THE LEGAL IMPLICATIONS OF LIVING WITH HIV/AIDS IN A DEVELOPING COUNTRY: THE AFRICAN STORY

Florence Shu-Acquaye*

INTRODUCTION

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) constitute a major public health problem in the world and, in particular, in sub-Saharan Africa. HIV/AIDS has been known for only 23 years, and yet today it is the most prevalent infectious disease, causing most of the deaths in Africa.[1] According to a Joint United Nations Program on AIDS (UNAIDS)/World Health Organization (WHO)[2] December 2002 report, HIV/AIDS was responsible for over 2.4 million deaths in sub-Saharan Africa in the year 2002[3] and 2.3 million in 2003.[4] These numbers represent more than 10

---

*By Florence Shu-Acquaye, Associate Professor of Law, Shepard Broad Law Center, Nova Southeastern University, Ft. Lauderdale, Florida. I would like to thank Ms Vicki Tucci and Ashia Jack for their excellent research assistance.

1. Diseases such as malaria and tuberculosis are also major causes of death in Africa. A coalition of governments and non-governmental organizations, led by the U.N. launched the Global Fund Against AIDS, Tuberculosis and Malaria in 2002 aimed at addressing these diseases. By August 2002, the total pledge to the fund was over $ 2 billion and it was estimated that a sizeable amount would be devoted towards AIDS. *See United Nations, Johannesburg World Summit on Sustainable Development, HIV/AIDS: Human Resources and Sustainable Development* (2002), at 29, *available at* http://www.eldis.org/static/DOC10301.htm (last visited Sept. 24, 2004).

2. The joint United Nations Program on AIDS consolidates the efforts of six agencies which deal with HIV/AIDS: United Nations Development Program (UNDP); United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); United Nations Educational, Social and Cultural Organization (UNESCO); World Health Organization and the World Bank. *See* U.S. Agency for Int'l Development, Discussion Papers on HIV/AIDS Care and Support: Human Rights and HIV/AIDS, at 39 (1998) *available at* http://www.syngery.com (last visited Sept. 24, 2004).

3. In four southern African countries, national adult HIV/AIDS prevalence has risen to over 30%: Botswana has the highest prevalence at "38.8%, Lesotho 31%, Swaziland 33.4% and Zimbabwe 33.7%." *Aids Epidemic Update, UNAIDS/WHO* at 16 UNAIDS/02.58E (Dec. 2002), *available at* http://www.who.int/hiv/facts/en/epiupdate_en.pdf (last visited Feb. 21, 2005). Yet, looking back to 1982, Uganda was the only country in Africa with an adult HIV prevalence rate higher than 2%. *See* Intensifying Action Against HIV/AIDS in Africa, Responding to a Development Crisis (African Region-World Bank) at 13. *See Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis, African Region Worldbank* at 13, 17 (1999), *available at* http://www.worldbank.org/afr/aids/aidstrat.pdf (last visited Feb. 21, 2005).

times the number of people who perished in wars and armed conflict in sub-Saharan Africa during the same period. At the end of 2002, more than 29.4 million adults and children, close to one in ten adults between the ages of 15 and 49 years, were living with HIV/AIDS. This represented about seventy percent of the global total of 42 million persons living with HIV/AIDS. Africa constitutes only about 10% of the world's population, yet 3.2 million out of the roughly 5 million newly infected people resided in Africa last year alone.[5]

Although people are susceptible to HIV irrespective of their race, ethnicity, gender, age or even sexual orientation, statistics show that the greatest burden of the disease is found in developing countries, mainly in Africa. AIDS related mortality is also alarmingly higher in these countries than in others. In this regard, the AIDS epidemic in Africa is said to bear little resemblance to that of the United States. For instance, most AIDS cases involve specific high-risk groups and are brought under control through the use of strong political action and expensive drug therapy.[6] It may seem quick and trite to attribute these astounding

---

4. The 2003 UNAIDS/WHO estimates suggest that the number of people living with HIV/AIDS in sub-Saharan Africa is lower than in 2002. This modest decrease may lead one to a false believe that the number of people living with the virus has decreased in Africa. However, this is not the case. Rather, through better data and understanding, the UNAIDS secretariat and WHO have arrived at a better and more accurate estimate. Nonetheless, the application of such improved data and understanding to the past years continues to show a steady increase in the number of people living with HIV/AIDS in sub-Saharan Africa. *See Aids Epidemic Update*, *supra* note 3, at 6. In obtaining these estimates, UNAIDS/WHO, in collaboration with these countries, use a six-step process to get estimates of HIV prevalence for men and women. National prevalence are based on surveillance systems that focus on pregnant women who attend a selected number of antenatal clinics (the presumption here is of course that the pregnant women are a good approximation of prevalence among the adult population between ages 15-49. Apparently, this assumption has been corroborated by studies carried out at the sub national level in some African countries, by comparing HIV prevalence among pregnant women at antenatal clinics to that of the adult population in the community. S*ee id.*

5. This number was again reduced to 26.6 million in the UNAIDS/WHO 2003 estimates. *See AIDS Epidemic Update*, *supra* note 3, at 6.

6. *See* Johanna McGeary, *Death Stalks A Continent*, TIME MAGAZINE at 37 (Feb. 12, 2001). There are three types of HIV transmission identified by WHO. In Pattern 1, the primary means of transmission is through homosexual and bi-sexual sex, prostitution, and drug use. This is prevalent in the industrialized countries such as the United States and Western Europe. In Pattern 2 transmission is mostly by heterosexual intercourse and is prevalent in Africa, the Caribbean and South America. While Pattern 3 is where HIV infection is growing but has not yet attained the levels of 1 & 2. *See* Anne N. Arbuckle, *The Condom Crisis: An Application of Feminist Theory to Aids Prevention in African Women*, 3 IND. J. GLOBAL LEG. STUD. 413, n.25 (1996). The HIV virus also continue to mutate into different forms known as sub-types, with others combining to form what is known as recombinant HIV sub-types. Currently there are about 10 HIV sub-types lettered from A to J (the lettering is based on the make-up of the sub-types and the order in which the scientist

numbers of infection and death in the developing countries to poverty, lack of access to basic health care and drugs, low socio-economic status, detrimental cultural beliefs, misinformation and illiteracy. However, enabling factors, such as inequitable statutory and customary laws regulating marriage in Africa (eg., polygamy and widow inheritance), tend to facilitate the spread of HIV/AIDS. Under the customary laws of some African countries, a man is expected to marry as many wives as possible to elevate the social status of that community. Also, a man may inherit the wife of his deceased brother or relative and continue to have a family. The statutory laws also tend to foster this trend through blatant discrimination favoring men. A man, for example, can only commit adultery in some countries if it is done in the matrimonial home, whereas for a woman it can be anywhere. Yet, because of the cultural idiosyncrasies women are generally less likely to indulge in extra-marital relationships than men.

I am of the view that removing or amending such laws that aggravate the transmission of HIV will not only encourage better physical, mental, and social well-being of the most affected populations, but would also be a step towards curtailing its spread.

This article looks at customary and statutory laws, such as polygamy, widow inheritance, and other cultural practices that have contributed to the entrenchment of the disease in Africa, particularly sub-Saharan Africa.[7] It also provides a discussion of the African dilemma with recommendations. The article further looks at how weak human rights laws are and how the stigmatization associated with HIV/AIDS has contributed to the multi-faceted and complex nature of this disease in Africa. Additionally, it evaluates the possibility of changing or amending some of the related existing laws by offering a

---

discover them) and several recombinant sub-types. *See The 13th Int'l Conference on AIDS & STDs in Africa: Recent Advances in War on HIV/AIDS* (2003), *available at* http://www.icasafrica.org/advances.html. Although no single factor, biological or behavioral, determines the spread of HIV infection as a whole, most HIV transmission in sub-Saharan Africa occurs through sexual intercourse, with unsafe blood transfusion and unsafe injections accounting for a small fraction. 2004 *Report on the Global AIDS Epidemic*, UNAIDS at 34, UNAIDS/04.16E (June 2004) *available at* http://www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf (last visited Feb. 21, 2005).

7. The countries in sub-Saharan Africa include: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Congo DR, Cote d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Reunion, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania (United Republic of), Togo, Uganda, Zambia, and Zimbabwe.

checklist for policy makers and legislators. Finally, the author illustrates the role played by international institutions, such as the World Bank, International Monetary Fund, International Finance Corporation, and International Labor Organization in the realm of HIV/AIDS.

I. CUSTOMARY AND STATUTORY LAWS

A. Inheritance Laws [8]

Under some customary laws, a married woman is considered the property of the man if he bought her with his money, chickens, cows, or whatever the tradition or custom of that ethnic tribe may have called for as bride price at the time of marriage.[9] Therefore, he may deal with his property as he deems fit. For instance, he may use it or even dispose of it as the circumstances may dictate. The woman, in turn, comes into the marriage with the belief that she is only second to her husband and basically subservient to him because he bought her. [10]

Hence, where a husband dies, leaving behind his wife and children, the husband may leave behind his will indicating that the wife be married to his brother, and even if that were not the case, the customary law may require the widow to do so.[11] What does this have to do with

---

8. When one thinks of inheritance laws, acquiring property through a will, trust or succession may come to mind. However, since there is very little to pass on in Africa, parents or grandparents do not pass on their property through these formal means. Hence, life insurance is not a common phenomenon. However, what some Africans may consider as property in the marriage may be surprising, unthinkable, and even repugnant to those in the West.

9. The bride price is also referred to as the dowry. A dowry encompasses what the bride's family may ask of the husband-to-be in order for him to marry the bride. The dowry may depend on the woman's status in society, such as whether she is educated, has a job, or comes from a good family.

10. The African woman's traditional role as wife is based in the home caring for the family. The contemporary African woman, today, however, can go to school, work or even have her own business. Even though they can now go beyond the traditional roles, women are not absolved from their duties as wives. Rather, they are expected to carry out the traditional role as wife, while they work or attend school. For example, in Swaziland the woman is not only perceived as the property of the husband and family, but also of the society through the numerous obligatory roles that she must hold as wife, mother-in-law, and grandmother. *See* Mamane Nxumalo, *Women's Health, Socio-cultural Practices, and HIV/AIDS in Swaziland,* AIDS & DEVELOPMENT IN AFRICA, A SOCIAL SCIENCE PERSPECTIVE 59-69 (R. Hope Sr. ed., Hayworth 1999).

11. In some instances, the inheritance is reversed. When a wife dies, the husband may be given his wife's younger sister as a new wife. This practice is common among the Sena people in the Nsanje and Chickwawa districts in south Malawi. Nuxumalo, *supra* note 10 at 169. An associated, although different, practice with a wife's younger sister is the "bonus wife." *Id.* at 170. In this practice, if a husband is hardworking, successful, and treats his wife as well as the extended family, the in-laws will show their appreciation and

HIV/AIDS?

Where the brother of the husband is infected or the widow for that matter, a marriage between them will likely result in the transmission of the AIDS virus to the uninfected partner, and possibly more people, given that the brother may be married himself. This effect would then be compounded if either party had an extra-marital relationship. Hence, the likely spread of the virus is enhanced by the implementation of such laws.[12]

In some parts of African societies, a similar practice known as "widow-cleansing" is predominant. As part of this custom, the brother of a deceased husband is expected to have sexual intercourse with the brother's widow, supposedly to "cleanse" her of her deceased husband's spirit, usually with no obligation to marry her.[13] Here, the use of condoms, even if desired, is irrelevant because the man must leave his seed in the widow to accomplish the desired goal of the ritual. Again, the medical status of the parties is usually inconsequential and unrelated to achieving this task. Thus, this has become another channel for the increase of the transmission of HIV/AIDS. The spread is made worse in some of these countries by the fact that any person may be appointed or paid as a cleanser, regardless of the relationship to the family. This is said to be typical in many villages across Africa. For example, in the Gangre village in Kenya, an individual referred to as "the terrorist" is paid to have sexual relations with widows and unmarried women of the village, supposedly to dispel evil spirits. After the "cleansing" these women can attend their husband's funeral or be inherited by their husband's brother or relative. Not only is such a ritual painful for the women involved, but it is also a volatile means of spreading AIDS. In this village, one in every three persons was said to be infected with

---

gratification by offering him his wife's junior sister. *Id.*

12. In Zimbabwe, for example, a clinical nurse at Binga hospital is said to have witnessed several cases of a whole family (husband, wives, and brothers) who inherited widows, all wiped out by AIDS. *See A Cultural Approach to HIV/AIDS Prevention and Care: UNESCO/UNAIDS Research Project, Zimbabwe's Experience*, at 16, *available at* http://unesdoc.unesco.org/images/0012/001206/12690e.pdf (last visited Sept. 24, 2004). One of the participants in the project said "Nyaya yakupindira iyi, tiri kufa, tapera", translated in English as: "This inheritance issue is killing us, we are finished." *Id.*

13. Cleansers are found in some rural parts of Uganda, Tanzania, Congo, Angola, Ivory Coast, Nigeria, and Ghana. The tradition dates back centuries and is rooted in the belief that a woman is not only haunted by spirits after her husband dies, but is also unholy and disturbed if she is unmarried and abstains from sex. *See* Emily Wax, *Kenyan Women Reject Sex 'Cleanser'; Traditional Requirement for Widows Is Blamed for Aiding the Spread of HIV-AIDS,* WASH. POST, Aug. 18, 2003, at A12.

HIV.[14]

B. Marriage (Polygamy)

Marriage in most African countries is not necessarily a sacred institution between one man and one woman (monogamy). Rather, polygamy is the rule, and monogamy is the exception.[15] In Cameroon there are two types of recognized marriages: in the former West Cameroon statutory marriage, otherwise known as monogamous marriage, and customary law marriage, otherwise known as polygamous

---

14. Villagers believe that the practice must be carried out in order to avoid having bad crops as a curse on the entire community. Wax, *supra* note 13, at A12. The cleanser in this village did not care or even wish to know of his HIV status, nor the number of women he had been paid to sleep with. For the entire story and interviews of the Gangre village Cleaner. *Id.*

15. Historically, polygamy did not only enhance the social status of the man as being economically powerful, but was also a means to regulate child spacing and sexual abstinence during pregnancy. In some African tribes, it is considered taboo to have sex during some periods of pregnancy, menses, lactation, and mourning. Thus, having other wives would permit the man to continue to have sex. Childbearing is essential for marriage in Africa. Hence, if a man has several wives, a childless wife may not necessarily be sent away by the husband since the other wives will have children for the husband. This secures her marriage and economic dependence.

Today, however, these factors may not necessarily be the driving force behind the continued practice of polygamy. This is because the contemporary woman could be educated and economically independent from the man. Also in some countries there is a shortage of men, and because the women have to be married according to societal norms, they settle for being a second or third wife. Also, the tacit acceptance by the African woman that men are inherently polygamous and there is nothing that can be done to stop them tends to encourage polygamy as a man's endowed right.

In a country study in 1999 in Uganda, where a cultural approach to HIV/AIDS as a means of prevention and care was explored, the respondents were asked to compare the prevalence of polygamy in the past with the contemporary situation. A majority of the respondents stated that nothing in terms of numbers had changed: men are inherently polygamous and it is their "normal" state to have more than one wife. They said what had changed today is that wives are kept in separate homes and sometimes do not even know of each other. In fact, either may only learn of the other's existence at the death of a husband, where they both are likely to be present. The respondents equally thought that an absolute monogamous marriage would be not only rare but also an aberration from the norm. *See* Dr. James Sengendo & Dr. Emmanuel K. Sekatawa, *A Cultural Approach to HIV/AIDS Prevention and Care: UNESCO AIDS Research Project, Uganda's Experience,* Issue 1 at 41 (1999), *available at* http://unesdoc.unesco.org/images/001206/120311e.pdf (last visited Sept. 24, 2004).

Some people make the argument that polygamy practiced in the traditional way, where a man has sexual intercourse with the same wives, would protect the man and his wives from HIV/AIDS. This argument is challenged by the fact that the man does not necessarily have a relation with all his wives at the same time. He has either married them over time, or perhaps may have become polygamous through substitution. Hence, if one of the women has been infected prior to her being married or substituted, the outcome is potentially disastrous for all parties in the marriage.

marriage. The former is governed by the Civil Status Ordinance of 1981, while the later is governed by the customs of the various tribes.[16] Although the parties married under the Civil Status Ordinance are required to elect on the marriage certificate whether they are married under a polygamous or monogamous marriage, it is usually an area of contention that sometimes results in the marriage not taking place at all. More often than not, the women prefer to elect monogamy and the men, polygamy.

In the rural areas the marriage is often exclusively celebrated according to the native laws and custom of a tribe. Such marriages under the native laws and customs are automatically polygamous. The man has the official "green light" to have extra-marital affairs under the legitimate guise of looking for another wife. It is generally believed that, the more wives a man has, especially the traditional African man,[17] the higher his status in society is elevated. This is very common with tribal chiefs who have hundreds of wives. Although they may not necessarily have sexual intercourse with all of these wives, as they may also inherit some wives as successors to their father's throne, they nonetheless sleep with many, especially the newlyweds. The likelihood of transmitting AIDS or other sexually transmitted infections from a multiple partner relationship becomes high. Also, there is really no guarantee that these women, especially the young ones, sit and wait for their turn to have a sexual relationship with their husband or the person appointed by the husband to satisfy this obligation. Hence, the likelihood of discrete extra-marital affairs cannot be eliminated. I say

16. Civil Status Registration Ordinance, No. 81/02 (June 29, 1981) (Cameroon).

17. AIDS is rampant in the rural areas and small towns. Many Africans follow traditional customs such as fathers selling their daughters to the highest bidder for marriage. Often the daughters are sold to older men who are already married to other wives. These men believe sending a girl to school is a waste of time and money, as she will become the property of a man someday who will invariably take responsibility of her. Having sex is supposedly a man's birthright and he determines with which woman and when. Another sexual right that is often conferred on the bridegroom's father at marriage and bad for HIV/AIDS transmission is the right of first access. Here the father of the bridegroom has the right to test "where his cows have gone" by having the first sexual access to the new bride. *See UNSECO/UNAIDS Uganda*, *supra* note 15, at 10.

In some African countries rape is even considered a badge of manhood and something to boast about. And to worsen matters, rapists may get away with the crime because the laws have made it difficult, if not impossible for women who dare to speak to meet the required burden of proof. In the rural areas, rape cases may be settled traditionally by having the man pay a fine to the family of the victim. *See* Janet Bujural & Carolyn Baylies, *Africa: Targeting Men For A Change To Prevent AIDS, Joint U.N. Programme on HIV/AIDS Expert Group Meeting on 'the HIV/AIDS Pandemic and its Gender Implications* (Nov. 13-17 (2000)).

discrete because of the shame and taboo that may be brought upon such a woman in the Fondom if caught. Besides, and more importantly, as a wife, a woman may loose all her economic privileges granted to her and her children by her husband.

In most of these countries, the church generally does not recognize polygamy. However, many people marry in the church, but undermine the church doctrine by engaging in polygamous relationships.[18] On the Ivory Coast, polygamy was formally outlawed in 1964, but many people continued polygamous relationships under customary and Islamic laws.[19] Moreover, African men often have had socially accepted extra-marital affairs while their wives generally have sexual relations only with their spouses. In a study conducted in Kigali, Rwanda, the progress of 460 HIV infected women of ages 18 to 35 was followed in comparison with a group of non-infected women.[20] The study revealed that of the 460 HIV infected women most were in a stable relationship, either in a legal marriage (30%) or in a common law marriage (47%).[21] Of these women, 53% reported that they have only had one life sexual partner.[22]

Another factor that tends to exacerbate and endorse the sexual behavior of African men is the double standard of laws regulating marriage in some countries. In Uganda, for example, a husband may be able to obtain a divorce if the wife is unfaithful, while the wife will be unable to do so simply on the grounds of adultery. Rather, she must prove a second ground as well, such as cruelty.[23] Likewise in Cameroon, for a man to commit adultery he must have done so in the matrimonial home, whereas for a woman, it can be anywhere.[24] These

---

18. This does not mean that religious beliefs may not impact on the spread of the disease. Spiritual beliefs has been said to interact closely with HIV/AIDS issue and used as a medium of addressing the AIDS crisis in many instances. The impact, however, depends on the intensity of the belief and religious practices. Hence, religious beliefs have led to organized charitable action towards the poor and sick; providing community based projects, for example, The Aids Support Organization Project in Uganda. *A Cultural Approach To HIV/AIDS Prevention and Care, UNESCO/UNAIDS Research Project, Summary of Country Assessment, An International Overview*, Issue 10 at 48 (2002), *available at* http://enesdoc.unesco.org/images/0012/001262/126289e.pdf (last visited Sept. 24, 2004).

19. *See* Wendy Patten & J. Andrew Ward, *Empowering Women to Stop AIDS in Cote D'Ivoire and Uganda*, 6 HARV. HUM. RITS. J. 210, 212 (1993) [hereinafter Pattern & Ward].

20. *See* Arbuckle, *supra* note 6, at 421 (this study was conducted by the Rwanda Ministry of Health and the Center for AIDS Prevention Studies at the University of California at San Fransisco).

21. *Id.*

22. *Id.*

23. *See* Pattern & Ward, *supra* note 19, at 213 n.24.

24. Not many men would want to have an affair in the matrimonial home.

loopholes in family laws tend to encourage promiscuity because there is no consequence for the man even if he is caught.

Having multiple sex partners increases the risk of being infected with HIV. According to one theory, [25] Africa's polygamous societies were generally not promiscuous, but when the western missionaries introduced the notion of monogamy and discouraged polygamous relationships, members of those societies substituted polygamy for promiscuity. Consequently, promiscuity has inevitably increased and has facilitated HIV transmission. As to whether promiscuity or polygamy is a better evil is another debate, but they both occur when one has multiple partners and neither are positive factors in the prevention of the spread of HIV in Africa. In Kenya and Uganda, prostitution was outlawed after sex workers were identified as a major source of HIV transmission.[26] The issue here is whether outlawing prostitution is the best way to prevent the spread of HIV/AIDS, and also how this may practically be enforced.[27]

C. Other Cultural Practices

1. Traditional or Herbal Doctors

Although both modern and traditional practices may expose people to HIV positive blood, this article focuses on the traditional practice. An alternative and cheaper means of obtaining healthcare in Africa, as it is in the West today, is through traditional native or herbal doctors.[28] These doctors, in some African countries, are legally recognized in the healthcare system. However, they are generally not monitored in the same way that a hospital or clinic would be monitored, and are therefore left to their own devices.[29] These doctors use unsterilized sharp objects

---

25. Kenneth Bartschi, *Legislative Responses to HIV/AIDS in Africa*, 11 CONN. J. INT'L L. 169, 176-76 (1995).

26. *Id.* at 185.

27. Peter Mosley, Worldwide Dilemma: Should AIDS Infection be a Crime? Reuters, June 29, 1992. See also Bartschi, *supra* note 25, at 185 (explaining that the Ugandan government, in pursuing its AIDS prevention policy, has also imposed a death penalty or punishment of life imprisonment for rape).

28. Traditional medicine is more popular in the north and up to 80 % of people in the South use it as part of primary health care. About 80% of the people in Africa are said to use traditional medicine. Press Release, World Health Organization, WHO Launches The First Global Strategy On Traditional And Alternative Medicine (May 16, 2002), *available at* http://www.who.int/inf/en/pr-2002-38.html (last visited Sept. 24, 2004).

29. A good example of how the traditional doctors are incorporated in the health system and instrumental in the fight against the spread of AIDS/HIV in Uganda. The Ugandan government, through the Uganda AIDS Commission (UAC), established in 1992,

such as razor blades, to cut the skin of their patients for purposes of applying the herbal treatment. This procedure is also performed to scar the skin in order to create an indelible mark of protection against the enemy (primarily witchcraft), or for beautification. Also, some blood rituals may require the sharing and drinking of small amounts of human or animal blood.[30] In Angola, the practice of blood brotherhood, where two people exchange and drink each other's blood as a symbol of mutual faithfulness, (this supposedly creates a pact that should not be broken and is severely punished if it is) assits the dissemination of HIV/AIDS.[31]

Other cultural practices such as female genital mutilation, which occurs in some parts of African countries, including Nigeria, Eritrea and Ethiopia, enhances the spread of HIV not only from the risk of the unsterilized instruments, but also from the scarring of the vagina. This may increase the likelihood of trauma during intercourse, thereby exposing the woman's blood to HIV-infected semen.[32] In 1999, over 130 million women were said to be victims of female genital mutilation, with 2 million subjected to the practice yearly.[33] Also, women who

---

was charged with the formulation and development of the national multi-sectoral approach to the AIDS/HIV challenge. The Traditional Healers and Modern Practitioners Together Against AIDS (THETA) is one of the country's over 1,000 ongoing projects addressing various aspects of HIV/AIDS. THETA was formed after a 1992 study showed the effectiveness and superiority of local herbal treatment for selected AIDS related symptoms such as herpes zoster, (than the modern drug). THETA respects traditional healers and believe the healers play a pivotal role in the control of AIDS. The traditional doctors, once admitted into THETA, undergo training (for a period of 18 months) to acquire skills that make them good community educators, counselors and condom distributors. This is said to be "a good example of using culturally relevant institutions in the combat against HIV/AIDS." *See* Sengendo & Sekatawa, *supra* note 15 at 37. Also worth noting is that in most African countries, people generally do trust the traditional doctors for their ability to listen and advise as a psycho-therapeutic practice. Hence, they can easily act as cultural intermediaries between people and the action plans in the fight against HIV/AIDS. The Zimbabwean Traditional Healers Association plays this similar role in Zimbabwe. However, some negative arguments have been made against traditional doctors that they are mere charlatans and often remain suspicious. *Id.*

30. UNSECO Zimbabwe, *supra* note 12, at 37.

31. Also common in Angola with the Kikongo young people is the exchange of blood during the rite of circumcision. During this ritual, after soaking a piece of cassava (yucca) in the blood of their foreskins, they eat "the bread of the brotherhood". Again, this practice facilitates the spread of HIV/AIDS. The tradition of female and male circumcision is passed down through the generation. *See A Cultural Approach To HIV/AIDS Prevention and Care, UNESCO/UNAIDS Research Project, Summary of Country Assessment, An International Overview*, *supra* note 18.

32. *See* Bartschi, *supra* note 25, at 5.

33. UNAIDS/IPU, *Handbook For Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic, and Social Impact*, 93 U.N. Doc. UNAIDS/99.48E (1999), *available at* http://www.unaids.org (last

have been circumcised experience severe pain during intercourse and thus, tend to have an adverse affiliation towards sex. Consequently, their partners tend to fulfill their desires outside of the relationship, thus encouraging promiscuity in those areas where female circumcision is practiced.

2. Sex and Condoms

In general, sex is not something that is openly discussed within African society, and bringing up the topic in order to introduce the use of condoms in a relationship, especially by African women, is rare and can have unusually negative consequences for women. Husbands or partners tend to generally exercise exclusive control over decision-making regarding sex.[34] This is exemplified by the case of a woman, who after attending a women's social gathering where they were given a talk on AIDS and the use of condoms, tried discussing some of the points she learned with her husband by proposing they use condoms until they were both tested for the virus. They fought all night, with the husband querying her as to who made her the head of the house. The husband did not only ban her from attending that social event again, but also accused her of wanting to see other men and thereby looking for an excuse to buy condoms.[35] Despite being aware that her husband was very promiscuous and knowing that she needed to protect herself, these discussions went against the vital norms where only the husband as the head of the family has the right to introduce such a discussion, and it almost ended her marriage. In another case, a woman reported knowing that her husband was quite promiscuous and that he had infected her with HIV. At the time of the interview, she had lived with the knowledge for five months, and neither of them had ever discussed it. She said she had no intention of confronting him, but promised to nurse him until he died.[36]

---

visited Sept. 15, 2004)[hereinafter *Handbook for Legislators*].

34. The man is supposedly endowed with this inherent decision making power by just being a man. This thought is very much incorporated into the unwritten law of society. *See* Pattern & Ward, *supra* note 19, at 214.

35. Conversation with Dr. Dora Mbanya, Hematologist and Professor at the University Teaching Hospital in Yaounde, Cameroon. This incidence, not atypical, was reported to me by Dr. Mbanya. *Id.* It is easier and more acceptable for a man to be in possession of condoms, but not a woman. *Id.*

36. An interview with anonymous Ivorian women patient at Centre Hospitalier et Universitaires in Ivory Coast. *See* Patten & Ward, *supra* note 19, at 213 n. 26. In some African societies, the status of a woman is linked to her ability to bear children, and that reproductive role is regarded as the property of the husband and his family. Consequently, a diagnosed HIV/AIDS wife may find it unrealistic in this cultural context to refuse to have

There are also a lot of misconceptions regarding the use of condoms. One misconception is that a condom sends the message to the other partner that he or she is not trustworthy, or that one is only interested in casual sex. Generally, it is very uncommon and perhaps considered an insult to use condoms in marriage. It raises suspicion of one having contracted a disease and hiding it. Hence, condoms are regarded negatively. In Zaire, for example, men view condoms as a form of western imperialism, compounded with the fact that many people believe that semen makes women healthy and, therefore, the use of condoms inhibits good health for their women. In Rwanda, they believe condoms cause sterility.[37]

In light of the above discussion as a whole, it is unquestionable that addressing the HIV/AIDS problem in Africa requires a substantial value change by the African man vis–a–vis his inherent and entrenched sexual values and behavior. Thus, focusing only on the women (who are more ready to listen and abide by rules)[38] and neglecting the mentality of the African man, hampers efforts to prevent the spread of HIV/AIDS. It is imperative that the men have a symbiotic understanding of sex with the women to result in a successful outcome in the fight against AIDS. There has been increasing recognition that in order to influence gender relations, men must be targeted. Hence, the view aptly expressed is: [39]

> [B]ecause men have more sexual partners than women, because men tend to control the frequency and form of intercourse and because women are physiologically more susceptible to the virus, it is men's behavior which determines how quickly, and to whom, the virus is spread. . .Such behavior does not mean that men are 'responsible' for the AIDS epidemic. Men are also at risk, since they cannot transmit the virus to others unless they contract it first themselves.[40]

---

children, even if she did not want to. On the contrary, the positive HIV test result may accelerate a woman's plans to conceive. *See* Allyn L. Taylor, *Women's Health at Crossroad: Global Responses to HIV/AIDS*, 4 HEALTH MATRIX 297, 316 (1994).

37. *See* Arbuckle, *supra* note 6, at 16.

38. The men, because they generally have and control the economic resources, also use that to have other girlfriends, or extra-marital affairs. Whereas the women tend to be in monogamous relationship, and lack the power to negotiate sexual "favors," such as the use of condoms. *See id. at* 6.

39. *Handbook for Legislators, supra* note 33, at 94.

40. *Id.*

II. CONTRIBUTION TO THE ENTRENCHMENT OF THE DISEASE IN AFRICA AS A RESULT OF HUMAN RIGHTS VIOLATIONS.

Human rights was an abstract concept in developing countries, because it was hard to convey in the political realm, when, for example someone was locked up in jail (usually without being tried in a court of law) for having expressed a view contrary to that of the government or head of state. Even then, this was not really looked upon as a human rights violation as such, but rather as a political rebellion or disobedience. Hence, human rights were not really an issue at the forefront. I believe that the HIV/AIDS pandemic has not only brought human rights issues to the forefront in these countries, but it has also been instrumental in heralding an unprecedented awareness of what human rights may entail.

Experience in addressing the HIV/AIDS epidemic over the years has confirmed that the promotion and protection of human rights is a paramount factor in preventing transmission of HIV and reducing vulnerability to infection.[41] A lack of human rights protection inevitably fuels the epidemic instead. For example, a person who is fired from his job based on discrimination because of his/her HIV status is faced with many problems, including burdens of healthcare as well as providing for a dependent family. People are certainly more vulnerable to infection when their economic, social, or cultural rights are not respected. A refugee for example, who is cut off from his family and hence, source of support, is more vulnerable to risk his health by engaging in unsafe sex than he would have been otherwise. Likewise, where civil and political rights are not respected, and freedom of speech and association are restricted, it is difficult for civil society to respond effectively to the epidemic. For example, where peer education is prevented by laws that deny official registration to groups with certain memberships, an organization or even an NGO with such membership is acting in violation of the law.[42] Unfortunately, this is not atypical in African

41. United Nations, *HIV/AIDS, Human Rights & Law, at* http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp (last visited Oct. 5, 2004). Human rights principles relevant to HIV/AIDS includes the rights to: non-discrimination, equal protection and equality before the law, life, the highest attainable standard of physical health, liberty and security of person, freedom of movement, seek and enjoy asylum, privacy, freedom of opinion and expression, the right to freely receive and impact information, freedom of association, freedom to work, marry and form a family, equal access to education, an adequate standard of living, social security, assistance and welfare, share in scientific advancement and its benefits, participate in public and cultural life, be free from torture and cruel, inhumane, or degrading treatment or punishment. *See Handbook for Legislators, supra* note 33, at 26-27.

42. *Handbook for Legislators*, *supra* note 33, at 24.

countries where the incumbent in power would tend to use any device to ensure and protect its supremacy.[43] Thus, it was crucial for the international community to intervene in a meaningful way to deal with human rights issues in light of the HIV/AIDS epidemic.

Hence, under the auspices of a joint effort between UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR), International Guidelines on HIV/AIDS and Human Rights were adopted and published in 1998 as a joint tool to help States implement an effective, rights-based, HIV/AIDS response.[44] This enabled states to translate human rights principles into practical observance in the context of HIV/AIDS.[45] These guidelines also set the standards for upholding HIV/AIDS related human rights at the national, regional, and international levels, as well as clarifying the obligations contained in existing human rights instruments.[46] What is commendable about these outlines is the emphasis placed on making governments the responsible parties under international human rights instruments. This is critical for African countries where without government commitment, a possible and successful implementation of

43. Generally, in some of these countries, the three arms of the government, the executive, judiciary and the legislature, are not distinctly separated. Consequently, the executive, through the head of state, often controls all three branches.

44. Including consultation with experts in the fields of AIDS and human rights, as well as government officials, people living with HIV/AIDS, academics, representatives of United Nations bodies, and agencies. *HIV/AIDS and Human Rights International Guidelines,* U.N. High Commissioner for Human Rights and the Joint U.N. Programme on HIV/AIDS, E/CN.4/1997/37 (1998).

45. Guideline 6: Access to Prevention, Treatment, Care and Support was revised in 2002 to provide an up-to- date policy guidance that is based on current international law and best practices. *See generally Advancing Care, Treatment and Support for People Living With HIV/AIDS; Updating Guideline 6 of the HIV/AIDS and Human Rights: International Guidelines,* Report of the Third International Consultation on HIV/AIDS and Human Rights, U.N. Commissioner for Human Rights, U.N. Doc. UNAIDS/02.49E (2002), *available at* http://64.233.161.104/search?q=cache:8Nh33hwMNa0J:www.unaids.org/html/pub/Publications/IRC-pub02/JC905-Guideline6_en_pdf.pdf+Guideline+6+and+U.N.+and+UNaids/02.49E&hl=en (last visited Feb. 21, 2005).

46. The other human rights instruments include: the United Nations Charter; the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Racial Discrimination; the Convention on all Forms of Discrimination Against Women; the Convention on the Rights of the Child; the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment; and Various International Labor Organization conventions and recommendations. *Handbook for Legislators*, *supra* note 33, at 26. Of course, these treaties only affect those nations that signed and ratified them.

human rights would be questionable because of the government's inherent supremacy powers under the rule of law in these countries.

In promoting this same spirit, the Declaration of Commitment by the United Nations General Assembly Special Session on HIV/AIDS in its paragraph 58 stated that:

> By 2003, enact strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, healthcare, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.[47]

Although all of these rights listed in the guidelines and declaration are critical to human rights, I am focusing primarily on the right to education and information; privacy and confidentiality; discriminnation and stigmatization; and the right to share in scientific research.

A. Education and Information

A paramount and fundamental objective to dealing with the spread of HIV/AIDS is information. People need not only be informed, but they need to be educated about the virus, the disease, and modes of transmission, prevention and protection. This is quintessential to effectively harnessing the disease especially in Africa, where some remote towns are not easily accessible, which makes communication with the locals there virtually impossible. It cannot be denied that the media is a valuable tool that can be employed in attempting to achieve this goal. Further, Article 19 [48] of the *Universal Declaration of Human*

---

47. *Declaration of Commitment on HIV/AIDS*, U.N. GAOR, 26th Spec. Sess., at 9, U.N. Doc. A/RES/S-26/2 (2001), *available at* http://www.unaids.org/DocOrder/OrderForm.aspx (last visited Oct. 6, 2004).

48. "Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers." G.A. Res. 217, U.N. GAOR, 3d Sess., at 74-75, U.N. Doc. A/810 (1948), *available at* http://www.un.org/documents/ga/res/3/ares3.htm (last visited Oct. 6, 2004). Subsection (1) provides: "(n)o one shall be subjected to arbitrary or unlawful interference with his privacy,

Rights and Article 17 of the *International Covenant on Civil and Political Rights* promote the right to information and education.[49] Guideline 6 of *The Human Rights International Guidelines* in the *Handbook for Legislatures*, provides for the "regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information, and safe and effective medication" at affordable prices.[50] Indeed, some countries such as Senegal have shown that its early decision to invest massively in HIV prevention and awareness programs in the 80's was worthwhile, as it is paying off today.[51]

Unfortunately, information and education relating to sexual health and HIV/AIDS prevention is still not yet accessible to all in Africa. Unlike in the urban cities in which there are many more televisions, radios, etc., in the rural areas, these media of communication can be afforded only by a very tiny portion of the population. Even if they are affordable, however, the absence or unavailability of electricity may prevent people from viewing and receiving such information. Also, the remote villages in Africa may tend to hear half-truths because the information is usually not tailored to the understanding of particular groups. For example, the distribution of condoms in a rural village without a strategy as to how this should affect the sexual attitude of the men and boys is futile.

Education is paramount not only to those living with HIV/AIDS, but also to those caring for them. Moreover, education is important to health workers, who are vulnerable to infection.[52] Health and education services that inform health workers about HIV/AIDS, including

---

family, home or correspondence, nor to unlawful attacks on his honor and reputation." G.A. Res. 2200, U.N. GAOR 3d Comm., 21st Sess., Supp. No. 16, 1495th plen. Mtg., at 55, U.N. Doc A/6316 (1966), *available at* http://www.unhchr.ch/thml/menu3/b/a_ccpr.htm (last visited Oct. 6, 2004).

49. *International Covenant on Civil and Political Rights*, G.A. RES. 2200A(XXI), 21 U.N. GAOR SUPP. (No. 16) at 52 U.N. DOC. A/6316 1966, 999 U.N.T.S. 171 art. 17 (entered into force March 23, 1976), *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm (last visited Feb. 21, 2005) [hereinafter *ICCPR*].

50. *Handbook for Legislators*, *supra* note 33, at 79.

51. UNAIDS, *Acting Early to Prevent AIDS: The Case of Senegal*, at 11 (1999).

52. The U.S. Agency for International Development [hereinafter *USAID*] instituted a project in 11 African countries where schools emphasize classroom-based prevention programs for children who have dropped out of school to care for ailing parents In some cases, as in Zambia, an interactive radio education program is available for orphans and vulnerable children. *See also Report on the Global HIV/AIDS Epidemic*, at 53, U.N. Doc. UNAIDS/02.26E (2002), *available at* http://www.unaids.org (last visited Oct. 5, 2004).

HIV/AIDS awareness training in schools curriculum, integrate HIV/AIDS awareness and anti-stigma messages into public leisure events. The use of market infrastructure to display HIV/AIDS prevention messages would be a useful step in enhancing education as a whole.[53]

B. Privacy and Confidentiality

One of the most fundamental rights that affects the dignity and perhaps the esteem of any human being is the right to privacy, especially with regard to health issues. That is why in developed nations citizens will fight hard to protect such rights, particularly in relation to health matters.[54] This right to privacy or confidentiality is essential to HIV/AIDS patients *a fortiori* because of the natural tendency to discriminate towards people living with HIV/AIDS. These rights are protected not only nationally, but are also required by international norms.

Article 12 of the *Universal Declaration of Human Rights*,[55] Article 17 of the *International Covenant on Civil and Political Rights*,[56] and Article 37 of the *Convention on the Rights of the Child* all protect the

---

53. *See Local Government Responses to HIV/AIDS: A Handbook* at 16, The World Bank Group (2003), *available at* http://www.worldbank.org/urban/hivaids/handbook.pdf (last visited Sept. 20, 2004).

54. In the United States for example, *The Patient's Bill of Rights in Medicare and Medicaid*, provides that patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Patients also have the right to review and copy their own medical records and request amendments to their records. *The Patient's Bill of Rights in Medicare and Medicaid,* U.S. DEPT. OF HEALTH & HUMAN SERVICES (1999), *at* http://www/hhs.gov/news/press/1999pres/990412.html (last visited Oct. 5, 2004).

55. *Universal Declaration of Human Rights,* Art. 12 states, "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks." *Universal Declaration of Human Rights,* G.A. Res. 217A (III), U.N. GAOR, 3rd Sess., at 73-74, U.N. Doc. A/810 (1948), *available at* http://www.un.org/overview/rights.html (last visited Oct. 5, 2004). Article 17(1) states, "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation." In addition, Article 17(2) states, "[e]veryone has the right to the protection of the law against such interference or attacks." *ICCPR*, *supra* note 49, art. 12. Article 37(d) states, "[e]very child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action." *Convention on the Rights of the Child*, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 167, U.N. Doc. A/44/49 (1989), *available at* http://www.unhchr.ch/html/menu3/b/k2crc.htm (last visited Oct. 5, 2004).

56. *ICCPR*, *supra* note 49.

fundamental right to privacy. The goal of protecting these rights in relation to HIV/AIDS is to ensure, for example, that counseling and testing are voluntary,[57] and that HIV test results are confidential, essentially guaranteeing the right of non-disclosure to third parties. Privacy rights are even more important in Africa because of the stigmatization and likelihood of being ostracized by the community if the HIV/AIDS status of a patient becomes known. However, this right may be employed to the disadvantage of family members and the community at large. For example, because infected people are not known by others to be infected, they move around trying to act normal by having sexual relationships without using condoms. In some cases, they are just intentionally out to spread the disease.[58] Furthermore, even after the patient has died, the family members bribe the doctors to indicate some other illness as the cause of death on the death certificate.[59] Why? So that they can disprove the community's view that their relative died from HIV/AIDS. Hence, to that extent, the privacy right may not be helpful. The fact that X died from HIV/AIDS should have a deterrent effect on Y and the rest of the community, and if this impact is hindered because of false information, then the community may suffer.

At the same time, anyone who may test positive and is asked to bring along a husband, wife, or partner so they too can be tested or counseled, generally will leave the doctor's office never to return. For example, Dr. Mbanya Dora,[60] encountered this with several of her patients. Thus, what later happens to these patients is not clear. The only certainty is that their refusal to return to the doctor was because they did not want their partners and perhaps others to know that they

57. Thus mandatory testing in some countries under the guise of general consent to medical services has been held to be illegal. The European Court of Justice has endorsed this view, by holding it was illegal to subject employees to a disguised HIV test without their informed consent. *Handbook for Legislators, supra* note 33, at 41 (discussing X v. Commission); *see Report on the Global HIV/AIDS Epidemic*, *supra* note 52, at 63. This issue is controversial for many reasons. On the one hand, the medical profession has an ethical and sometimes legal obligation to protect others against the spread of HIV/AIDS by tracing contacts of those infected. On the other hand, patient confidentiality is a fundamental aspect of the doctor-patient relationship, which allows patients to feel free to disclose sensitive information with health care providers. Coercive strategies, however, have been recognized as inappropriate, ineffective, and counterproductive because they deter those at risk of infection from seeking early counseling, testing, and treatment. The International Guidelines on HIV/AIDS and Human Rights support voluntary partner notification, leaving exceptions for extraordinary cases. *Handbook for Legislators, supra* note 33, at 45.

58. Coversation with Dr. Dora Mbanya, *supra* note 35.

59. *Id.*

60. *Id.*

were infected. Also, Dr. Dora's assumption is that they continue to live a sexual life as though nothing is wrong, hence, increasing the widespread nature of the disease.[61] With the continued struggle of South Africa to fight HIV/AIDS, Uganda's success was attributed to the openness surrounding the personal impacts of the disease and the role of leaders and communities in discussing this openly.[62] Hence, only being concerned with how the privacy rights of patients would be protected without taking the cultural context into consideration may not achieve the goal of preventive care. Moreover, in these countries people are not anxious to be tested in the first place. Unlike in developed nations, where the availability and affordability of drugs provides strong incentives to seek HIV testing for individuals who suspect they are at risk of infection, in Africa, the individual who is not capable of buying drugs would not even bother with testing. He thinks that if he is going to die anyway, there is no need to know. Although I believe testing should be based on voluntary consent, I still opine that policymakers should provide laws requiring an immediate family member, such as a wife, husband, sister, or brother to be informed.

C. Discrimination and Stigmatization

Discrimination is one of the most obvious human rights abuses when we talk about HIV/AIDS, and is visible in many areas including healthcare, employment, education, sports, and accommodation. It is also sad that discrimination is perhaps one of the most difficult problems to deal with in terms of implementing and enforcing legislation, especially in the African setting. Most African countries have not adopted legislation to prevent discrimination against people living with HIV/AIDS. Discrimination may come in different forms: direct or indirect.

> Direct discrimination occurs where a person treats another person less favourably than a third person would have been treated in comparable circumstances. . .Indirect discrimination occurs where unreasonable conditions or requirements, such as mandatory HIV testing, are applied

---

61. In 2002, HIV prevalence fell 8% in Kampala. This is significant, given that HIV was found in 30% of pregnant women who were treated at two urban antenatal clinics a decade ago. Indeed, double-digit prevalence rates are now rare in Uganda. *AIDS Epidemic Update, supra* note 3, at 10; *see also Global Report on HIV/AIDS Epidemic, supra* note 52, at 2.

62. *See Local Government Responses, supra* note 53.

> which a substantially higher proportion of persons of a different status must be able to comply with than persons of the same status as the person claiming to have been discriminated against.[63]

Regardless of what form it may take, discrimination has the adverse effect of impeding the full participation and integration of the persons living with the disease in the community.

Stigmatization, on the other hand, breeds discrimination and isolation for those with HIV/AIDS. This isolation only tends to worsen the impact of infection, while impeding effective responses to prevention, treatment, support and care.

With a focus on stigmatization and discrimination, the 2002–2003 World AIDS Campaign, as part of world-wide efforts among other things,[64] encouraged different leaders from all walks of life, to visibly challenge HIV-related discrimination, spearhead public action and act against the many other forms of discrimination that people face in relation to HIV/AIDS. Guideline Number 5 of the *Handbook for Legislators*[65] provides that States should enact or strengthen anti-discrimination laws and other laws that protect vulnerable groups—people living with HIV/AIDS and people with disabilities—from discrimination in both the public and private sectors.[66] In spite of this, HIV/AIDS discrimination is very common and acceptable in many African countries, where the disease is sometimes considered taboo. Anyone who is infected, and even non–infected family members, are ostracized from the community. Unfortunately, and perhaps unwittingly so, some governments have endorsed or fostered stigmatization and discrimination, by ensuring that HIV/AIDS patients are hospitalized in a special ward, usually away from the rest of the other wards. Hence, visitors to these wards are reluctant to visit for fear of being seen as associated with or related to someone with the disease.

---

63. *Handbook for Legislators, supra* note 33, at 66 (citing Watchirs H., *HIV?AIDS Discrimination and Privacy-the Need for Legislative Protection*, in D.C. Jayasuriya (Ed.) *HIV Law Ethics and Human Rights*, UNDP Regional Project on HIV and Development, New Delhi, 1995).

64. Including "monitoring violations of human rights, and ensuring that people are able to challenge discrimination and receive redress through national administrative, judicial and human rights institutions designed to safeguard rights." *Report on the Global HIV/AIDS Epidemic, supra* note 52, at 66-67 (States should "[monitor] violations of human rights, and [ensure] that people are able to challenge discrimination and receive redress through. . .safeguard[ing] rights."

65. *HIV/AIDS and Human Rights- International Guidelines, supra* note 44, at 11.

66. *Handbook for Legislators, supra* note 33, at 64.

A man was forced to break the engagement to his fiancée because she had been seen on several occasions visiting her relative in a hospital ward reserved for HIV/AIDS patients.[67] The ability of the law to remedy this kind of a situation is unlikely, especially with regard to proof and enforceability. Furthermore, the likelihood of the aggrieved party taking the matter to court is slim.

D. The Right to Share in Scientific Research and Its Benefits.

These rights are protected by Article 27 of the *Universal Declaration of Human Rights*, and Article 15 of the *International Covenant on Economic, Social and Cultural Rights*.[68]

Given the economic and financial imbalance between developed and developing countries, it is certain that developed countries are, and will always be, at an advantage when it comes to research and development, especially in the scientific realm. If this advantage is reaped but not shared in a meaningful way with developing countries, it could prevent developing countries from participating or sharing in scientific advances dealing with HIV/AIDS as required under subsection 2 of the *International Covenant on Economic, Social and Cultural Rights*.

Although there is no cure for HIV/AIDS as yet, antiretroviral drugs (ARV), which inhibit the replication of a retrovirus such as HIV, can dramatically reduce HIV related morbidity and mortality, thereby improving the quality of life. Indeed, the WHO Model List of Essential Medicines update in 2002 included ARV drugs as essential.[69] Thus, one

---

67. Conversation with Dr. Dora Mbanya, *supra* note 35.

68. *Universal Declaration of Human Rights*, *supra* note 55; *International Covenant on Economics, Social and Cultural Rights*, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), *available at http://www.unhchr.ch/html/menu3/b/a_cescr.htm* (last visited Feb. 23, 2005)[hereinafter *ICESCR*]. The *Universal Declaration of Human Rights* states, "1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits. 2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author." *Universal Declaration of Human Rights*, *supra*. The *ICESCR* states, "1) The States Parties to the present Covenant recognize the right of everyone. . .literary or artistic production of which he is the author. 2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture. 3) The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity. 4) The States Parties to the present Covenant recognize the benefits to be derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields." *ICESCR*, *supra*.

69. "Essential medicines are those that satisfy priority health care needs." *A*

can hardly undermine the value of ARV drugs as an effective response to treatment of the epidemic. As of the end of 2002, out of the 5-6 million adults in need of ARV in developing countries, only about 300,000 were using the drug.[70] In sub-Saharan Africa, 50,000 people were using the drug with 4,100,000 still in need, resulting in a coverage of only 1%.[71] Yet, Africa is home to 29.4 million people (adults and children) living with HIV/AIDS, with 3.5 million newly infected each year.[72] Why are these African countries unable to share and benefit from such scientific advances? Cost, cost, cost is the answer.

> Does anyone deserve to be sentenced to certain death because she or he cannot access care that costs less than $2 a day? Is anyone's life worth so little? Should any family become destitute as a result? Should children be orphaned? The answers must be no, no, no and no.[73]

Also, the developed countries have shown that the potential for treatment does mitigate the social and economic impact of HIV-related disease. Perhaps this was a factor taken into consideration by the U.N. Commission on Human Rights when it adopted, for the first time, a resolution recognizing access to medication in the context of HIV/AIDS.[74] Other efforts have been made by non-governmental organizations, including OXFAM and Médecins Sans Frontiéres, to facilitate access to treatment in low-income countries.

Low prices would inevitably improve access to those millions in Africa who are in dire need, but unable to afford ARV drugs. Although $2 a day may seem to be only change to someone in an industrialized

---

Commitment to Action for Expanded Access to HIV/AIDS Treatment, WHO Doc. WHO/HIV/2002.24 at 4 (2002), *available at* http://www.who.int.hiv/pub/arv/who_hiv_2002_24.pdf (last visited Oct. 4, 2004).

70. *Id.* at 1.

71. *Id.* at 4.

72. *See AIDS Epidemic Update*, *supra* note 3, at 7.

73. WHO, *Commitment to Action*, *supra* note 69, at 4. A survey conducted by WHO in 70 law-income countries around the world in 2001 addresses these questions by indicating that one-half of the countries surveyed had virtually no access to antiretroviral treatment (ART); one-half of the countries had virtually no access to services to prevent mother to child transmission of HIV; only one person in 50 living with advanced HIV infection had access to ART and only one pregnant woman in 30 had access to prevent mother to child transmission services. *Id.* at 2.

74. "One fundamental element for achieving progressively the full realization of the right of everyone to the enjoying of the highest attainable standard of health." G.A. Res. 33, U.N. GAOR, Hum. Rts. Comm., 57th Sess., 71st mtg. (2001).

country, it may be worth $100,000 or more to a patient in Africa. Consequently, although price reductions have been significant, recently (thanks to the efforts of the U.N. working with pharmaceutical companies like GlaxoSmithKline, Abbot and Merck & Co., Inc.) on the Accelerating Access Initiative there have been further reductions in prices.[75] In spite of these reductions, the cost is still not affordable in these countries.[76]

However, other national[77] and international organizations, such as the International HIV Treatment Access Coalition (ITAC), have facilitated access to anti-retroviral treatment in these countries amongst other things, by fostering national and international leadership and advocacy, including maintaining pressure for lower drug prices.[78] Even generic manufacturers have reduced their prices in developing countries. A price reduction to below $ 0.50 per person per day for first line regimens would be applauded. With continuous falling prices and international financial support, this expectation may be achieved and even exceeded.

However, there is still the potential and fundamental problem of ensuring that new research and development or improved HIV therapies are not compromised by the existing price reductions on current drugs.

---

75. At the beginning of 2000, the price of combination antiretroviral drug to treat a single patient for a year was between $ 10,000 and $12,000. By the end of 2000, prices of $ 500 and $800 were being negotiated by low and middle-income countries; and by December 2001, certain generic combinations were on offer for as low as $350 per person per year. *See Report, supra* note 6, at 146

Likewise, recently, the Clinton Foundation and four generic pharmaceutical companies, Aspen pharmacare Holdings, Cipla, Ranbaxy laboratories and Matrix Laboratories, agreed to dramatically lower the price of HIV/AIDS treatment in the developing world. Press Release, UNAIDS, UNAIDS Applauds Clinton Foundation's Agreement with Pharmaceutical Companies to Cut Prices of AIDS Drugs (Oct. 23, 2003), *at* http://www.unaids.org/html/pub/media/press-statements01/wto_010903_en_doc.htm.

76. Insufficient capacity of health sectors, including infrastructure and shortage of trained personnel, are also other contributing factors that inhibit health service delivery in these countries. *Aidsmap, The Declaration of Commitment on HIV/AIDS, available at* http://www.aidsmap.com/en/docs/B83BAE5B-00F4-41DE-A48A-51A4F24763E6.asp (last visited Oct. 4, 2004).

77. An analysis of over 90 countries' HIV/AIDS plans indicates that about 60% of countries have now either incorporated ART into their national plans or have defined specific ART coverage. Over 40 countries in Sub-Saharan Africa, as of 2002, have national HIV/AIDS strategies, which is about three times as many as two years ago. WHO, *Commitment to Action, supra* note 66, at 8. A coalition of partner organizations includes people living with HIV/AIDS and their advocates, NGOs, governments, foundations, academic and research institutions, and international organizations. *Id.* at 3. In addition, the World Bank has helped to foster treatment by supporting ART in the Multi-country AIDS program (MAP). *Id.* at 8.

78. *Id.* at 9.

This is even more worrisome given the fact that some HIV strains are resistant to drug therapy, thereby requiring innovation through further research and development. This is a difficult balance for pharmaceutical companies to reach because by investing substantial amounts of money in research and development, and with that investment being protected by intellectual property rights through patents, they are ensured their profits. Hence, a price reduction may deprive them of some of that revenue.

Related to this is the issue of whether such patent rights should be relinquished to give an edge to those pharmaceutical companies in developing countries to produce cheaper versions of the HIV drugs, given that it is a national and international public health issue. This debate has been ongoing and eventually clarified by the World Trade Organization Ministerial Conference in Doha, Qatar, by holding that the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) "must be part of a wider national and international action to address serious public health problems, including the AIDS epidemic in low-and middle-income countries."[79] In other words, the declaration explicitly stated, "public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency for which governments can issue a compulsory license authorizing, under certain conditions, the use of patent products."[80] Likewise, UNAIDS struck a deal with the pharmaceutical industry requiring that any new forms of HIV treatment are promptly made available to low and middle income countries.[81] This explains one of the major rationales for the increase in the availability and to a large extent the affordability of drugs by HIV/AIDS patients in sub-Saharan African countries.

In some cases, companies in particular countries have taken up the HIV/AIDS challenge by providing ARV for their employees, resulting in a positive outcome for not only the employees, but to the business itself. For example, Cote D'Ivoire, an electricity company (Compagnie Ivoirienne de L'Electricite), which offered ARV to its employees in 1999, benefited from reduced employee absenteeism. The annual cost of low productivity, employee replacements, and funerals decreased from $ 1.5 million to $ 60,000 for an investment of $ 338,000 in 1999

79. *2004 Report on the Global AIDS Epidemic*, *supra* note 6, at 149.

80. *Id.*

81. *See id.* (referring to the multiple approaches to be employed in attaining to make HIV treatment available to low and middle income companies).

and $ 153,000 in 2000 respectively.[82]

III. Discussions and Recommendations for the African Dilemma

The devastating and unprecedented effect of HIV/AIDS on the African continent has drawn the attention of almost all African leaders and their governments. Each of whom has expressed their commitment to curb its spread.[83] Hence, at the Summit of the Organization of African Unity (OAU) held in Abuja, in April 2001, OAU members pledged to allocate 15% of their national budgets to health in order to effectively deal with HIV/AIDS. [84]

Partnerships are being forged both at the national and international level to deal with the epidemic. For example, one partnership is the International Partnership Against AIDS in Africa (IPAA), a coalition of United Nations agencies, donors, and the private and community sectors, under the leadership of African countries. Also, some heads of State from several countries have formed "AIDS Watch Africa," a peer education initiative enabling members to communicate and seek solutions to problems posed by AIDS to development.[85] Indeed, some leaders in some countries have already made the AIDS issue a part of their health plan/budget. South Africa's budget includes a substantial allocation for AIDS prevention and care programs, while, in Zimbabwe, the government instituted an AIDS levy among the general population, in order to raise funds. [86] The leaders of African countries are now very concerned with the epidemic, especially given that the disease has undoubtedly affected the economic development, progress, and security

82. *See A Commitment to Action*, supra note 69, at 10.

83. Paradoxically, while medial care in the high-income countries, extends the lives of those living with HIV/AIDS, Africa faces the basic challenge of extending these lives through medical care.

84. *Time to Turn Commitments into Action in Africa, UNAIDS Says*, UNAIDS NEWS, Dec. 10, 2001, at 1, *available at* http://www.aegis.com/news/unaids/2001/UN011201.html (last visited Oct. 4, 2004); *see also Special Session of the General Assembly on HIV/AIDS: Report of the Secretary General*, U.N. GAOR, 55th Sess., Agenda Item 179, at 11, U.N. Doc. A/55/779 (2001), *available at* http://www.un.org/documents/ga/docs/55/a55779.pdf (last visited Oct. 4, 2004) (The Secretary General stated that "While the epidemic in Africa continues to spread, there is well documented evidence of success in the response to HIV/AIDS, particularly among young people. The epidemiological information coming from Zambia, Uganda and the United Republic of Tanzania, is evidence of a new generation responding to the threat of HIV/AIDS by changing their behavior in ways that appear to be protecting them from HIV"). *Id.*

85. The Heads of States include those from Mali, Nigeria, Rwanda, South Africa and Uganda. *Report on the Global HIV/AIDS Epidemic, supra* note 52, at 174-75.

86. *UNAIDS Says, supra* note 84, at 1.

of many of these countries.[87]

With regard to some of the issues raised, I would recommend that the customary laws be pre-empted by formal or statutory law. Thus, the legislature should introduce laws that will limit or even eradicate the traditional laws that tend to have an impact on the spread of AIDS. For example, polygamy could be limited to a maximum number of two wives as a first step towards encouraging monogamous marriage. In addition, it could be allowed only in those circumstances where it is inherent in the culture or religion; i.e., in Islam, Fondoms, and chieftaincies. Outlawing prostitution may be helpful, but it is doubtful as to how effective it may be, since it would require the government to monitor conduct that occurs in private.

Policies regulating traditional or herbal doctors should be implemented with guidelines for these practitioners to follow.[88] Also, educating the doctors on AIDS, its transmission through blood exchange and the proper use of sharp objects on patients may be helpful. [89] In the same vein, female circumcision should be banned. Progress has been made to this effect by some NGOs in some African countries including Kenya,[90] Uganda,[91] Ghana, [92]and Nigeria.[93]

---

87. *See UNAIDS, Report on the Global HIV/AIDS Epidemic*, *supra* note 52 (2002), at 174-74, *available at* http://www.unaids.org (last visited Oct. 14, 2004). The long- term impact of the disease is being felt now, as young adults die leaving only the old, who can barely contribute to the labor force of the country. *Id.* The population growth rate for sub-Saharan African has been estimated to drop to between 2% and 4 % as a result of AIDS. *Id.* The Heads of State include those from Mali, Nigeria, Rwanda, South Africa and Uganda. *Id.*

88. *See A Cultural Approach to HIV/AIDS Prevention and Care*, *supra* note 13, at 14. The WHO released a global plan that provided a policy framework to assist countries in regulating traditional, complementary or alternative medicine. *Id.* This would make its use safer, more accessible and sustainable. *Id.* In Africa, North America and Europe, three out of four people living with HIV/AIDS use some form of traditional or complementary treatment for various symptoms and conditions. *Id.*

89. This is less likely effective because some of these traditional doctors believe that they can cure HIV/AIDS. And for them to accept anything that may undermine their credibility and mystical powers may be difficult. For example, if drinking blood is the doctor's method of curing or treatment for a particular disease, it will be difficult for him to abandon that practice because he things it can cause AIDS.

90. *See Handbook for Legislators*, *supra* note 33, at 93. In Kenya, "the women's organization Maendeleo ya Wanawake has developed such community based programs." *Id.*

91. *Id.* In Uganda, "the Reproductive, Educative and Community Health program has shown that practices can change without compromising values." *Id.*

92. *Id.* In 1995, "the Ghanaian Association on Women's Welfare succeeded in its campaign to criminalize female genital mutilation, and continues to conduct community education to end such practices.

93. *See Handbook for Legislators*, *supra* note 33, at 93. "[A] multisectoral working group including representatives from NGOs, the Ministries of Health and Justice, and international agencies developed a national policy and plan of action to end femal genital

Widow inheritance and widow cleansing should be completely banned, or pre-empted by formal law in a way that reduces their significance or relevance. Also, educational programs designed to highlight the possible risks associated with these practices should be implemented. The local community should be involved, that means, chiefs, fons, traditional rulers, religious leaders, etc.[94]

The sub-Saharan Africa countries should eradicate the double standards in family laws regulating marriage and the grounds for divorce, regardless of gender or sex. This would essentially create uniformity in the law governing the grounds for adultery. Likewise, increasing women's participation in politics by creating a supportive policy and legislative context for women would be vital in curtailing the spread of HIV/AIDS. For example, women in parliament would become more aware and make informed choices in passing legislation. Hence the issue to the legislator would be whether the law ensures the equal legal status of men and women in marital relations (divorce and custody), ownership of property and inheritance.

Because the women make up the majority of those infected in many of these countries [95] and are also primarily responsible for nursing those suffering from AIDS, empowering women economically and socially would also equip them to be independent from men. These women will thereby not be obliged to stay in a marriage or a relationship with an infected or promiscuous man, just for the purpose of gaining support. Research and writings tend to show that narrowing the gap and power imbalance between African men and women will reduce the vulnerability of woman to HIV/AIDS.

Unless sex is understood in the African social and cultural context, and dealt with from that perspective, all the funding, programs and education on prevention in Africa may be a waste of resources. As one

---

mutilation." *Id.*

94. *See* Wax, *supra* note 14. Small but effective steps were taken in a village in Kenya by a group of women who put together a drama about refusing to be cleansed or inherited. *Id.* In the skit, after the death of her husband, a woman refuses to be cleansed or inherited until the cleanser takes an HIV test. *Id.* "I am clean like water, says the cleanser. "Then take the test," replied the woman. At the end, a village elder successfully forced her to be cleansed and inherited, and she too dies from complications of AIDS. A man in the audience admitted that his views that the traditions of cleansing should be adhered to, have been eroded by the skit. This is so, as he realized, because they may all die if the practice is not stopped. Education, such as this, has empowered the widows in that community to express that they are far less worried just knowing that today, they can say no to such practices. *Id.*

95. In sub-Saharan Africa, 55% of HIV-positive adults are women. *AIDS Epidemic Update*, *supra* note 3, at 6.

writer wrote: [96]

> There are widespread beliefs that males are biologically programmed to need sexual relations regularly with more than one woman. . .Partner's dynamics are characterized by an avoidance of direct communication, with the assumption that men should control the sexual encounter. Common to both young men and women is the belief that a man has a right, or even duty, to force himself unto a woman who displays reluctance or shyness. Gender-based violence itself is often seen as a sign of affection, showing how deeply the man cares. Sex in marriage is simply expected as part of the marriage '"deal' whenever the husband demands it. . . '[g]ifts for sex' is a practice that expresses itself most strongly in premarital and extramarital relationships.[97]

In fact, the importance of culture (heavily applauded by this author)[98] became the cornerstone of the new methodological approach to prevention and cure of the disease taken by UNAIDS in 1994. Following a proposal made by UNESCO's culture sector to UNAIDS Program a joint project, "A cultural Approach to HIV/AIDS: Prevention and Care," was launched in 1998. This approach was innovative in that the creation of action plans was to be done in reference to the culture; hence, deference to a population's characteristics, which include, lifestyles and beliefs, were considered paramount in addressing a change in behavior on a long-term basis.[99] In other words, people's motivation towards changing their risky behavior was considered in light of their cultural resources and references.[100] Thus, by 1998–1999,

---

96. *See* Suzanne Leclerc-Madlala, Silence, Aids and Sexual Culture in Africa, *available at* http://www.findarticles.com/p/articles (last visited Oct. 14, 2004).

97. *Id.*

98. Florence Shu-Acquaye, ASS'N AM. L. SCHOOLS: THE AFRICAN SECTION NEWSLETTER, vol. 5, p. 17 (2002). It appears that culture is instrumental in stopping the spread of HIV because it addresses behavior. Therefore, to effectively prevent the spread of HIV/AIDS, one should thoroughly consider the cultural idiosyncrasies of each African country. *Id.*

99. *See UNESCO/UNAIDS Research Project, A Cultural Approach to HIV/AIDS Prevention and Care: Summary of Country Assessments – An International Overview*, at 18, *available at* http://unesdoc.unesco.org/images/0012/001262/126289e.pdf (last visited Oct. 14, 2004). Culture, amongst other elements, consists of traditions, beliefs, values, family structures, and gender, group and personal relations. *Id.* [hereinafter *UNESCO/UNAIDS Research Project, Cultural Approach*].

100. *See UNESCO/UNAIDS Research Project Cultural Approach, supra* note 100, at

in the first phase of its project, nine country assessments were carried out in three sub-regions: sub-Saharan Africa (Angola, Malawi, South Africa, Uganda and Zimbabwe), South East Asia (Thailand), and the Caribbean (Cuba, the Dominican Republic and Jamaica).[101] Hence, cultural resources have been identified and exploited to combat dangerous sexual behavior, to provide information, education, and communication, as well as to encourage openness in dealing with HIV/AIDS.

A. Implementing and Enforcing Adopted Laws

Yes, having laws on the books or the signing and ratification of international treaties on human rights is one good step forward for these countries. However, it is usually a *completely* different issue when it comes to the implementation and enforcement of these laws in Africa. Although much has been achieved thus far, there is still a lot more to be done, especially in implementing and enforcing human rights laws. The requirement, for example, that States ensure a monitoring and enforcement mechanism to guarantee HIV-related human rights is a great pre-emption for the role of African governments.[102] However, the government can best execute this function if it allows human rights institutions to be established that deal with human rights violations, completely independent from the government's influence.[103] There is often that tension in the government between trying to protect its country's image (especially with regard to human rights violations) from the international community versus letting the established human rights institution taint that image with contrary, and usually truthful, unfavorable statements of human rights violations in that country. Thus, governmental influence tends to affect the latter.

Other methods or forms of enforcing and condoning

---

18. The main objective of the project is "meant to put people's cultures at the base of the design and implantation of action taken to [c]ombat the expansion of the virus" and to "[e]volve a more supportive culturally-based environment for people with AIDS. . ." *Id.*

101. *See id.* The findings of these studies were discussed and enhanced in three sub-regional workshops held in the Caribbean, Southern Africa, and South East Asia in 1998-1999. *Id.* at 7. Also, "seven shorter monographs have been carried out for Botswana, RDC Congo, Lesotho, Namibia, Mozambique, Swaziland, and Zambia." *Id.* at 30. The second phase of the project, the years 2000 through 2001, was based on training, networking, and developments of methodological tools. *See UNESCO/UNAIDS Research Project Zimbabwe*, *supra* note 13, at 31.

102. *See Handbook for Legislators*, *supra* note 33, at 101-02. International Guideline 11 provides for state monitoring and enforcement of human rights for those living with HIV/AIDS, for their families and communities. *Id.*

103. *See id.* at 102-03.

antidiscrimination laws could be brought about through simple action on the part of the African governments, such as publicly acknowledging the existence of the disease and acknowledging that it is okay to talk about it as well as interact with persons living with HIV/AIDS. In Zambia for example, a former president publicly announced that his son had died of AIDS. Likewise, "late Princess Diana of Wales publicly. . .made physical contact with people living with HIV/AIDS."[104] In so doing, governments would also be complying with International Guideline 9, which requires that States "should promote the wide and ongoing distribution of creative education, training, and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS."[105] Thus, enforcing or implementing basic human rights may, in some instances, not be an uphill task after all.

Likewise, continuous efforts towards antiretroviral treatment will reduce stigma and discrimination, as communities will be revitalized, household disintegration prevented and workers will stay productive. All of this would boost confidence, and people living with HIV/AIDS could be involved as experts in implementing human rights, not treated as outcasts.[106]

A general check list for policy makers and the legislators in addressing some of the other issues raised should include, but not be limited to the following: [107]

1) In the public health arena, legislation should empower public health authorities to provide comprehensive prevention and treatment services, such as protection of blood, tissue and organ supplies against HIV contamination.

2) In criminal law, States should reform criminal laws to ensure that they are consistent with international human rights requirements and not inappropriately used in the context of HIV/AIDS.[108] For example, if a new offense is

104. *Handbook for Legislators*, *supra* note 33, at 102-03.

105. *Id.*

106. *See A Commitment to Action*, *supra* note 80, at 5.

107. *See also Handbook for Legislators*, *supra* note 33, at 49-90. The Handbook provides useful checklists for legislation in various legislative areas. *Id.*

108. *Report of the Secretary General, Human Rights Commission, International Guidelines on HIV/AIDS and Human Rights*, 53rd Sess., Agenda Item 9(a), at 50, U.N. Doc.

created relating to transmission of HIV/AIDS, the offense should be generic rather than HIV specific, and apply to other communicable diseases as well; evidentiary issues, such as foreseeability, whether the accused knew that the act he or she was contemplating was criminal, intent (mens rea), causation (that the accused conduct did in fact infect the victim) and consent would need to be addressed.[109]

3) Antidiscrimination laws: the enactment of general antidiscrimination legislation that prohibits unfair and irrelevant distinctions of people or groups may be helpful in curtailing discrimination. For example, laws that provide for protection against discrimination on the ground of disability, now widely defined to include HIV/AIDS, or protection against discrimination based on membership of a group made more vulnerable to HIV/AIDS, such as gender and homosexuality.[110]

4) Laws that ensure equality of men and women in the ownership of property and inheritance, marital relations (divorce and custody), capacity to enter into contracts, prohibition of harmful traditional practices, such as genital mutilation, laws against sexual abuse and exploitation of children and so on.[111]

5) Privacy/confidentiality laws that protect the privacy of medical records that include HIV related information.

6) In the area of employment, there should be laws that protect employees who are HIV positive from unfair dismissal and provide social security or other benefits when workers are unable to work. The International Labor Organization (ILO) has provided guidelines for States to adopt in these instances.[112]

E/CN.4/1997/37 (1997).

109. *See Handbook for Legislators*, *supra* note 33, at 51

110. *Id.* at 64.

111. *Id.* at 72.

112. *See infra*. pp. 132-33.

7) Consumer protection laws, which provide protection against fraudulent claims regarding the safety and efficacy of drugs and vaccines, as well as regulate the quality, accuracy and availability of HIV tests. Also, those laws, which assure the accessibility and free availability of preventive measures such as condoms, needles and syringes.[113]

8) Laws which promote a supportive and enabling environment for women and other vulnerable groups, in accordance with International Guideline 8.[114]

IV. THE ROLE OF INTERNATIONAL ORGANIZATIONS IN DEALING WITH THE HIV/AIDS CRISIS IN AFRICA.

International financial organizations such as the World Bank, International Monetary Fund (IMF), International Financial Corporation (IFC), and the ILO[115] are making an impact on the prevention and care of the HIV/AIDS in Africa. Although much has been done by these organizations, it is still questionable whether some of these organizations are achieving optimal results.

The World Bank, for example, increased support for HIV programs in 2000 by launching its first phase of a multi-country AIDS program for Africa.[116] This effort made available $500 million in credits for African countries to increase national prevention care and treatment programs.[117] As of July 2003, the World Bank had committed more than $800 million for HIV/AIDS programs.[118]

However, because of the conditions often attached to giving financial assistance or loans to these countries, the World Bank and the IMF are being criticized for indirectly enhancing the precarious

113. *See Handbook for Legislators*, *supra* note 33, at 82.

114. *Id.* at 90.

115. Although the (ILO) is not a financial institution, it plays a pivotal role in dealing with HIV/AIDS.

116. PROGRESS REVIEW MISSION-FY01, THE U.S. $500 MILLION-COUNTRY HIV/AIDS PROGRAM (MAP) FOR AFRICA 1 (executive summary).

117. *Id.*

118. Press Release, World Bank Group, Long Term Economic Impact of HIV/AIDS More Damaging Than Previously Thought, No. 2003/24/S (July 23, 2003) *available at* http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20120894~menuPK:34466~pagePK:64003015~piPK:64003012~theSitePK:4607,00.html (last visited Mar. 16, 2005).

conditions facing the African governments that deal with the HIV/AIDS challenge.[119] In trying to meet the required conditions for structural adjustment programs,[120] these governments tend to undermine the health sector. This issue is compounded by the governments' already tight budget, as well as, the outstanding debts owed by various African countries.[121] The debt relief for most of these African countries does not go deep enough to deal with such problems. Half of the twenty-six countries receiving debt relief under the Enhanced Indebted Poor Countries (HIPC) Initiatives were still spending 15% or more of government revenue on debt repayment in early 2002, thereby "crowding out" investments in health and other sectors.[122] Similarly, sixteen countries, including several sub-Saharan African countries where adult HIV prevalence exceeded 1.5 % in 2001, were ineligible for the debt relief. Therefore, relaxing the debt relief eligibility for such countries would undoubtedly help in dealing with the epidemic. [123]

---

119. Ann-Louise Colgan, *Africa's Debt—African Action Position Paper*, *at* http://www.africaaction.org/action/debtpos.htm (last visited Mar. 16, 2005); *see also* Press Release, Africa Action, No! Loans: Not a Solution to the AIDS Pandemic in Zambia (Apr. 3, 2001).

120. A country may promise to undertake certain governance reforms in exchange for a loan from the lending institution. *See generally* Shu Acquaye, *The Taxonomy of The Director's Fiduciary Duty of Care: United States and Cameroon*, 22 N.Y.L. SCH. J. INT'L & COMP. L. 585, 605-06 (2003).

121. *See* Colgan, *supra* note 119; *see also* Press Release, Africa Action, *supra* note 119.

122. *See* Human Resources and Sustainable Development, *supra* note 1, at 28; *see also* Christina Daseking & Julie Kozack, *Avoiding Another Debt Trap*, Finance & Development, Dec. 2003, at 20, *available at* http://www.imf.org/external/pubs/ft/fandd/2003/12/pdf/daseking.pdf (last visited Oct. 14, 2004). Accordingly, the risk of future debt crisis between debtor and creditor is lower because both parties have learned from the past. *Id.* Lenders and donors have improved their lending policies. *Id.* For example, they have replaced non-concessional financing with concessional loans and grants, while creditors (low income countries) have strengthened macroeconomic policies and debt management and welcomed ambitious structural and institutional reforms that that bolster long-term growth potential. *Id.*

123. *See Human Resources and Sustainable Development*, *supra* note 1, at 28. It is worth noting that Africa's GDP growth is said to have remained resilient to the slowdown in the developed economies in the last three years. *Id.* In 2003, African countries are estimated to have grown at an average of 3.6%. *Id.* In fact, some countries such as Benin, Mozambique, Senegal, Uganda and Tanzania averaged growth rates of 5% over the past few years. *See* Agustin Carstens, *Luncheon Address at the IMF Seminar on the Role of the IMF in Low Income Counties* (Feb. 3, 2004), *available at* http://www.imf.org/external/np/speeches/2004/020304.thm (last visited Oct. 14, 2004). Paradoxically, economic and social conditions have deteriorated in Zimbabwe during 1999-2003, with the GDP declining to about 40%. Consequently, poverty levels are very high with Zimbabweans suffering from one of the highest HIV/AIDS infection rates in the world. In fact, Zimbabwe has been in continuous arrears to the IMF (as of Nov. 2003, Zimbabwe owed the $273 million) compounding one of the reasons for the Executive Board of the IMF

In keeping with the IFC mandate to further sustain economic development through the private sector, the IFC considers HIV/AIDS a business issue, as well as a health and humanitarian issue. Economic growth is sustainable only if it is environmentally and socially sound and invariably helps to improve the quality of life of those living in developing countries. Hence, the "IFC Against AIDS" works with client companies and provides tools and guidance in addressing workforce and community-related concerns resulting from the disease.[124]

The ILO's effort in the realm of workplace rules and policies that are based on fundamental rights and principles has on the other hand been applauded as vital in limiting the spread of HIV/AIDS and impacting the epidemic as a whole. The ILO Code of Practice on HIV/AIDS and the World of Work,[125] provides guidelines for the development of concrete responses to HIV/AIDS at the enterprise, community, and national levels in the areas of prevention, management, and mitigation of the impact of HIV/AIDS in the workplace.[126] Because the Code applies to a wide range of settings, (international partnerships, national action plans, enterprise agreements, as well as work in the informal sector), it can be adopted to the needs of a particular situation, sector or region.[127] Likewise, because the Code is quite comprehensive in its coverage of the issues that are likely to be encountered by an HIV/AIDS patient at work, it is very supportive of those living and working with the challenges encountered as a result of the disease. Hence, crucial and important issues, such as non-discrimination in employment and occupation; the banning of HIV screening for employee purposes; continuation of employment purposes; continuing the employment relationship; confidentiality; and gender equality, care and support are covered. Thus, where these policies are incorporated

---

to initiate compulsory withdrawal procedures for Zimbabwe – one of a series of measures the IMF applies to members who fail to meet their obligations under its Articles of Agreement. *See Press Release, International Monetary Fund, IMF Initiates Compulsory Withdrawal Procedures for Zimbabwe* (Dec. 3, 2003), *available at* http://www.imf.org/external/np/sec/pr/2003/pr03210.htm (last visited Oct. 14, 2004).

124. *International Finance Corporation Against AIDS*, *at* http://www.ifc.org/ifcagainstaids (last visited Oct. 14, 2004).

125. This Code was adopted by ILO in June 2001, after being finalized by a meeting of experts from all regions, including representatives from governments and employers' and workers' organization. *See Report on Global HIV/AIDS Epidemic*, *supra* note 52 (2002), at 18, *available at* http://www.unaids.org (last visited Oct. 14, 2004).

126. *See United Nations Commission on Human Rights*, 59th Sess., Provisional Agenda Item 14(d), at 7, U.N. Doc. E/CN.4/2003/81 (2003).

127. *See Human Resources and Sustainable Development*, *supra* note 1, at 15.

into the labor legislation of a country, especially where enforcement of such laws are procured, it is a step in the right direction in dealing with HIV/AIDS as a whole.

CONCLUSION

We must remember that Africa is a continent of different countries, with different cultural characteristics and legal systems intrinsic to each country. Some of the issues raised in this article do not apply to every African country, and even where applicable, it may only be in certain areas or a particular ethnicity. Therefore, a generalization of these issues to a particular country must be done with caution. In the same token, any reforms that are being carried out should be done in light of this fact. For what may be a workable solution to redressing the pandemic in one country may just be creating the same problem in another. Also, simply reading about Africa or attending seminars, conferences and workshops, although quite enriching, does not necessarily make one an expert on the continent and its issues. Thus, a reality check of actually visiting and spending time in regions of the continent may be helpful in making a more objective comment or recommendation in dealing with the HIV/AIDS epidemic.

Likewise, the challenges that may be encountered in effecting and implementing change must not be undermined. There is always a resistance to change in any culture, because of the fear and uncertainty with trying the unknown or unfamiliar. Hence, the reluctance in embracing such changes as condoms, the acceptance that AIDS exists, that the woman can play a decisive and equal role in sex, agreeing to be tested for HIV/AIDS, having only one wife, not engaging in extra-marital affairs, accepting and implementing international norms and human rights laws, etc., is daunting but not impossible.

In most traditional African societies, the fear of eroding the culture which has been held for generations in the society, in exchange for modernization or imported values, is a grave issue and a rationale for refusing to open to educational programs based on AIDS/HIV. This is fast changing, but more is still to be done to break through this barrier.

Men must be targeted as partners with a special role to play in curbing the spread of HIV/AIDS. [128] The women are generally ready to

128. An example of an approach that creates more equality between both gender groups while targeting Men as Partners (MAP) is conducted by the Planned Parenthood Association of South Africa, in collaboration with AVSC International and the Stepping Stones programs. Both organizations seek to foster constructive roles for men in sexual and reproductive health. *See* Geeta Rao Gupta, *Sexuality and HIV/AIDS: The What, the Why, the*

listen and protect themselves, but if they have little or no reciprocity from the men, it is a zero sum game. Educating men, and helping them to appreciate the benefits of monogamous relationships, could only positively impact on the fight against HIV/AIDS. It takes diplomacy by the right people to address this change.[129] A good starting point could be with the young males and females before they become ingrained with the old traditions.

Most important are the governments, whose commitments to reforms must be unwavering. The African governments must do much more beyond pledging certain percentages of the health budget towards HIV/AIDS problems. Rather, their unflinching commitment as leaders is imperative and expected for a positive outcome in dealing with HIV/AIDS in Africa. Accelerated economic growth in these countries is essential to reducing poverty, and hence, the vulnerability of their citizens to HIV/AIDS. No matter the amount of international aid or support that comes from other countries or donors to alleviate the AIDS crisis in Africa, if the governments do not do such things as develop structural, institutional, and good governance reforms and eliminate corruption, the successful goal may not be adequately attained. Thusfar, progress is being made in this light. The hope is that it will continue to be the case, especially with strong international financial support, resulting in a strong and vibrant Africa again.

How (Jul. 12, 2003), at 6, *available at* http://www.icrw.org/docs/DurbanSpeech.pdf (last visited Oct. 14, 2004).

129. Approaching men in a manner that portrays them as the cause of the AIDS problem, results only in animosity and the unwillingness to listen or to participate. Also, although most of the NGO's intend to handle the AIDS crisis in their countries as well, it still has to be done in a manner that does not undermine the man in his cultural setting. Conveying information about sex to a western woman, for example, is very different from the manner in which it should be conveyed to a rural African woman. Instilling to a rural woman that she is equal to her husband and must therefore not allow him to have sex with her at his will, is simply trying to destroy a marriage. It must be done with sensitivity and caution to the cultural idiosyncrasies. When a woman discusses her encounter with her peers or with her husband, the general tendency is to advise her simply not to do so. Thus, to be able to reach these targeted people for educational purposes, one must win their confidence and earn their respect for what they have to say or demonstrate. This can only be done in light of how they see things, rather than how we as the messenger see things.