the immediacy with which the virus begins to damage the infected person's white blood cells and the severity of the disease, we hold it is an impairment from the moment of infection. As noted earlier, infection with HIV causes immediate abnormalities in a person's blood, and the infected person's white cell count continues to drop throughout the course of the disease, even when the attack is concentrated in the lymph nodes. In light of these facts, HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection. HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease.

The statute is not operative, and the definition not satisfied, unless the impairment affects a major life activity. Respondent's claim throughout this case has been that the HIV infection placed a substantial limitation on her ability to reproduce and to bear children ... Given the pervasive, and invariably fatal, course of the disease, its effect on major life activities of many sorts might have been relevant to our inquiry. Respondent and a number of amici make arguments about HIV's profound impact on almost every phase of the infected person's life. ... In light of these submissions, it may seem legalistic to circumscribe our discussion to the activity of reproduction. We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities.

From the outset, however, the case has been treated as one in which reproduction was the major life activity limited by the impairment ... We ask, then, whether reproduction is a major life activity.

We have little difficulty concluding that it is. As the Court of Appeals held, '[t]he plain meaning of the word 'major' denotes comparative importance' and 'suggest[s] that the touchstone for determining an activity's inclusion under the statutory rubric is its significance.' ... Reproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself.

...

As we have noted, the ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act ... Rather than enunciating a general principle for determining what is and is not a major life activity, the Rehabilitation Act regulations instead provide a representative list, defining term to include 'functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.' ... As the use of the term 'such as' confirms, the list is illustrative, not exhaustive.

... In the absence of any reason to reach a contrary conclusion, we agree with the Court of Appeals' determination that reproduction is a major life activity for the purposes of the ADA.

The final element of the disability definition in subsection A is whether respondent's physical impairment was a substantial limit on the major life activity she asserts ...

Our evaluation of the medical evidence leads us to conclude that respondent's infection substantially limited her ability to reproduce in two independent ways. First, a woman infected with

HIV who tries to conceive a child imposes on the man a significant risk of becoming infected. The cumulative results of 13 studies collected in a 1994 textbook on AIDS indicates that 20 per cent of male partners of women with HIV became HIV-positive themselves, with a majority of the studies finding a statistically significant risk of infection ...

Second, an infected woman risks infecting her child during gestation and childbirth, i.e., perinatal transmission. Petitioner concedes that women infected with HIV face about a 25 per cent risk of transmitting the virus to their children ... Published reports available in 1994 confirm the accuracy of this statistic ...

Petitioner points to evidence in the record suggesting that antiretroviral therapy can lower the risk of perinatal transmission to about 8 per cent ... It cannot be said as a matter of law that an 8 per cent risk of transmitting a dread and fatal disease to one's child does not represent a substantial limitation on reproduction.

The Act addresses substantial limitations on major life activities, not utter inabilities. Conception and childbirth are not impossible for an HIV victim but, without doubt, are dangerous to the public health. This meets the definition of a substantial limitation. The decision to reproduce carries economic and legal consequences as well. There are added costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and, tragic to think, treated for the infection ... Respondent's HIV infection is a physical impairment which substantially limits a major life activity, as the ADA defines it ...

The petition for certiorari presented three other questions for review. The questions stated:

'3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

...

Of these, we granted certiorari only on question three. The question is phrased in an awkward way, for it conflates two separate inquiries. In asking whether it is appropriate to defer to petitioner's judgment, it assumes that petitioner's assessment of the objective facts was reasonable. The central premise of the question and the assumption on which it is based merit separate consideration.

Again, we begin with the statute. Notwithstanding the protection given respondent by the ADA's definition of disability, petitioner could have refused to treat her if her infectious condition 'pose[d] a direct threat to the health or safety of others.' ... The ADA defines a direct threat to be 'a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.' ...

...

The existence, or non-existence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence. *Arline*, supra, at 288; 28 CFR § 36.208(c) (1997); id., part 36, App B, page 626. As a health care professional, petitioner had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability. To use the words of the question presented, petitioner receives no special deference simply because he is a health care professional ...

In assessing the reasonableness of petitioner's actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority ...

...

Petitioner testified that he believed hospitals had safety measures, such as air filtration, ultraviolet lights, and respirators, which would reduce the risk of HIV transmission ... Petitioner made no showing, however, that any area hospital had these

safeguards or even that he had hospital privileges ... His expert also admitted the lack of any scientific basis for the conclusion that these measures would lower the risk of transmission ... Petitioner failed to present any objective, medical evidence showing that treating respondent in a hospital would be safer or more efficient in preventing HIV transmission than treatment in a well-equipped dental office.

...

There are reasons to doubt whether petitioner advanced evidence sufficient to raise a triable issue of fact on the significance of the risk. Petitioner relied on two principal points: First, he asserted that the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission. The study on which petitioner relied was inconclusive, however, determining only that '[f]urther work is required to determine whether such a risk exists.' ... Petitioner's expert witness conceded, moreover, that no evidence suggested the spray could transmit HIV. His opinion on airborne risk was based on the absence of contrary evidence, not on positive data ...

Second, petitioner argues that, as of September 1994, CDC had identified seven dental workers with possible occupational transmission of HIV ... These dental workers were exposed to HIV in the course of their employment, but CDC could not determine whether HIV infection had resulted ... It is now known that CDC could not ascertain whether the seven dental workers contracted the disease because they did not present themselves for HIV testing at an appropriate time after their initial exposure ... It is not clear on this record, however, whether this information was available to petitioner in September 1994. If not, the seven cases might have provided some, albeit not necessarily sufficient, support for petitioner's position. Standing alone, we doubt it would meet the objective, scientific basis for finding a significant risk to the petitioner.

...

Finding

We conclude the proper course is to give the Court of Appeals the opportunity to determine whether our analysis of some of the studies cited by the parties would change its conclusion that petitioner presented neither objective evidence nor a triable issue of fact on the question of risk. In remanding the case, we do not foreclose the possibility that the Court of Appeals may reach the same conclusion it did earlier. A remand will permit a full exploration of the issue through the adversary process.

The determination of the Court of Appeals that respondent's HIV infection was a disability under the ADA is affirmed. The judgment is vacated, and the case is remanded for further proceedings consistent with this opinion.

E3.5 HIV and confidentiality

Harvey & Another v PD (2004) NSWCA 97

This case involves confidentiality and doctors' duty to provide proper pre- and post-test counselling. The New South Wales Court of Appeal emphasised that there was failure to address 'the need for consent to disclosure, the manner of disclosure, and the possibility of discordant results'. The New South Wales Court of Appeal confirmed the decision of the trial court of negligence on the side of the appellants which caused the respondent to contract HIV from her husband.

Excerpts

...

Facts

[13] The appellants, Dr Harvey and Dr Chen appeal against the decision of Cripps AJ. The trial judge concluded that in breach of their professional duty to the respondent 'PD', they failed to take sufficient steps to cause her to be apprised that her future husband ('FH') was HIV-positive when FH had deliberately deceived her into believing that he was not. PD and FH had attended a joint consultation for the purpose, as understood by Dr Harvey who saw the couple together, of having blood tests to ensure that neither carried the Human Immunodeficiency Virus (HIV) or any other sexually transmitted disease. Dr Harvey knew this was required because they were proposing to get married. He also knew that PD had particular concern about the STD status of her future husband because (as the patient record noted) he came from Ghana. She believed there was a higher risk that a person from Ghana would be HIV positive than one from Australia. FH's deception of PD occurred after PD received her results. She received them not from their doctor at a further joint consultation - none had been advised - but from the clinic's receptionist, who told PD she was not entitled to receive FH's pathology report, which she had requested in view of the earlier joint consultation, but only hers.

[14] The focus of the appeal was first on deficiencies in the pre-test counselling and on advice given and omitted to be given by the appellants. The omissions included failing to advise that in the absence of consent, Dr Harvey was legally prohibited from disclosing any information concerning HIV or AIDS status of one to the other (under section 17(2) of the Public Health Act 1991 (NSW)). He also omitted to raise whether the test results were to be conveyed at a further joint consultation or separately.

[15] Second, the appeal focused on the advice and counselling given and omitted to be given to FH after the result of the test was known. This was when PD's partner was found to be HIV positive but not PD. I set out below those deficiencies found by the trial judge in the medical advice to FH, and in follow-up after the discordant test results were known:...

[16] The appellants seek to invoke the statutory obligation to take all reasonable steps to prevent disclosure of test results without consent as placing a fundamental obstacle to attributing any responsibility to the appellants for the respondent's injury. They also contended that the deceit of the husband operated as a superseding event. Moreover, they contend that when the receptionist told PD, correctly, that she was not entitled to see FH's test results, this should have made it clear to her that she was not entitled to rely on the doctors for that information any longer; that is, if indeed (as the appellants deny) she had ever relied on them rather than FH for that information.

[17] The respondent challenges that contention frontally. The respondent denies that this is a case about the duty of confidentiality of test results and when it can be breached. Rather, says the respondent, it is a case about the proper management of a couple who attend a doctor together for the known purposes of HIV testing prior to marriage and engaging in unprotected sex. It is also about the proper management of patients after they have been tested for HIV one of whom tests positive. The respondent relies on the finding of the trial judge that each of the doctors were negligent in their management of the situation that was presented to them. That negligence was evinced by their departure from, and ignorance of, established procedures which doctors are supposed to know and follow when dealing with HIV testing.

...

Application of law to facts

[23] First, there is the effect of the statutory obligation under section 17(2)(b) of the Public Health Act 1991 (NSW) ('the Act'), to take all reasonable steps to prevent disclosure of the test results, unless with consent. What was successfully pressed below as a critical fact was that the tests were undertaken pursuant to a joint consultation and for a purpose whose achievement depended on their truthful joint communication, most reliably achieved through disclosure at a further joint consultation. The question this poses is whether that statutory obligation of confidentiality nonetheless by its constraints precludes any negligence on the part of Dr Harvey from his failing at the initial joint consultation to raise:

- (a) the need for consent to disclosure,
- (b) the manner of disclosure, or
- (c) the possibility of discordant results.

[24] The Act also raises questions of what the Act permits in the way consent to disclosure is to be obtained and what constitutes a valid consent.

...

[26] Then there was the perfunctory and inaccurate post-test counselling of FH. It poses the question, was the failure by either doctor to urge on FH that he disclose his positive test result to PD negligent, or was such a course justified if not mandated by the statutory obligation? The appellants emphasise that the statutory provision is not just an obligation to refrain from disclosure, but a positive obligation to take all reasonable steps to prevent disclosure.

[27] It is contended by the appellants that, especially with the test result now known, such urging of FH (to disclose his positive result to PD) would have entailed the doctors breaching their statutory obligation not only to refrain from disclosure, but to take all reasonable steps to prevent disclosure.

...

[62] Turning to the judgment of the trial judge, a fair summary of that judgment, taken substantially from the appellants' careful summation, is as follows:

...

(vii) It was not the duty of the Doctors to tell PD (the patient at risk) that her partner or proposed partner was HIV positive. Nor was it the duty of the Doctors to convey to her by less direct or obvious means of communication the HIV status of FH. However, this did not have the consequence that there was nothing the Doctors could do to protect PD or at least make her aware of the risks to which she was exposed. While the Doctors were not expected to guarantee that PD would not become infected, and were prohibited from giving her direct information, they were not prohibited from undertaking fairly obvious steps designed ultimately to make her aware of the danger she was in. They could have sought advice from experts in the field, they could have sought advice from the Medical Defence Union, and they could have spoken to the Department of Health. In any case the result would have been advice that FH needed to be counselled to ensure he made PD aware of his condition. That duty was not discharged merely by referring him to RPAHIC.

...

(xii) The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment extended to the provision of information in an appropriate case. While the statutory obligations of confidentiality, and the circumstances in which disclosure may take place for the protection of a person, are relevant, the Doctors were not precluded from taking steps to present reasonably foreseeable harm by 'an overriding inconsistent duty'. The obligation to preserve confidentiality is overriding only in the sense that details could not be given to PD without the consent of FH, and the statutory obligation operated as a constraint only. It did not preclude the doctors from taking the steps they should have taken but did not take, which resulted in PD becoming HIV positive. It was significant that there was a joint consultation and although the topic of confidentiality was not raised, the duty of the Centre to PD did not end when the Doctors told her that, contrary to her reasonable expectations, she would not have access to FH's results.

...

[63] The appellants' case remains that their statutory obligation of confidentiality to FH under s17 of the Act was such that they could not lawfully have done anything to protect PD. They submit that her only protection was disclosure of FH's HIV positive status and that the only way to have achieved this would have involved breach of that statutory obligation of confidentiality.

[64] That statutory obligation is to be found in the mandatory provisions of section 17 of the Public Health Act 1991 (NSW) and in particular section 17(2)(b), which is in the following terms:

- 17. Protection of identity

(1) A medical practitioner must not state the name or address of a patient:

(a) in a certificate sent to the Director-General under section 14 in relation to a Category 5 medical condition, or

(b) except as may be prescribed, in a written or oral communication made by the medical practitioner for the purpose of arranging a test to find out whether the patient suffers from a Category 5 medical condition.

(2) A person who, in the course of providing a service, acquires information that another person:

(a) has been, or is required to be, or is to be, tested for a Category 5 medical condition, or

(b) is, or has been, infected with a Category 5 medical condition,

must take all reasonable steps to prevent disclosure of the information to another person.

(3) Information about a person that is of a kind referred to in subsection 2 may be disclosed:

(a) with the consent of the other person, or

(b) in connection with the administration of this Act or another Act, or

(c) by order of a court or a person authorised by law to examine witnesses, or

(d) to a person who is involved in the provision of care to, or treatment or counselling of, the other person if the information is required in connection with providing such care, treatment or counselling, or

(e) in such circumstances as may be prescribed.

(4) A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.

Maximum penalty: 50 penalty units.

[65] A 'category 5 medical condition' includes 'Acquired Immunodeficiency Syndrome' and 'Human Immunodeficiency Virus infection'.

[66] By section 75 of the Act, mirroring section 17(3), it is an offence to disclose information without lawful excuse. 'Lawful excuse' includes disclosure with the consent of the person to whom the information relates, and prescribed circumstances.

...

[69] Central to the appellants' case is section 17(2)(b) of the Act. Clearly enough section 17(2) was capable of application to and did apply to the appellants. Thus Dr Harvey was 'a person who in the course of providing a service' namely, procuring the blood test, acquired 'information that another person' (FH) has been tested for a category 5 medical condition (section 17(2)(a)) and that FH 'is, or has been, infected with a category 5 medical condition' (section 17(2)(b)).

[70] I consider that it is clear that the concluding 'another person' in section 17(2) (to whom disclosure is to be prevented) must mean to another person other than the person (FH) about whom the information had been obtained. In the present context this would certainly include PD unless FH consented to disclosure to her (section 17(3)(a)).

...

[80] The appellants' case in its essentials comes to this. That compliance with the statutory obligation to take all reasonable steps to prevent disclosure meant that it could not be lawfully done for the appellants to disclose to PD the result of FH's test, whether directly or by any indirect means. This is said to include means which merely facilitate the information coming to PD. Accordingly, fulfilment by the appellants of their duty to PD, when the content of that duty is thus properly understood, could not have avoided the tragic results for PD following her husband's cruel deception. It was submitted insofar as there were shortcomings in counselling PD or FH, pre or post testing, these were generally not in truth shortcomings when the statutory obligation is taken into account but in any event not such as to have been legally causative of PD's injury.

...

[87] The critical finding is then made at [48] that 'I am of the opinion that had the question arisen concerning what the parties intended to do with the results when they got them, both would have said the other could have access to them'. Moreover, the trial judge accepted PD's evidence that, 'if FH were not prepared to have results made available to her she would have discontinued her relationship with him'. As to reliance by PD on

her doctor, the trial judge records that 'it is common ground that PD should not have received her results from the receptionist but should have received them from a medical practitioner and to have been told, in effect, that the results were not necessarily definitive because of what has been described as the 'window' period of three months prior to the test being undertaken within which HIV could have been contracted but without a positive result appearing in the test'.

[88] Those findings need to be coupled with the fact that PD and FH arranged the tests through Dr Harvey by requiring a joint consultation. This was for the clearly stated purpose of ascertaining whether either had any sexually transmitted diseases, before engaging in unprotected sex in contemplation of a new relationship. Those findings and that evidence underpin the conclusion I reach. It is that, had Dr Harvey done what he was in duty bound to do, namely, raised the question of consent to disclosure, mutual disclosure of results, and the possibility of discordant results, the parties would more likely than not have consented to their results being made available to each other by Dr Harvey at a further joint consultation. I also infer that if FH had refused, then their relationship would have terminated. Had either occurred, I conclude that PD would not have been vulnerable to FH doing what he did, namely hiding his results and substituting forged ones with the tragic result that followed. I elaborate on my reasons below, starting with the statutory impact of section 17(2)(b) of the Act.

[89] In my view, section 17(2)(b) of the Act does not preclude a proper process of pre-test counselling encompassing the need for consent, how to receive the test results and dealing with the possibility of discordant results. Care would be needed on the latter, to avoid on the one hand being unduly alarmist while on the other remaining properly candid about the possibilities. The taking of all reasonable steps to prevent disclosure does not extend to require the further unreasonable step of holding back from counselling on those three matters. PD would certainly have wanted to receive the test results for her partner and herself in the most reliable way. Dr Harvey should have been conscious of the possibility of discordant results given PD's expressed concern that FH came from Ghana. This is especially as Dr Harvey accepted there was a greater risk of sexually transmitted diseases from that area (even if he did not concede that his understanding accorded with PD's belief that there was a higher risk that a person from Ghana would be HIV positive than one from Australia) ...

...

[92] Indeed if reliance had to be placed solely on post-test counselling (because no consent given in advance could be an informed one), there would be a much greater constraint on counselling. That is by reason of the concern about breaching section 17(2)(b) when the test results were known. Then the doctor may well feel constrained by knowing the actual test result from giving any hint of it in breach of section 17(2)(b). The doctor would equally be unwilling to risk vitiating any consent under section 17(3)(a), by reason of it being said to result from a breach of section 17(2)(b). However, in view of the conclusion I have reached on the pre-test counselling, and the variety of circumstances that can here arise, I express no conclusion on whether that concern would be well-founded in law.

...

[96] Indeed the very purpose of the joint consultation was not merely to carry out the relevant tests. That could have been done by a simple referral to a pathologist. Rather it was to obtain advice from their doctor as to sexually transmitted diseases and in particular as to the HIV virus. At a joint consultation with their doctor their results can be shared without risk of concealment and so that their implications, if discordant, can, as they would expect, be properly explained by their doctor. They had clearly signalled, by coming as a couple, that they were seeking joint and not separate advice. I have earlier concluded that the inference properly to be drawn is that had Dr Harvey raised the matter of disclosure and the possibility of discordant results they would either have agreed to joint disclosure or, if FH refused, PD would have discontinued her relationship with him.

...

[103] This passage indicates that instead of the receptionist pointing out that whilst the results were confidential they could

be made available with the consent of her partner, PD was simply given the misleading and incomplete information that she could not have access to his records because they were confidential. Had Dr Harvey raised the matter at the initial joint conference, I am satisfied on the findings and evidence that the most likely result is that he would have elicited the response that each consented to the other's results being made available at a further joint conference with Dr Harvey (or another doctor if he were unavailable). Having chosen to get joint medical advice rather than go to a pathologist direct, PD at least would hardly, if given the choice, have opted to receive the results from an unqualified receptionist with no knowledge of the circumstances of their original joint consultation. Had the results been conveyed to them together at a joint consultation, I consider that PD's damage would not have occurred. That would satisfy any common sense notion of causation as well as the 'but for' test; *March v Stramare Pty Ltd* (1991) 171 CLR 506 at 516, 522, 525 and 530.

[107] It is therefore not necessary, in order for the respondent to succeed, to rely on any failure in post-test counselling. Concededly, the post-test counselling was clearly inadequate. First, each doctor failed to urge upon FH the importance of disclosing his adverse test result to his sexual partners. Second, neither doctor ever raised with FH whether he intended informing PD of his condition. Had Dr Harvey carried out all of the post-test counselling, he would have been fully aware of PD's and FH's relationship from the earlier joint consultation. Had he properly recorded upon the treatment record card the fact of a joint consultation and that PD was about to enter a new relationship (he did neither) and had there been a system for that record in turn being automatically available to Dr Chen, he would have been aware of the circumstances concerning FH and PD's intention to marry and the purpose of the original tests. His counselling could then have taken that critical circumstance into account. It did not.

[110] The appellants deny that they owed any relevant continuing duty to PD, arising from her continuing status as a patient of the Centre, and as a person the doctors ought to have known was at risk from FH's known HIV status. It is however unnecessary to consider that question in light of the conclusion earlier reached. In particular I do not need to reach any final conclusion as to whether the statutory duty imposed by section 17(2)(b) would have precluded the doctors giving post-test counselling urging FH to disclose to PD his positive result or the likely result if they had. Nor do I need to consider the causal effect of the other inadequacies and omissions in post-test counselling and follow-up in relation to FH, or the likely result if the Director General had been notified. This latter is on the supposition that the doctor concerned worked out from proper cross-referenced medical records that PD and FH were engaging in unprotected sex following her attending for vaccinations to go to Ghana and for a prescription for the contraceptive pill. The appellants contend that to urge or even counsel FH to disclose his HIV status to PD is inconsistent with the statutory obligation imposed by section 17(2)(b) and that in any event it was not reasonable for her to rely on the doctors to procure such disclosure. The appellants contend that the content of the duty is limited to warning the infected patient of the need to take appropriate precautions. Further, that this duty was sufficiently fulfilled by

(a) Dr Harvey in advising FH not to have unprotected sex, though he did not raise any issue arising out of the joint consultation or ask whether he proposed to tell PD the result; and
(b) Dr Chen in telling FH when he attended to collect his results that illness was sexually transmissible and could be transferred to others;

citing *Bell J in BT v Oei* [1999] 1082 NSWSC at [60 to 98].

[111] It is unnecessary to consider these issues in light of my earlier conclusion that proper pre-test counselling would have resulted in a joint consultation to obtain the test results from a doctor (or if declined termination of the relationship), and that such disclosure so brought about would not have involved any breach of section 17(2)(b) of the Act or precluded the application section 17(3)(a). Questions concerning the scope for post-result counselling and the boundary line between on the one hand

taking reasonable steps to avoid disclosure and on the other providing proper advice designed to maximise the prospect of lawfully obtained consent to disclosure to a vulnerable partner, is best left to cases that require the resolution of those difficult issues.

...
Cross-appeal - Recovery of additional costs of child care for PD's second child conceived after PD became aware of her having become HIV positive from a second party.

[112] The essential facts relevant to this issue are not in dispute and are set out below:

...
(v) Sometime after the divorce in 2001 PD commenced a relationship with a man from Sweden, to whom she became engaged, who was also HIV-positive;

(vi) PD, prior to such engagement, in March 2002, gave a history to Dr Sippe psychiatrist in March 2002 that she was in a relationship with an HIV positive man from Sweden; that she expected he would return to Sweden and that he 'was not ready for commitment'. However, they did become engaged. The trial judge concluded that as an HIV positive man, the father would be unlikely to be given permission to reside permanently in Australia;

(vii) PD's treating immunologist Dr Garsie reported in January 2002 that PD was aware that she risked passing on HIV to any future offspring or sexual partner; that she 'displayed a high level capacity to understand and see the implications of the information for her';

(viii) PD's second child was born of that relationship, on 29 November 2002;

(ix) That second child was conceived voluntarily by PD in circumstances in which she knew she was HIV-positive;

(x) On the probabilities PD will become afflicted with an AIDS-defining illness in about 2014, and die in about 2016;

(xi) PD will be able to care for her children until 2014, but not thereafter;

(xii) For the period from 2014, PD was held entitled to damages for loss of future earnings on the footing that she would otherwise have been in fulltime employment. Similarly, she received damages for lost earnings during the 'lost years' on the same basis.

[113] There was no evidence before the trial judge that there is an increase in risk of offspring contracting HIV if both partners are HIV positive, that is, as distinct from just the mother.

[114] The Appellants submit that the trial judge correctly declined to award damages under this head, because the cost of future child care for the second child will be the result of the voluntary, informed and unreasonable (in the context of visiting the consequences on the appellants) decision of the respondent. This, importantly, is a category of consequential economic loss, though stemming from the injury PD ultimately suffered of HIV/AIDS.

...
[124] Considered as a question of causation the starting point is still the application of common sense (*March v E & M H Stramare Pty Limited* (supra)). This is also the test for whether some particular damage resulted from the negligent act or (as here) omission (*Medlin v State Government Insurance Commission* (1995) 182 CLR 1). The appellants as PD's doctors in common sense terms and certainly as a matter of historical involvement, played a significant role in the respondent being faced with the choice of limiting herself to one child or placing herself in likely need of child care once incapacitated. Though it be the case that she chose the latter course, that choice was in a sense forced on her, if she were to have a further child at all. That however still leaves a second question, similar to the scope of duty analysis. That question is whether the doctors 'ought to be held liable to pay damages for that harm'. That is the second stage of the two stage enquiry, described by Ipp JA as one which 'may involve normative issues of a general kind ... and whether the damage claimed is too remote.'; *Ruddock & Ors v Taylor* (supra) at [87]. Most recently Hayne J in *Pledge v Roads & Traffic Authority* [2004] HCA 13 speaking in the preferable

terms of 'legal responsibility' (at [10]) adopted just such a two stage enquiry:

...
[127] Here there is no guiding principle which, without recourse as well to legal policy, suffices to answer the scope of duty question. In determining what is here the proper scope of the doctors' duty of care (or the proper scope of their liability for the consequences of its breach) one must begin with the voluntary decision by PD to have a second child, knowing that she was HIV positive. This was when she was in no way incapacitated from making that decision by reason of the earlier negligence of the doctors, in contrast to the position in *Sullivan v Gordon*. The appellants contend that decision, and the consequences which followed, because it was the product of voluntary and informed conduct, in causation terms must amount to an interruption or termination of the causal force of the original negligence. That conduct, say the appellants, constituted a novus actus interveniens, involving independent and unreasonable action on the part of the respondent seeking to recover. That in scope of duty terms, broke the chain of legal responsibility eclipsing any role the doctors' negligence may have played. As I explain, I consider that approach unduly simplistic in its assumption of unreasonableness on the part of PD.

...
[132] Was then the decision of PD to have the second child with her consequent injury (in terms of post-incapacity cost of child care) not just the consequence of her independent action, but itself unreasonable action on her part? For reasons I explain, though indubitably the result of her independent, and indeed fully informed decision, it was not an unreasonable action on her part and from her viewpoint to choose to have a second child. In those terms, there was no novus actus interveniens in that decision and subsequent conduct.

[133] However, that still leaves the further question in assessing whether the respondent should recover, namely the appropriate scope of liability for the consequences of tortious conduct; in short, the scope of the duty. That question is resolved by determining whether in normative terms it would be unjust to hold the appellants legally responsible for that further decision to have a further child, reasonable though it was from PD's viewpoint to do so. That question is not answered simply by invoking the principle that a plaintiff takes a defendant as he find her; compare *Nader v Urban Transport Authority* (1985) 2 NSWLR 501.

[134] PD must be taken to have known that before the child reached mature age she, PD, would be incapacitated from looking after her child. This is so whether that age be 12 as the trial judge held or earlier as PD unsuccessfully argued. While the doctor's negligence did not therefore directly lead to the decision to have the second child or remove PD's capacity to make a reasonable decision in that behalf, nonetheless, but for the doctors' negligence, she could have had a further child without fear of incapacity and consequent need for child care. In causal terms, the link can be said to be more attenuated between the original negligence and the particular head of damage here claimed. That attenuation, while not removing the necessary causal link, is a factor in considering the proper scope of the duty.

...
[136] One such factor is that there is a legal obligation to care for children, as Mason P recognised. That may be compared to the moral obligation to care for an aged relative, important though that may be. A similar legal obligation applies here to PD. It cannot be said, contrary to the cross-respondent's submissions, that admitting such a claim ignores the role which the father of the child would play in providing for the care of the children. That role is likely to be a limited one, if PD remains in Australia. The trial judge found the father would be unlikely as an HIV positive person to be permitted to reside permanently in Australia, so his capacity to provide care cannot be counted upon.

[137] Nor could it be said that there was a failure to mitigate her damage in the sense that the law requires, namely, that PD not act unreasonably in the circumstances, so as to bring about an increase in the damage she suffered. The burden is of course on

the defendant to prove that the plaintiff's refusal to mitigate was unreasonable; Fleming 'Law of Torts' (LBC, 1998) 9th ed at 286, approved by the Privy Council in *Geest plc v Lasinquot* [2003] 1 All ER 383. I have already concluded that she did not act unreasonably in exercising her choice to have a second child. It must be kept in mind that she had just turned 24 when she first consulted Dr Harvey with FH and would have had every expectation of having children. PD was a woman of childbearing years who, but for the doctor's negligence would have had every expectation of having a family with no fear of incapacity inhibiting that choice.

...
[139] One answer is that the head of damage for pain and suffering from being deprived of further children is not the equivalent of the head of damage for cost of childcare after PD's anticipated incapacity by the time the child turns 12, or the equivalent of loss of capacity to care for a child after it turns 12. Moreover there is already an overlap in the claim for lost future earnings (including the lost years) which were assessed on the basis of PD being in fulltime employment. Finally, while in logic the two situations may appear the converse or reciprocal of each other, this is only in a very approximate sense. It by no means follows that because it may be justified to award damages for being deprived of the capacity safely to have children, damage should also follow when the risk of having further children has been safely circumvented.

[140] Ultimately this way of looking at the problem tells against PD's recovery. This is because it opens up the very considerations which in analogous cases pose such difficult issues of recovery. Though the damage is not in the fullest sense to an indeterminate class, it would in its implications open up liability for a potentially indeterminate amount as well as other questions of indeterminacy. It raises the question of just how many children should be potentially within the ambit of damage recovery, given that each later birth would involve an ever longer anticipated period of future incapacity till the child turns 18. Suppose indeed PD's precautions were to fail and she were to have a child that was HIV positive. Could she then recover a further head of damage based upon the additional care obligation for the child that this would entail? What of recovery by the child itself? It is true that this has not occurred and therefore the example is hypothetical. But it illustrates the difficulty of extending liability for the cost of care for the second child or loss of capacity to care for that child, and laying this at the door of the doctors; by what principle, consistently applied, can this be justified?

...
[142] Ultimately, whether one puts the matter in neutral terms of 'legal concerns' (Jane Stapleton's preferred terminology in 'The Golden Thread at the Heart of Tort Law' (2003) 24 Australian Bar Review 135 at 136) or in the more influential sense of 'legal policy', albeit still awaiting final recognition as binding principle, I consider that the trial judge was correct in denying this further item of damage. I do so not because I consider that there is no causal link between original negligence of the doctors and later injury suffered in loss of capacity to care for a second child after it turns 12. The doctors were undoubtedly historically involved in that injury. Rather, I do so because I consider that this causal link is too attenuated and its quality altered in a normative sense by PD's independent decision to have the further child, knowing of her condition. Reasonable as it was from her viewpoint to do so, it is unreasonable to hold the doctors legally responsible for its financial consequences.

Remedy

[148] I consider that this appeal should fail as also the cross-appeal. Accordingly, I would order that the appeal be disallowed with costs and the cross-appeal likewise disallowed with costs. But I would defer the coming into effect of the latter orders for 14 days to enable the parties if they so choose to make further submissions on costs.

C (A Child) (EWCA Civ 1999) 3007

The case is related to the application for permission to appeal made by an HIV positive mother and her partner who refused to consent to testing and medical treatment for their child because of their unconventional beliefs about the nature and causes of AIDS. Their application was directed against a finding of the primary Court which decided that the child be tested for HIV. In this case, the England and Wales Supreme Court of Appeal (Civil Division) refused to grant permission to appeal against the decision of the primary Court on the ground that 'the child has her own rights' which 'seem to be met by her being tested to see what her state of health is'.

Excerpts

...

Introduction

This is an application by the parents for permission to appeal against the decision of Wilson J given on 7th September 1999, when he directed that a little girl, born on 8th April 1999, should be taken to Great Ormond Street or to some other suitable hospital, and there she should be tested as to whether or not she was infected with HIV. The mother and the father both seek to appeal from that decision. The father is not present, having conducted his objection to the local authority's application for this test in person, and it appears from what was said in the judgment of Wilson J, he did it with great ability ...

Facts

The background to this sad case is that the mother, who had one or more previous relationships, found in 1990, from one previous relationship, that she was HIV positive ...

The mother, having found that she was HIV positive, came to terms with that sad state of affairs and imposed upon herself a regime of alternative medicine and of careful diet and healthy living, which has had the result, from her point of view, that she remains, some eight or nine years later, very fit and well, although she remains HIV positive. She met the father, whom she has not married, in 1997. He was tested and is negative. They planned a child and their daughter was born on 8th April 1999. They chose not to go through the normal system of registering at a hospital for anti-natal care because they were concerned that the conventional medical treatment would impose what to both of them would be an unacceptable approach to the birth, and the mother had the child at home with the assistance of a midwife. She had a natural birth and the child was born entirely fit.

...

They registered with a new general practitioner some weeks after the birth of the child. The mother told the general practitioner or produced some former notes of the previous general practitioner which showed that she was HIV positive. That was not picked up immediately by the general practitioner, but when she read the notes some days or weeks later she got immediately in touch with the parents and saw them and sought their consent to seeing a consultant at Great Ormond Street. Great Ormond Street is one of a comparatively small number of hospitals which have a unit dedicated to dealing with children who are HIV positive. With some reluctance the parents went to see a doctor at Great Ormond Street but refused to have the child tested and refused any sort of treatment for the child.

In due course the local authority became involved and applied for a specific issue order. They were given leave by Connell J to do so ... The hearing lasted, including judgment, some five days. The consensus of evidence was firmly in favour of a medical test ... All of them were of the opinion that there was a 25 to 30 per cent chance that this child would be HIV positive and that it was necessary to test the child. If the child was positive further

treatment would be highly desirable. The mother has from the onset of the birth breastfed the baby. If the baby is HIV positive, such breastfeeding obviously can continue. If the child is negative, then the medical experts were unanimous that the mother ought not to breastfeed.

...The consensus was ... that treatment for a baby under six months was important. If the child is negative but the mother continues to breastfeed, it may well be necessary to have further tests. Indeed, because the baby has been breastfed throughout, the test only applies to up to some eight weeks before the date of the test. It would be likely that it would be necessary to test again and if the mother continues to breastfeed to continue to test until the end of breastfeeding.

...

The parents do not accept the evidence of the doctors. They do not accept the decision of the judge, and the mother through counsel comes to us to say that they are good parents with very strongly held views. There is no emergency here. The judge recognised that he could not prevent the breastfeeding because to make such a direction would be ineffective with the mother, and that as responsible parents it is wrong for the court to intervene in decisions which are pre-eminently decisions for parents. The judge is criticised for setting out the parents' strongly held views but not evaluating those views, particularly not evaluating the impact upon the parents of any form of medical regime which would have an enormous impact on them and has already had sufficient impact for them to leave their home. They would find it difficult to abide by any step in the process, and the effect of their enormous upset and distress at having imposed upon them a decision to have their baby tested would inevitably affect the care which they are giving to this child ...

...

Application of law to facts

The issue before this court is an issue of knowledge. What is the position of this child? In my view, the child is clearly at risk if there is ignorance of the child's medical condition. The degree of intrusion into the child of a medical test is slight. The degree of intrusion into the family of taking the child to the hospital for a medical test would for most people be comparatively slight. The parents have magnified this into a major issue because they do not accept any of the premises upon which the tests will be carried out. But the welfare of the child is paramount. The court has been asked to deal with the case. It cannot shirk its duty. The space sought by Mr Horowitz, which is a space in which parental decisions are final, undoubtedly exists, but it exists subject to section 1(1) of the Children Act. It does not matter whether the parents are responsible or irresponsible. It matters whether the welfare of the child demands that such a course should be taken and, as Evans LJ was asking during this hearing in argument: Can it be in the child's best interests for the parents to remain ignorant of their own child's state of health? You only have to ask that question for most people to say No We are not talking about the rights of parents. We are talking about the rights of the child. Wilson J set out various articles of the UN Convention on the Rights of the Child. We do not in a sense need that. It is all encapsulated in section 1 of the Children Act, but it does give added strength to this most important of all points, that the parents' views, which are not the views of the majority, cannot stand against the right of the child to be properly cared for in every sense. This child has the right to have sensible and responsible people find out whether or not she is or is not HIV positive, either as a result of the birth to her mother, or as a result of the breastfeeding. There is a 25 per cent chance, according to the doctors, that she is HIV positive because of the birth. There is an increased danger because of breastfeeding. There is a 1 in 3 or one in four chance that she may be HIV positive. What seems to me to be crucial is that someone should find out so that one knows how she should be looked after.... Either way this child has her own rights. Those rights seem to me to be met at this stage by her being tested to see what her state of health is for the question of knowledge. That is as far as it goes. I therefore would refuse the application for permission to appeal.

...

E3.7 HIV and deportation/extradition

D v The United Kingdom (1997) ECHR

The applicant, a person suffering from AIDS-related illnesses, challenged a decision expelling him from the UK after serving a prison sentence for smuggling cocaine into the country. The European Court of Human Rights found that the expulsion of the applicant to St Kitts (his country of origin), where health and sanitation problems are dire and treatment for AIDS illnesses generally not available, 'would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment'.

Excerpts

Facts

...

[7] The applicant arrived at Gatwick Airport, London, on 21 January 1993 and sought leave to enter the United Kingdom for two weeks as a visitor. He was found at the airport terminal to be in possession of a substantial quantity of cocaine with a street value of about 120,000 pounds sterling (GBP). The immigration officer refused him leave to enter on the ground that his exclusion was conducive to the public good and gave him notice that he would be removed to St Kitts within a matter of days.

However, after being arrested and charged, the applicant was remanded in custody and subsequently prosecuted for being knowingly involved in the fraudulent evasion of the prohibition on the importation of controlled drugs of class A. He pleaded guilty at Croydon Crown Court on 19 April 1993 and was sentenced on 10 May 1993 to six years' imprisonment. He apparently behaved well while in H.M. Prison Wayland and was released on licence on 24 January 1996. He was placed in immigration detention pending his removal to St Kitts. Bail was granted by an adjudicator on 31 October 1996 after the Commission's report had been made public.

C. Diagnosis of AIDS

[8] In August 1994, while serving his prison sentence, the applicant suffered an attack of pneumocystis carinii pneumonia ('PCP') and was diagnosed as HIV-positive and as suffering from AIDS. The infection appears to have occurred some time before his arrival in the United Kingdom.

[9] On 3 March 1995, the applicant was granted a period of compassionate leave to be with his mother whose air fare to the United Kingdom to visit him had been covered by charitable donations.

[10] On 20 January 1996, immediately prior to his release on licence, the immigration authorities gave directions for the applicant's removal to St Kitts.

...

Application of law to facts

I. Alleged violation of article 3 of the convention

[39] The applicant maintained that his removal to St Kitts would expose him to inhuman and degrading treatment in breach of article 3 of the Convention, which provides:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

A. Arguments of those appearing before the Court

1. The applicant

[40] The applicant maintained that his removal to St Kitts would condemn him to spend his remaining days in pain and suffering in conditions of isolation, squalor and destitution. He had no close relatives or friends in St Kitts to attend to him as he approached death. He had no accommodation, no financial resources and no access to any means of social support. It was an

established fact that the withdrawal of his current medical treatment would hasten his death on account of the unavailability of similar treatment in St Kitts. His already weakened immune system would not be able to resist the many opportunistic infections to which he would be exposed on account of his homelessness, lack of proper diet and the poor sanitation on the island. The hospital facilities were extremely limited and certainly not capable of arresting the development of infections provoked by the harsh physical environment in which he would be obliged to fend for himself. His death would thus not only be further accelerated, it would also come about in conditions which would be inhuman and degrading.

[41] In June 1996, his life expectancy was stated to be in the region of eight to twelve months even if he continued to receive treatment in the United Kingdom. His health had declined since then. As he was now clearly weak and close to death, his removal by the respondent State at this late stage would certainly exacerbate his fate.

2. The Government

[42] The Government requested the Court to find that the applicant had no valid claim under article 3 in the circumstances of the case since he would not be exposed in the receiving country to any form of treatment which breached the standards of article 3. His hardship and reduced life expectancy would stem from his terminal and incurable illness coupled with the deficiencies in the health and social-welfare system of a poor, developing country. He would find himself in the same situation as other AIDS victims in St Kitts. In fact he would have been returned in January 1993 to St Kitts, where he had spent most of his life, had it not been for his prosecution and conviction.

[43] The Government also disputed the applicant's claim that he would be left alone and without access to treatment for his condition. They maintained that he had at least one cousin living in St Kitts and that there were hospitals caring for AIDS patients, including those suffering from opportunistic infections (see paragraph 17 above). Even if the treatment and medication fell short of that currently administered to the applicant in the United Kingdom, this in itself did not amount to a breach of article 3 standards.

[44] Before the Court the Government observed that it was their policy not to remove a person who was unfit to travel. They gave an undertaking to the Court not to remove the applicant unless, in the light of an assessment of his medical condition after the Court gives judgment, he is fit to travel.

3. The Commission

[45] The Commission concluded that the removal of the applicant to St Kitts would engage the responsibility of the respondent State under article 3 even though the risk of being subjected to inhuman and degrading treatment stemmed from factors for which the authorities in that country could not be held responsible. The risk was substantiated and real. If returned, he would be deprived of his current medical treatment and his already weakened immune system would be exposed to untreatable opportunistic infections which would reduce further his limited life expectancy and cause him severe pain and mental suffering. He would be homeless and without any form of moral, social or family support in the final stages of his deadly illness.

B. The Court's assessment

[46] The Court recalls at the outset that Contracting States have the right, as a matter of well-established international law and subject to their treaty obligations including the Convention, to control the entry, residence and expulsion of aliens. It also notes the gravity of the offence which was committed by the applicant and is acutely aware of the problems confronting Contracting States in their efforts to combat the harm caused to their societies through the supply of drugs from abroad. The administration of severe sanctions to persons involved in drug trafficking, including expulsion of alien drug couriers like the applicant, is a justified response to this scourge.

[47] However, in exercising their right to expel such aliens Contracting States must have regard to article 3 of the Convention, which enshrines one of the fundamental values of democratic societies. It is precisely for this reason that the Court

has repeatedly stressed in its line of authorities involving extradition, expulsion or deportation of individuals to third countries that article 3 prohibits in absolute terms torture or inhuman or degrading treatment or punishment and that its guarantees apply irrespective of the reprehensible nature of the conduct of the person in question (see, most recently, the *Ahmed v. Austria* judgment of 17 December 1996, Reports of Judgments and Decisions 1996-VI, p 2206, para 38; and the *Chahal v the United Kingdom* judgment of 15 November 1996, Reports 1996-V, p 1853, paras 73-74).

[48] The Court observes that the above principle is applicable to the applicant's removal under the Immigration Act 1971. Regardless of whether or not he ever entered the United Kingdom in the technical sense (see paragraph 25 above) it is to be noted that he has been physically present there and thus within the jurisdiction of the respondent State within the meaning of article 1 of the Convention since 21 January 1993. It is for the respondent State therefore to secure to the applicant the rights guaranteed under article 3 irrespective of the gravity of the offence which he committed.

[49] It is true that this principle has so far been applied by the Court in contexts in which the risk to the individual of being subjected to any of the proscribed forms of treatment emanates from intentionally inflicted acts of the public authorities in the receiving country or from those of non-state bodies in that country when the authorities there are unable to afford him appropriate protection (see, for example, the *Ahmed* judgment, *loc cit*, p 2207, para 44). Aside from these situations and given the fundamental importance of article 3 in the Convention system, the Court must reserve to itself sufficient flexibility to address the application of that article in other contexts which might arise. It is not therefore prevented from scrutinising an applicant's claim under article 3 where the source of the risk of proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that country, or which, taken alone, do not in themselves infringe the standards of that article. To limit the application of article 3 in this manner would be to undermine the absolute character of its protection. In any such contexts, however, the Court must subject all the circumstances surrounding the case to a rigorous scrutiny, especially the applicant's personal situation in the expelling State.

[50] Against this background the Court will determine whether there is a real risk that the applicant's removal would be contrary to the standards of article 3 in view of his present medical condition. In so doing the Court will assess the risk in the light of the material before it at the time of its consideration of the case, including the most recent information on his state of health (see the *Ahmed* judgment, *loc cit*, p. 2207, para 43).

[51] The Court notes that the applicant is in the advanced stages of a terminal and incurable illness. At the date of the hearing, it was observed that there had been a marked decline in his condition and he had to be transferred to a hospital. His condition was giving rise to concern (see paragraph 21 above). The limited quality of life he now enjoys results from the availability of sophisticated treatment and medication in the United Kingdom and the care and kindness administered by a charitable organisation. He has been counselled on how to approach death and has formed bonds with his carers (see paragraph 19 above).

[52] The abrupt withdrawal of these facilities will entail the most dramatic consequences for him. It is not disputed that his removal will hasten his death. There is a serious danger that the conditions of adversity which await him in St Kitts will further reduce his already limited life expectancy and subject him to acute mental and physical suffering. Any medical treatment which he might hope to receive there could not contend with the infections which he may possibly contract on account of his lack of shelter and of a proper diet as well as exposure to the health and sanitation problems which beset the population of St Kitts (see paragraph 32 above). While he may have a cousin in St Kitts (see paragraph 18 above), no evidence has been adduced to show whether this person would be willing or in a position to attend to the needs of a terminally ill man. There is no evidence of any other form of moral or social support. Nor has it been shown

whether the applicant would be guaranteed a bed in either of the hospitals on the island which, according to the Government, care for AIDS patients (see paragraph 17 above).

[53] In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant's fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment by the respondent State in violation of article 3. The Court also notes in this respect that the respondent State has assumed responsibility for treating the applicant's condition since August 1994. He has become reliant on the medical and palliative care which he is at present receiving and is no doubt psychologically prepared for death in an environment which is both familiar and compassionate. Although it cannot be said that the conditions which would confront him in the receiving country are themselves a breach of the standards of article 3, his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment. Without calling into question the good faith of the undertaking given to the Court by the Government (see paragraph 44 above), it is to be noted that the above considerations must be seen as wider in scope than the question whether or not the applicant is fit to travel back to St Kitts.

[54] Against this background the Court emphasises that aliens who have served their prison sentences and are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State during their stay in prison. However, in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of article 3.

...

Remedy

For these reasons, The Court unanimously

1. Holds that the implementation of the decision to remove the applicant to St Kitts would violate article 3 of the Convention;
2. Holds that having regard to its conclusion under article 3 it is not necessary to examine the applicant's complaint under article 2 of the Convention;
3. Holds that the applicant's complaint under article 8 of the Convention gives rise to no separate issue;
4. Holds that there has been no violation of article 13 of the Convention;
5. Holds
 - (a) that the respondent State is to pay the applicant, within three months, 35,000 (thirty-five thousand) pounds sterling in respect of costs and expenses less 33,216 (thirty-three thousand two hundred and sixteen) French francs to be converted into pounds sterling at the rate applicable at the date of delivery of the present judgment;
 - (b) that simple interest at an annual rate of 8% shall be payable from the expiry of the above-mentioned three months until settlement.

...

The appellant, a citizen of South Africa accused of defrauding a bank in his country, challenged the decision of the primary judge which upheld the order of extradition to South Africa issued by the Australian Minister of Justice and Customs. Setting aside the decision of the primary judge, the Full Court (Appeal Division) of the Federal Court of Australia found that due to prison conditions in South Africa where gang rape and HIV are rampant, it 'would be oppressive or incompatible with humanitarian conditions to surrender Mr De Bruyn to South Africa when there is a risk of contracting HIV/AIDS considerably greater than if he is not surrendered'.

Excerpts

[1] The appellant is a citizen of South Africa and the subject of a decision by the respondent that he be surrendered to the Republic of South Africa for an extradition offence. The offences with which the appellant is to be charged are defrauding the First National Bank of South Africa of \$1.2m rand or stealing that sum. An application for orders under s 39B of the Judiciary Act 1903 (Cth) was dismissed by a judge of this Court ([2004] FCA 880).

[2] The matter has a lengthy history, which his Honour the primary judge set out. The extradition request was made on 24 June 1997. On 11 August 1997 the Minister issued a notice under s 16 of the Extradition Act 1988 (Cth) ('the Act') to a magistrate stating that the request had been received. The magistrate determined that the appellant was not 'eligible for surrender' under s 19 of the Act. That decision was set aside by a judge of this Court and an appeal from that decision did not succeed (see respectively *Republic of South Africa v De Bruyn* [1999] FCA 516 and *De Bruyn v Republic of South Africa* [1999] FCA 1344). Mr De Bruyn, who had been at large, then absconded. In February 2003 he was arrested and remanded in custody pending a determination pursuant to s 22 of the Act as to whether he should be surrendered. The Minister made that determination on 29 January 2004.

Statutory requirements

[3] A warrant may be issued for the surrender of a person under s23 of the Act if the Attorney-General has made a determination '... under subsection 22(2) that a person is to be surrendered to an extradition country in relation to an extradition offence ...'. South Africa is such a country. Section 22(3)(b) of the Act relevantly provides that a person may be surrendered if:

(b) the Attorney-General is satisfied that, on surrender to the extradition country, the person will not be subjected to torture;

[4] Paragraph (e) of that subsection provides:

(e) where, because of section 11, this Act applies in relation to the extradition country subject to a limitation, condition, qualification or exception that has the effect that:

(i) surrender of the person in relation to the offence shall be refused; or

(ii) surrender of the person in relation to the offence may be refused; in certain circumstances - the Attorney-General is satisfied:

(iii) where subparagraph (i) applies - that the circumstances do not exist; or

(iv) where subparagraph (ii) applies - either that the circumstances do not exist or that they do exist but that nevertheless surrender of the person in relation to the offence should not be refused; ...

[5] Section 11(1) of the Act provides:

(1) The regulations may:

(a) state that this Act applies in relation to a specified extradition country subject to such limitations, conditions, exceptions or qualifications as are necessary to give effect to a bilateral extradition treaty in relation to the country, being a treaty a copy of which is set out in the regulations; or

(b) make provision instead to the effect that this Act applies in relation to a specified extradition country subject to other

limitations, conditions, exceptions or qualifications, other than such limitations, conditions, exceptions or qualifications as are necessary to give effect to a multilateral extradition treaty in relation to the country.'

[6] Regulation 5(4) of the Extradition (Republic of South Africa) Regulations ('the Regulations') then in force provided:

The Attorney-General may decline to issue a surrender warrant or temporary surrender warrant under Part II of the Act in relation to a person if:

(a) the person is an Australian citizen; or

(b) the Attorney-General, while taking into account the nature of the offence to which the extradition request relates and the interests of the requesting country is nevertheless of the opinion that, in the circumstances of the case, it would be unjust, oppressive or incompatible with humanitarian considerations to surrender the person to that country.

[7] Regulation 4 of the later regulations (the Extradition (South Africa) Regulations 2001) provides that application of the Act to South Africa is to be subject to a Treaty on Extradition between Australia and the Republic of South Africa ('the Treaty') which is scheduled to the regulations. Article 3 par (2)(g) of the Treaty relevantly provides that extradition may be refused:

if the Requested State, while also taking into account the nature of the offence and the interests of the Requesting State, considers that, in the circumstances of the case, including the age, health or other personal circumstances of the person whose extradition is sought, the extradition of that person would be unjust, oppressive, incompatible with humanitarian considerations or too severe a punishment; ...

[8] Regulation 6 of the 2001 regulations provides that the repealed regulations continue to apply to extradition requests made before 1 August 2001, which is here the case. His Honour the primary judge applied the repealed regulations and the respondent accepts that that approach was correct.

Background to the minister's decision

[9] The Minister had provided to him a briefing paper and recommendations. Before his Honour, and on this appeal, it has been assumed that the Minister's reasons for the determination under s 22(2) are those contained in the briefing paper, which the Minister is to be taken to have approved and adopted as his own.

[10] The briefing paper gave some background facts and identified issues arising under the Act. It identified, erroneously, the Treaty as containing criteria relevant to the case. The effect of this error was dealt with by his Honour the primary judge and will be referred to later in these reasons.

[11] The Minister was advised, by the briefing paper, that he might be satisfied of the matters required by the Act for surrender and that:

(f) none of the mandatory or discretionary grounds for refusal under the Treaty warrant refusing De Bruyn's extradition; and

(g) there are no grounds warranting refusal of De Bruyn's extradition under your general discretion to refuse extradition.

...

[12] One of the matters raised by the appellant for the Minister's consideration, and which assumes particular importance on the appeal, was the circumstances prevailing in prisons in South Africa. His representations referred to recent television programs, as well as newspaper articles and publications, which reported appalling conditions in South African jails. Five such newspaper articles were attached to his submission and were provided in the briefing report to the Minister. The appellant submitted that it was shown by these materials that:

Inmates are gang raped. AIDS are of an epidemic proportions. Assault and murder are regular occurrences. Mafia control the inside of the prisons. Prison wardens are understaffed and prisons over full. Wardens prefer to look [the] other way whilst rape and assault flourishes.

He said that there were factors pertaining to him which made him a particular target.

[13] The first newspaper article referred to corruption in prisons and to the practice of selling young inmates to other inmates for sex. The focus of the second was on an 'UNAIDS' report relating to the AIDS epidemic in South Africa. It contained the following passage:

According to the UNAIDS report men in prisons are at particularly high risk of contracting HIV. In South Africa, according to Gideon Morris of the Judicial Inspectorate's Office, a prison sentence is tantamount to a death sentence by HIV/AIDS. Morris estimated that between 70% and 80% of suspects held in South African jails are raped by fellow prisoners before they are even officially charged.

[14] Another reported Judge Fagan, the Inspecting Judge of Prisons, as saying that about 6000 of the 10 000 prisoners released monthly from South African jails are HIV-positive. The number of 'natural deaths' in prisons was increasing. Almost all of these were AIDS-related and conditions in overcrowded prisons were not conducive to the longevity of those who were HIV-positive, he is reported to have said. Overcrowding remained the root cause of the spread of contagious diseases, including HIV/AIDS.

[15] The fourth report said that the situation in South African jails 'has reached catastrophic proportions, with 45,000 prisoners dying of AIDS-related diseases every year.' The last report referred to prison gangs using HIV infection as punishment. It reported that gang members carrying the HIV virus were ordered to rape disobedient inmates in a ritual known as 'slow puncture', by which the victim would die over a period of time. This information was said to have an official source.

[16] In its response South Africa provided a copy of the annual report by the Inspecting Judge of Prisons, the aforementioned Judge Fagan, for the period 1 April 2002 to 31 March 2003. It pointed out, by reference to that report, that:

... it has not been established exactly how many prison deaths are as the result of HIV/AIDS. In the Annual Report for 2001/2002, it was stated that the number of HIV/AIDS related deaths in prison reflects the pandemic outside prison.... It is therefore not possible at the present time to indicate the incidence of contracting HIV/AIDS whilst in prison in South Africa.

[17] In his reply the appellant reiterated his claims that there was conclusive proof that the prison system 'is inhumane and unjust' by reference to gang rapes and the contraction of the AIDS virus. He also identified overcrowding and unhygienic conditions as relevant to the contraction of the virus.

[18] The briefing report, under the heading 'Discretionary Grounds' advised that extradition might be refused in certain circumstances under the Treaty and identified those referred to in art 3 par 2(g) above. It said however that neither it nor other discretionary grounds for refusal were made out. With respect to this particular basis for refusal it was said:

De Bruyn has made a number of representations claiming that his surrender to South Africa would be oppressive. A copy of these submissions is at Attachments D, E and J for your reference. However, there is no substantial evidence supporting a claim that the surrender of De Bruyn to South Africa would be unjust, oppressive, incompatible with humanitarian considerations or too severe a punishment.

[19] Under 'Submission 2: De Bruyn believes that the conditions in South African prisons are unfavourable', the author of the briefing note referred to and summarised the newspaper articles referred to above and listed the appellant's contentions:

30. De Bruyn has provided several news articles which detail the conditions in some South African prisons. These are attached for your reference at Attachment F. The first taken from The Guardian (dated 27/07/02) discusses the corruption and the abuse of inmates including the rape of younger inmates. The second article is undated and discusses the UNAIDS report of 2000 which found that men in prison in South Africa are at 'particularly high risk of contracting HIV' and further states that 'a prison sentence is tantamount to a death sentence by HIV/AIDS'.

31. The third article (of 21/05/02) states that 6,000 of the 10,000 prisoners released monthly from jail are HIV positive. Deaths from HIV/AIDS in prisons are increasing and include prisoners awaiting trial. It states that the prisons are overcrowded and there are long waiting periods for trials.

32. The fourth article (dated 4/06/01) states that 45,000 prisoners die of AIDS-related diseases every year in South African prisons while the final article dated 21/11/02 from Reuter's states that the prison wardens have been known to use HIV infection as punishment on inmates who misbehave by ordering that infected prisoners rape these inmates. It also points to the 'Jali Commission' which was set up in 2001 to investigate these allegations.

33. De Bruyn contends that 'assault and murder are regular occurrences' in South African prisons, the Mafia 'control the insides of the prison' and prisons 'are understaffed and ... over full.'

34. De Bruyn also believes that he will be a 'target' when in a South African prison because he is educated (he is a qualified chartered accountant with a doctorate in accountancy) and charged with a 'white collar crime.' He fears he will also be branded a 'sell-out' as he emigrated to Australia during the apartheid regime.

35. Being 54 years of age, De Bruyn believes he is in no position to defend himself 'against younger and fitter prisoners.'

[20] South Africa's comments were then referred to:

36. In response to De Bruyn's claims of the high incidence of HIV/AIDS in their prisons, the South African authorities comment that 'it has not been established how many prison deaths are as the result of HIV/AIDS' and that in the 'Annual Report for 2001/2002, it was stated that the number of HIV/AIDS related deaths in prison reflects the pandemic outside prison. It is therefore not possible at the present time to indicate the incidence of contracting HIV/AIDS whilst in prison in South Africa.' A copy of the Annual Report for the period 1 April 2002 to 31 March 2003 by the Inspecting Judge of Prisons, Judge J J Fagan, was attached for our reference. This is at Attachment I.

37. Responding to De Bruyn's claims that he will be a 'target' if given a prison sentence in a South African prison, South African authorities have stated that these allegations are 'with due respect, spurious and based solely on his personal opinion' and further that:

- i. educated prisoners are no more likely to be targeted than uneducated ones;
- ii. his perception that he will be branded as a 'sell-out' is based on out-moded concepts that have no place in present South Africa;
- iii. the ethnic group from which a prisoner comes, has no impact on his/her treatment in present South African prisons; and
- iv. the need to physically defend himself from younger prisoners has no basis.

[21] And the following 'Departmental Comments' were provided to the Minister:

38. The Annual Report to which the South African authority refers, states on page 20 that the natural death rate (ie those deaths caused by illness) among the prison population was 7.75 per 1000 and that 'natural deaths appear to be mostly caused by HIV/AIDS.' When compared with the incidence of HIV/AIDS in Australian prisons (which is around 0.2 per cent), this percentage appears quite high Australia, however, does not suffer from a HIV/AIDS pandemic as does South Africa. It is conceivable that the HIV/AIDS related deaths in prison reflect the situation in South Africa outside the prisons. There is no certainty that De Bruyn will contract HIV/AIDS if made to serve a sentence in a South African prison.

39. Further, the Department has no substantial evidence that De Bruyn will be specifically 'targeted' if made to serve a prison sentence in South Africa.

[22] There was a further submission made to the Minister that the appellant felt that his extradition would be effectively sentencing him to capital punishment, which is an assertion no longer pursued by the appellant. However the departmental comments on this contention were in the same terms as those relating to prison conditions, namely that 'there is no certainty that De Bruyn will contract HIV/AIDS if made to serve a sentence in a South African prison.'

[23] Although it was not a matter then raised by the appellant, the briefing paper necessarily dealt with the requirement of s 22(3)(b) of the Act, that the Minister be satisfied that the appellant would not be subjected to torture following his surrender to South Africa. It said that he could be so satisfied. South Africa had acceded to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on 10 December 1998. It then said:

There is no information available to the Department to support a conclusion that De Bruyn will be subjected to torture on surrender to South Africa.

The primary judge's decision

[24] The appellant was represented by counsel before his Honour the primary judge. Nevertheless reliance was placed

upon the substantial documentation the appellant had supplied which, his Honour noted, was largely irrelevant. His Honour considered that there were three primary grounds advanced in support of the application:

- that the appellant was denied procedural fairness;
- that the Minister erred in concluding that the appellant would not be subjected to torture in South Africa; and
- that the Minister erred in not declining to surrender the appellant on the basis that it would be unjust, oppressive or incompatible with humanitarian considerations to do so.

[25] His Honour rejected the claim of want of procedural fairness. The appellant claimed that he should have had more time to put material before the Minister. That material would have dealt further with conditions in South African jails. His Honour observed however that the appellant had been able to supply a substantial amount of material but in any event had been given an adequate opportunity to do so. He had been allowed a period of weeks in which to put material before the Minister. The extradition proceedings had been in train since 1997.

[26] In relation to the question of torture, relevant to s 22(3)(b) of the Act, his Honour referred to the definition of the word 'torture' provided by the *Shorter Oxford Dictionary*, since the word was not defined in the Act. That definition is, relevantly:

...(the infliction of) severe physical or mental suffering; anguish, agony, torment. ... The infliction of severe bodily pain as a punishment or as a means of interrogation or persuasion; a form or instance of this.

[27] In the Convention referred to in the briefing paper, and which is scheduled to the Crimes (Torture) Act 1988 (Cth), the word 'torture' is defined to mean:

... any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

[28] The appellant's argument before his Honour was that in the South African prison system, violence was often used by prisoners against fellow prisoners for coercive purposes and that the prison officials permitted, if not encouraged, this. His Honour considered that it was most unlikely that the Attorney-General had to be satisfied that no violence would occur in prison before making a decision as to extradition. Violence in prisons was not unknown nor was corruption of prison officials. In his Honour's view s 22(3)(b) of the Act is 'directed at institutionalised torture by government authorities, not at occasional and unpredictable violence occurring in prisons, even with the connivance of corrupt prison officers' (at [15]).

[29] In relation to the discretionary considerations for refusal of surrender, his Honour noted the error made by the relevant officer who had prepared the briefing paper, who had approached the matter on the basis that the Treaty and the new regulations applied. This might suggest that the Minister failed to consider the correct question. Because of the similarity between the relevant parts of the Treaty and the repealed regulations, his Honour then proceeded to examine the differences between the two sets of provisions and then the way in which the matter was dealt with by the Minister. The only relevant difference between the two was that the repealed regulations contained a reference to 'the circumstances of the case' as relevant and the Treaty referred to 'the circumstances of the case, including the age, health or other personal circumstances of the person whose extradition is sought ...'. The additional words in the Treaty provision, in his Honour's view, did no more than make it clear that 'the circumstances of the case' include those personal considerations. One infers that his Honour considered that there would therefore be no significant difference between the provisions and the question for the Minister would have been the same. If anything was added by the reference to personal circumstances, the appellant's personal circumstances had in fact been taken into account. The error therefore could have only worked to his advantage, his Honour observed.

[30] His Honour then turned to consider the arguments concerning the relevance of prison conditions to the question of extradition. His Honour was of the view that it was unlikely that the Parliament intended that the Attorney-General should address the question of the general conditions in prisons in an extradition country in determining whether or not a person ought to be surrendered. Such a consideration was likely to have been made anterior to identifying the country as an extradition country, in drafting the relevant treaty with the country or in making appropriate regulations for the purposes of s 11 of the Act. His Honour went on (at [22]):

This suggests that the words 'the circumstances of the case' should be construed as referring to the particular circumstances of the case in question. That would require a consideration of any special consequences of possible punishment for the relevant person, but not a general consideration of the conditions in the relevant country's gaols.

[31] So far as concerned the material put before the Minister concerning the risk of HIV/AIDS infection in prisons his Honour observed that the accuracy of some of the material might be doubted. However his Honour observed that the material was largely untested and there was no reason to doubt that the HIV/AIDS infection level in prisons is higher than in the general population in South Africa and higher than in other countries, including Australia. There was also no reason to doubt that on occasions prisoners have used HIV infection as a threat or punishment and that corrupt prison officials have been involved in such conduct. His Honour went on (at [32]-[33]):

[32] The Minister was obliged to take into account the nature of the alleged offence and the interests of the requesting country, as well as the considerations raised by Mr De Bruyn. The enforcement of the criminal law is an important aspect of any civilised society. An accused person will readily find arguments for exemption from such enforcement. He or she will always find it unpleasant to contemplate the consequences of a guilty verdict, particularly if imprisonment is likely. Once Mr De Bruyn's case is shorn of its hyperbole, particularly the assertion that any sentence of imprisonment is a death sentence because of the likelihood of HIV/AIDS infection, there is little in it which offers a basis for refusing to surrender him. The conditions in South African gaols may be unsatisfactory, but South Africa's interest in enforcing its criminal law is substantial. There is no reason to believe that Mr De Bruyn will be raped or that he will otherwise fall foul of other prisoners or prison authorities.

[33] Under both the repealed regulations and the new regulations and the Treaty, the Minister was required to determine whether the circumstances of this case should lead to a refusal of surrender. The Minister considered all of the material put before him and decided to permit surrender. There is no rational basis for suggesting that the decision was in any way affected by the erroneous application of the new regulations and Treaty. ... Mr De Bruyn had not demonstrated any operative error in the Minister's approach to this aspect of the case.'

The appeal

[32] The appellant's notice of appeal contains the following grounds:

- (a) There has been a miscarriage of justice in that there was not a fair trial.
 - (b) The judgement is unreasonable or cannot be supported having regard to the whole of the evidence and international laws (unsafe and unsatisfactorily judgement).
- Submissions filed by applicant per instructions from Judge on 15/4/04 not considered. [Name of barrister] never met with applicant, discussed his case and failed to plead submissions. Filed annexures (f) and (g) incorrectly. Failed to prepare for the hearing. Made secret deals with Minister not to plead some material. Failed to file vital material. Legal aid claimed conflict of interest.'

...

[33] The appellant's principal arguments concerning the Minister's decision, inferentially not appreciated by his Honour the primary judge, were that his material and representations were not considered by the Minister and as a result the Minister failed to appreciate the degree of risk to which he would be put of HIV/AIDS infection if he were returned to South Africa and incarcerated. He contended that the Minister had a duty to enquire into the numbers of persons who had become infected

and sought to put before the Courts supplementary material which might have been available to the Minister had he sought it. The material has not been accepted by the Court but I observe that it does not appear to add much to the earlier material.

[34] The appellant contended that the Minister was wrong, and his Honour also wrong, in determining that he would not be subjected to torture. This contention rested upon the fact that prison gangs raped prisoners and put them deliberately at risk of HIV/AIDS infection. This was apparent from the newspaper articles but the Minister did not address this issue. The appellant's point is that the Minister failed to characterise the conduct of the gangs as torture.

[35] The appellant also submitted that it was unreasonable or unfair and unjust to return him to South Africa if he could not be placed in protective custody. South Africa had advised that he would not be. This was not a point which was raised before his Honour, but in any event it has regard to the same allegations concerning the prison conditions which are to be considered in relation to the requirements of reg 5(4)(b) of the Regulations.

Consideration of the appeal

[36] The question as to whether the prison conditions referred to in the newspaper articles, concerning the rape of inmates by gang members, amounts to torture was not raised before the Minister. As his Honour's reasons disclose however the conclusion reached by the Minister, that the appellant would not be subjected to torture if surrendered, is correct. It is supported by a consideration of the meaning to be given to the term 'torture.' His Honour held that the reference to torture in the Act is directed to institutionalised conduct by government authorities for the purpose of punishment, intimidation or coercion. I respectfully agree. The conduct identified by the appellant, of inmates towards other inmates, is not of this kind. And it is not converted to institutionalised conduct in the sense referred to by his Honour because some corrupt wardens ignore or even encourage it.

[37] The case put forward by the appellant contained assertions that he was at particular risk of being raped and contracting HIV because of factors personal to him. They were not accepted in the briefing note, on the basis that there was no evidence to support them. The appellant's claims in this regard were mere assertions, unaccompanied by any material to support them. No relevant error is disclosed in such an approach.

[38] There were however newspaper reports which provided the basis for the appellant's claim that male prisoners generally in South African jails were at high risk of infection of HIV as a result of rape by fellow inmates and through overcrowding. The reference in par 38 of the briefing note to figures of 7.75 per 1000 as the rate of natural death in the prison population, caused primarily by HIV/AIDS, may suggest that the higher figures referred to in some newspaper reports were not accepted by the author of the briefing note as being as reliable as the Annual Report of the South African authorities, but that is as far as any assessment of the reports, and the appellant's claims based upon them, goes.

[39] His Honour the primary judge held that there was no reason to believe that the appellant would be raped in prison. With respect, that was not a finding made in the briefing note and is not one which can be attributed to the Minister. The briefing note, drawing upon a reference in the submissions for South Africa, merely observed that it was 'conceivable' that the rate of HIV/AIDS-related deaths was the same in prison as it was outside, in the general population. It was therefore unknown or 'uncertain' whether the appellant would contract HIV/AIDS if he was in prison.

[40] It was submitted for the Minister that the Court ought to assume that the Minister had read all of the material. In any event the summaries of the newspaper reports drew his attention to the allegations. The Court should therefore infer that the Minister had considered and rejected them.

[41] The difficulty with the submission is that there is nothing in the briefing note to suggest they were given any consideration. It might follow, logically, that if the rate of HIV/AIDS-related deaths was the same in the general population, then an argument that the prison deaths resulted from the rape of inmates or from overcrowding might be substantially undermined. But this

conclusion could not be reached because the facts were unknown. The Minister was dealing with a matter about which there was speculation and did not address the matters raised in the newspaper reports. They were simply by-passed to a conclusion of uncertainty. It is that conclusion which needs to be considered, in light of the Act and the Regulations.

...

[42] I do not suggest that the failure of the Minister to make findings as to the appellant's case itself involves jurisdictional error. The Minister may be taken to have regarded the question as not material to his considerations: *Minister for Immigration and Multicultural Affairs v Yusuf* (2001) 206 CLR 323 at [36], [37] and [74]. They were not material to the Minister's decision, one may observe from par 38 of the briefing note, because he considered that, unless one could be *certain* that the appellant would contract HIV/AIDS, it would not be oppressive or contrary to humanitarian considerations to surrender him. This approach denies the prospect that exposure to a level of risk of infection should be considered as incompatible with humanitarian considerations.

[43] Provisions such as reg 5(4) of the Regulations have been regarded as referring *broadly* to circumstances where it would be incompatible with humanitarian considerations to surrender the person: EP Aughterson, *Extradition: Australian Law and Procedure*, LBC, Sydney, 1995, p 171. The author points out that Anderson ('Protecting the Rights of the Requested Person in Extradition Proceedings: An Argument for a Humanitarian Exception', *Mich YB Int'l Leg Stud*, 1983, p 153 at p 154) cites three types of humanitarian claims: that the trial in the requesting state will be or was unfair; that the awaiting punishment will be excessive or cruel; and that the requesting country will be unable or does not intend to protect the requested person from assassination attempts. Aughterson (at p 172) also observed that the personal circumstances of the person are to be taken into account.

[44] That the 'circumstances of the case' include the personal circumstances of the person the subject of the extradition request is clarified by art 3 par (2)(g) of the Treaty. But the phrase has a wider operation. The identification of three types of claims is not to be taken as exhaustive. There is nothing in reg 5(4) nor in the Act which would suggest any limitation on factors which might arise following upon the surrender of the person which may affect them in such a way as to be incompatible with humanitarian considerations, nor that certainty is required in coming to a conclusion that there is present in a particular case humanitarian considerations which ought to weigh against surrender. In any event, exposure to the risk of HIV/AIDS may amount to a threat to the life and well-being of the person, in which case it is not dissimilar to the third type of claim. And such a threat, arising from prison conditions, may be viewed as associated with the punishment the person would receive if surrendered.

[45] For the reason that there is nothing in the terms of the Act or its purposes to indicate a limitation upon the circumstances pertaining to the person and their surrender in the context of humanitarian considerations I am unable, respectfully, to agree with His Honour the primary judge that prison conditions are excluded from consideration. Even if prison conditions in the requesting country were addressed prior to extradition arrangements being put in place, circumstances change. It cannot be taken as intended to exclude consideration of circumstances which may well qualify as inhumane. I am also unable to infer that the Minister approached the matter in this way. Whilst no detailed consideration was given the allegations of fact relating to conditions in South African prisons, the rate of deaths in prison was addressed. The Minister did not exclude the entire topic from consideration in connection with the 'circumstances of the case.' In that approach the Minister was correct.

[46] I am not suggesting that any exposure to risk of rape and HIV/AIDS infection would suffice as a humanitarian consideration which would weigh against surrender. As his Honour the primary judge correctly pointed out, prison conditions in countries such as Australia include some such risks. But there may well be a point where the level of risk or threat arising from conditions in the prison of the requesting country is

so high as to come within the circumstances of which the regulation speaks. That assessment is one for the Minister.

[47] In my view the Minister's decision involved an incorrect understanding of what may amount to humanitarian considerations for the purpose of reg 5(4) of the Regulations. Jurisdictional error has therefore been made out: *Minister for Immigration and Multicultural Affairs v Yusuf* at [84]. The notice of appeal did not contain this ground. The respondent however conceded on the hearing of the appeal that he would not be prejudiced if the Court were to treat the notice as amended so as to raise it.

[48] The appeal should be allowed and the orders of the primary judge set aside. In lieu of those orders the determination of the respondent made on 29 January 2004 should be set aside and the warrant signed on 29 January 2004 quashed.

...

***N v Secretary of State for the Home Department* 2005 (4)
All ER 1017 (UKHL 2005 31)**

The appellant came to the United Kingdom from Uganda. On her arrival she was diagnosed as suffering from advanced AIDS-related illnesses. She was provided with anti-retroviral treatment but was refused leave to enter and her claim for asylum was refused by the Secretary of State. The appellant's appeal to the Court of Appeal failed on the grounds that her evidence did not bring her case within the 'extreme' class of case to which it had to belong as a claim based on article 3 of the European Convention on Human Rights. She appealed to the House of Lords and the court decided that the applicant's condition was not critical. She was deemed fit to travel, and would remain fit if, and so long as, she could obtain treatment in Uganda, which was available but at a considerable cost.

Excerpts

...

Lord Nicholls of Birkenhead

Facts

[1] My Lords, this appeal raises a question of profound importance about the human rights obligations of the United Kingdom in respect of the expulsion of people living with HIV. The appellant, a woman 30 years of age, comes from Uganda. She was born there in December 1974. She came to London on a flight from Entebbe in March 1998. She was refused leave to enter this country. Her claim for asylum was rejected. The Secretary of State proposes to expel her. But there is a tragic complication: she suffers from advanced HIV/AIDS (full blown AIDS, in the old terminology).

[2] When the appellant arrived here she was very poorly. Within hours she was admitted to Guy's Hospital. She was diagnosed as HIV positive, with an AIDS defining illness. In August 1998 she developed a second AIDS defining illness, Kaposi's sarcoma. The CD4 cell count of a normal healthy person is over 500. Hers was down to 10.

[3] As a result of modern drugs and skilled medical treatment over a lengthy period, including a prolonged course of systematic chemotherapy, the appellant is now much better. Her CD4 count has risen to 414. Her condition is stable. Her doctors say that if she continues to have access to the drugs and medical facilities available in the United Kingdom she should remain well for 'decades'. But without these drugs and facilities her prognosis is 'appalling': she will suffer ill-health, discomfort, pain and death within a year or two. This is because the highly active anti-retroviral medication she is currently receiving does not cure her disease. It does not restore her to her pre-disease state. The medication replicates the functions of her compromised immune system and protects her from the consequences of her immune deficiency while, and only while, she continues to receive it.

[4] The cruel reality is that if the appellant returns to Uganda her ability to obtain the necessary medication is problematic. So if she returns to Uganda and cannot obtain the medical assistance

she needs to keep her illness under control, her position will be similar to having a life-support machine switched off.

[5] The history of the appellant's proceedings can be summarised shortly. On 28 March 2001 the Secretary of State refused her application for asylum. On 10 July 2002 the adjudicator, Mr Paul Norris, dismissed the appellant's appeal from that asylum decision. But he allowed her appeal on the ground that to return her to Uganda would be a breach of her convention right under art 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Sch 1 to the Human Rights Act 1998). He said that on the evidence her case for protection under article 3 was 'overwhelming'.

[6] On 20 February 2003 the Immigration Appeal Tribunal allowed an appeal by the Secretary of State. The appellant appealed to the Court of Appeal ([2003] EWCA Civ 1369, [2004] 1 WLR 1182). The court, comprising Laws, Dyson and Carnwath LJ, held unanimously that the tribunal's conclusion was flawed for want of legally sufficient reasons. But by a majority, comprising Laws and Dyson LJ, the appeal was dismissed on the ground that the appellant's evidence did not bring her case within that 'extreme' class of case to which it must belong if a claim based on article 3 is to succeed (see [2004] 1 WLR 1182 at [43], [49]). Carnwath LJ would have remitted the case to the tribunal for re-determination.

...

[8] Clearly there is no question of any breach of article 3 so long as the appellant remains here. So long as she is in this country she, like everyone else here, will continue to receive the medical treatment on which her health and life are dependent. The question is whether the act of expelling the appellant would itself be inhuman treatment within article 3. Unlike the separatist Sikh in *Chahal v UK* (1996) 1 BHRC 405, the appellant if expelled is not at risk of being subjected to intentional ill-treatment in her home country. The adverse prospect confronting the appellant in Uganda is of a different character. It derives from Uganda's lack of medical resources compared with those available in the United Kingdom. Thus the all-important question is whether expelling the appellant would be inhuman treatment within article 3 given the uncertainties confronting her in Uganda through shortage of the necessary drugs and medical facilities there.

...

[13] The difficulty posed by this decision is that, with variations in degree, the humanitarian considerations existing in the case of *D v UK* are not 'very exceptional' in the case of AIDS sufferers. In the case of *D v UK* the applicant was 'in the final stage of a terminal illness, AIDS, and had no prospect of medical care or family support on expulsion to St Kitts': see the court's appraisal of the 'exceptional circumstances' of *D v UK* in *Bensaid v UK* (2001) 11 BHRC 297 at 309 (paragraph 40). If unavailability of appropriate medical care or family support was regarded as an exceptional circumstance for the purpose of art 3 in the case of *D v UK*, why is this not equally so in the case of other AIDS sufferers? In *D v UK* there was the additional feature that D was dying. But the appellant's condition in the present case will rapidly become terminal, as soon as her life-preserving medication is discontinued. This prompts a further question: why is it *unacceptable* to expel a person whose illness is irreversible and whose death is near, but *acceptable* to expel a person whose illness is under control but whose death will occur once treatment ceases (as may well happen on deportation)?

...

[15] Is there, then, some other rationale underlying the decisions in the many immigration cases where the Strasbourg court has distinguished *D v UK*? I believe there is. The essential distinction is not to be found in humanitarian differences. Rather it lies in recognising that art 3 does not require contracting states to undertake the obligation of providing aliens indefinitely with medical treatment lacking in their home countries. In the case of *D v UK* and in later cases the Strasbourg court has constantly reiterated that in principle aliens subject to expulsion cannot claim any entitlement to remain in the territory of a contracting state in order to continue to benefit from medical, social and other forms of assistance provided by the expelling state. Article 3 imposes no such 'medical care' obligation on con-

tracting states. This is so even where, in the absence of medical treatment, the life of the would-be immigrant will be significantly shortened. But in the case of *D v UK*, unlike the later cases, there was no question of imposing any such obligation on the United Kingdom. D was dying, and beyond the reach of medical treatment then available.

[16] I express the obligation in terms of provision of medical care because that is what cases of this type are all about. The appellant, and others in her position, seek admission to this country for the purpose of obtaining the advantages of the medical care readily available to all who are here. What the appellant seeks in this case is the right to remain here so that she may continue to receive this medical treatment.

[17] That the appellant should seek to do so is, of course, eminently understandable. But, as the Strasbourg jurisprudence confirms, article 3 cannot be interpreted as requiring contracting states to admit and treat AIDS sufferers from all over the world for the rest of their lives. Nor, by the like token, is article 3 to be interpreted as requiring contracting states to give an extended right to remain to would-be immigrants who have received medical treatment while their applications are being considered. If their applications are refused, the improvement in their medical condition brought about by this interim medical treatment, and the prospect of serious or fatal relapse on expulsion, cannot make expulsion inhuman treatment for the purposes of article 3. It would be strange if the humane treatment of a would-be immigrant while his immigration application is being considered were to place him in a better position for the purposes of article 3 than a person who never reached this country at all. True it is that a person who comes here and receives treatment while his application is being considered will have his hopes raised. But it is difficult to see why this should subject this country to a greater obligation than it would to someone who is turned away at the port of entry and never receives any treatment.

...

[19] For these reasons, which are substantially the same as those of Lord Hope of Craighead and Lord Brown of Eaton-under-Heywood, I would dismiss this appeal.

Lord Hope of Craighead

[20] My Lords, the decision which your Lordships have been asked to take in this case will have profound consequences for the appellant. The prospects of her surviving for more than a year or two if she is returned to Uganda are bleak. It is highly likely that the advanced medical care which has stabilised her condition by suppressing the HIV virus and would sustain her in good health were she to remain in this country for decades will no longer be available to her. If it is not, her condition is likely to reactivate and to deteriorate rapidly. There is no doubt that if that happens she will face an early death after a period of acute physical and mental suffering. It is easy to sympathise with her in this predicament.

...

[22] Lord Bingham of Cornhill described the judicial task in *Brown v Stott (Procurator Fiscal, Dunfermline)* [2001] 2 All ER 97 at 114, [2003] 1 AC 681 at 703, in this way:

In interpreting the convention, as any other treaty, it is generally to be assumed that the parties have included the terms which they wished to include and on which they were able to agree, omitting other terms which they did not wish to include or on which they were not able to agree. Thus particular regard must be had and reliance placed on the express terms of the convention, which define the rights and freedoms which the contracting parties have undertaken to secure. This does not mean that nothing can be implied into the convention. The language of the convention is for the most part so general that some implication of terms is necessary, and the case law of the European Court shows that the court has been willing to imply terms into the convention when it was judged necessary or plainly right to do so. But the process of implication is one to be carried out with caution, if the risk is to be averted that the contracting parties may, by judicial interpretation, become bound by obligations which they did not expressly accept and might not have been willing to accept. As an important constitutional instrument the convention is to be seen as a 'living tree capable of growth and expansion within its natural limits' (*Edwards v A-G for Canada* [1930] AC 124 at 136

[1929] All ER Rep 571 at 577) per Lord Sankey LC), but those limits will often call for very careful consideration.

[23] The issue in this case has to be seen against that background. The need for careful consideration is made all the more acute by the fact that it is not the words of art 3 of the convention that we are being asked to construe but the jurisprudence of the European Court of Human Rights in Strasbourg which explains the application of that article in its decision in *D v UK* (1997) 2 BHRC 273. There is no question in this case of the appellant having been subjected to inhuman or degrading treatment in this country. Nor has it been suggested that there is any risk of her being subjected to any of the forms of treatment that article 3, page 1026 of [2005] 4 All ER 1017 proscribes from intentionally inflicted acts of the public authorities in Uganda or from those of non-state agents in that country against which the authorities there are unable to afford her appropriate protection. We are dealing here with a decision of the Strasbourg court which created what the Court of Appeal rightly accepted was an 'extension of an extension' to the article 3 obligation: see [2003] EWCA Civ 1369 at [37], [2004] 1 WLR 1182 at [37], per Laws LJ; Dyson LJ (at [46]). Our task is to determine the limits of that extension, not to enlarge it beyond the limits which the Strasbourg court has set for it.

...

[32] Here the court concentrated on the advanced state of his illness, on the availability of sophisticated treatment and medication in this country, on the care and kindness administered by the charitable organisation and on what the abrupt withdrawal of these facilities would mean for him. It was not just that his removal would hasten his death. There was a serious danger that the conditions in St Kitts would further reduce his limited life expectancy and subject him to acute mental and physical suffering. There was no evidence that any person was available to attend to the needs of what the court described in paragraph 52 as 'a terminally ill man' or of any other form of moral or social support. The court concluded (at 285 (paragraph 53)) that in view of these exceptional circumstances and bearing in mind what it described as 'the critical stage reached the applicant's fatal illness' it would be a breach of article 3 for him to be removed to St Kitts. In paragraph 53 it explained that, although it could not be said that the conditions in the receiving country were themselves a breach of the standard of article, his removal would expose him to a real risk of dying under the most distressing circumstances and that this would amount to inhuman treatment.

[33] The court concluded its assessment in paragraph 54 by emphasising that aliens who have served their prison sentences and are subject to expulsion cannot in principle claim any entitlement to remain on the territory of a contracting state in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state during their stay in prison. While this statement was directed to applicants whose stay in the contracting state has been prolonged by a prison sentence during which they have become accustomed to receiving the benefit of various forms of assistance, it must be understood as applying more generally. This is because a comparison between the health benefits and other forms of assistance which are available in the expelling state with those in the receiving country does not in itself give rise to an entitlement to remain in the territory of the expelling state. It was only because of the exceptional circumstances that were identified in D's case that he was found to be entitled to the absolute protection of article 3.

...

[35] It has to be said that it would have been helpful if the court had done more to identify the criterion by which such cases were to be identified. The phrase 'exceptional circumstances' does not provide that kind of guidance. It treats the issue as one of fact. But the judgment does not lack statements of principle. In paragraph 54 it is stated that aliens cannot in principle claim any entitlement to remain on the territory of a contracting state in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state. Without qualification, the application of this principle to D's case would have led to the conclusion that the decision to remove him would not be a violation of article 3. The court was clearly anxious not

to say anything that would undermine this principle. As Judge Pettiti said, a comparison between the medical and social benefits available in the respective states was not the criterion adopted.

[36] What was it then that made the case exceptional? It is to be found, I think, in the references to D's 'present medical condition' (para 50) and to that fact that he was terminally ill (paragraph 51: 'the advanced stages of a terminal and incurable illness'; paragraph 52: 'a terminally ill man'; paragraph 53: 'the critical stage now reached in the applicant's fatal illness'; Judge Pettiti: 'the final stages of an incurable disease'). It was the fact that he was already terminally ill while still present in the territory of the expelling state that made his case exceptional.

...

[48] The conclusion that I would draw from this line of authority is that Strasbourg has adhered throughout to two basic principles. On the one hand, the fundamental nature of the article 3 guarantees applies irrespective of the reprehensible conduct of the applicant. It makes no difference however criminal his acts may have been or however great a risk he may present to the public if he were to remain in the expelling state's territory. On the other hand, aliens who are subject to expulsion cannot claim any entitlement to remain in the territory of a contracting state in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state. For an exception to be made where expulsion is resisted on medical grounds the circumstances must be exceptional. In May 2000 Mr Lorenzen, a judge of the Strasbourg court, observed at a colloquy in Strasbourg that it was difficult to determine what was meant by 'very exceptional circumstances'. But subsequent cases have shown that *D v UK* is taken as the paradigm case as to what is meant by this formula. The question on which the court has to concentrate is whether the present state of the applicant's health is such that, on humanitarian grounds, he ought not to be expelled unless it can be shown that the medical and social facilities that he so obviously needs are actually available to him in the receiving state. The only cases where this test has been found to be satisfied are *D v UK*, where the fatal illness had reached a critical stage, and *BB v France* RJD 1998-VI page 2596 where the infection had already reached an advanced stage necessitating repeated stays in hospital and the care facilities in the receiving country were precarious. I respectfully agree with Laws LJ's observation in the Court of Appeal ([2004] 1 WLR 1182 at [39]), that the Strasbourg court has been at pains in its decisions to avoid any further extension of the exceptional category of case which *D v UK* represents.

...

The facts in this case

[51] The appellant's disease had reached an advanced stage by November 1998 when the anti-retroviral treatment was prescribed for her. Her CD4 count at presentation was just 10 cells/mm³, indicating severe damage to her immune system, and she was suffering from various AIDS defining illnesses. But as a result of the treatment her condition has now stabilised. So long as she continues to take the treatment she will remain healthy and she will have several decades of good health to look forward to. Her present condition cannot be said to be critical. She is fit to travel, and will remain fit if and so long as she can obtain the treatment that she needs when she returns to Uganda. The evidence is that the treatment that she needs is available there, albeit at considerable cost. She also still has relatives there, although her position is that none of them would be willing and able to accommodate and take care of her. In my opinion her case falls into the same category as *SCC v Sweden*, *Henao v The Netherlands*, *Ndangoya v Sweden* and *Amegnigan v The Netherlands*, where the court has consistently held that the test of exceptional circumstances has not been satisfied. In my opinion the court's jurisprudence leads inevitably to the conclusion that her removal to Uganda would not violate the guarantees in art 3 of the convention.

[52] The corollary of what I have just said is that a decision that her appeal should nevertheless be allowed would amount to an extension of the exceptional category of case which is represented by *D v UK* (1997) 2 BHRC 273. As I said at the start of this opinion, it is not open to the national court to extend the

scope of the convention in this way. If an extension is needed to keep pace with medical developments, this must be left to the Strasbourg court.

[53] It must be borne in mind too that the effect of any extension would be to widen still further the gap that already exists between the scope of articles 32 and 33 of the Refugee Convention and the reach of article 3 of the European Human Rights Convention to which the Strasbourg court referred in *Chahal v UK* (1996) 1 BHRC 405 at 424 (paragraph 80). It would have the effect of affording all those in the appellant's condition a right of asylum in this country until such time as the standard of medical facilities available in their home countries for the treatment of HIV/AIDS had reached that which is available in Europe. It would risk drawing into the United Kingdom large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources that are available in this country. This would result in a very great and no doubt unquantifiable commitment of resources which it is, to say the least, highly questionable the states parties to the convention would ever have agreed to. The better course, one might have thought, would be for states to continue to concentrate their efforts on the steps which are currently being taken, with the assistance of the drugs companies, to make the necessary medical care universally and freely available in the countries of the third world which are still suffering so much from the relentless scourge of HIV/AIDS.

Conclusion

[54] I agree with my noble and learned friend Lord Brown of Eaton-under-Heywood that the temptation to remit this case for further consideration of the facts should be resisted. I would dismiss the appeal.

Lord Walker of Gestingthorpe

...

[56] My Lords, the appellant is HIV positive and as a result has contracted a number of serious diseases. These have been successfully treated but of course she remains HIV positive. Her immune system is seriously and permanently compromised. These days sophisticated drug treatment can restore her ability to withstand infection. With it, she is currently well and can expect to remain so for decades. Without it, if she is exposed to infections, she can expect that they will take hold and, unless treated, kill her within a period of at most two years.

...

[60] Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in schedule 1 to the Human Rights Act 1998) is in absolute terms: 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment.' The test applied by the adjudicator was that set out in paragraph 2.1 of the Asylum Directorate's 1998 Instructions on the Grant of Exceptional Leave to Remain, which was obviously drawn from the decision of the European Court of Human Rights in *D v UK* (1997) 2 BHRC 273:

Where there is *credible* medical evidence that return, due to the medical facilities in the country concerned, would reduce the applicant's life expectancy and subject him to acute physical and mental suffering, in circumstances where the UK can be regarded as having assumed responsibility for his care.

The adjudicator had no doubt that all the requirements of that paragraph had been met in this case and that returning her to Uganda would be a breach of her article 3 rights.

...

[66] In the most recent of these cases, *Amegnigan v The Netherlands*, 25 November 2004, the court was faced with evidence that 'as soon as the anti-HIV therapy was stopped, the applicant would fall back to the advanced stage of the disease which, given its incurable nature, would entail a direct threat for life' (page 4) but that 'the HIV virus would be suppressed as long the applicant would continue taking medication, so that there was no direct threat for life' (page 5). It nevertheless concluded that, unlike the situation in *D v UK*

it does not appear that the applicant's illness has attained an advanced or terminal stage, or that he has no prospect of medical care or family support in Togo where his mother and a

young brother are residing. The fact that the applicant's circumstances in Togo would be less favourable than those he enjoys in the Netherlands cannot be regarded as decisive from the point of view of art 3 of the convention.

To this extent, therefore, the court has confronted the problem that in this country HIV is a long term but treatable illness whereas in sub-Saharan Africa for all but the tiny minority who can secure treatment it is a death sentence.

[67] The notion of compelling humanitarian considerations was invoked by Laws LJ in this case ([2004] 1 WLR 1182 at [40]):

... I would hold that the application of article 3 where the complaint in essence is of want of resources in the applicant's home country (in contrast to what has been available to him in the country from which he is to be removed) is only justified where the humanitarian appeal of the case is so powerful that it could not in reason be resisted by the authorities of a civilised state.

I do not find that concept at all helpful. The humanitarian appeal of this case is very powerful indeed. None of us wishes to send a young woman, who has already suffered so much but is now well cared for and with a future ahead of her, home to the likelihood of an early death in a much less favourable environment. But sadly her circumstances are not exceptional. There are millions of people in the world who are HIV positive, many of them in sub-Saharan Africa; thousands of people arrive in this country every year without leave to enter or remain but are for one reason or another able to stay here for some considerable time during which they will usually receive the medical care they need; the antiretroviral therapy now available here can, for as long as it continues, restore the compromised immune system to such an extent that life expectancy is greatly enhanced; for the fortunate few that or at least some therapy may be available in their home countries, but for most it will remain only a theoretical possibility for many years to come. If, as Laws LJ went on to say, the facts must be not only exceptional but extreme, she would not qualify.

[68] In common with Dyson LJ, I have found helpful the concurring opinion of Judge Pettiti in *D v UK* (1997) 2 BHRC 273 at 290:

The inequality of medical treatment was not the criterion adopted by the Court as medical equipment in the member states of the UN is, alas, not all of the same technological standard; the case of D, however, is concerned not with hospital treatment in general, but only with the deportation of a patient in the final stages of an incurable disease.

As Lord Hope's analysis shows, the later cases have made it clear that it is the patient's present medical condition which is the crucial factor. The difficulty is in understanding where conditions in the receiving country fit into the analysis. Even in those cases where the illness is not in an advanced or terminal stage, the court does refer to the medical care and family support available there. But it does so in terms of there being 'no prospect' of such care or support, rather than in terms of its being likely to be available. It is difficult to see, therefore, whether this consideration adds anything in those cases. Where the illness is in an advanced or terminal stage, then conditions in the receiving country should be crucial. It is not yet clear whether the applicant has to show that appropriate care and support during those final stages was unlikely to be available or whether again the 'no prospect' test applies. That was undoubtedly the situation in *D v UK* and the court has made it clear that the 'compelling humanitarian considerations' are those which arise in a case where the facts come close to those in *D v UK*. But if it is indeed the case that this class of case is limited to those where the applicant is in the advanced stages of a life-threatening illness, it would appear inhuman to send him home to die unless the conditions there will be such that he can do so with dignity. As the European court said in *Pretty v UK* (2002) 35 EHRR 1 at 37 (paragraph 65), 'The very essence of the Convention is respect for human dignity and human freedom.'

[69] In my view, therefore, the test, in this sort of case, is whether the applicant's illness has reached such a critical stage (ie he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity. This is to the same effect as the text prepared by my noble and learned friend, Lord Hope of

Craighead. It sums up the facts in *D v UK*. It is not met on the facts of this case.

[70] There may, of course, be other exceptional cases, with other extreme facts, where the humanitarian considerations are equally compelling. The law must be sufficiently flexible to accommodate them. The European Court of Human Rights took very seriously the claim of the schizophrenic patient in *Bensaid v UK* (2001) 11 BHRC 297 who risked relapse into hallucinations and psychotic delusions involving self harm and harm to others if deprived of appropriate medication. But it nevertheless concluded at 309 (paragraph 40):

Having regard however to the high threshold set by article 3, particularly where the case does not concern the direct responsibility of the contracting state for the infliction of harm, the court does not find that there is a sufficiently real risk that the applicant's removal in these circumstances would be contrary to the standards of article 3. It does not disclose the exceptional circumstances of *D v UK*... where the applicant was in the final stages of a terminal illness, AIDS, and had no prospect of medical care or family support on expulsion to St Kitts.

[71] For these reasons I conclude that we would be implying far more into our obligations under article 3 than is warranted by the Strasbourg jurisprudence, if we were to allow the appeal in this case, much though I would like to be able to do so.

...

Appeal dismissed.

...

E3.8 HIV and sexual orientation

Toonen v Australia (1994) Human Rights Committee

The complainant is a gay activist for the promotion of the rights of homosexuals in Tasmania, one of Australia's six constitutive states. He challenged, before the Human Rights Committee, several provisions of the Tasmanian Criminal Code that criminalise sexual acts between men in private. In its decision, the Human Rights Committee rejected the submission of the Tasmanian authorities that the challenged provisions were justified on public health grounds to prevent the spread of HIV. The Committee held that 'the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV' because it runs 'counter to the implementation of effective education programmes in respect of HIV prevention'.

Excerpts

...

Facts

[2.1] The author is an activist for the promotion of the rights of homosexuals in Tasmania, one of Australia's six constitutive states. He challenges two provisions of the Tasmanian Criminal Code, namely sections 122(a) and (c) and 123, which criminalise various forms of sexual contacts between men, including all forms of sexual contacts between consenting adult homosexual men in private.

[2.2] The author observes that the above sections of the Tasmanian Criminal Code empower Tasmanian police officers to investigate intimate aspects of his private life and to detain him, if they have reason to believe that he is involved in sexual activities which contravene the above sections. He adds that the Director of Public Prosecutions announced, in August 1988, that proceedings pursuant to sections 122(a), (c) and 123 would be initiated if there was sufficient evidence of the commission of a crime.

[2.3] Although in practice the Tasmanian police has not charged anyone either with 'unnatural sexual intercourse' or 'intercourse against nature' (section 122) nor with 'indecent practice between male persons' (section 123) for several years, the author argues that because of his long-term relationship with another man, his active lobbying of Tasmanian politicians and the reports about his activities in the local media, and because of his activities as a gay rights activist and gay HIV and AIDS worker, his private life and his liberty are threatened by the continued existence of sections 122(a), (c) and 123 of the Criminal Code.

[2.4] Mr. Toonen further argues that the criminalisation of homosexuality in private has not permitted him to expose openly his sexuality and to publicise his views on reform of the relevant laws on sexual matters, as he felt that this would have been extremely prejudicial to his employment. In this context, he contends that sections 122(a), (c) and 123 have created the conditions for discrimination in employment, constant stigmatisation, vilification, threats of physical violence and the violation of basic democratic rights.

[2.5] The author observes that numerous 'figures of authority' in Tasmania have made either derogatory or downright insulting remarks about homosexual men and women over the past few years. These include statements made by members of the Lower House of Parliament, municipal councillors (such as 'representatives of the gay community are no better than Saddam Hussein'; 'the act of homosexuality is unacceptable in any society, let alone a civilised society'), of the church and of members of the general public, whose statements have been directed against the integrity and welfare of homosexual men and women in Tasmania (such as '[g]ays want to lower society to their level'; 'You are 15 times more likely to be murdered by a homosexual than a heterosexual...'). In some public meetings, it has been suggested that all Tasmanian homosexuals should be

rounded up and 'dumped' on an uninhabited island, or be subjected to compulsory sterilisation. Remarks such as these, the author affirms, have had the effect of creating constant stress and suspicion in what ought to be routine contacts with the authorities in Tasmania.

[2.6] The author further argues that Tasmania has witnessed, and continues to witness, a 'campaign of official and unofficial hatred' against homosexuals and lesbians. This campaign has made it difficult for the Tasmanian Gay Law Reform Group to disseminate information about its activities and advocate the decriminalisation of homosexuality. Thus, in September 1988, for example, the TGLRG was refused permission to put up a stand in a public square in the city of Hobart, and the author claims that he, as a leading protester against the ban, was subjected to police intimidation.

[2.7] Finally, the author argues that the continued existence of sections 122(a), (c) and 123 of the Criminal Code of Tasmania continue to have profound and harmful impacts on many people in Tasmania, including himself, in that it fuels discrimination and harassment of, and violence against, the homosexual community of Tasmania.

The complaint

...

[3.2] For the author, the only remedy for the rights infringed by sections 122(a), (c) and 123 of the Criminal Code through the criminalisation of all forms of sexual activity between consenting adult homosexual men in private would be the repeal of these provisions.

[3.3] The author submits that no effective remedies are available against sections 122(a), (c) and 123. At the legislative level, state jurisdictions have primary responsibility for the enactment and enforcement of criminal law. As the Upper and Lower Houses of the Tasmanian Parliament have been deeply divided over the decriminalisation of homosexual activities and reform of the Criminal Code, this potential avenue of redress is said to be ineffective. The author further observes that effective administrative remedies are not available, as they would depend on the support of a majority of members of both Houses of Parliament, support which is lacking. Finally, the author contends that no judicial remedies for a violation of the Covenant are available, as the Covenant has not been incorporated into Australian law, and Australian courts have been unwilling to apply treaties not incorporated into domestic law.

The Committee's admissibility decision

[5.1] During its forty-sixth session, the Committee considered the admissibility of the communication. As to whether the author could be deemed a 'victim' within the meaning of article 1 of the Optional Protocol, it noted that the legislative provisions challenged by the author had not been enforced by the judicial authorities of Tasmania for a number of years. It considered, however, that the author had made reasonable efforts to demonstrate that the threat of enforcement and the pervasive impact of the continued existence of these provisions on administrative practices and public opinion had affected him and continued to affect him personally, and that they could raise issues under articles 17 and 26 of the Covenant. Accordingly, the Committee was satisfied that the author could be deemed a victim within the meaning of article 1 of the Optional Protocol, and that his claims were admissible *ratione temporis*.

[5.2] On 5 November 1992, therefore, the Committee declared the communication admissible inasmuch as it appeared to raise issues under articles 17 and 26 of the Covenant.

...

Examination of the merits

[8.1] The Committee is called upon to determine whether Mr. Toonen has been the victim of an unlawful or arbitrary interference with his privacy, contrary to article 17(1), and whether he has been discriminated against in his right to equal protection of the law, contrary to article 26.

[8.2] Inasmuch as article 17 is concerned, it is undisputed that adult consensual sexual activity in private is covered by the

concept of 'privacy', and that Mr. Toonen is actually and currently affected by the continued existence of the Tasmanian laws. The Committee considers that sections 122(a), (c) and 123 of the Tasmanian Criminal Code 'interfere' with the author's privacy, even if these provisions have not been enforced for a decade. In this context, it notes that the policy of the Department of Public Prosecutions not to initiate criminal proceedings in respect of private homosexual conduct does not amount to a guarantee that no actions will be brought against homosexuals in the future, particularly in the light of undisputed statements of the Director of Public Prosecutions of Tasmania in 1988 and those of members of the Tasmanian Parliament. The continued existence of the challenged provisions therefore continuously and directly 'interferes' with the author's privacy.

[8.3] The prohibition against private homosexual behaviour is provided for by law, namely, sections 122 and 123 of the Tasmanian Criminal Code. As to whether it may be deemed arbitrary, the Committee recalls that pursuant to its General Comment 16[32] on article 17, the 'introduction of the concept of arbitrariness is intended to guarantee that even interference provided for by the law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the circumstances'. The Committee interprets the requirement of reasonableness to imply that any interference with privacy must be proportional to the end sought and be necessary in the circumstances of any given case.

[8.4] While the State party acknowledges that the impugned provisions constitute an arbitrary interference with Mr. Toonen's privacy, the Tasmanian authorities submit that the challenged laws are justified on public health and moral grounds, as they are intended in part to prevent the spread of HIV in Tasmania, and because, in the absence of specific limitation clauses in article 17, moral issues must be deemed a matter for domestic decision.

[8.5] As far as the public health argument of the Tasmanian authorities is concerned, the Committee notes that the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV. The Australian Government observes that statutes criminalising homosexual activity tend to impede public health programmes 'by driving underground many of the people at the risk of infection'. Criminalisation of homosexual activity thus would appear to run counter to the implementation of effective education programmes in respect of the HIV prevention. Secondly, the Committee notes that no link has been shown between the continued criminalisation of homosexual activity and the effective control of the spread of HIV.

[8.6] The Committee cannot accept either that for the purposes of article 17 of the Covenant, moral issues are exclusively a matter of domestic concern, as this would open the door to withdrawing from the Committee's scrutiny a potentially large number of statutes interfering with privacy. It further notes that with the exception of Tasmania, all laws criminalising homosexuality have been repealed throughout Australia and that, even in Tasmania, it is apparent that there is no consensus as to whether sections 122 and 123 should not also be repealed. Considering further that these provisions are not currently enforced, which implies that they are not deemed essential to the protection of morals in Tasmania, the Committee concludes that the provisions do not meet the 'reasonableness' test in the circumstances of the case, and that they arbitrarily interfere with Mr. Toonen's right under article 17(1).

[8.7] The State party has sought the Committee's guidance as to whether sexual orientation may be considered an 'other status' for the purposes of article 26. The same issue could arise under article 2(1), of the Covenant. The Committee confines itself to noting, however, that in its view the reference to 'sex' in articles 2(1) and 26 is to be taken as including sexual orientation.

[9] The Human Rights Committee, acting under article 5(4), of the Optional Protocol to the International Covenant on Civil and Political Rights, is of the view that the facts before it reveal a violation of articles 17(1), *juncto* 2(1), of the Covenant.

[10] Under article 2(3)(a) of the Covenant, the author, victim of a violation of articles 17(1), *juncto* 2(1), of the Covenant, is

entitled to a remedy. In the opinion of the Committee, an effective remedy would be the repeal of sections 122(a), (c) and 123 of the Tasmanian Criminal Code.

...

USEFUL WEBSITES

AIDS Portal
www.aidsportal.org

African Union
www.africa-union.org

African Commission on Human and Peoples' Rights
www.achpr.org

Centre for Human Rights, University of Pretoria
www.chr.up.ac.za

Centre for the Study of AIDS, University of Pretoria
www.csa.za.org

Common Market for Eastern and Southern Africa
www.comesa.int

East African Community
www.eac.int

Intergovernmental Authority on Development
www.igad.org

NEPAD
www.nepad.org

International Labour Organisation
www.ilo.org

Office of the United Nations High Commissioner for Human Rights
www.ohchr.org

Southern Africa Litigation Centre
www.southernafricalawcenter.org

Southern African Development Community
www.sadc.int

United Nations
www.un.org

United Nations Development Programme
www.undp.org

Joint United Nations Programme on HIV/AIDS
www.unaids.org

World Health Organisation
www.who.int

World Trade Organization
www.wto.org

HOW TO GET HOLD OF THE TOOLS

This Compendium is part of a series of tools developed by the UNDP to improve the implementation of human rights norms in the context of HIV. Other tools in the series are: a Checklist, a Flipchart, a Guide, a CD-ROM and website (<http://www.chr.up.ac.za/undp> and http://www.undp.org/hiv/pa_africa.htm) containing the afore-mentioned tools, as well as a PowerPoint presentation.

For more information, or to obtain copies of any of the tools, please contact:

Shivaji Bhattacharya, Senior Policy Advisor, UNDP

Email: shivaji.bhattacharya@undp.org

or

United Nations Development Programme

Regional Service Centre

7 Naivasha Road

Sunninghill 2157

Johannesburg

South Africa

Tel: +27 11 603 5000