

# HIV/AIDS AND HUMAN RIGHTS IN ZIMBABWE



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# 1. INTRODUCTION

This country report on HIV/AIDS and human rights in Zimbabwe is the result of a one-year joint project between the Centre for the Study of AIDS and the Centre for Human Rights, both based at the University of Pretoria, South Africa. The research project was made possible through funds provided by the Open Society Foundation. This report is one of a series of eight reports focusing on HIV/AIDS and human rights in the following countries within the Southern African Development Community (SADC): Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. These countries have some of the highest and fastest growing rates of HIV/AIDS infection in the world, with the number of reported cases of HIV infection having tripled since the mid-1980s.

This research project was inspired by the need to develop a new approach to the HIV/AIDS epidemic in the SADC, an approach that is rights-based and that guarantees basic human rights to all people living with or affected by HIV/AIDS in the region. The study was guided by the document *HIV/AIDS and Human Rights – International Guidelines*<sup>1</sup> of 1996, adopted by UNAIDS and the Office of the United Nations High Commissioner for Human Rights. The Foreword of these *Guidelines* declares:

“In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination and the personal and societal impact of HIV infection is alleviated.”<sup>2</sup>

The aim of this research report, within the *SADC HIV/AIDS Framework for 2000-2004*, is to assist decision-makers to make informed policy choices for individual SADC countries. It is also intended for legislators, the judiciary, members of non-governmental organisations and people living with or affected by HIV/AIDS. All of these groups need: firstly, to be informed about

those human rights in the context of HIV/AIDS that are already protected within their countries; secondly, to be able to identify areas where there is a gap and a need to lobby for change; and finally, to initiate change in an effort to move towards a rights-based approach to HIV/AIDS.

This report is a summary of national HIV/AIDS policies, strategic frameworks, legislation, guidelines and court cases in Zimbabwe as they relate to HIV/AIDS and human rights. A national consultant in Zimbabwe collected the relevant documents, answered a questionnaire that was developed to structure the research, and commented on the final report.<sup>3</sup> This report begins by briefly sketching the HIV/AIDS background for SADC and Zimbabwe, through listing some critical statistics. The report then provides an analysis of the most important international, regional and SADC principles for HIV/AIDS and human rights, providing an overall framework against which the country report should be seen. The country report is a summary of the legal and policy framework for the protection of the human rights of those living with or affected by HIV/AIDS in Zimbabwe, and addresses areas such as labour, health, gender, children, prisons and criminal law. This is followed by a concluding chapter with some recommendations regarding moving towards a rights-based approach to HIV/AIDS in the SADC.

It needs to be emphasised that this study focuses on the legal framework alone and does not set out to establish empirically the extent to which the respective governments are implementing the provisions in place – that is beyond the scope of this study and will require further research. Furthermore, while all efforts have been made to ensure that the information presented is reliable and up-to-date as of end of 2003, the study's authors do not accept any responsibility for any errors or omissions in the country reports.

<sup>1</sup> Available at: <http://www.unhchr.ch/hiv/guidelines.htm>.

<sup>2</sup> The Foreword was written by Peter Piot, Executive Director of UNAIDS, and Mary Robinson, the former United Nations High Commissioner for Human Rights.

<sup>3</sup> Dorothy Mushayavanhu, Lecturer at the University of Zimbabwe, BL (UZ), LL.M Law and Development (SOAS - London).

## 2. BACKGROUND

With a national adult HIV prevalence rate of 33,7%, Zimbabwe is described by UNAIDS as one of four SADC countries that is facing a “rampant epidemic” with HIV prevalence rates that have “risen higher than thought possible”.<sup>4</sup>

The tables below provide statistical information on all the SADC countries, with the statistics for Botswana highlighted.

### 2.1 Geographical size and population

The following two tables illustrate the size and population of the SADC countries in this study:<sup>5</sup>

Geographical size			
Botswana	581 730 km <sup>2</sup>	South Africa	1 220 088 km <sup>2</sup>
Malawi	118 484 km <sup>2</sup>	Swaziland	17 365 km <sup>2</sup>
Mozambique	801 590 km <sup>2</sup>	Zambia	752 614 km <sup>2</sup>
Namibia	824 268 km <sup>2</sup>	<b>Zimbabwe</b>	<b>390 759 km<sup>2</sup></b>

Population size		
Country	Total population	Adult population
Botswana	1 564 000	762 000
Malawi	11 572 000	5 118 000
Mozambique	18 644 000	8 511 000
Namibia	1 788 000	820 000
South Africa	43 792 000	23 666 000
Swaziland	933 000	450 000
Zambia	10 649 000	4 740 000
<b>Zimbabwe</b>	<b>12 652 000</b>	<b>5 972 000</b>

### 2.2 First reported instances of HIV infection<sup>6</sup>

Country	First reporting year	Number of cases
Botswana <sup>7</sup>	1985	3
Malawi	1985	17
Mozambique	1986	1
Namibia <sup>8</sup>	1986	1
South Africa	1982	2
Swaziland	1987	1
Zambia <sup>9</sup>	1984	1
<b>Zimbabwe</b>	<b>1987</b>	<b>119</b>

4 UNAIDS Fact Sheet 2002 Sub-Saharan Africa available at: <http://www.unaids.org/worldaidsday/2002/press/index.html#facts>. The other three countries are Botswana (38,8%), Lesotho (31%) and Swaziland (33,4%).

5 Data from Africa Fact Sheet, published by African Institute of South Africa, July 1997.

6 According to the Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections (Update 2002), compiled by UNAIDS,

UNICEF and WHO. Available at [http://unaids.org/hiv/aidsinfo/statistics/fact\\_sheets/all\\_countries\\_en.html#N](http://unaids.org/hiv/aidsinfo/statistics/fact_sheets/all_countries_en.html#N).

7 Doctors in Princess Marina Hospital in Gaborone documented the first HIV/AIDS case in 1985.

8 Reported by UNAIDS in the International Partnership against AIDS in Africa - Namibia Country Visit Report, 1 May-4 June 1999.

9 Reported in the National HIV/AIDS/STD/TB Policy published in October 2001 by the Zambian Ministry of Health.

## 2.3 HIV prevalence rates

The following figures are provided by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, which works in close collaboration with national AIDS programmes.<sup>10</sup> Statistics are also obtained from the *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update*, issued by UNAIDS, UNICEF and the WHO.<sup>11</sup>

Population with AIDS					
Country	Adults and children	Adults (15-49 years)	Adults (%)	Women (15-49 years)	Children (0-14 years)
Botswana	333 000	300 000	39,9%	170 000	28 000
Malawi	850 000	780 000	15%	440 000	65 000
Mozambique	1 100 000	1 000 000	13%	630 000	80 000
Namibia	230 000	200 000	22,5%	110 000	30 000
South Africa	5 000 000	4 700 000	20,1%	2 700 000	250 000
Swaziland	170 000	150 000	33,4%	89 000	14 000
Zambia	1 200 000	1 000 000	21,5%	690 000	150 000
<b>Zimbabwe</b>	<b>2 300 000</b>	<b>2 000 000</b>	<b>33,7%</b>	<b>1 200 000</b>	<b>240 000</b>

HIV prevalence rates in young people aged 15-24 years				
Country	Female		Male	
	Low estimate	High estimate	Low estimate	High estimate
Botswana	29,99%	44,98%	12,86%	19,29%
Malawi	11,91%	17,87%	5,08%	7,62%
Mozambique	10,56%	18,78%	4,41%	7,84%
Namibia	19,43%	29,15%	8,88%	13,32%
South Africa	20,51%	30,76%	8,53%	12,79%
Swaziland	31,59%	47,38%	12,18%	18,27%
Zambia	16,78%	26,18%	6,45%	9,68%
<b>Zimbabwe</b>	<b>26,40%</b>	<b>39,61%</b>	<b>9,9%</b>	<b>14,86%</b>

Tuberculosis (TB) infection rates	
Country	TB prevalence for the year 2000 (unless otherwise stated)
Botswana	8 649 <sup>12</sup>
Malawi	22 570
Mozambique	Unknown
Namibia	10 497
South Africa	One sentinel site (Port Shepstone) outside major urban areas: 52% minimum, 52% median, 52% maximum.
Swaziland	2 143
Zambia	161 056. The average tuberculosis rate between 1964 and 1984 remained constant at 100 per 100 000 people. The rate of TB infections increased dramatically to nearly five-fold to over 500 per 100 000 people due to the impact of HIV/AIDS in 1996. <sup>13</sup> TB co-infection has resulted in an increased mortality rate of TB patients on treatment by over 15%. <sup>14</sup>
<b>Zimbabwe</b>	<b>51 805</b>

<sup>10</sup> The estimates are from the *Table of Country-specific HIV/AIDS Estimates and Data, End 2001*, available at [www.unaids.org/barcelona/presskit/barcelona%20reports/table.html](http://www.unaids.org/barcelona/presskit/barcelona%20reports/table.html). The estimates produced by UNAIDS/WHO draw on advice from the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections. A measure of uncertainty applies to all estimates, depending on the reliability of the data available. Most of the data are from routine sentinel surveillance. For a detailed description of the general methodology used to produce the country-specific estimates, see Annexure I at <http://www.unaids.org/barcelona/presskit/barcelona%20report/annex1.html>.

<sup>11</sup> Available at: [http://www.unaids.org/hivaidinfo/statistics/fact\\_sheets/all\\_countries\\_en.html#N](http://www.unaids.org/hivaidinfo/statistics/fact_sheets/all_countries_en.html#N). The methodology used in updating and compiling these country-specific estimates is summarised in the publication as follows: "In 2001 and during the first quarter of 2002, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates of people living with HIV/AIDS. These calculations are based on the previously published estimates for 1997 and 1999 and recent trends in HIV/

AIDS surveillance in various populations. A methodology developed in collaboration with an international group of experts was used to calculate the new estimates on prevalence and incidence of HIV and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV. Different approaches were used to estimate HIV prevalence in countries with low-level, concentrated or generalised epidemics. The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance and collect more information."

<sup>12</sup> Southern African Development Community *Health Annual Progress Report 2000-2001*.

<sup>13</sup> *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Ministry of Health of the Republic of Zambia. See par 1.2.3.

<sup>14</sup> *Ibid*, par 1.2.4.

Number of pregnant mothers who are HIV positive								
Country	HIV prevalence in antenatal clinics in urban areas (%)				HIV prevalence in antenatal clinics outside major urban areas (%)			
	Year	Median	Min	Max	Year	Median	Min	Max
Botswana	2001	44,9%	39,1%	55,8%	2001	34,8%	25,8%	50,9%
Malawi	2001	20,1%	18,6%	28,5%	2001	16,1%	4,5%	35,8%
Mozambique	2000	14,4%	13,0%	15,7%	2000	10,6%	4,0%	31,2%
Namibia	2000	29,6%	28,2%	31,0%	2000	17,3%	6,6%	32,5%
South Africa	2000	24,3%	8,7%	36,2%	2000	22,9%	11,2%	29,7%
Swaziland	2000	32,3%	32,3%	32,3%	2000	34,5%	27,0%	41,0%
Zambia	2001	30,7%	30,7%	30,7%	1998	13,0%	5,2%	31,0%
<b>Zimbabwe</b>	<b>2000</b>	<b>31,1%</b>	<b>30,0%</b>	<b>33,5%</b>	<b>2000</b>	<b>33,2%</b>	<b>13,0%</b>	<b>70,7%</b>

According to the 2002 Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, the highest prevalence of HIV infection was recorded amongst women aged 25-29 years.

## 2.4 AIDS deaths in adults and children in 2001

Botswana	26 000	South Africa	360 000
Malawi	80 000	Swaziland	12 000
Mozambique	60 000	Zambia	120 000
Namibia	13 000	<b>Zimbabwe</b>	<b>200 000</b>

## 2.5 Number of HIV/AIDS orphans (up to 14 years) by end of 2001

Botswana	69 000	South Africa	660 000
Malawi	470 000	Swaziland	35 000
Mozambique	420 000	Zambia	570 000
Namibia	47 000	<b>Zimbabwe</b>	<b>780 000</b>

### 3. OVERVIEW OF APPLICABLE INTERNATIONAL, REGIONAL AND SADC LEGAL NORMS

This section examines the international, regional and SADC framework for the protection of human rights, as it relates to HIV/AIDS, to form the backdrop against which the national framework of Zimbabwe should be considered. The international and regional human rights treaties examined do not include any HIV/AIDS-specific provisions. Nevertheless, a number of articles can be highlighted in the various treaties as they indirectly impact on people living with HIV/AIDS or their families. For instance, the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* affirms that state parties to the *Covenant* should recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<sup>15</sup> The *Covenant* then continues that state parties, in order to achieve this right, should prevent, treat and control epidemic, endemic, occupational and other diseases.<sup>16</sup> These provisions would clearly apply to HIV/AIDS.

This section also briefly summarises the state reports submitted by Zimbabwe in terms of its obligations under the various treaties that it has ratified, with a specific focus on HIV/AIDS reporting and recommendations made by the treaty monitoring bodies in relation to HIV/AIDS.<sup>17</sup>

Finally, SADC and Organisation of African Unity (OAU)/African Union (AU) HIV/AIDS instruments and policies are discussed, followed by a short discussion on *HIV/AIDS and Human Rights – International Guidelines*, issued by UNAIDS and the Office of the United Nations High Commissioner for Human Rights.

<sup>15</sup> Article 12(1) of the *ICESCR*.

<sup>16</sup> Article 12(2)(c).

<sup>17</sup> State reporting is a useful tool to monitor a state party's progress in implementing the various provisions of a treaty. Usually, states submit a report shortly after ratifying a treaty (initial report) and thereafter the state must report to the monitoring body every two

#### 3.1 Applicable international legal norms

There are no HIV/AIDS-specific treaties within the international legal framework. The *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* both came into force in 1976, about four years before the first HIV/AIDS case was documented. Nevertheless, specific provisions of these treaties may be applied to various legal situations affecting people living with or affected by HIV/AIDS. The *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* is similar, having been adopted in the early days of the epidemic. The *Convention on the Rights of the Child (CRC)*, however, was adopted in 1989, nearly ten years after the first reported case of HIV/AIDS. The fact that in the CRC no mention is made of HIV/AIDS with respect to children can be viewed as a missed opportunity to develop policy for this vulnerable group.

The status of these treaties is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):<sup>18</sup>

Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
Botswana	08/01/2000			12/09/1996		13/04/1995
Malawi	22/03/1994	11/09/1996	22/03/1994	11/04/1987	7/09/2000 <sup>s</sup>	01/02/1991
Mozambique	21/10/1993			16/05/1997		26/05/1994
Namibia	28/02/1995	28/02/1995	28/02/1995	23/12/1992	22/12/2000	30/10/1990

years. Unfortunately, most African states are behind in submitting reports internationally and regionally.

<sup>18</sup> Status of ratification of international human rights treaties as of 02 November 2003 provided by the Office of the United Nations High Commissioner for Human Rights. Available at [www.unhcr.ch/pdf/report.pdf](http://www.unhcr.ch/pdf/report.pdf). Date accessed: 24 November 2003.

<sup>19</sup> Zimbabwe's report in terms of the ICESCR can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/E.1990.5.Add.28.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/E.1990.5.Add.28.En?Opendocument).



Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
South Africa	10/03/1999	28/11/2002	03/10/1994 <sup>a</sup>	14/01/1996		16/07/1995
Swaziland						06/10/1995
Zambia	10/07/1984	10/07/1984	10/07/1984	21/07/1985		05/01/1992
<b>Zimbabwe</b>	<b>13/08/1991</b>		<b>13/08/1991</b>	<b>12/06/1991</b>		<b>11/10/1990</b>

States parties submit reports to the various treaty monitoring bodies that are established in terms of the treaties. These reports may include details of measures taken by the state to address the issue of HIV/AIDS, but it is not compulsory to report in this form. Treaty bodies in turn examine the state reports and issue Concluding Observations.

In general, international treaties do not have a direct impact on the domestic legal systems of specific countries. These treaties can – and should – guide legislators to draft national laws to fulfil their obligations and to incorporate the treaty rights into domestic legislation. However, it will become clear in Section Four that this has seldom been the case.

Various provisions in the selected treaties that are particularly relevant for HIV/AIDS are described below.

### ***International Covenant on Civil and Political Rights (ICCPR)***

- *Article 2:*
  - (1) Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
  - (3) Each State Party to the present Covenant undertakes:
    - (a) To ensure that any person whose rights or freedoms as herein recognised are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
    - (b) To ensure that any person claiming such a remedy shall have his right thereto determined

by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

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

- *Article 6:* (1) Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.
- *Article 7:* No one shall be subjected to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
- *Article 17:*
  - (1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
  - (2) Everyone has the right to protection of the law against such interference or attacks.
- *Article 19:* (2) Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally in writing or in print, in the form of art, or through any other media of his choice.
- *Article 22:* Everyone shall have the right to freedom of association with others ...
- *Article 24:* (1) Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.
- *Article 26:* All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

### ***First Optional Protocol to the International Covenant on Civil and Political Rights***

- *Article 1:* A State Party to the Covenant that becomes a Party to the present Protocol recognises the competence of the Committee to receive and consider communications from individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of any of the rights set forth in the Covenant. No communication shall be received

by the Committee if it concerns a State Party to the Covenant which is not a party to the present Protocol.

### ***International Covenant on Economic, Social and Cultural Rights (ICESCR)***

- *Article 2:*  
 (1) Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.  
 (2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- *Article 6:* (1) The States Parties to the present Covenant recognise the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
- *Article 7:* The States Parties to the present Covenant recognise the right of everyone to the enjoyment of just and favourable conditions of work which ensure in particular: ... (b) Safe and healthy working conditions; (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence ...
- *Article 9:* The States Parties to the present Covenant recognise the right of everyone to social security, including social insurance.
- *Article 10:* The States Parties to the present Covenant recognise that: ... (3) Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.
- *Article 11:* (1) The States Parties to the present Covenant recognise the right of everyone to

an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions ...

- *Article 12:*  
 (1) The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.  
 (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
- *Article 13:* (1) The States Parties to the present Covenant recognise the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms ...
- *Article 15:* (1) The States Parties to the present Covenant recognise the right of everyone: ... (b) To enjoy the benefits of scientific progress and its applications ...

### ***Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)***

- *Article 1:* For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.
- *Article 2:* States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:  
 (a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law

- and other appropriate means, the practical realisation of this principle;
- (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
  - (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
  - (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
  - (e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;
  - (f) To take all appropriate measures, including legislation, to modify or abolish existing law, regulations, customs and practices which constitute discrimination against women;
  - (g) To repeal all national penal provisions which constitute discrimination against women.
- *Article 10:* States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: ... (f) The reduction of female student drop-out rates and the organisation of programmes for girls and women who have left school prematurely; (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.
  - *Article 11:* (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: (a) The right to work as an inalienable right of all human beings; ... (e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave; (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
  - *Article 12:*
    - (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
    - (2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-

natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

- *Article 14:* (2) States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: ... (b) To have access to adequate health care facilities, including information, counselling and services in family planning; (c) To benefit directly from social security programmes; (d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency; ... (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

#### ***Optional Protocol to the Convention on the Elimination of Discrimination against Women***

- *Article 1:* A State Party to the present Protocol (“State Party”) recognises the competence of the Committee on the Elimination of Discrimination against Women (“the Committee”) to receive and consider communications submitted in accordance with Article 2.
- *Article 2:* Communications may be submitted by or on behalf of individuals or groups of individuals, under the jurisdiction of a State Party, claiming to be victims of a violation of any of the rights set forth in the Convention by that State Party ...

#### ***Convention on the Rights of the Child (CRC)***

- *Article 1:* For the purposes of the present Convention, a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.
- *Article 2:*
  - (1) States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
  - (2) States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, ex-

pressed opinions, or beliefs of the child's parents, legal guardians or family members.

- *Article 3:* (1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
- *Article 6:*
  - (1) States Parties recognise that every child has the inherent right to life.
  - (2) States Parties shall ensure to the maximum extent possible the survival and development of the child.
- *Article 13:* (1) The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
- *Article 15:* (1) States Parties recognise the rights of the child to freedom of association and to freedom of peaceful assembly.
- *Article 16:*
  - (1) No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
  - (2) The child has the right to the protection of the law against such interference or attacks.
- *Article 17:* States Parties recognise the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health ...
- *Article 24:*
  - (1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State 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: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the frame-

work of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (f) To develop preventive health care, guidance for parents and family planning education and services.

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

- *Article 26:* (1) States Parties shall recognise for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.
- *Article 27:* (1) States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
- *Article 28:* (1) States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all; (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need; (c) Make higher education accessible to all on the basis of capacity by every appropriate means; (d) Make educational and vocational information and guidance available and accessible to all children; (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
- *Article 33:* States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances ...
- *Article 34:* States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: (a) The inducement or coercion of a child to engage in any unlawful sexual activity; (b) The exploitative use of children in prostitution or other unlawful sexual practices; (c) The exploitative use of children in pornographic performances and materials.
- *Article 36:* States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

## 3.2 State reporting

Under all treaties, States must report periodically to the Committee established under the treaty.

The Committee on Economic, Social and Cultural Rights, established under the *ICESCR*, considered the initial report of Zimbabwe (E/1990/5/Add.28) in May 1997.<sup>19</sup> Zimbabwe referred to the HIV/AIDS epidemic as follows:

1. The situation of orphans has been aggravated by the AIDS epidemic and although traditionally orphans have been absorbed into the extended family, the present scenario is of more orphaned children in need of care in institutions.<sup>20</sup>
2. The *Children's Protection and Adoption Act* provides for the protection, welfare, interests and supervision of children and juveniles. The Act is meant to cater for the plight of children with HIV/AIDS, etc.<sup>21</sup>
3. Traditional healers have been taught about the dangers of spreading diseases such as AIDS through the use of unsterilised razor blades.<sup>22</sup>
4. An AIDS Prevention and Control Programme has been established to combat the spread of HIV/AIDS.<sup>23</sup>
5. As part of the measures taken by the government to reduce the stillbirth rate and infant mortality, and to provide for the healthy development of the child, the report noted treatment and health education to prevent the spread of sexually transmitted diseases, including AIDS.<sup>24</sup>

The Committee on Economic, Social and Cultural Rights did not make any reference to HIV/AIDS in its Concluding Observations for Zimbabwe (E/C.12/1/Add.12).<sup>25</sup>

Zimbabwe's initial report submitted to the Human Rights Committee in accordance with the *ICCPR* in March 1998 (CCPR/C/74/Add.3),<sup>26</sup> includes the following reference to the HIV/AIDS epidemic:

1. The capacity of the available children's homes is failing to meet the demand. The problem of orphans has been aggravated by the AIDS epidemic. Government has reacted to the situation by establishing a National Committee composed of government officials and NGO representatives. The Committee, which is chaired by the Department of Social Welfare, has been tasked to come up with an orphan care policy broadly representing the interests of orphan children.<sup>27</sup>

The Human Rights Committee noted the following in regard to the HIV/AIDS epidemic in Zimbabwe in its Concluding Observations (CCPR/C/79/Add.89):<sup>28</sup>

1. The Committee commended the provision of statistics on AIDS and the efforts undertaken to incorporate HIV/AIDS awareness campaigns in the school curricula.<sup>29</sup>
2. The Committee noted its concern about continued practices, in violation of various provisions of the *Covenant* such as *kuzvarita* (pledging of girls for economic gain), female genital mutilation, and early marriage. The Committee recommended that these and other practices that are incompatible with the *Covenant* be prohibited by legislation.<sup>30</sup>

The Committee on the Rights of the Child considered the initial report of Zimbabwe (CRC/C/3/Add.35) in May 1996.<sup>31</sup> The report referred to the HIV/AIDS epidemic as follows:

1. A National AIDS Control Programme was established.
2. The report indicated the number of AIDS cases reported in various age groups as compiled by the National Public Health Laboratory covering the period from 1989 to 1992. Whilst

<sup>20</sup> Par 78, page 13.

<sup>21</sup> Par 110(iv), page 18.

<sup>22</sup> Par 148, page 23.

<sup>23</sup> Par 155, page 24.

<sup>24</sup> Par 180, page 27.

<sup>25</sup> Concluding observations of the Committee on Economic, Social and Cultural Rights can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/E.C.12.1.Add.12.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.12.En?Opendocument).

<sup>26</sup> Zimbabwe's initial report under the *ICCPR* can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CCPR.C.74.Add.3.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CCPR.C.74.Add.3.En?Opendocument).

<sup>27</sup> Par 227, page 38.

<sup>28</sup> The concluding observations of the Human Rights Committee can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CCPR.C.79.Add.89.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CCPR.C.79.Add.89.En?Opendocument).

<sup>29</sup> Par 7, page 2.

<sup>30</sup> Par 12, page 3.

<sup>31</sup> The initial report of Zimbabwe submitted in accordance with the CRC can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CRC.C.3.Add.35.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CRC.C.3.Add.35.En?Opendocument).

the figures for 1992 by gender were similar amongst the under 5 year olds and the 5-14 year olds, dramatic changes were apparent amongst the 15-19 year age group, with girls accounting for 150 out of a total of 182 cases.<sup>32</sup>

3. The advent of AIDS and the economic situation were cited as contributing factors to barriers in the smooth implementation of health programmes in the country. As a result, the rate of decline of infant and child mortality fell.<sup>33</sup>
4. In Zimbabwe, major emphasis is placed on the maternal and child health component in the health care delivery system. The AIDS education programme supports this component.<sup>34</sup>
5. The National AIDS Coordination Programme (NACP) is tasked with the responsibility to plan, coordinate and monitor AIDS prevention activities and to provide technical support to NGOs, government departments and the private sector in the area of AIDS prevention. The aim of the STD/HIV/AIDS education programmes is to develop the knowledge and skills needed for healthy human relationships, effective communication, responsible decision-making and behaviour in youth to minimise their vulnerability to such infections.<sup>35</sup>
6. The Ministry of Health and Child Welfare, in conjunction with AIDS service organisations, conducts AIDS prevention activities for youth both in and out of school.<sup>36</sup>
7. Production of materials on HIV/AIDS for primary and secondary school pupils and teachers began in 1988. In 1989, training of personnel in the Ministry of Education and Culture was initiated. An interdenominational group has been formed to work with the Ministry of Health and Child Welfare on the development of relevant books on life skills education for schools. Constraints include lack of policy on STI/HIV/AIDS education for youth and inadequate training for focal persons in NGOs and government ministries.<sup>37</sup>
8. The future direction of NACP includes the development of policies and supporting legislation, efforts to integrate HIV/AIDS/STI education interventions into ongoing youth programmes, and training personal to deal with youth in HIV/AIDS education and adolescent health.<sup>38</sup>
9. Tuberculosis amongst children is on the rise mainly because of the HIV epidemic.<sup>39</sup>

32 Par 121, page 21.

33 Par 125(a), page 24.

34 Par 146, page 28.

35 Par 154, page 30.

36 Par 155, page 30.

37 Par 156 page 30.

38 Par 157 page 30.

39 Par 159(e) page 31.

The Committee on the Rights of the Child adopted Concluding Observations (CRC/C/15/Add.55) on 7 June 1996.<sup>40</sup> The following references were made with respect to the HIV/AIDS epidemic:

1. The Committee welcomed the intention of the government to incorporate the Convention into the school curricula. It further welcomed the attention paid by the government to “Let’s talk about it,” the campaign against AIDS in the educational system.<sup>41</sup>
2. The Committee noted its concern at the number of orphans and abandoned children as well as at the increase in child-headed families, as a result of the high incidence of AIDS. It further mentioned the inadequate measures taken to ensure the realisation of the fundamental rights of orphans and the lack of alternatives to their institutionalisation.<sup>42</sup>

The Committee on the Elimination of Discrimination against Women considered the initial report (CEDAW/C/ZWE/1) of Zimbabwe in January 1998 and adopted Concluding Observations in May 1998 (A/53/38,paras.120-166).<sup>43</sup> The Committee made the following observations with regard to HIV/AIDS:

1. The Committee noted its deep concern about the effect of the HIV/AIDS pandemic and the very high rate of infection amongst young women, who comprise 84% of those infected in the 15-19 year age group and 55% of the 20-29 year age group. The Committee noted that this was of particular concern given the risks of transmission to infants through childbirth and breastfeeding.<sup>44</sup>
2. The Committee urged the government to increase its efforts to combat the HIV/AIDS pandemic and to ensure that appropriate sexual and reproductive health information, education and services are provided to all women and, in particular, to adolescents.<sup>45</sup>

40 The Concluding Observations of the Committee on the Rights of the Child can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CRC.C.15.Add.55.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CRC.C.15.Add.55.En?Opendocument).

41 Par 8 page 2.

42 Par 17 page 3.

43 The Concluding Observations of the Committee on the Elimination of Discrimination against Women can be accessed at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/A.53.38,paras.120-166.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/A.53.38,paras.120-166.En?Opendocument).

44 Par 147 page 3.

45 Par 160 page 4.

### 3.3 Applicable regional legal norms

The *African Charter on Human and Peoples' Rights (ACHPR)* was adopted in 1981 but makes no specific reference to HIV/AIDS. The *African Charter on the Rights and Welfare of the Child (ACRWC)* was adopted nearly ten years later, in 1990, but still does not include any reference to HIV/AIDS. It is only within the *Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child* that mention is made of HIV/AIDS. The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, which has been adopted but is not yet in force, mentions HIV/AIDS in a cursory manner.<sup>46</sup> This is very unfortunate, given the impact of HIV/AIDS on African women.

The status of these treaties in respect of the states under discussion is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):<sup>47</sup>

Country	ACHPR	ACRWC
Botswana	17 July 1986	
Malawi	17 November 1989	16 September 1999
Mozambique	22 February 1989	15 July 1998
Namibia	30 July 1992	13 July 1999 <sup>s</sup>
South Africa	09 July 1996	07 January 2000
Swaziland	15 September 1995	29 June 1992 <sup>s</sup>
Zambia	19 January 1984	28 February 1992 <sup>s</sup>
<b>Zimbabwe</b>	<b>30 May 1986</b>	<b>19 January 1995</b>

Excerpts from various provisions in the regional treaties that are particularly relevant for HIV/AIDS are listed below.

#### *African Charter on Human and Peoples' Rights (ACHPR)*

- *Article 2:* Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.
- *Article 5:* Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status ...
- *Article 6:* Every person shall have the right to liberty and to the security of his person ...
- *Article 9:*
  - (1) Every individual shall have the right to receive information.
  - (2) Every individual shall have the right to express and disseminate his opinions within the law.
- *Article 10:* (1) Every individual shall have the right to free association, provided that he abides by the law.
- *Article 11:* Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law, in particular those enacted in the interest of national security, the safety, health, ethics, and rights and freedoms of others.
- *Article 12:* (1) Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
- *Article 15:* Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.
- *Article 16:*
  - (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
  - (2) States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
- *Article 17:*
  - (1) Every individual shall have the right to education.

<sup>47</sup> Article 14(1) states that: "States Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes:... (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS ..."

<sup>46</sup> Status of ratification and signature of the *ACHPR* and *ACRWC* compiled by the University of Minnesota, Human Rights Library as of 1 January 2000. Available at [www1.umn.edu/humanrts/instree/afchildratifications.html](http://www1.umn.edu/humanrts/instree/afchildratifications.html) and [www1.umn.edu/humanrts/instree/ratzlafchr.htm](http://www1.umn.edu/humanrts/instree/ratzlafchr.htm). Accessed: 13 September 2002.

(2) Every individual may freely take part in the cultural life of his community.

(3) The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State.

• *Article 18:*

(1) The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and morals.

(2) The State shall have the duty to assist the family which is the custodian of morals and traditional values recognised by the community.

(3) The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

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

• *Article 19:* All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.

• *Article 24:* All peoples shall have the right to a general satisfactory environment favourable to their development.

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

• *Article 3:* Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.

• *Article 4:* (1) In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.

• *Article 5:* (1) Every child has an inherent right to life. This right shall be protected by law.

• *Article 8:* Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.

• *Article 10:* No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against

such interference or attacks.

• *Article 11:*

(1) Every child shall have the right to an education.

(2) The education of the child shall be directed to: ... (h) the promotion of the child's understanding of primary health care.

(3) States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular: ... (e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.

• *Article 14:*

(1) Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.

(2) State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventative health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans ...

• *Article 21:* (1) States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.

• *Article 24:* State Parties which recognise the system of adoption shall ensure that the best interest of the child shall be the paramount consideration ...

• *Article 25:* (2) State Parties to the present Charter: (a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include among others, foster



placement, or placement in suitable institutions for the care of children;

- *Article 27:* States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:
  - (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
  - (b) the use of children in prostitution or other sexual practices;
  - (c) the use of children in pornographic activities, performances and materials.
- *Article 28:* States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances ...

According to Article 43(1) of the ACRWC, state parties must undertake to submit to the African Committee of Experts of the Rights and Welfare of the Child, through the Chairperson of the Commission of the African Union, reports on the measures that have been adopted to give effect to the provisions of the ACRWC, and the progress made in the enjoyment of the rights guaranteed in the Charter. The *Guidelines* for reporting specify that the state parties should indicate what measures are in place for children in need of special protection, specifically in reference to AIDS orphans, in terms of Article 26 of the *Charter*.<sup>48</sup> States are also encouraged to provide specific statistical information and indicators relevant to children in need of special protection.<sup>49</sup> The first report under ACRWC is due within two years of the state's ratification of the *Charter*, and thereafter reports are due every third year. Unfortunately, not one of the eight countries in this study has submitted reports to date.

### 3.4 SADC framework for addressing HIV/AIDS

In September 1997, the SADC Council of Ministers adopted the first relevant document addressing HIV/AIDS-related issues, the *Code of HIV/AIDS and Employment in SADC*, as developed by the Employment and Labour Sector. The main objectives of the *Code* are to sensitise employers to the issue of employee rights and HIV/AIDS, and to provide a framework for states to con-

solidate national employment codes on HIV/AIDS-related issues. It addresses public sector employers, legislators, employees and trade unions.

In August 1999, the 14 member states adopted the *SADC Health Protocol*.<sup>50</sup> Article 10 specifically deals with HIV/AIDS and sexually transmitted diseases (STDs). The article urges states parties to harmonise policies and approaches for the prevention and management of HIV/AIDS and STDs, and to develop regional policies and plans that work towards an inter-sectoral approach to the epidemic.

In December 1999, the SADC HIV/AIDS Task Force adopted the vision document *A SADC Society with Reduced HIV/AIDS*. It was adopted to guide the work of the SADC in the development and implementation of a multi-sectoral *HIV/AIDS Framework for 2000-2004* (hereinafter referred to as the *Strategic Framework*). The *Strategic Framework* is in principle guided by Article 10 of the *SADC Health Protocol*; all SADC sectors agree to use their comparative advantages to address the needs of those sectors and the communities they serve, whether transport, mining, tourism, etc. One of the principles that has been acknowledged as important in the development of the *Strategic Framework* is the respect for the rights of individuals.<sup>51</sup>

The only sector in the *Strategic Framework* that specifically mentions stigmatisation and discrimination is the Human Resources Development. This sector aims to provide information to reduce stigma and to change attitudes by, amongst other initiatives, integrating HIV/AIDS education and life skills into school curricula across the region.<sup>52</sup>

In September 2000, the SADC Council of Ministers approved the *Health Sector Policy Framework Document*, as developed by the SADC Health Ministers.<sup>53</sup> A significant part of the programme focuses on HIV/AIDS and sexually transmitted diseases. One of the policy objectives in the programme, geared towards HIV/AIDS control, is to protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS.

<sup>48</sup> Par 21(g) of the (Adopted) *Guidelines for Initial Reports of State Parties* under the ACRWC.

<sup>49</sup> Par 22.

<sup>50</sup> *SADC Health Protocol*. Available at: <http://196.36.153.56/doh/department/sadc/docs/protocol99.html>.

<sup>51</sup> *Managing the impact of HIV/AIDS in SADC*, August 2000, at page 8. Available at: <http://196/36/153/56/doh/department/sadc/docs>.

<sup>52</sup> *Ibid*, at p 28.

<sup>53</sup> Available at: <http://196.36.153.56/doh/department/sadc/docs/framework/html>.

A month prior to the adoption of the *Health Sector Policy Framework*, the SADC Health Ministers adopted *Principles to Guide Negotiations with Pharmaceutical Companies on Provision of Drugs for Treatment of HIV/AIDS-Related Conditions in SADC Countries*.<sup>54</sup> These principles focus on enabling SADC countries to make informed decisions in their negotiations with pharmaceutical companies and to consider factors such as sustainability, affordability, accessibility, appropriateness, acceptability and equity before accepting offers for free drugs or reduced prices on HIV/AIDS-related drugs.

In July 2003, the SADC Heads of Government signed the *SADC Declaration on HIV/AIDS*.<sup>55</sup> The *Declaration* affirms the commitment to address the pandemic and the issues relating to HIV/AIDS in the SADC region through multi-sectoral intervention. A new *SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007* was also issued.

### 3.5 Relevant OAU/AU resolutions on HIV/AIDS

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

In June 1994, the *Tunis Declaration on AIDS and the Child in Africa* was adopted by the OAU at the Assembly of Heads of State and Government in Tunis, Tunisia.<sup>56</sup> The *Declaration* declares a commitment to: "Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues."<sup>57</sup>

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a *Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa* was adopted by the Assembly.<sup>58</sup> The *Resolution* urged African leaders to

implement those declarations and resolutions that had been adopted in the past, specifically referring to the *Tunis Declaration*.

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*, and the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, aimed at implementation of the principles set forth in the *Abuja Declaration*.<sup>59</sup>

In the *Abuja Declaration*, the Heads of State acknowledged that "stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it."<sup>60</sup> The *Abuja Framework* conceptualises the commitments made in the *Abuja Declaration* into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas, and the following strategies are identified:

- develop a multi-sectoral national programme for awareness of and sensitivity to the negative impact of the pandemic on people, especially vulnerable groups;
- enact relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB;
- strengthen existing legislation to: (a) address human rights violations and gender inequities, and (b) respect and protect the rights of infected and affected people;
- harmonise approaches to human rights between nations for the whole continent; and
- assist women in taking appropriate decisions to protect themselves against HIV infection.

54 Available at: [http://196.36.153.56/doh/department/sadc/docs/negotiate\\_principles.html](http://196.36.153.56/doh/department/sadc/docs/negotiate_principles.html).

55 Available at: [http://www.sadc.int/index.php?lang=english&pth=legal/declarations/&page=declaration\\_on\\_HIV\\_AIDS](http://www.sadc.int/index.php?lang=english&pth=legal/declarations/&page=declaration_on_HIV_AIDS).

56 AHG/Decl I (XXX) 1994.

57 Par 2(1).

58 AHG/Res 247 (XXXII) 1996. Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.html>.

59 Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm>.

60 Par 12.

### 3.6 International guidelines on HIV/AIDS and human rights

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted *HIV/AIDS and Human Rights – International Guidelines*. The *Guidelines* focus on three crucial areas: “(1) improvement of governmental capacity for acknowledging the government’s responsibility for multi-sectoral co-ordination and accountability; (2) widespread reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and (3) support for increased private sector and community participation in the response to HIV/AIDS, including building the capacity and responsibility of civil society to respond ethically and effectively.”<sup>61</sup>

The *Guidelines* deal with the following human rights principles:

- *Guideline 1*: Encourage states to adopt a multi-sectoral approach through an effective national framework.
- *Guideline 2*: Enable community organisations to carry out activities in the field of ethics, human rights and law. Consult widely with such organisations in drafting all HIV policies.
- *Guideline 3*: Review and reform public health laws to adequately address HIV/AIDS.
- *Guideline 4*: Review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and address HIV/AIDS without targeting vulnerable groups.
- *Guideline 5*: Enact or strengthen anti-discrimination laws to protect vulnerable groups. Ensure privacy, confidentiality and ethics in research involving human subjects.
- *Revised Guideline 6*: Enact legislation to provide for the regulation of HIV-related goods, services and information in order to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. Ensure that all persons on a sustained and equal basis have access to quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for the treatment of HIV/AIDS and related opportunistic infections.<sup>62</sup>
- *Guideline 7*: Implement and support legal support services to educate people affected by HIV/AIDS about their rights, develop expertise on HIV-related legal issues and use means other than courts such as human rights commissions to protect the rights of people affected by HIV/AIDS.
- *Guideline 8*: States, together with communities, should promote an enabling and prejudice-free environment for women, children and other vulnerable groups.
- *Guideline 9*: Promote the distribution of creative education, training and media programmes designed to change attitudes of discrimination and stigmatisation around HIV/AIDS.
- *Guideline 10*: Translate human rights principles into codes of conduct with accompanying mechanisms to implement and enforce these codes.
- *Guideline 11*: States should ensure monitoring and enforcement mechanisms to guarantee and protect HIV-related human rights.
- *Guideline 12*: States should share experiences concerning HIV-related human rights issues at an international level and through UN agencies such as UNAIDS.

61 See Foreword in the *Guidelines*.

62 Guideline 6 was revised in 2002 and is available at: <http://www.unhchr.ch/hiv/g6.pdf>.

## 4. LEGAL FRAMEWORK FOR THE PROTECTION OF HIV/AIDS AND HUMAN RIGHTS IN ZIMBABWE

### 4.1 National legal system: General background

#### 4.1.1 The form of government and the domestic legal system within the country

Zimbabwe attained its independence from British colonial rule in 1980. It has a negotiated constitution also known as the *Lancaster House Constitution*. The *Constitution* is modelled along the lines of the Westminster model, with a Bill of Rights and freedoms such as the right to life, freedom of association and freedom of the press.

The system of governance comprises three administrative bodies. These are the Parliament, which is the supreme law-making body, the Executive and the Judiciary. The head of state is the President who has executive powers. The Parliament is unicameral. The appointment of the President and the members of Parliament (MPs) is through periodic elections where registered voters cast their votes. Of the 150 members of Parliament, 120 members are elected through elections, the President selects 12 members as non-constituent members, 8 are provincial governors, and 10 are chiefs elected from the Chiefs' Council.

Zimbabwe's legal system is characterised by the Roman-Dutch legal system, which is heavily influenced by English Common Law and Customary Law. Section 89 of the *Constitution of Zimbabwe* provides for the reception of Roman Dutch Law, English Common Law and Customary Law. Customary law is protected by Section 23 (2)(b) of the *Constitution* and includes all the family laws of the country, such as the laws governing inheritance, adoption, marriage and guardianship.

#### 4.1.2 Human rights provisions within the National HIV/AIDS Strategic Framework and the National HIV/AIDS Policy

In 1986, an AIDS Advisory Committee was established which was transformed in later years into the Zimbabwe AIDS Health Expert Committee. Between 1987 and 1988 a one-year emergency *Short Term Plan (STP)* aimed at creating public awareness about HIV/AIDS and training health personnel in different aspects of HIV/AIDS prevention and control was implemented. The *STP* was followed by a *Medium Term Plan (MTP 1)* from 1988 to 1993, which focused on consolidating the interventions initiated during *STP*, motivating appropriate behaviour change amongst specific population groups, counselling and caring for people with HIV/AIDS, and monitoring the epidemic through epidemiological surveillance.

The need to mobilise other sectors to actively participate in the fight against HIV/AIDS contributed to a multi-sectoral approach to challenge the pandemic. This resulted in the development of a multi-sectoral *Second Medium Term Plan (MTP 2)* from 1994 to 1998. The main objectives of *MTP 2* were to reduce:

- the transmission of HIV and other sexually transmitted diseases (STIs);
- the personal and social impact of HIV/AIDS/STIs; and
- the socio-economic consequences of the epidemic.

*MTP 2* identified the need for the development of a national HIV/AIDS policy and a unit was established within the National AIDS Co-ordinating Programme (NACP) to facilitate the process.

The *National HIV/AIDS Policy* was introduced in 1999. It acknowledged that HIV/AIDS should be addressed through a multi-sectoral approach to be co-ordinated by the National AIDS

Council. The *National HIV/AIDS Policy* urged all sectors to participate in the fight against AIDS utilising their comparative advantages. The *Zimbabwean National HIV/AIDS Policy* is guided amongst other principles by respect for human rights and the dignity of all people irrespective of their HIV status.<sup>63</sup> Chapter 3 is entitled “General Human Rights” whilst Chapter 6 lists specific “Human Rights” including rights regarding prisoners, discrimination, mandatory testing, commercial sex work, etc.

Guiding Principle 2 of the *National HIV/AIDS Policy* reaffirms the importance of respecting human rights and the dignity of persons affected and infected with HIV/AIDS and avoidance of discrimination and stigmatisation of PLWHAs. Guiding Principle 2 reads as follows: “The human rights and dignity of people living with HIV/AIDS should be promoted and protected. Discrimination and stigmatisation should be avoided as far as is consistent with the rights of society and those who are uninfected.”<sup>64</sup> Zimbabwe enacted the *National AIDS Council of Zimbabwe Act No. 16 of 1999*, which provides for a broadly representative National AIDS Council (NAC). The NAC has four strategic areas: care, prevention, mitigation and support.

A *National AIDS Strategic Framework* was introduced in November 1999 for the period 2000-2004.<sup>65</sup> Amongst the strategies to promote mitigation by caring and supporting the affected, the Strategic Framework identifies the following key objectives that relate to human rights:<sup>66</sup>

- reducing the stigma associated with HIV/AIDS;
- promoting policies and legislation which safeguard the rights of those affected by HIV. A key area is the assurance of equity in service programming delivery and utilisation; and
- ensuring gender sensitivity in policies and plans and programmes.

#### 4.1.3 Domestication of international and regional human rights treaties

The domestication of international law is based on a dualist or transformation approach. The incorporation of international obligations is in terms of Section IIIB of the *Constitution*. It provides the following: “Except as otherwise provided by this *Constitution* or by or under an Act of

Parliament, any convention, treaty or agreement acceded to, concluded or executed by or under the authority of the President with one or more foreign states or governments or international organisations:

- (a) shall be subject to approval by Parliament; and
- (b) shall not form part of the law of Zimbabwe unless it has been incorporated into the law by or under an Act of Parliament.”

This provision allows for a three-pronged approach to the domestication of legislation. The process starts with the executive signing the convention or treaty. Parliament is then mandated with ratification, after which the line ministry prepares the legislative measures to be put in place to give effect to the convention’s provisions.

The government of Zimbabwe has established an Inter-ministerial Committee on Human Rights and International Humanitarian Law, which comprises 12 government ministries.<sup>67</sup> The Committee is mandated with the co-ordination of government efforts on the enforcement of human rights issues, advising government on human rights issues and making recommendations to government on which conventions or treaties it should sign. It is also mandated with the compilation of reports for the United Nations in relation to the implementation of the articles of the various conventions and treaties to which it is party. The Committee has powers of recommendation and not of enforcement.

## 4.2 HIV/AIDS-specific regulations

### 4.2.1 Litigation on HIV/AIDS and human rights within domestic courts

There is no case law on HIV/AIDS in Zimbabwe.

<sup>63</sup> Page 2 of the National HIV/AIDS Policy, 1999.

<sup>64</sup> See page 38 of the Strategic Framework for a list of all guiding principles of the National HIV/AIDS Policy.

<sup>65</sup> Working Document for National AIDS Council Strategic Framework for a National Response to HIV/AIDS (2000-2004).

<sup>66</sup> See page 34 of the Strategic Framework.

<sup>67</sup> The following Ministries form part of the Committee: Ministry of Health and Child Welfare; Ministry of Foreign Affairs; Ministry of Public Service, Labour and Social Welfare; Ministry of Education and Culture; Ministry of Higher Education; Ministry of Youth Development, Gender and Employment Creation; The Ombudsman’s Office; The Attorney General’s Office; The President’s Office; The Ministry of Defence.

<sup>68</sup> Chapter 17:04.

#### 4.2.2 National legislation that addresses (directly or indirectly) issues in relation to HIV/AIDS

At present, HIV/AIDS legislation is limited to criminal and labour law. The following Acts legislate directly and indirectly on HIV/AIDS issues:

- *National AIDS Council of Zimbabwe Act No. 16 of 1999*
- *Sexual Offences Act No. 8 of 2001 [Chapter 9:21]*
- *Criminal Law and Evidence Amendment Act No. 8 of 1997*
- *Labour Relations Regulations on HIV/AIDS and Employment SI 202 of 1998*
- *Labour Relations Amendment Bill, 2001*
- *National Social Security Act [Chapter 17:04]*

#### 4.2.3 HIV/AIDS policies, guidelines and programmes

- *Zimbabwe National HIV/AIDS Policy, 1999*
- *National AIDS Strategic Framework 2000-2004*
- *The Orphan Care Policy*
- *Community Home Based Care Policy, July 2001*
- *National Gender Policy for the Republic of Zimbabwe, 2000*
- *The Patient's Charter (non-binding)*

The National AIDS Council (NAC) is primarily responsible for coordinating a multi-sectoral approach to HIV/AIDS. The NAC is an adjunct of the Ministry of Health and Child Welfare.

#### 4.2.4 Domestic incorporation of the International Guidelines on HIV/AIDS and Human Rights

Whilst it appears that the government is aware of the *International Guidelines*, there has been little or no implementation.

#### 4.2.5 HIV/AIDS within the government's social assistance plan

People living with HIV/AIDS qualify for social assistance through the *National Social Security Act*, Chapter 17:04. The Act provides for payment to all beneficiaries, including those who

suffer from HIV/AIDS and are unable to work. Employers contribute a certain percentage towards the National Social Security Authority on behalf of their employees. This is done in accordance with the provisions of the Act.<sup>68</sup>

### 4.3 Health sector

#### 4.3.1 HIV/AIDS and the right of access to health care

The *Constitution* does not guarantee the right to health but reference is made to health care. The provision of anti-retroviral drugs and the treatment of opportunistic infections are also referred to in both the *Strategic Framework* and the *National HIV/AIDS Policy*.

The *Working Document for National AIDS Council Strategic Framework for a National Response to HIV/AIDS (2000-2004)* identifies the following activities of the health sector as a response to the HIV/AIDS epidemic:<sup>69</sup>

- STI management protocols and flowcharts have been produced and are updated every 2-3 years.
- Improved promotion, distribution and education on condoms has increased condom uptake significantly.
- Activities by the National Blood Transfusion Service have gone a long way to achieving the objective of providing safe blood for transfusion.
- HIV/AIDS activities have been integrated into reproductive health projects.
- New policies have been developed to give guidance to activities such as guidelines on infant feeding as it relates to HIV/AIDS.

In July 2001, the Ministry of Health and Child Welfare issued the *Zimbabwe Community Home Based Care Policy*. Guiding Principle 5 recognises that particular attention must be paid to ethical issues, specifically confidentiality, allocation of resources, informed consent and safeguarding of human rights.

<sup>69</sup> Section 4.3, page 24 of the *Strategic Framework*.

<sup>70</sup> Page 39 of the *National HIV/AIDS Strategic Framework*.

### 4.3.2 HIV testing, notification and confidentiality

HIV/AIDS is not a notifiable disease in terms of the *Public Health Act*, Chapter 15:09. Nevertheless, Guiding Principle 24 of the *National HIV/AIDS Policy* advises that, where HIV/AIDS is deemed to be a public health concern, the Ministry of Health should be notified separately and confidentially by the practitioner in terms of the *Public Health Act*.<sup>70</sup>

The *National HIV/AIDS Policy* identifies strategies and guidelines for HIV testing. Guiding Principle 3 emphasises that confidentiality regarding a person's HIV status should be respected and that legal provisions should be enacted to enable health professionals to disclose a patient's HIV status if critical reasons for disclosure exist.<sup>71</sup> At the same time, Guiding Principle 23 encourages partner notification of HIV status for both men and women.

Guiding Principle 18 declares that: "access to information and counselling is necessary for informed consent to HIV testing and is ensured as a fundamental human right."<sup>72</sup> It further states that pre- and post-test counselling should be provided by people with the appropriate technical and professional ability. Guiding Principle 21 extends the 'testing' protection by stipulating that legalising mandatory testing is not recommended in any situation other than in the case of a person charged with any sexual offence where the risk of HIV transmission exists. Prompt testing of such an offender is recommended by the *National HIV/AIDS Policy* whilst the victim should be offered voluntary counselling and testing, and where appropriate, treatment at the expense of the state.<sup>73</sup>

### 4.3.3 Patients' rights

The *Patients' Charter* was developed under the auspices of the Consumer Council of Zimbabwe. The *Patient's Charter* has basic provisions to facilitate access to proper treatment and is based on general ethical and human rights principles, including non-discrimination in relation to the provision of health care to patients regardless of race, disability and gender. Some of the rights enshrined in the *Patients' Charter* are: the right to choice of care, the right to be consulted before actions are taken, informed consent to medical action, the right of access to

labelled drugs, the right to a healthy environment, the right to redress for grievances and the right to education.

### 4.3.4 Access to essential HIV/AIDS drugs

Zimbabwe has declared HIV/AIDS a national disaster through regulations enacted by the President using the power enshrined in the *Presidential Powers Temporary Regulations*. This declaration was meant to expedite access to HIV/AIDS drugs. It is however not clear whether the government proposed to procure the drugs for the National AIDS Council and distribute them to those who are infected, or to import drugs without being subjected to patent restrictions. At the end of 2002, the government announced that it would allocate 2,5 billion Zimbabwean dollars to the health sector for the procurement of anti-retrovirals.<sup>74</sup> It was also reported that there are over 35 mother-to-child transmission sites across the country administering Nevirapine.

### 4.3.5 Medical trials on human subjects

The *National HIV/AIDS Policy* recommends the following in terms of volunteers participating in HIV/AIDS clinical trials: "Ensure that all those involved in research strictly observe ethical standards with particular attention to issues of confidentiality, informed consent and the safeguarding of human rights."<sup>75</sup>

### 4.3.6 Condoms

Guiding Principle 9 of the *National HIV/AIDS Policy* recommends that condoms should be made available, accessible and affordable to all sexually active individuals.<sup>76</sup>

Female and male condoms are distributed by Population Services International (PSI) and the Zimbabwe National Family Planning Council respectively. Condom Social Marketing has been appointed to distribute condoms throughout the country. The National Social Marketing Programme (NASOMA) sells male and female condoms to pharmacies, petrol stations and traditional outlets such as bars and food shops at a reasonable price (the equivalent of R10.00 for a

71 Page 38.

72 Page 39.

73 Ibid.

74 State hailed for allocating billions to AIDS drugs published in the *Sunday Mail* 17 November 2002 page 1.

75 This forms part of the strategies set out under Guiding Principle 43 of the *National HIV/AIDS Policy*, page 35.

76 Page 9 of the *National HIV/AIDS Policy*.

77 See Sections 4 and 5 of the *Sexual Offences Act*.

packet of 6 condoms). Generally, condoms are available in hospitals, supermarkets, pubs and bars, but not accessible in hotels. Condoms are also sold at pharmacies and clinics but they are not sold to children. Government also distributes condoms through the National AIDS Co-ordination Programme (NACOP) to health services, government sectors, non-governmental organisations and private companies, and institutions of higher learning. Due to the unavailability of foreign currency, branded condoms are no longer locally available and accessible. The few that are available are unaffordable for many Zimbabweans. This situation has also adversely affected the quality control of condoms manufactured locally because there are no testing kits available. There are no laws dealing with the quality of condoms.

#### 4.3.7 HIV/AIDS and the mentally ill

The *National HIV/AIDS Policy* is silent on disability and therefore there are no projects on HIV/AIDS that include this sector. The National Association of Societies for the Care of the Handicapped (NASCOH), an umbrella body of 53 member organisations, carried out an audit of the *National HIV/AIDS Policy* and found that there was no provision for sexual education of the disabled and that the exclusion of this sector was a result of stereotypes and traditional notions.

The recent *Sexual Offences Act of 2001* criminalises extra-marital sexual intercourse or immoral or indecent acts committed with intellectually handicapped persons, as well as the sexual exploitation of intellectually handicapped persons outside Zimbabwe.<sup>77</sup>

## 4.4 Equality and non-discrimination

### 4.4.1 The Constitution and the right to equality and non-discrimination

The *Constitution* prohibits discrimination in Section 23 on the grounds of race, tribe, place of origin, political opinions, colour or creed. Labour legislation prohibits discrimination on the

grounds of HIV status in Zimbabwe. The *Statutory Instrument 202 of 1998* prohibits discrimination based on HIV/AIDS in the workplace.<sup>78</sup> A similar prohibition is found in Section 7 of the *Labour Relations Amendment Bill of 2001*. However, the *Labour Relations Act* addresses the issue of non-discrimination but does not include HIV status.<sup>79</sup>

### 4.4.2 Specialised legislation on equality and non-discrimination

The *National HIV/AIDS Policy* states as part of its general human rights strategies that legislation which protects individuals against human rights violations and discrimination in respect of HIV/AIDS should be promoted and enforced.<sup>80</sup> Currently, however, only labour legislation refers to HIV status as a ground for non-discrimination.

## 4.5 Labour rights

### 4.5.1 HIV/AIDS in the workplace

The *Constitution* protects employees against discriminatory practices in general. The *Labour Relations Act* expands this protection in labour and industrial relations in Zimbabwe. Part II guarantees the fundamental rights of employees such as protection of employees against discrimination and the protection of employees' rights against unfair labour standards. Unfair labour standards and incapacitation of workers due to illness or accidents are dealt within Parts III and IV of the *Labour Relations Act* respectively.

*Statutory Instrument 202 of 1998*<sup>81</sup> prohibits discrimination based on HIV/AIDS in the workplace and specifically aims to "ensure non-discrimination between individuals with HIV infection and those without and between those with HIV/AIDS and other comparable life-threatening medical conditions."<sup>82</sup> The Regulations were enacted under the *Labour Relations Act*<sup>83</sup> and therefore only cover workers in the private sector and parastatals; groups in other sectors such as civil servants and uniformed forces are not covered by the *Regulations*.<sup>84</sup> Section 4(1) and (2) of

78 *Labour Relations (HIV and AIDS) Regulations 1998*.

79 SI 202 of 1998.

80 See page 5 of the *National HIV/AIDS Policy*.

81 *Labour Relations (HIV and AIDS) Regulations 1998, SI 202 of 1998*.

82 See preamble to the *Regulations*.

83 Chapter 28:01 in Part II.

84 The preamble to the *Regulations* nevertheless states that although all Zimbabweans are not covered by the provisions of SI 202 of 1998, it should give an indication of the intention of the tripartite parties as to what should apply across all sectors of employment.

85 See page 32 of the *Strategic Framework*.



the *Regulations* state that pre-employment testing should not be undertaken except in circumstances where fitness for work is a precondition to the offer of employment. Section 5 states that: “no employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his employment, his HIV status.” Section 6 stresses that an employee may not be fired on grounds of HIV status alone. Similarly, such a person may not be prejudiced for purposes of promotion, transfer, etc. on the grounds of HIV status alone. The *HIV/AIDS Regulations* extend beyond addressing employed persons and include recruitment, education of employees, and leave conditions.

The public sector is regulated by the *Public Service Regulation SI 1 of 2000*. Section 38 relates to sick leave. Subsection 2 of this provision provides that: “[D]uring any one year period of service a member may be granted a maximum of ninety days’ sick leave on full pay and ninety days’ sick leave on half pay.” Sick leave is applicable in any calendar year. The provision is not cumulative; an employee who has been on sick leave can come to work for a day or two and this will result in a count beginning from zero days. This is a novel provision and is especially significant for employees who have HIV/AIDS, who are usually negatively impacted by stringent leave regulations.

Section 38(5) of the *Public Service Regulations* continues: “Sick leave on half pay which extends beyond the period of sick leave on full pay may only be granted by the head of department if recommended by a medical board appointed by the Secretary for Health, if in the opinion of the medical board it is probable that the member concerned will be able to resume duty after such further period of sick leave.” Subsection 6 further states that: “If a medical board has established that a member will be unable to resume duty because of illness or injury, the head of department shall take steps to have the member retired on the grounds of ill health.”

Finally, the *Strategic Framework* identifies the need to introduce a national code of practice on HIV/AIDS and employment at every workplace as one of its key strategies to promote prevention.<sup>85</sup>

Currently, the government is in the process of harmonising labour laws that will address informal and formal workers regardless of the sector, private or public. The *Labour Relations Amendment Bill of 2001* contains “HIV/AIDS status” as a ground of non-discrimination in Section 7. The effect of this amendment is to extend the range of prohibition against discrimination in employment by including the grounds of pregnancy, HIV/AIDS status and disability. The proposed amendment also replaces the term “sex” with “gender.” The amendment is very progressive in protecting infected and affected persons in the workplace.

#### 4.5.2 HIV/AIDS and medical schemes

The Premier Services Medical Aid, which falls under the National Association of Medical Aid Schemes (NAMAS), covers all civil servants. The government subsidises the premiums.

There are no specific measures in place to ensure that HIV-infected employees are not discriminated against through existing medical schemes. However, Section 7 of the *Labour Relations (HIV and AIDS) Regulations of 1998* deals generally with employee benefits and states as follows:

- HIV status will not affect an employee’s eligibility for any occupational or other benefit schemes provided for employees; and
- where the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV/AIDS test, the conditions attaching to HIV/AIDS shall be the same as those applicable to comparable life-threatening illnesses. Any such test must be accompanied by pre- and post-test counselling.

#### 4.5.3 Insurance and HIV/AIDS

There are no policies or regulations with respect to the granting of life insurance to people living with HIV and AIDS. The *National HIV/AIDS Policy* recommends the following with respect to the insurance industry:<sup>86</sup>

- assess the impact of the demand by the insurance industry for an HIV test before an insurance policy is adjudicated; and

<sup>85</sup> Page 20 of the *National HIV/AIDS Policy*.

<sup>86</sup> However, it appears that the ratio per applicant is not balanced and the quality of counselling may be affected.

- encourage the insurance industry to develop and apply policies that take into account the insurance needs of persons with HIV/AIDS.

Insurance companies have both compulsory and non-mandatory testing for HIV/AIDS for life insurance. For example, the First Mutual Life Assurance Society of Zimbabwe may require testing for coverage up to Z\$1 000 000 for private life insurance, and Z\$2 000 000 for group life insurance, which is for pension purposes. First Mutual has pre- and post-test counselling services provided by an in-house state-registered nurse (SRN).<sup>87</sup> The services of the SRN are supplemented by a “panel of medical examiners, pathologists and radiologists” that provide similar services, and are responsible for testing the blood samples.

The application form for life coverage states the following: “With each application for life assurance, the assessor must assess the ‘risk’ on the life to be assured. The occurrence of AIDS throughout the world in recent years introduced a new risk factor. If you agree to have a blood test, a sample of your blood will be taken at the public health laboratory by a doctor or medically trained person for analysis at the public health laboratory approved by the Ministry of Health. The result of the test will be given to the general practitioner nominated by the Life to be assured. The result will be disclosed to this doctor only. The result will not be disclosed personally to you by our medical officer. It is considered that your own doctor will be in a better position to discuss the result with you. This is in accordance with our normal practice with health reports. If you do not agree to have blood test, we will decline your application. If you are doubtful whether you should disclose any particular information, we urge you to disclose it. We require full disclosure.”

There are two additional forms that are sent to the applicant’s medical doctor, requesting “abstracts from clinical records” and “pathology request for HIV”. Other than life assurance, there are other policies with disclaimer clauses that require the insured to survive for at least two years before the company will pay out the benefits.

## 4.6 Gender rights

### 4.6.1 Legal status of women and the role of cultural practices

The *Constitution* guarantees women equal rights to men. Section 23 (3)(b) prohibits discrimination, but it nevertheless may allow discrimination in the private sphere, which covers family laws such as adoption, marriage and inheritance.<sup>88</sup>

In October 2000, the *National Gender Policy for the Republic of Zimbabwe* was issued with the aim of “providing guidelines, institutional framework, and parameters to ensure the availability of resources for the successful and sustainable implementation of the Zimbabwe Constitution and legislative requirements, regional and international conventions, protocols, declarations and agreements on gender equality, equity and non-discrimination.”<sup>89</sup> The Gender Policy recommends the following with respect to gender and HIV/AIDS:

- sensitising and creating awareness on gender and health issues, including HIV/AIDS;
- developing gender-sensitive multi-sectoral programmes for empowerment of women and girls and to enable men to assume their responsibilities in prevention of HIV/AIDS; and
- introducing measures to counter the exposure of girls to HIV/AIDS through traditional and religious beliefs and practices.<sup>90</sup>

Zimbabwean legislation does not state that cultural practices, such as *kuzvarira* (marrying off of young girls), *kuripira ngozi* (the payment of reparations or compensation by giving away the girl child to aggrieved claimants), inheritance of wives and estates, or virginity testing, are harmful practices that promote higher rates of infection or transmission. Whilst traditional leaders acknowledge the HIV/AIDS epidemic, they are reluctant to prohibit the cultural practice of wife inheritance. Culturally, women are not able to negotiate safer sex with their husbands or partners.

There have been a few legal judgments that deal with the status of women in Zimbabwe. In the case of *Magaya v Magaya*, the Court ruled that women are minors and cannot inherit

<sup>88</sup> This section reads as follows: “Nothing contained in any law shall be held to be in contravention of subsection (1) (a) to the extent that the law in question relates to any of the following matters: the application of African customary law in any case involving Africans or an African and one or more persons who are not Africans where such persons have consented to the application of African customary

law in that case.”

<sup>89</sup> Page 1 of the *Gender Policy*.

property from their fathers or husbands. This case was decided after Zimbabwe's accession and ratification of the *Convention on the Eradication of All Forms of Discrimination Against Women (CEDAW)* and the Beijing Platform for Action. In *Rattigan and Others v Chief Immigration Officer*,<sup>91</sup> the Court held that the immigration law discriminated against Zimbabwean women as the law allowed for foreign wives of Zimbabwean men automatic citizenship, but did not allow the same for non-Zimbabwean husbands. Following the Rattigan case and the *Ruwoto NO v Ministry of Home Affairs and Others*<sup>92</sup> decision, the government amended the *Constitution* (14<sup>th</sup> Amendment), adopting a gender-neutral approach for immigration purposes.

#### 4.6.2 Legislation and policies protecting women and the most vulnerable in society

There are several laws that are important for women and other vulnerable groups, including:

- the *Termination of Pregnancy Act*, which provides grounds for legal abortion. HIV/AIDS is not a listed ground. Women are not given a choice in terminating pregnancies on this ground;
- The *Public Health Act*, which deals with communicable diseases, but does not include HIV/AIDS. The medical status of a person cannot be disclosed without the patient's consent;
- The *Legal Age of Majority Act*; and
- The *Administration of Estates Amendment Act No. 6 of 1997*, which entitles widows to continue living at their husband's premises and to have access to the deceased husband's estate, without "inheriting." This law has been criticised by male traditional leaders as introducing foreign concepts into traditional inheritance practices since the law empowers the widow to administer the estate without the assistance of an executor, and entitles the widow and children to a share of deceased's estate.

The *Strategic Framework* recognises that government should change the underlying socio-cultural structures that perpetuate the vulnerability of women to HIV infection and transmission.<sup>93</sup>

90 See page 12 of the *Gender Policy*. In Section 6.2.3, the *Gender Policy* recommends the following strategies in an effort to guarantee human rights and democracy: 1) Lobbying for the promotion of equal and equitable participation of women and men in decision-making positions. 2) Legislate and enforce against discriminatory practices, beliefs and traditions that hinder the advancement of women and men, especially the girl child. 3) Incorporate provisions of international human rights instruments into domestic law.

91 [1994] I LRC 343.

92 [1994] I LRC 86.

93 See page 32 of the *Strategic Framework*.

The *National HIV/AIDS Policy* encourages wide debate on cultural issues that have a negative effect on the status of women, in an effort to eliminate such practices.<sup>94</sup> According to Guiding Principle 38, gender violence and sexual harassment are unacceptable and should be prohibited by law and through enforcing existing legislative measures.<sup>95</sup>

#### 4.6.3 Administering ARVs to rape survivors

There are presently no measures in place to ensure the administration of anti-retroviral drugs to women and girls who have been raped.

#### 4.6.4 Commercial sex workers

Part IV of the *Sexual Offences Act*,<sup>96</sup> deals with the suppression of prostitution. A prostitute is defined as: "A person who for money or reward –

- (a) Habitually allows other persons to have extra-marital sexual intercourse with him or her; or
- (b) Solicits other persons to have extra-marital sexual intercourse with him or her."

The *Sexual Offences Act* does not criminalise the act of prostitution but rather criminalises the keeping of a brothel and pimping, the procuring of prostitutes, or coercing a person into having extra-marital sexual intercourse.<sup>97</sup>

Guiding Principle 31 of the *National HIV/AIDS Policy* recognises that: "The most effective policies and strategies must be applied to deal with commercial sex work in order to reduce the transmission of HIV and STIs and deal appropriately with legislative provisions and revise those which do not comply with current community concerns."<sup>98</sup> Guiding Principle 32 advocates for accessible and affordable education, counselling and the distributing of condoms (male and female) to all sex workers and their clients.

94 This falls under Guiding Principle 35 set out on page 29 of the *National HIV/AIDS Policy*.

95 Page 31 of the *National HIV/AIDS Policy*.

96 Chapter 8 & 9:21.

97 Sections 9-14 of the *Sexual Offences Act*.

98 Page 40 of the *National HIV/AIDS Strategic Framework, 2000-2004*.

99 See pages 9-10 of the *National Orphan Care Policy*.

#### 4.6.5 Homosexuality and HIV/AIDS

Homosexuality is illegal in Zimbabwe under the common law offence of sodomy. Section 16 of the *Sexual Offences Act* states: “Where a person is convicted of – (a) rape or sodomy and it is proved that at the time of the offence, the convicted person was infected with HIV, whether or not he was aware of his infection, he shall be sentenced to imprisonment for a period not exceeding 20 years.”

The *National HIV/AIDS Policy* and the *Strategic Framework* do not cater for the rights of homosexuals and lesbians. The government has spoken out strongly against gays and lesbians, backed by strong homophobic statements from the President.

### 4.7 Children’s rights

#### 4.7.1 Health care, orphans and HIV/AIDS

In May 1999, the Department of Social Welfare in the Ministry of Public Service, Labour and Social Welfare launched the *National Orphan Care Policy*. The *National Orphan Care Policy* aims to ensure that orphans are accorded their rights as prescribed in the *UN Convention on the Rights of the Child* and the *African Charter on the Rights and Welfare of the Child*. It is also anchored on the Zimbabwean cultural adage that a child belongs to the community and not to the parents or guardians only, and provides for the input of children to continuously review the country’s responses to children’s issues.

Two primary strategies of intervention are identified in the *National Orphan Care Policy*. The first requires the establishment of a six-tier safety net system involving the biological nuclear family, the extended family, community care, formal foster care, adoption and institutional

care.<sup>99</sup> The second advocates the formation of a partnership between the government and the Child Welfare Forum to ensure that the following goals are met:<sup>100</sup>

- medical care for all needy orphans;
- facilitation of the provision of education to orphans;
- provision of free legal representation and counselling to orphans and their guardians in matters pertaining to orphans where necessary;
- putting in place clear inheritance laws prioritising the importance of all children benefiting from their deceased parents estate all the time; and
- putting in place a basket fund.

An office responsible for the prevention of mother-to-child transmission (MTCT) was established in the National AIDS Co-ordinating Programme and a number of clinics have been designated for preventing MTCT.<sup>101</sup>

It is difficult for children to access anti-retroviral drugs for a number of reasons. The most prevalent reason is that HIV-infected children, especially those in farming communities, live far away from health care centres. Even if barriers to accessing treatment are eliminated, the unavailability of the necessary medicines reduces the prospect of access for most children.

#### 4.7.2 HIV/AIDS and the educational system

In 1993, the Ministry of Education and Culture introduced HIV/AIDS education in schools from Grade 4 to A-level through the AIDS Action Programme for Schools.<sup>102</sup> This programme is supposed to be compulsory and includes training for headmasters and teachers.<sup>103</sup> The Ministry also encourages headmasters to support the establishment of anti-AIDS clubs at schools. The Ministry of Education has a HIV/Life Skills Desk that co-ordinates HIV/AIDS teaching in

<sup>100</sup> See page 10-11 of the *National Orphan Care Policy*.

<sup>101</sup> See page 26 of the *Strategic Framework*. One such programme was piloted in Gweru, where pregnant women and those mothering were given free condoms and artificial feeds. It was later discovered that many women disposed of the handouts rather than using them. This could have been as a result of stigmatisation attached to non-breast feeding or a lack of knowledge as to the correct use of the condoms and artificial feeding. The other problem was that HIV/AIDS-related issues such as formula substitutes for breastfeeding were addressed amongst women in the absence of their spouses or partners. This problem was exacerbated by the fact that the community was

not educated prior to this programme. The justification for the exclusion of the community and the spouses was based on the need to maintain confidentiality.

<sup>102</sup> Programme was declared through the Chief Education Officer’s Circular Minute No 16 of 1993 dated 28 June 1993.

<sup>103</sup> In terms of this programme each school was to receive a copy of *HIV/AIDS: a Teaching Guide for Teachers*.

<sup>104</sup> A study on the *Impact of AIDS on the Education Sector* indicated that the needs of the teachers were not properly addressed. The as-

schools. It trains teachers to employ materials and information in the curricula through appropriate methods.<sup>104</sup>

Guiding Principle 25 of the *National HIV/AIDS Policy* states that the rights of children and young people infected or affected by HIV/AIDS must be protected and respected.<sup>105</sup> Other Guiding Principles in the *National HIV/AIDS Policy* that impact on children are the following:<sup>106</sup>

- HIV/AIDS orphans should not be discriminated against in any way. (Principle 26).
- Children have the right to information regarding sex, unwanted pregnancy and HIV/STI. Girls, in particular, should have access to education, training and employment. (Principle 27).
- Children below 16 have the right to appropriate counselling and care services and advice on means to prevent HIV/STIs.

## 4.8 Criminal law and HIV/AIDS

Part V of the *Sexual Offences Act* entitled “Prevention and Spread of HIV” deals with the deliberate spread of HIV, sentencing for certain offences where the offender is HIV positive, testing of sexual offenders for HIV infection and presumptions regarding HIV infection.<sup>107</sup> Section 15 says the following: “(1) Any person who, having actual knowledge that he is infected with HIV, intentionally does anything which he knows or ought reasonably to know - (a) will infect another person with HIV; or (b) is likely to lead to another person becoming infected with HIV; shall be guilty of an offence, whether or not he is married to that other person, and shall be liable to imprisonment for a period not exceeding 20 years.” Section 16 provides for a sentence of up to 20 years where an HIV-positive person is convicted of rape or sodomy, regardless of whether he was aware of his status. Furthermore, Guiding Principle 30 of the *National*

*HIV/AIDS Policy* recommends that the wilful transmission of HIV in any setting should be considered a crime similar to inflicting other life-threatening injuries to another.<sup>108</sup>

## 4.9 HIV/AIDS and prisons

Guiding Principle 33 of the *National HIV/AIDS Policy* recognises that prisoners have basic rights that must be respected and protected including the right to HIV/AIDS/STI information, counselling and care. Principle 34 states that routine segregation of HIV-positive prisoners is undesirable and impractical.<sup>109</sup>

Some of the recommended strategies in relation to prisoners and HIV/AIDS are as follows:<sup>110</sup>

- ensuring that all prisoners and detainees have access to voluntary HIV counselling and testing on admission to custodial remand or imprisonment;
- providing information, education and training on HIV/AIDS/STI prevention to prisoners and staff;
- initiating and promoting peer education;
- promoting the development of and implementation of measures to reduce chances of sexual abuse in prison; and
- applying disciplinary measures to, or solitary confinement of, prisoners who are violent, irrespective of their HIV status.

The current situation for prisoners appears to be as follows:

- Prisoners have the right to information in relation to the epidemic, receive voluntary counselling and have access to voluntary HIV testing.

sumption was that they should educate as if they are not affected by HIV/AIDS, when there is high incidence of HIV/AIDS infection and deaths amongst teachers. Teachers who are not involved in teaching HIV/AIDS have little or no access to information on the subject matter. Similar problems are experienced by nurses, nurse students and the elderly involved in home based care. The University of Zimbabwe, Department of Community Health embarked on a holistic training programme for the community, teachers, parents and students. This was a progressive and value-adding programme that came to an end due to a lack of funding.

<sup>106</sup> Ibid.

<sup>107</sup> Sections 15 to 18 of the *Sexual Offences Act*.

<sup>108</sup> Page 39 of the *National HIV/AIDS Strategic Framework 2000-2004*.

<sup>109</sup> See page 40 of the *National HIV/AIDS Strategic Framework 2000-2004*.

<sup>110</sup> See pages 27-28 of the *National HIV/AIDS Policy*.

- There is no policy on mandatory HIV testing upon admission to prison.
- Prisoners do not have access to anti-retrovirals at government expense. They do, however, have access to anti-retrovirals and other prescribed medication (if it is not available in the prison hospital) if they can afford to pay for them, or from friends and relatives.
- The number of prisoners that are HIV infected is unknown. The prison capacity in Zimbabwe is 16 000 but currently there are about 23 000 inmates.
- Prisons Services have no specific HIV/AIDS leaflets.
- Prisoners that are HIV positive are not kept separately, especially when they do not disclose their status. But if their status is known, those with HIV and TB are separated from the general population in an effort to contain the infection. At prison hospitals, there are separate wards for patients with HIV and related infections. Where prisons do not have hospitals, inmates are referred to general hospitals.
- Condoms are not distributed in prisons.

## 5. CONCLUSIONS AND RECOMMENDATIONS

This research project has shown that although HIV/AIDS has not been included in any international or regional treaties, relevant resolutions and guidelines do exist, and specific provisions in the major treaties will apply to the situations of people living with or affected by HIV/AIDS. Some states have included the measures that they undertook to address HIV/AIDS in their state reports, and the treaty monitoring bodies have often commented on these efforts in Concluding Observations. Clearly, most, if not all, of the 8 SADC countries surveyed have yet to incorporate treaty obligations into domestic legislation. It is also clear that most countries still operate with a policy-based approach to HIV/AIDS, rather than a rights-based approach, even though the UNAIDS and OHCHR *HIV/AIDS and Human Rights – International Guidelines* offers guidance to move from policy to rights.

It is against this background that the country reports should be analysed. Firstly, the aim is to identify those human rights principles that already exist which can assist with the adoption of a human rights-based approach, and secondly, to identify and make recommendations where the governments' responses have not included human rights.

Three general trends should be highlighted:

- Firstly, the HIV/AIDS responses in the various countries from the reporting of the first case in the mid-1980s has followed a very similar approach. Initially, in each country the Ministry of Health co-ordinated the response through a short-term plan, which focused mainly on issues of blood screening. This was followed by one or more medium-term plans in the mid-to late 1990s, ultimately heralding the multi-sectoral approach adopted by all the countries by the end of the 1990s. Thus, all eight countries adopted national strategic frameworks on HIV/AIDS and all except South Africa, Namibia and Mozambique adopted further national policies on HIV/AIDS to give effect to the goals in the strategic frameworks. To varying degrees, this development from short-term plans to multi-sectoral strategic frameworks was also

accompanied by a gradual inclusion of human rights provisions in the HIV/AIDS discourse. This coincided with an overall trend in the SADC countries to adopt new constitutions with a bill of rights. For example, new constitutions were adopted by Namibia in 1990, and by both South Africa and Malawi in 1994.

- Secondly, the legislative frameworks analysed indicate overwhelmingly that in addressing the HIV/AIDS epidemic, and affording protection to the rights of those affected or infected, states elect to respond by introducing policies, codes or guidelines, rather than legislation. This means that government interventions are not legally binding and generally cannot be enforced in the courts. Thus, people living with or affected by HIV/AIDS have few specific enforceable rights. Obligations with respect to human rights are further minimalised by states' reluctance to transform ratified human rights treaties into domestic legislation.
- Thirdly, where legislation does address HIV/AIDS issues, it tends to be limited to the areas of criminal law and labour law. Countries are inclined to promulgate criminal laws that try to "contain" the disease based on a model of "control" over the spread of the disease. Botswana, Namibia, South Africa and Zimbabwe have amended their criminal laws to provide for harsher sentencing of HIV-positive sexual offenders, whilst Zimbabwe has also criminalised the deliberate transmission of HIV. Swaziland and Zambia have declared that they will follow suit in the near future. With the exception of South Africa (in relation to homosexuality), governments have targeted homosexuals and commercial sex workers, groups that are already stigmatised in society, by criminalising their behaviour. In terms of labour legislation, governments have attempted to secure economic stability by focusing on the "economic active," people between the ages of 19 and 45 years, which is the age group that is hardest hit by the epidemic. Mozambique, Namibia, South Africa and Zimbabwe have adopted workplace legislation that outlaws discrimination on the basis of HIV status, prohibits pre-employment testing and secures medical benefits for HIV-positive employees. These efforts with respect

to labour rights are commendable; however, governments' efforts should not end with employment, but rather with an attempt to guarantee human rights in all spheres.

To guide governments toward a more inclusive human-rights-based response, the following steps are recommended:

- Those countries that have not developed a national HIV/AIDS policy to complement the national strategic framework should do so.
- In revising the current strategic frameworks and national policies (usually revised every two or five years), the inclusion of human rights provisions in all spheres/sectors should be a priority. Currently, most frameworks merely mention discrimination and stigmatisation.
- Countries should comply with international and regional treaty obligations and domesticate the provisions of these treaties through national legislation.
- Countries should review and revise national legislation on social assistance and security to provide specifically for AIDS orphans, families caring for people with AIDS, and people living with AIDS. This would avoid the difficulties of interpreting claims in terms of disability grants.
- Countries should develop a separate national policy on voluntary HIV testing, pre- and post-test counselling and factors affecting confidentiality (such as informing an HIV-positive person's partner of his/her status), and avoid the principle of shared confidentiality.
- Countries should develop legislation protecting the rights of volunteers in medical trials testing the effects of new HIV drugs and vaccines. Legislation should also regulate the treatment of HIV-positive patients by private and public health care services, specifically prohibiting discrimination against HIV-positive patients.
- HIV/AIDS-specific legislation prohibiting discrimination on the grounds of HIV status should be developed for all spheres.
- Where countries have not developed HIV/AIDS-specific legislation for the workplace, this must be made a priority, focusing on issues such as non-discrimination against HIV-positive employees, prohibition of pre-employment HIV testing, offering medical benefits that cater for the special needs of HIV-positive employees, and ensuring that employees have access to information and educational programmes on HIV/AIDS.
- Governments should ensure that national strategic frameworks and policies address the needs of the mentally ill and the disabled. Currently, only Botswana has undertaken a programme

to ensure that people with disabilities have access to HIV/AIDS education and information.

- Where legislation does not already exist, states need to legislate on the rights and treatment of orphan children and children in difficult circumstances.
- Governments need to focus on the provision of HIV/AIDS medicines. The focus to date has been on negotiations with pharmaceutical companies for price reductions. The possibility of compulsory licensing and importation (production) of generic substitutes has not received much attention. The exceptions allowed for under the WTO's *Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)* should be exploited fully.
- Legislation should be promulgated to regulate public and private medical schemes in an effort to ensure that people living with HIV/AIDS are not discriminated against or excluded.
- Governments should investigate ways of addressing the issue of restrictions on HIV-positive persons applying for and being granted life insurance.
- Customary practices that increase the risk of HIV infection in women and men should be addressed through a comprehensive approach, including involving traditional leaders and healers, sensitising communities about the dangers of such practices, suggesting alternatives, and ultimately legislating against harmful (inhuman and degrading) practices.
- Practices that put women in a vulnerable position in society and increase their risk of HIV infection – such as domestic violence and restrictive inheritance laws – should be made a priority and legislation must be adopted to secure women's rights.
- Steps should be taken to decriminalise commercial sex work and homosexuality.
- Only Botswana and South Africa have specific policies on HIV/AIDS and prisons. The other countries in this study have included some guidelines in their national policies or strategic frameworks, but with the special conditions prevailing in prisons that increase the risk of HIV infection, every country should adopt a separate policy or legislation on HIV/AIDS and prisons. Issues that should be addressed include the dissemination of education on HIV/AIDS and STDs, voluntary testing and counselling, non-segregation of prisoners, condom distribution, and access to treatment for opportunistic infections.
- The lack of capacity to develop appropriate legislative frameworks has been invoked by states to explain the legislative impasse. A comprehensive model code on HIV/AIDS should be developed, providing a general framework for states to develop a specific legislative response to the pandemic.
- Heads of state need to take an active lead in the lobbying and reform efforts regionally and internationally.



## 6. BIBLIOGRAPHY

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- *Public Health Act*
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## ANNEXURE: HIV/AIDS and human rights in SADC – summary of findings

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
<b>Form of government</b>	Constitutional democracy	Constitutional democracy	Semi-presidential constitutional democracy	Constitutional democracy	Constitutional democracy	Absolute monarchy with no Constitution	Constitutional democracy	Constitutional democracy
<b>Domestic legal system</b>	English Common law and Roman-Dutch law	English Common law	Civil or Continental law system inherited from Portugal	English Common law and Roman-Dutch law	Roman-Dutch law and English Common law	Roman-Dutch law and Swaziland customary law	English Common law	Roman-Dutch law and English Common law
<b>National HIV/AIDS Strategic Framework (NSF): time frame, human rights provisions</b>	2003-2009 NSF refers to human rights	2000-2004 NSF refers to human rights	2000-2002 National Strategic Plan to Combat STDs/HIV/AIDS makes almost no reference to human rights	1999-2004 National Strategic Plan on HIV/AIDS (MTPH) refers to human rights	2000-2005 HIV/AIDS/STD Strategic Plan for South Africa refers to human rights	2000-2005 Swaziland National Strategic Plan for HIV/AIDS refers to human rights	2002-2005 National HIV/AIDS/STI/TB Intervention Strategic Plan refers to human rights	2000-2004 NSF provides for human rights
<b>National HIV/AIDS Policy: human rights provisions</b>	2002 National AIDS Policy refers to human rights	2002 Draft Malawi National HIV/AIDS Policy. Policy refers to human rights with emphasis on rights based approach.	None	None	None	1998 Swaziland Policy Document on HIV/AIDS and STD Prevention and Control refers to human rights	2002 National HIV/AIDS/STI/TB Policy refers to human rights	1999 National HIV/AIDS Policy refers to human rights
<b>HIV/AIDS jurisprudence</b>	Yes	None	None	Yes	Yes	None	None	None
<b>HIV/AIDS specific legislation<sup>1</sup></b>	Yes. (In realm of criminal law)	None	Yes (Labour law)	Yes	Yes	None	Yes	Yes
<b>Government awareness of UNAIDS guidelines on HIV/AIDS and human rights</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Social security and PLWHA</b>	No specific assistance is provided for PLWHA. Revising the <i>National Destitute Policy</i> to cater for PLWHA and orphans does form part of the NSF for 2003-2009	No special provisions are made to cater for the social assistance needs of PLWHA.	No special provisions are made to cater for the social assistance needs of PLWHA.	Social assistance is provided for PLWHA in terms of a disability grant and a special grant for HIV/AIDS orphans.	PLWHA can qualify for a disability grant in terms of the <i>Social Assistance Act</i> . In August 2002 the <i>National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS</i> were published.	No special provisions, NSF however refers to access to social services for PLWHA.	No special provisions, do qualify for assistance applicable to all Zambians.	No special provisions, do qualify under general <i>Social Security Act</i> .

<sup>1</sup> None of the eight countries that formed part of the study have a comprehensive HIV/AIDS specific law in place. This section was answered in reference to sections of existing or new legislation that included specific reference to HIV or AIDS.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
<b>Constitutional protection of the right to health</b>	None	Equal access to basic health services is incorporated in the right to development, section 30(2) of the <i>Constitution</i> .	Article 94 of the <i>Constitution</i> guarantees the right to health subjected to the law in place.	Article 95 of the <i>Constitution</i> refers to public health but as a matter of state policy and not as a fundamental right.	Article 27(1)(a) of the <i>Constitution</i> .	<i>Constitution</i> is suspended, the drafting of a new <i>Constitution</i> is underway.	The right to health care is provided for under the <i>Directive Principles of State Policy</i> incorporated in Part IX of the <i>Constitution</i> . <sup>2</sup>	None
<b>HIV/AIDS as a notifiable disease</b>	No	No, although it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	No	No	No	Yes	Yes	No
<b>Rights of HIV positive patients</b>	No HIV specific guidelines exist currently within the health profession, according to Bonera <sup>3</sup> a policy is in the pipeline.	No special protection exists currently but it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	Ethical guidelines for health workers are foreseen in the <i>2000-2002 National Strategic Plan</i> .	HIV specific guidelines and a <i>Namibian Charter on HIV/AIDS</i> exist. (non-binding)	Protected by the 2001 HPCSA guidelines on the <i>Management of Patients with HIV Infection or AIDS</i> and the <i>SAMA Guidelines on Human Rights, Ethics and HIV</i> .	None	No special provisions.	Provisions within the (non-binding) <i>Patient's Charter</i> .
<b>Constitutional and legislative protection of equality and non-discrimination</b>	Section 15 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 20 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 66 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Law no 5/2002 deals specifically with discrimination against employees and candidate employees and HIV/AIDS is covered by the law.	Section 10 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Section 107(1) of the <i>Labour Act</i> lists grounds of non-discrimination in employment. Although it does not include HIV status, see the Labour Court ruling on exclusion. <sup>4</sup>	Section 9(3) of the <i>Constitution</i> lists grounds for non-discrimination (non-exhausted list). HIV is not a listed ground. Specialised legislation on non-discrimination: <i>Promotion of Equality and Prevention of Unfair Discrimination Act</i> no 4 of 2000, section 34 provides for the possibility of including HIV status as a ground for non-discrimination.	Swaziland does not have a <i>Constitution</i> although negotiations around the drafting of a <i>Constitution</i> with a bill of rights are being considered.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. <i>Statutory Instrument 202 of 1998</i> prohibits discrimination on the basis of HIV status in the workplace.

2 The Directive Principles of State Policy are not in themselves binding and are subject to the availability of funds under article 110.

3 Botswana Network on Ethics, Law and HIV/AIDS.

4 *Haindongo Nghidipohamba Nanditume v Minister of Defence* Case No. LC 24/98.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
<b>HIV/AIDS and the workplace: discrimination and pre-employment testing</b>	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Law no 5/2002 outlaws discrimination on the ground of HIV status in employment and prohibits pre-employment HIV testing.	Guidelines were promulgated in terms of section 112 of the Labour Act for the implementation of the <i>National Code on HIV/AIDS in Employment</i> and for application of relevant provisions of the <i>Labour Act</i> in respect of HIV/AIDS. The guidelines outlaw discrimination on HIV status and pre-employment testing for HIV.	Article 6 of the <i>Employment Equity Act</i> no 55 of 1998 lists HIV status as a ground for non-discrimination. HIV testing of an employee is prohibited by section 7(2) unless justifiable by the Labour Court in terms of section 50(4).	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing. The Defence Force requires HIV tests and do not recruit HIV positive candidates.	<i>Statutory Instrument</i> 202 of 1998 prohibits discrimination based on HIV status in the workplace and states that pre-employment testing should not be required except where fitness for work is a precondition to the offer of employment. <i>Labour Relations Amendment Bill</i> of 2001 includes HIV status as a ground for non-discrimination.
<b>Legislative protection of PLWHA in medical schemes</b>	No	No	No	No, although the 2002 <i>Health Plan</i> provides policy protection in terms of the Aid for AIDS benefit scheme.	Yes	No	No	No
<b>HIV/AIDS and insurance policies</b>	No legislative regulation, policies for PLWHA determined by companies at higher premiums or not at all.	Currently no legislative protection, the issuing of policies is up to the private company (no granting of life insurance to HIV positive people).	No legislative regulation of the insurance industry, life insurance policies do not cover PLWHA.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry. The Life Office's Association's <i>HIV Testing Protocol</i> clearly states that life insurance will not be granted to people who test HIV positive. Those companies that do offer special packages do it at higher premiums or limit the amount of insurance.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.
<b>Existence of cultural practices that enhance spread of HIV</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Legality of commercial sex work</b>	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal
<b>Legality of same sex relationships</b>	Illegal	Illegal	Illegal	Illegal	Legal	Illegal according to common law offence of sodomy, last case tried in 1983. Lesbianism seems legal according to 1992 judgment. <sup>5</sup>	Illegal	Illegal

5 Mngomezulu case discussed on [http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/swaziland/swaziland\\_index.html](http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/swaziland/swaziland_index.html).

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
<b>HIV education in schools: non-discrimination in schools</b>	HIV/AIDS education (for pupils and teachers) is provided for in the 1998 <i>Policy on HIV/AIDS Education</i> , the <i>National Strategic Plan</i> and the <i>National Policy on HIV/AIDS</i> .	HIV/AIDS education is included in formal primary and secondary school curricula. This effort is expanded upon in the NSF and <i>National HIV/AIDS Policy</i> .	NSF sets forth the policy on education in schools whilst also declaring that implementation has been delayed. <sup>6</sup>	<i>National Teachers Union Policy on HIV/AIDS</i> (2000) together with the <i>National Policy on HIV/AIDS</i> for the education sector (4th draft) 2002 provides for HIV education in schools and non-discrimination.	1999 <i>National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions</i> . The <i>South African Schools Act</i> protects learners from unfair discrimination.	NSF provides for integration of HIV education in pre-schools, schools and institutions of higher learning and provides for training of teachers.	HIV/AIDS education is integrated in the school curricula. No special training is provided for teachers. No specific policy on non-discrimination in schools exist.	AIDS education was introduced in schools in 1993. HIV/Life Skills Desk in Ministry of Education trains teachers and coordinates HIV teaching in schools. <i>National Policy on HIV</i> includes provisions on non-discrimination in schools.
<b>Criminal legislation on HIV/AIDS</b>	Harsher sentencing for HIV positive rapists in terms of the <i>Penal Code (Amendment) Act No 5 of 1998</i> .	No HIV/AIDS specific provisions in the Malawi criminal law rather the 2002 <i>National HIV/AIDS Policy</i> aims to promote the use of generic criminal law and not HIV specific criminal codes and to apply HIV status only as a mitigating or aggravating factor.	No HIV/AIDS specific provisions in Mozambique criminal law.	Harsher sentencing for HIV positive rapists provided in the <i>Combating of Rape Act of 2000</i> .	<i>Criminal Law Amendment Act of 1997</i> provides for harsher sentences for HIV positive rapists. <i>Criminal Procedure Second Amendment Act</i> – more difficult to obtain bail in rape cases involving HIV positive accused. New <i>Sexual Offences Bill</i> and <i>Compulsory HIV Testing of Alleged Sexual Offenders Bill</i> tabled in 2003.	No HIV/AIDS specific provisions in Swaziland criminal law although the <i>Public Health Bill</i> envisages penalties for knowingly transmitting HIV.	No HIV/AIDS specific provisions in Zambian criminal law. Rape carries life sentencing in the <i>Penal Code</i> regardless of HIV status. <i>National AIDS Policy</i> recommends criminalising of wilful HIV transmission.	<i>Sexual Offences Act No 8 of 2001</i> , harsher sentencing for HIV positive rapists and criminalizing of deliberate transmission of HIV.
<b>HIV/AIDS and prisons: education, testing, condoms and separation</b>	The following policies are in place: <i>National Policy on HIV testing and education in prisons</i> , the <i>Health Care Delivery Policy</i> , a <i>Policy on HIV/AIDS/STD for inmates</i> and a <i>HIV/AIDS Policy and Procedure Manual for Prison Staff and their families</i> .	No official policy on HIV/AIDS in prisons the only reference to prisons is found in the 2002 draft <i>Malawi National HIV/AIDS Policy</i> . Addressing issues such as voluntary testing and counselling, non-segregation of prisoners and the distribution of condoms.	No official policy on HIV/AIDS in prisons guidelines are however included in the <i>National Strategic Plan on HIV/AIDS</i> . Prisoners have access to education on HIV/AIDS and condoms. Prisoners are not separated.	No official policy on HIV/AIDS in prisons. Non-separation of HIV positive inmates. Condoms are not distributed. AIDS campaign training inmates to counsel fellow inmates exist, voluntary testing is provided.	2002 <i>Policy on Management Strategy of HIV/AIDS in Prisons</i> : 1) Voluntary testing, counselling and education. 2) Non-segregation. 3) Condoms are distributed.	The <i>Swaziland National Strategic Plan on HIV/AIDS</i> and the <i>Policy Document on HIV/AIDS</i> set forth guidelines on prisons on education, non-separation and voluntary testing and counselling. Condoms are not distributed.	No official policy on HIV/AIDS in prisons exist. Condoms are not distributed in prisons, prisoners are not separated.	Prisons are addressed in the <i>National Policy on HIV/AIDS</i> : 1) Voluntary testing and counselling together with education is provided. 2) Condoms are not distributed. 3) HIV positive prisoners are not separated.

The table above is not conclusive as to all the findings of the study for certain areas analysing access to essential HIV/AIDS drugs, the rights of volunteers in HIV/AIDS medical trials, condom distribution or discussions around legislation and policies protecting women and the most

vulnerable in society could not be comparatively tabled. For a discussion on these areas the individual country reports should be accessed.





The University of Pretoria established the Centre for the Study of AIDS in 1999 to 'mainstream' HIV/AIDS through all aspects of the University's core business and community-based activities. Its mission is to understand the complexities of the HIV/AIDS epidemic in South Africa and to develop effective ways of ensuring that all the students and staff of the University are prepared both professionally and personally to deal with HIV/AIDS as it unfolds in South African society.

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