

NORTH-WEST UNIVERSITY

MAFIKENG CAMPUS

**HIV/AIDS AND THE LAW IN SOUTH AFRICA AND NIGERIA
WITH PARTICULAR REFERENCE TO THE RIGHTS OF WOMEN:
A COMPARATIVE PERSPECTIVE**

BY

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ABSTRACT

This thesis is an attempt to investigate the contribution of law, statutory or customary, and other associated legal and non-legal factors, including the adequacy or otherwise of public policy responses, in South Africa and Nigeria, as contributory factors rendering women more susceptible to HIV/AIDS.

The analysis of women's susceptibility to HIV/AIDS in South Africa and Nigeria, is the main thrust of this work. Complimentary to this major thrust is a focus on the etiology, causes, manifestations and prevention of HIV/AIDS and the legal implications, the underlying factors that render women most susceptible to it and how the law can be utilized to redress the issue of vulnerability. Though the rights of women as guaranteed by domestic and international instruments are discussed, their application is limited to the extent of their utilization to enforce women's legal rights.

Some of the major findings of the thesis are as follows:

- Fewer shortcomings were identified in the South African legal regime and public policy responses on HIV/AIDS than in the Nigerian responses.
- The higher vulnerability of women to HIV/AIDS in both countries indicates that all the identified gender-related factors are actually impacting adversely on women.
- The study established some causal nexus or connecting links between HIV/AIDS, poverty and human rights abuse; gender discrimination, gender factors, customary law/traditional practices and HIV/AIDS.

- The higher vulnerability of Nigerian children stems from the poor or inadequate legal and public policy responses to the epidemic and the vulnerability of women.

These are some of the recommendations of the thesis:

- Limited derogatory and coercive measures, with due regard to the tenets of human rights, in terms of mandatory HIV testing of all pregnant women and new born babies, and all intending marriage partners, to afford early diagnosis and treatment for HIV if necessary.
- The South African government must take reasonable steps to ensure greater access to health care services.
- The South African Constitution should be amended to incorporate justifiable right to health care in the context of HIV/AIDS, including the right to home- based care.
- The Nigerian government must domesticate all her international law/treaty obligations, some of which impose both negative and positive obligations, for the benefit of those vulnerable to HIV/AIDS.
- In Nigeria, constitutional amendments providing for enforceable socio-economic rights, embracing health care and home-based care, especially in the context of HIV/AIDS, and a dynamic national HIV/AIDS agenda that provides for free and voluntary HIV counselling, testing and treatment at state expense, should be undertaken.
- Governments in both countries must address more vigorously the customary law and gender-related factors that render women more vulnerable to HIV/AIDS.

DECLARATION BY SUPERVISOR

I, Professor Melvin Mbao hereby declare that this thesis by Emmanuel Joseph Uko for the degree of Doctor OF Laws (LLD) be accepted for examination.

.....

PROFESSOR M.L.MBAO

June 2005

DECLARATION

I, Emmanuel Joseph Uko, declare that this thesis for the degree of Doctor of Laws (LLD) in the North-West University hereby submitted, has not previously been submitted by me for a degree at this or any other university, that it is my own work in design and execution and all material contained herein has been duly acknowledged.

The law is stated as at 31 December 2004.

SIGNED-----

EMMANUEL JOSEPH UKO

DEDICATION

This work is dedicated to my family here in South Africa, including my wife- Gloria, and our children- Uko-Obong-Joseph, Uduak-Obong-Dorathy, Ekemini-Abasi-David and our new-born baby- Ini-Ubong-Abasi-Jacob, who was born in December 2004. They all have been my key allies and co-compatriots in our struggle for social and academic survival in South Africa. They provided me with immeasurable physical, moral and spiritual support, without which the possibility of completion of this work would have been far too remote.

My family and I here are most grateful to the Almighty God of Heaven and Earth for the singular fact that the harsh realities of life we experience in South Africa since 2001 has drawn us much closer to him.

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Finally, I thank God for my mother, Mrs Angelica J. Uko; my first child and daughter, Ime E. Uko- who is graduating as a pharmacist; and my second daughter, Idongesit E. Uko- a year

one LLB student, for their inspiration and encouragement, that propelled my resolve to forge ahead despite numerous problems and seemingly insurmountable obstacles.

LIST OF INTERNATIONAL INSTRUMENTS

ACRWC – African Charter on the Rights and welfare of the Child
(1989)

ACHPR- African Charter on Human and Peoples' Rights (1981)

ACRWC- African Charter on the Rights and Welfare of the Child
(1981)

CEDAW- Convention on the Elimination of All Forms of
Discrimination Against Women (1979)

ICCPR-International Covenant on Civil and Political Rights
(1966)

ICESCR- International Covenant on Economic, Social and
Cultural Rights (1966)

UDHR- Universal Declaration of Human Rights (1948)

UNO- United Nations Organisation

UNAIDS- United Nations AIDS

UNCRC- United Nations Convention on the Rights of the Child

UP- University of Pretoria

WHO- World Health Organisation

LIST OF ABBREVIATIONS

CHR- Centre for Human Rights

CMV- Cytomegalovirus

CRH- Committee on the Right to Health

CSA- Centre for the Study of AIDS

DA- Democratic Alliance (Political Party in South Africa)

DNA- Deoxyribonucleic Acid

NFMH- Nigerian Federal Ministry of Health

HCHR- High Commissioner for Human Rights

KS- Kaposi Sarcoma

LASU- Lagos State University

LRC- Law Reports of the Commonwealth

MMWR- Morbidity and Mortality Weekly Report

MTCT- Mother-to-Child Transmission

NACOSA- National AIDS Council of South Africa

PATICC- Pietermaritzburg AIDS Training Info. & Counselling Centre

PCP- Pneumocystis

RNA- Ribonucleic Acid

SANAC- South African National AIDS Council

SERAC- Social and Economic Rights Action Committee

TAC- Treatment Action Campaign

LASU- Lagos State University

MMWR- Morbidity and Mortality Weekly Report

NACOSA- National AIDS Council of South Africa

RNA- Ribonucleic Acid

SANAC- South African National AIDS Council

SERAC- Social and Economic Rights Action Committee

TAC- Treatment Action Campaign

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CHAPTER ONE:

INTRODUCTION

1.0 INTRODUCTION

Since the dawn of civilization, no other epidemic like HIV/AIDS has so menaced humankind, with the potential for mass destruction of humanity. With HIV/AIDS the control options are so bedevilled by overwhelming medical, social, political, cultural and economic difficulties, thereby indicating the utmost necessity for legal and other cross-cutting measures as intervention mechanisms to curb its excesses. This disease has been shown to possess the characteristic of a death sentence because there is no other disease affecting human beings where those who are infected are potentially able to transmit the virus for the duration of their lifetimes.

It is common cause that the devastation caused by the HIV/AIDS epidemic has impacted adversely on women, adjudged to be the most vulnerable group. Because of the problem of mother- to-child transmission of HIV/AIDS, women's vulnerability embraces the vulnerability of children¹. Unfortunately, the reality before us is that women and children in sub-Saharan countries are the most vulnerable groups to HIV/AIDS. This is occasioned by various factors touching on medico-legal, socio-cultural, socio-economic, epidemiological, gender-related, biological and physiological dimensions. Since a lasting solution to the challenges of HIV/AIDS has eluded humankind so far, the time

¹ Albertyn, C. "Using rights and the law to reduce women's vulnerability to HIV/AIDS" (2001) 2 Law, Democracy and Development 179.

therefore becomes ripe for human rights law, as a discipline, to assume a leading role in the quest for a resolution of the conflicts arising from the HIV/AIDS epidemic.

The justification for human rights law assuming a leadership role in this pandemic is grounded on the fact that the nexus or link between HIV/AIDS and human rights is explicit and well established. For instance, the social and legal status of women in many societies illustrates the connectedness of HIV/AIDS and human rights.² Laws, traditions, customs, and practices in some cultures and religions promote and entrench the subordinate status and exploitation of women in marriage and relationships, thereby increasing women's and children's vulnerability to HIV/AIDS.³

The protection of the human rights of women is indispensable to reducing their vulnerability and for them to be able to cope when confronted with HIV/AIDS. Knowledge of their human rights guarantees women the freedom from sexual exploitation and trafficking, both of which are contributory factors that exacerbate the HIV/AIDS epidemic and the high vulnerability of women⁴. Women need to have a general knowledge of human rights law and how some aspects of the law as well as other non-legal factors contribute to their vulnerability to HIV/AIDS so that they

² Piot, P. "HIV/AIDS, Stigma, Discrimination, and Racism" A UNAIDS, WHO, HCHR Panel, 2001. See sford@uusc.org p1.

³ Piot Ibid n. 2 p 2.

⁴ Piot Ibid n. 3 p 2.

can invoke the protection offered by human rights law to reduce vulnerability. An understanding of their fundamental human rights will enable women to make informed choices and also to enforce their rights to equality, non-discrimination, dignity of their persons, and other fundamental rights when actually infected or affected by HIV/AIDS. The Biblical significance of the sermon on knowing the truth (thou shall know the truth and the truth shall make you free) equally applies in this circumstance of women having to know and enforce the truth about the vast potentials of human rights law to liberate them. In view of these realities, the HIV/AIDS epidemic must be grounded in respect, dignity and human rights as a practical solution to curbing its excesses.

According to Ford⁵, respect for human rights reduces the spread of AIDS by addressing the root causes of vulnerability to the disease: powerlessness, poverty, racism, lack of education, homophobia, and gender disparities. A human rights approach is grounded in all indivisible rights: civil and political, as well as socio-economic.⁶ Knowing and exercising their rights empowers families and communities to respond to the pandemic and lessen the adverse impact on those affected or infected.⁷

Human rights awareness engenders a multi-sectoral approach to confronting and reducing stigma, the domination and exploitation

⁵ Ford, S. "Exploring the Link: HIV/AIDS, Stigma, Discrimination, and Racism" A UNAIDS, WHO, HCHR Panel, 2001.

See sford@uusc.org.

⁶ Ford Ibid n. 5 p 1.

⁷ Ford Ibid n. 6 p 1.

of women/girls, and poverty.⁸ Since HIV triggers widespread hate and discrimination, often reinforcing existing stereotypes based on gender, race, national origin, sexual orientation and economic status, a human rights approach is indispensable to the lessening of the negative effects on the vulnerable victims.⁹

The fact that girls and women are most susceptible to HIV infection physically, while social norms and harmful traditional practices contribute to their high rate of vulnerability, further buttresses the intersection of gender and HIV and the justification for a human rights approach to reducing their vulnerability.¹⁰

Women and girls are also vulnerable due to their low social status and unequal power relations in marriage or intimate relations, making it difficult to negotiate safer sexual practices, including refusal of condom use.¹¹ Further still, girls and women suffer the consequences of early marriage, female genital mutilation, and exploitation for commercial sex work, rape, and violence. At the family level, adolescent sexual health is a topic that many parents, teachers, religious leaders, and politicians are afraid of addressing.¹²

⁸ Ford Ibid n. 7 p 1.

⁹ Ford Ibid n. 8 p 1.

¹⁰ Ford Ibid n. 9 p 2.

¹¹ Ford Ibid n. 10 p 2.

¹² Ford Ibid n. 11 p 2.

Albertyn¹³ succinctly highlights in her work that in Africa, women now constitute the majority (55%) of people living with HIV/AIDS and that women and girls (15-24) experience the highest rates of infection. These figures have been collaborated by the UNAIDS Global Report.¹⁴ According to her, the spread and extent of the epidemic are directly related to global and national social and economic inequalities, while vulnerability to being infected and affected is inextricably linked to levels of poverty and underdevelopment.¹⁵

From her work, it is increasingly recognised that social, cultural and economic conditions will influence the frequency of risky sexual behaviour. Underlying this is the inequality of women and girls that shape their increased vulnerability to HIV infection and their disproportionately high responsibilities as care givers for the sick and dying, as well as the living. From her exposition, it is clear that while physiology affects women/girl's greater risk of HIV transmission, it is their lack of power over their bodies and their sexual lives, supported and reinforced by their social and economic inequality, that make them such a vulnerable group.¹⁶

Albertyn¹⁷ also sheds more light on the discriminatory manner in which women, disproportionately affected by HIV/AIDS, are treated by society. She has shown that women tend to bear the

¹³ Albertyn *Op Cit* n. 1 p 1.

¹⁴ UNAIDS *Global Report* 2004, p 96.

¹⁵ Albertyn *Op Cit* n. 13 p 4.

¹⁶ Albertyn *Ibid* n. 15 p 5.

¹⁷ Albertyn *Ibid* n. 16 p. 5; See also UNAIDS *Global Report*: 2004 p 101.

greater burden of care for the sick but that when women are themselves HIV- positive or ill as a result of AIDS, the same global and gender inequalities that are implicated in the epidemiology of HIV infection shape the discriminatory manner in which society treats them. This affects women's unequal ability to access affordable treatment and care. From her work, an understanding of gender inequality is critical to a country's ability to address women's vulnerability to HIV/AIDS.

Her work is equally useful in understanding the causal connection between gender and HIV/AIDS and the rationale for legal intervention by human rights law. She exposes the links between men's relative power and women's relative powerlessness and why women are relatively more at risk. From these, it becomes recognised that men's sexual behaviour, fuelled by harmful cultural norms and beliefs about masculinity, shapes their relationships with women. From her position, it becomes clear that not only is women's vulnerability rooted in their sexual, social and economic inequality, but this gender inequality is further reinforced by factors such as race, class, urban/rural location, sexual orientation, religion and culture.¹⁸

From Albertyn's work,¹⁹ it is shown that demographic portrayals of the epidemic in South Africa suggests that it is worse in women, as they are the ones most at risk of infection. People living with AIDS are not only more likely to be women, they are

¹⁸ Albertyn Ibid n. 17 p 5.

¹⁹ Albertyn Ibid n 18 p 5.

more likely to be poor, African women, young African women and girls. According to her, however, infection rates are also particularly high amongst monogamous married women, as well as vulnerable groups such as sex workers, migrant and refugee women.

An added dimension to Albertyn's work²⁰ suggests that for the African woman in South Africa, HIV vulnerability emerges from the Apartheid past, characterised by racial inequalities, a migrant labour system, the disintegration of family life and deepening racial and gendered poverty. More immediately, it emerges from an intersection of poverty with culture as African women are more likely to be subject to social and cultural norms that result in their having no control over sexual relations.²¹

The above work also highlights the negative impact of violence against women in the spread of HIV/AIDS. According to her, violence is so endemic that men and women come to accept coercive, even violent sex as normal. Survey and research in the Gauteng Province of South Africa found that nearly one-third of women and men surveyed agreed that forcing sex on someone you know is never sexual violence.²²

Her work also portrays the reality that poor women may resort to bartering sex for survival. This not only occurs under the rubric

²⁰ Albertyn Ibid n. 19 p 6.

²¹ Albertyn Ibid n. 20 p 7.

²² Albertyn Ibid n. 21 p 7.

of commercial sex work, but also in other forms of bartering behaviour that are not seen as sex work. This includes sexual relationship to ensure food and maintenance and sex traded for job, permit or promotion. Accordingly, sex of this nature is unsafe because women risk the loss of economic support by insisting on safer sex. Her work shows, also, that HIV positive women face discrimination in health care, education and legal rights. They are also more likely to be blamed, stigmatised and even abandoned by their families. Rural women are particularly at risk, she adds.²³

1.1 STATEMENT OF THE PROBLEM

South Africa and Nigeria, with their vast similarities and differences, exhibit much of the characteristics of other countries in sub-Saharan Africa. The perplexing problem of high vulnerability of women to HIV/AIDS in Africa is peculiar to both countries.²⁴

The major issue under investigation is the role played by law, as a contributory factor, in rendering women more vulnerable to HIV/AIDS in South Africa and Nigeria. Incidental to this investigation, and adding value to it, is the complimentary role played by other non-legal factors in promoting the general susceptibility of women to HIV/AIDS. Another intrinsic aspect of the general problem under investigation is the adequacy or

²³ Albertyn Ibid n. 22 p 7.

²⁴ UNAIDS Op Cit n. 14 p 5; A detailed discussion on the similarities between South Africa AND Nigeria is undertaken under 1.4- Rationale for South Africa and Nigeria as Study Focus.

otherwise of public policy responses to the pandemic and vulnerability of women in both countries.

The links or nexus between HIV/AIDS, discrimination and women's vulnerability are explicit and well established. UNAIDS²⁵ clearly indicate that the driving force behind the spread of HIV are stigma, discrimination, poverty, gender, and racism. Since HIV/AIDS gives rise to unimaginable hate and discrimination, often reinforcing existing prejudices, fears and stereotypes based on gender, sexual orientation, etc, UNAIDS particularly addresses this issue.

The gender factor is specifically addressed in the UNAIDS 2004 Global Report.²⁶ The said report notes that women are more physically susceptible to HIV infection than men and that data from a number of studies suggest that male-to-female transmission during sex is about twice as likely to occur as female-to-male transmission.²⁷ According to the report, also, young women are biologically more susceptible to infection than older women before menopause.²⁸ The report adds that women's increased risk is also a reflection of gender inequalities. According to the report, gender refers to the societal beliefs, customs and practices that define 'masculine' and 'feminine' attributes and behaviour. It further says that in most societies, the rules governing sexual relationships differ for women and

²⁵ UNAIDS Ibid n. 24 p 8.

²⁶ UNAIDS Ibid n. 25 p 9.

²⁷ UNAIDS Ibid n. 26 p 9.

²⁸ UNAIDS Ibid n. 27 p 9.

men, with men holding most of the power. This means that for many women, including married women, their male 'partners' sexual behaviour is the most important HIV-risk factor.²⁹

The report highlights that the epidemic has a disproportionate impact on women and that their socially defined roles as carers, wives, mothers and grandmothers mean they bear the greatest part of the AIDS-care burden.³⁰ It adds that when death and illness lead to household or community impoverishment, women and girls are even more affected due to their low social status and lack of equal economic opportunities.³¹

The undeniable reality that women, already entrusted with traditionally gender-related roles in the family and community environments, are the most vulnerable group to HIV/AIDS, while also having to care for their HIV-positive children and other family and community members, including themselves, demands further re-examination, because it is gender-sensitive. It demands that the cultural dimensions of gender related issues and role prescription must be reviewed.

Gender-related inequality and discrimination, gender role functions in the traditional setting, and long-standing stereotyped ideas on gender and femininity that adversely affect the interests of women, deserve special re-ordering and re-assessment,

²⁹ UNAIDS Ibid n. 28 p 9.

³⁰ UNAIDS Ibid n. 29 p 10.

³¹ UNAIDS Ibid n. 30 p 10.

especially in the context of the current HIV/AIDS epidemic. This is necessarily so because women, as the most vulnerable group to HIV/AIDS, need special care and assistance. In circumstances of incapacitation due to AIDS-related illnesses, women, who themselves need to be cared for, can no longer fulfil their traditional gender-related role functions as care givers in the family and community. To avoid additional serious problems that affect social functions and social responsiveness, in the wake of the HIV/AIDS crises, there is the need to reassess and reorder gender role functions in the traditional African society.

The 2004 UNAIDS Global Report also addresses issues of AIDS-related stigma and discrimination. It points out that AIDS-related stigma and discrimination directly hamper the effectiveness of AIDS responses.³¹ According to it, stigma and concerns about discrimination constitute a major barrier to people coming forward to have an HIV test, and directly affect the likelihood of protective behaviours. For example, the silence around HIV can prevent the use of condoms or can lead to HIV-positive women breastfeeding their infants for fear of being identified.³²

UNAIDS therefore advises national governments to adopt national HIV/AIDS policies that address issues of HIV-related stigma and discrimination since these tend to drive the disease underground and exacerbate its continued cycle. When carriers of the virus are openly stigmatised and discriminated against,

³¹ UNAIDS Ibid n. 30 p 10.

³² UNAIDS Ibid n. 31 p 11.

there is the general tendency for people to refuse to go for voluntary testing and/or treatment for fear of being identified and stigmatised. This is bad for public health because those people who refuse voluntary testing, or those who hide their HIV status, may be spreading the virus, at the expense of uninfected members of the public.

The stigma and discrimination that people with HIV/AIDS face are usually multiple and complex. Individuals tend not only to be stigmatised and discriminated against on the grounds of HIV/AIDS, but also in accordance with what it connotes. For example, women with HIV/AIDS may be doubly stigmatised both as 'women' and as 'people living with HIV/AIDS.'³³ Yet, all international human rights instruments and the African Charter prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, fortune, birth or other status.

The UN Commission on Human Rights resolutions³⁴ has unequivocally stated 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. These resolutions have also confirmed that discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards. Discrimination against people living with HIV/AIDS, or those thought to be infected, on

³³ UNAIDS *Ibid* n. 32 p 11.

³⁴ Commission on Human Rights: Resolutions 1999/49 and 2001/51, at pages 1-23.

whatever grounds, is therefore a clear violation of their human rights.

Another legal issue that this study undertakes to examine involves the problems posed by indigenous laws and customary practices that have the potential to cause harm to the health of women as well as rendering them susceptible to HIV/AIDS. Gender-related issues and human rights violations, in the traditional setting, have been shown to have profound effect on the physical and psychological health of women³⁵. These factors impact adversely on women's ability to make informed decisions about their sexual and reproductive health.

The links between customary laws, gender and HIV/AIDS are equally explicit and well established.³⁶ As will be shown in this work³⁷, the social and legal status of women in many traditional societies illustrates the connectedness of HIV/AIDS and gender. Laws, traditions, customs, and practices in some cultures promote the subordinate role and exploitation of women in marriage and relationships, thereby increasing women's vulnerability to HIV/AIDS.

The UNAIDS also indicates that in most societies, dominant gender constructions and ideologies determine how and what

³⁵ Guerny and Sjobern "Interrelationship Between Gender Relations and the HIV/AIDS Epidemic" in Mann, J.M. AIDS, Health and Human Rights, Cambridge: Harvard School of Public Health, 1999 p 202.

³⁶ UNAIDS Op Cit n 33 p 11.

³⁷ Intra at page 295, under 6.2.2- Customary Law and Harmful Traditional Practices.

men and women know about sexual matters and sexual behaviour.³⁸ According to the report, gender norms are frequently linked to attitudes and behaviours that contribute to the risk of and vulnerability to HIV. For instance, the high value placed on virginity in some cultures may encourage older men to seek out younger women, or it may encourage unmarried women to practice anal sex so as to protect their virginity, the report adds.³⁹ It also states that HIV-related risks are often greater in situations where women are socialised to please men, not to say 'no' to unwanted sex, and defer to male authority. Accordingly, therefore, there are a number of growing gender-related concerns that have important consequences for HIV prevention, including rape and violence against women, female genital mutilation, the lack of social support for single women, forced sterilization and wife inheritance, the report highlights.⁴⁰

The report equally highlights that among the broader policy realities that create a context of vulnerability to HIV/AIDS are gender and age-related discrimination. Gender-related discrimination is often supported by laws, policies and customs that prevent women from owning property, land and other productive resources, and which deny women equal adult status with men. The report also shows that this broader context frequently contributes to the feminization of poverty, heightens women's economic vulnerability to HIV infection, and creates

³⁸ UNAIDS Op Cit n. 36 p 13.

³⁹ UNAIDS Ibid n. 38 p 14.

⁴⁰ UNAIDS Ibid n. 39 p 14.

significant barriers to women's ability to seek and receive care and support when they are infected.⁴¹

This study also addresses the fact of non-domestication of international treaty obligations by South Africa and Nigeria, especially those that relate to health care, resulting in women not benefiting from the protection regimes in these instruments.

It is the purpose of this study to examine the impact of the failure to streamline and bring up to date some existing provisions on public health law to adequately addressing the scourge of HIV/AIDS.

The study equally evaluates the circumstances of complete absence of a legal framework for the protection of the legal rights of people, including women, vulnerable to HIV/AIDS in Nigeria. The limitations in the enforcement of the legal rights of people, including women, infected with, or affected by, HIV/AIDS in South Africa, is another crucial area of examination by this study. In the epoch-making case of Minister of Health And Others v TAC And Others,⁴² the Constitutional Court enforced the right of HIV-positive pregnant women to receive free niverapine anti-retroviral treatment, at state expense, to prevent the incidence of mother-to-child transmission of HIV.

⁴¹ UNAIDS Ibid n. 40 p 14.

⁴² 2002 (4) BCLR 356 (CC).

In the case of South Africa it is also the purpose of this study to examine the extent to which the Employment Equity Act protects the rights of HIV-positive women workers or prospective employees. The research examines the effectiveness of the responses to the terms of the Act by employees, prospective employees and employers, as well. This is done by reviewing relevant case law on the matter, amongst other approaches, to ascertain the degree of discontent with the provisions of the Act, if any, and how the Courts deal with the issue.

The availability or unavailability of similar protective regime in Nigeria is equally examined. Employment equity or affirmative action in favour of women, especially those living with HIV/AIDS, becomes imperative in view of the "double jeopardy effect" HIV/AIDS has on women. The factors that fuel this are the gender-related discrimination that women traditionally face in Africa and the added HIV-related discrimination and inequalities that HIV-positive women are likely to experience in the workplace. At issue are the interrelationship between gender relations and the embedded role of women in society and their adverse impact on the vulnerability of women to HIV/AIDS.

1.1.1 The Legal Problems:

This thesis is an investigation of the role of law, statutory or customary, and the complimentary role of other related legal and non legal aspects, as contributory factors, in rendering women more susceptible to HIV/AIDS. Central to the furtherance of this objective, the study equally undertakes an examination of the

adequacy or otherwise of legal and public policy responses to the pandemic in South Africa and Nigeria in an comparative perspective.

With the aim of presenting a consolidated and comprehensive view on the links or nexus between HIV/AIDS and discrimination, the research also examines the impact of discrimination on women who suffer from HIV/AIDS. This second leg of discrimination occurs at the societal level against people known or suspected to be carriers of the virus. For women carriers of the HIV virus, their HIV positive status endows them with additional problem of discrimination. This presents a double jeopardy since, as women, they already face gender-based discrimination. Because HIV/AIDS, on its own, attracts widespread stigma and discrimination, any inference of HIV infection of a woman connotes extensive or multiplied discrimination. This has the potential to drive the epidemic underground and to enhance its further spread. This happens when prospective carriers of the virus, in an attempt to avoid testing or identification for fear of stigmatisation, continue to spread the virus to others.

When people who are vulnerable to HIV/AIDS are discriminated against in employment and in the workplace, they are subjected to greater poverty. It is now both common knowledge and a well documented fact that poverty fuels the vicious cycle of the

HIV/AIDS epidemic.⁴³ There is also a unique link between HIV/AIDS and poverty. According to a World Bank report,⁴⁴ most people with AIDS are poor and poverty offers a fertile breeding ground for the epidemic's spread, and infection sets off a cascade of economic and social disintegration and impoverishment. According to the report, households with few financial assets may find themselves unable to seek treatment for sexually transmitted infections, and the existence of untreated sexually transmitted diseases increases the risk of contracting AIDS, while poor women and young girls may need to resort to unprotected sex to provide for their families.⁴⁵ The report adds that in the face of disintegrated family and community structures, people may be encouraged to live only for the present and to use sex to satisfy a range of other emotional needs.⁴⁶

The links between poverty and HIV/AIDS are bi-directional.⁴⁷ On the one hand, poverty contributes to vulnerability and exacerbates the impact of HIV/AIDS. On the other hand, the experience of HIV/AIDS by individuals, households and communities that are poor readily leads to an intensification of poverty. Thus, HIV/AIDS frequently impoverishes people in such a way as to intensify the epidemic itself.

⁴³ UNAIDS 2004: 1-100.

⁴⁴ World Bank (2000) *Confronting AIDS*. New York: Oxford University Press, pp 1-85.

⁴⁵ World Bank *Ibid* n. 44 p 18 .

⁴⁶ World Bank *Ibid* n. 45 p 18.

⁴⁷ Collins, J. and Rau, B. (2000) AIDS in the Context of Development, UNAIDS.

It should be noted that the dual or double edged examination of the two legs of discrimination against women, as shown in this work, articulates a comprehensive picture on the negative impact of discrimination. It exposes some of the links between HIV/AIDS and discrimination. It also confirms the links between poverty and HIV/AIDS, as it reinforces the fact that extensive economic deprivation can impoverish them and render them vulnerable to HIV/AIDS. This research explicitly attempts to establish this causal nexus between HIV/AIDS and discrimination by means of an analysis of these and other relevant legal and non-legal issues.

Discrimination is against the dictates of international and domestic human rights norms. Every human rights regime abhors discrimination in all its ramifications.

Secondly, this thesis focuses, to a large extent, on the problems posed to women by indigenous laws, customs, and harmful traditional practices. In effect, these cause more harm than good to women's health. In addition, they have the propensity and established potentials to render women more susceptible to HIV/AIDS.

These laws and traditions exacerbate unequal power relations between men and women, rendering women more powerless. They even give added advantage for men to capitalise on women to the extent of committing the offence/act of rape on young girls and women. Besides, almost all customary laws promote early marriages, while some traditions permit female genital mutilation.

It has been established that all of these factors create a conducive environment for women's susceptibility to HIV/AIDS.⁴⁸

Thirdly, another concern of this study is that some international human rights norms on health care have not been domesticated in South Africa and Nigeria despite these two countries being States Parties to these instruments. The resultant implication is that women in these jurisdictions do not benefit from the protective regimes in these instruments. The study attempts an examination of this aspect of non-domestication of treaty obligations.

One other crucial concern of this study is that certain provisions on public health law in both countries are not in consonance with the imperatives to address the peculiar circumstances of HIV/AIDS in line with human rights norms. The double edged significance of this is that while some coercive public health laws are adopted to compel adherence to certain forms of behaviour, coercion is against human rights norms and produces adverse results. This study examines this aspect with a view to bringing the public health laws in line with modern norms.

On the contributions of certain branches of law towards the vulnerability of women to HIV/AIDS, one scathing irony is that law provides divergent contributions to the HIV/AIDS epidemic. While some aspects of the law contribute negatively, others contribute positively, to the susceptibility of women to HIV/AIDS.

⁴⁸ UNAIDS Op.Cit n. 43 p 18.

The positive contributions by certain aspects of law are of utmost importance to this study because it is from these that the legal rights of women and other people who are vulnerable to HIV/AIDS are derivable. It is however submitted that, for these aspects of law that offer positive contributions, there is still the need to subject them to further law reform for purpose of rendering them more responsive to women's vulnerability.

1.1.2 The Research Questions:

The statement of the problem and the related legal problems give rise to a formulation of the following research questions:

1. To what extent has the law impacted negatively or Positively on the vulnerability of women to HIV/AIDS?
2. Who are the most vulnerable groups to HIV/AIDS globally and in sub-Saharan Africa?. What legal factors contribute to this vulnerability?.
3. How, in particular, have the legal rights of people within the vulnerable groups, especially women, been violated in South Africa and Nigeria?.
4. Is there a causal nexus or link between- gender and HIV/AIDS; HIV/AIDS and discrimination; and between customary law/traditions, gender, and HIV/AIDS?

1.2 RATIONALE AND JUSTIFICATION OF THE STUDY

The impetus to embark on this research was largely informed by the overwhelming need to address the problem of higher

vulnerability of women to HIV/AIDS in South Africa and Nigeria from a multi-disciplinary point of view.

The fundamental human rights of women and others who are vulnerable to HIV/AIDS are internationally and domestically protected by appropriate human rights instruments. Human rights law, in particular, plays a crucial role in the present dispensation, in view of its ability to permeate the entire fabric of human existence. This work will attempt to delineate the key role played by human rights law in the on-going battle to ameliorate the menace of HIV/AIDS, address the high vulnerability of women and reduce its adverse consequences.

It is the aim of this work to adumbrate and bring into a clearer perspective the legal rights of people, especially women, vulnerable to HIV/AIDS. This must ideally take into account the fact that in a democratic dispensation, before the benefits offered by law can be effectively utilized, the legal rights of people, especially those living with HIV/AIDS, including women, must be understood in all their ramifications.

The need for knowledge of the dangers of HIV/AIDS in all its ramifications is further reinforced by the fact that no effective preventive vaccine against HIV/AIDS has so far been manufactured. As a solution continues to elude medical science, the focus now shifts to law, and particularly- human rights law.

1.3 JUSTIFICATION FOR PROTECTING THE HUMAN RIGHTS OF WOMEN IN THE CONTEXT OF HIV/AIDS:

As already argued, the justification for human rights law assuming a leadership role is substantiated by the fact that the nexus or links between HIV/AIDS and human rights are explicit. The protection of human rights of women is indispensable to avoid their vulnerability to HIV/AIDS. It is also useful for them to invoke these rights in coping with and in lessening the social impact of the epidemic if they become infected or affected. A solid knowledge of the guarantees and protection offered by human rights law and international human rights instruments engenders capacity-building and empowerment for women. This sense of empowerment and capacity building, it is submitted, gives added impetus for women to enforce their rights to freedom from domination, sexual exploitation and trafficking. The long term enforcement of women's fundamental human rights will ultimately lead to a dramatic reduction in their vulnerability to HIV/AIDS.

It will be shown in this work that respect for human rights reduces the spread of HIV/AIDS by addressing the root causes of the epidemic. These include: powerlessness, poverty, homophobia, sexual exploitation or domination by men, gender-based violence, gender inequality and discrimination, and disrespect for women's dignity and other rights, etc. A human rights approach is grounded in all indivisible rights⁴⁹: civil and political rights as well as socio-economic rights. Knowing and

⁴⁹ UNO: Declaration of Tehran, 1968; Vienna Declaration, 1993.

exercising their rights empowers individuals, groups, families, and communities to respond to the epidemic/pandemic and to lessen the adverse impact on those infected or affected.

A human rights approach embraces multi-dimensional and cross-cutting measures to confront and reduce stigma, domination, exploitation of girls and women, poverty, gender-based violence, and gender-based discrimination and inequalities.⁵⁰ Since HIV/AIDS triggers unwanted hate and discrimination, often reinforcing existing prejudices, fears and stereotypes based on gender, sexual orientation, economic status, etc, a human rights approach helps to reduce its impact.⁵¹

As can be noted, all of the above issues are matters within the competence of human rights law and norms to address and resolve. This study therefore makes a spirited attempt to justify the adoption of a human rights approach in the search for solution to the HIV/AIDS crises ,especially its adverse impact on women.

It is envisaged that at the end of this study, the importance of a human rights approach would be easily discernable. It is the aim of this study to highlight human rights law as promoting respect for individuals or groups, in as much as such respect is indispensable to improving public health. Human rights law, in the context of the current HIV/AIDS epidemic, demonstrates its

⁵⁰ UNAIDS Op Cit n. 48 p 20.

⁵¹ UNAIDS Ibid n. 50 p 24.

central role in safeguarding, promoting and protecting public health, especially of those most vulnerable to HIV/AIDS infection.

Public health authorities are now compelled to adopt legal interventions that address HIV/AIDS- related issues. HIV/AIDS therefore creates pressures on the entire legal system and various branches of the law. Despite the initial misleading impression that HIV/AIDS was purely a medical problem, it is very clear today that HIV/AIDS is more or less a legal problem, with a focus on human rights law. This is true because the epidemic seriously challenges and tests the legal system and its legal values. This challenge is in the context that medical science, with its vast technology, is helpless in providing a cure. A prompting of the overwhelming need for legal intervention to protect vulnerable groups, especially women, from the ravages of HIV/AIDS, informs the rationale of this study and gives added impetus to this work.

An added impetus that inspired this work, complimentary to the need to resolve the problem of women's vulnerability to HIV/AIDS, is the need to resolve another social problem involving mother-to-child transmission of HIV. It is now an established fact that a significant percentage of children born to HIV-positive mothers/women stand the risk of contracting the virus from their mothers at birth.⁵² This was also the major issue

⁵² UNAIDS Ibid n. 51 p 24.

and crux of the case in Minister of Health And Others v TAC And Others.⁵³

A resolution of the problem of women's susceptibility to HIV/AIDS shall go a long way towards resolving many other social problems incidental to, and arising from, women's vulnerability. These include the high rate of paediatric AIDS arising from the high incidence of mother-to-child transmission of HIV. This study views this social problem with seriousness and hopes that the research will raise the necessary awareness and policy changes to address this double edged issue of vulnerability to HIV plaguing women and children.

Another catastrophic and direct consequence of the high vulnerability of women to HIV/AIDS is the social problem of AIDS orphanage that has now assumed dangerous proportions. The rapidly increasing number of children orphaned by AIDS poses major challenges for their well-being as well as for the development of the communities in which they live. All over the world, including South Africa and Nigeria, children and young persons are among those most affected by HIV/AIDS. Many children have been orphaned by AIDS and many more stand the risk of losing one or both parents to the pandemic sooner or later.⁵⁴

An increasing number of children are living in households with an HIV-infected member and children are taking on the

⁵³ (2002) 4 BCLR 356 (CC).

⁵⁴ UNAIDS Op Cit n. 52 p 25.

responsibilities of caring for sick parents, generating income and producing food.⁵⁵ Due to the intense impact of the HIV/AIDS epidemic and the high AIDS-related death rates in South Africa and Nigeria, as indicated in the statistics in chapter two of this work⁵⁶, many AIDS orphans are taking up responsibilities as heads of households. The increasing number of child-headed households is, therefore, another social disaster that is fast assuming catastrophic dimensions in South Africa and Nigeria.

Another cardinal motivation for the study on the rights of women is to exemplify the use of law as an instrument of social change, in resolving associated social problems.

Equally still, a resolution of the problem of women's vulnerability to HIV/AIDS is instrumental in reducing the social and economic impact of HIV/AIDS at the national level. It is notable that HIV/AIDS has caused developmental problems in all African countries. A UNAIDS 2002 report shows that in many countries, the AIDS epidemic has undermined the institutions and human resources on which a society's future health, security and progress depend.⁵⁷ According to the report, in the hardest countries, over one-quarter of the medical staff who are needed to help those living with HIV/AIDS are themselves infected.⁵⁸ In some countries, experienced teachers are dying faster than new

⁵⁵ UNAIDS *Ibid* n. 54 p 26.

⁵⁶ *Intra* at pages 74 - 78, under 2.4- Target/Vulnerable Groups.

⁵⁷ UNAIDS 2002 Report, pp 1-78.

⁵⁸ UNAIDS *Ibid* n. 57 p 27.

teachers can be trained, the report adds.⁵⁹ From the report, heavy industries and the military suffer because men who have to work away from their homes often have higher rates of infection than the general population.⁶⁰

Very high rates of HIV prevalence, as exhibited in South Africa, affects the national economy as a greater percentage of the national resources are allocated towards fighting AIDS. This overstretches the already overstretched budgets of a nation, giving no room to allocate resources to other important sectors that require budgetary allocation.

A high percentage of AIDS-related deaths destabilises the work force and human capital development as well as the national economy. Its effect on training or recruitment to replace professionals like teachers, nurses, civil servants, etc, who die of AIDS can best be imagined. In addition, huge financial resources must also be devoted to payment of pensions and gratuities, and other social grants to the families of the deceased. When the problem of women's vulnerability to HIV/AIDS is sufficiently addressed and resolved, the above far-reaching implications of HIV/AIDS at the family, community and national levels would equally have been addressed and resolved.

⁵⁹ UNAIDS Ibid n. 58 p 27.

⁶⁰ UNAIDS Ibid n. 59 p 28.

1.4 RATIONALE FOR SOUTH AFRICA AND NIGERIA AS STUDY FOCUS

As already shown earlier on in this work,⁶¹ South Africa and Nigeria, with their vast similarities and differences, exhibit much of the characteristics of other countries of sub-Saharan Africa. The perplexing problem of high vulnerability of women to HIV/AIDS in Africa is peculiar to both countries.

The similarities and differences that characterise South Africa and Nigeria cut across social, cultural, political and legal spheres. A comparative review of South African and Nigerian social, cultural, political and legal systems identified the following similarities and differences:

- Both countries have a history of colonisation, oppression, multi-ethnic and ethnocentric characteristics. The predominant destabilising force and structures of apartheid in South Africa were only successfully rendered impotent in 1994. On the Nigerian part, the equally destabilising evil of military dictatorship was only brought to an end in 1999.
- Both countries are currently operating and enjoying constitutional democracy.
- Both countries have a multiplicity of legal systems, while also enjoying the benefits of multiple sources of law.
- Both countries enshrine Bills of Rights in their constitutions, though the depth, extent, content, enforceability, and degree of protection of these rights vary

⁶¹ Supra, at page 8, under 1.1- Statement of the Problem.

in both countries. The South African Bill of Rights feature far-reaching and extensive provisions for enforceable and justiciable civil and political rights as well as socio-economic rights. This cannot be enthusiastically said of the Nigerian Bill of Rights.

- Both countries have equality provisions in their constitutions though these are more detailed in the South African Constitution.
- Both countries are endowed with rich economic, natural and human resources. From UNAIDS: 2004 statistics, however, while Nigeria is the most populous African country with a population of about 130 million people, South Africa is averagely populated with a median population of about 44 million people.

The above and other unique features provide a sound bases for a comparative study of both countries in regard to HIV/AIDS and the law and the public policy responses. The major emphasis of the study, however, remains the higher vulnerability of women to the HIV/AIDS epidemic. The comparative method conveys the benefit of allowing for a wider regional view, scope and perspective of the problem under investigation and its control mechanisms. The findings and generalisations provide some insight and picture of the magnitude of the problem and its resolution in South Africa and Nigeria in particular, and in Africa in general. The rationale for this is that the two countries, put together, epitomise the social, cultural, political and legal

characteristics of most African countries, though with minor differences.

1.5 LITERATURE REVIEW

Gostin and Lazzirini have poignantly argued that the AIDS pandemic presents a major challenge to public health and human rights practitioners world-wide.⁶² The burden of the AIDS pandemic extends well beyond public health. To them, this is true since it has been shown that poverty and other socio-economic factors contribute to vulnerability to HIV/AIDS. According to them, where poverty prevails and other socio-economic rights are not within the reach of the masses, HIV/AIDS poses incalculable human, social, cultural and economic costs. In their estimation, international human rights norms, as a complex and evolving body of law, must intervene by playing an active role to resolve the HIV/AIDS crises.

The rationale behind this position is that human rights doctrine has always held that human rights and fundamental freedoms are indivisible, the full realization of civil and political rights without the enjoyment of economic, social and cultural rights is impossible.⁶³ In this regard, guaranteeing, fulfilling and enforcing the socio-economic right to health care, to the extent of Governments providing free and voluntary HIV counselling, testing and treatment, at state expense, can be a step in the

⁶² Gostin and Lazzirini, Human Rights and Public Health in the AIDS Pandemic, New York: Oxford University Press, 1997, pp 1-5.

⁶³ UNO: Declaration of Tehran, 1968; Vienna Declaration, 1993.

right direction towards reducing the adverse impact of the HIV/AIDS pandemic. Although the above viewpoints are highly valued and respected, the point of departure is that while the doctrine of indivisibility of rights in tune with human rights norms is vigorously pursued, it must be approached cautiously, setting aside and derogating from some human rights norms where necessary. This is done by applying some limited coercive measures in the overall interest of the public, at appropriate points. The experience of some other comparable jurisdictions, like New York State in USA, which offers some limited derogations from the norms and applies limited coercive measures on pregnant women and newborns in order to reduce their vulnerability to HIV/AIDS,⁶⁴ offers important lessons for countries like South Africa and Nigeria. Such approaches are highlighted in the later chapters of this work.⁶⁵ It is against this backdrop that the fundamental human rights of people, particularly women, who are vulnerable to HIV/AIDS must be interpreted, exercised and protected in South Africa and Nigeria. Thus it should be noted that it is going to take a resolute but carefully programmed response from all segments of society to protect and enforce the fundamental human rights of people already living with HIV/AIDS.

It is also true that, though HIV/AIDS sufferers are vested with what are called "first generation rights", that is, the right to dignity, privacy and autonomy, these rights are beset with

⁶⁴ New York Public Health Law No. 2500F (Mackenney Supp. 1997) p 177.

⁶⁵ *Intra*, at page 286, under 6.1.3-Public Health Law.

controversy.⁶⁶ This results from disagreement about the rights of the infected and those of society.⁶⁷ In their tripartite roles to protect, promote and fulfil the rights of people vulnerable to HIV/AIDS, in the midst of controversy, the courts have a domineering role in various legal jurisdictions. In the USA case of N. O. L v District of Columbia,⁶⁸ at issue was whether a hospital's refusal to disclose the HIV status of a wife to the husband was actionable in view of the prevailing confidentiality law and in the absence of consent by the wife. In holding that the hospital's refusal to disclose the wife's HIV status was not actionable, the court took into account the fundamental human rights of the individuals as against those of society. A USA court in Florida did find the City of West Valley liable in damages for a claim of violation of privacy rights resulting from police disclosure of a report of HIV infection to the family members of a HIV-positive arrestee in the case of A. I. A. v West Valley City.⁶⁹

While the above two cases exemplify the necessity not to derogate from laid down norms of international human rights law, the cases of Washington v Miller⁷⁰ and People v Jones⁷¹ in USA confirm the overriding need to derogate from the norms at certain times. In Washington v Miller, the court ruled that a drug dealer must undergo HIV testing against his will in derogation from the norms of human rights law. Similarly, in People v Jones, another

⁶⁶ Hope, K.R. AIDS and Development in Africa, New York: Harworth Press, 1999, p 79.

⁶⁷ Hope Ibid n. 66 p 33.

⁶⁸ 674 A. 2d 498 (DC 1996).

⁶⁹ 26 F. 3d 989 (10th Cir. 1994).

⁷⁰ No. 24891-3-11 (Wash. App. Div. 2 April, 2001).

⁷¹ No. FO40275 (Cal. App. 5 Dist. April, 2001)

court ruled that a victim of attempted rape could seek HIV testing of the attacker, contrary to the human rights norms of voluntary testing.

Marais,⁷² Guerny,⁷³ Khoza,⁷⁴ Tallis,⁷⁵ Barolsky⁷⁶ and Brouard et al⁷⁷ argue that HIV/AIDS represents human and economic disaster of massive dimensions. Their arguments, which appear to go along the same line of reasoning, tend to indicate that women are particularly at risk in Africa because of their unique physiology, powerlessness and inability to control their own sexuality in the context of most African societies. There is also substantial vertical (mother-to-child) transmission.⁷⁸ In sub-Saharan African, unlike some other regions, the principal mode of transmission of HIV is heterosexual intercourse.⁷⁹

Cameron and Swanson have argued with greater vigour on the implications of public health officials opting to adopt the indirect or direct coercive forces of law as measures aimed at tackling the HIV/AIDS epidemic.⁸⁰ On its part, UNAIDS discusses the role

⁷² Marais, H. To the Edge, AIDS Review 2000, CSA: UP, 2000 PP 4-11.

⁷³ Guerny, J. "Leadership and Reproductive Health" (2001) 3 SAFAIDS: 1-2.

⁷⁴ Khoza, S. "Reducing Mother-to-Child Transmission of HIV: The Niverapine Case" (2002) 3 ESR Review: 2-6.

⁷⁵ Tallis, V. "Issues Regarding Women, HIV/AIDS and Pregnancy" (1997) 43 PATICC Bulletin 4-5.

⁷⁶ Barolsky, V. AIDS Review 2003, CSA:UP, 2003 PP 35-41.

⁷⁷ Brouard, et al HIV/AIDS in South Africa, CSA, UP, 2004. PP 22-24.

⁷⁸ Ateka, G. K. "HIV/AIDS: Global Impact and Human Rights- a Southern African Perspective" (2000) 12 AIDS Scan: 3-4.

⁷⁹ UNAIDS "Unsafe Sex is Primary Mode of HIV Transmission in Africa" in UNAIDS Report 2003.

⁸⁰ Cameron and Swanson "Public Health and Human Rights: the AIDS Crises in South Africa" (1992) 8 Journal of Human Rights, pp 200-232.

of international human rights law in the AIDS pandemic,⁸¹ while UNDP is concerned that the HIV/AIDS pandemic, although global in distribution, has wrecked its maximum devastation within the sub-Saharan African region. Two-thirds of people living with HIV/AIDS come from this region.⁸²

On the role of law in controlling HIV/AIDS, Peters discussed the extent to which the law could contribute and showed some limitations on legal strategies.⁸³ Nguena emphasises the recognition of the right of access to health care as a human right.⁸⁴ The right to health care in the best interest of the child and AIDS was argued by Nicholson⁸⁵.

Smith and Friedman,⁸⁶ Webb,⁸⁷ Schoub⁸⁸ and Webber⁸⁹ discuss the medical aspects of HIV/AIDS.

⁸¹ UNAIDS: 2004 Global Report.

⁸² UNDP (1995) AIDS and Africa: A Challenge to Human Development. New York: UNDP.

⁸³ Peters, D. "HIV/AIDS Prevention and Control: Can the Law Help" (2000) LASU Law Journal 56-82.

⁸⁴ Nguena C. "AIDS in Africa: Access to Health Care as a Human Right" (2000) 15 SAPR/PL 2-3.

⁸⁵ Nicholson, C.M.A. "The Right to Health Care: The Best Interest of the Child and AIDS in South Africa and Malawi." 92(2002) 35 Comparative and International Law Journal of South Africa: 351-376.

⁸⁶ Smith and Friedman, "Transmission and Treatment" in Buris, S. AIDS Law Today, New Haven: Yale University Press, 1993 pp 18-43.

⁸⁷ Webb, D. HIV and AIDS in Africa, London: Pluto Press, 1997 pp 50-250.

⁸⁸ Schoub, B. AIDS and HIV in Perspective, London: Cambridge University Press, 1999 pp 1-100.

⁸⁹ Webber, D. AIDS and the Law- 3rd Edition Supplement, New York: Aspen Publishers, 1999 pp 25 - 105.

By far the Centre for Reproductive Law and Policy,⁹⁰ Whellan⁹¹ Pieterse⁹² and Albertyn⁹³ have made the most direct contributions and arguments on the rights of women and the possible factors that can render them vulnerable to HIV/AIDS.

The above authors seem to overstress one vital area of importance- employing the remedies offered by law to accord women their fundamental rights to equality, non discrimination and dignity of their persons, as antidotes to the resolution of the problem of women's vulnerability to HIV/AIDS. This is accepted as a very commendable point. But one key area of my departure, which forms a key highlight of the conclusions and recommendations of this thesis, is the desirability to also invoke the principle of limited derogation from the norms of human rights law. This thesis proposes that under some special circumstances, pregnant women and newborn infants, as well as prospective marriage partners should be made to undergo mandatory HIV counselling and testing, in their interest and in the overall public interest. This encapsulates the principles of limited coercive measures and limited derogation from the norms of international human rights law.

⁹⁰ Centre for Reproductive Law and Policy, Women of the World: Laws and Policies Affecting their Reproductive Lives, New York: CRLP, 1997 PP 1-300

⁹¹ Whellan, D. "Human Rights Approaches to an Expanded Response to Address Women's Vulnerability to HIV/AIDS" (1998) 3 Health and Human Rights 21.

⁹² Pieterse, M. "Beyond the Reach of Law? HIV, African Culture and Customary Law" (2003) 3 TSAR 428 .

⁹³ Albertyn Op Cit n. 20 p 7.

The above exemplify the general discussion on HIV/AIDS in Africa. There, however, appears to be a poverty of literature specifically on "the law and HIV/AIDS and the legal rights of women vulnerable to HIV/AIDS in South Africa and Nigeria". This work is therefore an attempt to contribute to the existing store of knowledge and to the current efforts aimed at resolving, through legal remedies, the problems posed by the HIV/AIDS pandemic.

1.6 DATA COLLECTION AND RESEARCH METHODOLOGY

This work utilized both primary and secondary sources of data relevant to the study. The interview and/or the questionnaire methods of data collection were adopted at appropriate points. The study also relied substantially on library sources such as articles in journals, newspapers reports, text books, domestic and international human rights instruments, reports of conferences, decided cases and other useful publications. Internet sources were also a valuable tool in locating current information. While the legal sources were the main focus, non-legal sources, like cultural practices, health policies, and other policy initiatives having a bearing on the topic were also gainfully explored. Available data and statistics on the prevalence, intervention programmes and future projections relating to HIV/AIDS epidemic were obtainable from UNAIDS, the South African authorities and the Nigerian authorities.

The methodology adopted in this work was qualitative as opposed to quantitative. From common knowledge, while the qualitative method embraces the non-numerical examination and

interpretation of observation for the purpose of discovering underlying meanings and patterns of relationships, the quantitative method is different. It is generally accepted as the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that these observations reflect.

Within the ambit or parameters of the qualitative methodology, the analytical and comparative styles were employed in the study since comparisons and evaluations had to be made. In the context of this work, the comparative method provides the advantage of facilitating a wider regional view, scope and perspective on matter. The findings and generalisations provide some insight and picture of the magnitude of the problem and its resolution within a wider context. In the peculiar circumstances of this study, it provides a wider scope of the magnitude of the problem and its resolution in South Africa and Nigeria, in particular, and in Africa, in general. Besides, this comparative study offers an opportunity to compare the legal and non legal responses to the HIV/AIDS epidemic and the vulnerability of women to them in both countries.

1.7 SCOPE AND LIMITATIONS OF THE STUDY

The research attempts to investigate the role of law, statutory or customary, and other associated legal and non-legal aspects, as contributory factors rendering women more vulnerable to HIV/AIDS. Complimentary to the furtherance of this research objective, the study also examines the public policy responses to

the HIV/AIDS epidemic and the vulnerability of women in South Africa and Nigeria.

The analysis of women's vulnerability to HIV/AIDS in South Africa and Nigeria is the main aspect of this focus. The study also focuses on the etiology, causes, manifestations and prevention of HIV/AIDS and the legal implications, the underlying factors that render women most vulnerable to it and how the law can be utilised to redress the issue of vulnerability. Although the fundamental human rights of women as guaranteed by domestic and international human rights instruments are discussed, these are applied only to the extent that they can be utilized by women to enforce their legal rights.

This work consists of seven chapters. In addition to this chapter, there are six more chapters.

Chapter two is on the historical and contextual framework of the HIV/AIDS pandemic and public policy responses. In furtherance of this, the meaning, origin, mode of infection and transmission and methods of control of HIV/AIDS are treated, as a prelude to understanding how and why women become an easy target. For a better evaluation of the legal and other factors that influence women's vulnerability to HIV/AIDS, available statistics, globally and nationally are first highlighted. Thereafter, an analysis of related factors, such as socio-economic, socio-cultural, physiological/biological, rape, domestic violence and gender

related factors, that influence women's vulnerability to HIV/AIDS is undertaken.

Chapter three discusses the legal factors that render women susceptible to HIV/AIDS. In this chapter, the adverse inputs of family law, customary law and public health law, as contributory factors towards women's vulnerability to HIV/AIDS, are examined. The chapter, however, exonerates the South African family law, to some extent, from blame in this regard because a number of laws have been enacted to ameliorate the position of women. These include: the Domestic Violence Act 116 of 1998; the Recognition of Customary Marriages Act 120 of 1998; the Prevention of Family Violence Act 133 of 1993; the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000; etc. However, the elements of Nigerian family law that have impacted negatively is brought to the forefront in this chapter.

This chapter also focuses on the legal issues that impact on women infected with or affected by HIV/AIDS.

Chapter four is on human rights norms. It addresses aspects of the law that positively impact on women's vulnerability to HIV/AIDS. This chapter represents a very important aspect of this work in that most of the legal rights available to women vulnerable to HIV/AIDS are derivable from these branches of law. Of major consideration are the positive impact occasioned by international human rights law, constitutional law and labour law. An in-depth analysis of the contributions of these branches of

law is given in this chapter. It is however shown in this chapter that despite the positive contributions of these aspects of law, further adjustments or reforms still need to be made to them so as to render them more responsive to women's vulnerability to HIV/AIDS. Such reforms are designed to re-position these aspects of the law to be able to cope with newer challenges of changing times, with particular reference to the vulnerability of women to HIV/AIDS.

Chapter five discusses public policy responses to the HIV/AIDS pandemic and the higher vulnerability of women to it in South Africa and Nigeria. A historical review and an examination of public policy responses as captured in national policies are also undertaken in this chapter. As a public policy incentive, issues related to the fact that women living with HIV/AIDS are also saddled with additional responsibility as care givers, equally receive attention in this chapter. In furtherance of this objective, the trend towards home-based care, its social impact and legal implications are particularly brought into the focus.

Chapter six highlights the broad findings and evaluates the short-comings of the legal and public policy responses to the HIV/AIDS pandemic in the two countries.

Chapter seven carries our broad conclusions and recommendations.

In undertaking this work, the initial challenge was the task of narrowing down the scope of study to focus mainly on HIV/AIDS and the law in South Africa and Nigeria, with particular reference to the rights of women. Secondly, there was a dearth of literature relevant to the subject. Only marginally related literature was found. Both challenges, however proved advantageous at the end in that they energised the researcher to attempt a modest contribution to existing knowledge in this field of law.

1.8 SUMMARY:

This chapter has given a general and introductory background to the study. The chapter has identified the problem under investigation. It states the rationale of the study as well as review existing works. The approach to data collection and research methodology, along with the scope and limitations of the study, are all enunciated. In the next chapter it is proposed to discuss "Historical and Contextual Framework of the HIV/AIDS Pandemic and Public Policy Responses".

CHAPTER TWO:
HISTORICAL AND CONTEXTUAL FRAMEWORK OF THE
HIV/AIDS PANDEMIC AND THE LAW

2:0 INTRODUCTION: INTERSECTION OF MEDICINE AND LAW

This chapter attempts a detailed examination of the historical and contextual framework of the HIV/AIDS pandemic and their points of intersection with the law. It is common knowledge that law is a system of principles and processes by which people who live in a society deal with their disputes and problems, seeking to solve or settle them without resort to force. It is equally a well-known fact that law governs the relationship between individuals and organisations, and between individuals and the government. In as much as law serves as a guide to conduct it has a key role to play in all the enfolding ramifications of the HIV/AIDS pandemic since people infected and affected by HIV/AIDS must know where their rights begin and end within that context.

The chapter explores the historical and contextual analysis of the meaning, origin, mode of infection and transmission as well as methods of personal control of HIV/AIDS and their legal implications. These are pre-requisites for a better understanding of the rationale behind the high statistics of vulnerable women worldwide, regionally and nationally. This also provides a basis for easier understanding of the factors that render women most vulnerable to HIV/AIDS. One very important aspect of the HIV/AIDS pandemic's changing demographics is its increasing

and continuous impact on women, and, by implication, children. HIV/AIDS has now become a major threat to women worldwide.

2.1 BASIC BACKGROUND OF HIV INFECTION

The basic background information on HIV infection is examined hereunder. This includes the meaning of HIV/AIDS; origin; mode of infection and transmission and methods of personal control of HIV/AIDS. The examination of the historical and contextual characteristics of HIV/AIDS are pertinent in the light of the necessity for people infected with or affected by HIV/AIDS to have a basic understanding of the rationale behind their unique affliction, the possible legal connotations, and the cause or causes of action open to them, if any.

2.1.1 Meaning of HIV/AIDS and its Import in Law

People infected and affected by HIV/AIDS need to know, from a historical and contextual framework, the nature of the virus that plagues them. In this perspective the name of the virus, how the said name is derived, and the import in law, are of utmost importance, from a legal stand-point.

Human Immuno-deficiency Virus (HIV) is a retrovirus, identified in 1983 as the cause of AIDS, and known since 1986 as the human immuno-deficiency virus and the human T-cell lymphotropic virus (HTLV) which was identified in 1980¹. AIDS is the acronym for acquired immuno-deficiency syndrome and was a

¹ Webb, D. HIV and AIDS in Africa, London: Pluto Press, 1997 pp 4-10.

term coined early on in the history of the disease². AIDS is, by definition, the end- stage disease manifestation of an infection with the human immuno-deficiency virus (HIV). Eventually, it was determined that AIDS was caused by a virus called lymphadenopathy- associated virus (LAV), by some, and human T- cell lymphotropic virus type3 (HTLV-3), by others³. The virus was later re-named the human immuno-deficiency virus (HIV) and a blood test was developed and marketed to identify antibodies to the virus.⁴ The name – Human Immunodeficiency Virus (HIV) is thus a neutral name, by international convention, chosen for the virus.⁵

Two types of HIV have been identified, namely HIV-1 and HIV-2.⁶ Reports of a third type of HIV discovered in Cameroon point to the possible existence of many more variants and a high rate of mutation.⁷ In recent years, these variants have been classified further, with varying degrees of transmissibility and virulence.⁸ HIV-1 is far more geographically extensive than HIV-2, which is mostly confined to West Africa.⁹ The viruses are both transmitted in the same way which involve mixing of fluids. The virus is found in blood, seminal and vaginal fluids.¹⁰ They belong

² Schoub, B.D. AIDS and HIV in Perspective, Cambridge: University of Cambridge Press, 1999 pp 19-20.

³ Schoub, Ibid n 2 p 45.

⁴ Schoub Ibid n. 3 p 45.

⁵ Schoub Ibid n. 4 p 45.

⁶ Schoub Ibid n. 5 p 45.

⁷ Webb Op Cit n. 1 p 44.

⁸ Webb Ibid n. 7 p 45.

⁹ Webb Ibid n. 8 p 45.

¹⁰ Webb Ibid n. 9 p 45.

to the family of retroviruses and are so-called because of the very slow and prolonged nature of the disease they cause.

The history of the discovery of the second HIV virus shows that in 1986, a second HIV virus was isolated by Luc Montagnier's group from AIDS patients in Guinea Bissau and the Cape Verde Islands, and was called LAV-2.¹¹ At about the same time, an American group under Myron Essex also isolated, in neighbouring Senegal, a second virus which they called HTLV-4. Although the French-American dispute initially prevented a comparison of these two viruses, it was subsequently shown to be the same virus and was called HIV-2.¹²

2.1.2 Origin of HIV

HIV infection is viewed¹³ as a single spectrum of a disease, with manifestations that evolve over time in infected individuals. It is recognised as AIDS when certain specific, severe complications develop.¹⁴ The historical origin of HIV, however, is fraught with controversies.¹⁵ Schoub summarised it thus:

Surrounding the origins of this remarkable virus and its equally remarkable disease have fired the imagination given the intense and unique social, political and human implications of AIDS, it is small wonder that questions ever since it was

¹¹ Schoub Op Cit n. 6 p 45.

¹² Schoub Ibid n. 11 p 46.

¹³ Smith and Friedman, "Transmission and Treatment" in Buris, S. AIDS Law Today, New Haven: Yale University Press, 1993, p 30.

¹⁴ Smith and Friedman Ibid n.13 p 46.

¹⁵ Smith and Friedman Ibid n.14 p 46.

first recognised. Is AIDS a new or an old disease?. Did it first arise in Africa or in the USA?. Where did the virus come from?. These questions have been debated and argued at great depth in scientific and lay forums alike and still arouse considerable controversy. In reality, the answers to these questions, if they are ever forthcoming, will have little relevance to the control and management of the disease. In fact, little is known about the origin of any human virus, let alone HIV. Nevertheless, the drive and curiosity to search for answers to these tantalizing questions has prompted a great deal of investigation as well as wide ranging speculation. What is uncontestable is that the disease of AIDS was first recognised in the USA and only somewhat later was the pandemic observed in Europe and Africa. However, various scenarios of the birth and development of the epidemic have been built around pieces of knowledge recruited from a number of diverse sources. At present, the answers to both the origin of the disease as well as the ancestry of the virus remain as unresolved as when the questions were first posed.¹⁶

The first recognition of AIDS as a unique phenomenon came in June 1981 with a brief mention of the Center's for Disease Control publication entitled "Morbidity and Mortality Weekly

¹⁶ Schoub Op Cit n. 12 p 46.

Report"¹⁷ in USA. Within the next six months, several articles followed in which physicians from Los Angeles and New York described a series of young gay men who were dying from "opportunistic" infections or malignancy and in whom laboratory studies revealed a profound suppression of the immune system (immuno suppression) that was both unexpected and unexplained.¹⁸

Early epidemiologic studies of these men showed¹⁹ that they had multiple sexual partners, which suggested that a new sexually transmitted infectious agent might account for the disease. The nature of the illness in these men was also radically new to medical experience. As the number of AIDS cases increased, initially doubling every six months, several other so-called risk groups were identified in the United States and Western Europe. These included intravenous drug users and hemophiliacs, both suggesting a blood-borne route of transmission.²⁰ Simultaneously, numerous cases of a virtually identical disease were noted among Haitians, and soon thereafter among Central Africans, where no obvious risk behaviour emerged, except monogamous heterosexuality.²¹

The reality therefore is that the AIDS epidemic became evident between October 1980 and May 1981 when an alert physician,

¹⁷ Smith and Friedman Op Cit n. 15 p 46.

¹⁸ Smith and Friedman Ibid n. 17 p 47.

¹⁹ Smith and Friedman Ibid n. 18 p 48.

²⁰ Smith and Friedman Ibid n. 19 p 48.

²¹ Smith and Friedman Ibid n. 20 p 48.

Dr. M. Gottlieb,²² together with colleagues at three different hospitals in Los Angeles, became intrigued by a cluster of five young male patients whose ages ranged between 26 and 36 years, under their care.²³ All five men who had previously been healthy were diagnosed as having a highly unusual form of pneumonia due to a parasite called pneumocystis carinii.²⁴ Pneumocystis carini pneumonia (often abbreviated to PCP) had previously been found virtually exclusively in patients with severe suppression of their immune systems, caused by drugs or disease.

In addition, all of these patients had evidence of having been infected with a virus called cytomegalovirus (CMV) which is similarly common in immuno suppressed patients.²⁵ All five of these patients were also infected with thrush, which is characteristic of immuno-suppressed individuals. There was evidence of marked disturbances in the functional capacities of their immune systems. A further feature of the five men was that all were sexually active homosexuals.²⁶ The first report of these observations appeared in a relatively small, unobtrusive insert in the Morbidity and Mortality Weekly Report of the Centre for Disease Control on 5th June 1981,²⁷ as explained earlier. A month later, the 3 July issue carried a similar report of 26 homosexual men, 20 from New York and 6 from California with a

²² Schoub *Op Cit* n.16 p 47.

²³ Schoub *Ibid* n. 22 p 48.

²⁴ Schoub *Ibid* n. 23 p 48.

²⁵ Schoub *Ibid* n. 24 p 49.

²⁶ Schoub *Ibid* n. 25 p 49.

²⁷ Schoub *Ibid* n. 26 p 49.

very uncommon tumour called Kaposi Sarcoma- named after the nineteenth century Hungarian dermatologist, Moritz Kaposi, who first described this skin tumour. Kaposi Sarcoma (often abbreviated to KS) had previously only been observed in elderly men, often of Mediterranean and Jewish extraction, and also in tropical Africa, mainly in children and young adults.²⁸ It was also becoming increasingly evident in patients undergoing kidney transplantation who were on immuno-suppressive drug therapy. As with the original five PCP patients, the KS patients also had evidence of infections such as CMV, thrush and PCP. Meanwhile a further 10 PCP cases in homosexual men were reported in California.²⁹

Thus it was at the beginning of the 1980s that the relatively unremarkable few cases of homosexual male patients with unusual infections and tumours heralded an epidemic of one of the most devastating of all diseases to face humankind. It is also one which would have, perhaps, the most profound effect on the practice of medicine of any single disease. Because the disease was obviously transmissible from person to person and because of its striking effect of the suppression of the immune system of patients, it became known as the -Acquired Immunodeficiency Syndrome, or AIDS. By May 1985, in the United States of America, 10,000 cases of AIDS had been reported.³⁰

²⁸ Schoub Ibid n. 27 p 49.

²⁹ Schoub Ibid n. 28 p 49.

³⁰ Schoub Ibid n. 29 p 50.

In the United Kingdom, in 1982, an AIDS surveillance programme was established by the Public Health Laboratory at the Communicable Disease Surveillance Centre in London. In that year, only three cases of AIDS were reported in the UK.³¹ However, by 1983, there were 28, in 1984, 77 and in 1985, 165.³² Similar patterns emerged elsewhere in other countries in the developed world, mostly found in homosexual men and also, to some extent, in persons who injected themselves intravenously with drugs.³³

Early in 1983, similar vigilance and alertness resulted in a finding of almost equal importance to the original uncovering of the AIDS epidemic. Doctors in Belgium and France became aware that their African patients with AIDS appeared to lack the two life style risk factors of male homosexuality and intravenous drug abuse, so characteristic of the disease in western countries.³⁴ It also differed with respect to being found equally among females as well as males, unlike the marked male dominance (owing to its prevalence in homosexual men) of western countries.³⁵ The trail of investigation led to their countries of origin in Africa and, in the beginning, particularly Rwanda and Zaire, where a vast reservoir of the disease existed and provided a sizeable source

³¹ Schoub Ibid n. 30 p 50.

³² Schoub Ibid n. 31 p 50.

³³ Schoub Ibid n. 32 p 51.

³⁴ Schoub Ibid n. 33 p 51.

³⁵ Schoub Ibid n. 34 p 51.

of AIDS patients found in Europe, especially in countries such as Belgium.³⁶

2.1.3 Natural History of the Origins of HIV/AIDS

In essence, three conjectural accounts of the natural history of HIV/AIDS epidemic have been put forward, two of them pointing to the African continent for the origin of the virus. One of the earliest of these postulates, published in 1984- a year after the African connection was uncovered in Belgian and French- African workers - holds that the disease of AIDS is not a new disease but is rather one of the old endemic diseases of Africa which has been, hitherto, silent or unrecognised.³⁷ That the infection could have existed undetected in humans for centuries should not be particularly surprising as laboratory diagnostic facilities in many African countries have always been poor or virtually non-existent.³⁸

Over the past few decades, a number of formidable viral diseases, and in particular the African viral haemorrhagic fevers, have suddenly made dramatic appearances in humans, causing acute, virulent and often fatal illnesses. The origins of two of these diseases, Marburg and Ebola viral haemorrhagic fevers are still shrouded in mystery. Others such as Lassa fever, have been demonstrated to have long been endemic in African populations, causing silent infections in most Africans and the dreaded

³⁶ Schoub Ibid n. 35 p 51.

³⁷ Schoub Ibid n. 36 p 51.

³⁸ Schoub Ibid n. 37 p 52.

haemorrhagic fever disease usually in non-African expatriates.³⁹ Thus, HIV could also have been an endemic virus, present for centuries in Central Africa, and contained by the sparse contact with outsiders until political developments in Africa, together with the revolution in regional and international travel, broadened the ecological niche of the virus and introduced it into Western countries. Here, the spread was facilitated by the sexual revolution and the widespread use of the hallow-bore needle for illicit intravenous drug administration.⁴⁰

The evidence is much stronger that the virus is indeed new in humans, possibly having been introduced into the human population in the 1950s.⁴¹ The earliest serum specimen retrieved from archived frozen material, shown to be positive for HIV antibodies, was taken from a patient in 1959 in Kinshasha in the then Belgian Congo (now DRC).⁴² Before then, no material has then been shown to have HIV antibodies. Also, given the rapid spread of infection which has been observed throughout the world since 1980, it is hardly likely that the virus could have circulated in humans for much before the 1950s and still have been unrecognised.⁴³

The second scenario holds that the human virus originated from the monkey immuno-deficiency virus, or as it is more

³⁹ Schoub Ibid n. 38 p 52.

⁴⁰ Schoub Ibid n. 39 p 52 .

⁴¹ Schoub Ibid n. 40 p 53.

⁴² Schoub Ibid n. 41 p 53.

⁴³ Schoub Ibid n. 42 p 53.

scientifically correctly called, the Simian Immunodeficiency Virus or SIV.⁴⁴ There are in fact a number of SIV strains, each one specific to the monkey species that it infects.⁴⁵ Each strain will, under natural conditions, infect only its specific species of monkeys and, similarly, no SIV will infect humans. HIV also cannot infect any animal other than humans, except under experimental laboratory conditions where infection can be induced in chimpanzees (although it apparently does not cause disease in this species). There are also immunodeficiency viruses in other animals, for example cats, cattle, horses, sheep and goats, and, again, natural infections with each of these viruses will only occur in their specific host animal.⁴⁶ Thus the closest relative of HIV is SIV. Within the SIV group of viruses the sooty mangabey virus (SIVsm) shows the closest relationship to an HIV strain, in fact HIV-2. The geographical distribution of HIV-2 virus is quite remarkable in that it appears relatively confined to West African countries and also to the former Portuguese colonies of Angola and Mozambique.⁴⁷ It is also of interest that the natural habitat of the sooty mangabey monkey is also the forests of West Africa.⁴⁸

More recently, allegations have been made, incriminating early oral polio vaccines as the source of SIV infection in humans, with

⁴⁴ Schoub Ibid n. 43 p 53.

⁴⁵ Schoub Ibid n. 44 p 53.

⁴⁶ Schoub Ibid n. 45 p 53.

⁴⁷ Schoub Ibid n. 46 p 53.

⁴⁸ Schoub Ibid n. 47 p 54.

its subsequent mutation to HIV.⁴⁹ According to these allegations, early trials of oral polio vaccines in the late 1950s were carried out by spraying prototype vaccines into the mouth and throat of people in Rwanda, Zaire and Burundi, precisely the early epicentres of the HIV/AIDS epidemic in Africa. Oral polio vaccine consists of a suspension of a live vaccine strain⁵⁰ of polio virus and certainly during the initial production lots of vaccines, these were not tested for contaminating simian viruses. These vaccines are produced on cell cultures derived from monkey kidneys and those coming from the African green monkey could well have been contaminated with SIVagm.⁵¹ However, there is as yet no evidence that even HIV can be contracted from ingesting contaminated materials other than the rare reported cases of HIV transmitted via oral sex or to infants from breast feeding.⁵²

The postulated sequence of events with all these hypotheses thus relate mutations in monkey virus leading to a crossing of the species barrier and to the infection of humans in Africa, followed by the subsequent introduction into the western world where its spread was accelerated by the sexual revolution. This hypothesis has support from observations of the first known appearances of the disease in various parts of the world.⁵³ As earlier stated, this is reinforced by the fact that the first laboratory demonstration of human infection by detection of antibodies was from an archived

⁴⁹ Schoub Ibid n. 48 p 54.

⁵⁰ Schoub Ibid n. 49 p 54.

⁵¹ Schoub Ibid n. 50 p 54.

⁵² Schoub Ibid n. 51 p 55.

⁵³ Schoub Ibid n. 52 p 55.

serum specimen taken in 1959 in Zaire. The first isolation of the virus also came from an archived serum specimen from Central Africa taken in 1976.⁵⁴

As already shown, towards the end of the 1970s and the beginning of the 1980s, AIDS cases were found on the island of Haiti and among Haitians living in USA. Some analysts in 1994 then tried to establish a link between the African continent and Haiti on the one hand, and between the USA and Haiti on the other hand, as Haiti was seen as a favourite holiday playground for homosexual men from the USA.⁵⁵ There is, however, no concrete evidence, as yet, to confirm such route of origin.⁵⁶

The third viewpoint on the origins of AIDS and HIV is one based largely on more general observation of the global HIV/AIDS epidemic, with an almost simultaneous appearance and spread of the epidemic in the USA, Europe and Africa, the first set of reported cases, however, being recorded in the USA and highlighted by the Centre for Disease Control's weekly reports.⁵⁷

While some of the theories of the origin of AIDS are founded upon reason, others appear to be rooted in ignorance, hysteria and prejudice. A few of the theories do serve to explain in part

⁵⁴ Schoub *Ibid* n. 53 p 55.

⁵⁵ Schoub *Ibid* n. 54 p 55.

⁵⁶ Schoub *Ibid* n. 55 p 56.

⁵⁷ Schoub *Ibid* n. 56 p 56.

the reason for the spread of HIV/AIDS, but they do not identify the source of the disease.⁵⁸

Various other theories had also been proposed on the origin of HIV/AIDS. These include:

Patient Zero Theory

This theory proposed that very early in the history or evolution of the epidemic, when it was still possible to keep close track of all the reported cases of AIDS, researchers discovered a common link in approximately forty individuals with AIDS.⁵⁹ That link was a young gay man named Gaetan Dugas who worked as a flight attendant for Air Canada and who was infected with HIV.⁶⁰ He travelled around the world and engaged in sex with numerous partners. Many of them got AIDS and eventually he did too.

This theory, like others, does not appear to resolve the issue of the origin of HIV/AIDS. Retrospective evidence demonstrates that AIDS was present prior to Dugas.⁶¹ Furthermore, even if he was 'patient zero', we still would not know how Dugas got HIV/AIDS. However, the theory supports the proposition that sex with multiple partners and

⁵⁸ Webber, D.W. AIDS and the Law-3rd Edition Supplement, New York: Aspen Publishers 1999 pp 11-30.

⁵⁹ Webber Ibid n. 58 p 56.

⁶⁰ Webber Ibid n. 59 p 57.

⁶¹ Webber Ibid n. 60 p 57.

international morbidity do contribute to the spread of HIV/AIDS.

God's Retribution Theory

The retribution theory is the much preached theory that postulates that AIDS is God's punishment against gay men, intravenous drug users and humankind generally for their alleged violations of the laws of nature (Webber, 1999:12). This theory fails to explain why infants and newborns who have never offended nature should become victims or why HIV/AIDS should have disproportionate trend of infection or disease along racial, socio-economic and certain gender lines.⁶²

Biological Warfare Theory

Proponents of this theory believe that HIV/AIDS became the end result of research and testing aimed at developing weapons for biological and chemical warfare.⁶³ Adherents are somewhat divided as to whether some germ or virus was accidentally created and escaped into the environment to pillage as it has, or whether the germ or virus was purposely unleashed into gay and drug using populations in the mistaken belief that it would remain confined to those groups. There seems to be no objective evidence, so far, to support these claims.

⁶² Webber Ibid n. 61 p 57.

⁶³ Webber Ibid n. 62 p 58.

Co-factor Theory

This theory is popular among some medical researchers and others who believe that HIV/AIDS is the result of some combination of factors that, by happenstance, cause the suppression of the immune system.⁶⁴ These co-factors are behavioural matters, such as sexual practices, lifestyle, diet, use of drugs and general health. It is so far not possible to prove this theory.

Poppers Theory

In a number of initial cases, doctors discovered that the patient had used an inhalant stimulant known as amil nitrate or poppers- either alone or in conjunction with some other co-factor, and thereby attributed this to be the cause of HIV/AIDS.⁶⁵ Equally, still, this theory has not been proved.

Mutation Theory

A substantial number of knowledgeable people from both the medical and scientific fields believe that HIV originated as a mutation from some virus that afflicted another animal species (thus the reason why this theory is also referred to as the primate or simian theory of origin of HIV/AIDS).⁶⁶ There are similarities between AIDS and diseases in cats and monkeys, and body parts of monkeys were used in the research and cultivation of the polio vaccine. There also was extensive

⁶⁴ Webber Ibid n. 63 p 58.

⁶⁵ Webber Ibid n. 64 p 58.

⁶⁶ Webber Ibid n. 65 p 59.

testing of the vaccine in Africa. Many researchers think that perhaps that was the jumping - off point for AIDS, but as already pointed out, there is no concrete evidence to confirm this.⁶⁷

Whatever the case, it is well known that HIV is not a simple virus but a number of variations of a virus that is subject to frequent mutation. This constant variation in the virus complicates the efforts of medical science to discover ways to treat and prevent the infection. Indeed, it has been posited that if AIDS originated as a mutation from some other virus in another species, we may have to await another mutation that will fortuitously render AIDS non-deadly or will cause the virus to disappear naturally.⁶⁸

In summary, therefore, while many theories as to the origin of HIV/AIDS have been formulated, the issue as to the most perfect source remains shrouded in mystery. It is, however, certain that although there is now competent retrospective evidence that AIDS has afflicted mankind since, at least, the 1950s, the disease was not recognised as a unique condition until 1981.

Despite all of the above postulates, in 1999, however, scientists, for the first time, announced that they have concretely identified the source of HIV-1 to be a chimpanzee

⁶⁷ Webber Ibid n. 66 p 59.

⁶⁸ Webber Ibid n. 67 p 59.

in Western Africa.⁶⁹ Despite this announcement, confusion continues to reign on the true origin of HIV as the issue still remains shrouded in mystery since adequate details have not been disclosed. One actually wonders how the said chimpanzee would have introduced HIV to humans by eating chimpanzee meat as in Zaire, Cameroon, etc.

2.2 MODE OF INFECTION AND TRANSMISSION AND THE LEGAL IMPLICATIONS

An understanding of the mode of infection and transmission of the HIV virus is important if sufferers or victims of HIV infection are contemplating legal action against others for their wrongful acts that gave rise to the infection. Equally, a good knowledge of their legal rights, particularly in the context of HIV/AIDS, is necessary in this dispensation.

Despite all the public fear and misunderstanding surrounding the HIV/AIDS epidemic, a few simple facts have been clear for some years now and they continue to be confirmed by some data.⁷⁰ For infection to occur, an infected person's blood, semen, or vaginal secretions (hereinafter "body fluids") must come into intimate contact with the blood or mucous membranes (such as the mouth, eyes, urethra, vagina or anus) of an uninfected person. Only in this way can the virus find its way into a new cell. Sweat, tears

⁶⁹ Gao *et al* 1999: 436-440.

Weiss and Wragman 1999: 385.

Altman, L. K. "HIV Linked to a Subspecies of Chimpanzee" 1999 N Y Time, Feb. 1. at A1.

⁷⁰ Smith and Friedman *Op Cit* n. 21 p 48.

and saliva are not considered to be infectious body fluids because the virus, if present at all, occurs in such low numbers that it is medically insignificant. No case of transmission has been shown to have resulted from contact with any of these fluids.⁷¹

The concept that only certain types of body tissues or cells are susceptible is important. What seems to make a cell susceptible is primarily the presence of CD4 protein on its surface. Blood itself contains the richest supply of vulnerable CD4 cells. Conversely, an infected person's blood also has the highest concentration of infectious virus, as compared to semen or vaginal secretions.⁷² Blood – to- blood contact therefore carries the highest risk of transmission. However, any contact between an infected body fluid and mucous membranes- especially in sexual intercourse must be considered potentially infectious.⁷³

On a worldwide scale, sex is responsible for the largest number of infections. All sexual activity involving genital contact carries some risk of transmission if engaged in with an infected partner. Also, individual risk increases with the number of sexual partners, and especially if a partner has other sexually transmitted diseases, particularly those that cause genital ulcers.⁷⁴

⁷¹ Smith and Friedman Ibid n 70 p 61.

⁷² Smith and Friedman Ibid n 71 p 62.

⁷³ Smith and Friedman Ibid n. 72 p 62.

⁷⁴ Smith and Friedman Ibid n. 73 p 62.

Receptive anal intercourse is the highest risk activity for sexual transmission of HIV due to the possibility that during the vigour of intercourse tiny tears in the lining of the rectum can allow blood or semen to enter the system.⁷⁵ It is equally important to recognise that intact skin does not permit the virus to enter the body and is not a route for transmission. Even direct contact between intact skin and infected blood is not a risky exposure. Moreover, HIV does not survive well outside the human tissue and is easily inactivated by many household cleaning agents, including bleach, alcohol, hydrogen peroxide and Lysol.⁷⁶

Therefore, HIV, unlike those diseases associated with other historic epidemics, is not transmitted by air, food, or water, or by the shared use of household objects. Casual contact cannot spread it, nor can the communal activities of daily living. Instead, there is only one mechanism of transmission, that is intimate contact with infected body fluids, which translates into a limited repertoire of risk behaviours or situations: sex, use of shared needles (intentionally or accidentally), transfusion of blood or blood products, and pregnancy.⁷⁷

There is however, unpredictability of individual outcomes as some partners become infected after a single sexual contact, whereas others remain negative after years of exposure.⁷⁸ This suggests that there are biological determinants of transmission

⁷⁵ Webber *Op Cit* n 68 p 60.

⁷⁶ Smith and Friedman *Op Cit* n. 74 p 62.

⁷⁷ Smith and Friedman *Ibid* n. 76 p 63.

⁷⁸ Smith and Friedman *Ibid* n. 77 p 63.

that we do not fully understand, since not every person exposed to HIV becomes infected and not everyone infected with HIV actually develops AIDS.⁷⁹

The risk of transmission through oral sex and deep kissing is an area of significant public anxiety. The question is difficult to study in part because this behaviour usually occurs in association with other, higher- risk behaviour, particularly intercourse. Early studies of gay men found that neither insertive nor receptive oral sex was an independent risk factor.⁸⁰ There has been no documented case of transmission by kissing. Although HIV has been detected in human saliva in vanishingly small amounts, experts in the field do not consider saliva to be a source of infection.⁸¹ It has been confirmed that receptive oral intercourse is of low, but non- trivial infectivity.⁸²

The second major route for transmission of HIV is sharing of unsterilized syringes used in intravenous drug injection, due to the exchange of infected blood.

2.2.1 Mother –to- Child Transmission of HIV and the Legal Duty to Act with Due Care

The escalating incidence of mother-to-child transmission of HIV, not only in Nigeria and South Africa but the world over, raises the question whether a duty of care is not being owed to infants

⁷⁹ Smith and Friedman *Ibid* n. 78 p 63.

⁸⁰ Smith and Friedman *Ibid* n. 79 p 63.

⁸¹ Smith and Friedman *Ibid* n. 80. 64.

⁸² Rothenberg *et al* 1998: 2095-3001.

and babies, including yet unborn babies, to prevent their contracting the HIV virus. This was one of the questions that engaged the minds of the Honourable Judges in both the High Court and the Constitutional Court of South Africa that tried the TAC case.⁸³ It is hereby respectfully submitted that not only the Government (that was ordered by the Courts to provide niverapine anti-retroviral drugs at state expense to all HIV-positive pregnant women) owes the yet unborn babies a duty of care, but their mothers and the society at large also owe them such a duty, in varying degrees. It is respectfully submitted that a HIV-positive mother who does not understand the methods of prevention of mother-to-child transmission of HIV in all its ramifications and goes ahead to breastfeed the new-born baby with breast milk that is laden with HIV-virus can be adjudged, by society standard, of negligently transmitting HIV-virus to her baby.

A major route of transmission of HIV is mother-to-child transmission. As more women become infected with HIV, through either shared needles or heterosexual activity, the problem of mother-to-child transmission escalates proportionately.⁸⁴ These children all carry the HIV antibody in their blood at birth, although this reflects the transfer of maternal antibody across the placenta rather than the infant's own response to the virus. Some studies have suggested that the use of the antiretroviral

⁸³ (2002) 4 BCLR 356 (CC).

⁸⁴ Smith and Friedman Op.Cit n. 81 p 64.

drugs such as aziothymidine (AZT) during pregnancy can possibly reduce or decrease transmission.⁸⁵

It was in line with this understanding that the Treatment Action Campaign (TAC) in South Africa made a strong case to the government for the roll out of antiretroviral drug treatment (nevirapine) to all HIV-positive pregnant women undergoing treatment in all government hospitals, at government expense. Following government's initial reluctance, the issue had to be resolved at the Pretoria High Court and the Constitutional Court of South Africa, where the courts ordered the South African government to provide nevirapine to all HIV- positive pregnant women at all government hospitals, at government expense.⁸⁶

Again, exposure to maternal blood and secretions during the trauma of a spontaneous vaginal delivery may be an independent risk for those infants who escape transplacental infection, suggesting that the trauma of the first birth leads to increased infection and that delivery by cesarean section may decrease the risk.⁸⁷

Additionally, viral particles have been isolated from breast milk and case reports have documented the reality of this route of infection, although breastfeeding is generally believed to account

⁸⁵ Smith and Friedman. Ibid n 84 p 65.

⁸⁶ Minister of Health and Others v TAC and Others (2002) 4 BCLR 356 (CC).

⁸⁷ Smith and Friedman Op Cit n. 85 p 65.

for a small percentage of perinatal transmission and to be of relatively low inherent risk.⁸⁸

2.2.2 Blood Product Transmission and the Principle of Liability for Negligence in Rendering Blood Services:

Receipt of donations of blood, semen, breast milk, organs and other human tissue, or products contaminated with HIV is another potent source of transmission.⁸⁹ It must be noted that hospitals and providers of care owe patients due care in rendering blood services since they can be held liable in negligence for sub-standard blood services or for improper screening of blood or blood products.⁹⁰

2.2.3 Other Possible Modes of Transmission

Invasive medical procedures such as surgeries or dental extraction of teeth are other possible modes of transmission of the virus if contaminated equipment, exposed to infected blood, are not properly sterilized.⁹¹

2.2.4 Non- Transmission of HIV:

Just as it is important to recognise which behavioural factors give rise to a high risk of transmission, it is equally important to recognise those that do not. Public intolerance has been strongly associated with ignorance of the fact that casual contact does

⁸⁸ Smith and Friedman *Ibid* n. 87 p 66.

⁸⁹ Webber *Op Cit* n. 75 p 62.

⁹⁰ The USA case of Amos v Vanderbilt, 2001 WL 1635476 (Tenn. 12/20/01), illustrates this point.

⁹¹ Webber *Op Cit* n. 89 p 66.

not transmit HIV. One study⁹² obtained detailed information about sharing razors, toothbrushes, bath towels and toilets, sharing unwashed utensils and drinking glasses, and hugging, kissing or sleeping in the same bed with an infected person. None of these activities resulted in a single case of viral transmission, although many of them involved sharing objects that were soiled with saliva, faeces, and urine.⁹³ Similarly, spitting, biting, and exposure to urine or faeces are not routes of transmission, because in most such situations the skin remains intact, and the amount of virus present in these fluids is, in any case, insignificant.

It is important to recognise that simply because the virus can be isolated from these body fluids in the laboratory does not mean that they play any significant role in the transmission of the virus.⁹⁴

Finally, less intimate contact in the workplace, for example, shaking of hands and sharing objects such as telephones, does not constitute a risk factor for transmission. Indeed, the fear that surrounds HIV has at times been so extreme that even the spectre of insect related transmission has been raised.⁹⁵ One study in Florida confirmed that mosquitoes played no role in transmission.⁹⁶

⁹² Smith and Friedman Op Cit n. 88 p 66.

⁹³ Smith and Friedman Ibid n. 92 p 67.

⁹⁴ Smith and Friedman Ibid n. 93 p 67.

⁹⁵ Smith and Friedman Ibid n. 94 p 68.

⁹⁶ Smith and Friedman Ibid n. 95 p 68.

2.2.5 Special Features of HIV that Facilitate Infection and Transmission:

HIV belongs to a particular family of viruses (the retroviruses) whose members share a specific mechanism of reproduction and are characterised by two distinct features. First, the genetic information for the virus is stored in molecules or building blocks of RNA, rather than in the usual deoxyribonucleic acid (DNA) of human genes. Second, the virus possesses a unique enzyme or protein, not otherwise present in human cells, called "reverse transcriptase", that enables it to translate its ribonucleic acid (RNA) into an equivalent DNA sequence.⁹⁷ These features are basic to the reproductive strength of the virus and its capacity to survive in human cells.⁹⁸

The life cycle of the virus indicates that each viral particle is composed of the viral genome (RNA) protected by a coating of structural proteins. These proteins enable the virus to attach to a specific receptor protein (referred to as CD4) on the outside of certain human cells that are crucial to the normal functioning of the human immune system. Once attached, the virus enters these cells and activates its own reverse transcriptase to copy viral RNA into its analogous DNA sequence. The resulting fragment of DNA then inserts itself into DNA strands of the host cells genes, ensuring life-long infection of that cell and its descendants. At this point, the virus may either turn off and become latent or remain active. In the first case, the infected cell continues to

⁹⁷ Smith and Fredman Ibid n. 96 p 68.

⁹⁸ Smith and Friedman Ibid n. 97 p 68.

function normally but carries the more or less quiescent virus. In the second, the viral genes remain turned on, taking over the normal machinery of the cell and forcing it to produce huge numbers of viral particles. These new viruses move on to infect other tissue, and eventually the host cell dies.⁹⁹

The virus, once within the blood stream, targets the CD4 T-lymphocyte cells, which constitute a vital component in the immune system as they co-ordinate antibody production and all immune responses. HIV viral RNA is transcribed to DNA within the T-cell cytoplasm. The viral DNA is then incorporated into the host's nuclear DNA.¹⁰⁰ Replication of the cells results also, in viral replication, possibly concentrated within the lymph nodes. Drugs such as azidothymidine (AZT) slow down this replication process but ultimately do not prevent it.¹⁰¹

Recent experience in drug therapy in Africa shows that antiretroviral therapy works by preventing HIV from replicating and suppressing its level in the host.¹⁰² Treatment with one type of antiretroviral therapy such as AZT is generally not successful. It has become conventional to administer antiretroviral therapy through a combination of drugs, the so- called cocktail or combination therapy.¹⁰³

⁹⁹ Smith and Friedman *Ibid* n. 98 p 69.

¹⁰⁰ Webb *Op Cit* n. 10 p 45.

¹⁰¹ Webb *Ibid* n. 100 p 70.

¹⁰² Nguena, C. "AIDS in Africa: Access to Health Care as Human Right" (2000) 15 *SAPR/PL* 3.

¹⁰³ Nguena *Ibid* n. 103 p 70.

In order to appreciate the subtleties of transmission and the consequences of this particular viral infection, it is necessary to have some understanding of the human immune system. The human immune system comprises many cells and tissues, each of which plays a unique role. Many of the most important immune cells move freely back and forth between blood and solid tissues such as muscle and brain. When found in the blood, these cells are called 'white blood cells'.¹⁰⁴ The immune system is therefore comprised of lymphocytes, which are special white blood cells composed of B-cells and T- cells. The B-cells produce the antibodies that identify and begin to destroy disease causing organisms. The T-cells are divided into two groups – T4 helper cells which encourage B-cells to produce more antibodies and suppressor cells which work to shut down B-cell production once infection is overcome.¹⁰⁵ HIV shuts down the immune system by gradually killing off T4 helper cells.

This depletion of T4 cells has two effects; firstly the B-cell antibody production drops sharply, limiting the body's ability to fight infection, and secondly, the ratio of helper to suppressor cells is reversed, thus effectively shutting down what little antibody activity is still taking place.¹⁰⁶

It must be noted that white blood cells form a large family comprising many different subtypes- the major subtypes include

¹⁰⁴ Smith and Friedman Op Cit n. 99 p 69.

¹⁰⁵ Peters, D. "HIV/AIDS Prevention and Control: Can the Law Help?" (2000) LASU Law Journal 57.

¹⁰⁶ Peters Ibid n. 105 p 71.

lymphocytes, monocytes, and neutrophils , each of which performs a different function in protecting the body from infection. When not in the bloodstream, lymphocytes concentrate in the lymph nodes, where they form two main subsets named after the tissue in which they originate: 'B' cells from the bone marrow and 'T' cells from the thymus.¹⁰⁷

Further subcategories have been identified when observed that some lymphocytes carry the CD4 protein, whereas T8 cells carry the CD8 protein. These proteins have particular biologic functions that determine the cells' role in immunity. The CD4 protein receives and recognises foreign materials. Thus CD4 lymphocytes, also referred to as T4 or T helper cells, perform the extremely important function of initiating or stimulating immune system activities. CD8 lymphocytes, also called T8 or T suppressor cells, control an overenthusiastic immune response and thereby prevent the body from attacking itself.

A healthy immune system requires a sophisticated interaction and balance between T4 and T8 cells.¹⁰⁸ HIV infection disrupts this normal balance. In fact, the virus enters and infects a new organism precisely by attaching to the CD4 protein. It then reproduces inside the T4 cells and destroys them. In short, HIV's primary target is the human immune system itself.¹⁰⁹

¹⁰⁷ Peters Ibid n. 106 p 71.

¹⁰⁸ Smith and Friedman Op Cit n. 104 p 70.

¹⁰⁹ Smith and Friedman Ibid n. 108 p 72.

People who die as a result of the disease condition known as AIDS do actually die from one or more of the opportunistic infections that afflict people with HIV/AIDS, since HIV/AIDS causes a person's immune system to become suppressed or ineffective in performing its primary role of fighting disease and infections.¹¹⁰

A particularly important aspect of infection with HIV is the fact that individuals presenting clinical symptoms merely account for a small proportion of all those infected with the virus. A far larger number of people have been infected but have not yet reached the stage of clinical manifestation of the disease, confirming a long period of incubation or silent infection.¹¹¹

HIV infection is an example of a slow virus disease in humans. Following infection, the virus establishes itself throughout the body, and in so doing involves many tissues and organs. The body may react immunologically against the infection in the very early stages and this immune response may result in an acute disease called the 'acute HIV syndrome', which is of short duration. The virus then 'lies low' in a latent or concealed state, producing no symptoms.¹¹² During this period, there is a progressive build-up of the mass of virus in the body and an increasing number of cells, in particular cells of the immune system, become infected. The first tissue to show clinical signs

¹¹⁰ Webber *Op Cit* n. 91 p 67.

¹¹¹ Schoub *Op Cit* n. 57 p 56.

¹¹² Schoub *Ibid* n. 111 p 72.

and symptoms of infection with HIV after the silent phase is usually the lymph nodes- which house the lymphocytes of the immune system. This clinical stage manifesting the enlargement and swelling of the lymph nodes, called lymphadenopathy, is referred to as progressive generalized lymphadenopathy (PGL) or the lymphadenopathy syndrome (LAS).¹¹³

At a later stage, further clinical signs of HIV infection may become evident, including weight loss, diarrhoea, fever, and recurrent thrush infections of the oral and genital mucous membranes. This stage is often referred to as pre-AIDS or AIDS-related complex (ARC). There are therefore five clinical stages of HIV infection – the acute HIV syndrome, the silent (latent) stage, progressive generalized lymphadenopathy, AIDS-related complex, and AIDS itself.¹¹⁴

Therefore, the first recognisable event in HIV infection is the period of acute infection associated with seroconversion. Seroconversion is an important event as it constitutes an important part of the body's natural defences against HIV.¹¹⁵ Within weeks to a few months after exposure, a newly infected person may experience a syndrome of fever, malaise, and swollen lymph glands with or without a rash and a sore throat. As the virus now reproduces rapidly, the immune system responds rapidly and effectively to this initial burst of infection, and it is

¹¹³ Schoub Ibid n. 112 p 73.

¹¹⁴ Schoub Ibid n. 113 p 73.

¹¹⁵ Smith and Friedman Op Cit n. 109 p 72.

part of this response that produces the first signs of swollen or activated lymph glands. As the normal immune defences are activated, they produce antibodies against HIV.¹¹⁶ There is a period of time when a person who is infected with HIV will not test positive on a HIV antibody test. This 'window' period lasts somewhere between three weeks and six months in 95% of infected persons.¹¹⁷ This denotes the presence of a 'window' of seronegativity, during which infected persons do not yet carry antibodies in their bloodstream.¹¹⁸

2.3 'WESTERN AIDS' AND 'AFRICAN' AIDS'

Soon after the discovery of HIV infection and AIDS in Africa in 1983 it became apparent that the characteristic of the epidemic in Africa differed quite markedly from those in Western countries.¹¹⁹ In 1988, the WHO proposed that the global epidemiology of AIDS be divided into three patterns. In pattern 1 countries found in North America, Western Europe, Australia and New Zealand, the essential component of HIV epidemiology is that infection is concentrated in the so-called high risk groups, mainly homosexuals and bi-sexual men and intravenous drug abusers.¹²⁰ Because of the relatively low numbers of women involved, paediatric infection or mother-to-child transmission is very low in these countries.¹²¹

¹¹⁶ Smith and Friedman Ibid n. 115 p 74.

¹¹⁷ Webber Op Cit n. 110 p 72.

¹¹⁸ Smith and Friedman Op Cit n. 116 p 74.

¹¹⁹ Schoub Op Cit n. 114 p74.

¹²⁰ Schoub Ibid n. 119 p 75.

¹²¹ Schoub Ibid n. 120 p 75.

Pattern 2 countries comprise sub-Saharan Africa, Central America, and also the inner city populations in the big cities of the USA, living in deprived socio-economic communities. Infection is predominantly transmitted by heterosexual intercourse, with males and females almost affected equally, or, with a slight predominance in females. Intravenous drug abuse, is rare in Africa. However, because of the large number of women infected with the virus, paediatric AIDS is a sizeable problem, being responsible for up to 15% or more of the AIDS cases in those countries.¹²²

In pattern 3 countries, the virus has been introduced at a much later stage than in patterns 1 and 2 countries, and has, as yet not fully become established. However, as the disease progressed globally and contacts between these countries and other parts of world increased, some countries, previously in pattern 3, move on to belong with patterns 1 or 2 countries. Originally, pattern 3 countries included North Africa, the Middle East, Eastern Europe, Asia and the Pacific. HIV infection was initially rare in most countries in these regions and was essentially confined to foreigners, prostitutes and intravenous drug abusers.¹²³

In South Africa, the AIDS epidemic began with pattern 1, predominantly in the higher socio-economic white population, affecting mainly homosexual men. The first reported case of AIDS in a black person in 1987, heralded the beginning of a

¹²² Schoub Ibid n. 121 p 75.

¹²³ Schoub Ibid n. 122 p 75.

pattern 2 epidemic which, a few years ago, overtook pattern 1 and is now the dominant pattern.¹²⁴

The HIV epidemic in Nigeria, and in almost all of the other African countries, is principally characteristic of pattern 2, where heterosexual sex is the major mode of transmission.

2.4 TARGET/VULNERABLE GROUPS IN SOUTH AFRICA AND NIGERIA

South Africa:

Whereas the East African region started feeling the HIV/AIDS impact in the early 80s, the Southern African region was largely spared the scourge until the mid- 80s when sporadic cases were reported.¹²⁵ By 1997 however, the epicentre of the epidemic had shifted from the Eastern to the Southern African region.¹²⁶ By 1998, South Africa had acquired the dubious distinction of being the country with the fastest growing epidemic, despite the fact that it lagged behind its neighbours at the start of the 1990s.¹²⁷

The first case of AIDS in South Africa was reported in 1982 in a white homosexual who contracted the virus while in California.¹²⁸ The subsequent pattern 1 epidemic was overwhelmingly amongst whites. By 1988, for example, 75% of the 166 reported cases of AIDS- related deaths had occurred among white male

¹²⁴ Schoub *Ibid* n. 123 p 76.

¹²⁵ Ateka. G.K. "HIV/AIDS: Global Impact and Human Rights- A Southern African Perspective" (2000) 12 Sanlam AIDS Media Resource Centre 3.

¹²⁶ Ateka *Ibid* n. 125 p 77.

¹²⁷ Ateka *Ibid* n. 126 p 77.

¹²⁸ Webb Op Cit n. 101 p 70.

homosexuals.¹²⁹ Thereafter, the HIV/AIDS situation in South Africa took a dramatic turnabout as the epidemic started to adopt the pattern 2 mode of spread, predominantly amongst the black population indulging in heterosexual practices, with women and children the most vulnerable.

The annual national HIV surveys of ante-natal clinic attenders provides a picture of this emerging geography of HIV epidemic in South Africa.¹³⁰ The HIV prevalence rate among pregnant women attending ante-natal clinics in South Africa jumped from 0.76% in 1990 to 1.49% in 1991, to 2.29% in 1992, 4.69% in 1993, 7.57% in 1994, 10.44% in 1995, 14.07% in 1996, 16.01% in 1997, 22.8% in 1998, 24.5% in 2000, to 24.8% in 2001,¹³¹ and to 24% at the end of 2002, according to the 2004 UNAIDS report,¹³² while the Centre for the Study of AIDS of the University of Pretoria indicates a 26.5% prevalence rate from a 2002 survey of women who attended antenatal clinics.¹³³ According to the UNAIDS 2004 Global Report, South Africa, with a population of about 44 million people, has about 5.3 million of its population living with HIV/AIDS.¹³⁴

South Africa has thus become, for now, the site of one of the fastest growing HIV epidemic in the world.¹³⁵ Projections now

¹²⁹ Schoub Op Cit n. 124 p 76.

¹³⁰ Webb Op Cit n. 128 p 77.

¹³¹ CSA, UP 2001: 4.

¹³² UNAIDS, 2004: 1-100.

¹³³ CSA, UP 2004: 1-3.

¹³⁴ UNAIDS Op Cit n. 132 p 78.

¹³⁵ Schoub Op Cit n. 129 p 77.

show the country will be in the most devastating throes of the AIDS epidemic by the year 2008.¹³⁶ A risk scenario conducted by the Metropolitan Life Insurance firm estimates that more than 6 million South Africans will be infected by 2005 and that by the same year, over 2.5 million people will have died from AIDS-related illnesses.¹³⁷

Of all these reported cases, the most vulnerable groups with the highest incidents of infection and deaths continue to be young girls and women of child bearing age and children.¹³⁸

2.4.1 Iatrogenic and Hospital Acquired Infections and the Hospital's General Duty to Act with Due Care:

Hospitals owe their patients a duty of care to the extent that proper sanitary and aseptic standards must be maintained at all times to avoid patients contracting iatrogenic and other hospital acquired infections.

There is the additional problem of hospital-acquired HIV infections that have added value to HIV acquired from other modes of infection. Some reports¹³⁹ have pointed to the hazards which some health care workers and other people seeking care in hospitals and health care facilities face with regards to acquiring hospital-acquired infections. Most of these infections are

¹³⁶ CSA, UP Op Cit n. 133 p 78.

¹³⁷ CSA, UP Ibid n 136 p 78.

¹³⁸ UNAIDS Op Cit n. 134 p 78.

¹³⁹ Raufu, A, "Rising HIV Infection Through Blood Transfusion Worries Nigerian Health Experts" (2000) AIDS Analysis Africa, 15; See also- International Journal of Standards and AIDS, 2003; American Journal of Epidemiology No. 146, 1997.

accidental and may involve unexpected contacts with infected needles used on HIV infected individuals.

But it has been argued¹⁴⁰ that with prompt action, the effect of HIV transmission due to needle-stick injuries can be significantly reduced. Therefore, such injury and accidental exposure to the risk of HIV infection is just a very insignificant percentage of the general HIV infection rates in South Africa. There have been excellent results in preventing HIV transmission in health workers who have had needle-stick injuries, by giving them the anti-HIV drugs within an hour of the injury and then for a month afterwards (post-exposure prophylaxis).¹⁴¹

What is of a greater and more serious concern with regards to iatrogenic infections, in the context of HIV, is the impact of infected, but undetected, blood products that contribute to the high rate of HIV infection in Nigeria. As reported,¹⁴² most anaemic pregnant women and sick children in Nigerian hospitals and health facilities face the risk of acquiring HIV through blood transfusion, from infected, but undetected blood products.

Nigeria

The general trend of infection due to heterosexual intercourse is equally well established in Nigeria, with young girls, women and

¹⁴⁰ Brouard *et al*, 2004: 1-10.

¹⁴¹ Brouard *et al Ibid* n. 140 p 79.

¹⁴² Raufu *Op Cit* n. 139 p 79.

children becoming the most vulnerable groups.¹⁴³ Although, from government reports,¹⁴⁴ less than 4 million people out of a population of over 120 million are living with HIV/AIDS in Nigeria, other sources put the figure at over 5-6 million Nigerians.¹⁴⁵ The April 2004 report of the 2003 national HIV sero-prevalence sentinel survey in Nigeria shows that as at the end of 2003, about 3.8 million Nigerians were living with HIV/AIDS out of a population of about 130 million people.¹⁴⁶ The latest 2004 UNAIDS report puts the prevalence rate of HIV infection in Nigeria at 4.2%,¹⁴⁷ as at the end of 2003.

The trend of the epidemic indicates a consistent increase in HIV prevalence rate. For example, the rate increased from 1.8% in 1993, to 3.8% in 1994, to 4.5% in 1996, 5.4% in 1999 and 5.8% in 2001, according to a government report,¹⁴⁸ and to 5.0% in 2003, according to the 2003 sentinel report released in April 2004.¹⁴⁹

2.4.2 Trends, Similarities and Differences Between South Africa and Nigeria:

A closer examination of the trends of the HIV/AIDS epidemic in both countries, confirms that the epidemic has continued to grow

¹⁴³ Nigerian Federal Ministry of Health 2003: 1-14.

¹⁴⁴ Akinsete, I. Transmission of HIV and the Vulnerable Groups in Nigeria. 2002, A Lecture to Participants of Senior Executive Course No. 24, National Institute for Policy and Strategic Studies, Kuru, Nigeria (Unpublished Paper), p 1.

¹⁴⁵ Raufu *Op Cit* n. 142 p 80.

¹⁴⁶ NFMH *Op Cit* n. 143 p 80.

¹⁴⁷ UNAIDS *Op Cit* n. 138 p 79.

¹⁴⁸ Akinsente *Op Cit* n. 144 p 80.

¹⁴⁹ NFMH *Op Cit* n. 146 p 81.

in both countries, largely through heterosexual unprotected sexual exposures. The trend or pattern of infection in both countries shows some degree of consistency or similarity in the urban-rural rates of infection. As observed by this study from available data, in both countries, though there are indications of explosive epidemics in certain specific locations, the general national rural prevalence rates are not markedly different from the urban prevalence. From our analysis,¹⁵⁰ the areas with the highest prevalence rates are areas that exemplify absolute maintenance of the tenets of customary practices. After a thorough analysis by this study, it is submitted that this holds true for Kwazulu Natal in South Africa, with the highest national prevalence rate of about 28%, despite the general national rate of about 26.5%.¹⁵¹ In the same vein, as observed by this study, it also holds true for the Cross River State of Nigeria, with the highest national prevalence rate of 12%, despite the general national rate of 5%.¹⁵²

Since almost all the prevalence rates were derived from HIV sentinel survey results of tests conducted on pregnant women attending ante-natal clinics in both countries, the South African statistics and trends seem to buttress the findings by Albertyn.¹⁵³ For the benefit of justifying the extent to which the said report has a bearing with the situation in Kwazulu-Natal, some

¹⁵⁰ From our research data analysis leading to this thesis we discovered that the areas with the highest prevalence rates are areas that exemplify absolute maintenance of the tenets of cultural and customary practices.

¹⁵¹ CSA, UP Op Cit n. 137 p 78.

¹⁵² NFMH Op Cit n. 146 p 81.

¹⁵³ Albertyn Op Cit n. 93 p 36.

highlights of the report are hereby reviewed. That report supports the view that for the African woman, HIV vulnerability emerges from the Apartheid past characterised by racial inequality, a migrant labour system, the disintegration of family life and a deepening racial and gendered poverty. The report also attributed the high susceptibility of women to HIV/AIDS to the gendered perspective of cultural practices in traditional settings. It authoritatively maintains that it is the convergence of multiple levels of inequalities and factors that shape women's vulnerability to HIV/AIDS. These factors appear to exert some influence on the trend, especially as it reflects on Kwazulu Natal.¹⁵⁴ It is respectfully submitted that while Kwazulu Natal, as a province, is one of the provinces that experienced the worst disruption or disintegration of family life due to Apartheid racial inequalities, it is also the epitome of culture and traditions in South Africa, a custodian of traditional customs. This view-point is generally shared by many other resident foreigners in South Africa, including Nigerians.

A similar trend can be found in the Cross River State of Nigeria- the state with the highest HIV prevalence. It is the State that experiences the worst disintegration of family life, where migrant labour work force converge. People from all over Nigeria converge in the state capital and its environs because it is generally a hospitable environment, attracting visitors because of

¹⁵⁴ From the research data analysis leading to the writing of this thesis, it is submitted, with respect, that the above factors appear to exert tremendous influence on the general trend, especially as it reflects on Kwazulu-Natal.

a number of communal activities. Although it was diplomatically arranged, even Charles Taylor, the former President of Liberia, is living there because it is the most hospitable state that welcomes and accepts everybody.¹⁵⁵ The words that make up the name of the state capital- CALABAR depict the nature of its heritage. It connotes :

C-COME

A-AND

L-LIVE

A-AND

B-BE

A-AT

R-REST

It must be noted that a reference cannot be made to a particular source as being the architect of those words, letters or names that connote "CALABAR". They were customarily given and have simply existed from time immemorial.

The words : come and live and be at rest- attract different people to converge at Calabar and its environs, leaving their families. The city boasts of a large concentration of migrant labour work force who come to work in the rubber plantations and numerous estates in Calabar and the entire state. It is respectfully submitted that besides, Calabar, the entire Cross River State is

¹⁵⁵ While 'hospitality,' as a factor, might not have been the sole criteria for C. S. Taylor, the former leader of Liberia, to seek asylum in Nigeria and to particularly settle in Calabar, I submit, with respect, that the general hospitable nature and life style of Calabar, in addition to other diplomatic and political considerations, might have had serious persuasive effect.

the epitome of culture and traditions in Nigeria, a custodian of the peoples' customs.¹⁵⁶ To a great extent, these attributes collaborate Albertyn's¹⁵⁷ exposition on some of the factors behind the highest prevalence rates of HIV/AIDS in South Africa.

Another similar trend in both countries is that women, and especially young girls between the ages of 15-24, are the most vulnerable, as confirmed by UNAIDS.¹⁵⁸ One of the largest representative surveys of South African youth aged between 15 and 24 shows that by the age of 23, one in five South African youth are HIV positive.¹⁵⁹ The same report indicates that despite high levels of awareness about HIV/AIDS, the vast majority of youth do not think that they are personally at risk of contracting HIV.

A similar trend holds true for Nigeria. Apart from the UNAIDS 2004 report, the April 2004 Report of the last Nigerian National HIV Sero-Prevalence Sentinel Survey, indicates that the population mostly at risk are youth, especially girls, between the age 15-25. In my interview with the Federal Director of Public Health Services in the Nigerian Federal Ministry of Health in Abuja, in 2001, on which group constituted the most vulnerable

¹⁵⁶ It is respectfully submitted that there is no specific or general reference on Calabar as the epitome of culture and traditions in Nigeria, except for the fact that from general customary and traditional practices of the Calabar people, and from their customs and belief system, passed on from one generation to another, it is common knowledge amongst Nigerians, of which I, as a Nigerian, can confirm, that Calabar is the epitome of culture in Nigeria.

¹⁵⁷ Albertyn *Op Cit* n. 153 p 82.

¹⁵⁸ UNAIDS *Op Cit* n. 147 p 81.

¹⁵⁹ CSA, UP *Op Cit* n. 151 p 82.

group to HIV/AIDS, I was told that young women and girls were the most vulnerable. Accordingly, the government is doing its utmost to target youth in schools and other segments of the population, to acquaint them with a range of options with regard to HIV/AIDS prevention and care.¹⁶⁰

2.5 PERSONAL METHODS OF PREVENTION AND CONTROL OF HIV/AIDS AND THE HUMAN RIGHTS IMPLICATIONS

Arising from the harsh reality that we cannot eradicate HIV/ AIDS from the human body once it is established there, prevention is still the most powerful intervention available. From epidemiologic studies, it is noteworthy that sex is responsible for the largest number of HIV infections.¹⁶¹ Being that sexual practices hinge on behavioural norms, controlling or changing sexual behavioural patterns will work positively to control the spread of the infection. The importance of individual responsible behaviour in the control and prevention of HIV/AIDS has been recognised and affirmed by various resolutions and declarations on AIDS.¹⁶² In its resolution, the World Health Assembly on Global Strategy for the Prevention and Control of AIDS stressed in 1987 that every individual owes others a responsibility to prevent contracting or transmitting HIV infection.¹⁶³ The same stand was reiterated by the London Declaration on AIDS Prevention when it noted that

¹⁶⁰ Personal communication by way of an interview of the Director of Public Health Services in the Federal Ministry of Health, Abuja, Nigeria, on November 7, 2001.

¹⁶¹ UNAIDS *Op Cit* n. 158 p 85.

¹⁶² Peters *Op Cit* n. 105 p 71.

¹⁶³ Resolution WHA 40.26 of May 15, 1987.

HIV transmission can be prevented through informed and responsible behaviour.¹⁶⁴

Informed and responsible behaviour includes but not limited to total abstinence from premarital and extramarital sex. Individuals should avoid multiple sexual partners, while men are particularly encouraged to dissociate themselves from the practice of polygamy.¹⁶⁵ The control and prevention of AIDS should be championed jointly by the government and individuals in their private capacities. While government needs to discharge its responsibility in providing adequate health care services and creating an environment where fundamental human rights are not only respected but protected, individuals must reciprocate by exhibiting responsible behaviour.¹⁶⁶

It is necessary for government to create an atmosphere conducive for a full guarantee of the fundamental rights of those vulnerable to HIV/AIDS and those potentially at risk of contracting the virus. This can be achieved by making confidential HIV testing widely available, accessible and affordable, while ensuring that the stigma and discrimination associated with HIV/AIDS are completely eliminated. This will go a long way in empowering those at risk to seek help, protect themselves and equally protect others, thereby promoting responsible behaviour and curbing the further spread of

¹⁶⁴ World Summit of Ministers for Health on Programmes for AIDS, Held in London on January 28, 1998.

¹⁶⁵ Peters *Op Cit* n. 162 p 86.

¹⁶⁶ Peters *Ibid* n. 165 p 87.

infection, noting that their rights end where the rights of others begin. This falls in line with the legal principle of 'right and duty', as no right exists in isolation of a corresponding duty. Again, since individuals living with HIV/AIDS do not have wide freedom to transmit the virus, they owe others a duty to protect them from contracting the virus.

To buttress the necessity for government to eliminate HIV/AIDS-associated stigma and discrimination and to guarantee individuals vulnerable to HIV/AIDS their fundamental human rights to privacy and confidentiality, a review of some case law and judicial decisions in some jurisdictions become important. In this regard, it is appropriate to draw inference from the observation of the court in the Florida civil court in the State of Florida, USA.

In the case of Rasmussen V South Florida Blood Service Inc.,¹⁶⁷ a civil litigant sought to obtain the identities of fifty one blood donors who might have caused HIV transmission by donating HIV-infected blood for transfusion. Ruling under Florida civil court discovery rules, the court expressed concern that even an enquiry as to whether an individual was at risk of HIV infection or AIDS disease would be highly stigmatising to that individual. In balancing the harm to the fifty one donors and the deterrent effect such an inquiry might have on future blood donations with the lack of probative value of the inquiry, the court concluded

¹⁶⁷ 500 So 2d 533, 535 (Fla. 1987).

that the discovery of the donor identities should not be allowed.

The Court said, inter alia as follows:

AIDS is the modern day equivalent of leprosy. AIDS or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment.

Again, in the case of Poveromo-Spring V Exxon Corp.,¹⁶⁸ the court opined:

*---AIDS has a stigma attached to it unparalleled by any other disease. AIDS sufferers are often shunned and ignored, and an intentional disclosure of such a diagnosis ---- could certainly fall within the framework of extreme and outrageous-
-.*

Any breaches of confidentiality by state or local government agencies without the consent of the HIV/AIDS patient does not help in the long term goal of prevention and control because people will be reluctant to go for testing and treatment, fearing that their privacy cannot be guaranteed. Many jurisdictions therefore regard breaches of the fundamental human rights to privacy and confidentiality in the context of HIV/AIDS as very serious violations. In USA, the court, in the case of Hill V Evans¹⁶⁹ concluded that testing without a patient's consent violated the equal protection provision of the US Constitution. Several cases have considered the question of whether a

¹⁶⁸ 968 F Supp. 219 (D.N.J. 1997).

¹⁶⁹ NO. 91-A-626-N, 1993 WL- 595676 (M.D. Ala.Oct.7, 1993).

government official or employee is entitled to a qualified immunity for disclosure. The holdings in these cases leave little doubt that a constitutional right to privacy in regard to HIV information is clearly established. In Doe V Borough of Barrington,¹⁷⁰ the court ruled that such right to privacy extended to the immediate family members of an individual with HIV infection, whether or not they were infected. Here, local police officers had disclosed their knowledge of an individual's HIV infection to neighbours. The court held there was no compelling reason for the disclosure.

Similarly, in A.I.A. v West Valley City,¹⁷¹ the Court of Appeals for the Tenth Circuit in USA upheld the claim of violation of privacy rights resulting from police disclosure of a report of HIV infection to an arrestee's family and friends. Similarly, in Doe v Town of Plymouth,¹⁷² police coercing resulting in disclosure of the plaintiff's HIV status to the plaintiffs' neighbours was held to violate her constitutional right to privacy.

Perhaps, it was such heightened state of awareness as regards the legal rights to non-discrimination on HIV- positive individuals that informed the appeal and the decision in the Botswana's case of Makuto V State.¹⁷³ The facts of this case were that the appellant, M, was convicted of rape. Under section 142 (2) of the Botswana Penal Code, he was required to undergo HIV testing

¹⁷⁰ 729 F. Supp. 376 (D.N.J. 1990).

¹⁷¹ 26 F. 3d 989 (10th Cir. 1994).

¹⁷² 825 F. Supp. 1102 (D. Mass. 1993).

¹⁷³ (2000) 5 LRN 183 (2000 Vol. 5, London: Butterworths).

before he was sentenced. Section 142 had been amended by the Penal Code (Amendment) Act 1998 (No. 5 of 1998) and new sentencing provisions regarding offenders with HIV had been introduced.

Thus, under section 142(4)(a), a person convicted of rape who proved to be HIV-positive, but unaware of that status, would be sentenced to a minimum of 15 years imprisonment. The minimum sentence for a person convicted of rape who was aware of his HIV status was 20 years.¹⁷⁴ The sentence for rape committed by someone who was not HIV-positive was 10 years. The rationale behind the new provision was the need to restrict the spread of HIV/AIDS in Botswana, which had assumed pandemic proportions, according to the ruling.

After a committal to the High Court for sentencing, M was sentenced to 16 years imprisonment and 2 strokes of the light cane. He appealed. One of his grounds of appeal was that s.142(4) offended against s.15 of the Constitution in that it was discriminatory and unjust to provide for heavier penalties on the basis of an offender's HIV status and that s.142(4) was unjust and unfair as it presumed that an offender who tested HIV-positive after conviction must have transmitted the virus to the victim. Section 15 of the Constitution provided that no law should be discriminatory, which it defined in sub-s(3) as 'affording different treatment to different persons, attributable wholly or

¹⁷⁴ Section 142(4)(b).

mainly to their respective descriptions by race, tribe, place of origin, political opinions, colour or creed--'.

The Court of Appeal of Botswana, on 28th July 2000, allowed the appeal against sentence and consequently reduced the sentence to 10 years. Thus, different treatment on the basis of a person's HIV status did amount to discrimination. The Court of Appeal went an extra mile, in its ruling, to demonstrate that any kind of discrimination on the basis of HIV status, even when it concerned a convicted criminal, must be discouraged.¹⁷⁵

A range of other health interventions can be implemented to reduce or control HIV transmission. These include the training of health workers who can educate individual members of the community on prevention and control, reducing medical care associated transmissions, including those from injections and blood transfusion, STD control and testing,¹⁷⁶ and other categories of hospital acquired infections.

With regards to the prevention and control of HIV infection in children, several strategies can be adopted. Routine childhood immunizations should be given, and polio vaccine should be administered in the killed virus, injectable form, rather than the live- attenuated virus, oral form.¹⁷⁷ In addition, children with HIV

¹⁷⁵ *Makutu v State* (2000) 5 LRC- Ruling of the Court of Appeal of Botswana at pages 183-187.

¹⁷⁶ Ngweshemi, J. *HIV Prevention and AIDS care in Africa*, Netherlands: Royal Tropical Institute, 1997 pp 15-20.

¹⁷⁷ Hutton, N. "Health Prospects for Children Born to HIV Infected Mothers" in *AIDS*

should receive pneumococcal and influenza vaccines. Early identification and treatment is important as well as monitoring physical growth and nutritional status to identify and intervene to solve problems with appetite, intolerance and malabsorption before serious malnutrition or wasting occurs.¹⁷⁸

Above all, governments in South Africa and Nigeria must initiate all necessary measures, including relevant drug therapy to stop or control perinatal or mother-to-child transmission of HIV.

Finally, as a control measure by means of early intervention to treat seropositive HIV patients and others living with AIDS, the initiation of antiretroviral (AZT) therapy should be encouraged as soon as the T4 cell count falls below 500,¹⁷⁹ though there is an inclination to delay the AZT therapy until the CD4 cell count falls to 350 or even 250 per cu.mm of blood. There are essentially, three main elements in the therapy of AIDS: first- the treatment of the indirect effects of HIV, that is the opportunistic infections and the HIV associated tumours; secondly, the reconstitution of the immune system which has been so profoundly damaged by the infection; and thirdly, the direct antiviral treatment of HIV infection itself.¹⁸⁰

and childbearing, Edited by Faden Ruth. New York: Oxford University Press, 1996 pp 72-75.

¹⁷⁸ Hutton Ibid n. 177 p 92.

¹⁷⁹ Smith and Friedman Op Cit n. 118 p 74.

¹⁸⁰ Schoub Op Cit n. 135 p 78.

2.6 LEGAL COERCIVE MEASURES AS MEANS OF PREVENTION AND CONTROL OF HIV/AIDS AND THEIR HUMAN RIGHTS IMPLICATIONS

In a different dimension, a more radical approach to prevention and control of HIV infection involves the invoking of the coercive force of law by adopting both the direct and indirect measures.¹⁸¹ This obviously poses a threat to individuals' fundamental human rights. Indirect coercive measures involve oblique efforts to stop the spread of HIV through criminalizing or discouraging conduct which may lead to transmission, like in the Botswanan case reported above. Examples include laws which restrict or criminalize activities such as prostitution, sodomy, extra-marital sex and intravenous drug use. Direct coercive measures, on the other hand, are designed to slow the spread of HIV by targeting the movements or conduct of, or affecting the civic status of known or presumed HIV carriers.

Internationally, a broad range of direct measures has been considered or adopted in the fight against HIV/AIDS. These include quarantine or isolation of individuals known to carry the virus, criminal punishment of persons who have negligently or knowingly infected others, mandatory screening of specified segments of the population, and disclosing an individual's HIV status or AIDS diagnosis without consent. Indirect measures

¹⁸¹ Cameron and Swanson "Public Health and Human Rights: the AIDS Crises in South Africa" (1992) 8 Journal of Human Rights pp 200-232.

have also been considered, principally involving prohibitions on certain types of sexual conduct.¹⁸²

Certainly, coercive measures, direct or indirect, have one thing in common: they affect an individual's civic or social status, or limit his or her freedom of movement, freedom of choice or personal autonomy, with the object of protecting public health. These imply that respect for human rights is eroded in the midst of strong and far-reaching decisive action to curb the transmission of HIV. But, then one wonders whether restrictive legal measures can, in fact, help society to contain the threat of HIV/AIDS? One would ask whether an individual's rights to liberty and privacy do compete with the needs of society to protect itself from AIDS, or whether enhancing one diminished the other.¹⁸³

It is instructive to consider some decided legal authorities in regard to public health coercive measures. The US Supreme Court once had an occasion to decide on the constitutionality of a certain coercive measure, as several states in the US have justified laws criminalizing certain types of sexual activity on the ground that these laws help to stop the spread of diseases by deterring conduct responsible for its transmission. In defending its anti-sodomy statute, in the case of Bowers V Hardwick,¹⁸⁴ the

¹⁸² Cameron and Swanson Ibid n. 181 p 93.

¹⁸³ Cameron and Swanson Ibid n. 182 p 94.

¹⁸⁴ 106 S.Ct. 2841 (1986).

State of Georgia urged the court that the prohibition helped in fighting HIV transmission.

The US Supreme Court, in upholding the constitutionality of the law, did not mention this justification, though it found by a 5 – 4 majority decision that the Georgian Statute was constitutional on the ground that the federal constitution confers no fundamental right on homosexual men to engage in sodomy. However, the American Psychiatric Association and the American Public Health Association had argued in their brief filed in respect of the Bower's case, in response to the said State of Georgia's argument, that community effort and support are made more difficult in an environment in which a concomitant of participating in educational efforts is self – incriminating. This is because laws which punish behaviour seen to be linked to transmission of HIV are thus themselves likely to keep away from voluntary testing precisely those individuals most likely at risk of being infected.¹⁸⁵

In so doing, such legislation may actually contribute to the spread of the virus by preventing individuals from learning that they are HIV-positive and from receiving counselling on how to modify their behaviour to protect others. In this regard, an American federal district court had pointed out in Baker V Wade,¹⁸⁶ before the Supreme Court decision in Bowers, that

¹⁸⁵ Cameron and Swanson Op Cit n. 183 p 94.

¹⁸⁶ 106 FRD 526 (ND Texas 1985).

criminalizing homosexual conduct in an effort to combat HIV/AIDS would be a public health disaster.

One would hasten to say, however, that with the peculiar circumstances and mode of transmission in sub-Saharan Africa, including South Africa and Nigeria, the HIV/AIDS epidemic raises special problems, calling for exceptional responses for efforts to criminalize behaviour, because it is heterosexual conduct that is the primary means of transmission of HIV.¹⁸⁷

2.7 LEGAL ISSUES CONCERNING SODOMY AND GAY/LESBIAN EQUALITY, DISCRIMINATION AND HIV/AIDS

As a coercive measure, and in order to check the spread of HIV/AIDS, different jurisdictions adopt different approaches in an attempt to criminalize sodomy or to deny gay/lesbian equality rights. For example, in the USA, different states approach the same issue differently.¹⁸⁸ In Africa, too, South Africa appears to stand apart from other countries on the issue of lesbian/gay equality rights.¹⁸⁹ Discrimination against groups perceived to be carriers of HIV has been a general and well known practice throughout the period of the epidemic. In many parts of the world, the spread of HIV has been associated primarily with lesbian women and gay men. This has generally led to human

¹⁸⁷ Cameron and Swanson *Op Cit* n. 185 p 95.

¹⁸⁸ *Intra*, at pages 99-100. See page 99-100 for details of the USA States and the court decisions in USA and Australia.

¹⁸⁹ *Intra*, at page 97 (the next page). See page 97 for a detailed discussion on this matter.

rights violations and discrimination against people perceived to be homosexuals.

In Nigeria, in the general society as widely known, the practice of sodomy, or gay/lesbian lifestyle is not common and there are generally no reported cases or legislations on such matters.

In South Africa, the criminalisation of sodomy was challenged in the Constitutional Court in the case of National Coalition for Gay and Lesbian Equality and Others v Minister of Justice.¹⁹⁰ Sodomy was included as a scheduled offence in the Criminal Procedure (Act 51 of 1977) and the Security Officer's (Act 92 of 1987), and in Section 20(a) of the Sexual Offences (Act 23 of 1957). The Constitutional Court found that the common law offence of sodomy and its inclusion in certain statutory schedules was not a reasonable or justifiable limitation on the rights of gay men to equality, dignity and privacy. The offences were accordingly found to be unconstitutional and invalid.

In a related development, lesbian couples wanted to marry in South Africa. The Constitutional Court held that they could adopt a child but could not be legally married in South Africa. This was highlighted in the case of Du Toit and Another v Minister of Welfare and Population Development and Others.¹⁹¹ However, in a very recent but related case involving Cecilia Bonthuyys and

¹⁹⁰ 2000 (2) SA 1 (CC); 1999 (1) SA 6 (CC).

¹⁹¹ 2003 (2) SA 198 (CC).

Marie Fourie v Minister of Home Affairs,¹⁹² the Supreme Court of Appeal, in a ground-breaking judgment, ruled that same- sex marriages had to be legalised. The Court, in a majority decision, declared that under the Constitution, the common law concept of marriage had to be developed to include same sex marriages. Edwin Cameron JA said that the definition of marriage should read as follows:

*Marriage is the union of two persons to
the exclusion of all others.*

This case is of added significance and adds a new dimension to the current topical controversy as to whether the fundamental human rights, as guaranteed by international and domestic human rights instruments to individuals and groups, have no limited dimensions or cannot be curbed or derogated from, in the overriding public and religious interest.

It is however noted that the Minister of Home Affairs has appealed against that ruling, to the Constitutional Court.

The USA example, as it pertains to gay/lesbian equality rights is helpful in this dispensation. It guides the young democracy in South Africa, and even in Nigeria, to learn from its experience and legal/public policy responses with regards to issues of gay/lesbian equality rights. It confirms that in such an advanced democracy like USA, there is no uniform legal interpretation and

¹⁹² Recent Supreme Court of Appeal Judgment Delivered in Pretoria on Tuesday, November 30, 2004.

enforcement of the notion of gay/lesbian equality rights, neither is there a blanket and unchallenged acceptance of the social concept involving gay and lesbian life-styles. The concept of gay/lesbian lifestyle or their equality rights further fuels the issue of discrimination and inequalities in the larger society and this is not good in the context of HIV/AIDS and stereotyped discrimination against women.

The situation, as it pertains to gay/lesbian equality and marriage, in USA, is fluid, with lack of uniformity, controversies and disagreements, in the sense that different states approach the matter uniquely. For instance, it is hereby respectfully submitted that there is no uniformity in the legal interpretation of the provision that "everyone is endowed with inalienable rights, including life, liberty and pursuit of happiness."¹⁹³ This is true because different states in USA interpret relevant provisions to suit their purpose.

In June 2003, the USA Supreme Court issued a decision in Lawrence and Garner v Texas,¹⁹⁴ which struck down sodomy laws nationwide and provides a right to privacy for all citizens.

According to the February 27, 2004 issue of AIDS Policy and Law, the following States in the USA have adopted the following approaches:

- The State of Utah, on its own, is pushing through an amendment barring gay/lesbian couple marriages.

¹⁹³ American Declaration of Independence 1776.

¹⁹⁴ US Supreme Court Decision, June, 2003, in AIDS Policy and Law, Vol. 18 n. 18, Oct. 24, 2003, LRP Publications: Hershey, Pennsylvania, 2003, p 5.

- Hawaii approved gay marriage in 1993, but amended the State Constitution to outlaw same sex marriages in 1998.
- Texas ban on sodomy was struck down by the US Supreme Court in 2003. Now the State wants an amendment to ban gay marriages.
- Minnesota banned gay marriages in 1997 but grants benefits to same sex partners.
- Vermont approved a civil union law in 2000, providing gay couples with benefits of married couples.
- Massachusetts High Court allowed gay marriages from May 2004.
- South Carolina banned gay marriages in 1996.
- City authorities in California performed scores of same sex weddings and issued marriage licences to gay and lesbian couples in February 2004.

The right to non-discrimination had gained a unique international audience in a case combining this principle with the rights to equality and privacy for homosexuals. In the case of Toonen v Australia,¹⁹⁵ a petition reviewed before the United Nations Human Rights Committee, the criminalization of homosexual sodomy was found to violate the right to privacy and the right to non-discrimination protected by the International Covenant on Civil and Political Rights.

¹⁹⁵ UN GAOR, HUM. Rts. Cte. 15th Sess. Case 488/1992, UN Doc CCPR/C/50/D/488/1992 (April 1994).

2:8 GLOBAL, REGIONAL AND NATIONAL DIMENSIONS OF THE HIV/AIDS PANDEMIC AND THE IMPLICATIONS FOR WOMEN'S VULNERABILITY TO HIV/AIDS:

2.8.1 Global Dimension of the HIV/AIDS Pandemic:

Several years ago, a WHO report indicated that over 36 million people suffered from HIV/AIDS as at 2000.¹⁹⁶ The same report shows that roughly 3 million adults and children died of HIV/AIDS worldwide in 2000. About 80% or 2.4 million of those deaths were in sub-Saharan Africa. It is the hardest hit region with nearly 70% of all HIV/AIDS cases reported in the world, according to the WHO, and 72% of new infections reported in 2000.¹⁹⁷ In 2000 alone, 5.3 million people became infected with the virus. In addition, an estimated 21.8 million people or more had died from the epidemic, as at 2000, since it started in the 1980s.

A 2004 UNAIDS Global Report indicates that about 42 million people in the world were living with HIV/AIDS as at 2003. Of this figure, about 28 million people from sub-Saharan Africa were living with HIV/AIDS by the end of 2003.¹⁹⁸

In Asia and the Pacific, an estimated 6.4 million people were living with HIV at the end of 2000. Most of the infections were concentrated in few large countries in South and South East

¹⁹⁶ AIDS Policy and Law, Vol. 16, No. 9, May 2001, LRP Publications: Horshein, Pennsylvania, USA, PAGE 10. See also Vol. 17, No. 1, Jan. 18, 2002, page 2.

¹⁹⁷ AIDS Policy and Law *Ibid* n. 196 p 101.

¹⁹⁸ UNAIDS *Op Cit* n. 161 p 86.

Asia.¹⁹⁹ By 2003, the number of people living with HIV/AIDS in this region had risen to about 9.6 million.²⁰⁰

Approximately 1.8 million people were believed to have the virus in Latin America and the Caribbean at the end of 2000. But, according to the WHO, anti-retroviral drug therapy has reduced AIDS death rate in the region. It has also cut the rate of transmission of the virus from mothers to children.²⁰¹ However, according to the latest 2004 UNAIDS Global Report, the number of people infected with the virus in the Caribbean and Latin America, had risen to about 2.9 million.

At the same time, Eastern Europe and Central Asia have seen some of the sharpest increases in HIV infection. The regions reported 250,000 newly infected people in 2000.²⁰² By 2003, the number of people living with HIV/AIDS in the region stood at about 1.9 million.²⁰³

In North America and Western Europe which include some of the most industrialized countries in the world, thousands of people continue to be infected with HIV. In North America, 920,000 people lived with HIV/AIDS as at 2001.²⁰⁴ However, by the end of 2003, the number had increased to about 1.6 million, while in

¹⁹⁹ AIDS Policy and Law Op Cit n. 197 p 101.

²⁰⁰ UNAIDS Op Cit n. 198 p 101.

²⁰¹ AIDS Policy and Law Op Cit n. 199 p 102.

²⁰² AIDS Policy and Law Ibid n. 201 p 102.

²⁰³ UNAIDS Op Cit n. 200 p 102.

²⁰⁴ Smith and Friedman Op Cit n. 179 p 93.

Western Europe, the number had increased to 730,000 by 2003.²⁰⁵

In summary, therefore, at the end of 2001,²⁰⁶ it was estimated that 40 million adults and children were living with HIV/AIDS and over 28.1 million of these were in sub-Saharan Africa. The number of deaths from HIV/AIDS globally in 2001 was 3 million and 2.3 million of these were also in from sub-Saharan Africa. Altogether, from the beginning of the epidemic to the end of 2001, 28.1 million adults and children had died from HIV/AIDS. The number of persons newly infected in 2001 was 5 million and 3.4 of these were from sub-Saharan Africa.

From the 2004 UNAIDS Global Report, it appears the statistics on sub-Saharan Africa had begun to stabilise, while other regions are experiencing increases in the number of people infected with HIV. For example, while the total number of people in the world living with HIV/AIDS increased to about 42 million at the end of 2003, the number of people infected in sub-Saharan Africa remained at about 28 million. From the same 2004 UNAIDS report, it is shown that the total number of AIDS death in the world had risen to about 3.3 million by 2003.²⁰⁷

²⁰⁵ UNAIDS Op Cit in. 203 p 102.

²⁰⁶ Akinsele Op Cit n. 148 p 80.

²⁰⁷ UNAIDS Op Cit n. 205 p 103.

2.8.2 Further Analysis of the USA Statistics

The situation of the HIV/AIDS epidemic in USA deserves special analysis in order to provide some measure of comparative review with the situation in sub-Saharan Africa. At least, the USA statistics, which records high prevalence of HIV in poor-deprived communities shows the concomitant nexus between HIV/AIDS and poverty, a lesson for poor African countries and communities to learn from.

The statistics of the HIV/AIDS epidemic in USA have revealed an increasing inequality of vulnerability and exposure. While AIDS has become endemic in pockets of urban poverty, this inequality has come increasingly to mirror the larger socio-economic inequalities.²⁰⁸ In addition to gay men, people of colour have experienced a disproportionate amount of the epidemic. This is judged from the distribution in terms of reported cases showing that 31 percent were among African-Americans, and 17 percent were among Hispanics, figures representing, respectively, two and one half and two times the expected proportions based on the population distribution of these groups in USA.²⁰⁹

It is essential to recognise that these groups reflect population prevalence. Causative factors show that communities at increased risk are defined not just by a single, clearly identifiable risk behaviour, for example, men having sex with men or intravenous drug users sharing needles, but by much

²⁰⁸ Smith and Friedman Op Cit n. 204 p 102.

²⁰⁹ Smith and Friedman Ibid n. 208 p 104.

broader social and economic structures within which these behaviours occur, such as geography, race, social institutions (such as prostitution), and economic class.²¹⁰

The rising impact of HIV/AIDS on women in USA, and its close link, for women, with heterosexual sex, warrants attention. Women account for 12 percent of reported cases, but 61% of all cases attributed to heterosexual contact.²¹¹ AIDS has become the leading cause of death for African-American women between the ages of fifteen and forty- four. It is estimated that AIDS will surpass cancer as the single leading cause of death for African-American women in this age group.²¹² It therefore becomes certain that certain sub- populations in USA suffer from HIV/AIDS in much larger numbers than the population as a whole.²¹³ The incidence of AIDS is six times greater for African-Americans than it is for whites. For Hispanic- Americans, the figure is three times larger than for whites, African-Americans now account for 38%, and Hispanic-Americans for 18%, of the total number of AIDS cases in USA,²¹⁴ despite their minority status and very low population figures in terms of the general population of the USA, a country in which whites assume over two-thirds overwhelming majority in population.²¹⁵

²¹⁰ Smith and Friedman *Ibid* n. 209 p 104.

²¹¹ Smith and Friedman *Ibid* n. 210 p 105.

²¹² Smith and Friedman *Ibid* n. 211 p 105.

²¹³ Webber *Op Cit* n. 117 p 74.

²¹⁴ Webber *Ibid* n. 213 p 105.

²¹⁵ Webber *Ibid* n. 214 p 105.

The 2004 UNAIDS Global Report shows that the number of adults and children living with HIV/AIDS continue to increase in the USA and most of the newly infected are from minority backgrounds.

The number of women who are HIV- positive is also growing at an alarming rate in USA as women now make up over 18% of new AIDS cases. African- American women are particularly vulnerable. They are estimated to be about fifteen times more likely than a white woman to be HIV- positive.²¹⁶ The trend in USA, a country that once championed the crusade on slave trade and racial discrimination, with growing disparities between blacks and whites, shows some similarities with South Africa. It is noted that South Africa equally experienced such “teething” racial and deep-rooted social problems like the USA. The vulnerability of blacks and women in USA, as in South Africa, is thus considered by this study to also emerge from the past, characterised by racial inequalities, a migrant labour system, the disintegration of family life and deepening racial and gendered poverty. Women therefore account for a growing proportion of HIV infection in USA- where drug usage by means of injection and heterosexual contact become the predominant modes of HIV transmission.²¹⁷

²¹⁶ Webber *Ibid* n. 215 p 105.

²¹⁷ Eldred and Chaisson. *The Clinical Course of HIV Infection in Women* (ed) by Faden Ruth, New York: Oxford University Press, 1996 p 15.

In the USA, while paediatric AIDS or perinatal or mother-to-child transmission of HIV have been on the decline, however, the racial disparity among children with AIDS continued with 83% of children reported with AIDS being blacks or Hispanics.²¹⁸ General figures for subsequent years in USA, from 1997 to 2000 show the number of children reported with AIDS continuing to decline further, while a greater percentage of the few cases reported were Blacks or Hispanics.²¹⁹

As a summary of the position in USA, race and concomitant factor of poverty continue to define who is vulnerable to HIV/AIDS. A historical perspective on the root cause of poverty and glaring inequalities and discrimination in USA confirm that the foundational roots of racial discrimination against the blacks, their low academic and social background, as with the blacks in South Africa, did much harm. For one, it provided the conduit wire connection to the present attendant poverty that contributes to vulnerability to HIV/AIDS. The 2004 UNAIDS Global Report again confirms this position in USA, with the increase in the number of infected adults and children from poor economic and minority background. The same UNAIDS report equally confirms the nexus between HIV/AIDS and poverty.

On the whole, in USA, developments in the medical treatment of HIV/AIDS continue to be effective in turning the disease into a

²¹⁸ Centre for Disease Control (CDC) HIV/AIDS Surveillance Report, 10 Year End Edition, Washington, DC, 1999 pp 1-200.

²¹⁹ CDC Ibid n. 218 p 107.

manageable, chronic disease, instead of what was termed a "death sentence" in the past, with HIV/AIDS being the fourteenth - leading cause of death as at 1997.²²⁰ What has contributed to this positive result is the role of law, particularly in regard to legal prohibitions or limits on syringe exchange and related HIV prevention programmes, as crucial elements in the US national prevention strategies.

In Western Europe, the number of people living with HIV/AIDS was about 540,000, while over 15,000 people were living with HIV/AIDS in Australia and New Zealand, as at 2001.²²¹ By 2003, however, the number of people living with HIV/AIDS had increased to 730 000 in Western Europe.²²²

It is also reported that East Asia holds an enormous potential for the spread of the HIV/AIDS epidemic since the sex industry and use of illegal drugs is widespread.²²³ This appears to be one of the regions with the fastest growth in the epidemic. By 2003, about 1.5 million people were living with HIV/AIDS in the region.²²⁴

2.8.3 Regional Dimension of the HIV/AIDS Pandemic:

The HIV/AIDS pandemic, although global in distribution, has wrecked its maximum devastation within the sub-Saharan African

²²⁰ Webber Op Cit n. 216 p 106.

²²¹ AIDS Policy and Law Op Cit n. 202 p 102.

²²² UNAIDS Op Cit n. 207 p 103.

²²³ AIDS Policy and Law Op Cit n. 221 p 108.

²²⁴ UNAIDS Op Cit n. 222 p 108.

region. Statistics indicated that as far back as 1998, two-thirds of people living with HIV/AIDS in the world, (an estimated 21 million people as at then) were in the sub-Saharan African region. Over the years, 83% of all AIDS deaths have been in the African region. It is home to 80% of women and 87% of children living with HIV/AIDS.²²⁵

Despite the fact that the statistics of HIV infection in sub-Saharan Africa appears to have stabilised, this region still harbours the largest number of people living with HIV/AIDS in the world and still remains the world's epicentre.²²⁶ According to the joint United Nations Programme on HIV/AIDS(UNAIDS) and the WHO, 7 out of 10 people newly infected with HIV live in sub-Saharan Africa.²²⁷ Among children under 15, the proportion is even higher at 9 out of 10.²²⁸ Though sub-Saharan Africa accounts for only one-tenth of the world's population, it has so far borne 83% of mortality from AIDS. By 2000, over 34 million sub-Saharan Africans had been infected with HIV. That statistic appears to have been an over-estimation by the Star Newspaper as the 2004 UNAIDS Global Report indicates that by 2003, about 28 million sub-Saharan Africans were living with HIV/AIDS.²²⁹

²²⁵ Ateka *Op Cit* in. 78 p 34. See also UNAIDS Report: 1998.

²²⁶ Nguena *Op Cit* n. 102 p 70.

²²⁷ UNAIDS and WHO Epidemic Update (1998). See also UNAIDS Global Report, 2004 pp 1-100.

²²⁸ Nguena *Op Cit* n. 226 p 109.

²²⁹ The Star Newspaper, 26 June, 1998; See also the SA Dept. of Health Survey 1999.

2.8.4 National Dimensions of the HIV/AIDS Pandemic: South Africa and Nigeria

Within the sub-Saharan African region, South Africa is exhibiting the fastest growing epidemic. It accounts for more than 50% of all new infections in Southern Africa. It also has the highest population of people living with AIDS, in terms of absolute numbers, for a single country, with about 3.5 million of its people revealed to be HIV-positive as at 1998.²³⁰ By the mid 1999, the number of South Africans estimated to be living with HIV/AIDS had risen to 3.6 million.

The SA National Department of Health 1998 HIV/AIDS Survey found that one in every eight adults was living with HIV/AIDS - a 33.8% increase on the previous year's figures, while infection rates per day in South Africa were estimated to be 1500²³¹ by the middle of 1999 and 2000⁴³ by the end of 1999. Statistics show South Africa as having over 4.7 million of its citizens living with HIV/AIDS, with women having the highest figures and being the most vulnerable group.²³² Of this number, 2.7 million are women and approximately 1 million are children who are infected through mother-to-child transmission of HIV.²³³ However, according to the recent UNAIDS Epidemic Update in 2004, the number of South Africans with HIV/AIDS as at 2003 is 5.3

²³⁰ The Star Newspaper *Ibid* n. 229 p 109.

²³¹ CSA, UP *Op Cit* n. 159 p 85 (2001:5).

⁴³ Simbayi, L. C. "AIDS Awareness and Sexual Behaviour Change in South Africa" in Kemp, R. *AIDS and Development in Africa*, New York: The Harworth Press, 1999 pp 48-49.

²³² Pretoria News of South Africa, June 11, 2002, p 2.

²³³ Pretoria News *Ibid* n. 232 p 110.

million, out of a population of about 44 million people.²³⁴ At the same time, Ethiopia followed with 2.5 million and Nigeria with 2.2 million, as at 1998.²³⁵ According to recent UNAIDS report, the number of Ethiopians currently living with HIV/AIDS is 1.5 million.

The epidemic update for Botswana is worth mentioning as it is indicated as having the highest incidence of HIV infection in the world. Botswana, with a population of approximately 1.6 million people, has 350,000 of its population living with HIV/AIDS.²³⁶

In Nigeria, the general trend of infection through heterosexual conduct is well established, with women, young girls, women of child-bearing age and children being the most vulnerable groups to HIV/AIDS.²³⁷ As already shown in chapter one of this work, the links between gender-based discrimination and HIV/AIDS, between discrimination/inequality and HIV/AIDS, and between customary law/traditions, gender and HIV/AIDS are clear and well established. These links are very well pronounced in Nigeria, a typical traditional African society, from available statistics, though there appears to be a dearth of convincing HIV/AIDS-related statistics, or even litigations, in Nigeria.

Despite the limitations as to HIV/AIDS statistics/data in Nigeria, there are clear indications about the prevalence of HIV/AIDS in

²³⁴ UNAIDS *Op Cit* n. 224 p 108.

²³⁵ The Star Newspaper *Op Cit* n. 229 p 109.

²³⁶ UNAIDS *Op Cit* n. 234 p 110.

²³⁷ UNAIDS *Ibid* n. 236 p 111.

Nigeria and the undisputable fact that young girls, women and children are the most vulnerable targets. The then Minister of Health, Dr. Ikechukwu Madubuike, confirmed during the HIV Day Remembrance Programme in Nigeria that 5,207 Nigerians were infected with HIV by 1996, while 201 others had died of AIDS.²³⁸ That was a rather very conservative estimate as a later survey conducted in 1998 revealed that 2.2 million Nigerians were infected with HIV as at that year.²³⁹ One report, in 2000, put the statistics of Nigerians living with HIV/AIDS, with women being the most vulnerable group, at 5 million.²⁴⁰

However, the latest statistics as released by both the Nigerian Federal Government and UNAIDS show that the number of Nigerians living with HIV/AIDS as at 2003 are about 3.8 million²⁴¹ and 3.6 million²⁴² respectively. The position of women and young girls in Nigeria is of special significance since the prevalence of gender-based discrimination and inequality in the Nigerian traditional and cultural settings make them more susceptible to HIV/AIDS.²⁴³

2.9 SOME CAUSES/FACTORS LEADING TO HIV INFECTION

These are indicated hereunder.

²³⁸ The Nigerian Daily Times, Thursday, July 16, 1997, p 29.

²³⁹ The Star Newspaper Op Cit n. 235 p 110.

²⁴⁰ Raufu Op Cit n. 145 p 80.

²⁴¹ NFMH Op Cit n. 146 p 81.

²⁴² UNAIDS Op Cit n. 237 p 111.

²⁴³ Peters Op Cit n. 166 p 87.

2.9.1 Socio-Economic Factors and their Legal Implications for Women's Vulnerability to HIV/AIDS:

It is because socio-economic and cultural factors have played key roles, and have serious legal implications, in women's vulnerability to HIV/AIDS both in South Africa and in Nigeria that this study adjudges them worthy of receiving more in-depth analysis, far beyond the introductory remarks earlier given in chapter one of this work. The legal implications of certain customary laws, traditional practices and gender issues on the susceptibility of African women to HIV/AIDS cannot be overstated.

The links between socio-economic and cultural factors and HIV/AIDS are ripe both in South Africa and Nigeria and the UNAIDS 2004 report confirms these links as impacting seriously on HIV/AIDS, and especially on the high susceptibility of women.

It has been confirmed that there is a greater sense and incidence of cultural violence in South Africa.²⁴⁴ The first report²⁴⁵ featured in its comments thus:

*crises in male identity behind South
Africa's culture of violence.*

²⁴⁴ Pretoria News of Tuesday, September 21, 2004; the Pretoria News of Monday, November 15, 2004; and the Pretoria News of Tuesday, February 19, 2004, and the Pretoria News of Tuesday, December 7, 2004.

²⁴⁵ Pretoria News Ibid n. 244 p 113 (Tuesday, September 21, 2004).

It states that a paradigm shift, a mental gear is required for the values of equality and dignity to take hold in the collective psyche. The paper highlighted the news thus:

.....'These are all manifestations of an alienated identity'- says Nhlanhla Mkhize, a lecturer in psychology at the University of Kwazulu-Natal. Nkhize traces the origin of this alienation to factors that defined the era of apartheid: marginalisation, poverty, violence, and the forced migration that uprooted men from families and communities. These social ills transformed male identity into something typified by aggressiveness, risk-taking, sexual prowess and dominance over women. Such notions of masculinity have now become entrenched. With the introduction of HIV into the social equation, their consequences are also deadlier than before. Experts now agree that the twin epidemics of AIDS and violence against women and children in South Africa are linked to these concepts of male identity. Frequent casual sex, unprotected sex and forced sex put men and women at risk of HIV infection...

On the other hand, the second newspaper report²⁴⁶ boldly reported thus:

SA Leads World in Rape, Wife Beating.

Again, another news report²⁴⁷ added another heart-breaking news thus:

²⁴⁶ Pretoria News Ibid n.245 p 113 (Monday, November 15, 2004).

43 children raped per day.

In a related development, another news report²⁴⁸ unambiguously reported thus:

African women take a stand against lobola, saying custom contributes to gender inequality and domestic violence, and that women in these marriages are unable to refuse sex or insist that their husbands wear condoms.

In view of the above publications, it is acutely clear that despite numerous punitive legislation designed to address gender imbalance and violence in South Africa, the problem of gender based violence, that creates avenues for women's higher vulnerability to HIV/AIDS, is still overly pronounced.

This situation places women at a greater risk of HIV infection because one of such sexual partners could be a carrier of the virus. The status of women in society is further lowered by the fact that they have fewer economic options while at the same time assuming multiple roles in the family as well as society. They often combine the role of family care with that of breadwinner.²⁴⁹ Conditions of serious economic pressure compel women to yield to sexual advances by men, for purpose of economic survival, and in the process get infected with the virus.

²⁴⁷ Pretoria News Ibid n. 246 p 114 (Tuesday, December 7, 2004).

²⁴⁸ Pretoria News Ibid n. 247 p 114 (Tuesday, February 19, 2004).

²⁴⁹ Kemp Op Cit n. 67 p 33.

This is generally true in Africa and, especially in South Africa and Nigeria.

The adverse economic circumstances of the past two decades have affected the economic fortunes of women, especially young girls.²⁵⁰ Though South Africa is now booming economically, the majority of the dominant blacks, especially women, are very poor.²⁵¹ One need not overstress the fact that commercial sex workers contribute significantly to the spread of HIV/AIDS in Africa.²⁵² There is also another group which includes young teenage girls who take to prostitution to support themselves because of AIDS - related poverty. For the girl-child orphan, in order to face the challenges of life, prostitution becomes the only way out and the vicious cycle of HIV/AIDS spread is refuelled and continuously guaranteed.²⁵³

2.9.2 Socio-Cultural factors and their Legal Implications for Women's Vulnerability to HIV/AIDS

As in socio-economic factors, socio-cultural factors have unique legal implications for women's vulnerability to HIV/AIDS. The socio-cultural traditions of female genital mutilation, male dominance, and a number of others, while denying women the fundamental human right to dignity of their human persons, equally render them easily susceptible to HIV/AIDS.

²⁵⁰ Kemp Ibid n 249 p 115.

²⁵¹ Kemp Ibid n. 250 p 115.

²⁵² Kemp Ibid n. 251 p 115.

²⁵³ Kemp Ibid n. 252 p 115.

Some socio-cultural traditions and practices that are unique to Africa have a major impact on the transmission of HIV/AIDS in the region. Sexual relations with multiple sexual partners, as widely embraced in South Africa and Nigeria contribute to the high prevalence of HIV infection.²⁵⁴ It is respectfully submitted that in South African and Nigerian, there prevails some aspects of sexual promiscuity, though in varying degrees, which, to my mind, contributes to the high prevalence of HIV/AIDS in these countries.

Though the need for behavioural change is preached at all levels of society in the circumstance of the high incidence of HIV/AIDS, the magnitude of actual change appears, however, from available reports, to be slow. While it is true that a high percentage of people are now cautious and adopt condom use, studies have indicated that most youth still take the risk of unprotected sex, believing that they cannot be the unlucky victim of HIV/AIDS.²⁵⁵

2.9.3 Physiological/Biological Factors and their Implications for Women's Vulnerability to HIV/AIDS

Biologically or physiologically, women are more vulnerable to HIV/AIDS than men. The reason for this is obvious, because infection is much more concentrated in vaginal fluids. This makes it more likely for infected men to pass on the disease to women than the other way round.²⁵⁶ Therefore, the females biological

²⁵⁴ Kemp Ibid n 253 p 115.

²⁵⁵ CSA, UP Op Cit n. 159 p 85.

²⁵⁶ Kemp Op Cit n. 254 p 116.

systems, which render the receptive female partners prone to infection and more readily vulnerable than the male receptive partners for the HIV virus during heterosexual intercourse, are an important contributing factor to women's vulnerability to HIV/AIDS.

2.9.3 Rape and its Legal Implication for Womens Vulnerability to HIV/AIDS

It has been confirmed by the Pretoria News that South Africa leads the world in rape and the worst of it is child rape.²⁵⁷ This issue of rape of children even extends to the rape by parents/fathers of their own daughters, as shall be confirmed by case law shortly in this work.

Rape is another serious problem for women in all societies. It contributes, in a serious dimension, to the transmission of the HIV virus to women.²⁵⁸ In African societies, a woman who has been raped is much disadvantaged as she is overly restricted by a stringent social structure, making her reluctant or unwilling to report the rape case for fear of unexpected consequences.²⁵⁹ This limits her ability to receive guidance, counselling and treatment, and in the process, she could have contracted the virus and passed it on to another person.

²⁵⁷ Pretoria News Op Cit n. 246 p 114.

²⁵⁸ Kemp Op Cit n. 256 p 117.

²⁵⁹ Kemp Ibid n 258 p 118.

In Nigeria, generally, the incidence of rape is very low and is rarely reported. On the other hand, in South Africa, there is an alarming incidence of rape cases, especially on infants, babies, presumed virgins and young girls. The problem is exacerbated by the myth that sex with a virgin gives rise to a miraculous cure with regards to HIV/AIDS.²⁶⁰ The negative impact of this state of affairs in South Africa is so grave that the State had to send a communication to the United Nations Committee on the Rights of the Child, on the issue of child rape. Key highlights of the communication²⁶¹ were as follows:

The HIV/AIDS epidemic can be regarded as a Contributory cause and consequence of the Sexual exploitation of children. The dangerous Myth that sex with a virgin or young girl will cure AIDS has resulted in an increase in child sexual exploitation. In addition, HIV/AIDS leaves increasing numbers of children orphaned, who often resort to selling their bodies to survive in child-headed families.

Female-child rape or sexual abuse, as a contributory factor to the vulnerability of females to HIV/AIDS, deserves special mention and detailed examination. Child sexual abuse has become a subject of worldwide concern. In South Africa, specifically, incidents of child sexual abuse are frequently reported by the mass media. Most pathetic and unfortunate are reports of rape and sexual abuse of babies who are few months

²⁶⁰ South Africa's Report to the Committee on the Rights of the Child No. CRC/C 51/Add2, 4 December, 1997 Confirms the Existence of the Myth.

²⁶¹ South Africa's Report *Ibid* n. 260 p 118.

or years old. Numerous other cases of child sexual abuse or rape of infants, children and teenage girls abound in South Africa.

A well celebrated and widely reported case of rape of a baby in the Northern Cape Province is that of BABY TSHEPANG. Most mass media in South Africa, including the radio, television networks, and newspapers continuously reported²⁶² on the sad and barbaric state of affairs with regard to the unfortunate incident of rape of Baby Tshepang in 2003, at a tender age of about six months. Decided legal authorities on rape of young girls and infants in South Africa includes the case of S v M,²⁶³ where the appellant was accused of raping his 6 year old daughter.

Various theories explain why men sexually abuse children. First, there is the prevention theory, which is based on the assumption that all sexually active people are likely to be HIV infected.²⁶⁴ Children aged four to twelve are considered sexually inactive and uninfected. Uninfected individuals wishing to engage in safe sexual activity therefore find a safe haven in young children.²⁶⁵

Second, there is the cleansing theory, which suggests that by engaging in sexual intercourse with a specific target group, like infants, virgins and old women who have reached the age of

²⁶² E News Television Network, Johannesburg, and the Pretoria News were prominent among the media organizations in South Africa that condemned the rape of Baby Tshepang in 2003/2004.

²⁶³ 2003 (1) SA 552 (SCA).

²⁶⁴ Kemp Op Cit n. 256 p 117.

²⁶⁵ Kemp Ibid n. 264 p 120.

menopause, HIV/AIDS can be passed from the infected individual to his or her partner. During this passage, the infected individual is simultaneously cleansed of the virus.²⁶⁶ The target population changes with time and location. Presently, infants and very young children form the easiest prey or the most accessible target groups.²⁶⁷

The third theory is one of retribution. It maintains that individuals who know or believe themselves to be infected try to spread the infection to all sectors of society, including infants and young children who are easy to abuse.

All these factors also portray the increased vulnerability of girl children to HIV/AIDS, in addition to other factors like HIV transmission through infusion with infected blood and mother-to-child transmission of HIV.

2:9.5 Domestic Violence and its Legal Implication for Women's Vulnerability to HIV/AIDS

Domestic violence is another factor that promotes the spread of HIV/AIDS. An abused, emotionally upset or destabilised husband or wife, due to domestic violence, suddenly turns elsewhere for emotional support or solace. This amounts to psychological violence and it is even more dangerous and implicating than physical violence. Sexual comfort is usually one avenue to psychologically calm down such serious emotional turbulence. If

²⁶⁶ Kemp Ibid n. 265 p 120.

²⁶⁷ Kemp Ibid n. 266 p 120.

acted on the spur of the moment, the victim's sense of perception can be distorted and he/she can become subject to wrong sexual decisions. This can lead him/her to be infected with the virus and to transmit the same to other partners, in due course, and especially to the initial partner, after reconciliation.

As already discussed, it is amazing that despite many punitive legislations, including the Domestic Violence Act, Act 116 of 1998, there is still a high rate of violence, especially, gender-based violence, in the South African society.

2.9.6 Gender Related Factors and their Legal Implications for Women's Vulnerability to HIV/AIDS

The position of women and young girls in Africa, as reflected in South Africa and Nigeria, is significantly important because of the prevalence of gender-based inequality and discrimination. Many African countries are generally noted for cultural practices that encourage the subordinated roles of women and gender inequality.²⁶⁸ Nigeria and South Africa are among the African countries that embraced these and other traditional practices that appear to relegate women to the background, though after the apartheid era, things have changed in South Africa. Due to socio-cultural traditions in the African traditional and cultural setting, many women and young girls are more susceptible to HIV infection.²⁶⁹

²⁶⁸ Albertyn Op Cit n. 157 p 84.

²⁶⁹ Peters Op Cit n. 243 p 112.

Particularly in view of their subordinate status, women and girls have less access than men to education, health care, economic opportunity and social support, all of which combine to relegate them to an inferior status.²⁷⁰ This makes it difficult for women and girls to have control over their own sexuality and reproductive health.²⁷¹ A combination of factors, including cultural attributes, economic dependence on men, cultural socialisation to be submissive to men, inability to negotiate safer sex or avoid the HIV related consequences of multi-partner syndrome, and a number of other gender- related factors jointly render young girls and women in South Africa and Nigeria most vulnerable to HIV infection and AIDS related deaths.²⁷² The situation applies in most other African countries.

The situation becomes more precarious particularly in marriage and procreation where women are denied reproductive rights and the control of their own sexuality.²⁷³ The resultant effect is the high prevalence of mother-to-child transmission of HIV in South Africa and Nigeria, due to the fact that many women who have been vulnerable to HIV/AIDS have no control over their reproductive rights.²⁷⁴ The practice of polygamy and acquisition of multiple sexual partners have also contributed to the high prevalence of HIV/AIDS, most especially, in Nigeria.

²⁷⁰ Albertyn *Op Cit* n. 268 p 122.

²⁷¹ Peters *Op Cit* n. 269 p 122.

²⁷² Raufu *Op Cit* n. 240 p 112.

²⁷³ Peters *Op Cit* n. 271 p 122.

²⁷⁴ Albertyn *Op Cit* n. 270 p 122. See also UNAIDS Report: 2004.

Traditions, customs, culture and economic circumstances render women willing and submissive partners who are unable to deny sexual advances to most male partners. Most women who have become victims of HIV/AIDS were infected by their husbands.²⁷⁵ Wives have very limited ability to autonomously control their personal risk of exposure to HIV/AIDS. They are unable to control their own sexuality, in the context of most African societies,²⁷⁶ and particularly in South Africa,²⁷⁷ and Nigeria. This equally occurs in many other African countries, characterised by typical African traditional 'roots'.

This finding is collaborated by Mmabatho Ramagoshi, Director, Gender Equity, Department of Education, Pretoria, at a workshop in Pretoria in September 2003. She reported:

.....Violence against women has reached endemic proportions in our continent. It might differ in severity but women all over the continent endure different forms of abuse and violence daily in their lives, whether in the private or public domain. In South Africa, reports indicate that not only domestic violence is high, but also that femicide is on the increase and also what I could term communal suicide, where we see men irrespective of race or class, when they are tired of life and have decided to exit, they do not want to leave this earth alone but decide to kill their partners and sometimes kids before killing themselves.

²⁷⁵ Gostin and Lazzirini, Human Rights and Public Health in the AIDS Pandemic, New York: Oxford University Press, 1977, pp 1-73.

²⁷⁶ Gostin and Lazzirini Ibid n. 275 p 123.

²⁷⁷ Albertyn Op Cit n. 274 p 123.

Rape is another form of abuse women in this continent have to endure daily in their lives. South Africa is regarded as a country with the highest rape victims in the world.

Due to patriarchy, many women are illiterate which implies that they are not working and depend on their partners for survival. They endure violence in different forms. There are many other examples of violence against women, like dowry related violence, trafficking in women, etc. Let me share my thoughts about harmful traditional practices. Firstly, I will use the definition of Article 1(e) of the Protocol that states that all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as the right to life, health, dignity, education and physical integrity amount to harmful traditional practices. What comes to mind as harmful traditional practices include female genital mutilation, as practised in 28 African countries, including some Arab and Asian countries, and early marriages, as common in some cultures. Early marriages have negative impact on the young girl because once married, they no longer continue with their education and depend on their husbands for support. In this condition, they are subject to abuse and battery. Early marriages also put the young girls into major health risks. It is reported that early marriage results in early child bearing, with severe consequences for the health of young mothers and their babies.

*Violence against women is a phenomenon that cuts across geographical, cultural and political boundaries and varies only in manifestation and severity.*²⁷⁸

2.10 THE LEGAL CONSEQUENCES OF WOMEN'S VULNERABILITY TO HIV/AIDS

The far-reaching implication for the high degree of vulnerability of women, who are normally within the range of child bearing ages, is the corresponding vulnerability of children. This is due to vertical or perinatal or mother-to-child transmission of HIV at the birth of the infant. The resultant effect is that not less than one-third of all children born to infected mothers are themselves infected,²⁷⁹ globally,²⁸⁰ but especially in Africa. This is so because babies born to women infected with HIV have a 20 to 40 percent chance of contracting the virus from their mothers.²⁸¹

Millions of children who escape mother-to-child transmission at birth when their mothers are HIV-positive, but the babies are themselves not infected, suffer from emotional and economic deprivation because their parents have died or are chronically ill.²⁸² Most of these children grow up to face the predicament of becoming AIDS orphans. Another consequence is that the extended family system, which has traditionally absorbed

²⁷⁸ Mmabatho, R. Lecture Delivered at a Workshop in Pretoria, South Africa in September 2003. Mmabatho, Ramagoshi is the Director, Gender Equity, Department of Health, Pretoria, South Africa.

²⁷⁹ Kemp Op Cit n. 267 p 120.

²⁸⁰ UNAIDS Op Cit n. 242 p 112.

²⁸¹ UNAIDS Ibid n 280 p 125.

²⁸² Kemp Op Cit n. 279 p 125.

orphans, is increasingly coming under severe strain as parents die of AIDS.²⁸³

2.11 SUMMARY

This chapter has discussed the historical and contextual framework of the HIV/AIDS pandemic. The meaning of HIV/AIDS, origin, mode of infection and control of HIV/AIDS, legal and other related factors that contribute to women's vulnerability to HIV/AIDS infection have been analysed. Available statistics at the global, regional and national levels, as well as socio-economic, cultural and physiological and other related factors, including gender-related factors, with implications for women's vulnerability to HIV/AIDS, are among the issues highlighted in the chapter. In the next chapter, it is proposed to discuss how legal aspects contribute to women's vulnerability to HIV/AIDS.

²⁸³ Kemp Ibid n. 282 p 125.

CHAPTER THREE:

THE LAW AND WOMEN'S VULNERABILITY TO HIV/AIDS

3.0 INTRODUCTION

The effect of legal and other non-legal factors, including customary law, traditions, gender related factors, etc, on the HIV/AIDS epidemic and women's vulnerability, have been discussed in chapter one of this work. In that chapter, the links between customary law, gender and HIV/AIDS, as well as between HIV/AIDS and gender-based discrimination are very distinct.

The reality before us, not only in Africa but the world over, is that legal and other related factors jointly contribute to place women in their position as the most vulnerable victims of the HIV/AIDS devastation, as already shown in chapter one.¹ It is submitted that the general abuse of women's legal rights to equality and non-discrimination, added to socio-economic, socio-cultural, physiological/biological and gender related factors, all combine to make women easy preys to the epidemic.² Besides, other human factors like rape and domestic violence add a new dimension to the problem of women's vulnerability to HIV/AIDS.

This chapter examines some aspects of the law that contribute adversely to women's vulnerability to HIV/AIDS. These include family law, public health law and customary law. This study, however, particularly emphasizes or addresses the weaknesses

¹ Intra, at pages 1-25.

² Albertyn Op Cit no. 277 p 123.

and adverse contributions of the Nigerian family law and customary law more than it does the South African family law and customary law. This is due to the obvious reason that numerous legislations in South Africa, unlike in Nigeria, have directly addressed the perceived weaknesses or deficiencies of the South African family law and customary law. These legislations, which are women-oriented and generally protect women, include the Recognition of the Customary Marriages Act 120 of 1998; the repealing of Section 11A of the Black Administration Act 38 of 1927; the Prevention of Family Violence Act 133 of 1993; and the Domestic Violence Act 116 of 1998.

In addressing the deficiencies of the South African family law and customary law, these legislations address most aspects of gender imbalance and violence in marriage and in social relationships that are adverse to the interests of women. They attempt to restore gender equity while addressing, inter-alia, the loop-holes in customary family law marriages which relegate customary law marriage to the background and render its incidents inferior to civil law unions.

In addressing the weaknesses and deficiencies of the Nigerian family law and customary law, it is shown in this work that where the legal or legislative framework to resolve women's social problems are lacking, the inadequacies of the law must be addresses. Equally, where there are neither public policy responses nor any new legal or policy initiative to address these issues, there is the ardent need to address the short- comings of

the law.

This chapter therefore examines the adverse contributions of some branches of law to the vulnerability of women to HIV/AIDS. The negative attributes of Nigerian family law and customary law as well as the public health laws of both South Africa and Nigeria, are particularly examined. The examination is with a view to highlighting the peculiar characteristics of each of these branches of law, which are detrimental to women's welfare, in the context of HIV/AIDS.

3.1 NIGERIAN FAMILY LAW

Family law, directly or indirectly, has a part to play in the vulnerability of women to HIV/AIDS, in the sense that it governs sexual and marital relations. Under Nigerian family law, marriage can be contracted after fulfilling the essential and formal pre-requisites of statutory or common law requirements, or those pre-requisites as laid down by customary law. This essentially gives rise to two types of marriages in the Nigerian setting, statutory/common law system of marriage and customary law system of marriage.

3.1.1 Statutory/Common Law of Marriage in Nigeria:

In contracting marriage by virtue of the statutory/common law provisions, two key provisions require further examination in order to determine the extent and degree of their contribution to the vulnerability of women to HIV/AIDS. These concern the provisions on the age of marriage and the marriage contract, and

the ease of dissolution of marriage.

3.1.2 Age of Marriage and the Marriage Contract

For countries that were influenced by the English legal tradition and which, at a point, inherited the English common law, including Nigeria, marriage under statutory/common law provisions entails fulfilling both the essential and formal requirements of the marriage.³ However, the essential validity of marriage, with regards to capacity, is overly relevant in this discussion. Possession of the requisite capacity to marry under the statutory/common law system entails being of single status; not being an infant at law; and not requiring parental consent if the parties are over twenty one years old. How these three factors impact on the issue of women's vulnerability to HIV/AIDS in Nigeria deserve some in-depth exploration.

3.1.3 Single Status

It has been noted in chapter two of this work that the African society is, to some extent, a traditional society, where a good number of men hold sexual relations in high esteem, whether in South Africa or in Nigeria. With a vicious cycle, fuelled by socio-economic and socio-cultural factors, acquisition of a single status, as a precondition for contracting a valid statutory/common law marriage, makes little or no difference to susceptibility to the HIV virus. This implies that because of the promiscuous nature of the society where even partners who have

³ Nwogugu, E.T. Family Law in Nigeria Ibadan: Heinemann Educational Books. 1999 pp 1-42.

exchanged the marriage vows in Africa and in the Western world still indulge in extra-marital affairs, young men and women in single status, do worse. In the current dispensation where HIV/AIDS is no respecter of persons, it means that the more the number of sexual contacts and exposure to sex, the higher the probability and risk of contracting the HIV virus. It is respectfully submitted that single status and youthful exuberant may even fuel the desire to be more sexually active, thereby leaving one vulnerable to HIV/AIDS.

It is a well-noted fact that the socio-cultural tradition of sexual relations with multiple sexual partners, as embraced in most African countries including Nigeria, makes nonsense of the concept of acquisition of single status before a valid marriage. Undoubtedly, the multiple partner syndrome has contributed immeasurably to the spread of HIV/AIDS. Going ahead to contract a modern or common law marriage on the basis of being of single status, may, on the contrary, exacerbate the spread of HIV/AIDS.

3.1.4 Age of Majority

Different legal systems have different ages as their ages of infancy and adulthood. Some regard 16 years, while others accept 18 years, as the ages of adulthood. Yet still, 21 years remain the universal age of adulthood or majority. The legal age of majority in Nigeria is twenty one years. But this is generally not held "tightly", since recourse, most times, are had to the official requirements of one having to attain the age of 18 years

before he/she can vote, or be allowed to drink alcohol, etc. The African Charter on the Rights and Welfare of the Child⁴ indicates that a child means every human being below the age of 18 years.

It becomes necessary to evaluate if the higher age of adulthood, under modern/common law systems of marriage, as against the lower or younger age of puberty, under customary law systems of marriage, plays any significant role in curbing the spread of HIV/AIDS, in marital relations. In making this evaluation, one must take cognizance of the fact that the sexually active members of the population belong to the age group 15 – 44. Within the age limits of 16 to 22, young people, if not properly guided or counseled, have the tendency to become sexually over-active.⁵ This is dangerous because they can become exposed to the dangers of HIV/AIDS during the early stages of their sexuality, and thereby carry the virus onto marriage. The point of concern to this study is the fact that any age of marriage younger than 18 years does not accord the mental maturity to withstand marital pressures and stress. This study shall present a position that, for any system of marriage, no marriage should be contracted at an age less than 18 and that parental consent should remain a requirement so that parents can morally guide their children unto marriage.

⁴ Article 2 of the African Charter on the Rights and Welfare of the Child.

⁵ It is respectfully submitted, from the point of view of a studious observer, that the most sexually active members of the population belong to the age group 15-44. See also UNAIDS 2004 Report, pages 1-100, which indicates that the most sexually active members of the population belong to the age group 15-45.

3.1.5 Parental Consent

Parental consent is a major requirement for customary law marriage, as well as for statutory law marriage where the parties are under the age of 21 years, in Nigeria.⁶ It is not required where the parties who are contracting a statutory law marriage are over the age of 21. It is respectfully submitted that parental consent should be made a mandatory requirement for any kind of marriage so that parents, who must give consent before their children's marriage, can take full moral responsibility for the bringing up of their children, preparatory to marriage. When this is done, the issue of sexual immorality that has become the order of the day, and which can render any youth susceptible to contracting the HIV-virus prior to marriage, can be addressed.

But, presently, parties contracting a customary law marriage are obliged to obtain parental consent before they can contract a valid marriage.⁷ It is hereby respectfully submitted that when young prospective married couples are convinced that the parental consent is not required before marriage, their sense of psychological freedom and independence can make them to be 'morally loose'. This can expose them to the HIV virus. At marriage, the virus may unknowingly be transmitted to the other partner. A pre-condition of 'parental consent' can be a deterrent factor in regulating the sexual behaviour of youth so that they do not incur the wrath of their parents.

⁶ Nwogugu Op Cit n. 3 p 130 (pages 1-125).

⁷ Nwogugu Ibid n. 6 p 130.

3.1.6 Ease of Dissolution of Marriage

There is so much ease in the dissolution of not only customary law marriage but also modern/common law marriage in Nigeria. Though the processes of dissolution of statutory law marriages in Nigeria are more cumbersome than those involved in the dissolution of customary law marriages, it is common knowledge, from daily occurrences and personal observations, that there are high rates of divorce of civil/statutory law unions in the society today. This makes nonsense of the cumbersome processes. The social, emotional and psychological impact of divorce, as we all know, can imply serious sexual consequences for some people who cannot manage the situation. Sexual consequences, at this period of HIV spread, I respectfully submit, have implications for contracting HIV/AIDS.

3.2 CUSTOMARY LAW

The part played by customary law in the vulnerability of women to HIV/AIDS shall further be discussed hereunder.

3.2.1 Impact of Customary Law:

The extent to which customary law adversely influences women's vulnerability to HIV/AIDS is hereby examined:

3.2.2 Age of Customary Law Marriage and the Marriage Contract

Customary law, especially in Nigeria, adopts the age of 'puberty' as the age of majority.⁸ At puberty, a young boy or girl is

⁸ Nwogugu Ibid n. 7 p 133.

traditionally qualified to contract a customary law marriage. The contract of marriage under native law and custom attaches great premium to parental consent and payment of dowry/bride price.

One must note that the age of puberty varies amongst individuals and is actually controlled by hormonal changes that direct the development of sexual organs. Conversely, in these modern times, young girls and boys attain the age of puberty very early in life, possibly between the ages of 12 and 16.

I respectfully submit that the implication of this is that due to socio-economic factors, the harsh economic realities, and the poor financial situation of some parents in the traditional environment, many of our very young girls, who invariably attained the age of puberty so early in life, are given away by their parents to customary law marriages. As a studious and interested observer, I have witnessed that in many instances, wealthy older men, who are already involved in polygamous associations or are enjoying multi-partner relationships, use their affluence and economic power to win the hearts of traditional parents and their young daughters in customary law marriages.

The problem with this type of marriage is that, because of the multi-partner syndrome influencing these wealthy older men, and the polygamous nature of their relationships, very young African girls who are involved with these men face the imminent danger or risk of exposure to the HIV virus quite early in life. This is because these men, already enjoying multi-partner and/or

polygamous relationships, are open to contracting the virus from one or more of their multiple partners and in turn transmitting the said virus to their new wives.

Because of the traditional setting, the cultural milieu, the acculturation process, and the embedded doctrine of gender inequality, the young wives cannot question any breach or violation of their fundamental human rights. They find out, to their detriment, sooner or later, that they can neither deny/resist sexual advances nor even make any attempt to invoke their sexual or reproductive rights. They find out, too, that they cannot exercise any degree of control over their own bodies or reproductive rights, to the extent that they cannot insist on condom use, HIV test before marriage or on other preventive guarantees.

The above corroborates the exposition of Albertyn⁹ on the South African experience, as elaborately highlighted variously in this work. Equally, UNAIDS succinctly put it thus:

Women's increased risk is also a reflection of gender inequalities. Gender refers to the societal beliefs, customs and practices that define 'masculine' and 'feminine' attributes and behaviour. In most societies, the rules governing sexual relationships differ for women and men, with men holding most of the power. This means that for many women, including married women, their male partners"

⁹ Albertyn Op Cit n. 2 p 127.

*sexual behaviour is the most important
HIV-risk factor.*¹⁰

Due to these shortcomings, young African girls, including those in South Africa and Nigeria, become easy preys to the HIV/AIDS epidemic. UNAIDS 2004 statistics give the numbers/percentage of young girls/women affected by/infected with HIV/AIDS as follows:

- South Africa: 2.9 million women (approximately-54.9% or 55%), out of a total infected/affected adult population of 5.3 million, and a total affected children population of 230,000 (approximately 4.3%), and males accounting for 41%. This lower figure/statistic for South African males also confirms that South African women account for the highest figure/statistic of 54.9% as shown above.¹¹
- For Nigeria, UNAIDS statistics show 1.9 million women (approximately 50.1%) living with/affected by HIV/AIDS, out of a total affected adult population of 3.6 million and a total affected children population of 290,000 (approximately 8%), and males accounting for 42%. This lower figure/statistic for Nigerian males also confirms that Nigerian women account for the highest figure/statistics of 50.1% as shown above.¹²

The above statistics of affected Nigerian children, numbering approximately 290,000 or 8%, suggest that the rate of incidence of mother-to-child or peri-natal transmission of HIV is higher in Nigeria than South Africa. This gives rise to a higher incidence of pediatric AIDS in Nigeria, signifying that there is a major lack

¹⁰ UNAIDS Global Report, 2004: 1-100.

¹¹ UNAIDS *Ibid* n. 10 p 136.

¹² UNAIDS *Ibid* n. 11 p 137.

of legal and policy incentives or responses to reduce peri-natal transmission of HIV, as in South Africa. In practical terms, the South African example exemplified by the decision on the provision of free niverapine antiretroviral therapy for all HIV-positive pregnant women in order to prevent or reduce the incidence of mother-to-child transmission of HIV,¹³ is notably absent in Nigeria. Equally, the policy incentive of free but voluntary HIV counseling, testing and treatment, at government expense in South Africa, is also absent in Nigeria. The high vulnerability of Nigerian children to HIV/AIDS shows that other factors like free health care for children and HIV infection due to infected but undetected blood is also prevalent in Nigeria.

Beyond the surface, the above statistics suggest that factors that promote the higher vulnerability of women, whether in varying forms, proportions or magnitudes, are prevalent in both countries. These could be the factors that reinforce the subjugation of women, gender inequalities/discrimination, gender-based violence, offensive customs and harmful traditional practices, in addition to the particularly South African factor of vulnerability emerging from the apartheid past. As noted,¹⁴ the apartheid past, which was characterized by racial inequalities, a migrant labour system, the disintegration of family life and deepening racial and gendered poverty, may have been the additional factor that added more weight and significance to make South African women more vulnerable than Nigerian

¹³ Minister of Health and Others v TAC and Others, (2002) 4 BCLR 356 (CC).

¹⁴ Albertyn Op Cit n. 9 p 136.

women, as demonstrated by the higher statistics. This appears to be true in the sense that though the apartheid system in South Africa crumbled about 10 years ago, the adverse impact from the psychological, emotional and social trauma it inflicted on the South African blacks will still take many more years to disappear.

In both countries, the percentage of vulnerable males is almost the same, with 41% for South Africa and 42% for Nigeria, showing that males are less vulnerable than women, since women have already been shown to have higher infection rates. This confirms the hypothesis that physiological/biological and social factors combine to render women more susceptible to HIV infection while men are not readily vulnerable.

3.3 OTHER INCIDENTAL MATTERS RELATIVE TO CUSTOMARY NORMS AND WOMEN'S VULNERABILITY TO HIV/AIDS

These are discussed under various headings hereunder.

3.3.1 The Sharia System and other Traditional Methods of Termination of the Marriage Contract

Under Nigerian customary law, marriage can be dissolved judicially or non judicially at the instance of any of the partners.¹⁵ One notable weakness of Nigerian customary law tradition is the ease with which marriage contracted under native law and custom can end or be dissolved. Under Islamic or Moslem systems of marriage, a mere mention of 'talak' by the husband, to the hearing of the wife, three times, brings the

¹⁵ Nwogugu Op Cit n. 8 p 134.

marriage to an end.¹⁶ Under other traditional systems, in Nigeria, a dissatisfied husband can end the marital relationship by throwing the wife's property outside of their matrimonial home.¹⁷ Dissolution of customary law marriage by customary or Islamic-Sharia court is almost always a last resort, only after contending claims or denials of due dissolution by non-judicial means.

Easy and unimpeded efforts at dissolution of marriages under native law and custom have serious implications. As already stated, the emotional, economic, and psychological impact which such effortless dissolution creates on the parties, if not properly controlled, can cause serious or miscalculated sexual, emotional or economic harm.

3.3.2 Polygamy

The institution of polygamy in Africa is so wide-spread as to attract the attention and concern of African women and other legal, social and political experts that gathered to complete work on the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.¹⁸ Because of the impact of polygamy in Africa and the seriousness attached to it, it is stated in Article 5(C) of the said Protocol that monogamy should be encouraged as the preferred form of marriage in Africa. However, the said Protocol to the African Charter is not yet in

¹⁶ Nwogugu Ibid n. 15 p 139.

¹⁷ Nwogugu Ibid n. 16 p 139.

¹⁸ Protocol to the African charter on Women's Rights, Maputo, July 2003.

force.

Polygamy is the widely practiced tradition of a man marrying two or more wives. The negative impact of this tradition is that despite assurances of faithfulness and fidelity, either the husband or one or more of the wives can have extra-marital affairs and can contract HIV in the process. Another disturbing phenomenon in Africa, including South Africa and Nigeria, is the high degree of disregard for the use of condoms, as a preventive measure against HIV/AIDS and other sexually transmitted diseases.¹⁹ Sex and condom use is generally a private activity that may not be accurately recorded, but from an official report of a social survey, as highlighted hereunder in this page, it is possible to determine as to what extent people use condoms as a preventive measure against HIV/AIDS.

According to Wits. University Survey Report, South African youth generally exhibit risky sexual behaviour. The largest representative survey of South African young people aged between 15 and 24, conducted by the University of Witwatersrand's Reproductive Health Research Unit (RHRU), confirms that young people still take to risky sexual behaviour.²⁰ The said survey confirms that despite high levels of awareness about HIV/AIDS, the vast majority of young people do not think they are personally at risk of contracting HIV. Even more disconcerting was that 62% of young people who tested HIV-

¹⁹ CSA, UP Op Cit n. 255 p 117.

²⁰ CSA, UP Ibid n. 19 p 141.

positive in the study, thought they were at no risk at all or had a small chance of getting HIV, according to the report.²¹ The report further highlights that while 94% of young people reported that they knew how to avoid HIV infection, the survey showed that young people were persisting in risky sexual behaviour and had not internalized the extent to which they could contract HIV. It further adds that while 33% of young people who had sex in the past 12 months reported using a condom, 67% were still not using condoms consistently.²² Further still, the report elaborates that young people who were surrounded by death felt that taking a risk by having unprotected sex, "far outweighed the benefit" of preventing something that might occur in 10 to 15 years time.²³

On the basis of these attributes, one can understand the rationale for the fast spread of HIV/AIDS within the family circles in Africa, especially where people tend to indulge in unsafe sexual relations in the hope that they are not vulnerable to HIV-infection.²⁴ These bitter truths or facts underscore the necessity to over-repeat/over-stress the plights Africans face so that they can understand the magnitude of the epidemic and the need for more serious action to protect themselves from the HIV/AIDS epidemic.

²¹ CSA, UP *Ibid* n. 20 p 141

²² CSA, UP *Ibid* n. 21 p 141.

²³ CSA, UP *Ibid* n. 22 p 142.

²⁴ UNAIDS 2004 Global Reports, pages 1-150

3.3.3 The Argument For and Against Polygamy as a Contributory Factor to the Spread of HIV/AIDS

The general discussions and arguments in society concerns polygamy as a contributory factor to the spread of HIV/AIDS. In Nigeria, where there is a large population of Moslems and others that are involved in polygamous associations or marriages, it is common cause that polygamy, a typical traditional African system of marriage, inflames the spread of HIV/AIDS. It is equally a common cause that other adherents believe to the contrary. From my personal observation, I respectfully submit that those who agree that polygamy exacerbates the spread of HIV/AIDS do so on the main ground that Africans are generally promiscuous, often maintaining many sexual partners. In such circumstances, therefore, there is the possibility that either of the married wives or the husband can contract HIV outside of the marriage bed and easily spread it within the family circle, and vice versa.

In similar vein, in Nigeria, it is common cause that other groups of people, opposed to the above theory, are of the opinion that polygamy actually encourages a man to confine his sexual contacts within his family or wives, thereby avoiding other multiple partner- affairs outside of marriage or the polygamous association he is already enjoying.

This proposition is supported by the fact that moral attributes and sex within marriage, as sanctioned by Islamic standards, are key elements in the fight against HIV/AIDS. The situation in Islamic countries which have successfully prevented the rapid

spread of HIV/AIDS, buttresses this point and confirms that polygamy, when practiced within the confines or parameters of morality and sex within marriage, can curtail the spread of HIV/AIDS.²⁵

In Nigeria, it is generally accepted that the supporters of the above theory further strengthen their position by making a comparison with the western culture and alluding to the fact that even where monogamy is the only recognized system of marriage, as in the USA and other Western countries, men and women still indulge in extra-marital affairs and patronize prostitutes or commercial sex workers. I respectfully submit that it is a general view of the supporters of this theory that it is better to remain polygamous and be confined to sex within the polygamous marriage situation only. I equally respectfully submit that this position is more advantageous than being monogamous but yet continuing to indulge in extra-marital affairs and patronizing sex workers, the most likely candidates to transmit HIV virus, considering their network of daily sexual contacts.

3.3.4 WIFE INHERITANCE

As confirmed by the recent Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003, another popular African custom, practiced in South Africa and Nigeria, especially in the rural/traditional cultures, is wife

²⁵ Abdulahi, A. "Islam and Human Rights" INTERIGHT BULLETIN 1996 Volume 10 No. 1 pp 1-46

inheritance. This practice is in consonance with the belief that the unity and cohesiveness of the family must be preserved even if a member of the family dies, leaving a wife or wives and children behind, thereby enhancing family continuity. Marriage of a woman by a man into the family connotes that the woman is an integral part of the larger family. Therefore, if her husband dies, custom dictates that the larger family must choose a close relation of the deceased spouse to inherit the bereaved woman, along with her children. The implication of this custom, in the context of the current HIV/AIDS epidemic, is the possibility that either the bereaved wife, who is being inherited, or the family member who inherits the bereaved wife, could be living with HIV/AIDS. If this proves to be true, then the cultural practice of wife inheritance can be seen to be detrimental by contributing to the spread of HIV/AIDS.

Article 20(c), on the rights of widows in Africa in the said Protocol to the African Charter on the Rights of Women, confirms that the practice of wife inheritance is very widespread in Africa and should be abolished, with the right of widows restored so that they can marry persons of their choice. It is respectfully submitted, from the point of view of a studious observer, that the practice of wife inheritance is mostly prevalent in rural communities of both South Africa and Nigeria, since modern African men and women adopt various strategies to circumvent such a traditional requirement.

3.3.5 FEMALE GENITAL MUTILATION

UNAIDS 2004 report refers to female genital mutilation as harmful traditional practices and confirms that it is one of the causes of women's vulnerability to HIV/AIDS. The recent Protocol to the African Charter on Human and Peoples' Rights, on the Rights of Women in Africa, also confirm the wide-spread nature of this practice in Africa, and wants it abolished.²⁶

Female genital mutilation involves the cultural ritual of "mutilating" certain parts of the female sexual organ. Such operation may be performed by cutting off the female clitoris so as to eliminate passion for sexual gratification in young girls. The cultural value is to curtail women's promiscuity, to the advantage of the male partner. Detrimentially, this operation may be performed with unsterilized instruments which could as well be used on many other individuals, at the same time. The health hazards of this practice, especially in the context of the HIV/AIDS epidemic, can best be imagined, since one unsterilized equipment may be used on several young girls within a particular cultural setting. This practice is very common in Nigeria, but not so common in South Africa.

However, with regards to harmful traditional practices in South Africa, the South Africa's Initial Report²⁷ to the Committee on the Rights of the Child, already mentioned, referred, inter-alia, to

²⁶ Article 5 of the Protocol to the African Charter on the Rights of Women in Africa, Maputo, July 2003.

²⁷ Report No. CRC/C/51/Add. 2 submitted on 4 December, 1997.

scarification of the skin. The said report highlighted harmful traditional practices and how they relate to HIV/AIDS. It specifically referred to scarification of the skin with subsequent application of "medicine" which is commonly practiced either as a preventive measure or to "release the disease" from a painful part of the body. According to the report, the instrument, usually a razor blade, is not sterilized and raises the potential risk of spreading HIV and the hepatitis B virus.²⁸

Another dangerous/harmful traditional practice that is widely practiced in South Africa is the customary ritual of circumcision of males. This is done at an advanced age as one of the traditional requirements for entry into "manhood". As in the case of scarification of the skin, the instruments which are used on several other boys needed to be circumcised at the same time, are not sterilized and therefore pose the potential for HIV spread.

All of the above harmful traditional practices are expressly and impliedly included in the UNAIDS:2004 reference to harmful traditional practices as contributory factors to HIV/AIDS.

3.3.6 Other Traditional Norms:

These include other practices like sexual cleansing, HIV/AIDS cleansing myth, and the traditional belief system of male dominance over females.

²⁸ SA Report Ibid no 27 p 146.

Sexual Cleansing

This belief system reflects a general customary belief system in some traditional African societies. Custom refers to traditional values, information, attitudes, cultural practices, etc, known to a given set of people with the information passed on from one generation to another, without actually being written down.

A belief system highly valued in some traditional African societies, including South Africa and Nigeria, is that after the death of a married man, his spirit hovers around and remains close to the bereaved wife. To compel the spirit of the deceased to go away and leave the widowed wife alone, the customary ritual of sexual cleansing becomes pertinent. In this context, the family elders choose a male- family member to have sex with the bereaved wife. The belief is that the deceased spirit, on witnessing this act, will finally depart from the widowed wife. As in other customary practices, sexual cleansing can enhance the spread of HIV/AIDS since either of the parties involved in the sexual cleansing act can be HIV- positive, thereby transmitting the virus to the other. It is generally accepted by members of the public and society- at-large in Nigeria and South Africa, including eye-witness accounts that modern African women, however, modify this custom by personally choosing their new sexual partners.

Though the extent of the widespread application of this custom may not be documented in "black and white" as to provide a reference, I submit, from personal eye-witness accounts in

Nigeria and South Africa, that this position reflects the true state of affairs in many African countries, including Nigeria.

HIV/AIDS Cleansing Myth

A myth is a general belief system, dictated by cultural perspectives, customs and traditions in a particular society. The myth may not be actually written down but holds true of the prevailing view point, attitudes or belief system, whether rightly or wrongly.

As already shown in chapter 2 (2.9.4), under "Rape", the South African initial report to the Committee on the Rights of the Child, had recognized the wide-spread nature of adoption of the myth of HIV/AIDS cleansing that promotes child sexual rape in South Africa. The said report specifically notes that the dangerous myth that sex with a virgin or young girl will either cure or prevent AIDS has resulted in an increase in child sexual exploitation. Also, according to the said report, HIV/AIDS leaves increasing numbers of children orphaned, who often resort to selling their bodies to survive in child-headed families.

Traditional Belief System of Male Dominance Over Females

In African traditional settings, many factors operate to promote the belief system of male dominance and patriarchy which, in turn, serves to encourage gender inequality in South Africa and Nigeria.²⁹

²⁹ Eze, O. C. Human Rights in Africa: Some Selected Problems, Lagos: Macmillian Nigerian Publishers, 1984 pp 141-144.

As matters stand, it becomes clear that this factor of male dominance and patriarchy make it possible for older males to influence younger girl and win them in marriages. It also becomes true that through these older men, many young girls get infected with HIV, thereby laying credence to the high vulnerability of women to HIV/AIDS.

3.3.7 Legal Implications of Customary/Traditional Practices on African Women

The far-reaching implication of the above customary practices and traditions on women in Africa, most particularly, by the situation in Nigeria, is that their fundamental human rights, as guaranteed by international and domestic human rights instruments, are flagrantly violated with impunity.

Though in South Africa, there are appropriate human rights regimes to address the inequalities or imbalances and issues of discrimination against women, the degree of actual progress or resolution of the problem remains in doubt. As unambiguously evident from the various reports of the Pretoria News³⁰ it is rather unfortunate that despite all the noble constitutional provisions/guarantees and bold legislative initiatives, women's rights to equality, non-discrimination, freedom from degrading or inhuman treatment, etc, are disregarded with impunity in South Africa. The said newspaper reports, as shown in chapter 2, under socio-economic and cultural rights, speak for themselves and

³⁰ Pretoria News dated September 21, 2004; November 15, 2004; December 7, 2004; and February 19, 2004.

clearly confirm that much more still needs to be done to restore women's basic human rights.

Since the links between HIV/AIDS, health, and human rights are well established, in the context of the HIV/AIDS epidemic, the promotion and protection of human rights and the promotion and protection of health are fundamentally linked. When human rights are not promoted and protected, it is harder to prevent HIV transmission. When these rights are not promoted and protected, the impact of the epidemic on individuals and communities is worse.³¹ Second, to the extent that societies can reduce discrimination and promote respect for rights and dignity of everyone, they will be increasingly successful in preventing HIV transmission.³²

3.4 PUBLIC HEALTH LAW

Because HIV/AIDS has assumed pandemic levels, with no curative breakthrough in sight, all sectors of society are overly concerned on how best to curb its menace. Public health preventive strategy concerns the use of certain coercive instruments to halt the spread of HIV/AIDS. But the reality is that there is a conflict between public health and human rights. The conflict arises because coercive measures, whether direct or indirect, have a common element of affecting an individual's civic or social status, or limit his or her freedom of movement,

³¹ Haig, T. 2003. Contact Thomas Haig at- thaig@aidslaw.ca

³² Mann, J. M. AIDS, Health and Human Rights, Cambridge, Massachusetts: Harvard School of Public Health. 1993 pp 8-10.

freedom of choice or personal autonomy, with the object of protecting public health.³³

In advocating coercive measures to combat HIV/AIDS, advocates are faced with a dilemma: Are the rights of the individual to liberty and privacy reconcilable with the needs of society to protect itself from AIDS?. And does enhancing the one diminish the other?.³⁴ In truth, however, the protection of individual human rights and the protection of the common good are not in fact antithetical.³⁵ In approaching the issue, the key questions to ask are:³⁶

- Do public health coercive measures and laws actually achieve the objects of slowing the spread of HIV/AIDS?.
- If they do, is it at the cost of intruding on individual human rights?.
- Does any benefit to public health so attained in fact warrant the intrusion on individual human rights?. This is the proportionality test.

The answers to these and other questions shall unfold below.

3.4.1 Coercive Nature of Public Health Law

Historically, the successful combating of some infectious diseases has depended not only on the successful treatment of the infected person, but also on the adoption of certain preventive measures designed to check the spread of the

³³ Cameron and Swanson Op Cit n. 185 p 95

³⁴ Cameron and Swanson Ibid n. 33 p 151.

³⁵ Cameron and Swanson Ibid n. 34 p 152.

³⁶ Cameron and Swanson Ibid n. 35 p 152.

infection.³⁷ In view of this, HIV/AIDS has brought into question whether traditional public health measures such as quarantine and isolation, compulsory isolation, and contact- tracing may be effective in the fight against the pandemic.³⁸ The prevailing view,³⁹ shared by many international human rights law practitioners and governments, is that if such measures were to be used coercively, they would be ineffective. In particular, such measures may alienate the public and HIV/AIDS sufferers from supporting efforts to combat HIV/AIDS by reason of their huge potential for flagrant abuse of human rights.⁴⁰

Some decided legal authorities, as shown hereunder in this page, have actually supported the view that coercive laws or public health measures are in fact detrimental to the long term interest of public health in combating the spread of HIV/AIDS

The decision in the South African case of Janson Van Vuuren and Another NNO v. Kruger⁴¹ supports this viewpoint. This case exemplifies public disclosure of private medical facts involving a HIV- positive individual, by his doctor, the defendant after the plaintiff had specifically requested that such disclosure should not be made. The court found the defendant liable for infringement of the right to privacy, holding that such disclosure was not in the public interest.

³⁷ Nguena, C., "Responses to AIDS" in Frankowski, S. (ed) Legal Responses to AIDS in Comparative Perspective, University of the Free State, SA, 1998 p 50.

³⁸ Nguena Ibid n. 37 p 152.

³⁹ Nguena Ibid n.38 p 153.

⁴⁰ Nguena Ibid n. 39 p 153.

⁴¹ 1993 (40 SA 482.

In another related case of C v. Minister of Correctional Services,⁴² the court ruled that it amounted to an infringement of the right to privacy when a blood sample for an HIV test was drawn from a HIV-positive prisoner, serving sentence, without his informed consent.

Another South African judicial decision took side with the modern trend to uphold international human rights standards as against the urge to protect public health. The case of Hoffman v. South African Airways,⁴³ in which a HIV-positive applicant was denied employment because of his HIV status, illustrates this point. The defendant averred that such denial was necessary to protect the health of others. The court decided that such act amounted to unfair discrimination on account of HIV status and that it violated the fundamental human rights of the applicant.

In invoking the coercive force of law, broadly, two techniques are at issue: indirect and direct measures.⁴⁴ Indirect coercive measures involve oblique efforts to stop the spread of HIV through criminalizing or discouraging conduct which may lead to transmission. Examples include laws which restrict or criminalize activities such as prostitution, sodomy, extra-marital sexual intercourse and intravenous drug use.⁴⁵

Direct coercive measures, on the other hand, are designed to

⁴² 1996 (4) SA 292.

⁴³ 2000 (11) BCLR 1211 (CC).

⁴⁴ Cameron and Swanson Op Cit n. 36 p 152.

⁴⁵ Cameron and Swanson Ibid n. 44 p 154.

slow the spread of HIV by targeting the movements or conduct or affecting the civic status of known or presumed HIV carriers.⁴⁶ Internationally, a broad range of direct measures has been considered or adopted in the fight against HIV/AIDS.⁴⁷ These include quarantine or isolation of individuals known to carry the virus, criminal punishment of persons who have negligently or knowingly infected others, mandatory screening of specified segments of the population, and disclosing an individual's HIV status or AIDS diagnosis without consent.

A number of countries have taken steps to invoke the coercive force of law in the context of preventing the spread of HIV/AIDS. The United States, for example, though an advanced democracy, has derogated from the international human rights norms that guarantee rights to equality and non discrimination on grounds of status to everyone, including people living with HIV/AIDS. By having a discriminatory immigration policy against people vulnerable to HIV/AIDS and targeting their movements the USA is, in effect, discriminating against HIV carriers, in breach of international norms. Perhaps, the rationale for this approach is that at the initial stage of the HIV/AIDS epidemic, there was speculation that HIV came to America from Africa or Haiti, brought by tourists, business visitors or immigrants. The suggestion in the mid-80's that the virus came from elsewhere helped to fuel a political aim of protecting the United States from AIDS by excluding people with the virus from visiting or

⁴⁶ Cameron and Swanson *Ibid* n. 45 p 154.

⁴⁷ Cameron and Swanson *Ibid* n. 46 p 155.

immigrating.⁴⁸

Other countries have either advocated measures aimed at criminalizing harmful HIV-related behaviour,⁴⁹ or have a legal machinery that works to punish HIV-positive individuals who infect others with the HIV virus. This was evident in the South African case of Venter v. Nel.⁵⁰ In this case, the court found the defendant liable in a civil action for damages for infecting the plaintiff with HIV. The plaintiff, in an undefended action, sought damages on the ground that the defendant had infected her with HIV when they had sexual intercourse in 1995. The court found in her favour.

A Canadian case, Regina v Cuerrier,⁵¹ buttresses the criminal application of the law in regards to infecting another with the HIV virus. The court convicted a HIV-positive offender for aggravated assault and held that the accused had a positive duty to disclose his HIV status, and that the HIV- positive accused, having endangered the complainants' lives by exposing them to risk of HIV infection through unprotected sexual intercourse, should not require the crown to prove that the complainants were actually infected.

⁴⁸ Leonard, A S "United States AIDS Law: Pragmatism and Politics" in Frankowski, S. (ed) *Legal Responses to AIDS IN comparative Perspective*, University of the Free State, SA. 1998 pp 18-28.

⁴⁹ Van Wyk, C. "The Need for a new Statutory Offence Aimed at Harmful HIV-Related Behaviour: The Public Interest Perspective" (2000) 41 *Codicillus* 2; See also- Vukor-Quarshie, G. N. "Liability for AIDS: Infection Under the Criminal Law of Nigeria" (1991) 10 *Scandinavian Journal of Development Alternatives*: 101-117.

⁵⁰ 1997 (40 SA 1014.

⁵¹ Indexed as R v Cuerrier (Unreported) Court File No. 25738, Supreme Court of Canada: Heard March 27, 1998; Judgment Rendered: Sept. 3, 1998.

In the USA case, Johnson v. State of Indiana,⁵² a US Appeal's Court upheld the felony conviction of a man who infected four women with HIV over a period of seven years. Similarly, in State of Louisiana v Roberts,⁵³ Johnie Roberts Jr. of Louisiana was convicted of forcible rape and intentional exposure to HIV virus. He was HIV-positive when he raped a woman. His argument that lack of proof of exchange of bodily fluid or failure to prove that his teeth were an AIDS contaminated object exonerated him, failed to convince the court otherwise.

3.4.2 Public Health Laws that Influence Vulnerability to HIV/AIDS:

South Africa:

Within the first decade of the epidemic, there was the naïve belief in South Africa that the HIV/AIDS menace could be legislated away if only the infected could be identified and put away.⁵⁴ Two robust public measures were passed in this regard. First, in 1987, the Minister added AIDS to the schedule of communicable diseases. The effect of the regulation⁵⁵ was to confer on public health officials and authorities extensive powers over persons suffering or suspected to be suffering from AIDS.

The provisions⁵⁶ empowered a local authority, medical officer or

⁵² No. 34A 05- 0205-CR- 215 (IND. APP. 4 Cir. 04/02/03).

⁵³ No. 2002-KA-2520 (La. APP. 4 Cir. 03/26/03).

⁵⁴ Cameron and Swanson Op Cit n. 47 p 155.

⁵⁵ Communicable Diseases and Notification of Notifiable Medical Conditions Act of 1987: GNR 2438, in GOVERNMENT GAZETTE 11014 of 30 Oct. 1987, Passed Pursuant to the Health Act 1977.

⁵⁶ Sections/Regulations 2(1)(d); and 3(1)&(2); 4(1)&(2); 14(3); 17, 19 and 7(1)(a).

a Director General of Health, to place persons suffering from AIDS or suspected to be suffering from AIDS under quarantine for up to 14 days. This period could be extended by the Director General. The person could also be compulsorily hospitalized, treated, and isolated. The Regulation also imposed a duty to notify appropriate authorities in three instances. First, a medical officer was required to submit to public authorities a report disclosing the identity of the person subject to the Regulation. Second, where a child had been in contact with a person suffering from AIDS, the parent or guardian was required to inform the principal of the school of that fact. Finally, where a school principal knew or suspected that a pupil or a person employed at the school suffered from AIDS, or had been in contact with a person suffering from AIDS, the principal was required to notify a medical officer.⁵⁷

Again, in 1987, the Home Affairs Minister issued Regulations declaring persons suffering from AIDS to be deportable.⁵⁸ These regulations conferred on immigration officials the power to compel persons suspected of being sero-positive to submit to a medical examination, and made it illegal for an employer to hire such a person.⁵⁹

These regulations were criticized on the ground that the measures would exacerbate discrimination against AIDS

⁵⁷ Cameron and Swanson *Op.Cit* n 54 p 157.

⁵⁸ GNR, 2439 in GOVERNMENT GAZETTE of 30 Oct., 1987. The Rules were passed subject to s. 54 of the Admission of Persons to the Republic Act 1972.

⁵⁹ Admission of Persons to the Republic's Act of 1972: S. 34.

sufferers and sero-positive persons and thereby alienate them from the efforts to control the pandemic.⁶⁰ For these reasons the government's own advisers on AIDS, and the medical profession in general expressed their disapproval of the Regulation and advocated their repeal.⁶¹ The government's advisory bodies on AIDS discouraged reliance on coercive measures and recommended that AIDS be removed from the list of notifiable diseases under the Communicable Diseases and the Notification of Notifiable Medical Conditions Regulations.⁶²

In 1991, the Immigration Regulations were amended without ever being implemented.⁶³ Although the 1987 Communicable Diseases and Notification of Notifiable Medical Conditions Regulations have not been invoked in practice, there has been an on-going debate⁶⁴ about whether HIV/AIDS should be compulsorily notifiable, not so much for the sake of quarantine, but for the specific purpose of identifying the source of infection, collecting accurate statistics and facilitating appropriate response from government.⁶⁵

3.4.3 HIV/AIDS and President Mbeki and the ANC Government's Position

I respectfully submit that the observed sense of dynamism and approach to resolving the HIV/AIDS pandemic in South Africa, as

⁶⁰ Cameron and Swanson *Op Cit* n. 57 p 158.

⁶¹ South A Law Commission, *Supra* Note 4, at 144.

⁶² South African Law Commission *Ibid* no. 61 p 159 (*Supra* Note 4, at 144).

⁶³ Alien's Act of 1991: published in *GOVERNMENT GAZETTE* 13521 of 13 Sept., 1991.

⁶⁴ Nguena *Op Cit* n. 40 p 152.

⁶⁵ Nguena *Ibid* n 64 p 159.

exhibited by legal and policy- oriented programmes to resolve it, does not appear to be in tandem with President Mbeki's public comments or stand. The President's comment or position that there is no AIDS in South Africa, or that Africans are not generally promiscuous as to warrant the high incident of HIV occasioned by heterosexual contact, is neither in support of, nor in consonance with, the high level of governmental and inter-governmental activities to reverse the tide and curb the adverse impact of HIV/AIDS in South Africa.

The President's statement as well as the position of the ANC government had been widely reported by media organizations.⁶⁶ The said statement or stand of President Mbeki and the ANC as a political party, have been sharply criticized by the opposing political parties in South Africa, especially the DA.⁶⁷ The DA and other opposing political parties view such a comment as a political statement only meant to portray South Africa in good light. Conversely, the high UNAIDS:2004 statistics on the HIV/AIDS situation in South Africa, which are glaring and undisputed, have proved the President's statement and the ANC Government's position to be wrong.

⁶⁶ The E News and SABC 3 Television networks, both in Johannesburg, widely reported President Mbeki's comments on the situation of HIV/AIDS IN south Africa in 2003/2004.

⁶⁷ The criticism of President Mbeki and the ANC Government's position on AIDS in South Africa by the DA and other political parties were widely reported by various news media organizations throughout South Africa, including the E News and SABC 3 Television Networks in 2003/2004.

Nigeria

The recent Nigerian national policy on HIV/AIDS, which apparently endorses the international human rights perspectives on the rights to equality and non discrimination but falls short of practical steps to eradicate the epidemic in terms of free, voluntary HIV counseling, testing and treatment, is fraught with limitations. This is due to inadequate constitutional provisions on public health and health care. Thus, while the Nigerian Constitution of 1999 guarantees the right to personal liberty to every Nigerian,⁶⁸ this right can be denied to persons suffering from an infectious or contagious disease, in the greater public interest, for the purpose of their care or treatment or the protection of the community.⁶⁹ In addition, the Public Health Laws of the Federating States of Nigeria contain some obnoxious provisions which negate the essence of the constitutional provisions on the right to personal liberty or the provisions of the National Policy on HIV/AIDS. For instance, s. 25 of the Lagos State Public Health Laws⁷⁰ empowers a medical officer of health to compel a person suffering or suspected of suffering from an infectious disease to be removed to a government hospital or any designated place and detained there until he/she was no longer a danger to public safety and health. Any person living in the same house or compound is also liable to be quarantined in a similar manner.

⁶⁸ Nigerian Constitution of 1999: Sec 35(1).

⁶⁹ Nigerian Constitution of 1999: Sec 35(1)(e).

⁷⁰ Laws of Lagos State 1995: Cap 88.

In practice, however, it must be noted that the above laws are rarely invoked, though they have not yet been formally repealed. Their continued existence is certainly not in accord with international human rights norms, in the context of HIV/AIDS.⁷¹

3.5 OTHER INCIDENTAL FACTORS RELATIVE TO THE LAW AND WOMEN'S SUSCEPTIBILITY TO HIV/AIDS

Other incidental matters relative to women's vulnerability to HIV/AIDS and the law are discussed hereunder.

3.5.1 Customary Norms

Certain customary norms, in Africa, have been shown to reinforce stereotyped ideas on gender inequality and discrimination, thereby perpetrating acts of discrimination against women.⁷²

Custom, for what it is, entails that the tradition or practice which has been in existence from time immemorial continues to be passed on from one generation to another. The prospect for the abolition of a well- established custom that has passed the test of time remains an uphill task in Africa, but requires coordinated and sustained efforts by all segments of society.

What this implies for women affected by HIV/AIDS is that their plight signals a "double jeopardy" in the sense that women, in the cultural environment, who are already subjected to wide-scale gender- related discrimination and inequality, are again re-subjected to the adverse impact of HIV/AIDS-related stigma,

⁷¹ Laws of Lagos State *ibid* n 43:S. 26.

⁷² Albertyn *Op Cit* n. 14 p 138.

discrimination and inequalities. A resolution of these conflicts in the interest of women living with HIV/AIDS requires a total re-assessment, overhaul, re-ordering and re-prioritising of gender-related issues, gender role prescription and the traditional concept of gender inequality. Above all, it demands a thorough re-think about the African traditional belief system, particularly as it touches and concerns women. From observations I respectfully submit that this appears to be a very difficult task, considering the African customary value system.

A few cases and judicial decisions on African customary law highlight the difficulty in changing traditional norms, particularly as these affect women in Africa. The cases and judicial decisions do not only indirectly re-affirm the notion of gender inequality and discrimination in Africa, they also establish, by implication, at the same time, the supremacy of customary law over modern law, in the event of a conflict between the two systems of laws in Nigeria.

The Nigerian Constitution of 1999 accords customary law a prominent place in history.⁷³ The said section 315 of the Nigerian Constitution accords Nigerian customary law recognition as an existing law that prevailed even before the coming into being of the Nigerian Constitution, thereby expressly and impliedly indicating that customary law be treated with respect and accorded full rights.

⁷³ Section 315 of the Nigerian Constitution 1999.

A few cases in Nigeria and two other African countries shall highlight the extent of recognition and rights accorded customary law as the "living law of the people".

The Nigerian case of Asiata V Goncallo,⁷⁴ though old and apparently dated, is still a 'locus classicus' on customary matters in Nigeria. In that case, the court upheld the supremacy of customary law over modern law in the situation of a conflict between a prior statutory law marriage and a subsequent customary law marriage. Herein, Alli Elese, a Yoruba, was taken to Brazil as a slave. There he married Selia, in accordance with the Moslem rites, first, and thereafter, in accordance with the Christian rites in a Christian church. There were two daughters of the marriage. Subsequently, Alli Elese returned to Lagos, Nigeria with Selia. During his lifetime with Selia, in Nigeria, and after the passing of the Nigerian Marriage Ordinance, Alli Elese again contracted a Moslem customary law marriage with Asiata-the plaintiff in this case, and they had one child. After his death, the question to be determined by the court was how his estate was to be distributed.

Under Nigerian Family Law,⁷⁵ a Christian monogamous marriage after a customary law union between the same parties, can be accepted as a valid common law/statutory law marriage if certain legal requirements are fulfilled. This will exclude any other marriage, whether under statutory law or customary law, during

⁷⁴ (1900) NLR 41.

⁷⁵ Nwogugu Op Cit n. 17 p 139.

the subsistence of this first marriage. In Elese's case, his first marriage would have been taken as such to qualify as a common law/statutory law marriage and the subsequent marriage with Asiata would have been illegal, null and void, and only the children of Selia would have been entitled to his estate. The Nigerian Appeal Court held that the subsequent customary law marriage with Asiata was valid and the children of both Selia and Asiata were entitled to the distribution of the estate.

In yet another Nigerian case, Lawal-Osula v Lawal-Osula,⁷⁶ the supremacy of customary law over modern law was demonstrated. It must at this point be made clear that there is no expressly stated repugnancy clause in the Nigerian Constitution. However, at the reception of the English Common Law, Doctrines of Equity and Statutes of General Application into Nigerian law, as at 1900, it was expressly stated that the received English law must neither outlaw customary law, nor be seen to be superior to customary law, as long as the applicable customary law was not repugnant to natural justice, equity and good conscience. Most of the existing customary laws and traditional practices in Nigeria had survived the test of time and passed the repugnancy test.

The facts of the Osula case were that one Chief Usman Lawal-Osula died in 1972 and left a will. In the will, he willed most of his property including his dwelling house to his wife and the defendant in this case, Mrs Lydia Modupe Lawal-Osula, with whom he had a civil law marriage. Prior to this civil law marriage, Chief Usman Lawal-Osula had contracted customary

⁷⁶ 1995 32 LRCN 291.

law marriages with other women and had children from those marriages. He had devised nothing in his will to those prior wives or to their children.

In modern Nigerian law terms, a will, as the last testamentary disposition, is accorded the force of law if executed correctly and it supersedes customary or traditional values. Under customary law of Benin community in Nigeria, where the late Chief belonged, the Chief was bound by the native laws and customs of Benin. By Benin tradition, a traditional Chief is succeeded at his death by his eldest son. His will, however, completely omitted the 1st plaintiff, being the eldest son by another woman of the marriage. In its lead judgment, the Supreme Court of Nigeria said inter-alia, that the wills law was subject to the customary law of an area. It further said that the customary law of Benin entitled the eldest surviving son to succeed to his father's house and to occupy and own the late father's dwelling house. On these bases, therefore, devising the dwelling house by will to a wife of the deceased amounted to a void disposition as it was contrary to the customary practices of the area.

Zimbabwe and Kenya exemplify some other legal jurisdictions in Africa that apply customary laws, like Nigeria, but are yet to bring customary law marriages to be at par with civil law unions, as is the case in South Africa. Some related cases are hereby discussed:

The Zimbabwean Supreme Court case of Re Venia Magaya⁷⁷ further illustrated the principle of superiority of customary law over modern law, in the event of a conflict. The said court decided, inter alia, that customary law takes precedent over modern law, even in matters that portrayed inequalities and discrimination against women. The court ruled that women cannot be considered equal to men before the law because of the African cultural norms and the nature of African society. Though such ruling violated the provisions of several international and domestic human rights instruments, the court relied on Section 23 of the Zimbabwean Constitution which prohibits discrimination in Section 23(1) but recognises exceptions to this general prohibition against discrimination in issues relating to, amongst others, marriage; divorce; burial; devolution of property on death; matters of personal law or tribal law and application of African customary law, in accordance with section 23(3). Viena Magaya's claim to inheritance rights were, accordingly, denied by the court.

In a related Kenyan case, the Court of Appeal, in Nairobi, exemplified the supremacy of customary or tribal law over common or modern law, in the case of Virginia Edith Wamboi Otieno v Joash Oching Ougo and Omolo Siranga.⁷⁸ The ruling confirmed that tribal or personal law, in the context of customary law of Kenya, takes precedence over modern law if a conflict

⁷⁷ Unreported Zimbabwean Supreme Court (2000) case.

⁷⁸ Civil Appeal No. 31 of 1987-Kenyan Appeal Reports (1982-88) 1 KAR.

arose between the two systems of law. In this case, the widow of the deceased who had died intestate sought to invoke her right to claim his body and bury him, relying on the common law, the Constitution, the Judicature Act, and the Married Women's Property Act 1882, in priority to the two defendants (the deceased brothers) who claimed such rights under customary law. The key issue for determination was whether a Kenyan-African could abandon his tribal origins even in circumstances where the deceased was not getting involved in tribal affairs and had dissociated himself from tribal matters. The court ruled that an African citizen of Kenya could not divest himself of association with the tribe of his father if the customs of the tribe were patrilineal.

A careful review of each of the above cases shows that they all involved women who were protesting and appealing against the tenets of discrimination and inequality which were sanctioned by the customary law of their communities. In each case, the court upheld the existing and seemingly discriminatory customary practices against the women as not being unfair but legally normal and proper in the circumstances of African norms and value system. By ruling in favour of customary law and traditions, where the identified customs evidently conflicted with modern law, the courts affirmed the supremacy of customary law over modern law.

The above rulings and many other unreported court decisions identify the trend in Africa, especially in Nigeria where the law

on customs, and particularly customary law marriages, has not changed, as in South Africa. The development should provide a justifiable basis for worry and apprehension by African women subject to customary law and additionally affected by HIV/AIDS, especially in Nigeria. The category of such women, in the context of HIV/AIDS, includes women who are survivors of deceased husbands who died on account of AIDS-related diseases. It also includes widowed women who are themselves infected with the HIV-virus, single-parent mothers who are either infected or affected by HIV/AIDS in the sense of having to care for themselves, infected husbands, children, family or community members.

3.5.2 Inheritance and Succession to Property

Going by the principle of customary law, as reflected in the above cases, it is trite that women have no inheritance rights under the Nigerian traditional system. This implies that Nigerian women, as a group, are already experiencing discrimination and are regarded as unequal to men in the traditional setting, contrary to the provisions of the Covenant on the Elimination of all Forms of Discrimination Against Women (CEDAW) 1979, which calls for the elimination of all forms of discriminatory practices against women. For women who are directly and indirectly affected by HIV/AIDS and are already experiencing HIV-related inequalities and discrimination, their desire to enforce their rights to inheritance and succession suffers another form of gender-related inequalities and discrimination in the traditional environment. They would have no recourse to their fundamental

rights to equality and non-discrimination, while their dream of inheritance and succession to property becomes unrealistic under the present system of customary law.

3.5.6 Re-marriage

Women, affected by, or infected with, HIV/AIDS, in the traditional environment, may find it distressing, as they seek re-marriage. This is due to the obvious fact that stigma, discrimination, prejudice, inequalities and unfair treatment against them are beyond their scope or comprehension. At the present level of social belief system, cultural responses and individual or collective reaction in the context of HIV/AIDS, the acts of discrimination against women infected with, or affected by, HIV/AIDS is at its peak. It will require concerted efforts, innovative policies, forceful legislative enactments and a re-ordered mental or psychological ideology to change the current trend.

3.6 Associated Legal Issues

The above issues highlight the extreme nature of discriminatory practices against women affected by HIV/AIDS and the adverse impact or detrimental effect on them, especially those in the customary environment. But international human rights law, and even domestic law, accord everybody, including women, enforceable fundamental human rights. The rights to equality and non-discrimination are the corner-stones of human rights

norms.⁷⁹ Denying women and others affected by HIV/AIDS the full enjoyment of their fundamental human rights to equality and non-discrimination amounts to a clear justiciable violation of their fundamental rights.

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) 1979⁸⁰ clearly stipulates in all its provisions the necessity for States Parties to take appropriate measures to eliminate all forms of discrimination against women and to ensure the exercise and enjoyment of their human rights and fundamental freedoms on a basis of equality with men. The answer lies in the adoption of all appropriate measures by States Parties, including legislation, to abolish or modify existing laws, regulations, customs and practices which constitute discrimination against women (Article 2(f) of CEDAW 1979).

Fortunately, in response to general outcry, there are on-going moves to change the status quo in Africa in the current context of customary law and traditions that are detrimental to the vested interests of women, especially, women infected with, and affected by HIV/AIDS. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa⁸¹ is

⁷⁹ UN Charter of 1945: Articles 1 and 56

UDHR of 1948: Articles 1 and 2; ICESCR of 1966; ICCPR of 1966: Articles 2 and 3; ACHPR of 1981: Article 2; CEDAW of 1979: Article 2; South African Constitution of 1996: Section 9; and the Nigerian Constitution of 1999: Section 42.

⁸⁰ CEDAW of 1979: Articles 2, 3, 4 and 5 are on the issues of discrimination and inequalities against women in the cultural or traditional environment.

⁸¹ Articles 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 17, 19, 20, & 21 of the Protocol to the African Charter on Women's Rights in Africa-2003 addresses issues affecting women

highly commended for making serious in-roads in attempts to eliminate cultural, customary and traditional prejudices, inequalities, discrimination and other adverse traditional practices and the detrimental effects of customary law against women. Though not yet in force, it calls for necessary legislative and administrative reforms that address current discriminatory and adverse practices against women in the traditional, cultural, social, legal and health contexts. When ratified, implemented and enforced by States Parties, the said Protocol shall have added another dimension or milestone towards redeeming women in the African traditional environment from the ravages and devastating impact of certain customary laws and traditional practices.

3.7 SUMMARY

In this chapter, aspects of the law that contribute to women's vulnerability to HIV/AIDS have been discussed. The impact of family law, including customary and modern law of marriages, has been assessed. The effects of other traditional practices, like polygamy, wife inheritance, female genital mutilation and other practices have been brought to the fore. Of great significance are the implications and the negative contributions of public health law and its coercive nature, on the HIV/AIDS epidemic, as discussed in this chapter.

in different spheres of cultural, traditional and even modern life and advocate equality and non-discrimination for all classes of women regardless of disability, particularly attacking cultural and gender-based inequalities, discrimination and other practices that are detrimental to women.

In the next chapter it is proposed to examine human rights norms, including aspects of the law that positively impact on women's vulnerability to HIV/AIDS.

CHAPTER FOUR: HUMAN RIGHTS NORMS

4.0 INTRODUCTION

Since this thesis is focused on “HIV/AIDS and the law in South Africa and Nigeria, with special emphasis on the rights of women” there is the necessity for the study focus to cover not only aspects of the law that contribute negatively, but also those aspects that contribute positively to women’s vulnerability. Besides, the legal rights of women vulnerable to HIV/AIDS, which forms an important component of this research study, are derivable from the positive aspects of the law. These considerations, therefore, make this chapter one of the most important chapters of this thesis. However, this work attempts a further strengthening and re-adjustments of these aspects of the law that offer some positive contributions, with a view to making them more responsive to the needs of women who are vulnerable to HIV/AIDS.

4.1 INTERNATIONAL HUMAN RIGHTS LAW

International human rights law has made some positive strides and courageous inroads especially as regards standard setting, promotion and enforcement of the socio-economic and civil and political rights of people living with HIV/AIDS, especially those of the most vulnerable groups, women and children.

International human rights law seeks to promote and protect individual’s rights against the state’s interference or neglect

thereof. As already noted in chapter one of this work, a human rights framework is indispensable in promoting respect for the fundamental rights of people vulnerable to HIV/AIDS. The protection of human rights plays a key role in reducing vulnerability to HIV/AIDS and in eliminating all forms of discrimination against those infected or affected¹ by HIV/AIDS.

International human rights instruments that guarantee some measure of human rights to people living with HIV/AIDS include the UN Charter, the Universal Declaration of Human Rights (UDHR) 1948; the International Covenant on Civil and Political Rights (ICCPR) 1966; the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979; the UN Convention on the Rights of the Child (UNCRC) 1989; the Standard Minimum Rules for the Treatment of Prisoners (1957); International Convention on the Elimination of All Forms of Racial Discrimination (1965); African Charter on Human and Peoples' Rights (ACHPR) 1981; African Charter on the Rights and Welfare of the Child (ACRWC) 1989 and a host of other international resolutions and agreements on human rights and HIV/AIDS issues. In addition, national constitutions and legislative provisions guarantee a wide range of rights for the benefit of people living with HIV/AIDS.

To effectively apply the provisions of international human rights

¹ Gostin and Lazzirini, Human Rights and Public Health in the AIDS Pandemic, New York: Oxford University Press, 1997 p 22.

instruments to the advantage of people infected or affected by HIV/AIDS, the Commission on Human Rights had a simple task of clarifying and relating the human rights provisions therein to satisfy the yearnings and aspirations of people living with HIV/AIDS. This was done by means of resolutions which state, inter-alia, that the term 'or other status' in non-discrimination provisions covers health status, including HIV/AIDS. The resolutions also confirmed that discrimination on the basis of HIV/AIDS, actual or presumed, is prohibited by existing human rights standards.²

4.1.1 The UN Charter (1945)

The Preamble to the UN Charter re-affirms the determination of Member States to uphold the fundamental human rights and to respect the dignity and worth of the human person. The Charter re-affirms the faith of member States in the promotion of respect for fundamental freedoms and basic human rights for all, without distinction, as among the UNO'S central purposes.³ Member States of the UN had pledged to promote respect for human rights and fundamental freedoms for all, regardless of race, sex, language or religion.⁴

By re-affirming their faith in the promotion of respect for fundamental freedoms and basic human rights for all without distinction, the UN Charter had set the stage for all countries of

² Commission on Human Rights: Resolutions 1999/49 and 2001/51.

³ UN Charter of 1945: Article 1.

⁴ UN Charter of 1945: Article 56.

the world to promote, protect and respect the fundamental human rights of every human being or persons within their jurisdictions universally, without reference to the status of the said persons, including people suffering from HIV/AIDS.

4.1.2 Universal Declaration of Human Rights (UDHR) (1948)

The Universal Declaration of Human Rights⁵ proclaims civil and political rights as well as socio-economic rights and the right to health care, all of which are of major significance to people living with HIV/AIDS. This instrument recognises the inherent dignity and the equal and inalienable rights of all people, including individuals living with HIV/AIDS, adjudging them to have been born free and equal in dignity and rights. It affirms, inter-alia, that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.⁶

The UDHR sets the tone in its Articles 1 and 2 thus:

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as to race, colour, sex, language, religion, ----- or other status (UDHR, 1948:articles 1and2).

From the above provisions, one must admit that the inclusion of

⁵ UDHR of 1948: Articles 1 and 2.

⁶ UDHR of 1948: Article 25.

'or other status' in the language of Articles 1 and 2, expressly and by implication, guarantees people living with HIV/AIDS the rights to equality and non-discrimination. It must be realized that the rights to equality and non-discrimination are the cornerstones of human rights and these two form the bases of most human rights instruments.

With specific reference to the right to health care, a provision that is advantageous to people living with HIV/AIDS, Article 25 of the UDHR states thus:

- 1. Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including---, medical care and necessary social services- in the event of unemployment, sickness, disability,*
- 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same material protection.*

Additionally, Article 3 of the UDHR guarantees everyone the right to life. Taken together, these provisions convey some meaningful rights to people or individuals living with HIV/AIDS. Article 25(2) guarantees special care and protection to women and children, over and above the standard of rights guaranteed to people generally. It would be unrealistic to say that the special protection offered women and children in the above provisions played no significant persuasive role in the Pretoria High Court

and the Constitutional Court rulings that went in favour of the Treatment Action Campaign and HIV- positive pregnant women in the case of Minister of Health and Others v TAC and Others.⁷

One major limitation of the UDHR, however, is that it lacks the force of law since it is neither a treaty nor international agreement with binding obligations under international law. In that sense, the UDHR is largely exhortatory and lacks concrete normative force, not directly imposing obligations on states under international law.⁸ This is not to say that it lacks persuasive force. Much of its provisions, notwithstanding, have been adopted in other domestic and international human rights instruments.

4.1.3 International Covenant on Civil and Political Rights (ICCPR) (1966)

This Covenant guarantees justiciable fundamental rights and freedoms within territories of States Parties to the Covenant. A core fundamental right guaranteed by it, and which impacts on all the other fundamental rights, is the right to life.⁹ This means that people living with HIV/AIDS have their right to life protected by law.

In the same vein, it is respectfully submitted that yet unborn babies in their mothers wombs, whom their mothers have no

⁷ 2002 (4) BCLR 356 (CC); 2002 (4) BCLR 356 (T).

⁸ Nguena, C. "AIDS in Africa: Access to Health Care as a Human Right" (2000) 15 SAPR/PL 6.

⁹ Art. 6(1) ICCPR (1966).

cause or intention to abort before delivery, equally have their right to life protected by law. This opinion has religious backing in the sense that all existing life started from the time fertilization took place. The undeniable reality is that all existing human beings today, whether prominent or low in social status, began their lives the very moment their mothers conceived them and if that conception had been terminated or aborted, such individuals would be nowhere today.

In support of the above viewpoint which is also is strongly supported by the Catholic Church, I therefore equally submit, with respect, that by virtue of such natural endowment, yet unborn babies have a legal right to life, especially if their mothers strongly desired their existence. In this regard, I again respectfully submit that governments have a corresponding duty to provide an enabling environment conducive to the protection of the right to life of such unborn babies, just as it has for other living members of the public within their territorial jurisdictions. The government can do this by putting appropriate and adequate budgetary provisions, policy initiatives, and human and material resources in place in order to successfully provide adequate, available and accessible health care to its unborn babies and other citizens, especially in the wake of the HIV/AIDS scourge.

Above all, in the interest of pregnant mothers and their yet unborn babies, there is an overriding need for governments to take adequate steps to prevent peri-natal transmission or mother-to-child transmission of HIV. The South African

experience is a good example in this regard¹⁰. The situation where limited, but highly competitive life saving measures, like organ transplants, are denied people suffering from HIV/AIDS, while other HIV-negative members of the public are given preferential treatment, amounts to an abuse of such peoples' rights to life, equality and non discrimination.¹¹ This is true in as much as they are alive, like others, and are endowed with certain inalienable rights, protected by domestic and international human rights law.

In a different dimension, guarantees and enforcement of socio-economic rights¹² also enhance the right to life. Without the rights to food, water, health, housing and other socio-economic rights or major social needs, it makes nonsense of the right to life. It is the socio-economic rights that enhance the enjoyment of the right to life. The South African case of Government of the Republic of South Africa v Grootboom & Others,¹³ is apposite on the enforcement of socio-economic rights in South Africa. That case, on the right of access to housing reawakened the need for legal and public policy to provide for, guarantee, fulfill and enforce socio-economic rights. For all intents and purposes, though it sets in motion the legal machinery for the enforcement of the socio-economic right of access to housing, it also provided the impetus on the enforcement of the right of access to health

¹⁰ See the South African case of Minister of Health And Others v TAC And Others (Supra),

¹¹ ICCPR of 1966: Article 2.

¹² ICESCR of 1966.

¹³ 2001 (1) SA 46 (CC).

care as witnessed later in the case of Minister of Health And Others v TAC And Others. In the TAC case, the Constitutional Court deliberated on the issues of “reasonable access to health care” and “standard of reasonableness”. Viewed from these perspectives, this work subsequently examines whether the Government has met the above imperatives, in the context of the Constitutional Court’s decision in the TAC case.

Prior to the decision in the Grootboom case, the Government was reluctant to enforce socio-economic rights, as decided in the case of Soobramoney v Minister of Health Kwazulu-Natal.¹⁴

Viewed from a different perspective, the right to life, as enshrined in the International Covenant on Civil and Political Life entails States Parties to take steps to eliminate epidemics that can jeopardise public health and the lives of the citizens.¹⁵ In this context, individuals vulnerable to HIV/AIDS can invoke the relevant provisions and enforce their right to the extent of demanding appropriate preventive and curative services from their governments in order to prevent or control HIV/AIDS, as decided in the TAC case.

The ICCPR embodies other provisions that are advantageous to people living with HIV/AIDS. These include rights to freedom from torture or cruel, inhuman or degrading treatment or

¹⁴ 1997 (12) BCLR 196 (CC).

¹⁵ It is implied from the non-derogable nature of the right to life that states should take steps to eliminate epidemics.

punishment,¹⁶ freedom of movement,¹⁷ Others are the rights to equality and non-discrimination,¹⁸ privacy,¹⁹ etc.

Flowing from the guaranteed right to freedom from torture or cruel, inhuman or degrading treatment, HIV- positive individuals or AIDS sufferers can exercise this right by not subjecting themselves to involuntary medical tests, experiments or treatments, without their free, voluntary and informed consent. National laws must be brought in line with international law obligations. Fortunately, South Africa has taken a positive step, worthy of emulation by other African States, in this direction. Such steps include the implementation of the international human rights norms in the context of HIV/AIDS, as witnessed by the liberal constitutional provisions on the right of access to health care, and the enforcement of such right by the Courts.²⁰ The practice of subjecting pregnant women attending ante-natal clinics, in some jurisdictions, like Nigeria, to different types of blood tests, without adequate explanation as to the purposes of such tests or blood withdrawals from their bodies, and without their informed and voluntary consent, is contrary to international human rights law.²¹

¹⁶ ICCPR of 1966: Article 7.

¹⁷ ICCPR of 1966: Article 12.

¹⁸ ICCPR of 1966: Articles 2, 3, & 26.

¹⁹ ICCPR of 1966: Article 17.

²⁰ Section 27(1) of the South African Constitution 1996 and the Courts decisions in the TAC case (supra) on provision of niverapine to HIV-positive pregnant women.

²¹ See the unreported HIV/AIDS- related case instituted by SERAC and Georgina Ahamefule against the Imperial Medical Centre-Lagos, Nigeria and a Lagos State High Court Judge: SERAC Report, Lagos, July 2001.
See also - serac@linkserve.com.ng.

The rights to freedom of movement and freedom of association, on the other hand, entitle people living with HIV/AIDS to move and associate freely, without any threat of being confined or quarantined in view of their HIV/AIDS status.

It must also be noted that States Parties to the ICCPR have minimum core obligations as highlighted under Article 2. Under the said Article 2, States Parties, inter-alia, undertake to respect and to ensure to all individuals within their territories the rights recognized in the Covenant, without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. They also undertake to adopt such legislative or other measures as may be necessary to give effect to the rights recognized in the Covenant, where not already provided for by existing legislation or other measures in accordance with their constitutional processes.

4.1.4 Limitations to the ICCPR

It must be noted, however, that the ICCPR (1966) provides for derogations from the entrenched rights, in Article 4, in time of public emergency which threatens the life of a nation. The key point to note here is that if unduly exploited, this provision can prove detrimental to the interest of people suffering from HIV/AIDS.

A review of the Nigerian position shows that the provisions of the ICCPR have been domesticated in the Nigerian Constitution as

enforceable fundamental rights. But despite the domestication, the issues of enforcement and the national will to protect the rights of vulnerable individuals, especially in the context of HIV/AIDS, remain unresolved.

One on-going but yet unresolved litigation in Nigeria as at the time of writing, is worthy of mention here since it exemplifies a complete breach of international human rights law and an abuse of the fundamental human rights of a HIV-positive pregnant female worker. A final decision in this case has been delayed because the initial judge was changed following a petition to the Lagos State Chief Judge and the case had to start afresh after it was re-assigned. In the said case, being the first ever HIV-related case in Nigeria²¹, instituted by SERAC and Georgina Ahamfule against the Imperial Medical Centre, Lagos and a Lagos State High Court Judge, the evolving issues concern HIV testing without consent, absence of pre- and post-test counseling, summary termination of employment because of HIV status and denial of the right of association, appearance and hearing in a court of law because of zero-positive HIV status, thereby equally denying the right to a fair hearing.

This case has attracted international attention since Nigeria, a populous African country, is bound by her stance in international affairs, as a State Party to most of the international Covenants,

²¹ Unreported HIV/AIDS- related case instituted by SERAC and Georgina Ahamfule against the Imperial Medical Centre-Lagos, Nigeria and a Lagos State High Court Judge: SERAC Report, Lagos, July 2001.

See also - serac@linkserve.com.ng and the entire SERAC REPORT: 2001.

Conventions and international human rights treaties, to domesticate her international law obligations and to abide by the terms of international treaties.

The facts of the case are that Georgina Ahamefule, an auxiliary nurse, working at the Imperial Medical Centre, Lagos, Nigeria, was sick, with some boils on her body, during pregnancy. She reported her condition to her boss, the Chief Medical Director of the said Imperial Medical Centre who thereafter took samples of Georgina's blood and carried out some tests, without any explanation as to what tests he was carrying out. Thereafter, the Chief Medical Director directed Georgina Ahamefule to another medical doctor in another hospital for the purpose of carrying out other tests, for which Georgina Ahamefule knew nothing about. At the Lagos University Teaching Hospital, this second doctor withdrew samples of Georgina's blood and carried out further tests, at the end of which he referred Georgina back to the Chief Medical Director of the Imperial Medical Centre. It was at this point that the Chief Medical Director and employer of Georgina, told her that she was HIV- positive and that her employment was summarily terminated because of her HIV status.

On learning of Georgina's plight, SERAC, a NGO with expertise in the enforcement of socio-economic rights, instituted a case of wrongful termination of employment on account of HIV status at the Lagos High Court. At the said court, most unfortunately, the High Court Judge, a woman, refused to allow Georgina to appear before her to be heard, fearing that Georgina might infect others

present in court, thereby denying Georgina the right to a fair hearing, in addition to other fundamental human rights, like equality and non-discrimination, already violated, breached, abused and denied her.

Because of the public outcry and the international attention this case has attracted, much delay has occurred in resolving this case because the case was later transferred to another court presided over by another judge, to start afresh. The government, however, in a swift reaction, and in liaison with human rights organizations, has been conducting induction courses for senior government officials, including Magistrates and High Court Judges, to keep them abreast of the norms of international human rights law, in the context of HIV/AIDS.

Georgina's case mirrors a distressing reality and unfortunate state of affairs in Nigeria in the context of the current HIV/AIDS epidemic and the treatment of people vulnerable to it. It epitomizes the fate of women and others suffering from HIV/AIDS in that their fundamental human rights to voluntary consent, pre and post test counseling, equality and non discrimination, or other fundamental rights, are violated, abused, disrespected and disregarded with contempt. It pictures a near state of anarchy where the rights of women are subjected to scorn and ridicule, even by fellow women in places/positions of authority, like the Lagos State High Court Judge, a woman, as discussed above.

4.1.5 International Covenant on Social, Economic and Cultural Rights (ICESCR) (1966)

The International Covenant on Economic, Social and Cultural Rights guarantees justiciable socio-economic rights. In this Covenant, the right to health care²² readily appeals to the interests of people infected with, or affected by, HIV/AIDS. Article 12 of the ICESCR enshrines the right to the enjoyment of the highest attainable standard of physical and mental health. States Parties are enjoined to take appropriate measures to achieve the realisation of this right, including the prevention, treatment and control of epidemics, endemic, occupational and other diseases, and the creation of conditions which would assure to all medical services and medical attention in the event of sickness.

The said Article 12 could be seen as nebulous and vague since it allows States Parties undefined discretion. Despite the original aims and objectives of the Limburg Principles,²³ which obviously had intended a gradual but smooth implementation of socio-economic rights, most, if not all, socio-economic rights are guaranteed subject to progressive realization. However, this sense of progressive realization is often misinterpreted and misapplied by governments who find reasons to delay full

²² Art. 12 of ICESCR (1966).

²³ It is important to note that it was the Limburg Principles and the Maastricht's Guidelines on the Limburg Principles that laid down the guiding principles concerning the minimum core obligations in the implementation of socio-economic rights by States Parties.

See also General Comment No. 3, Thirteenth Session of the UN General Assembly 1981.

implementation of socio-economic rights and to hide under the cloak of resource constraints.

Despite the existence of the minimum core obligations as per the Limburg Principles and the Maastricht's Guidelines on the Limburg Principle concerning the minimum core obligations with regards to the ICESCR by States Parties, as highlighted above, enforcement of socio-economic rights is relegated to the background. In many African States including South Africa and Nigeria, where there are resource and budgetary constraints, it is not impossible to adduce good reasons for not keeping to the guidelines on minimum core obligations and progressive implementation or realization of socio-economic rights. Even the requirement of State reports on progressive achievements or implementation is most often evaded. However, South Africa, with her advanced Constitution, must be commended on implementation and enforcement of socio-economic rights as epitomized not only by constitutional provisions, but by case law.

Unfortunately, courts are extremely reluctant to enforce socio-economic rights. The case of Soobramoney v Minister of Health Kwazulu Natal (Supra) demonstrates this sense of reluctance. However, the decisions of the Pretoria High Court and the Constitutional Court of South Africa, in Minister of Health And Another v TAC And Another (Supra), represent a departure from past precedents. Those decisions are hailed in many quarters as victory for the progressives in their determination to enhance the enforceability of socio-economic rights.

But despite this sense of victory, there is reason to be cautious. This is because two years later, after the Constitutional Court judgment, the measures taken by the Government cannot be considered to be reasonable²⁴ in the context of accessibility and availability of antiretroviral drug therapy for all HIV-positive pregnant mothers and other people living with HIV/AIDS in South Africa. There are marked delays in the roll-out of the antiretroviral drugs to HIV-positive individuals in the various Provinces of South Africa, contrary to the judgment of the highest court of the land. The slow or delayed action by the Government in this regard calls into question and indicts the South African Government, on the aspect of minimum core obligation and the requirement of reasonable access to health care, as ruled by the Constitutional Court in the TAC case.

Even more disturbing is the posture of the Government, including president Mbeki, in the continued denial of the existence of AIDS in South Africa, in the face of public outcry, as widely reported by the mass media in South Africa.²⁵ But, with the undisputed UNAIDS: 2004 Report showing an unprecedented high statistics which give a gloomy picture on the HIV/AIDS situation in South Africa, and with the comments of the DA and

²⁴ In an unstructured personal communication by means of an unstructured interview with the Manager of the HIV/AIDS- Skinner Street Clinic, Department of Health, Pretoria, on 14 February, 2005, it was conceded that the comprehensive roll- out of anti- retroviral drugs to all HIV-positive individuals was somehow slow.

²⁵ In 2003/2004 various media organizations in South Africa including the E News and SABC 3 Television Networks commented against the Government's and President Mbeki's position on AIDS, and also highlighted the public outcry including the DA's and other opposing political parties' condemnation of President Mbeki's and the Government's position.

other opposing political parties, as also widely reported by the news media, the denial is considered wrongful.

The South African Constitutional Court, in delivering its judgment on the niverapine case involving TAC and the Government, said that by confining niverapine to research and training sites, the Government had in effect failed to address the needs of mothers and their newborn children who had no access to these sites. Indirectly put, the government's action amounted to discriminatory practice against those mothers and newborns who had no access to the project sites. Those statements by the Constitutional Court formed part of the ruling that marked the end of a long-drawn argument on the reasonableness or otherwise of government action on the niverapine issue. While commenting on the concept of minimum core obligation, the Court opined that the Constitution envisaged a much more restrained and focused role for the courts that centers on whether the State has met the constitutional imperatives of reasonableness. The Court read section 27(1)(a) and section 27(2) together to mean that the right of access to health care services has to be realized progressively within available resources. This interpretation essentially means that the right to health care, and by implication, other socio-economic rights, are entirely programmatic. It is hereby submitted that the Court's ruling on minimum core obligations has the effect of reducing socio-economic rights to the status of reasonable policy entitlements, as against the dictates of the Committee on Economic, Social and Cultural Rights.

However, the Constitutional Court's ruling that sections 27(1) and (2) of the Constitution require government to devise and implement, within its available resources, a comprehensive and coordinated plan to progressively realize the rights of pregnant women and their children to have access to health care services in order to combat mother-to-child transmission of HIV is not too different from the requirements of minimum core obligation and the concept of progressive development/realization of the right to health care.

The constitutions of many African countries, including Nigeria, show a clear dichotomy between justiciable human rights and non-justiciable socio-economic rights, often times enshrined as fundamental objectives and directive principles of state policy. The fact that provisions of human rights are included within the rubric of 'fundamental objectives and directive principles' in some domestic constitutional provisions, as well as the imprecise nature of the language in which they are couched, obviously undermine their justiciability.

Socio-economic rights to health care are presently not justiciable in Nigeria, even as they are so provided for under the rubric of 'Fundamental Objectives and Directive Principles of State Policy' in chapter 2 of the Nigerian Constitution. A round- about way of enforcing socio-economic rights in Nigeria is to invoke the provisions of the African Charter on Human and Peoples' Rights, since Nigeria has incorporated its provisions as part of Nigerian

domestic law.²⁶ Despite its incorporation, it is worthy to note that the enforcement of the provisions of the African Charter in Nigeria could face some obstacles or constitutional problems, as shall be discussed subsequently.

4.1.6 The Enforcement of Socio-economic Rights to Health Care in Nigeria: The Case of the Ogoni People:

In Nigeria, there is as yet no reported legal authority on the enforcement of socio-economic right to health care. Despite the landmark decision on Communication No. 155/96 by the African Commission on Human and Peoples' Rights on the Ogoni- land case in Rivers State of Nigeria, as brought to the Commission by SERAC and the Ogoni people, the rights to health care, shelter, etc, as enunciated, have not been enforced till now. It is one thing to make a ruling and another thing to enforce the ruling. Noting the weak enforcement machinery of the African Charter, the African Commission on Human and Peoples' Rights is largely seen to be a "toothless bulldog" that can "bark but not bite". An example of this state of affairs is the Ogoni case in Nigeria. Their land produces the major oil and mineral resources in Nigeria. The government derives much revenue from the mineral resources, but in the process their environment is seriously polluted beyond acceptable health standards.

They complained to the then Military Government of Nigeria.

²⁶ The ACHPR (Application and Enforcement) Act, Cap 10, Laws of the Federation of Nigeria 1990.

Instead of meeting their demands, the Military Government responded with force, detained their leaders and destroyed their property and degraded the environment even further. Their leader, Ken Sarowiwa, was executed in the process. SERAC, following its inability to utilize domestic legal sources to adjudicate on the grievances by the Ogoni people, resorted to the African Commission. with Communication No. 155/96 against the Nigerian Government. The Communication²⁷ alleged, inter alia, violations of Articles 2, 4, 14, 16, 18(10, 21, and 24 of the African Charter of Human and Peoples' Rights. The African Commission, in October 2001, decided and ruled in favour of SERAC and the Ogoni people.

Before the said decision, the new Nigerian civilian Government had laid claims to instituting a number of remedial measures to solve the problems of the Ogoni people. The claims include the establishing a Federal Ministry of Environment and enacting into law the establishment of the Niger Delta Development Authority. A closer examination of each of the above remedial measures confirms that none of those measures can be seen as meeting the Ogonis' rights to health care or housing, etc. After the decision or ruling by the African Commission, nothing more has been done about the Ogoni case. Ministries of Environment, no doubt, have been established at the Federal level and in every State of the Federation of Nigeria, but they have done little or

²⁷ Communication No. 155/96 was made by the Social and Economic Rights Action Committee (SERAC), an NGO in Nigeria, to the African Commission on Human and Peoples' Rights, on behalf of the Ogoni People of Nigeria.

nothing to stop environmental degradation in Ogoni-land or in Nigeria as a whole. These Ministries of Environment have not restored or enforced the right to health care of the Ogoni people.

I submit that it is correct to say that the problems of the Ogoni people of Nigeria have not been resolved till now. They are still complaining today. As one of the States of Nigeria that produces mineral oil, the Rivers State of Nigeria to which Ogoni-land belongs get a share of the oil revenue for developmental purposes. The Federal Government of Nigeria still retains a substantial part of the revenue that accrues from mineral resources. What gets to the coffers of Ogoni-land is an insignificant/minimal amount that they receive from a share of their State's allocation.

In summary, therefore, neither the rights to health care, nor of housing, or any other right, as decided by the African Commission, in favour of SERAC and the Ogoni people of Nigeria, has so far been enforced. The weak enforcement mechanisms of the African Charter accounts significantly for this. It is hoped that when the African Court of Justice comes into being and becomes operational, the decisions of the African Court of Justice shall become enforceable.

4.1.7 Convention on The Elimination of all forms of Discrimination Against Women (CEDAW) (1979) and United Nations' Convention on the Rights of the Child (UNCRC) (1989)

The plight of women and children and the factors that render

them most vulnerable to HIV/AIDS, as discussed variously in this work, lay credence to the fact that the provisions of established international instruments need to be adopted and domesticated by States Parties.

The Convention on the Elimination of All Forms of Discrimination Against Women and the UN Convention on the Rights of the Child²⁸ contain special provisions that offer protection to the rights of women and children. These provisions are of interest to women living with HIV/AIDS.

Article 12 of CEDAW (1979) provides:

1 States Parties shall take all appropriate measures to eliminate discrimination against women in the fields 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.

These provisions represent the minimum core obligations of

²⁸ CEDAW OF 1979: Article 12; UNCRC of 1989: Article 24.

States Parties. After a closer examination of the situation in Nigeria, it is respectfully submitted that it is very doubtful if Nigeria has come close to meeting these minimum core obligations, while South Africa must be commended for her efforts so far.

On the whole, CEDAW (1979) legally redresses the imbalance against women in terms of gender inequality and discrimination in the traditional and social contexts that invariably operate along with other variables to render women the most valuable target of HIV infection and AIDS disease. The entire provisions of CEDAW 1979 is a potent source of legal rights to equality and non- discrimination in the interest of women, including those living with HIV/AIDS.

With reference to the right to health care for children, Article 24 of the UNCRC (1989) provides:

1. states parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilitate the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her 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 to diminish infant and child mortality----

(c) to combat disease and malnutrition, -

-- within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritional foods,-----

(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....

These provisions also represent the core obligations of States Parties but, once again, it is very doubtful if Nigeria is in anyway closer to meeting these core obligations. However, South Africa is a worthy example of an African State that has tried, and is closer, to fully meeting the core obligations of States Parties. Following that women and children are the most vulnerable groups to HIV/AIDS, it stands to reason that something must be done urgently to rescue these groups. Provisions that embody 'implementation of rights within the contexts of primary health care' or those that stress 'progressive development' do not exonerate States Parties from taking some urgent steps to alleviate the suffering of people living with HIV/AIDS, starting progressively with the most vulnerable groups.

It is important to note that in every judicial decision, a number of factors do play a persuasive role and have persuasive effects on the judicial decision, apart from the substantive law on the issue. This means that apart from the law on point, a High Court Judge or Magistrate or anybody acting in any judicial capacity may have

some other factors, whether legal or otherwise, that play a decisive persuasive role in the decision he/she eventually arrives at, though these may not be officially recorded. The decision on the provision of niverapine- antiretroviral drug therapy to reduce the rising incidence of mother-to- child transmission of HIV, could have attracted some persuasive dimensions. This implies that numerous other factors, apart from the direct substantive law on point do have, or can have, persuasive effects, working on the mind of the Judge, before a judicial decision is arrived at.

The provisions of Article 12 of CEDAW (1979) and UNCRC (1989), as highlighted above, especially Article 12(2) of CEDAW, and Articles 24(1) and 2(a),(c),(d) & (f) of UNCRC could have provided some of those persuasive dimensions in arriving at the decisions in the TAC case on provision of niverapine. These would be in addition to the substantive law on the point. The Courts are normally not expected to comment on factors that acted as persuasive effects.

In view of the compelling need to salvage humanity and particularly women and children, from the devastation of the HIV/AIDS epidemic, the positive aspects of the above provisions can be made to impact advantageously on the most vulnerable groups. This is achievable when governments meet their domestic core obligations and take positive steps, even progressively, to achieve these core obligations. This can be done by compelling governments to provide free and appropriate treatment for effective pre-natal and post-natal care of women,

children and even yet unborn babies, as a starting point aimed ultimately at a comprehensive package for all people infected with, and affected by, HIV/AIDS.

4.1.8 The Standard Minimum Rules for the Treatment of Prisoners (1957), the UNO Basic Principles for the Treatment of Prisoners (1990), and the WHO Guidelines on HIV Infection and AIDS in Prison (1993):

When the UN's Standard Minimum Rules for the Treatment of Prisoners are applied along with the Basic Principles for the Treatment of Prisoners and the WHO Guidelines on HIV Infection and AIDS in Prison, the rights of prisoners vulnerable to HIV/AIDS are protected. The minimum health needs of prisoners, and particularly those of women inmates, are specially guaranteed²⁹. Women prisoners are given special protection, with emphasis on pre and post-natal care and treatment. The UN Basic Principles for the Treatment of Prisoners (1990) provide in Article 9 that prisoners shall have access to health services available without discrimination on grounds of their legal status or situation. In addition, the WHO's Guidelines on HIV Infection and AIDS in Prison (1993) provide standards on how to deal with cases of HIV/AIDS in prison. Taken together, these instruments and their entrenched provisions guarantee legal rights for prisoners living with HIV/AIDS, with some special protection for

²⁹ Arts. 22, 23, 24, 25, & 82 of the Standard Minimum Rules for the Treatment of Prisoners (1957).

See also Arts. 23(1)&(2) which protect women inmates, with emphasis on pre and post natal care and treatment.

See also Art. 9 of the UN Basic Principles for the Treatment of Prisoners (1990).

women inmates. The case of B v Minister of Correctional Services³⁰ illustrates the enforcement by four HIV-positive prisoners in South Africa of their legal rights to health care appropriate to their needs. The defence of lack of resources by the prison authorities could not avail the defendants. The court ordered that antiretroviral drug therapy be provided by the defendants, as demanded by the plaintiffs.

4.1.9 African Charter on Human and Peoples' Rights (ACHPR) (1981) and African Charter on the Rights and Welfare of the Child (ACRWC) (1989)

The African Charter on Human and Peoples' Rights, as a regional instrument, provides for the right to health care³¹. The enshrined right to health care is a socio-economic right which individuals, including those belonging to the most vulnerable groups to HIV/AIDS, can invoke to their advantage at the regional level to compliment national efforts. Article 16 of ACHPR provides:

- 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.*

In addition to Article 16 of the ACHPR, Article 18(3) enshrines protection for women and children and their rights as guaranteed

³⁰ 1997 (6) BCLR 78 (CC).

³¹ ACHPR of 1981: Article 16.

by international instruments.

The above provisions of Article 16 of the ACHPR illustrate the core obligations of States Parties, of which South Africa and Nigeria belong, with regards to promoting, protecting and enforcing the right to health care. South Africa has enshrined in its Bill of Rights enforceable socio-economic rights, including an enforceable right to health care, backed up by a number of case law. The same cannot be said of Nigeria which does not provide for an enforceable right to health care, much-less of enforceable socio-economic rights, in her constitution. The Ogoni Case (Supra), illustrates the attempt by the African Commission to enforce the right to health care in Nigeria, but, in practical terms, despite the decision or ruling of the said Commission, the decision could not be enforced and this right has eluded the Ogoni people till now. This means that Nigeria has a long way to go in terms of meeting the domestic core obligations of States Parties, unlike South Africa.

However, despite the weak enforcement mechanisms, the ACHPR is a potent source of legal rights to people living with HIV/AIDS in Africa, following the unambiguous terms of the provisions of Article 16. This legal right becomes more strengthened in countries like Nigeria that have incorporated the provisions of the African Charter as part of their domestic law³². It is hoped that as time goes on, modern and dynamic Nigerian Judges shall

³² ACHPR (Application and Enforcement) Cap 10, Laws of the Federation of Nigeria, 1990.

see the need to enforce the provisions of the African Charter, as incorporated in Nigerian law. Until then, Nigerians who cannot get relevant justice at the domestic forum should await the establishment of the African Court of Justice, on which they can hope to rely, with regards to the enforcement of the provisions of the African Charter.

The euphoria of the incorporation of the provisions of the African Charter as part of Nigerian law must be reconciled with the provisions of Section 1(3) of the Nigerian Constitution 1999, which states:

If any other law is inconsistent with the provisions of this constitution, this constitution shall prevail, and that other law shall, to the extent of its inconsistency, be void.

Because of the stated problem of absence of enforceable right to health care in the Nigerian Constitution, this study adopts the view that Nigerian law must be made to conform to, or brought in line with, regional and international treaty provisions and obligations.

It is appropriate to acknowledge, at this point, that the Protocol to the African Charter on Women's Rights³³ contains innovative and elaborate provisions that address women's rights, and are generally beneficial to women, in the context of HIV/AIDS, though not yet in force..

³³ The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003-Moputu is not yet in force.

On its part, the African Charter on the Rights and Welfare of the Child (ACRWC) 1989 contains elaborate provisions on health care from which children, infants, unborn babies and their mothers can benefit³⁴.

People living with HIV/AIDS and, particularly, HIV-positive pregnant mothers would find certain provisions of the ACRWC to be significantly useful to their interests.

Article 14 of the ACRWC provides:

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 :to reduce infant and child mortality rate; to ensure the provision of necessary medical assistance and health care to all children with emphasis on development of primary health care; to ensure the provision of adequate nutrition and safe drinking water ;to combat disease and malnutrition within the framework of primary health care.....; to ensure appropriate health care for expectant and nursing mothers;to develop preventive health care and family life education and provision of service,.....

Even within the constraints of primary health care, some of the above provisions provide important relief to mothers and children

³⁴ ACRWC of 1989: Article 14.

living with HIV/AIDS, especially expectant mothers and their unborn children. Expectant and nursing mothers and children who are vulnerable to HIV/AIDS can rely heavily on these provisions as key, justiciable sources of legal rights to health care. This then re-echoes the fact of domestication of regional treaty obligations. The South African Government has, to a great extent, attempted the domestication of her regional treaty obligations regarding the provisions of the African Charter on the Rights and Welfare of the Child. The South African National Programme for the Prevention of Mother-to-Child Transmission of HIV incorporates most of the requirements and provisions of Article 14 of ACRWC. The reverse, however, cannot be said about Nigeria on the domestication of her regional treaty obligations.

As already shown in this work, a number of untold factors do have a persuasive, if not forceful, effect or impact on judgments given in courts or elsewhere. Apart from the substantive provisions of the law on point, I submit that many other non-substantive or related factors impact as persuasive factors. The court in question need not mention or elaborate on these. Though the unambiguous wordings of the ruling of both the Pretoria High Court and the Constitutional Court are clear, I am once again submitting, with due respect, that the clear provisions of Article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC) 1989, which also had some bearing on the issue of right to health care of children, could have provided some persuasive impetus on the rulings in the TAC case (*supra*), even

as the Courts did not refer to that Treaty.

4.2 RIGHT TO EQUALITY AND NON-DISCRIMINATION

In discussing International Human Rights Instruments and their provisions on socio-economic rights to health care, it becomes necessary to highlight the importance of the rights to equality and non-discrimination. The essence is to show that without guaranteeing the rights to equality and non-discrimination, the right of access to socio-economic rights and other rights guaranteed by these instruments become a farce.

Equality and non-discrimination are the twin- pillars and corner-stones of human rights instruments. Expressly or impliedly, all international human rights instruments provide for the right to equality. They underscore the essence of equality of everyone, while clearly giving a message that everyone, regardless of status, deserves an enjoyment of all human rights on the basis of equality and non-discrimination.

At this point, it becomes necessary to note that since each of the international human rights instruments and the associated cases are applicable in different fundamental human rights related circumstances, there shall be obvious repetition of these instruments and the applicable cases as these apply in various other fundamental human rights situations in this chapter. This becomes obvious since this chapter deals with human rights norms. For example, in discussing the Right to Equality and Non-discrimination, different international human rights instruments-

like the UDHR, ICCPR, UNCRC, CEDAW, ACHPR, ACRWC, etc, obviously apply and must be discussed and shown how they apply, and vice-versa. In the same vein, a particular case law that illustrates the right to equality and non-discrimination under the UDHR OR ICCPR, for instance, may equally apply when discussing the right to equality or any other fundamental human right under one or more of the above international human rights instruments.

In order to present a balanced report of its findings, this thesis gives appropriate illustrations in each case or factual situation. What, therefore, may appear as seeming repetition of cases or of international human rights instruments, or even of fundamental human rights may, in actual fact, not be repetitions or duplications in the true sense, but an attempt to illustrate the wide-ranging application of the cases, fundamental rights and international instruments to the different factual human rights situations.

The UN Charter³⁵ stipulates that the promotion of respect for human rights and for fundamental freedoms for all, without distinction, are some of its central purposes. The UDHR³⁶, ICESCR³⁷ and ICCPR³⁸ are not left behind in affirming similar principles of equality and non-discrimination. They all affirm the equal rights of men and women to enjoy and exercise enshrined

³⁵ UN Charter of 1945: Article 1.

³⁶ UDHR of 1945: Article 1 & 2.

³⁷ ICESCR of 1966: Article 2.

³⁸ ICCPR of 1966: Article. 3.

rights, without distinction or discrimination. The African Charter on Human and Peoples' Rights³⁹ is equally committed to the principle of non-discrimination.

CEDAW (1979) fully addresses issues of inequality and discrimination against women in the traditional, cultural, social and modern settings. Gender inequality and discrimination against women have been noted in UNAIDS 2004 Report as the underlying causes of the high vulnerability of women to HIV/AIDS in Africa. CEDAW enshrines the rights of all women to equality and non-discrimination. Equally, Article 2 UNCRC (1989) and Article 3 of ACRWC (1989) guarantee to children the right to freedom from discrimination.

The notion underlying issues of equality and non-discrimination in the context of HIV/AIDS is the crux to the resolution of problems associated with stigma, voluntary counseling, testing and treatment. It holds the key to effective public health preventive, diagnostic and treatment programs. A commitment to the tenets of equality or equal rights of all persons and to the ideals of non-discrimination provides the moral and legal foundation to the utilization and enjoyment of the right to health care and other classes of human rights.

Apart from international human rights instruments, domestic instruments provide for the rights to equality and non-discrimination. These are rights from which people vulnerable to

³⁹ ACHPR of 1981: Article 2.

HIV/AIDS, especially women sufferers, can benefit immensely in the traditional context, in view of the long standing stereotyped attributes of enhancement of gender inequality and discrimination. The South African Bill of Rights⁴⁰ liberally promotes the virtues of equality and non-discrimination in its constitutional provisions. The clear and unambiguous provisions of section 9 on equality and non-discrimination attest to this.

The Nigerian Constitution⁴¹ equally guarantees the fundamental rights to equality and non-discrimination. Under its 'Fundamental Objectives and Directive Principles of State Policy', Section 17(1) states that the State Social Order is founded on ideals of freedom, equality and justice while section 17(2)(a) provides that every citizen shall have equality of rights, obligations and opportunities before the law. Unfortunately, however, the Fundamental Objectives and Directive Principles of State Policy are not justiciable and confer no justiciable rights on any citizen.

Section 42 of the Nigerian Constitution, dealing with justiciable fundamental rights, provides for the right to freedom from discrimination. People suffering from HIV/AIDS in Nigeria can take advantage of these provisions as sources of their legal rights to equality and non-discrimination.

One sad development however remains that despite the provisions of international and domestic human rights

⁴⁰ SA Constitution of 1966: Sections 7 and 9.

⁴¹ Nigerian Constitution of 1999: Sections 17(1)&(2) and Section 42.

instruments guaranteeing equality and non-discrimination to all citizens without regards to status, etc, those diagnosed with HIV/AIDS continue to face not only physical debilitation and death, but also severe social discrimination at every level of society.

Discrimination against HIV-infected persons, is recognized as contributing to the spread of the disease since it encourages denial and risk behaviour, while discouraging voluntary testing. The South African National HIV/AIDS Policy Guidelines abhor stigmatization and discrimination of any kind in the context of HIV/AIDS. The need to combat all forms of discrimination and inequality, whether based on skin colour, gender, sexual orientation, poverty, or HIV/AIDS is one of the most important issues and challenges of this decade. AIDS, or a suspicion of it, can lead to discrimination in employment, education, housing, and even the utilization of health care services and medical treatment.

As discussed in chapters one and two, the ruling of the USA State of Florida Supreme Court, in the case of Rasmussen v South Florida Blood Services, Inc⁴², is of special significance in assessing the stigma associated with HIV/AIDS. Issues of stigma and discrimination in the context of HIV/AIDS form a major core of the human rights dimension or strategy to reduce the adverse impact of the epidemic. Any overstressing of these issues is respectfully designed to convey the message. Discriminatory

⁴² 500 So . 2d 533 (Fla. 1987).

forms of human rights abuse against persons affected by HIV/AIDS take different forms. Apart from general discriminatory practices against the person suffering from HIV/AIDS, their partners, families, etc, may be discriminated against.

The history of HIV/AIDS reveals an itinerary of inhumanity to its sufferers. The idea of blaming the victim is a long standing prejudice in the minds of members of the public. Consequent upon this stereotyped prejudice, victims of HIV/AIDS are not only marginalized, stigmatized and discriminated against, they are also held responsible for the epidemic. The unreported Nigerian case of SERAC And Georgina Ahamefule v Imperial Medical Centre And a Lagos High Court Judge⁴³ supports this claim.

The courts in different jurisdictions, including the Hoffman's case in South Africa (supra), have had occasions to examine the issues and rule on cases involving breaches of the rights to equality and non-discrimination. The Botswana's case of Makuto V State (supra) is an example. But while the decision in the Botswana's case seeks to extend the protection and enforcement of the rights to equality and non-discrimination to everyone including HIV-positive offenders, some statutes in South Africa justify a derogation from these norms. The South African Criminal Law Amendment Act⁴⁴ provides for harsher sentencing

⁴³ Unreported First Nigerian Case on HIV/AIDS. In South Africa, the jurisprudence on the case of Hoffman v South African Airways provides the answer to the case of Goergina Ahaemafule. Nigeria shall need to learn from the position in South Africa.

⁴⁴ Criminal Law Amendment Act No. 105 of 1997.

of HIV-positive rapists. Also, the Criminal Procedure Act⁴⁵ makes granting of bail more difficult in instances where the suspected rapist is known to be HIV-positive.

In another development, the Johannesburg High Court ordered Buccleuch Montessori Nursery School in Johannesburg, in the case of Tholakeli Nkosi and Karen Pereira (Foster Parent) V Buccleuch Nursery School⁴⁶, to admit a four year old HIV-positive girl, though the court noted that the school authorities had indicated they were only delaying admission until the child was beyond the biting age, being three years of age, to prevent the transmission of HIV to others through biting.

In the USA, in addition to constitutional guarantees, several legislations prohibit discrimination on the basis of disability. HIV/AIDS is considered a disability in USA, as decided by the US court in the case of Runnebaum V National Bank of Maryland⁴⁷ and by the US Supreme Court in the case of Bragdon V Abbott⁴⁸, where the highest court confirmed asymptomatic HIV infection as a disability⁴⁹.

In a related development, in the USA, a HIV discrimination law

⁴⁵ Schedule 6(a)(iv) of the Criminal Procedure Second (Amendment) Act No. 85 of 1997.

⁴⁶ 2002 Unreported Johannesburg High Court case no. 02/4377.

See Pretoria News of Wednesday, June 12, 2003, page 3; and Pretoria News of Friday-June 14, 2002, page 2.

⁴⁷ 95 f. ed 1285, 1290 (4th Cir. 1996).

⁴⁸ 118 S. Ct. 2196 (1998).

⁴⁹ See the Americans with Disability Act (ADA) 1990.

suit, Doe V Corrections⁵⁰, was instituted by past and present HIV-positive inmates against the Michigan State authorities for denying them placement in community residential programs because of their HIV-status. They won. The court barred such discriminatory policy.

The Canadian legislative and judicial machineries also support the concepts of equality and non-discrimination for everyone, including those who are physically handicapped. HIV infection is held in Canada to constitute a physical disability and accordingly, human rights legislations provide protection for people suffering from HIV/AIDS against any form of discrimination. The Ontario Human Rights Code, 1990, prohibits discrimination on the basis of a 'handicap' and thereby ensures that the disabled, including people living with HIV/AIDS, are entitled to equal protection against discrimination. This code has, since 1985, recognized HIV/AIDS as illness falling within the definition of 'handicap'. Some reported Canadian court decisions have confirmed that HIV infection constitutes a physical disability on which basis the sufferer must not be discriminated against. This was so decided in the cases of Biggs v Hudson⁵¹ and Fontain v Canadian Pacific Ltd⁵².

Discrimination can be defined as any form of differential treatment. Discrimination against women and children is

⁵⁰ 2001 WL 1666146 Mich. APP. 12.28.01.

⁵¹ (1988) 9 CHRR D/5391.

⁵² (1990) 11 CHRR D/288.

especially pervasive and affects their health. In the context of HIV/AIDS, any form of discrimination against women and children creates a negative impact and makes the task of preventing the spread of HIV/AIDS an uphill task, if not an impossibility. Discrimination in health care occurs globally in varying dimensions. It includes stigmatization due to HIV/AIDS status.

4.2.1 Derogations and Limitations on the Rights to Equality and Non-discrimination:

Some legal rights do not give rise to absolute enjoyment or protection. The law therefore permits of certain derogations from the norm, under some specific circumstances that are protective of the general welfare, especially in times of public emergency that threatens the life of a nation⁵³.

In a related issue, the Siracuse Principle,⁵⁴ in clarifying and construing the clauses on the Limitation and Derogation provisions in the ICCPR, states that public health may be invoked as a ground for limiting certain rights in order to allow states to take measures dealing with a serious threat to the health of the population.

The above approach is important to people living with HIV/AIDS so that they can comprehend that the law, at some points, allows

⁵³ UDHR of 1948: Art. 29(2); ICESCR of 1966: Arts 4, 4(1), 12(3), 18, 19, 21 & 22;

See also ACHPR of 1981: Art. 2 and Ghana Constitution of 1992: Sect. 12(2).

⁵⁴ The Siracusa Principles (1984) were drafted by international lawyers in terms of the Limitation and Derogation provisions in the ICCPR 1966 to further clarify and construe the relevant clauses.

for derogations from, and limitations of, certain rights. The reality, of course, is that certain jurisdictions have introduced some legal measures to directly or indirectly limit the enjoyment of the rights to equality and non-discrimination or other fundamental rights.

In South Africa, section 7(3) of the Bill of Rights approves of some limitations. It provides as follows:

The rights in the Bill of Rights are subject to limitations contained or referred to in section 36, or elsewhere in the Bill of Rights.

Again, though sections 9(1), (2),(3)&(4) of the South African Constitution 1996 enshrine equality and non-discrimination, section 9(5) permits certain derogations from, or limitations to, the enjoyment of the rights to equality and non-discrimination. Section 9(5) provides:

Discrimination on one or more of the grounds listed in sub-section 3 is unfair unless it is established that the discrimination is fair.

The South African case of Harksen v Lane,⁵⁵ with its two stage enquiry clearly laid down, sheds some light on the limitation of rights in the public interest. This case which is an embodiment of some aspects of constitutional law, human rights law, and insolvency law lays down the test on derogations from the norm and limitation of rights in the public interest. The lead judgment

⁵⁵ 1998 (1) SA 300 (CC).

was to the effect that expropriation, without compensation, involving rights in property, by public authorities, fell short of compulsory acquisition or of infringing Sections 64 and 65 of the Insolvency Act 24 of 1936. The judgment also clarified that the right to equal protection of the law was not infringed because the differentiation had a rational connection to section 21 of the Insolvency Act.

Some key aspects of the ruling in the above case, with implications for constitutional law as well as human rights law, with emphasis on limitation of rights in the public interest, are as follows:

- That the said discrimination was not unfair because it did not affect vulnerable group or group which had suffered discrimination in the past.
- That the purpose of the measure was not inconsistent with the underlying values of section 8(2) of the constitution which guarantees the right to equality as well as the right not to be unfairly discriminated against.
- That the inconvenience and burden imposed by Section 21 did not lead to impairment of fundamental dignity or constituting impairment of comparable serious nature.

The above tests provide some yardsticks which could be applicable in other comparable circumstances of infringement or limitation of rights in the public interest.

In the Nigerian context, the constitutional provisions that guarantee basic rights also provide for reasonable derogations. For example, section 35(1) of the Nigerian Constitution, 1999 which provides for the rights of everyone to personal liberty also offers limitations to the enjoyment of such rights, in section 35(1)(e). The sections provide:

35(1)-Every person shall be entitled to his personal liberty and no person shall be deprived of such liberty save in the following cases and in accordance with a procedure permitted by law...

35(1)(e)-...in case of persons suffering from infectious or contagious disease, persons of unsound mind, persons addicted to drugs or alcohol or vagrants, for the purpose of their care or treatment or the protection of the community

In the above perspective, people afflicted with HIV/AIDS could be denied their rights to personal liberty and be quarantined, segregated or otherwise denied their rights to equality if the Nigerian government should declare HIV/AIDS to be an infectious disease in accordance with the provisions of Section 35(1)(e) of the Nigerian Constitution, 1999.

In totality, these provisions have obvious implications for persons infected with, or affected by, HIV/AIDS. Though the provisions of the above sections are rarely implemented, people living with HIV/AIDS need to satisfy themselves that their legal rights, as guaranteed by international and domestic human rights

instruments, are not absolute, but that these rights can be limited in justifiable circumstances. In derogating from some rights, with the aim of protecting the general welfare, states must be very cautious, realizing that some limitations on human rights, or that certain coercive measures, may actually create a paradox and thwart public health goals.

Section 36 of the South African Constitution makes provision for reasonable derogations from entrenched rights. Other jurisdictions have similar provisions that permit reasonable derogations from specified human rights norms. To buttress their justifications to deviate from the norms of, or to derogate from the rights to equality and non-discrimination, some states in some jurisdictions adduce various reasons which they claim to be in the interest of public health, in the context of HIV/AIDS. For example, as already noted in chapters one, two and four of this work, some states in USA legally allow mandatory testing for HIV without informed consent, in breach of international human rights norms and guaranteed fundamental rights. A typical example, as already discussed in chapter one, is that of New York State which allows mandatory testing of pregnant mothers and New born babies for HIV, under conditions of confidentiality, in a sharp derogation from the norm.

Similarly, the State of Florida statutorily provides for testing without consent, in cases where individuals are significantly at risk after exposure to HIV, or where a person is convicted of

prostitution⁵⁶. The states of Vermont and Illinois can legally subject persons convicted of rape, sexual assault or sexual abuse of a child to mandatory HIV testing, without consent.⁵⁷ Further still, in confirming the need to derogate from the norm, the Washington State Court in USA held that a drug dealer must undergo HIV test without his consent⁵⁸. In South Africa, some statutes have exhibited this sense of derogation from the human rights norms of equality and non-discrimination⁵⁹.

4.3 RIGHT TO FREEDOM OF ASSOCIATION

Because HIV/AIDS attracts widespread discrimination, inequality, stigma and intolerance, the legal rights of the sufferers to freedom of association can be seriously jeopardized. It is submitted that when people living with HIV/AIDS are scorned by other members of the society, their rights to freely associate with others cannot become a reality. Once a person's HIV status is disclosed, he or she is subjected to ridicule and prejudice. Firstly, to avoid being stigmatized by society, people who are vulnerable to HIV/AIDS simply refuse to go for HIV counseling and testing. The consequence of this behaviour is obvious. While such people knowingly or unknowingly have the virus, they continue to spread the virus through unprotected sexual contacts.

⁵⁶ Florida Statute of 1989: Section 381. 609(3)(a) and FLA. STAT. Sub.Sect. 381.609(3)(f)(12) SUPP. 1990.

⁵⁷ AIDS Policy and the Law, June 2001 Issue, LRP Publications: Horshein, Pennsylvania, 2003.

⁵⁸ Washington V Miller, No. 24891 - 3 - 11 (Wash. App. Div. 2 April, 2001).

⁵⁹ Criminal Law Amendment Act No. 105 of 1997.

Criminal Procedure Second (Amendment) Act No. 85 of 1997, Schedule 6(a)(iv).

To ameliorate the adverse impact of stigma in the context of HIV/AIDS, international human rights law and UNAIDS guidelines explicitly guarantee the right to freedom of association, in addition to guaranteeing the rights to equality and non-discrimination, amongst other enforceable fundamental rights .

A number of international and domestic instruments guarantee everyone, including people living with HIV/AIDS, the enforceable fundamental right to freedom of association. Article 20 of the UDHR, 1948 enshrines the right to peaceful assembly and association. On its part, the ICCPR, 1966 guarantees the right of everyone to peaceful assembly and freedom of association in Articles 21 and 22. The African Charter on Human and Peoples' Rights (ACHPR), 1981, in Article 10, guarantees the right to freedom of association and peaceful assembly in conformity with the law, a qualified right, while Article 11 guarantees the right to assemble freely with others. The African Charter on the Rights and Welfare of the Child (ACRWC), 1989 equally provides for the rights to free association and freedom of peaceful assembly, in Article 8. The UN Convention on the Rights of the Child (UNCRC), 1989 also enshrines the right to freedom of association, in Article 15. Domestically, the South African Bill of Rights guarantees freedom of association, in Section 18, while the Nigerian Constitution, on its part, provides for the right to peaceful assembly and association in Section 40.

The above guarantees and provisions in international and domestic instruments are protective of all citizens, without

regard to status or other factors. This expressly means that people living with HIV/AIDS have unqualified rights to freedom of association.

The reality before us, however, is that despite all the guarantees and safeguards, people living with HIV/AIDS are denied entrenched rights once the HIV status is known. Many of them who seek employment are discriminated against and denied employment for the obvious reason that they should not associate with others. The South African case of Hoffman v South African Airways⁶⁰, where the plaintiff was denied employment by the defendant Airways because of his HIV status, illustrates this point. The Airways attempted to justify its position, basing its defence on the inherent operational requirements of the job of flight crews, international practice in the airlines industry, safety considerations and its international and domestic civil aviation obligations. The respondent airline contended that it would have been seriously disadvantaged as against its competitors if it were to employ HIV-infected individuals as flight-deck attendants. To ignore this would entail serious commercial consequences, the respondent argued.

Initially, on the arguments of the respondent airlines, the High Court found that the policy applied by the respondent was justified in the circumstance since it was aimed at promoting the health and safety of the passengers and crew. On appeal to the Constitutional Court, the appeal was upheld and the judgment of

⁶⁰ 2000 (11) BCLR 1211 (CC)

the High Court was accordingly set aside as being unconstitutional or in violation of the Bill of Rights. The Constitutional Court found that the respondent had clearly discriminated against the appellant because of his HIV status. The Constitutional Court also ruled that while commercial requirements were a legitimate consideration, it was necessary to guard against allowing stereotyping and prejudice to be fostered under the guise of commercial interest.

In this case, one must admit that fostering commercial interest, in the context of the airline's defence, meant denying HIV-positive individuals the possibility of employment and association with other members of the public. The epoch-making judgment of the Constitutional Court went a long way in protecting the rights of HIV-positive individuals to equality, non-discrimination and freedom of association.

HIV-positive learners are also discriminated against and refused the right to freely associate with other learners, as in the case of Perreira v Buccleuch Montessori School (supra) in Johannesburg already discussed under a different human rights norms heading. In South Africa, it took the government's bold legislative⁶¹ intervention machinery to halt the trend of discrimination against HIV-positive learners⁶².

⁶¹ Dept of Education Notice 1998 in Terms of Sect .7 of the National Education Policy Act of 1966: Act No. 27, and in terms of Sect. 3(3)&(4) of the said Act.

⁶²The Preamble to the South African Schools' Act No. 84 of 1966 seeks to protect children against discrimination.

4.3.1 The African Value System and Right to Freedom of Association

Since Africans must adapt their unique circumstances to reduce the impact of the HIV/AIDS epidemic, it is worth restating that the African Charter on Human and Peoples' Rights⁶³ upholds the right to freedom of association in a rather special context. This context is unique since the African value system of collective responsibility and morality forms the cornerstone of African's sense of unity and solidarity. The UDHR⁶⁴ enshrines the rights of everyone to freely participate in the cultural life of his/her community. By implication, this could be interpreted to mean freedom of association with everyone, including people infected with, and affected by, HIV/AIDS. Added to this is the fact that the African value system of collective responsibility embraces equality, non-discrimination and freedom of association. There is reason, therefore, to extend this value system to the circumstances of people living with HIV/AIDS in Africa by integrating them into the mainstream of society. This concept can also find expression, or be made to apply, in the circumstances of AIDS orphans in society. On this basis, AIDS orphans should more readily be absorbed into the extended family structure and social institutions. The societal safety net that consolidates the African social systems and holds families together must not be allowed to break apart or disintegrate completely, although there are signs that this is happening already.

⁶³ ACHPR of 1981: Article 27.

⁶⁴ UDHR of 1948: Articles 27, 28, and 29

4.4 RIGHT TO FREEDOM OF MOVEMENT

The fundamental human right to freedom of movement is closely related to the right to freedom of association. Article 13(1) of the UDHR, 1948, Article 12 of the ICCPR, 1966 and Article 12 of the ACHPR, 1981 entrench the right to freedom of movement. The South African Constitution guarantees the right to freedom of movement in Section 21, while the Nigerian Constitution, 1999 provides for the right to freedom of movement in Section 41.

It must be noted that the fundamental right to freedom of movement, which is advantageous to the interest of people living with HIV/AIDS, is particularly vulnerable to limitations. Article 12(3) of the ICCPR permits some restrictions on the right to freedom of movement. It approves of limitations, as may be provided by law or that are necessary to protect national security, public order, public health or morals or the rights and freedoms of others. Likewise, Article 12(2) of the African Charter on Human and Peoples' Rights provides:

this right may be subject to restrictions provided by law for the protection of national security, law and order, public health or morality.

Under the South African Constitution, 1996, the right to freedom of movement is subject to the general limitation of rights in section 36 of the said constitution.

On the contrary, Section 41(2) of the Nigerian Constitution, 1999 upholds the power to limit the enjoyment of the right to freedom

of movement, by law that is reasonably justified in a democratic society. When this section is applied in connection with Section 35(1)(e) of the Nigerian Constitution,⁶⁵ etc, there is reason for individuals living with HIV/AIDS to feel threatened

4.5 RIGHT TO PRIVACY

A discussion⁶⁶ with AIDS inmates of the Salvation Army AIDS home in Johannesburg has confirmed that privacy and confidentiality are two attributes that people living with HIV/AIDS cherish most. As noted by UNAIDS and already discussed in previous chapters of this work, when the privacy and confidentiality of the health/medical information of people suffering from HIV/AIDS are guaranteed, in addition to according them due respect to their persons and dignity, then public health efforts to curb the spread of HIV/AIDS can yield meaningful results.

The fundamental human right to privacy or confidentiality is protected by Article 12 of the UDHR, 1948, Article 17 of the ICCPR, 1966, Article 16 of the UNCRC, 1989, and Article 10 of the African Charter on the Rights and Welfare of the Child, 1989. Domestic constitutions also guarantee the right to privacy. Section 14 of the South African Constitution, 1996 protects the right to privacy, while Section 37 of the Nigerian Constitution,

⁶⁵ For instance- the Communicable Diseases and Notification of Notifiable Medical Conditions Act 1987 of South Africa and Cap 88, Laws of Lagos State of Nigeria, 1995.

⁶⁶ Personal communication by way of an unstructured interview in Johannesburg on 20 January, 2005.

1999 provides for the right to private and family life. These provisions can be invoked by persons living with HIV/AIDS, including women victims of the dreaded virus.

In the context of HIV/AIDS, the right to privacy entails confidentiality of communications with counsellors and care providers. It also implies non-disclosure of health or medical information without due consent. It equally means that blood samples for HIV test cannot be drawn from a person without the due processes of informed consent.

While the cases that appear below seem to be repetitive in the sense that they have already been cited under different human rights norms or principles, they equally apply as key illustrations on infringement of the right to privacy. The courts have had occasion to adjudicate on issues of privacy or confidentiality, as these affect people living with HIV/AIDS. The South African case of Janson Van Vuuren and Another v Kruger (supra) exemplifies the position of the law on infringement of the right to privacy of a HIV-positive individual. The court found the defendant medical practitioner liable for infringement of the right to privacy of the plaintiff. The defendant medical doctor had publicly disclosed the private medical facts of the plaintiff, who was also his patient, to another doctor and a dentist, both of whom were known to the plaintiff. The court held, on the dictates of a doctor-patient relationship, that the defendant's disclosure was unreasonable, unjustified and wrongful. The court accordingly awarded five thousand Rand damages in favour of the plaintiff.

Another related case that demonstrates the right to privacy is the case of C v Minister of Correctional Services⁶⁷. Here, blood sample for HIV test was drawn from a prisoner serving sentence, without the due processes of informed consent being followed. The court held that the Department of Correctional Services liable in delict for infringement of the right to privacy, ruling that the consent obtained did not comply with the norms of the Department. The court further said that the prisoner was entitled to the right of informed consent as determined by the Department.

In the USA case of Commonwealth of Massachussets v Ortiz⁶⁸, the court, in upholding the rights to confidentiality and privacy, blocked a police bid to learn of a suspect's HIV status. In yet another USA case, Multimedia WMAZ v Kubach⁶⁹, the court upheld a five hundred thousand dollar jury verdict against a television station that broadcast a seven second image of a man with AIDS, in breach of the plaintiff's rights to privacy and confidentiality, though the plaintiff had disclosed his status to many individuals.

In another case, People v Cabrera⁷⁰, the court protected the right to privacy of a partner by ruling that court ordered HIV- testing was not mandated in a domestic dispute. In its ruling, the court opined that because the court ordered HIV testing must protect

⁶⁷ 1996 (4) SA 292

⁶⁸ No- Sj- 2001- 0055 (Mass 2/15/01)

⁶⁹ 443 S. E . 2d 491 (Ga Ct. App)

⁷⁰ No. Co 42146 (Cal. App. 3 Dist. 08/01/03)

the privacy of those who may be infected, involuntary testing was strictly limited by statute. According to the court, biting a partner during a domestic dispute was not one of the crimes covered by statute that ordered involuntary testing.

A landmark HIV disclosure case was being heard at the time of writing, by the Australian Supreme Court⁷¹. The facts are that a woman identified only as P.A. in court documents sued one Dr. Nicholas Harvey and Dr. King Weng Chen of the Alpha Medical Centre for negligence and breach of contract for failing to reveal her fiancé's HIV status following a joint pre-marital consultation about sexually transmitted diseases in November 1998. The said fiancé, who had emigrated from Ghana, had been informed by Dr. Chen that he had both HIV and Hepatitis B and that he should refrain from unprotected sex. The fiancé thereafter told PA that he was HIV negative and he subsequently falsified a test result certificate to back up his statement. PA, who had earlier tested negative during the pre-marital consultation, did not find out the true result of the fiancé's test until 1999, after her marriage. She was pregnant and later tested positive for HIV. The final judgment of this case is being anxiously awaited.

In another USA case bordering on disclosure of private or confidential medical facts, the court ruled that a Social Security Administration (SSA) disclosure of HIV status might have caused emotional distress and, for this, the court awarded damages

⁷¹ AIDS Policy and Law, May 23, 2003, Vol. 18, No. 10

against the SSA. The facts in Stokes V Barnhart⁷², which was heard by the US District Court, District of Maine, were that one Alan Stokes was treated for cancer at Maine Medical Centre in the fall of 2000. While he was hospitalised, Jo Anne Barnhart, an agent for the SSA visited Stokes to discuss his supplementary security income benefits. During the conversation, Stoke's friend- Andrea Robinson entered the room to visit. As Bernhard left, she said:

*when your HIV status turns to full blown
AIDS, you need to notify the office.*

Robinson heard and told several others that Stokes had AIDS. Stokes said that as a result of the disclosure of his confidential medical information, he suffered feelings of depression, isolation, anxiety and embarrassment. He said the disclosure strained relationship with his family and friends and he accordingly sued the SSA for inflicting emotional distress and asked for US \$25,000.00 in damages. Judge David M. Cohen, ruling in favour of the plaintiff, said:

*one who gives publicity to the private life
of another is subject to liability to the
other for invasion of his privacy.*

International human rights law views with concern the overriding need for respect and promotion of the rights to privacy and confidentiality in the context of HIV/AIDS. These rights are unambiguously supported and detailed in the South African

⁷² No. 02 - 103 - P (D Me. 03/13/03)

Government's guidelines on Charter of Rights on AIDS and HIV⁷³ as well as the National Policy on Testing for HIV⁷⁴. Also, the New York Public Health Law⁷⁵, while employing the principle of limited derogation from the norms of human rights in invoking the coercive force of law on pregnant women and new born babies in the context of compulsory HIV tests, does do with due regard and respect for the rights to privacy and confidentiality of those involved. In the same vein, the United Nations' Basic Principles for the Treatment of Prisoners⁷⁶ and the WHO's Guidelines on HIV/AIDS in Prison⁷⁷ both indicate that the rights to privacy and confidentiality of inmates must be upheld, respected and enforced.

4.6 RIGHT TO DIGNITY OF THE HUMAN PERSON

The right to dignity of the human person is an important fundamental human right, in the context of HIV/AIDS and, especially, for women and children so afflicted, since they belong to the most vulnerable groups. It is respectfully submitted that when one is ill-treated and no respect is accorded to his dignity, perhaps due to his or her HIV status, the emotional and psychological consequences are enormous. He or she feels seriously stigmatised and depressed, with signs of withdrawal syndrome. Further, still, this withdrawal syndrome manifests itself as active refusal to participate in HIV counselling, testing

⁷³ Charter of Rights on AIDS and HIV, August, 2000.

⁷⁴ National Policy on Testing for HIV, August, 2000.

⁷⁵ New York Public Health Law No. 2500F (Mckenney Supp 1997) p 40.

⁷⁶ United Nations' Basic Principles for the Treatment of Prisoners, 1990, pp 1-120.

⁷⁷ WHO's Guidelines on HIV/AIDS in Prison 1993, pp 1-150.

or treatment, in order to avoid being ridiculed by society. The negative impact of such deviant behaviour to public health and the larger society, in the context of HIV/AIDS, is obvious. One consequence is that, as human beings with human instincts, the urge to indulge in secret sexual contacts without disclosing any known HIV status is real. This ultimately gives rise to the spread of HIV/AIDS.

Any kind of degrading, inhuman treatment amounts to a breach of the legal right to dignity of the human person. The practice in some jurisdictions whereby pregnant women or newborns, or even school children are subjected to HIV tests without sufficient explanation as to the reasons and nature of the test, or without the due processes of informed consent amounts to unwarranted violation of the right to dignity of the human person.

The right to dignity of the human person is an entrenched fundamental right, protected by Article 7 of the ICCPR 1966, that forbids torture, cruel, inhuman or degrading treatment. The ACHPR, 1981, equally enshrines the right to dignity of the human person in Article 5, while Article 16 of the African Charter on the Rights and Welfare of the Child 1989 provides for dignity of the human person by protecting children against abuse and torture. In the same vein, Article 19 of the UN Convention on the Rights and Welfare of the Child, 1989, which protects against all forms of physical and mental violence against children, invariably provides for the right to dignity of the human person. At domestic levels, national constitutions also guarantee the fundamental

right to dignity of the human person. Section 10 of the South African Constitution, 1996, provides for the right to human dignity. Its Nigerian counterpart, guarantees the right to dignity of the human person, in Section 34.

The above provisions of international and national legal instruments are a potent source of legal rights to individuals, including women, infected with, or affected by, HIV/AIDS.

4.7 RIGHT TO FREEDOM TO RECEIVE AND IMPART INFORMATION

It is important for people living with HIV/AIDS, especially women, to receive and impart information in an atmosphere of confidentiality. The right to freedom to receive and impart information is an important fundamental human right that substantially promotes the worth of the individual. In the context of HIV/AIDS, this right promotes the worth of HIV/AIDS sufferers, especially the worth of women and children, as the most vulnerable groups to HIV/AIDS. The rationale is that if information on the state of health of people living with HIV/AIDS cannot be confidentially imparted to appropriate health care providers, officials, family members or others who are in a position to offer meaningful assistance, then information cannot be received on the best methods of prevention, control and care. The fundamental human right to receive and impart information is provided for in Article 19 of the UDHR 1948, Article 19(1) of the ICCPR 1966, Article 9 of the ACHPR 1981, Article 7 of the ACRWC 1989 and Article 13 of the UNCRC 1989. The South

African Constitution, 1996 guarantees the rights to freedom of expression in Section 16(1), and the right of access to information in Section 32. There is also the Promotion of Access to Information Act, 2 of 2000. The Nigerian Constitution, 1999 provides for the right to freedom of expression and the press in Section 39.

Some judicial decisions illustrate the resolve of the courts to enforce the right to information, in the context of HIV/AIDS.

One case in the USA confirms the need to inform a patient of a potential danger of contracting HIV. In Amos v Vanderbilt⁷⁸, the Tennessee Supreme Court reinstated a \$4.3 million damage award against Vanderbilt University Medical Centre for failing to inform a patient that she might have contracted HIV from tainted blood. The facts were that in 1984, Julie Strong received four units of blood during jaw surgery at the medical centre of Vanderbilt University. One of the units was contaminated with HIV. Blood screening for HIV was not available in 1984 but Vanderbilt commenced it in 1985. In 1987, the Medical Centre began offering free HIV screening to all patients who had received blood transfusion at its facilities.

The Medical Centre began notifying some of its former patients after hearing that a donor who tested positive for HIV had donated blood at the Medical Centre. But Vanderbilt University did not undertake to identify and warn all prior patients who had received blood transfusion that they could be exposed to HIV

⁷⁸ 2001 WL 1635476 (Tenn. 12/20/01)

virus. Julie Strong was accordingly not notified and she did not learn of her HIV infection for 5 years after her marriage to Ron Amos in February 1989 and the birth of her HIV infected daughter, Alison Amos, in September 1989, who died of complications later that year. Strong died of AIDS in 1992. The court awarded damages to her estate and husband, against Vanderbilt Medical Centre, for wrongful birth, negligence, failure to warn and infliction of emotional distress.

At this point, it becomes important for this study to defend the continuous reference to, and highlights of, USA cases in this work. In the complex situation that Africans find themselves, the overriding need to adopt a multisectoral approach to resolving the HIV/AIDS crisis need not be overstressed. It is crucial for Africans to learn about what transpires in some other key jurisdictions so as to ascertain if there is any applicable positive or results- oriented initiatives that can suit the African situation. The USA cases are instructive and informative so that African governments can learn from other jurisdictions, if the need arises.

Accessibility and availability of information, as well as freedom of the press and other members of society to report and spread information, is crucial to development in all spheres of life in a democratic society. In the context of HIV/AIDS, it is even of greater importance since knowledge about the characteristics of the virus and the possibility of a breakthrough on preventive and curative measures depend on information received and imparted

at appropriate levels. All over the world, as we very well know, governments restrict the right to receive and impart information, as this can sometimes be abused. In this context, therefore, the right to information is not absolute or non-derogable but is subject to limitations. To people living with HIV/AIDS, the right to information is a "double edged sword", with both advantages and disadvantages. It works to the advantage of HIV/AIDS sufferers in that they can receive information about the virus, modes of transmission, methods of control and curative measures. It is detrimental to their interest if the privacy and confidentiality of their health information are not guaranteed but violated, abused and uncontrollably released to the public, thereby subjecting them to stigma, discrimination and inequality. This will in turn act as a psychological barrier to the necessity for voluntary counselling, testing and treatment, thereby thwarting public health's efforts to curb the spread of the virus.

Governments, all over the world, on their part, restrict the right to information in the interest of national security. The need to derogate from the norm of according respect to the right to information is provided for in Article 19(3) of the ICCPR 1966, which states that the right to information could be restricted by law. Article 9(2) of the ACHPR 1981 also limits the right to express and disseminate opinions. It provides that this can be done within the law. The ACRWC 1989, in Article 7 provides for freedom of expression, subject to restrictions as are prescribed by law. In like manner, the UNCRC 1989 provides for restrictions on the right to information, in its Article 13. The South African

Constitution 1996, which enshrines a general limitation of rights clause in the Bill of Rights, in Section 36, provides for restrictions on the right to freedom of expression, in Section 16(2). In the Nigerian Constitution 1999, the right to freedom of expression and the press, guaranteed in Section 39(1), is subject to limitations in Section 39(3)(a)&(b).

4.8 CONSTITUTIONAL LAW

Bills of Rights enshrine certain fundamental rights or other human rights that impact positively or otherwise on the health rights of women and of other groups of people who are vulnerable to HIV/AIDS. Some provisions in the South African and Nigerian Constitutions which address these fundamental rights shall now be examined.

4.9 SOUTH AFRICA'S CONSTITUTIONAL AND STATUTORY PROVISIONS ON WOMEN'S RIGHTS TO HEALTH CARE

The South African Bill of Rights provides for justiciable socio-economic as well as other fundamental human rights. Sections 27, 28, and 35 of the South African Constitution 1996 incorporate justiciable rights to health care, to the advantage of everyone, including women, children, and even detained prisoners⁷⁹. The following cases, some of which have been cited under different human rights norms, equally show the enforcement of the right to health care in the context of HIV/AIDS. The cases are: Minister

⁷⁹ South African Constitution of 1996: Sections 21(1)(a), 28(1)(c) and 35(2)(e).

of Health And Others v TAC And Others⁸⁰, B V Minister of Correctional Services⁸¹, and Schmidt v Administrator of the Transvaal⁸².

Section 27(1) of the South African Constitution provides for the right of access to health care for everyone. It states:

Everyone has the right of access to health care services, including reproductive health care sufficient food and water, and social security

Access to reproductive health care in subsection (a) particularly caters for the health interests of women. Section 27(1)(a), in so far as it deals with reproductive health care, provides added impetus to women's health rights when invoked in conjunction with Section 12(2)- which enshrines the right to bodily and psychological integrity, including decisions concerning reproduction, security in, and control over, their bodies, etc.

The government's challenge to the High Court's decision in the TAC case was on the ground that the order was essentially a judicial prescription of policy for the executive. The government argued that the order was in conflict with the principle of separation of powers and was accordingly constitutionally untenable.

⁸⁰ 2002 (4) BCLR 356 (CC); 2002 (4) BCLR 356 (T).

⁸¹ 1997 (6) BCLR 78 (CC).

⁸² WDL 3 April 1992, Case No. 793792- Unreported.

In its judgment, the Constitutional Court reaffirmed its position on its role and powers in the enforcement of socio-economic rights. It reiterated that it was constitutionally mandated to evaluate, using the test of reasonableness, whether a government's action or omission complied with the constitutional imperatives. It confirmed that socio-economic rights were justiciable. However, the crucial question for determination was whether the government programme to prevent mother-to-child transmission of HIV was reasonable in both its formulation and implementation.

The respondents had anchored their case on the government fulfilling its minimum core obligation in regard to protection of health care rights. They argued that the right of access to health care services under section 27(1) was a self-standing individual right that was vested in everyone. When that section was read with the State's duty to respect, protect, promote and fulfil the rights in the Bill of Rights as stated in section 7(2), it imposed certain minimum core obligations on the State. The respondents however conceded along the line that although this minimum core might not be easy to define, it included, at least, the minimum decencies of life consistent with human dignity. When applied to the context of pregnant women with HIV, they argued that the provision of niverapine, including voluntary testing and counselling, constituted the minimum core obligation under section 27(1) of the Constitution.

The Court significantly reiterated that, in order to satisfy the test of reasonableness, those whose needs were most urgent and whose ability to enjoy all rights therefore was most in peril, must not be ignored in the measure aimed realising a relevant socio-economic right.

Additionally, the South African Bill of Rights provides for all other fundamental rights or freedoms which impact on the right to health care and for which people living with HIV/AIDS can avail themselves⁸³. The rights to equality, human dignity, life, freedom from forced labour, environment, housing, food, water and social security, etc, enshrined therein are particularly important.

The details of the Constitutional Court's emphasis on reasonableness of government measures, the policy changes and government compliance have been discussed variously within this chapter. The government's immediate compliance with the roll out of niverapine to all HIV-positive pregnant women, even starting from the time the High Court decision was made, has been noted by this study. The planned progressive roll out of antiretroviral drugs to all HIV-positive individuals, as announced by the different Provinces, is commendable but much remains to be done to meet the expectations of the public, in the context of the Court's decision.

⁸³ South African Bill of Rights/Constitution of 1996: Sections 7-36.

4.10 NIGERIA'S CONSTITUTIONAL AND STATUTORY PROVISIONS ON WOMEN'S RIGHTS TO HEALTH CARE

(a) Constitutional Provisions

Having discussed South African's constitutional and statutory provisions on women's rights to health care, the stage is set to discuss Nigeria's constitutional and statutory provisions on women's rights to health care.

In countries with written constitutions, like Nigeria, adherents of the pure theory of law and others might be tempted to regard the constitution as the first and foremost legal instruments from which no other laws may derogate. The constitution thus becomes a grundnorm and constitutes the program of action or the supreme law. Where human rights provisions are included in the substantive parts of the constitution, they are, in general, legally binding though the wording of such provisions, as seen in chapter 2 of the Nigerian Constitution, providing some rights to health care, may render them non-justiciable in practice. What is clear is that human rights, as legal rights, are those guaranteed by positive law within a given legal system creating enforceable rights and obligations within the law. No matter how fundamental a right may be, unless it is guaranteed under a given legal system as a positive right it has no judicial leg to stand on⁸⁵.

⁸⁵ Eze, O. C., "African Concept of Human Right" in Perspectives on Human Rights, Lagos: Federal Ministry of Justice, Federal Government Press, 1992 pp 9- 79.

In Nigeria, socio-economic rights are retained in the Fundamental Objectives and Directive Principles of State Policy, in chapter ii of the Nigerian Constitution 1999. They are not justiceable like those in chapter iv of the Nigerian Constitution which are fundamental, implying that their enjoyment cannot be secured in a court of law by any person who alleges an infringement, as in the case of those under chapter iv.

Within the realm of socio-economic rights in the Fundamental Objectives and Directive Principles of State Policy in chapter ii of the Nigerian Constitution, the general right to health care, and the specific rights to health care, are neither provided for nor guaranteed. There are equally no specific provisions that offer any measure of protection or guarantee to vulnerable groups like women and children, most likely to be afflicted by health epidemics, especially HIV/AIDS. The best fundamental guarantees that chapter ii of the Nigerian Constitution provides in terms of health rights or rights to health care are found in sections 3(c), (d), (f), (g) & (h). These sections provide as follows:

..... 3(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused.

3(d) there are adequate medical and health facilities for all persons.

3(f) children, young persons and the aged are protected against any exploitation

whatsoever, and against moral and material neglect.

3(g) provision is made for public assistance in deserving cases or other conditions of need.

3(h) the evolution and promotion of family life is encouraged

Sections 3(c), (d), (f), (g) and (h) could be said to convey some rights to health care but these provisions are very vague and are not addressed to benefit any vulnerable groups to diseases or epidemics.

Even if there were clear provisions in chapter ii of the Nigerian Constitution to the specific benefits of vulnerable groups like women, children and others, what is obvious is that they could not claim protection under such provisions because the Fundamental Objectives and Directive Principles of State Policy under chapter ii are generally regarded as social objectives which are not justiciable, but subject to progressive development.⁸⁶ They are considered under common law jurisprudence not to confer rights and obligations and are consequently non- justiciable in courts of law.⁸⁷ This study shall make a recommendation that these and other specific socio-economic rights, including the right to health care, be made justiciable and enforceable rights, by constitutional amendment.

⁸⁶ Eze Ibid n. 85 p 242.

⁸⁷ Eze Ibid n. 86 p 244.

However, chapter iv of the Nigerian Constitution, 1999 confers some fundamental rights,⁸⁸ with the force of law, with collateral duty on the part of the state and other persons to respect, promote, protect and fulfil. But the fact remains that these rights are not actually promoted or fulfilled to the advantage of people living with HIV/AIDS.

From a comparative perspective, it is clear that people vulnerable to HIV/AIDS can rely on these provisions of the law as sources of legal rights in both South Africa and Nigeria. However, the extent of protection and enforcement of these rights in both countries differ. These legal rights include the rights to life,⁸⁹ personal liberty,⁹⁰ fair hearing,⁹¹ private family life,⁹² non-discrimination,⁹³ dignity,⁹⁴ and freedom of movement,⁹⁵ among others.

It must be noted that while the above stated rights have limitations,⁹⁶ the Nigerian National Policy on HIV/AIDS, as shown in detail in the next chapter, attempts to highlight the rights of people living with HIV/AIDS, although one cannot say that these rights are actually protected or enforced.

⁸⁸ Nigerian Constitution of 1999: Chapter iv, Sections 33-44.

⁸⁹ Section 33 Nigerian Constitution 1999.

⁹⁰ Section 35 Nigerian Constitution 1999.

⁹¹ Section 36 Nigerian Constitution 1999.

⁹² Section 37 Nigerian Constitution 1999.

⁹³ Section 42 Nigerian Constitution 1999.

⁹⁴ Section 34 Nigerian Constitution 1999.

⁹⁵ Section 41 Nigerian Constitution 1999.

⁹⁶ Nigerian Constitution of 1999: Chapter iv, Section 35(1)(e).

(b) Nigerian Policy Framework

Until recently, there was no national policy on HIV/AIDS in Nigeria. The new policy⁹⁷, however, is neither coherent nor comprehensive enough and does not provide for free, voluntary HIV counselling, testing and treatment, even for the most vulnerable groups, women and children, at government expense. From all perspectives, it is generally agreed that the new Nigerian national policy on HIV/AIDS does not make any meaningful impact. On the other hand, and in a different note, there is also a dearth of HIV/AIDS – related litigations in Nigerian courts, thereby giving rise to absence of judicial guidelines or pronouncements in the context of HIV/AIDS, apart from the first ever HIV-related case instituted by SERAC and Georgina Ahamefule and a very recent case recently instituted by the Centre on the Right to Health Care (CRH) on behalf of one Mr. Cliff. Elisha Ishaku at the Federal High Court, Abuja⁹⁸.

In this later case, the Centre on the Right to Health Care (CRH) and Cliff Elisha Ishaku has taken the authorities of the Nigerian Naval Training College, Onne, Port Harcourt to court for allegedly denying him admission into the college on the grounds of his health status despite passing the recruitment test. The plaintiff was seeking, amongst others, a declaration

⁹⁷ Nigerian National HIV/AIDS Policy 2003.

⁹⁸ Unreported Abuja Federal High Court Case- February 2004. Hearing of the substantive suit was adjourned to February 18, 2004 while first hearing was on February 1, 2004. The outcome of the case, though not yet concluded at the time of this thesis, is being anxiously awaited.

that his withdrawal from the school by the Naval College and Ministry of Defence, on account of his testing positive to the HIV virus was illegal, unconstitutional, unlawful and breach of his fundamental right to personal dignity. The outcome of this 2004 case is still pending in 2005, at the time of writing.

One point, however, that must be noted is that by virtue of the incorporation of the provisions of the African Charter of Human and Peoples' Rights into Nigerian law, the legal rights to health and health care enshrined therein and conferred by Articles 16(1) & (2) of the ACHPR 1981 can be invoked by groups vulnerable to HIV/AIDS. Article 16 of the ACHPR states:

- 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.*

In practice, however, nobody in Nigeria has attempted to invoke, let alone successfully invoking, these provisions to enforce his or her rights to health or health care, apart from the Ogoni people (pages 186-189; 195-196). The rationale for this may not be far-fetched. The perceived conflict of the African Charter, laden with both elements of socio-economic rights as well as with civil and political rights, with the provisions of the Nigerian Constitution, which relegate socio-

economic rights to the background (by including some socio-economic rights-including the rights to health care in the non-justiciable section of Fundamental Objectives and Directive Principles of State Policy), may provide the answer.

The above facts go a long way to confirm that certain constitutional or legislative guarantees of human rights can be rendered nugatory or illusory because they are subject to certain limitations which derive from:

- (a) their location in the constitution;
- (b) the language and manner in which the relevant provisions have been formulated;
- (c) the machinery and procedures for enforcement or determining the constitutionality of legislative or executive action;
- (d) the possibility of legal action and remedy for individuals whose rights have been breached and
- (e) a number of other factors, including provisions for amendment.

4.11 LABOUR LAW

The positive contributions of labour law, in terms of employment equity, regardless of status or disability, with particular reference to South Africa's Employment Equity Act,⁹⁹ is important in the present dispensation of HIV/AIDS. A realistic demonstration of the tenets of equality and non-discrimination in

⁹⁹ Employment Equity Act No. 55 of 1998.

public and private sector employment is vital in the fight against HIV/AIDS. A causal nexus between poverty and HIV/AIDS has been confirmed by UNAIDS. Because poverty inflames HIV/AIDS and HIV/AIDS breeds poverty, when the economic interests of people living with HIV/AIDS are understandably accommodated and the effects of stigma reduced, then the excessive negative impact of HIV/AIDS can be effectively curbed.¹⁰⁰

4.12 EMPLOYMENT EQUITY IN SOUTH AFRICA

The Employment Equity Act 55 of 1998 is a landmark legal instrument in South Africa, designed to redress discrimination and inequality and ensure equity in the work place. Apart from setting in motion a statutory framework for affirmative action, the novel parameters of the Act are not confined only to affirmative action based on race or gender. The Act equally extends the quest for a just and equitable society to the elimination of HIV-related discrimination and securing work equity and redress for people with disabilities.¹⁰¹ The said Act is an important instrument in eliminating HIV/AIDS- related stigma and unfair discrimination in the workplace. It is complemented by the Promotion of Equality and Prevention of Unfair Discrimination Act, of 2000. The highlights of the Act are that it outlaws unfair discrimination against an employee on one or more

¹⁰⁰ UNAIDS 2004 Global Report, pp 1-100

¹⁰¹ Nguena, C. "HIV/AIDS and Equal Opportunities in the workplace: the Implications of the Employment Equity Act" (2000) 33 CILSA: 96-113.

grounds, including HIV status¹⁰² and also prohibits medical testing of an employee, including an HIV test.

Other highlights of the Act are the prohibition of the determination of an employee's HIV status unless such testing has been determined to be justifiable by the Labour Court in terms of the Act, and the provision for affirmative action benefiting women, blacks, minorities and people with disabilities, which include individuals and, especially, women living with HIV/AIDS.

Women employees or prospective employees, and women living with HIV/AIDS are especially protected by the Act in view of the Act's beneficial gender based affirmative action guarantees. With statistics indicating that women are the most vulnerable group to HIV/AIDS, and with South Africa experiencing the fastest growing epidemics, the Employment Equity Act comes as a great relief to South African women infected with, and affected by, HIV/AIDS. Because women workers or women prospective employees already face widespread gender related discrimination¹⁰³ and inequality, the Act secures equity and redress for women, particularly women living with HIV/AIDS.

Other HIV-positive employees are also subject to the positive impact of the Act. The situation where HIV-positive employees

¹⁰² See the case of Hoffman v South African Airways 2000 (11) BCLR 1211 (CC).

¹⁰³ Albertyn, C. "Using rights and the law to reduce women's vulnerability to HIV/AIDS" (2001) 2 Law, Democracy and Development 179.

are dismissed from their employment because of their HIV status is outlawed by the Act.¹⁰⁴

The Employment Equity Act vests the Labour Court with the responsibility of justifying the necessity of determining an employee's HIV status. Since the Act explicitly prohibits testing of an employee to determine HIV-status, such testing can only be conducted if determined to be justifiable by the Labour Court. The significance of the prohibition against HIV-testing lies in the involvement of the Labour Court. The court has been made the watch-dog against abuse by employers. The Labour Court is allowed discretion by the Act to develop standards for testing, if overly necessary, that are consistent with the constitution and other international human rights instruments.

It must be noted that the Employment Equity Act has, to a great extent, consolidated the provisions in the South African Constitution in providing for equality and non-discrimination in the work place. The constitutional guarantees of rights to equality¹⁰⁵ fair labour practices¹⁰⁶, and freedom to choose a trade, occupation or profession¹⁰⁷ directly and indirectly confer on present and prospective employees, including women and other people living with HIV/AIDS, the rights to equal

¹⁰⁴ The Nigerian case involving the dismissal of Georgina Ahamaefule from her work because of her HIV-positive status would have been subjected to immediate review and reinstatement if there was a similar legislation like the Employment Equity Act in Nigeria

¹⁰⁵ South African Constitution of 1996: Section 9.

¹⁰⁶ South African Constitution of 1996: Section 23.

¹⁰⁷ South African Constitution of 1996: Section 22.

opportunities in the workplace. The Employment Equity Act, however, is innovative in the sense that it provides, for the first time, additional and more explicit protection for people living with HIV/AIDS, and a clear machinery for enforcing the law, though its application is limited to certain categories of employees.

Nigeria and Employment Equity Legislation

In Nigeria, very unfortunately, there is no law similar to the Employment Equity Act, 1998 to safeguard the interests of women and other people, including workers and prospective employees, living with HIV/AIDS, in employment and other labour related matters. This may be due to differences in history and other factors like the apartheid past between South Africa and Nigeria. It is noted that the South African Employment Equity Act is part of the transformation of society as a result of the imbalances of the past. But one wonders what kind of transformation there is in Nigeria to address either the imbalance of the past colonial administration or military regime, on the one hand, or the interest of the vulnerable groups in Nigeria, on the other hand. However, under the present democratic dispensation in Nigeria, while the administration of President Obasanjo is doing its utmost best to correct societal ills, there does not appear to be a clear-cut policy on transformation.

It is worthy to allude to a situation that warrants employment equity legislation in Nigeria because if it has occurred in South Africa the provisions of the Employment Equity Act would have

prevailed. For the sake of this illustration, the Nigerian case of SERAC and Georgina Ahamfule v Imperial Medical Centre, which has been highlighted several times in this work, exemplifies the fate of HIV-positive employees in their work places. A further example to illustrate another issue that warranted employment equity is the USA case of Gilbert v United Realty Trust¹⁰⁸. In this case, one Roger V. Gilbert of Albuquerque was fired within weeks after telling his supervisors at United Dominion Realty Trust that he was HIV- positive. That was a clear case of discrimination on ground of HIV- status. The court later declared the termination invalid.

It is submitted that a significant number of employers discriminate unfairly against employees or prospective employees living with HIV/AIDS for the obvious reason of avoidance of costs of operation of business. With the greatest devastation being concentrated on the economically active workforce of the population, comprised of young workers, the adverse impact of HIV/AIDS is severely felt by employers who understandably fear that recruiting additional HIV-positive employees would amount to a greater liability. Such liability would obviously ensure during the period such employees experience acute illness and AIDS-related diseases.

This study has found out from an unstructured interview discussion with some five employers of labour in Pretoria¹⁰⁹,

¹⁰⁸ CW 00-1739 DNM. Suit filed 12/12/01.

¹⁰⁹ Interview conducted on December 17, 2004.

selected at random, that employers see the HIV/AIDS epidemic as inevitably representing significant costs to business. Their fear is supported by the reality that the progression from asymptomatic HIV to full blown AIDS is characterized by intractable illness and eventual incapacity. It has a deleterious effect on productivity and competitiveness. To those employers, AIDS-related illness means that the worker becomes less capable or is absent from work. New workers must be trained to replace those who no longer have the capacity to perform the job. Illness and premature death from AIDS accelerate claims on a number of employment related benefits. But the truth remains that not all HIV-positive workers are incapacitated, because, many of them, as healthy carriers, still operate optimally, as long as they watch their health, take proper antiretroviral medication, and receive timely treatment for any opportunistic ailments. To invoke a general discriminatory employment policy against all HIV-positive employees or job applicants would therefore be inhuman.

It must be realised, however, that where the job applicant or employee is otherwise capable of performing the job but constitutes a risk to the health and safety at work because of an HIV-positive status, the employer can justify unfair discrimination, though a positive status is not an automatic justification. The common law imposes upon the employer a duty of care, to take reasonable steps to maintain health and safety in the workplace. In the USA case of Wadde] v Valley Forge Dental

Associates¹¹⁰, the US Federal Appeals Court in Georgia ruled that a HIV-positive dental hygienist posed a direct health threat to his dental patients and that his dismissal from his job was justifiable in the circumstance. The USA case provides a good example of justifiable derogation from the norm in the public interest, for South Africa and Nigeria to learn from.

4.13 SUMMARY

In this chapter, aspects of the law that positively impact on women's vulnerability to HIV/AIDS have been discussed, along with appropriate case law. The contributions of international human rights law, constitutional law, and labour law, as these impact positively on women vulnerable to HIV/AIDS, have been examined.

This gives credence to a detailed review of legal and public policy responses to the HIV/AIDS epidemic and women's vulnerability as well as other intrinsic needs of women living with HIV/AIDS, like home based care, backed up by law, in chapter five.

¹¹⁰ No. 0014896, 11th Cir. 12/21/01.

CHAPTER FIVE:
PUBLIC POLICY RESPONSES

5.0 INTRODUCTION

The degree and nature of legal and public policy responses to the pandemic shows to what extent governments in South Africa and Nigeria have sought to deal with the HIV/AIDS pandemic. This chapter seeks to determine the adequacy or otherwise of the legal and public policy responses and other governmental actions to the plight of women and others vulnerable to HIV/AIDS.

The legal measures adopted to contain the pandemic include such measures like the domestication of international treaty obligations on human rights norms and HIV/AIDS, and relevant legislations addressing both the vulnerability and the special circumstances of women. Others are judicial precedents on HIV/AIDS. It also includes other legal measures in pursuit of the goals of guaranteeing, promoting, protecting, fulfilling and enforcing the fundamental human rights of people vulnerable or susceptible to, infected with, or affected by, HIV/AIDS.

Public policy responses, on the other hand, embody administrative and governmental initiatives to control the epidemic. This includes policy initiatives, HIV/AIDS national policies, budgetary initiatives incidental to containing the epidemic, provision of adequate facilities and human resource development strategies.

The legal and public policy responses to the HIV/AIDS epidemic in South Africa and Nigeria are examined:

5.1 LAW AS AN INSTRUMENT OF SOCIAL CHANGE

Law can be seen as a valuable tool or veritable instrument of social change, and could thus be harnessed for achieving societal goals and objectives and in bringing about social order (Uko:1989). Though one important function of law has been the settlement of disputes, law can equally be seen and appreciated as a “cement of society”.

From a human rights point of view, one realises that both the South African Constitution of 1996 and the Nigerian Constitution of 1999 have guaranteed fundamental rights needed to realize the worth of individuals, thereby enhancing the resolution of man’s social problems. Jurisprudentially, as postulated by Immanuel Kant and other great philosophers, the human rights provisions have, as their goals, the desire to bring about social order, social justice, social harmony, and a society free of social conflicts and where equity prevails.

In the founding provisions of both the South African and Nigerian Constitutions,¹ the promotion of the welfare of all persons on the principles of freedom, equality, non-discrimination, dignity and justice are expressed or implied. The questions then are: How can the dignity of individuals be restored with the present

¹ Section 1 of the South African Constitution 1996.
Preamble to the Nigerian Constitution 1999.

scourge of HIV/AIDS plaguing humankind in South Africa and Nigeria, with women as the most vulnerable victims?; Why was there the need to engage in a major legal confrontation up to the Constitutional Court in order to realise the need to ameliorate or reduce a major societal or health catastrophe of mother-to-child transmission of HIV/AIDS in South Africa?. Why is there no free and voluntary HIV counselling, testing and treatment at state expense in Nigeria, whereas so much money is being spent by the government on defence contracts?. Why is there a near-total absence of a legal framework to address the HIV/AIDS epidemic in Nigeria?. Why are there deficiencies in the legal and public policy responses to the epidemic in both countries?.

One important reason for these conflicts is that from the beginning of the world, the rights of man, expressed in forms of individual autonomy, freedom, social equality and human dignity have always been scorned by the privileged and those in authority.² Though the phrase "human rights" is a popular expression used in national and international politics, the past few years have witnessed the most humiliating and improper application of the term in national and international politics involving the HIV/AIDS issue, military might, and other matters. From the beginning of the world, the history of man has always been a continuous and bitter struggle against the forces of oppression. There has always been a tension between right and might as evidenced in the political struggles leading to the Bill of

² Uko, E.J. "Law as an Effective Instrument for Resolution of Social and Cultural Conflicts" (1989) UNICROSS BULLETIN: Uniuoyo Faculty of Arts, Nigeria pp 15-23.

Rights in 1688 in England; American Declaration of Independence in 1776; and the French Revolution of 1789.³

The solution is that we need to build a disciplined society, disciplined through law, where a true sense of human rights prevails; where the tenets of natural justice, equity and good conscience are placed above all other considerations; and where law can be effectively utilized as an instrument of social change to resolve the HIV/AIDS crisis, the high vulnerability of women to HIV/AIDS, and other social problems arising out of the adverse impact of the HIV/AIDS epidemic.

5.2 LEGAL AND PUBLIC POLICY RESPONSES TO THE HIV/AIDS PANDEMIC AND THE VULNERABILITY OF WOMEN IN SOUTH AFRICA

In presenting the legal and public policy responses to the HIV/AIDS pandemic in South Africa, this study relied on various reports, interviews and observations, as shown hereunder:

5.2.0- Human Rights Provisions Within the HIV/AIDS Strategic Framework and the National HIV/AIDS Policy

In 1994, the National AIDS Council of South Africa's (NACOSA) National AIDS Plan⁴ for South Africa was launched. This covered the period from 1996/7-2000/1. The HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005, replaced the NACOSA Plan in

³ Sieghart P. The Lawful Rights of Mankind London: Oxford University Press 1995 pp 1-75

⁴ NACOSA National AIDS Plan for South Africa was the first major national HIV/AIDS plan to be launched in South Africa in 1994.

February 2000. The Strategic Plan outlines a multi-sectoral approach to the epidemic. The Department of Health monitors implementation of the Strategic Plan. Five priority areas were identified in the Plan: prevention; treatment, care and support; human rights and legal issues; research, surveillance, monitoring and evaluation; and information, education and social mobilization.

The following guiding principles in the Strategic Plan impact on human rights:

- people with HIV/AIDS, their partners, families and friends shall not suffer from any form of discrimination;
- the vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, or remain unable to take effective measures to prevent infection; and
- confidentiality and informed consent with regard to HIV testing and test results shall be protected.
- Free and voluntary pre and pro- HIV test counselling.

Another aspect of the South African government's framework on HIV/AIDS is the Partnership Against AIDS, launched in October 1998. Initially, the government's efforts in combating HIV/AIDS were restricted to the health sector. The launch of the Partnership Against AIDS included other government departments and key sectors of society in a broad-based and multi-sectoral fight against the disease. The Partnership Against AIDS aims to

expand sectoral involvement in HIV/AIDS as part of a mass mobilization campaign.⁵ In January 2000, the partnership was formalised in the South African National AIDS Council (SANAC), under the leadership of the Deputy President. The government strengthened its contribution to the Partnership Against AIDS in 2002 by establishing a Presidential Task Team on AIDS consisting of Ministers and led by the Deputy President.⁶

5.2.1 Domestication of International and Regional Human Rights Treaties

As shall be seen shortly when a list of legislations that relate to legal measures to assist women and the most vulnerable members of society is presented in this work, it shall become clear that South Africa has domesticated many related international treaties in the context of HIV/AIDS. Many of the provisions relate to the ICCPR of 1966; ICESCR of 1966; CEDAW of 1979; UNCRC of 1989; ACHPR of 1981; ACRWC of 1989 and many other UNO Declarations and Conventions or agreements relating to HIV/AIDS.

5.2.2 National Legislations that Address Issues in Relation to HIV/AIDS

These include the following:

- Code of Good Practice on Aspects of HIV/AIDS and Employment, issued in terms of Section 54(1)(a) of the Employment Equity Act.

⁵ Department of Health's Official Report, 2002: 1-60.

⁶ Department of Health Ibid n. 5 p 261

- Compulsory HIV Testing of Alleged Sexual Offenders Act of 2005
- Criminal Law Amendment Act, Act 105 of 1997, which provides for harsher sentencing of HIV-positive rapists.
- Employment Equity Act, Act 55 of 1998, with Sections 6, 7(1)&(2), and 50(4) dealing specifically with HIV/AIDS.
- Medicine and Related Substances Control (Amendment) Act 90 of 1997, on the use of generic medicines
- Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, with Section 34(1) and (2) directly referring to HIV/AIDS.
- Schedule 6(a)(iv) of the Criminal Procedure Second (Amendment) Act 85 of 1997, which makes the granting of bail more difficult in instances where the suspected rapist is known to be HIV-positive.

5.2.3 HIV/AIDS Policies, Guidelines and Programmes

The HIV/AIDS policies, guidelines and programmes include the following:

- Charter of Rights on AIDS and HIV, 1992.
- Department of Defence Policy on the Management of HIV/AIDS, 2001
- Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research, January 2000
- Guidelines for Good Clinical Practice in the Conduct of Trials in Human Participants in South Africa, Department of Health, 1999

- Guidelines on the Adequate Treatment of Opportunistic Infections, 2002
- HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005
- Life Office's Association Protocol on HIV Testing, October 2000, which ensures that the insurance industry adequately protects the rights of HIV-positive people
- Management of Occupational Exposure to HIV, Dept. of Health, 1999
- Management Strategy: HIV/AIDS in Prisons, October 2002
- National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, August 2002
- National Patients Rights, 1999
- National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions, 1999
- National Policy on Testing for HIV, August 2000
- Social Welfare Action Plan on HIV/AIDS, 1997
- The South African Medical Association Guidelines on Human Rights, Ethics and HIV, 2001

These policies, guidelines and programmes, put together, have contributed to give a good sense of direction in addressing the HIV/AIDS pandemic in South Africa.

5.2.4 HIV/AIDS Within the Government's Social Assistance Plan

Section 27(1)(c) of the South African Constitution enshrines that everyone has the right to have access to social security. Section

27(2) states that the State must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of the rights.

The Social Assistance Act 59 of 1992, was enacted to provide for rendering of social assistance to different categories of people. The Act does not specifically mention HIV/AIDS but people living with HIV/AIDS can qualify for a disability grant.

5.2.5 HIV/AIDS and the Right of Access to Health Care

A discussion on the right of access to health care has already been adduced in this work. HIV/AIDS is, by the standards of the Department of Health, not a notifiable disease in South Africa. The Department of Health ensures access to essential HIV/AIDS drugs, ensures that medical trials on human subjects are done with due regards to the right to bodily and psychological integrity, in conformity with the provisions of Section 12(2) of the Constitution. The Department also ensures that condoms are widely distributed. It has a program on the prevention of mental illness, including a focus on HIV/AIDS, while also ensuring that people living with HIV/AIDS have their rights to equality and non-discrimination respected in accordance with the provisions of Section 9 of the Constitution.

5.2.6 Gender Rights: Legal Status of Women and the Role of Cultural Practices

The equality clause in the South African Constitution provides in Section 9(3) that 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. Women therefore have formal equality. A commission on Gender Equality was established in accordance with Section 187 of the Constitution, with its purpose and functions set out in the Commission of Gender Equality Act 39 of 1996.

Besides, the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 lists gender, sex, pregnancy and marital status as grounds for non-discrimination in an effort to grant full and equal enjoyment of rights and freedoms to women. The Employment Equity Act, on the other hand, makes special provision for women as part of the so-called “designated groups” to ensure equal employment opportunities through affirmative action policies to rectify the imbalances between men and women in employment.

Some key legislations have gone a long way to redress the social imbalance against women and to address aspects of gender inequality and gender-related discrimination against women in the society. For example, I submit that the Recognition of Customary Marriages Act of 1998, which brings customary marriages on par with “modern” marriages and accords both the same degree of recognition and legal weight or incidents, has restored the dignity and rights to women married under customary law. Also, the Prevention of Family Violence Act, 1993

and the Domestic Violence Act, 1998 have attempted to address issues of gender-based violence against women.

5.2.7 Commercial Sex Workers, Homosexuality and HIV/AIDS

Commercial sex work is criminalized in South Africa in terms of the Sexual Offences Act, 23 of 1957. This was challenged in the case of Jordan and Others v Republic of South Africa⁷ The Constitutional Court ruled unanimously that the law criminalizing the keeping of brothels was constitutional.

As pointed out earlier, the criminalisation of sodomy was challenged in the Constitutional Court in the case of National Coalition for Gay and Lesbian Equality and Another v Minister of Justice⁸ The Court found that the common law offences of sodomy and its inclusion in certain statutory schedules and legislation were not reasonable or justifiable limitations on the rights of gay men to equality, dignity and privacy. The offences were accordingly found to be unconstitutional and invalid.

5.2.8 Children's Rights, HIV/AIDS and the Educational System

Section 28(1)(c) of the Constitution enshrines that every child has the right to basic nutrition, shelter, basic health services and social services. Government has introduced free health care for children under six and free health care for pregnant women up to six weeks post-delivery.

⁷ 2002 (6) SA 642 (CC)

⁸ 1999 (1) SA 6 (CC).

Section 9 of the constitution protects children against discrimination. Additionally, Section 29(1) states that everyone has the right to basic education. The Preamble to the South African Schools Act 84 of 1996, seeks to protect children against discrimination. Part of the Act is to the effect that learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practised against them.

5.2.9 Criminal Law and HIV/AIDS and Prisons

The Criminal Law Amendment Act, Act 105 of 1997, provides for life imprisonment for an HIV-positive first offender who is convicted of rape, but a lesser minimum sentence of ten years for a first offender who is not HIV-positive. The Act does not require evidence of HIV transmission to support the imposition of a higher sentence.

While this sentencing requirement may not be considered fair discrimination, it is understandable in the sense that the law is used as a deterrent factor in this regard, in order to deter prospective offenders. However, this appears to differ significantly in scope, approach and philosophy from the system in Botswana, in view of the decision in Makuto v State (Supra). While the law and the sentencing requirement in South Africa

appear to be in clear violation of the international human rights norms of equality and non-discrimination because of HIV status, the Botswana decision went the extra mile to preserve, protect, fulfil and enforce these norms.

The Department of Correctional Services has a Management Policy/Strategy on the Management of HIV/AIDS in prison which is a revision of the 1996 Management Strategy: AIDS in Prisons: Desegregation of Prisoners with HIV/AIDS and provides for the needs of all offenders. Additionally, Section 35(2)(e) of the South African Constitution makes provision for the rights to adequate health care for prisoners.

Despite all these arrangements, guidelines and provisions with regards to management of HIV/AIDS in prisons, I submit that there is a public outcry from members of the general public that the Department of Correctional Services must do more to ensure a more effective and efficient management of HIV/AIDS in prisons. Particularly, I submit, the public outcry concerns the issue of rape and transmission of HIV in prisons.

5.3 LEGAL AND PUBLIC POLICY RESPONSES TO THE HIV/AIDS EPIDEMIC IN NIGERIA AND THE VULNERABILITY OF WOMEN

5.3.0 Legal Responses

This study has confirmed that there appears to be a near-total absence of a legal framework for addressing the HIV/AIDS epidemic and the vulnerability of women to it in Nigeria. There is no legislation , like the type adopted in South Africa, to address

the needs of women and the vulnerable members of the society. International law or treaty obligations with a relevance to HIV/AIDS have not been domesticated in Nigerian law, as widely done in South Africa. Besides, there is a dearth of case law on HIV/AIDS in Nigeria, apart from the two cases discussed in the prior chapters of this work. Above all, the Nigerian Constitution does not provide for an enforceable right to health care or any socio-economic rights.

5.3.1 Public Policy Responses

The Nigerian National HIV/AIDS Policy 2003 as well as some unstructured discussions with some officials of the Nigerian Federal Ministries of Health and Justice in Abuja in 2001 provided the needed information on both the legal and public policy responses in Nigeria.⁹

The disheartening but bitter reality about the so-called Nigerian National HIV/AIDS Policy is that it provides for HIV counselling and testing but this is at the expense of the members of the public. In short, what may be termed a National Policy on HIV/AIDS in Nigeria amounts to nothing or no policy at all for the mere fact that there is "no free and voluntary HIV counselling at State expense". The import of this is that the majority of the poor masses of people cannot afford to go public or private

⁹ Personal Communication by way of an Unstructured Interview in Abuja, Nigeria on 7 November, 2001.

laboratories to pay the exorbitant costs of HIV counselling and testing. The end result is that the majority of people do not know their HIV status in Nigeria.

5.3.2 Goals, Objectives and Targets of the Nigerian National HIV/AIDS Policy

According to the Nigerian National Policy on HIV/AIDS, 2003, the guiding principles of the National Policy on HIV/AIDS¹⁰ are as follows:

- 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 is 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 is to be fulfilled by the provision of adequate health and social services.
- The nation is to adopt strategies that are cost effective, practical, socially acceptable, and scientifically sound to

^{10 4} Federal Ministry of Health, Nigerian National Policy on HIV/AIDS FMH, Abuja, 2003 pp 1-50.

ensure that the HIV/AIDS epidemic is brought under control.

According to the Policy Document on the Nigerian National Policy on HIV/AIDS,¹¹ the overall goal of the HIV/AIDS Policy is to control the spread of HIV in Nigeria, to provide equitable care and support for those infected by HIV and to mitigate its impact to the point where it is no longer of public health, social and economic concerns, such that all Nigerians will be able to achieve socially and economically productive lives free of the disease and its effects.

The Policy Guidelines list the objectives as follows:

- Promote a national multi-sectoral and multi-disciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its coordination.
- Identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors' comparative advantages and core competencies.
- Increase awareness and sensitisation among the general population about HIV/AIDS.
- Foster behaviour change as the main means of controlling the epidemic.
- Improve national understanding and acceptance of the principle that all persons must accept responsibility for

¹¹ Nigerian Federal Ministry of Health, National HIV/AIDS Policy Guidelines 2003 pp 1-50

prevention of HIV transmission and the provision of care and support for those infected and affected.

- Provide access to cost-effective care and support for those infected, including anti-retroviral drugs.
- Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic.
- Remove all possible barriers to HIV/AIDS prevention and control.
- Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.
- Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.
- Stimulate research, monitoring and evaluation of programmes, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population.
- Ensure that preventive programmes are developed and targeted at vulnerable groups such as women, children, adolescents and young adults, sex workers, long distant commercial vehicle drivers, prison inmates. migrant labour, etc.

The policies and strategies, as indicated in the Nigerian National HIV/AIDS Policy¹² include the following:

¹² Nigerian National Policy on HIV/AIDS Ibid n. 11 p 271.

- Prevention of HIV/AIDS
- Law and Ethics
- Care and Support
- Communication
- Programme Management and Development.

Under prevention of HIV/AIDS, the policy document lists the following strategies:

- Promotion of safe sexual behaviour
- Appropriate use of condoms.
- Prevention of HIV 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
- Adolescent and youth focused interventions.

The above are some of the key highlights of the Nigerian National HIV/AIDS Policy Document. It is rather unfortunate that the so-called policy document falls far short of a policy paper. It places the entire burden on individuals. It clearly states that all persons must accept responsibility for prevention of HIV, and for the care and support of those infected and affected. The Policy Document also clearly states that the key role of Government is to foster behaviour change as the main means of controlling the epidemic.

When compared to South Africa, it is clear that Nigeria has not yet begun the process of putting in place any legal or policy initiative to effectively address the HIV/AIDS epidemic and the high vulnerability of women to it.

5.4 PUBLIC POLICY RESPONSE AFFECTING WOMEN LIVING WITH HIV/AIDS AS CARE-GIVERS

5.4.0 Home-Based Care:

It is clear that home-based care is presently a part of the array of public policy responses to the HIV/AIDS pandemic in South Africa. The response followed the need to bring health care closer, and render it available, accessible and acceptable, to the increasing number of vulnerable victims of the HIV/AIDS pandemic who have contracted AIDS-related sicknesses or diseases, are bedridden, and are unable to travel to health care institutions to receive care. From all indications, it is not yet operational in Nigeria.

This thesis makes an attempt to make a case for upgrading matters concerning home-based care, in the context of HIV/AIDS, beyond the parameters of a policy initiative, to the realm of an enforceable legal right, both in South Africa and Nigeria. This becomes necessary because UNAIDS:2004 statistics or reports for both South Africa and Nigeria indicate an increasing number of vulnerable people, especially women, to HIV/AIDS. The far-reaching implication is that since HIV/AIDS remain incurable, when the large population of people in both countries who are living with the virus experience AIDS-related terminal illness and

are bedridden, the need for home-based care as a right, and not merely as a policy prerogative, becomes evident. For Nigeria, since home-based care, in the context of HIV/AIDS, is not yet operational, it serves a good purpose to highlight the need to make it an enforceable right, beyond the prerogatives of a policy imperative. In tackling this aspect, this work examines different provisions of the law and of international human rights instruments to see if existing provisions on the right to health care cannot be justifiably made to accommodate an enforceable right to home-based care in both Nigeria and South Africa.

This work also examines the general role of women as caregivers, despite their peculiar disability as the most vulnerable victims of HIV/AIDS. This work looks at the implications of this “double jeopardy” situation for women in the context that while children, family members and the general society depend on women for care, women again find themselves in a precarious situation needing more care and understanding in view of their greater vulnerability to HIV/AIDS. Because of this development, the resultant social trend towards home based care is enhanced. In this context, the resultant social impact and legal implications, as well as gender related issues are examined here.

5.4.1 Trend Towards Home-Based Care

The current reality witnessing a high proportion of women in the age group 15- 48 and beyond infected with, and affected by, HIV/AIDS, while they still attempt to fulfil their traditional functions as care- givers, warrants an innovative scheme in

health care. As care-givers to their children, husbands, family members and the extended family members, as well as to other members of their communities, women, as the most vulnerable groups to HIV/AIDS, find themselves in a dilemma as they need utmost care, themselves. The touching aspect is that women with full blown AIDS are physically unable to function and cope as care givers. Such incapacitation has necessitated the implementation of the home- based care program at an enhanced and more responsive capacity.

The home based care scheme should be made to guarantee availability, accessibility and acceptability of qualitative health care to people living with HIV/AIDS, especially women, in their homes. As AIDS sets in, vulnerable women who previously had been giving general care to their HIV-positive children and family members, become bed-ridden and can no longer fulfil their roles and traditional obligations to family and society. Home based care scheme provides a major relief if professionally handled. Apart from women, other people living with HIV/AIDS can also benefit immensely from home based care program.

Home based care, with emphasis in primary health care and some aspects of secondary care, is most desirable in the context of HIV/AIDS, as opportunistic infections and AIDS manifest. However, where complications occur and life saving devices are needed, then home based care may not be the most appropriate. It should, at this point, give way to tertiary or specialised care in the hospital environment.

5.4.2 Social Impact and Legal Implications

Although home-base care is presently a South African policy perspective, this work attempts to justify the position that home based care legally qualifies, given the provisions of some domestic and international instruments, to be made a binding and enforceable legal right to health care. The study also notes that this policy imperative is presently not obtainable in Nigeria. It is the aim of this study to justify the status of home-based care as an enforceable legal right, where appropriate, in South Africa and Nigeria.

Because a public policy instrument or intervention can be applied indiscriminately or incoherently, since it is not based on a rights-based approach, it is hereby submitted that home-based care, as a policy response or initiative, can be effectively harnessed to function within the confines or framework of a rights-based approach to health care. A policy-based approach to HIV/AIDS is, for the most part, about discretion.¹³ It gives the policy-makers (who are most often the government) the discretion to determine the content of these policies, the time-frames for implementation, the beneficiaries of such policies, the allocation of resources to such policies and who would be bound by such policies. Society is then dependent on the proper exercise of such discretion. However, within the framework of a policy-based approach, there is no mechanism to test the exercise of that discretion. This means that there is no mechanism to ensure that the exercise of

¹³ CSA, UP AIDS REVIEW 2002 Pretoria 2002 pp 1-30.

such discretion is free from prejudice and bias, or that it is justifiable, or that, ultimately, it is really the best that a government can do.¹⁴

A rights-based approach, on the other hand, means locating the needs of those infected and affected by HIV/AIDS in human rights that can be claimed and asserted, whatever an individual's, or a community's, or a government's view on HIV/AIDS might be. It means using the language of rights to implement certain actions.¹⁵ The strength of the rights-based approach is that its primary tool in the fight against HIV/AIDS is something inherent in all individuals and belonging to all individuals -human rights. Notionally, one has these rights simply by virtue of being a human being and nothing more. The rights-based approach seeks out those mechanisms whereby these rights can be translated into a concrete form and given status and recognition as international and national law. As such the rights-based discourse has the potential to be a powerful and an empowering one.¹⁶

It is for these reasons that the government's policy framework initiative on home-based care should be implemented within the framework of a rights-based approach to health care. It is respectfully submitted that it is possible for a public policy instrument or intervention to be made a rights-based instrument.

¹⁴ CSA, UP Ibid n. 13 p 277.

¹⁵ CSA, UP Ibid n. 14 p 278.

¹⁶ CSA, UP Ibid n. 15 p 277.

As a starting point, a constitutional amendment can incorporate a public policy instrument as an enforceable right. Equally, new legislation can upgrade such a policy as an enforceable right or law. Alternatively, existing constitutional provisions, or other provisions of the law, can be given expanded interpretations to justify a judicial interpretation or pronouncement in favour of implementing such a policy as an enforceable right. For instance, section 27 of the South African Constitution, which provides for the right to have access to health care, does not specifically mention a right to health care in the context of HIV/AIDS. However, both the High Court and the Constitutional Court judgments in the TAC case (supra) applied an expanded interpretation of that section, as well as an expanded scope of the right to health care, in the context of HIV-positive pregnant women. Such reasoning informs the attempt by this thesis to seek a justification to explore the provisions of existing laws or instruments to see if a case cannot be made to adopt home-based care within the parameters of a rights-based approach.

The legal implication arising from the necessity for home based care is the heightened need to incorporate home based care within the constraints of primary health care and rights to health care as provided by international and domestic instruments.

On this basis, this thesis examines the possibility of expanding the scope of the right to health care for people living with HIV/AIDS, beyond the limits presently constituted by

international and domestic human rights instruments, to provide for an enforceable right to home based care.

Some domestic and international provisions on the right to health care are hereby examined to see if these provisions cannot be accorded an expanded interpretation by incorporating the right to home based care for people living with HIV/AIDS.

5.4.3 South African Constitution

In order to justify the necessity of making home based care an enforceable legal right, the provisions of domestic and international instruments shall be highlighted and examined to see how home-based care fits in within the general legal framework.

In making an attempt to justify the implementation of home-based care within the parameters of a rights-based approach, it is excusable for some relevant constitutional provisions, and other provisions of international human rights instruments on health care to be repeated or highlighted hereunder. This is with a view to showing how an expanded interpretation can be given to the provisions so as to incorporate a justiciable right to health care.

Section 27(1) of the South African Constitution, 1996, which provides for the right to health care states as follows:

27(1) Everyone has the right to have access to health care services, including

reproductive health care; sufficient food and water, and social security, including, if they are unable to support themselves and their dependants, 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.....

It can be argued here that access to “health care services”, as used in this context and indicated in section 27(1)(a), could cover ‘home based health care’. “Home based health care” could also be interpreted to come under ‘appropriate social assistance’ in section 27(1)(c).

Section 27(2) which enjoins the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights, could be interpreted to allow the state time within which to progressively pass laws or establish policy guidelines on the implementation of home- based health care services.

Also, section 28(1) of the South African Constitution, 1996, provides as follows:

(1) Every child has the right-.....

(c) to basic nutrition, shelter, basic health care services and social service.

Here again, “basic health care services” and/or “social services” could be interpreted to incorporate “home based health care services”.

5.4.4 The African Charter on Human and Peoples’ Rights

Article 16 of the African Charter on Human and Peoples’ Rights 1981 articulates as follows:

- 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..*

It is equally noteworthy that the rights to home based health care could be embodied in the broader scope or perspective of “*the best attainable state of physical and mental health*”

because, without such basic service, women and other people who have developed full blown AIDS, are bedridden and cannot afford to leave their homes cannot be said to have enjoyed the best attainable state of health peculiar to their circumstance. Also, by providing that “States Parties shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick”, ‘home based health care’ can be interpreted to be one of such “measures” taken by States Parties to protect the health of people living with HIV/AIDS who truly need to

receive such “medical attention” because of their peculiar health circumstances. In this regard, home based-care can equally be seen as a policy imperative, thereby becoming a “double edged sword” with a policy focus as well as a rights-based initiative.

Article 18(1) of the ACHPR, by implication, incorporates home based health care by the state. It states:

The family shall be the natural unit and basis of society. It shall be protected by the state which shall take care of its physical health and morals.

In view of the above, providing home based health care to needed families affected by HIV/AIDS satisfies this purpose.

5.4.5 The African Charter on the Rights and Welfare of the Child

In considering the provisions of the African Charter on the Rights and Welfare of the Child, an analysis of its provisions confirms that home-based health care is implicitly embodied.

Article 14 provides:

- 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:
to reduce infant and child mortality rate ;
to ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary health care;.....
to ensure appropriate health care for expectant and nursing mothers;
to integrate basic health service programs in national development plans.

A review of the above provisions justifies the implication that “home based health care” services fits within the broad parameters of each of the above provisions. For example, a bedridden HIV-positive child at the terminal stage of AIDS disease, whose HIV-positive mother is equally bedridden of AIDS disease, cannot be said to enjoy the right to the best attainable state of physical, mental and spiritual health; nor could the sad consequence of infant and child mortality rate be reduced in such circumstances where the provision of home based health care, though desirable and of vital importance, is not provided. In such a situation, home based health care, as “necessary medical assistance” would have been provided within the limits of primary health care as provided by Article 14(2)(b) of the said Charter. Also, a sick, nursing or expectant mother of the child would also have received “appropriate health care” in the peculiar circumstances of their AIDS ailment, in line with the provisions of Article 14(2)(e). A sustained implementation of “home based health care” services will eventually result in

“integrating one of the basic health service programs in national development plans”, in the language of Article 14(2)(g).

5.4.6 The International Covenant on Social, Economic and Cultural Rights (ICESCR)

On its part, the ICESCR 1966 could be explored to incorporate provisions on “home based health care”. Article 12 provides:

1. The States Parties to the present Covenant recognize the rights 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 realization of this right shall include those necessary for:

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

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

A careful evaluation of the above provisions justifies the assertion that the right to “home-based health care” in the peculiar interest of women, children and other people suffering from HIV/AIDS fits well within the perspective, framework, or parameters, of the right to health care in each of the provisions. After the onset of AIDS, the associated sickness makes life unbearable to people living with HIV/AIDS. At that stage, and in their special circumstance, home based health care can offer them the opportunity to enjoy the “highest” attainable standard of

physical and mental health, as provided for in Article 12(1). Such “step”, when taken by a State Party, becomes “necessary to achieve the full realization of the right concerning the prevention, treatment and control of epidemic or other diseases”, as stated in Article 12(2)(c).

This argument is supported by the fact that at the stage where the AIDS patients are bedridden they can still enjoy the highest attainable standards of physical and mental health by the provision of home-based care. This saves them the additional agony of having to become an inmate in a public or private hospital. The situation then affords them the full realization of their right, considering their peculiar circumstance, concerning their treatment for HIV-related ailment. Undoubtedly, this step, when taken, will affect people living with HIV/AIDS, as the “condition that would assure to all medical service and medical attention in the event of sickness”,- in the language of Article 12 (2)(d), (being AIDS-related sickness, in this case).

5.4.7 The United Nation's Convention on the Rights of the Child (UNCRC)

The provisions of the UN Convention on the Rights of the Child 1989 could both directly and indirectly be interpreted in such a way as to incorporate the right to home based health care for a sick or disabled child, especially children disabled by HIV/AIDS.

Article 6 provides as follows:

- 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 23 provides as follows:

1. States Parties recognize 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.

3. Recognizing 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 -- in a manner conducive to the child's achieving the fullest possible integration and individual development, including his or her cultural and spiritual development

Article 24 equally provides as follows:

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 or her 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:

To diminish infant and child mortality

To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

To combat disease and malnutrition including within the framework of primary health care.....

To ensure appropriate pre-natal and post-natal health care for mothers.

After a careful scrutiny of each of the afore-stated provisions, it can be argued that the provision of basic home health care services, in addition to other needed health services, when effectively integrated into the entire spectrum of health care services, could provide some major answers to the needs of children suffering from HIV/AIDS. Home-based health care can ensure the child's "inherent right to life", in tune with the provisions of Article 6(1), and can also help in the "survival and development of the child", as enshrined in Article 6(2).

Equally, a physically or mentally disabled child suffering from AIDS-related sickness can be made to "enjoy a full and decent life in a condition which ensures dignity and promotes self-reliance" by making home based health care services widely available, accessible and acceptable, at state expense, in

accordance with Article 23(1). This would in turn aid the child to achieve “social integration and individual development”, in line with Article 23(3), starting with his family and immediate community. Likewise, home based health care can help a child, seriously stricken with HIV/AIDS, to “achieve the highest attainable standard of health” and can “facilitate treatment and rehabilitation” of the said child, as provided for in Article 24(1).

While directly helping to “diminish infant and child mortality”, home based health care services ensure the provision of necessary medical assistance and health care to children living with HIV/AIDS, as well as assisting in “combating disease, within the framework of primary health care”, in tune with the provisions of Articles 24(2)(a)(b)(c)&(d).

5.4.8 The Universal Declaration of Human Rights (UDHR)

The Universal Declaration of Human Rights (UDHR) 1948, though not a binding instrument on its own, provided most of the background on fundamental human rights that other international instruments became modelled on.

Article 25 provides as follows:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness,

*disability, widowhood, old age or other
lack of livelihood in circumstances beyond
his control.*

It is submitted that "right to medical care and necessary social services---- in the event of----- disability--- in circumstances beyond his control", as provided in Article 25, fits perfectly within the framework of the provision of home based health care for women and other people suffering from AIDS-related diseases.

This study has noted that home-based care is a policy instrument or initiative in South Africa to relieve congestion in state facilities. But the study also notes that apart from the function of relieving congestion, there are deserving cases that truly and rightly warrant the provision of home-based care in South Africa and Nigeria in the context of HIV/AIDS. It is for this purpose and reason that this study makes an attempt to justify the right to home-based care as a justifiable right within the framework of existing provisions on the right to health care in international and domestic instruments that bind South Africa and Nigeria.

It is respectfully submitted that the initiative to give an expanded interpretation to the above provisions in order to ground an argument in favour of making home-based care a rights-based initiative can be termed a "conformance" approach. However, it is my submission that an instrument on the implementation of home-based care can be made a

“double edged sword,” with the attributes of being implemented both as a policy imperative as well as a rights-based initiative.

5.4.9 The Nigerian Situation

In the Nigerian context, where there is no provision for a justiciable right to health care in the constitution, the above provisions make no meaning. However, by virtue of the incorporation of the provisions of the African Charter on Human and Peoples’ Rights 1981 as part of Nigerian law, the applicable discussion on incorporating home-based health care services as these pertain to the African Charter, can be applicable. But this would be subject to any limitations in the legal enforcement of the provisions of the African Charter as part of Nigerian law, as discussed above.

Noting the perceived hindrance to the implementation of the provisions of the African Charter in Nigeria, this thesis shall recommend that any Nigerian Constitutional provisions that would impede the implementation of the provisions of the African Charter on Human and Peoples’ Rights, as part of Nigerian law, as incorporated, be constitutionally amended.

5.5 SUMMARY

In this chapter, the legal and public policy responses to the HIV/AIDS epidemic and the vulnerability of women have been highlighted. Other health care related legal needs of women living with HIV/AIDS, who, themselves, are also care-givers,

have been discussed. In this regard, the trend towards home based care, its social impact and legal implications, and applicable gender related issues have been discussed. A justification for upgrading the policy instrument or initiative on home-based care, as applicable in South Africa, to the realm of a justiciable right to health care in South Africa and Nigeria, within the limits of the existing provisions of international and domestic instruments, has also been shown.

In the next chapter, it is proposed to critically evaluate and synthesize the legal framework and public policy responses and to draw broad conclusions and findings.

CHAPTER SIX:
SYNTHESIS AND EVALUATION OF THE LEGAL FRAMEWORK
AND PUBLIC POLICY RESPONSES

6.0 INTRODUCTION

The aim of this chapter is to critically evaluate and synthesize the legal and public policy responses in South Africa and Nigeria, and to draw broad conclusions and findings.

6.1 SOUTH AFRICA

From UNAIDS:2004 Global Report, it apparent that out of a total number of 5.3 million South Africans living with HIV/AIDS, 2.9 million, or 54.9% are women; 230 million, or 4.3% are children; while males account for 41%. Also, from the University of Pretoria's-Center for Study of AIDS' 2004 Report, it was found that about 66% of youth indulge in risky sexual behaviour without the benefit of protecting themselves against HIV/AIDS, falsely believing that they cannot be vulnerable victims.¹

On the negative impact of certain traditional norms, the results of a random unstructured discussion with 15 "traditional" individuals and 50 women in the Gauteng Province in January 2005 and in November 2005 confirmed that polygamy and wife inheritance are still in practise, but in diminishing dimensions, in the rural and major traditional areas of the country, but not in the urban cities.² It must be noted that traditional leaders are few in

¹ CSA, UP: 2004 Ibid n. 13 p 277.

² Personal Communication by way of an Interview on January 17, 2005.

number, as every single one of them represents a large group of followers. This accounts for why only fifteen traditional individuals were randomly chosen and interviewed.

The survey also confirmed that the problem of rape of young girls may remain for a long time because, apart from other societal factors that contribute to it, the prevailing HIV/AIDS cleansing myth that sex with a virgin cures HIV/AIDS fuels the scourge of the offence of rape of children and young girls. The study confirmed that the belief system of sexual cleansing is a prevailing myth in South Africa. This view is largely collaborated by the South African Report to the Committee on the Rights of the Child which referred to the HIV/AIDS epidemic and the HIV/AIDS cleansing myth.

6.1.2 Family Law and Customary Law of South Africa

This thesis, after an evaluation of the South African family law and the system of polygamy, made a finding that these may not have been the major factors that contributed significantly to the high vulnerability of women to HIV/AIDS. Any deficiencies of the South African Family Law or the system of polygamy may have been remedied, to some extent, by the following legislations:

- The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
- The Prevention of Family Violence Act 133 of 1993
- The Domestic Violence Act 116 of 1998

- The Recognition of Customary Marriages Act 120 of 1998
- The 2004 Constitutional Court ruling on primogeniture in the case of Bhe and Others v Magistrate, Khayelitsha and Others,³ declaring primogeniture as unconstitutional.

The study only wishes to add that the age of marriage under any system of marriage should be kept at not less than 18 years for the benefit of physical and mental maturity of the partners. In addition to this, the study intends to recommend that all prospective marriage partners be subjected to a free, but mandatory HIV test, under conditions of respect for the rights to dignity, privacy and confidentiality, but the results shared by both partners.

6.1.3 Public Health Law

The study found out, with satisfaction, that the public health system in South Africa has responded to the HIV/AIDS epidemic with zeal and dynamism, though members of the public may still be complaining about inadequacies. Noteworthy here is the stance of the opposition parties, including the DA, against President Mbeki's and the ANC'S public comments about the HIV/AIDS' situation in South Africa, as widely reported by various media organisations in South Africa.⁴

South Africa has brought its public health laws in line with international human rights norms. The aspect of international human rights norm of voluntarism in the context of HIV/AIDS has

³ 2004 (2) SA 544 (CC).

⁴ Media Reports:2003/2004 Op Cit nos. 66, 67, and 25 on pages 160 and 192.

been usefully adopted in South Africa. The human rights norm of free and voluntary counselling, testing and treatment for HIV, the protection of the rights of vulnerable people to dignity, privacy, freedom from stigmatisation, discrimination and inequalities, and not making HIV/AIDS a generally notifiable condition are commendable and worthy of emulation by other African States. Equally commendable is the jurisprudence in the case of Minister of Health and Others v TAC and Others (supra).

But one short-coming which this study uncovered is the lack of some limited coercive measures or limited derogation from the norm in the public interest. The HIV/AIDS disaster in South Africa has assumed pandemic dimensions, placing South Africa as both the world and African epi-centre of the epidemic.

South Africa can learn a good example from an applicable situation in New York, USA, or from other states in USA that apply some limited coercive or derogatory measures⁵ in the context of HIV/AIDS, in the overriding public interest. In the New York example, a limited coercive measure was applied to the extent of mandatory HIV counselling and testing of all pregnant women and their new-born babies. This study shall recommend that South Africa borrows from the New York example and introduce mandatory HIV counselling and testing on all pregnant women and their new-born babies. Such test should be subject to the respect for the rights to dignity, privacy and confidentiality

⁵ New York Public Health Law No. 2500F (Mckenney Supp. 1997), page 40.

and the test results made available to the pregnant woman and her husband.

The study shall also recommend that the provisions of the Communicable Diseases and Notification of Notifiable Medical Conditions Act of 1987 be formally repealed. The study views this provision as a major short-coming in that it conveys extensive powers on public health officials over persons suffering from AIDS or suspected to be suffering from AIDS. Again, it is highly coercive and is against the tenets of international human rights norms. Its continued existence does not serve any useful purpose in the light of domestic and international treaty obligations and human rights norms in the context of HIV/AIDS.

6.1.4 Human Rights Law

This study has made a finding that most of the human rights principles as guaranteed by international human rights instruments, law and norms, in the context of HIV/AIDS, have been reasonably domesticated, implemented or enforced in South Africa. The noble ideals of UNAIDS international guidelines on HIV/AIDS, as given by the UNO in 1996, find expression in all HIV/AIDS programmes in South Africa. The study accordingly commends the dynamism of the South African government in this direction. But the study is of the considered view that a limited application of coercive measures and derogation from the norms

of human rights law, in the public interest, is justifiable in the South African situation, as already indicated in this work.⁶

6.1.5 Constitutional Law

Clear provisions for justiciable socio-economic rights as well as specific rights to health care for different categories of people, including women, children, prisoners, etc, makes the South African Constitution exemplary and the most advanced constitution in the world. Besides, case law expatiates the constitutional ideals on the tripartite role of promoting, protecting and fulfilling the right to health care of which people vulnerable to HIV/AIDS have benefited.

This study would, however, wish to recommend that the constitution be amended to clearly provide for a justiciable right to health care for women, children and others who are vulnerable to HIV/AIDS.

In some unstructured interviews involving NGO's,⁷ CSA- UP⁸ and CHR-UP,⁹ there seem to be a near unanimous agreement that in view of the delay or slow progress by the government in

⁶ In the "Abstract", limited derogatory or coercive measures, under conditions of respect for human rights, have been indicated as some of the recommendations.

⁷ Personal Communication by way of an unstructured Interview with Carey, Deputy Chief Executive of People Opposing Women Abuse in Johannesburg on 20 January, 2005.

⁸ Personal Communication by way of unstructured Interviews with Rakdgardi Prisca Mohlalane- Gender Specialist, and with Mary Crew- Director, all of the Centre for the Study of AIDS, University of Pretoria, on December 7, 2004.

⁹ Personal Communication by way of an Unstructured Interview with Lirette Louw, Consultant in charge of HIV/AIDS Projects, Centre for Human Rights, University of Pretoria, on January 23, 2004.

implementing the roll out of anti-retroviral drugs, and also because of the general reluctance to enforce socio-economic rights, there is need to amend the constitution to incorporate the justiciable right to health care in the context of HIV/AIDS.

6.1.6 Labour Law

This study finds that the South African labour legislation including the Employment Equity Act of 1998, is sufficiently protective of women and the vulnerable groups in the context of HIV/AIDS. However, the study shall make a recommendation concerning job advertisements for which HIV-positive individuals can apply.

6.1.7 Legal Responses

South Africa has attempted an effective, commendable, practicable and results-focused legal response to the HIV/AIDS crisis and the vulnerability of women. The South African human rights regime articulates a well coordinated legal machinery to address most of the HIV/AIDS issues. The legislative initiatives that put in place the different pieces of legislation already mentioned, for the benefit of the vulnerable groups, the domestication of international law/treaty obligations in the context of HIV/AIDS, the jurisprudence to resolve the issue of mother-to-child transmission of HIV, are noble achievements. The issues of gender-based violence and discrimination, harmful traditional practices and offensive customs are all brought under check by legislation and other policy initiatives in South Africa.

Unresolved Problems:

Some major legal problems however remain unresolved in view of the prevalent culture of violence against women and the wide-scale rape of infants, children and young girls and women, despite substantive legislative principles against these harmful practices. This warrants further attention to make the law more responsive.

The study was also concerned about government's slow compliance with the decision of the Constitutional Court in the Minister of Health v TAC (supra), that government must take reasonable steps to facilitate access to health care. This is evident in the slow roll out of ant-retroviral drugs to HIV-positive persons, even with government's declaration of readiness to comply and start the comprehensive roll out. But about three years after the Court's decision, the extent of compliance is slow,¹⁰ while there is an alarming public outcry against not only government's approach to the issue, but also against President Mbeki and the ANC's public pronouncements on the situation of HIV/AIDS in South Africa.

The South African National Policy on HIV/AIDS is not only comprehensive but also practical and results-oriented. The UNAIDS:2004 Report confirmed that the HIV infection rates have

¹⁰ In an unstructured personal communication by means of an unstructured interview with the Manager of the HIV/AIDS- Skinner Street Clinic, Department of Health Pretoria, on 14 February, 2005, it was conceded that the comprehensive roll-out of anti retroviral drugs to all HIV-positive individuals was somehow slow.

stabilised in South Africa. This gain, though seemingly insignificant when compared to the high number of 5.3 million people living with HIV/AIDS, within a population of only 44 million, can be attributed to the comprehensiveness, resourcefulness and effective implementation of the South African National HIV/AIDS policy.

Despite the noble achievement outlined above, South Africa must still adopt more innovation measures to make the programme more results-oriented to the needs of vulnerable people to HIV/AIDS.

The study was also concerned about the issue of mother-to-child transmission of HIV and the fact that infant feed formula is not supplied along with anti retroviral drugs to HIV-positive pregnant women, at government expense, since this was not ordered by the Constitutional Court. The government must be seen to take additional steps to reduce the incidence of mother-to-child transmission of HIV, in addition to niverapine roll-out. This shall be an additional dimension that adds value to the niverapine treatment in that the subsequent transmission of the virus through the mother's breast milk to the infant baby can be controlled. This study has already attempted to show the causal nexus between poverty and HIV/AIDS, implying that most of the vulnerable HIV-positive mothers are poor-black women. Provision of infant milk formula shall go the extra mile to produce meaningful results in reducing mother-to-child transmission of HIV.

Thirdly, the proposed progressive roll out of antiretroviral drugs to all HIV-positive individuals in South Africa should be implemented immediately, starting with all women, whether pregnant or not, that are HIV-positive. This policy incentive shall address two key areas of social problems and reduce the high incidence of paediatric AIDS, as well as the high number of AIDS orphans or children-headed households due to the AIDS-related deaths of their mothers or both parents.

6.2 NIGERIA

The legal and public policy responses to the HIV/AIDS epidemic and the vulnerability of women to it in Nigeria is given hereunder, as follows:

6.2.0 GENERAL FINDINGS

The study found out that out of a total number of 3.6 million Nigerians living with HIV/AIDS, 1.9 million, or 50.1%, are women; 290,000 or 8% are children; while men account for 42%. The general trend of youth and young persons between the age 15-30 exhibiting the most risky sexual behaviour and thus becoming the most vulnerable is also established in Nigeria.¹¹

The above statistics suggest that the rate of incidence of mother-to-child or perinatal transmission of HIV is higher in Nigeria than South Africa. This gives rise to a higher incidence of paediatric

¹¹ (UNAIDS:2004; Nigerian 2004 National HIV Sentinel Survey Report).

AIDS in Nigeria, signifying that there is a major lack of legal and policy incentives or responses to reduce perinatal HIV as in South Africa, as exemplified by the decision in the TAC case. It also shows that other factors like free health care for children, and HIV infection due to undetected but infected blood, are prevalent.

Beyond the surface, the statistics further reveal that the factors that promote the subjugation of women, gender inequalities/discrimination, gender-based violence, offensive customs and harmful traditional practices are highly prevalent in both South Africa and Nigeria, though slightly higher in South Africa. In both countries, the percentage of vulnerable males are almost the same, at 41% for South Africa and 42% for Nigeria, while women in both countries account for the highest percentage of 54.9% for South Africa and 50.1% for Nigeria. These high statistics for women go a long way to confirm that physiological/biological factors in addition to gender-related factors combine to render women more susceptible to HIV infections, while males are not as readily vulnerable.

The study noted that in Nigeria there is notable absence of constitutional provision on the justiciable right to health care. There is also no provision for any other justiciable socio-economic right, nor of any human rights guarantees in the context of HIV/AIDS. There is also notable absence of progressive legislation that protects the rights of women and the most vulnerable in society, as in South Africa. In view of this

lacunae, the short-comings of certain aspects of law that contribute adversely to women's vulnerability to HIV/AIDS in Nigeria were examined. These include the Nigerian family law/customary law of marriage, aspects of the general customary law, and some aspects of public health law.

6.2.1 Family Law and Customary Law

This study uncovered some major weaknesses, lapses or short-comings in the Nigerian Family Law and Customary Law of Marriage and in some aspects of the general customary law, as shown hereunder:

Age of Marriage

The age of puberty, as prescribed by customary law, as one of the requirements for a valid customary law marriage, varies between 12 to 16.¹² This study is of the view that such tender age is far too low to withstand the physical, emotional and psychological pressures of marriage. Such a young age has wider implications for women's well being in marriage, which can indirectly contribute to a number of risks, including HIV/AIDS.

Parental Consent in Marriage

Under customary law marriage in Nigeria, parental consent is a sine-qua-non before marriage, but under statutory law marriage,

¹² Nwogugu Op.Cit n. 75 p 164.

parental consent is only required if the parties are under 21 years of age.¹³

It is hereby submitted that parents have a high degree of responsibility in the moral upbringing of their children. A requirement of parental consent before any system of marriage is contracted will be consistent with the need to morally guide one's children till marriage. This can prevent moral laxity that can give room to contracting HIV/AIDS before marriage.

Blood Test in Marriage

This study has noted that in the present circumstances of the HIV/AIDS epidemic, it will be in the general interest of parties to a proposed marriage to know of their HIV status prior to marriage. From the evaluation of its findings, this study views that prospective marriage partners under any system of law should be made to mandatorily undergo HIV test, with due regards to their rights to privacy, confidentiality, and respect to dignity.

6.2.2 Customary Law and Harmful Traditional Practices

This study has noted that harmful traditional practices are prevalent in South Africa and Nigeria, under their system of customary laws. These have adverse impact on women and contribute, directly or indirectly, to women's vulnerability to HIV/AIDS. From an evaluation of research findings, this study maintains that both countries, which are States Parties to

¹³ Nwogugu Ibid n. 12 p 304.

CEDAW 1979, and which also supported and promoted the Protocol to the African Charter on Women's Rights in Africa 2003, should fulfil the international law obligations inherent in these two instruments. Nigeria shall be specially called upon to adopt and incorporate some key provisions of these instruments as part of her domestic law.

6.2.3 Human Rights Law

Nigeria lags behind, as noted by this study, in terms of domestication of international human rights norms in the context of HIV/AIDS. As a starting point, Nigeria's failure to implement a policy of free and voluntary HIV counselling and testing, at state expense, confirms that much remains to be done to address HIV/AIDS and the vulnerability of women. This study shall recommend that Nigeria meets her international law and treaty obligations and domesticate all aspects of international human rights norms in the context of HIV/AIDS.

6.2.4 Constitutional Law

There is no legislation in Nigeria, like that in South Africa, to protect women and other vulnerable members of society. It is respectfully submitted that Nigeria, as a State Party to the ICCPR 1966 and ICESCR 1966, both of which impose positive and negative obligations, should fulfil her international treaty obligations. A constitutional amendment to incorporate justiciable right to health care as well as other socio-economic rights in Nigeria should be effected. Above all, any constitutional

amendment must also make direct provision for a justiciable right to health care in the context of HIV/AIDS.

6.2.5 Labour Law

Women and others vulnerable to, or living with, HIV/AIDS have no recourse to any labour law in Nigeria to protect them from HIV-related discrimination as workers or prospective employees, as in South Africa. The study therefore shall recommend the enactment of legislation similar to the Employment Equity Act to protect the labour-related interest of people living with HIV/AIDS and protect them from job related discrimination. In addition to the terms of the South African Act, the Labour legislation shall also make it mandatory for prospective employers to state in their job advertisements that a HIV-positive status is not a disability for the job apart from having the required competence for the job.

6.2.6 Legal and Public Policy Responses

Despite the Nigerian Government's assertions about legal and public policy responses and the comprehensiveness of the Nigerian HIV/AIDS National policy, this study discovered that there appears, in practical terms, to be a total absence of a concrete or normative framework to address HIV/AIDS in Nigeria. With the non-provision of free and voluntary HIV counselling and testing, at State expense, the so-called National HIV/AIDS Policy appears to be a farce. This is true because many people, especially the poor rural dwellers cannot afford the high cost of a laboratory test to ascertain their status, with the implication that

many people do not know their HIV status. This connotes that the Nigerian statistics on HIV/AIDS are under-reported. Since public expenditure in the context of the HIV/AIDS pandemic represents a huge investment on human development, it is respectfully submitted that the Nigerian Government should provide free and voluntary HIV/AIDS counselling, testing and treatment, regardless of budgetary implications, by making sacrifices in other sectors.

A closer perusal of the provisions of the Nigerian HIV/AIDS National Policy reveals that the State leaves the bulk of the responsibility to the individual to prevent and treat HIV/AIDS. Besides, there is no protective legal regime to protect vulnerable individuals as in South Africa. The State has not met her international treaty obligations or implemented most human rights norms, in the context of HIV/AIDS.

This study has noted that apart from condom distribution and the limited and ad-hoc distribution of anti-retrovirals from donor countries/international agencies that benefit only very few at specific sites, not much has been done to address HIV/AIDS and the vulnerability of women. This study shall make recommendations or proposals for legal and policy reforms to address HIV/AIDS and women's vulnerability in Nigeria. Such recommendation shall include a reform of family law, customary law, public health law, constitutional law, human rights law and labour law to specifically address HIV/AIDS. A dynamic HIV/AIDS policy initiative that embraces free and voluntary HIV

counselling, testing and treatment, at state expense shall form one of the key points. Above all, constitutional amendments to incorporate an enforceable right to health care, especially in the context of HIV/AIDS, shall form the nucleus of the reforms, amongst others.

6.3 BROAD FINDINGS:

The broad findings of the thesis are as follows:

6.3.0 General: South Africa and Nigeria

In spite of the ANC'S national government and President Mbeki's reluctance to acknowledge AIDS in South Africa, the study identified fewer shortcomings in the South African legal regime and public policy responses to address HIV/AIDS and the vulnerability of women, than in the Nigerian responses. However, from UNAIDS:2004 statistics on HIV/AIDS prevalence in both countries, a unique pattern of infection and vulnerability, is evident. The statistics revealed that out of a total number of 5.3 million people living with HIV/AIDS in South Africa, 2.9, or 54.9% are women; 230,000 or 4.3% are children; while males account for 41%.

For Nigeria, out of a total number of 3,6 million people living with HIV/AIDS, 1.9 million or 50.1% are women; children are 290000 or 8%; while males account for 42%.

The higher percentage of vulnerable women in South Africa indicates that all the factors identified by this study as impacting adversely on the vulnerability of women to HIV/AIDS, are real

and actually contributory. These factors, as already discussed, include gender-related factors like gender-based violence, discrimination, inequalities, disrespect for women's dignity, male dominance and harmful traditional practices. The study had made an attempt to establish the causal nexus or connecting links between HIV/AIDS and human rights abuse; HIV/AIDS and poverty; gender discrimination and HIV/AIDS; customary law/traditional practices and HIV/AIDS. The study concludes that these factors were some of the contributory factors that impacted adversely on women in South Africa and Nigeria. In addition, for women in South Africa, the research study found that the additional factor that contributed to their higher vulnerability than Nigerian women may not be unrelated to the Apartheid past. As Albertyn¹⁴ succinctly described it, their vulnerability emerged from the apartheid past, characterised by racial inequality, a migrant labour system, the disintegration of family life and deepening racial and gendered poverty. This factor has the potential to be the singular most important factor that accounts for South Africa's high statistics of 5.3 million people with HIV/AIDS as against Nigeria's 3.6 million.

On the higher percentage of vulnerable Nigerian children, the study concludes that their vulnerability stems from the poor or inadequate legal and public policy responses to the epidemic and the vulnerability of women. It reveals a non-responsive and incoherent national HIV/AIDS policy, inability and lack of the political will to address the HIV/AIDS epidemic and the issue of

¹⁴ Albertyn Op Cit n. 103 p 250.

mother-to-child transmission. It shows lack of proper infrastructures/facilities to address HIV/AIDS, including the transfusion of infected but undetected blood on anaemic pregnant women and children, as identified by Raufu.¹⁵ It confirms that the absence of policy initiative incorporating free and voluntary HIV counselling, testing and treatment is taking a serious toll on Nigerians, especially women and children. It draws a dividing line between the well articulated legal regime and dynamic public policy responses in South Africa as epitomized by the decision in Minister of Health V TAC (supra), including the government's compliance.

¹⁵ Raufu Op Cit n. 272 p 123.

CHAPTER SEVEN:
CONCLUSIONS AND RECOMMENDATIONS

7.0 INTRODUCTION

This is the concluding chapter of this thesis. The chapter includes the conclusions and recommendations.

This thesis is on HIV/AIDS and the law in South Africa and Nigeria, with special emphasis on the rights of women. The study attempted an investigation of the role of law, statutory or customary, and other associated legal and non-legal factors, as contributory factors rendering women more vulnerable to HIV/AIDS. The countries of focus in the study were South Africa and Nigeria. The study also examined the adequacy or otherwise of legal and public policy responses to the HIV/AIDS epidemic and the vulnerability of women in both countries. This was with a view to recommending legal reforms, policy changes, newer policy initiatives and other appropriate responses.

The major conclusions of the study are as presented hereunder:

7.1 Specific Recommendations Applicable to Both Countries

In consideration of all the material facts, observations, and findings, and in the greater interest of resolving the higher vulnerability of women to HIV/AIDS, this study attempts a contribution to knowledge by recommending as follows:

7.1.1 That it would be in the best national and public health interest of both countries to adopt some limited coercive

measures, learning from a jurisdiction like New York in USA. This involves mandatory HIV testing of all pregnant women and newborn babies under conditions of respect for their rights to privacy, confidentiality and dignity, but the results shared by the mother/woman and her husband, if any.

7.1.2 That it would also be in the best interest of public health and humanity to adopt another limited coercive measure, which derogates from the norms of human rights, by having mandatory HIV test of all prospective marriage partners under any system of marriage in both countries. This shall be subject to conditions of respect to the party's rights to privacy, confidentiality and dignity, but with the results of the tests shared by both partners.

7.1.3 Adopting 18 years as the minimum age of marriage under any system of law, for the purpose of ensuring sound physical and mental maturity before marriage.

7.1.4 Mandatory parental consent, as a prerequisite or one of the essential requirements of a valid marriage under any system of marriage. This will ensure proper moral upbringing of children before marriage so that they do not contract HIV/AIDS prior to marriage.

7.1.5 Addressing Gender-Related Issues in Both Countries

It is a major finding and conclusion of this study that gender factors have played a key role as contributing factors that render

women and young girls more susceptible to HIV/AIDS in South Africa and Nigeria.

This study found out that violence against women in South Africa and Nigeria generally occurs at three levels, namely- in the family, community and in the public arena. Violence against women, as confirmed by this study, can take on physical, economic, psychological or emotional form. The phenomenon of violence against women, from this study's stand point, reflects, but can also be attributed to, the patriarchal nature of South African and Nigerian societies and reflects, as mentioned earlier, the unequal power relations between women and men. This relations result in domination and discrimination.

It is submitted that the incidence of violence against women appears not to be slowing down in both South Africa and Nigeria. It is now very clear, from our discussion in this thesis, that a number of socio-economic and socio-cultural factors operate to increase women's vulnerability to HIV/AIDS.

This study has noted that South Africa has stepped up efforts and has introduced measures to prevent and eradicate violence against women. The constitutional imperative for a Commission for Gender Equality in South Africa is commendable. The equality and non-discrimination clause in the South African Constitution covers, by far, wider grounds than any other constitution, extending to 'sexual orientation'. What is, however, not clear, and cannot be ascertained now, is if these measures have

yielded fruitful results or reasonable dividends. For Nigeria, the study is concerned that nothing significant has been put in place by way of positive measures to eradicate general violence, including gender-based violence, against women.

The study also found that the recognition accorded to customary law and other personal law poses the greatest impediment to gender equality. With the exception of South Africa, most constitutions, including the Nigerian Constitution, contain only general statements regarding gender equality. Customary law generally gives men total control over women, children and property. The existence of customary laws which are generally unwritten and subject to various interpretations, means that for many women customary notions and practices that disadvantage them continue to govern their lives. The South African legislation on The Recognition of Customary Marriages Act of 1998 has, however, brought customary law marriages on par with civil marriages. The South African position of the law on primogeniture as evidenced by the Constitutional Court's 2004 ruling outlawing primogeniture has also affected the status of customary law. However, in Nigeria, the status quo remains, while customary law rules, to the detriment of women.

On these bases, this study further recommends as follows:

(1) Repealing and Reforming Laws, Constitutional Amendment and Enacting Empowering Gender Sensitive Laws:

- That since South Africa already has a number of pieces of legislation, facilities and institutions in place to check

gender abuse and maintain gender equilibrium, it is particularly recommended that Nigeria learns from the South African example. Nigeria should thus repeal or reform her laws, amend the 1999 Constitution and outlaw or proscribe social practices that still subject women to discrimination, while enacting empowering gender-sensitive laws, like South Africa. A constitutional provision for, and establishment of, a Commission for Gender Equality in Nigeria is also strongly recommended.

- It is also recommended that Nigeria specifically enact laws making violence against women clearly defined crimes and introducing appropriate punitive measures.
- It is also recommended that Nigeria adopts and incorporates certain key provisions of CEDAW 1979 and The Protocol to the African Charter on Women's Rights 2003, as part of her domestic law, since these provisions have addressed most issues concerning gender equality, discrimination, customary law and practices and women's rights.
- Furthermore, it is recommended that the South African and Nigerian governments take urgent measures to prevent and deal with the increasing levels of violence against women and children at the family, community and public levels. At the family level, families must be made to ensure education concerning women's vital role in culture, the family and

socialization and that socialization is the process by which a child is taught the roles he or she is to play in society. The family as an agent of socialization assigns different status, values and roles to girls and boys.

- Discrimination against women and girls can therefore start in the family before birth, with parental preference and societal attitude that promote a preference for sons over daughters. The governments in both countries must make the families to realize, through mass public education programmes, that they have an important role to play in eliminating gender-based discrimination and inequalities against women. Social and cultural traditions and practices should be reformed towards a common civil code that upholds the dignity of women as equal partners with men in the family, including removal of gender bias in matters of marriage, divorce, custody and property rights. Though South Africa has implemented some aspects of these recommendations, much more remains to be done to ensure that positive results are achieved.
- At the community and public level, the government can take a number of measures to stop violence against women. Governments in both South Africa and Nigeria must adopt special measures to eliminate trafficking in women and girls and to assist female victims of violence due to prostitution and trafficking.

The study noted that though South Africa has made general or domestic violence against women, including rape within marriage, wife battering, sexual harassment, etc, to amount to a criminal offence, there is no such or similar law in Nigeria. This study hereby recommends that the Nigerian government adopts a similar law/laws, in the interest of women.

For South Africa that appears to derive no marked dividends from these laws, so far, this study recommends that the laws be reviewed and a two-thronged approach adopted. One is an aggressive and intensified public awareness campaign on the dangers of these societal vices. The second involves a more aggressive and punitive legal measures, as deterrent factors.

(2) Economic Empowerment of Women/Empowerment of Women as a Transformative Strategy for Poverty Eradication:

This study has attempted to show the link between poverty and HIV/AIDS as also confirmed by UNAIDS:2004. The study has noted that the struggle against poverty, the economic empowerment of women and the promotion of sustainable livelihood for the youth is a moral, political and economic obligation and responsibility of both the South African and Nigerian governments. The poverty experienced by women should not be seen only from a welfare perspective. Women living in poverty represent an under-utilization of productive potential. Measures to reduce or eliminate poverty are major parameters of growth, empowerment and overall political stability. To resolve issues of poverty that affect women and in turn render them less

vulnerable to HIV/AIDS, the governments of South Africa and Nigeria must have policies that are gender sensitive and that accommodate the needs and interests of women. It also requires specific and gender-based anti-poverty policies, programmes and actions that are integrated into overall economic planning at local, national, regional and international levels.

7.2 Specific Findings, Conclusions and Recommendations: South Africa

The study is impressed that South Africa has domesticated most of her international law treaty obligations, by means of existing legislations. Such legislations which protect the interest of women include:

- The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.
- The Recognition of the Customary Marriages Act 120 of 1996
- The Prevention of Family Violence Act 133 of 1993
- The Domestic Violence Act 116 of 1998

Because of the existence of these pieces of legislation, this study paid less attention to any deficiencies or short-coming attributable to the South African Family law or Customary law, after its findings that these aspects of the law do not contribute extensively to women's vulnerability to HIV/AIDS. Besides, the above Acts have, to a great extent, ameliorated any adverse impact of these branches of law. However, it is hereby

recommended that the South African Government puts an effective machinery in place for efficient implementation of the laws so as to achieve the desired results of gender equity and equilibrium.

The study has noted that a coherent national HIV/AIDS policy which incorporates free and voluntary HIV counselling, testing and treatment is in place, as well as a good programme for prevention of mother-to-child transmission of HIV.

Despite the noble achievement outlined above, more still remains to be done to improve upon the gains already made. Such innovations shall make the programme more responsive to the needs of vulnerable people to HIV/AIDS. This study is particularly of the opinion that the free and voluntary HIV counselling, testing and treatment should be expanded to accommodate free and voluntary testing of CD4 cell count. This shall enable a large population of those infected to know their enhanced status early and to seek early treatment before it is too late, since it is the CD4 count that determines when to start anti-retroviral drug treatment.

7.2.1 Public Health Law: The Communicable Diseases and Notification of Notifiable Medical Conditions Act of 1987

The study found out that this law has outlived its usefulness, especially in the present dispensation of human rights approach to HIV/AIDS issues. This approach discourages certain forms of coercive public health measures. This particular law is extremely

coercive, in the context of HIV/AIDS. Though the law may not have been invoked, its continued existence is not in the best interest of human rights norms. This study recommends that it be formally repealed, because of its extreme coercive characteristics, notwithstanding that limited coercive measures have been recommended elsewhere in this work.

7.2.2 Constitutional Law

While the constitutional provisions on the right to health care can conveniently be adopted in the context of HIV/AIDS, the study recommends a constitutional amendment to incorporate a justiciable right to health care in the context of HIV/AIDS, including a right to home-based care for deserving AIDS patients. It is respectfully submitted that home-based care should be upgraded from the ambit of policy imperative to the status of an enforceable legal right, for the benefit of deserving AIDS patients in different families in South Africa.

Secondly, the problem of higher vulnerability of women to HIV/AIDS and the corresponding issue of mother-to-child transmission of HIV must be addressed aggressively. In this connection, this study recommends that the Constitutional Court's ruling on niverapine roll out to HIV-positive pregnant mothers be redressed to also make provision for the availability and distribution of infant feed formula to HIV-positive pregnant and nursing mothers, at government expense. This is necessary because new born babies who escaped mother-to-child

transmission of HIV at birth can still contract HIV through breastfeeding from HIV-positive mothers. The government can simply show a gesture of progressive contribution to reduce the high incidence of mother-to-child transmission of HIV by reviewing this aspect, as a policy initiative, without a resort to the court.

7.2.3 Labour Law

The study equally notes South Africa's ingenuity on the Employment Equity Act of 1998. While the Act has gone a long way towards resolving issues of discrimination against HIV-positive applicants seeking jobs as well as HIV-positive individuals who are already working, it is respectfully submitted that something more must be done to allay the fears of job seekers who are HIV-positive. In furtherance of this, the study recommends that the Employment Equity Act of 1998 be amended to incorporate a provision that employers must include in their advertisements for jobs that a person's HIV status shall not prejudice any job applicant but that job skills are of paramount importance. There is need for this clear and unambiguous provision, notwithstanding the inclusion of the provision that discrimination on the basis of status is unconstitutional.

7.3 Specific Findings, Conclusions and Recommendations: Nigeria

The study found out that Nigeria lags far behind South Africa as far as legal and public policy responses to the HIV/AIDS epidemic and the vulnerability of women are concerned. There

are no constitutional provisions that guarantee the right to health care and there are no direct or indirect legislative initiatives that address HIV/AIDS related issues. The unfortunate reality is that there is a near-total absence of any meaningful legal or policy framework to address HIV/AIDS and women's vulnerability in Nigeria, in as much as the so-called national HIV/AIDS policy is a "farce", by all indications.

In view of these findings, this study therefore recommends as follows:

7.3.0 Specific Recommendations:

7.3.1 Family Law/Customary Law

To check against the fast method of dissolution of customary law marriages by non-judicial methods, this study recommends that only the judicial method of dissolution of customary law marriages should be adopted in Nigeria. This approach is feasible in the Moslem dominated Northern part of Nigeria because, in this particular situation, the Moslems' special Sharia Courts would be the only recognised judicial body to adjudicate on matters of divorce of Islamic marriages. This would require changes to the Sharia Law.

On the overwhelming influence of customary law and harmful traditional practices, as well as culture- related/gender- based violence, discrimination, inequalities, practices and belief system that impact adversely on women, this study recommends the adoption and domestication of certain provisions of CEDAW 1979 and the Protocol to the African Charter on Women's Rights

2003. These provisions have addressed issues on gender, customary law and harmful traditional practices adequately well.

7.3.2 Public Health Law

This study is of the view that the continued existence of any coercive public health law, in the face of lack of reasonable legal and public policy responses to HIV/AIDS and women's vulnerability, simply 'adds more insults to injury'. In view of this the study recommends either a repeal of the Public Health Laws of the Federating States and in the Nigerian Constitution, having to do with infectious diseases, or an amendment indicating that infectious diseases, in the context used, do not include HIV/AIDS.

7.3.3 Constitutional Law/Constitutional Amendment

In view of the finding of lack of legal or constitutional framework to address either HIV/AIDS or the right to health care, the study recommends a constitutional amendment to provide for not only a justiciable right to health care, but other socio-economic rights.

The study equally noted that Nigeria is a State Party to the ICCPR, ICESCR, CEDAW, UNCRC, ACHPR, ACRWC and other international instruments, some of which impose negative and positive obligations. This study therefore recommends that Nigeria domesticates its international law and treaty obligations, in the interest of the disadvantaged members of society who would benefit from the protective regimes in those instruments.

Noting the higher vulnerability of women to HIV/AIDS and equally noting the high statistics of children who are living with HIV/AIDS in Nigeria, the study recommends a specific constitutional amendment to provide for free and voluntary HIV counselling and testing for everyone, as well as free and voluntary HIV counselling, testing and treatment for women and children, including a comprehensive programme for prevention of mother-to-child transmission of HIV, all at State expense.

The study also recommends a constitutional amendment to provide for a justiciable right to health care in the context of HIV/AIDS, including the enforceable right to home-based care for deserving AIDS patients.

The study equally recommends a constitutional amendment to provide for a Commission for Gender Equality in Nigeria.

7.3.4 Constitutional Law/Legislative Measures

The study recommends that as a short term measure, to address the gender imbalance against women, the following legislations be enacted in Nigeria:

- The Promotion of Equality and Prevention of Unfair Discrimination Act. This legislation is important in view of the Nigerian situation whereby there are so many ethnic groupings and the major ethnic groups oppress and discriminate against minority ethnic groups, denying them their rights. It is also necessary because of the peculiar gender-biased cultural setting in Nigeria.

- The Recognition of Customary Marriages Act to accord customary law marriages the same rights as statutory law marriages
- The Prevention of Family Violence Act to declare marital rape a crime
- The Domestic Violence Act to provide for the arrest without warrant of anyone suspected of having committed an act of domestic violence
- HIV-Related Sexual Offences Act to provide for mandatory testing of all rape suspects and for life imprisonment for all HIV-positive rape suspects, with or without evidence of HIV transmission.

7.3.5 National HIV/AIDS Policy

The study recommends that Nigeria reviews or re-examines her national HIV/AIDS policy with a view to making it comprehensive, dynamic, results-oriented and encompassing all the above points, so as to adequately address the HIV/AIDS epidemic and the vulnerability of women and children. There is ardent need to incorporate free and voluntary HIV counselling, testing and treatment, including free CD4 cell counts, at government expense.

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ANNEXURE "A"

DEFINITION OF SOME TERMS/ABBREVIATIONS:

The definition of some of the terms used in this work- ANNEXED AS ANNEXURE "A" HERETO.

DEFINITION OF SOME TERMS/ABBREVIATIONS:

Some of the terms used in this work are defined as follows:

- AIDS- ACQUIRED IMMUNE-DEFICIENCY SYNDROME. This is the end-stage manifestation of an infection with the HIV-virus.
- AZT- Aziothymidine. This is an anti-retroviral drug
- BIOLOGICAL WARFARE THEORY. This is one of the proposed theories on the history of the evolution of the HIV epidemic.
- CO-FACTOR THEORY. This is one of the proposed theories on the history of the evolution of the HIV epidemic.
- DNA- This means Deoxyribonucleic Acid
- MUTATION THEORY. This is one of the proposed theories on the history of the evolution of the HIV epidemic.
- MTCT- This means "Mother-to-Child Transmission
- NACOSA- This means National AIDS council of South Africa
- PATIENT ZERO THEORY. This is one of the proposed theories on the history of the evolution of the HIV epidemic.
- CDC- CENTRE FOR DISEASE CONTROL. This is a centre in USA that oversees all functions pertaining to disease control in USA.
- CD4 CELLS- Special Receptor Protein

- **CD4 T-LYMPHOCYTE CELLS-** These cells constitute a vital component in the immune system as they coordinate antibody production and all immune responses. These cells are also referred to as T4 or T-HELPER which initiate or stimulate immune system activities.
- **CD8 LYMPHOCYTES.** These cells are also called T8 or T-SUPPRESSOR CELLS. They control an over-enthusiastic immune response and thereby prevent the body from attacking itself since a healthy immune system requires a sophisticated interaction and balance between T4 and T8 cells.
- **CMV- CYTOMEGALOVIRUS.** This is a virus that causes infection in HIV infected individuals.
- **COERCIVE MEASURES:** This refers to a more radical approach to prevention and control of HIV infection by invoking the coercive force of law, by means of the direct or indirect methods of coercion.
- **HIV- HUMAN IMMUNODEFICIENCY VIRUS.** This is a retrovirus which causes the infection that eventually results in AIDS.
- **LAV- LYMPHADENOPATHY VIRUS.** This virus is associated with the virus that was initially determined to cause AIDS.
- **LYMPHOCYTES-** These are special white blood cells and are composed of B-CELLS and T-CELLS. The B-CELLS produce the antibodies that identify and begin to destroy disease causing organisms. The T-CELLS are divided into two groups- T4 HELPER CELLS- which encourage B-CELLS

to produce more antibodies, and SUPPRESSOR CELLS- which work to shut down B-CELL production once infection is overcome.

- LYMPHADENOPATHY- This refers to the clinical stage manifesting the enlargement and swelling of the lymph nodes. It is also referred to as- PROGRESSIVE GENERALIZED LYMPHADENOPATHY (PGL) or LYMPHADENOPATHY SYNDROME (LAS)
- M-C-T. This means- Mother-to-Child Transmission
- PCP-PNEUMOCYSTIS CARINI PNEUMONIA. This is a highly unusual form of pneumonia, commonly prevalent in individuals with the HIV- virus.
- RNA- This means Ribonucleic Acid
- SANAC- This means South African National AIDS Council
- SIV- SIMIAN IMMUNODEFICIENCY VIRUS. A second scenario holds that the human virus originated from the monkey immunodeficiency virus which is also called the Simian Immunodeficiency Virus.

ANNEXURE "B"
LIST OF QUESTIONS AND OFFICIALS INTERVIEWED

Annexure "B1": List of Officials/People Interviewed

- Personal communication by way of an unstructured interview with the Director of Public Health Services in the Nigerian Federal Ministry of Health- Dr (Mrs) E.A. Abebe, in Abuja, Nigeria on 7 November, 2001.
- Personal communication by way of an unstructured interview with Babatunde, I. Esq, - a Litigations Officer and Attorney in the Civil Litigations Department, Office of the Attorney General of Nigeria, Federal Ministry of Justice, Abuja, Nigeria on 7 November, 2001.
- Personal communication by way of an unstructured interview with Balogun, J. Esq.- Director, International and Comparative Law Department, Federal Ministry of Justice, Abuja, Nigeria on 7 November, 2001
- Personal communication by way of unstructured interviews with 15 "traditional" individuals and 50 women picked at random in the Gauteng Province of South Africa on 17 January, 2005 and on 21 November, 2005
- Personal Communication by way of an unstructured Interview with Carey, Deputy Chief Executive of People Opposing Women Abuse in Johannesburg on 20 January, 2005.
- Personal Communication by way of unstructured Interviews with Rakdgardi Prisca Mohlahlane- Gender Specialist, and with Mary Crew- Director, -all of the Centre for the Study of AIDS, University of Pretoria, on December 7, 2004.
- Personal communication by way of an unstructured interview with Lirette Louw, Consultant in Charge of HIV/AIDS Projects, Centre for Human Rights, University of Pretoria, on January 23, 2004.
- Personal communication by way of an unstructured interview with the Manager of the HIV/AIDS- Skinner Street Clinic, Department of Health, Pretoria, on 14 February, 2005.
- Personal Communication by way of unstructured interview with inmates of the Salvation Army Church AIDS' Home in Johannesburg on Jan.20, 2005
- Personal communication by way of unstructured interview with 5 Employers of Labour in Pretoria on December 17, 2005.

QUESTIONNAIRE:

Interview Questions/Questionnaire for Officials of the
Ministries/Departments of Justice and Health- Annexed as
ANNEXURE "B2" HERETO:

CENTRE FOR HUMAN RIGHTS
FACULTY OF LAW
UNIVERSITY OF PRETORIA
PRETORIA, RSA

JANUARY 13, 2002

INTERVIEW QUESTIONS/QUESTIONNAIRE FOR OFFICIAL OF THE MINIS-
TRY OF JUSTICE AND MINISTRY OF HEALTH

INTRODUCTORY REMARKS: It is clear that the HIV/AIDS pandemic is now an in-
controvertible reality before us. Available evidence indicate that black people in Sub-
Saharan Africa are the most vulnerable. At the same time, there appears to be much
aparthty at the international and national levels towards the victims of HIV/AIDS.

This is a doctoral research work that probes and explores further the issues with an
aim of determining the most vulnerable groups to HIV/AIDS among black people in
Sub-Saharan Africa. It also questions the rationale behind the slow global and na-
tional response to the plight of people who have fallen prey to the HIV/AIDS crises,
with a view to making useful recommendations bothering on legislative approaches,
budgetary provisions and policy initiatives, to the benefit of vulnerable groups living
with HIV/AIDS in Africa.

We are particularly desirous of obtaining your response because your position and ex-
perience will contribute significantly towards achieving the aims and objectives of this
study.

It will be appreciated if you will answer the questions or complete the questionnaire promptly. We would welcome any comments that you may have concerning any aspects not covered in the questions or questionnaire. A summary of the study report shall be sent to you if you desire.

Thank you for your co-operation

Sincerely yours

E J UKO Esq.

Question 1: What are your names and your position in government?

Question 2: Are you aware of the current controversies surrounding the HIV/AIDS pandemic in your country?

Question 3: How serious is the HIV/AIDS crisis in your country?

Question 4: From available statistics, and by all possible implications, who are the most vulnerable groups to HIV/AIDS in your country?

Question 5: Any statistics to buttress your viewpoint?

Question 6: *Are* you aware of any government policies to address this issue of vulnerability to HIV/AIDS pandemic? If so, what are they?

Question 7: Have legislation been introduced, directed at the problems posed by HIV/AIDS in your country? If so, what are they? *Are* there any pending legislations?

Question 8: What about government budgetary provisions on prevention and treatment of HIV/AIDS in general and particularly, among the most vulnerable groups? Please give details of budgetary provisions.

Question 9: *Are* there any reports of seminars, symposia, conferences, special committees, etc. sponsored or organised by your government to discuss the impact of HIV/AIDS and/or proper solution? If so, could you please provide us with the copies of such reports as you respond to these questions?

Question 10: Are there any court proceedings, whether criminal or civil, either concluded or pending in court, whether instituted by government or against government that touch on AIDS/HIV related issues in your country? If so, please provide details.

Question 11: Are there other HIV/AIDS related issues not directly mentioned here that you would like to comment on?