The Botswana Review of Ethics, Law and HIV/AIDS

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The Botswana Review of Ethics, Law and HIV/AIDS (BRELA)

The *Botswana Review of Ethics, Law and HIV/AIDS* is a journal published by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) based in Gaborone, Botswana. BONELA is a non-governmental organisation in Botswana, dedicated to creating an enabling and just environment for people infected and affected by HIV/AIDS through the integration of ethical, legal, and human rights dimensions into the national response to HIV/AIDS. BONELA is involved in research, training, advocacy, legal assistance and public education. *BRELA* is a peer-reviewed journal intended to create a participatory forum for critical and analytical discussion of a broad range of multi-sectoral issues and debates surrounding HIV and AIDS.

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BONELA

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EDITORIAL

Welcome to the second issue of the *Botswana Review of Ethics, Law and HIV/AIDS (BRELA)*. The inaugural issue of this publication was launched at a ceremony at the President Hotel in Gaborone on 24th July 2007. In an engaging presentation on this occasion, BONELA Chairperson Duma Boko introduced *BRELA* as, a 'new and significant contribution to the literature on human rights and advocacy in the context of HIV/AIDS', 'a platform for extensive research' and hoped it will be 'a fertile ground for critical thinking and reflective practices'.

We envisage that *BRELA* creates an opportunity to contribute to Goal 5 of Botswana's National Strategic Framework on HIV/AIDS 2003-2009, towards a 'Strengthened Legal and Ethical Environment'. *BRELA* aims to inform policy makers and other stakeholders; to be a forum for individuals, institutions and organizations from a diversity of backgrounds to present ideas, research and programmes, and thus contribute to the development of skills and capacity building; to serve as a resource guide for a broad range of readers, from users of public libraries around the country, to civil society organizations, government institutions and development partners, providing an accessible way of updating, informing and stimulating discussions on HIV/AIDS. In this way, it is hoped that BRELA will become a tool for advocacy and education in the national, regional and international arenas.

This issue consists of a rich body of literature on a variety of aspects around HIV/AIDS. Virtually all the papers touch on issues relating to persons, groups or countries who/which need specific attention due to certain sensitivities or vulnerabilities, attracting stigma, discrimination and unequal legal treatment. They include People Living with HIV/AIDS; children; the military; those affected by inadequate/inequitable legal regimes; and peoples in resource-limited settings especially those in certain African countries disproportionately affected by HIV/AIDS. The idea of vulnerabilities *vis-a-vis* the epidemic or the circumstances which exacerbate the situation of those infected and/affected by HIV, therefore assumes thematic significance. It buttresses the call for a human rights approach, and the importance of responsibilities of governments and all stakeholders.

Hitomi Kuwabara in *Do Children's Rights Matter in the 'National Emergency' of HIV/AIDS in Botswana?* addresses two pertinent issues in

children's rights, which she examines in the context of Botswana, where free ARVs are available to citizens. For children, further challenges are posed in ensuring that 'availability' becomes 'accessibility' and that the element of consent is safeguarded, and does not become an obstacle in their treatment. She concludes that the Botswana example shows that a rights-based approach can be a tool to further public health initiatives, since the mission now is to develop the existing system to make it work more effectively for children and other vulnerable groups.

In *Reflections on Causes, Consequences and Control of HIV/AIDS in the Military: The Case of Nigeria*, Babafemi Odunsi presents a detailed analysis of a topical issue, yet inadequately discussed. Drawing support from the example of the Nigerian military, and seeing no justification for a 'military route' which adopts draconian measures for the armed forces, Odunsi makes a plea in favour of the recognition and implementation of a rights based approach to HIV/AIDS: "The military, notwithstanding the predisposition to use coercion and force to control personnel, remains a part of the larger society. It therefore cannot take a route radically different from that of the larger society in the war against HIV/AIDS".

Uyapo Ndadi in *HIV/AIDS and Employment Law in Botswana,* analyses the current status of the law in point in Botswana, and argues the case for the enactment of a law on HIV and employment in the country. He surveys both statute law and decided cases in relation to the issues of access to employment of people living with HIV, their continuity in employment and termination of work, and draws examples from best practices in the Southern African region to buttress the argument for a specific law which will afford protection from discrimination to employees who are HIV positive, particularly in the light of the availability of free antiretroviral treatment to all citizens.

Enga Kameni in *Implications of Indian Intellectual Property Law on Sub-Saharan African Countries*, considers the possible implications of an appeal in *The Novartis Case.* Though the pharmaceutical company's case challenging the Indian Patent Act's compatibility with the agreement on Trade Related Intellectual Property Rights was unsuccessful, the potential negative implications of its challenge to India's refusal to grant a patent to *Glivec,* on developing countries especially in Africa, are serious. If an appeal by Novartis succeeds, access to medicines would be greatly hampered in countries which depend on generic drugs from India. Kameni supports continued domestic and international lobbying, to stop Novartis from pursuing an appeal.

Approaching the idea of vulnerability, Rekha Kumar and Mukul Raizada in *Realization of Human Rights: A Path Towards the Reduction of Vulnerability to HIV/AIDS by the Government of Botswana*, find that the fundamental linkages between HIV/AIDS and human rights have been well

understood to different degrees and at various levels by all stakeholders. The challenge they perceive, relates to the practical implementation of these linkages, through policymakers, program managers, service providers and other relevant parties. Kumar and Raizada argue that in Botswana, there is a need to give people more information on rights, to identify gaps and to lobby for change.

In her Book Review of Helen Epstein's *The Invisible Cure. Africa, the West and the Fight Against AIDS* (2007), Fanny Chabrol takes us systematically through this book, in a manner similar to how the author tells of her personal journey as a scientist working on HIV/AIDS in Eastern and Southern Africa. Epstein addresses some of the most basic and controversial questions: How and why did the HI virus begin in Africa? Why has the southern African region been so severely affected by HIV/AIDS when seroprevalence rates had been kept at very low levels in Western countries? The review both highlights the complex nature of the issues raised, and Epstein's approach to them.

Jeannie Olesitse and Boitshepo Balozwi present *Two Recent Events at BONELA*, the Annual General Meeting held on 7th December 2007 and the Members' Forum on the following day. These highlight key issues currently addressed by BONELA, which include: The Treatment Literacy Programme; Prevention Initiative for Sexual Minorities, Sexual and Reproductive Health Rights of Women Living with HIV and the National AIDS Council Sector on Ethics, Law and Human Rights. The BONELA Chairperson's justifications of a human rights approach and guest speaker Sisonke Misong's plea for a society driven by love not hatred, buttressed BONELA's AGM theme: 'Turning up the Volume – Amplifying Community Voices'. The description of the *Activities of BONELA* and the list of the *Publications of BONELA* further illustrate how the Botswana Network on Ethics, Law and HIV/AIDS operationalizes its goal to create a just and enabling environment for people infected and affected by HIV/AIDS, through its activities and publications.

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ARTICLES

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DO CHILDREN'S RIGHTS MATTER IN THE 'NATIONAL EMERGENCY' OF HIV/AIDS IN BOTSWANA?

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Introduction

The HIV/AIDS pandemic has not only threatened human lives, but also the human rights of those affected and infected by it. The President of Botswana, Festus Mogae, described the country's HIV/AIDS situation as a National Emergency.[1] The fear and panic generated by the virus has meant that the concept of people as rights holders has been to a large extent disregarded, despite the widely accepted consensus that protection of human rights contributes to efforts to stem the tide of further infections. However, the idea that human beings are entitled to certain rights and that they are bound by corresponding responsibilities ought not to flounder when it faces a crisis. That is precisely the time when these principles should inform our responses and actions.

In the case of children this is especially important since they are equally or perhaps more affected when human rights are disregarded as they are often less able to speak up for themselves. The idea that children are entitled to rights and that they are rights-holders as much as other human beings is becoming more widely accepted.[2] Children also attract specific and extra rights because they are still developing physically, mentally and emotionally. Being dependent on others for their welfare and wellbeing, many children continue to be limited in their ability to influence decisions until adulthood. Therefore, they have the right to be protected by their families and the State in order to participate in decisions that affect their development.

The concept of children's rights should be an integral part of national responses to HIV/AIDS. But all too often, children are ignored or forgotten despite bearing a major burden in terms of the effects of the pandemic. The virus affects not only those children who are infected, but also those whose parents, friends, and other relatives are HIV positive.

1 Republic of Botswana, Botswana National Strategic Framework for HIV/AIDS 2003-2009, Gaborone, 2003, pp. 1, 11.

2 All countries except for the USA and Somalia have ratified or acceded to the Convention on the Rights of the Child. The Convention was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. It is the most widely accepted legal document of the United Nations. Botswana acceded to this Convention in May 1992, but has not proceeded to demonstrate its acceptance by enacting domestic legislation.

There are many AIDS orphans, and several households tend to have more members because of children orphaned by HIV/AIDS, or relatives needing care. Children may be the sole carers for sick parents and other relatives. Their teachers, shopkeepers, nurses and other community members may be sick or dying from the illness. In Botswana, the very high national prevalence rate[3] makes the safeguarding of children's rights in the context of HIV/AIDS a national priority - one which this paper argues, has not been sufficiently realised. Specifically, this paper focuses on two areas of significance for children in Botswana: testing and access to treatment:- Testing being the only certain means of knowing one's HIV status, which in turn is the only way forward to access to treatment, particularly to antiretroviral therapy (ART) which can enable one to stay healthy and avoid opportunistic infections. Both testing and access to treatment are thus central to preventing the spread of HIV, and addressing the national emergency posed by the pandemic.

Testing

What is Consent: National Policy

The draft version of the National HIV/AIDS Policy includes provision on the concept of consent. It has set the age of consent for an HIV test at 16.[4] It also allows for the medical officer to give consent if none is forthcoming from the parents or legal guardian, "provided there is demonstrable evidence of a medical need for such a test".[5] This is a positive step as it recognizes that the application of the 'best interests of the child' principle does not only have to include parents and legal guardians. It further recognizes that due to the widespread socio-cultural taboo associated with sexual activity in adolescents which could also influence these persons, the involvement of other persons responsible for the welfare of the child is helpful. Even in the case of adults, for instance, it is normal for doctors to make decisions in the best interests of patients, if they cannot get in touch with relatives.

3 32.4% among pregnant women aged between 15 and 49: Republic of Botswana, Ministry of Health (MOH), Department of AIDS Prevention and Care, MOH, Botswana, 2006; 17.1% in children over 18 months: National AIDS Co-ordinating Agency (NACA), Civil Society Organizations (CSO) and other Development Partners, *Botswana AIDS Impact Survey (BAIS 11)*, NACA, Botswana, 2004.

4 Republic of Botswana, Ministry of Health, Draft Botswana National Policy on HIV & AIDS, 2005, unpublished. Although this draft was submitted last year, MOH sources suggest that the reason for the delay in adopting the policy lie with the controversial nature of the suggestions for lowering the legal age of consent.

5 *Ibid.*

The current Guidelines for Routine HIV Testing constitute policy[6] which is distinct from law, although the distinction between law and policy is not always appreciated. The policy could eventually lead to a change in the law. In relation to categories of individuals who are subject to routine testing, the Guidelines make reference to: "[p]atients aged 16 years and above visiting health facilities (for patients below 21 please obtain parental/guardian consent)". This means that children under the age of 16 will not be routinely tested and will only be able to test with their parents' or guardians' consent through other processes such as voluntary counselling and testing (VCT) or if they require post-exposure prophylaxis after an incident of rape. Persons between 16 and 21 will be offered an HIV test as part of RHT, but will still need parental/legal guardian consent. In practice, adolescents especially those aged 18 and over, sometimes test by giving verbal assurances that they have obtained their parents'/legal guardians' consent. Therefore, the practice is disregarding the constraints of the law and guidelines because of the recognition that it can be impractical. Since Botswana faces a problem of teen pregnancies and HIV testing is required by PMTCT, many under-aged girls are tested for HIV when they fall pregnant.[7] Thus the fact that HIV testing is provided as part of the PMTCT programme to teenage expectant mothers, can also raise the question of why males and non-pregnant females of similar age cannot also be tested, although of course, there are stronger reasons for testing the former category of persons.

This discrepancy between legally being able to consent to sexual intercourse at age 16, and yet not legally being able to consent for testing for HIV until you are 21 was discussed in a report submitted to the National AIDS Council Sector on Ethics, Law and Human Rights.[8] The report reviewed all laws and policies relating to HIV/AIDS, and the consultants identified the lack of certainty determining the age at which a person can consent to testing as a challenge that negatively affects public health efforts to control the pandemic. It stated that a study commissioned by the National AIDS Council on this issue recommended that the age of consent be set at 16, but the report also raised additional considerations by citing the Policy Guidelines and Service Standards on Sexual and Reproductive Health which seem to suggest that any person, regardless of age, seeking reproductive health services should be provided with the service.[9] This differs significantly from setting a legal age of consent- and rather, evaluates the ability to consent to an HIV test according to sexual experience. The view adopted in the report was that both age and sexual

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6 Republic of Botswana, Ministry of Health, Guidelines for Routine HIV Testing in Botswana, October 2003.

7 From a conversation with an employee of the Ministry of Health, AIDS Prevention and Care Department, 26 July 2007.

8 Molatlhegi & Associates, *Consultancy Services for Review of Laws and Policies Relating to HIV/AIDS: Final Report submitted to NAC Sector on Ethics, Law and Human Rights*, unpublished, p. 52.

9 *Ibid.*

experience were important determinants. The report proposed that a Public Health Act (Amendment) Bill be drafted stating:

Capacity for giving informed consent for purposes of testing for HIV to be based on a combination of age (16), the fact of sexual activity, reasons for wanting to have the test and whether the person seeking to undergo the testing has the capacity to understand the consequences for such tests.[10]

This consideration of the minor's experiences, intention and understanding all combine to develop a fuller understanding of their capacity, and the fact that this capacity evolves over time. The concept of evolving capacity is important in understanding children's rights, as the Committee on the Rights of the Child states:

> [w]hile the evolving capacities of the child will determine whether consent is required from him or her directly or from his or her parent or guardian, in all cases, consistent with the child's right to receive information under articles 13 and 17 of the Convention, States Parties must ensure that, prior to any HIV testing, whether by health-care providers in relation to children who are accessing health services for another medical condition or otherwise, the risks and benefits of such testing are sufficiently conveyed so that an informed decision can be made.[11]

The Committee was created by Article 43(1) of the Convention on the Rights of the Child (CRC) to ensure compliance with the Convention. The need for Botswana to implement the CRC in its domestic legislation and not to act in ways contrary to this international legal instrument to which it acceded will be discussed in more detail below.

What is Consent: Legal Position

Testing is undoubtedly to be encouraged, but only with the requisite support and human rights considerations in place. The voluntary nature of the testing, as well as the 3 Cs of consent, confidentiality and counselling are crucial for both adults and children.[12] However, for children in Botswana, consent in particular is a contentious issue. Consent as a general legal principle involves a determination of capacity which has two elements: mental and physical competence- for example, not being intoxicated at the time of decision making; and a defined age or status

10 *Ibid;* pp. 2-13-2.

11 Committee on the Rights of the Child, thirty-second session, 13-31 January 2003, General Comment No. 3 (2003), http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.3.En?OpenDocument accessed 15 June 2007.

12 For more on the importance of human rights principles in the context of routine testing see S. Puvimanasinghe, 'Lest We Do Not See the Wood For the Trees: Human Rights and Routine HIV Testing', *The Botswana Review on Ethics, Law and HIV/AIDS*, Vol. 1, No. 1, 2007, pp. 61-74.

that has been legally enshrined as determining the ability to consent.[13] It is this latter element that particularly affects children in the context of HIV testing because in Botswana the age of majority has been established to be the age at which a person can legally consent to contract, and this could extend to medical treatment, including an HIV test. Therefore, under the law, a child under the age of 21 appears to be unable to give consent for an HIV test.[14] Instead, their parents or legal guardians can provide parental permission. Therefore, the parent/guardian has consented, in the eyes of the law, in the place of the child, due to the child's status as a minor who is incapable of giving consent him/herself because of his/her age. The latter, parental permission, is based on the concept that the right to consent still resides with the child, despite his/her inability to exercise that right due to being underage. In the meantime, the parent/guardian can give permission for the medical procedure to take place. Whichever concept is used, the effect is that someone other than the child is able to allow for the medical procedure to take place. In essence, it is an intellectual exercise (with practical implications) to balance the general principle of the need for consent to be given by patients, with the view that there are some categories of people who are not capable of giving this consent.

A look at other legislation in Botswana presents some challenges, since the age requirement for consent varies according to the particular issue and the specific context. For example, a child aged 10 and over can consent to being adopted.[15] A child aged 16 and over can consent to sexual intercourse[16] and only children 18 and over can vote.[17] These variations raise the question of how a 'child' is defined in Botswana, and perhaps constituted one of the reasons why a reservation was entered when Botswana acceded to the Convention on the Rights of the Child because this document defines a child as aged between 0 and 18 years old.[18] However, no such reservation was entered when Botswana ratified the African Charter on the Rights and Welfare of the Child in 2001, which has the same definition of 'child', thus adding to the inconsistency.[19]

Further complications arise when examining the application of the law. In his paper on informed consent to HIV testing, C.M. Fombad states that:

13 American Academy of Pediatrics, Committee on Bioethics, 'Informed Consent, Parental Permission and Assent in Pediatric Practice', *Pediatrics*, Vol. 95, No. 2, February 1995, pp. 314-317, http://www.cirp.org/library/ethics/AAP/ accessed 22 June 2004.

14 Section 49, Interpretation Act (of Botswana) 1984.

15 Section 4(2)(e) Adoption of Children Act (of Botswana) 1952.

16 Section 147(1) Penal Code of Botswana.

17 Section 67(1)(b) Constitution of Botswana.

18 *Op cit*. n. 2.

19 OAU Doc. CAB/LEG/24.9/49 (1990), entered into force 29 November 1999.

In the absence of any specific legislation in Botswana dealing with the capacity of children to make medical decisions, the relevant Roman-Dutch law principles dealing with children's legal capacity to perform legal acts generally will apply.

These principles differentiate between children below the age of 7, and those between the ages of 7 and 21.[20] Children under 7 are termed 'infants' and regarded as lacking capacity and unable to give consent under any circumstances. For 'minors', those over 7 years of age but still under the age of majority, the need for parental or legal guardian consent depends on "the age and maturity of the child and his ability to understand the whole procedure".[21] This assessment of the current law in Botswana indicates that there is recognition that the simple fact of being under 21 is not enough to deny capacity.

A Need to Clarify the Position

The current situation in Botswana with regards to HIV testing therefore needs to be clarified through specific guidelines. Laws, policies and practices in this sphere at the moment, can sometimes lead in different directions. The Ministry of Health is in the process of developing HIV Testing and Counselling Guidelines. This would bring together all the currently disparate elements of PMTCT, RHT, VCT and how children should be dealt with in relation to these.[22] It is hoped that the recommendations in the policy and legislative review will be acted upon so that both test providers and those being tested are clear about the requirements needed to be tested for HIV. It would also help health care workers who are currently being put in the difficult moral dilemma of having to refuse to test under-aged children who have not obtained parental/legal guardian consent or go ahead without consent.

The dilemma also needs to be solved in order to send positive messages about sexual responsibility. When individuals aged 16 or over are legally able to consent to sex but are, under the law, unable to test for HIV without their parents/legal guardians' consent for the consequences of their actions, this transfers the responsibility from the individuals concerned to their parents, who however, also have an interest in protection of their children. This arguably strikes an opposite note to the national policy of encouraging and supporting testing. This is a tangible example of where the failure to make the definition of a 'child' consistent, results in inadequacy in terms of protection of children.

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20 C.M. Fombad, 'Children and Informed Consent to HIV/AIDS Testing and Treatment in Botswana', *University of Botswana Law Journal,* December 2005, p. 62.
21 *Ibid.*
22 *Op. cit.* n. 7.

The piecemeal approach in which children's rights and laws about children have been considered in the past fails to reflect the inter-related nature of children's issues. One of the most fundamental- sex and its role in HIV/AIDS transmission- ought to be thought through to its logical conclusion: that children aged 16 and above who engage in sexual relations should be able to test for HIV. This change will remove the anomaly and enable the state to act in the best interests of its children. This paper does not go on to consider cultural considerations which are also very significant, and must be taken into account in the process of review. Preparing the legal groundwork is only the first step, but is crucial in improving the current situation for children. Not only should the laws and policies be clarified and made consistent, the resulting clarification should be both workable and child-friendly. It should make testing accessible to children over 16 who require it and understand the meaning, process and consequences of the test- even without their parents' or guardians' consent.

The existing international emphasis on the 3Cs of consent, counselling and confidentiality is an effective way of ensuring that all elements that ought to be considered when determining whether a child can consent to an HIV test alone are fully examined. The pre-test counselling is especially important, since it is here that healthcare workers will be able to assess whether he/she is capable of consenting by looking at whether the minor has taken part in sexual activity, why he/she wants the test, and the level of maturity and ability to understand the consequences of the test. Such counselling will also enable healthcare workers to ensure that the consent given is sufficiently informed. It is therefore a two-way process. The more information that can be gained about the child, the more engagement the child has with the testing process, the better healthcare workers will be able to judge the individual child's ability to consent independently or with family support. The counselling element is also advantageous in enabling the child to participate in decisions affecting his/her life - a key element in the modern understanding of children's rights.[23] However, children's rights to confidentiality is critical in encouraging more children and their families to find out their status.

Making the 3Cs a reality in every testing facility is a challenge for the Government of Botswana. The routine testing policy should, if necessary, be revised to make the 3Cs the core of the testing experience.

23 Article 12 of the CRC: "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".

Apart from laws enshrining a lower age of consent and the consideration of other elements such as sexual activity and maturity, test providers may need additional training,[24] as well as specialised training in counselling children and adolescents. Guidelines for counselling minors should be developed to aid health care workers.[25]

Access to Treatment

Access to treatment is another crucial issue for children, although it may not at first glance seem like a problem in Botswana which was the first African country to provide free anti-retrovirals (ARVs) to its citizens. However, this paper argues that 'availability' and 'accessibility' are two very different issues, and that while Botswana may be a leader in the region with regard to making treatment available, it still faces challenges in terms of ensuring that children access this treatment. One issue is the shortage of paediatric facilities and personnel trained in dealing with children. Currently there are only 18 paediatricians working in the public sector in the country,[26] serving the needs of 800,000 children.[27] Ten of them are based in the Botswana-Baylor Children's Clinical Centre of Excellence ('Baylor') in Gaborone.[28] This high concentration of paediatricians in the capital means that they are insufficiently distributed in the rest of the country, especially in rural and hard to reach areas. Although all sites included in the national coverage of ARV provision under the Masa antiretroviral treatment programme are meant to provide paediatric ARVs, doctors have raised concerns because of the difficulties of treating HIV in children, as opposed to HIV in adults.[29] Differences, such as in the methods of dosage, require confidence as well as knowledge and experience in dealing with these types of patients. Although training is being conducted for healthcare workers by the Ministry of Health (as

24 S.D. Weiser, M. Heisler, K. Leiter, F. Percy-de Korte, S. Tlou *et al.*, 'Routine HIV Testing in Botswana: A Population-Based Study on Attitudes, Practices and Human Rights Concerns', PLoS Med 3(7), June 2006, http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030261 accessed 20 February 2007. This study states that a disturbing two thirds of participants felt that they could not refuse the HIV test, thus illustrating that the human rights considerations regarding testing are not effectively being communicated to the public. (p. 1019)

25 For example, the Government of Zambia has adopted guidelines on counselling that specifically refer to children as a vulnerable group and has developed special guidelines for them. See Zambia AIDS Law Research & Advocacy Network (ZARAN), *Children's Right to Access HIV/AIDS Related Treatment & Services in Lusaka*, December 2006, p. 13 and note 43.

26 Republic of Botswana, Ministry of Health, UNICEF, Centers for Disease Control (CDC), WHO and UNFPA, presentation on 'Botswana PMTCT and Paediatric HIV/AIDS Care and Treatment Situation Analysis', Gaborone, March 2007.

27 http://www.unicef.org/infobycountry/botswana_statistics.html accessed 26 July 2007.

28 *Op. cit.* n. 26.

29 Republic of Botswana, *op. cit.* n. 26.

part of the KITSO training programme),[30] and by Baylor, which utilise their doctors' expertise in paediatric medicine to train other doctors around the country, ensuring that all clinics and hospitals around the country are able to provide specialised HIV treatment and care for children is an important issue that needs to be addressed further.

Of special concern is the lack of data and knowledge about children's access to treatment. 6,831 children below the age of 15 are currently on ARVs, and this amounts to 10% of the total number of people receiving ARVs in Botswana.[31] Although UNICEF cites a figure of 14,000 children between the ages of 0 and 14 in Botswana as living with HIV/AIDS,[32] government officials admit that they do not know the actual number of children *who require ARVs.*[33] Projections made using a range of studies sets the percentage of children requiring ARVs between 17.5% and 97.5%, thus revealing the true extent of uncertainty on this issue.[34] The difference between these two figures casts doubt on the accuracy of this analysis. Being the 'shining light' and an example to other nations in terms of free provision of ARVs does not mean that Botswana can become complacent in its efforts against HIV/AIDS. Monitoring and evaluation must become a priority to assess whether children are actually benefiting from these policies, and to identify areas of improvement in order to reach the zero-transmission goals of Vision 2016.[35]

'Availability' and 'Accessibility': International Law

Botswana's international obligations in relation to availability and accessibility derive from two international legal instruments: the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child (ACRWC). Both deal with the issue of

30 Republic of Botswana, Ministry of Health, *Masa Programme Report* available on: http://www.moh.gov.bw/fileadmin/documents/Reports/Masa_ARV_Program.doc accessed 26 July 2007. According to the Ministry, as of May 2006, 4,566 of Botswana's health care workers have been trained in HIV/AIDS clinical care fundamentals.

31 *Op. cit.* n. 26.

32 UNICEF, *State of the World's Children 2007,* New York, 2006, p. 114.

33 Not all children who are living with HIV/AIDS are eligible for free treatment under the Masa programme. The eligibility criteria state the following in relation to children: HIV positive with a CD4 cell count of less than or equal to 200 and/or presence of an AIDS defining illness or children under the age of 13 years. HIV positive children over the age of 6 months who are in-patients are categorised as one of the priority groups within the population. *Op. cit.* n. 3.

34 *Op. cit.* n. 26. The Situation Analysis clearly demonstrates the absurdity of the situation by creating a table to show how a range of studies have all used different methods to calculate the number of children who require ARVs. The main problem appears to be that most of these are projections, based originally on numbers obtained years ago. During the seminar accompanying the Situation Analysis, both government and UN agencies identified the need to deal with this issue.

35 Botswana Vision 2016, 'A Compassionate, Just and Caring Nation', available at: http://www.vision2016.co.bw/html/about_compassionatenation.shtm accessed 26 July 2007.

access to treatment but this paper will argue that they do so in slightly different ways. The effect of this difference and whether it affects how Botswana should apply the principles in its domestic legislation will also be discussed.

Starting with the CRC, Article 24(1) is the main provision for the right to access health. It states:

> States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. *States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services*. [Emphasis added]

The first sentence of the provision sets out the general right to health, specifying that it is the 'highest attainable standard of health'. Not only has the standard been specified, but the child must also enjoy the 'facilities for the treatment of illness and rehabilitation of health'. Therefore, both the quality of care, and how the care should be delivered (through the facilities) is articulated in the first sentence.

The second sentence is of crucial importance because it stipulates that access is a distinct element of the right to health. Even if the requirements in the first sentence were met, the right contained in Article 24 would still be violated if access was not available. But this is couched in language that allows States Parties some leeway. It could be argued for instance, that what is measured is whether the States Parties 'strove', for example, by creating policies, and not whether children have been able to access healthcare services as measured by the numbers of children taking ARVs.

Another problem is the use of the negative in the second sentence: "that no child is deprived of his or her right of access". As it stands, the sentence begins with the premise that a child has a right of access to the healthcare services mentioned in the first part of Article 24. What the italicised portion therefore does is to state that State Parties should not deprive children of this right. Does this entail creating access anew where there has been none to begin with? The right to access treatment should inform concrete actions designed to facilitate and enable children to access health care services. But because the only obligation that is placed upon State Parties in Article 24 is to 'strive' to ensure that this deprivation does not take place, it falls short of actually demanding the change from an abstract conception of a 'right to access', to actual quantitative demonstrations that children are accessing facilities. In Botswana this is exemplified by the lack of statistics discussed above concerning the numbers of children who need to be on ARVs. Despite the government's recognition of children's rights to access ARV treatment, which led to the

policy of free provision of ARVs, the assessment of whether the children who need the treatment are accessing it has so far been a secondary concern.

Article 24(2)[36] contains categories that highlight six aims that States Parties should 'take appropriate measures' to achieve. This focus on the measures to be adopted, takes a more proactive approach to achieving the goals contained in the article. The categories are more specific and if the issue of access to HIV treatment is considered, it could come under several categories, including, 'diminish infant and child mortality'. However, this will be, at best, an indirect way of achieving the goals of universal access to HIV treatment and facilities for children.

'Availability' and 'Accessibility': The African Charter on the Rights and Welfare of the Child

The ACRWC also deals with the issue of the right to health for children at a regional level. Article 14 states:

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right (...)

As in the CRC, the first section deals with the right to health itself, touching on the different aspects of the standard of health. It considers in more detail the type of health that should be provided, but otherwise the provision is similar to Article 24(1) in the CRC. What is different is that the ACRWC does not mention the need to ensure access to healthcare services or facilities. Instead, it simply states that State Parties shall 'undertake to pursue the full implementation of this right' and lists ten particular goals to pursue. This omission of access rights in the ACRWC suggests

36 Article 24(2). "States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services".

that the obligations placed on States Parties in this Charter in terms of the right to health are less onerous than those placed by the CRC. The problem arises since the right to access is a more difficult right to protect and provide for in real terms because it not only consists of making the services and facilities available, but also ensuring that people can and do use them – Accessing services involves difficulties. This may involve: changing people's behaviour and perceptions of the medical profession; publicising available facilities; ensuring that services are affordable or free to enable universal access and having sufficient numbers of facilities to ensure full coverage of the population.

The Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child: Combined Effects on Botswana

Applying the CRC and the ACRWC to the situation of treating HIV positive children in Botswana, the 'availability' of facilities for the treatment of illness is achieved by the free provision of ARVs through the government's Masa programme. This includes provision of paediatric formulations. However, there are only two centres in the whole country that provide paediatric HIV services: Baylor in Gaborone and Nyangabwe in Francistown. Whether this is sufficient for the number of HIV positive children in Botswana needs to be investigated further since we do not have accurate numbers of how many children require treatment for HIV in Botswana, as discussed above.[37]

Sufficient coverage also affects accessibility. Even if doctors in the clinics have been sufficiently trained and have enough confidence in dealing with children, there are only 32 hospital sites and 48 clinics nationwide which administer ARVs.[38] Botswana has a relatively small population size compared to neighbouring countries: 1.765 million,[39] but this population is spread over a large area and many anecdotal accounts state the need to travel large distances to clinics and the cost of transport, as problems for accessing treatment, as well as adhering to the ARV regimen.[40] This is especially the case for children who are dependent on adults to be taken to healthcare facilities.

At this point it is appropriate to consider the effects of the relevant articles of the CRC and ACRWC on Botswana. Access to treatment is an integral part of the right to health. However, under the Constitution of Botswana there is currently no right to health.

37 *Op. cit.* n. 26.
38 *Ibid.*
39 *Op. cit.* n. 32, p. 102.
40 H. Kuwabara, 'Two teens share what life is like living with HIV', *BONELA Guardian*, Vol. 4, Issue 2, 2007.

Although section 4(1) of the Constitution identifies the right to life, the question is whether this extends further than simply a right not to be killed.[41] Although currently no domestic case law exists on this point, courts in some jurisdictions have interpreted the right to life broadly, to include concepts such as the right to a livelihood and quality of life. Adopting this line of argument, it could perhaps be submitted that the right to life includes the right to health, as well as healthcare facilities and treatment. In Botswana, international obligations need to be incorporated into domestic law through Acts of Parliament, to be legally binding locally. The government of Botswana has ratified both the CRC and ACRWC and is therefore under the obligation to incorporate the right to health (amongst other rights for children) into domestic legislation. The courts too have an important role in interpreting domestic legislation consistently with international obligations.[42]

As a signatory to both instruments, Botswana must ideally implement both Conventions through its domestic legislation. The ACRWC was made later in time than the CRC, from which according to Article 46 of the Charter, it is to draw inspiration. Yet, the right to access treatment is not explicitly stated, thus raising the question of whether this was a conscious omission. If so, this may suggest that the drafters of the ACRWC recognised the obligations it imposed on States Parties as being too onerous in the African context. However, this disregards the fact that Botswana and other African nations have ratified the CRC as well, and are thus bound by the right to access treatment provision in any case. Also, the omission on the grounds that it poses too great a burden, is unfortunate since the right to access is what gives the right to health its power and efficacy. There is no point in recognising the right to health if children cannot benefit from it.

Conclusion

This paper has addressed two key issues in the area of children's rights and has examined them in the context of the current situation in Botswana. The Botswana example is highly illuminating if we consider it as a case study of what happens after a nation has achieved provision of free ARVs for its citizens.

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41 "No person shall be deprived of his life intentionally save in execution of the sentence of a court in respect of an offence under the law in force in Botswana of which he has been convicted".

42 The status of international instruments in domestic law has been articulated in the case of *Attorney-General* v *Dow* which held that, "Botswana is a member of the community of civilised states which has undertaken to abide by certain standards of conduct and, unless it is impossible to do otherwise, it would be wrong for its courts to interpret its legislation in a manner which conflicts with the international obligations Botswana has undertaken". [1992] *Botswana Law Reports (BLR)* 119 at 154.

Although this is, for now, the goal for many developing countries, Botswana's experience shows that this is not the end of the road by any means. Further challenges will be posed about ensuring that 'availability' becomes 'accessibility' and that the crucial element of consent is safeguarded, without becoming an obstacle in the treatment of HIV in children.

Even without such a clinical approach, the developments taking place in Botswana at this time, around two decades after the first confirmed case of HIV/AIDS was discovered in the country, are important as we take stock of what has been achieved so far in efforts to protect her people from this disease. The current situation in Botswana shows that a rights based approach can be a tool to further public health initiatives, since the mission now is to develop the existing system to make it work more effectively for children and other vulnerable groups in general.

In relation to the 'national emergency' of HIV/AIDS, the above discussion around children's access to testing and treatment in Botswana, shows that children's rights in this context have in several respects not received adequate attention. Laws, policies and practices reveal inconsistencies and anomalies requiring harmonization, and do not systematically incorporate obligations undertaken at the international level. International and regional instruments also at times lack clarity in laying down targets to be achieved in the provision of healthcare for children. Steps need to be taken towards optimal measures in prevention, care and treatment for children. At the same time, sexually active legal minors can also transmit the HIV virus, thus there are major public health implications in the questions discussed above, both for children and others. Maximizing the realization of children's rights can enhance protection from the virus for young people in the context of the national emergency, and at the same time enhance protection for society as a whole.

REFLECTIONS ON CAUSES, CONSEQUENCES AND CONTROL OF HIV/AIDS IN THE MILITARY: THE CASE OF NIGERIA

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Introduction

Conflicts and deployments of armies across the world have several consequences, including the spread of diseases. The interplay between armies, conflicts and spread of diseases is particularly important in the context of the global HIV/AIDS crisis. Soldiers are prone to HIV infection because of the nature of the setting in which they operate and the propensity of soldiers to engage in high-risk sexual and other behaviours. Generally, soldiers are potent vectors of HIV because their engagements regularly take them to different places where they interact with other soldiers and non-military members of society.[1] Males and females constitute armies, playing different roles. However, in the context of this paper, the emphasis is on male soldiers. The main reason for this is that the factors that contribute to HIV/AIDS spread are addressed mainly from the perspective of male members of the Nigerian army, who are used as a case study. This study however has ramifications for armies elsewhere, given the many common factors that exist.

It is important to devise means to effectively control HIV/AIDS in the armed forces. How a society perceives a disease would ordinarily influence the control measures adopted to combat it. However, the success or effectiveness of a control measure depends on a proper understanding of the nature of the disease. Therefore, HIV/AIDS control in the armed forces must be based on a proper understanding of factors that make military men more prone to HIV/AIDS.

It is now widely accepted that a human rights-based approach offers a better chance of effective control of HIV/AIDS than an approach which transgresses the rights of people living with HIV/AIDS (PLWHA) and uninfected persons. However, the army is an organization that relies principally on coercion and is constituted of members largely perceived as persons deprived of their basic rights. In this military context, a rights-based approach appears to be an anachronism. A basic question arises, in relation to the preferable choice between 'tough military measures' and rights-based measures in the battle against HIV/AIDS in the military.

1 See generally, S.B. Odunsi, 'Global Security, Human Rights, Public Health and Military Policies on HIV/AIDS: Nigeria as a Case Study', LL.M Thesis, Faculty of Law, University of Toronto, Toronto, 2005, particularly p. 2.

High Prevalence of HIV/AIDS: Nature of Military Setting as Underlying Factor

Comparatively, HIV/AIDS tends to be more prevalent among military populations than civilians.[2] The factors responsible for high prevalence of HIV/AIDS in the military can be analysed in the context of conflict and non-conflict situations. One underlying factor that applies in both situations is the congregate nature of the military.[3] One manifestation of military congregation in non-conflict situations is the long-standing military custom of garrisoning soldiers. Fighting together in designated units illustrates the congregation of soldiers in conflict situations. However, congregation in the military is not only in terms of physical proximity. It extends to shared-bonds which tend to produce 'peer pressure' behaviours by soldiers. By nature of their duties, military personnel are apt to stay and operate together for varying periods in conflict or non-conflict situations. The staying and operating together promote a bond of fraternity between soldiers, which makes them influence each other's behaviours and feel responsible for one another.[4]

Soldiers are apt to act *en masse.* In the HIV/AIDS context, this could reflect in *mass* high-risk sexual behaviours, drug uses or such other negative conduct. No soldier would want to lose the esteem of his colleagues or be ostracized by them.[5] Conversely, it is also possible that the tendency to act *en masse*, if approached in the right way, could result in soldiers behaving positively as a group, and positive potential could be harnessed in responding to HIV. It is against the backdrop of the congregate setting of the military that the specific factors responsible for HIV infection will be examined.

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2 See e.g. J. M. Forman and M.C. Julio, 'A Policy Critique of HIV/AIDS and Demobilization', *Red de Seguridad Y Defensa De Americana Latina* (*RESDAL*) 1-4, p. 3 <http://www.resdal.org/art-mendelson.htm> accessed on 8 December 2004. See also L. Heinecken, 'Living in Terror- The Looming Security Threat to Southern Africa', http://www.iss.co.za/ASR/10No4/Heinecken.html accessed 19 November 2007 and S.A Chatterjee, 'AIDS, War and Women' *Statesman* [newspaper], (India), 22 December 2004.

3 The features of a particular congregate setting determine the mode of spread among the population. With regard to HIV/AIDS spread in the military, the responsible factors include drug use, sexual activity and high-risk behaviours- see L.O. Gostin, Z. Lazzarani, *Human Rights and Public Health in the AIDS Pandemic,* Oxford University Press, New York, 1997, pp. 107-117.

4 See M.J. Osiel, *Obeying Orders, Atrocity, Military Discipline and the Law of War*, Transaction Publishers, New Brunswick, 1999, p. 215.

5 *Ibid.*

HIV/AIDS in the Military: Contributing Factors

There is a connection between unsafe sexual practices among soldiers and spread of HIV/AIDS.[6] Separation of soldiers from families[7] is a significant factor. With the ages of persons normally recruited being within the sexually active age groups,[8] it is predictable that they would have sexual urge and the natural desire to satisfy it. Being separated from spouses, married soldiers may seek sexual gratification from other women including commercial sex workers.[9] For those who are unmarried, separation from the circle of relations removes the social or communal censures that can check their frolics.

Rape and other forms of sexual abuse have been regular features in conflicts, and are even perceived as legitimate components of adventurism or warfare.[10] Demonstrably, in speech and other manners, military authorities tend to lend credence to the impression that sexual indiscretion or recklessness is an acceptable military tradition. The following excerpt illustrates one aspect of the tacit indulgence of military authorities:

> The behaviour of the Dutch contingent in Cambodia lends statistical weight to a truism of military life: that for as long as there have been wars and young men to fight them, soldiers have found opportunities for sex and, inevitably, for the transmission of sexually transmitted diseases. *Until very recently such illnesses were considered among the least of a soldier's worries…often handled with "wink and a nod" by local commanders and a strong dose of antibiotics from the medics.*[11]

6 See e.g. L. Garret, 'The Lessons of HIV/AIDS', *Foreign Affairs,* Vol. 84, No. 4, July/August 2005, pp. 51-64, especially at 57.

7 The willingness to serve in any location is a usual requirement for serving in the armed forces. See for example, section 42 Armed Forces Act, Cap. A20, Laws of the Federation of Nigeria 2004. [hereinafter 'Armed Forces Act']

8 Section 28(2) Armed Forces Act.

9 A study conducted on military personnel in Nigeria revealed that a significant number have the propensity to have unprotected sex with sex workers. In some contexts, particularly those where poverty and gender inequity are widespread, there is a higher prevalence of HIV among sex workers. See U.A. Nwokoji , A.J. Ajuwon 'Denial of AIDS Puts Sailors at Risk' *EurekAlert!* 1, available at: <http://www.eurekalert.org/pub_releases/2004-06/bc-doa061704.php>, accessed 8 December 2004.

10 See for example, F. Nduwimana, *The Right to Survive Sexual Violence, Women and HIV/AIDS,* Rights & Democracy, Montreal, 2004, p. 54; Human Rights Watch, 'Democratic Republic of Congo, Seeking Justice, The Prosecution of Sexual Violence in the Congo War', *Human Rights Watch,* 17, 2005, p. 7.

11 M. Fleshman, 'AIDS Prevention in the Ranks: UN Targets Peacekeepers, Combatants in War Against the Disease', 15 *Africa Recovery,* 2001, p. 16, at 17, 18, available online < http://www.africarecovery.org> accessed: 8 December 2004. [emphasis added]

In another respect, failure of military authorities to sanction sexual misconducts by soldiers suggest acceptability of sexual indiscretion of soldiers. The following examples illustrate this point. In the Democratic Republic of Congo, peacekeepers were alleged to have sexually abused the local populace:

> While the 150 allegations of rape, pedophilia and solicitation in Congo may be the United Nations' worst sex scandal in years, chronic problems almost guarantee that *few of the suspects will face serious punishment*.[12]

Similarly, in the course of the United Nations Transitional Administration in Cambodia (UNTAC):

> Local women's organisations lodged numerous complaints against male military and civilian police peacekeepers including sexual harassment [and] sexual abuse …*The response from UNTAC's leadership was to warn peacekeepers to be more discrete*.[13]

Bravado which, by their military calling, soldiers are expected to display serves as catalyst for risky sexual behaviors. The importance of courage in the military is underscored by the provision of severe sanctions for acts of cowardice under military law.[14] In Nigeria and other sub-Saharan countries, there is strong belief in witchcraft, *juju* and some other fetish mediums as means of magical fortification against harm of any sort, ostensibly, including HIV infection. Related to this is a belief in the existence of unorthodox cure for HIV/AIDS. For example, in Nigeria there was a story that a doctor had a potent cure for HIV/AIDS. The Nigerian military authorities lent credibility to the purported existence of a cure with claims that the doctor had cured a number of Nigerian soldiers of HIV/AIDS.[15] The HIV/AIDS scenario in the Nigerian military is one in which a sense of magically induced immunity collaborated with an induced belief in the existence of a 'miracle cure'. In an environment where there is an inherent propensity of soldiers to engage in risky sexual behaviours, belief in magical immunity and cure for HIV/AIDS may further spur unsafe sexual practices to a high level.

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12 N. Wadhams, 'UN Battles Sex Abuse by Peacekeepers', online: <http://news.yahoo.com/news?tmpl=story&cid=535&u=/ap/20041124/ap_on_re_as/punishin>, accessed: 24 November 2004. The commentator did not specify what the 'chronic problems' were. It can however be assumed that they include the default of military authorities to sanction sexual indiscretions of soldiers.

13 *Ibid.* [emphasis added]

14 See e.g. Osiel, *op. cit.* n. 4, pp. 201-221; 247-261.

15 See S. Lovgren, 'African Army hastening HIV/AIDS Spread', *Jenda: A Journal of Culture and African Women Studies,* 2001, p. 4, online <MSNBC.com>, accessed 12 August 2004: "The head of the Nigerian army, Gen. Victor Malu, last week endorsed the claims of a controversial doctor, Jeremiah Abalaka, who claims to have found a cure for AIDS. Malu told a news conference in Lagos…that the majority of HIV-positive soldiers who had received the 'cure' had experienced an improvement in health".

The high-risk sexual behaviors of soldiers raise complex problems especially in conflict situations. This has made conflicts a dominant factor in the spread of HIV/AIDS by military men.[16] In situations of conflict, soldiers move around on a larger scale, as combatants, peacekeepers or allies of any of the warring parties. Furthermore, in a state of anarchy, soldiers are generally difficult to control because "[o]n the battlefield and in difficult peace operations, commanders at the rear often have difficulty monitoring compliance with directives to soldiers at the front".[17]

Sexual partners are not in short supply in conflict situations. Many of the local women may be compelled to offer themselves to the soldiers as means of avoiding or ameliorating the hardships of war, while others resort to outright prostitution in order to survive. Rape and other sexual abuses are also common features of conflicts.[18] The movement of soldiers, within or outside their countries may entail transfer from HIV/AIDS endemic areas to non-endemic areas, making them couriers of the disease.

A Unit Head of the UN Department of Peacekeeping Operations (DPKO) stated:

> [C]onflict tends to bring together two groups at very high risk of HIV infection-commercial sex workers and 15-24 year old men. Among refugees and displaced people it is common for the number of commercial sex workers to increase because women feel they have no other way to keep their family alive.
>
> A similarly risky dynamic…occurs among soldiers. Military culture tends to exaggerate male behaviour… by removing thousands of young men in their sexual prime from the behavioural constraints of family and community, inculcating a sense of risk-taking and invincibility, and promoting aggression and toughness as the male ideal-attitudes that extend to sexual behaviour and often lead to contact with commercial sex workers.[19]

Impact of HIV/AIDS in the Military: The Security Factor

In addition to shouldering the constitutional burdens of defending their countries against external aggression and suppressing internal uprising,[20] armed forces also participate in peace keeping operations and other international military operations.[21] Furthermore, armed forces

16 Nduwimana, *op. cit.* n. 10 p. 54; see *Human Rights Watch, op. cit.* n. 10, p. 7.
17 Osiel, *op. cit.* n. 4, p. 321.
18 Nduwimana, *op. cit.* n.10; *Human Rights Watch*, *op. cit.* n. 10.
19 Fleshman, *op. cit.* n. 11, at 17-18.
20 See e.g. section 217(1) and (2), Constitution of the Federal Republic of Nigeria 1999. [hereinafter the 'Nigerian Constitution']
21 The Nigerian Army, 'The Nigerian Army Campaigns, International Peace Keeping Operations', available at: <http://www.nigerianarmy.net/nac.htm> accessed 14 August 2005.

play important roles in ensuring regional stability in different parts of the world. For example, Nigeria in collaboration with other countries through military intervention in the armed conflicts in Liberia and Sierra Leone at different times has assisted the cause of peace and stability in the West African sub-region.[22]

HIV/AIDS poses an enormous threat to security at domestic, regional and global levels.[23] This fact has been underscored by UN Security Council resolution 1308,[24] whereby HIV/AIDS was formally pronounced as a threat to international peace and security. In the context of this paper, global security connotes a situation where every country of the world is protected against or free from illegitimate use of force or aggression by another country or groups of persons. It also refers to a situation where a country is able, singularly or in association with others or groups to use military force, when necessary, to defend, pursue and protect legitimate economic, political and other interests.[25] Though it may seem paradoxical, global security in one respect encompasses situations where a country is able to make armed reprisals for acts of aggression by another country or groups.[26] And by extension, a situation where countries of the world, with force of arms when necessary, are able to enforce peace and stability in their individual territories and, the world at large, in line with the ideal of the United Nations.[27]

Generally, until the modern era, nations did not keep standing armies. The practice was for a community or the ruler to mobilize able-bodied men on an *ad hoc* basis to prosecute battles as necessary.[28] With different countries now maintaining standing armies, the duty of maintaining security lies with the armies.[29] Specific sets of laws create and govern the conduct and operation of the armies or armed forces.[30] For an army to be effective, the

22 *Ibid.*

23 See Fleshman, *op. cit.* n. 11, pp. 16-17; Forman and Julio, *op. cit.* n. 2; J. Fisher-Thompson, 'AIDS Among African Militaries Concerns Former Top US Commander', *News, US Mission, Nigeria>Press Releases*, March 5, 2004, pp. 1- 2; see also B. Gellman, 'AIDS is Declared Threat to Security', *Washington Post*, April 30, 2002.

24 UN Security Council Resolution 1308 (2000) on the Responsibility of the Security Council in the Maintenance of International Peace and Security: HIV/AIDS and International Peace-keeping Operations, *SC Res. 1308*, UN SCOR, 55th Sess., 4172nd mtg., para 3, UN Doc. S/RES/1308 (2000).

25 See A.C. Arend and R.J. Beck, *International Law and the Use of Force,* Routledge, New York, 1993, pp. 16-19.

26 *Ibid.*

27 See generally, articles 39-51, chapter vii, Charter of the United Nations, June 26, 1945, 59 Stat. 1031, TS 993, 3 Bevans 1153, *entered into force* 24 Oct.1945. [hereinafter 'UN Charter']

28 R.A. McDonald, *Canada's Military Lawyers,* Ministry of Public Works and Government Services, Ottawa, Canada, 2002, p. 1.

29 G. Glenn, *The Army and the Law,* Columbia University Press, New York, 1943, pp. 1-2, 7-12.

30 See e.g. section 217 of the Nigerian Constitution and Armed Forces Act, section 1(3).

human components must be healthy, fit[31] and disciplined.[32] This evidently explains why fighting units of armies normally consist of healthy, able-bodied young persons within a certain age range.[33] It also explains why armies normally discharge personnel who become unfit or reassign them to less demanding units.[34] As stated by one commentator:

> Several years ago, I visited a country [in Africa] that had two air force squadrons. They tested one squadron and 85 per cent of its personnel were HIV positive. So they stopped testing because they didn't want to know what the other squadron would be like. If the pandemic plays out there, the impact and challenges to that nation's security are going to be huge.[35]

Another way in which HIV/AIDS can affect the strength of a country's army is the depletion of the number of young men that normally constitute an army. While HIV/AIDS can infect any age group, the prevalence is higher among young adults,[36] the age group that normally constitute the fighting units of armed forces. It is through its effect on the health and depletion of troops, and the consequential impacts on the overall strength of armies that HIV/AIDS affects security at domestic and global levels. This manifests in two ways. First, following the natural tendency of the powerful to prey on the weak, weakened and ineffective armies may become easy preys for other countries. Similarly, internal armed groups may be encouraged to confront weakened government forces. The latter is more likely to occur in Africa, especially, the Western and Central sub-regions, where several countries have experienced political instability. Secondly, it may become difficult for the UN to carry out its peacekeeping and other international security operations as provided in its Charter.[37] Having no standing army, the UN relies on member nations

31 W. Egbewunmi, '[Nigerian] Armed Forces Programme on AIDS Control (AFPAC), HIV/AIDS in the Military-5' *Nigeria-AIDS.Org.Home* 1, <http://www.nigeria-aids.org/msgRead.cfm?ID=408> accessed: 8 December 2004.

32 C.F. Blair, 'Military Efficiency and Military Justice: Peaceful Co-Existence?' 42 *University of New Brunswick Law Journal (UNBLJ)*, 1993, p. 237.

33 See n. 8 above.

34 See e.g. (US) Department of Defense Directive, Number 6485.19 March 1991 (Administrative Re-issuance Incorporating Change 1, August 10, 1992). [hereinafter *US DoD Policy*]

35 Fisher-Thompson, *op. cit.* n. 23; Forman and Julio, *op. cit.* n. 2, p. 3: "According to a document released by Stephen Morrison, who oversees the CSIS Task Force on AIDS, many regions of the world, including Africa, 'face grave national stability issues' because of the disease. Large numbers of soldiers, specifically young men between the ages of 15 and 24 have contracted the disease. *In some cases, the virus has depleted entire units* and has spread to the civilian population". [Emphasis added]

36 'Armed Forces HIV/AIDS Control Policy Guidelines', issued under the authority of the Minister of Defence, October 2003. [hereinafter 'Nigerian Military HIV/AIDS Policy'] at p. 6. See 'HIV/AIDS in Nigeria' *A USAID Brief* July 2002, p. 1, at 3 <www.usaid.gov/pophealth/aids> accessed 8 December 2004; L.O. Gostin, *The AIDS Pandemic,* University of Carolina Press, Chapel Hill, 2004, p. xii.

37 Chapter vii.

to provide troops whenever the Security Council so requests.[38] According to the Nigerian Military HIV/AIDS Policy:

> HIV/AIDS is expected to impact on various social and economic sectors of the country, if it is allowed to spread unchecked. In the military it will have untold consequences for the military readiness and the country's ability to defend itself *or take on assignments that are necessary to maintain world peace.*[39]

The Military and Control of HIV/AIDS

As in the case of civilian populations, the issue of best approach is crucial in HIV/AIDS control in the military. Here the underlying question is whether HIV/AIDS should be treated as a human rights issue or a military issue to be confronted with tough military measures. This paper goes on to discuss how military organizations *should* approach the control of HIV/AIDS control. The focus is on the Nigerian military. The underlying reason for adopting Nigeria is that the country offers a good case study. HIV/AIDS in the Nigerian military and the country as a whole is at a troubling level, with Nigeria harbouring the third highest number of people living with HIV after India and South Africa. In another vein, Nigeria is a military, political and economic power in Africa. It could be a role model for other developing countries.

History of HIV/AIDS Control in the Nigerian Military

The Nigerian military has adopted different control measures since the first HIV/AIDS case was diagnosed in Nigeria in 1986. It opened the first HIV/AIDS screening centre in Nigeria, and inaugurated an expert committee on AIDS in 1988.[40] Between 1990 and 1991 it set up the Armed Forces Blood Transfusion and AIDS Control Committee (FOBTAC) and launched a programme titled 'War against AIDS within the Armed Forces'.[41] In 1993, it set up the Armed Forces Programme on AIDS Control (AFPAC), which has been "responsible for planning and implementing various programs aimed at controlling the HIV/AIDS scourge within the [Nigerian] armed forces".[42] AFPAC has been training and educating military personnel on HIV/AIDS control through seminars, workshops and other means.[43] Between 1994 and 1999, AFPAC formulated and adopted different policy guidelines, setting out its methodology in controlling the disease.[44]

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38 UN Charter Arts. 43-45.
39 Clause 5. [Emphasis added]
40 Nigerian Military HIV/AIDS Policy, p. 9.
41 *Ibid.*
42 Egbewunmi, *op. cit.* n. 31, pp. 1-2; see also Nigerian Military HIV/AIDS Policy, pp. 9-10.
43 Egbewunmi, *ibid.*, p. 2.
44 Nigerian Military HIV/AIDS Policy, p. 10.

The Nigerian Armed Forces has also benefited from the efforts of the national government at different times.[45] In 2000, the Nigerian government inaugurated the Presidential Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA) in efforts to control HIV/AIDS; the Nigerian Armed Forces and the Ministry of Defence were members of the committees.[46] In the same year, the committees formulated a three year HIV/AIDS Emergency Plan (HEAP). The plan consists of HIV/AIDS control activities and strategies "which include many targeted at the Armed Forces".[47]

Presently, the blueprint for HIV/AIDS control in the Nigerian military is set out in the Military HIV/AIDS Policy. The Policy came into effect in October 2003 "under the authority of the Minister of Defence".[48]

The Nigerian Military HIV/AIDS Policy

The preamble to the Nigerian Military HIV/AIDS policy points out that in confronting HIV/AIDS, the Nigerian military adopts a *multi-sectoral approach,*[49] entailing the induction of various groups such as wives of military officers and religious leaders. This is a reflection of the organization's treatment of HIV/AIDS as a *welfare issue*.[50] The policy does not specifically interpret 'welfare issue'. However, with emphasis on care, well being and safeguarding the rights of military personnel, related to some other provisions of the policy as discussed below, there is a strong basis to argue that the policy tilts towards a rights-based approach. Moreover, the policy objective, in addition to reduction of the vulnerability of soldiers to HIV/AIDS, encompasses caring and supporting those infected with HIV. This paper analyses the welfare orientation to determine whether the Nigerian policy is based on a rights based approach. Further analysis of the salient provisions of the policy is undertaken below.

HIV/AIDS/STI Education and Provision of Protective Devices

The policy recommends education on HIV/AIDS preventive measures. This is to be complemented with the provision of protective devices and materials. HIV/AIDS education starts on enlistment into the military and continues throughout the career of soldiers. HIV/AIDS prevention education is not limited to the military personnel but also extends to their spouses. Educating the spouses should serve as additional impetus in the control efforts. In one vein, the spouses would be enlightened

45 See 'Nigerian President Orders Free Condoms for Soldiers to Combat HIV/AIDS', *Pro-Quest* 1, <http://proquest.umi.com/pqdweb?index=26&srchmode=1&vinst=PROD&fmt=3&s> accessed 8 December 2004.
46 Nigerian Military HIV/AIDS Policy, pp. 10-11.
47 *Ibid* at p. 11.
48 Nigerian Military HIV/AIDS Policy, front cover page.
49 *Ibid.*, p. 4 ; see Egbewunmi, *op. cit.* n. 31, p. 2.
50 Nigerian Military HIV/AIDS Policy, p. 3.

as to how to protect themselves. Similarly, they can use the knowledge acquired in stimulating appropriate behaviors on the part of their spouses in the military.

Voluntary Testing, Consent and Confidentiality

Testing of serving military personnel for HIV is to be carried out only with their full consent.[51] Also, there is guarantee of full confidentiality for medical records and health information of soldiers. Medical information of personnel should be released only to those who 'need to know' and such people equally have a duty to maintain confidentiality.[52] Section 35(1) of the Nigerian Constitution guarantees citizens the right to personal liberty. Deprivation of liberty is not limited to physical restraints, detention or confinement at a particular place. For instance, the European Human Rights Commission had held that the compulsory taking of blood constituted a deprivation of liberty.[53]

The Nigerian Constitution also guarantees the right to privacy.[54] In healthcare settings, the right to privacy manifests in the right of a patient to medical confidentiality.[55] An underlying rationale for keeping patients' confidence is that it would encourage patients to disclose information to their doctors without inhibition.[56] In the military, the principle of confidentiality generally does not apply between the military doctor and the soldier patient.[57] Therefore, information obtained in such a relationship does not enjoy any confidentiality and could even constitute evidence in disciplinary or 'adverse personnel action'[58] against the soldier.

The *privac*y provisions of the Nigerian Military HIV/AIDS Policy accord with the prevailing global views that the protection of the rights of patients would be more effective in the drive to control HIV/AIDS than the violation of rights. The provisions also accord with the positions in some jurisdictions where the right of military personnel to privacy, in respect

51 *Ibid.,* p. 16. Presumably, 'full consent' connotes 'informed consent'.
52 *Ibid.*, pp. 16-17.
53 See *X* v *Austria* (8278/78), Decision of the Commission (1979) DR 11, p. 216.
54 'The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed'.
55 For a detailed discussion of privacy and medical confidentiality, see J.K Mason, G.T Laurie, M. Aziz, *Mason and McCall Smith's Law and Medical Ethics,* 7th ed., Oxford University Press, Oxford, 2006, pp. 253-295.
56 See British Medical Association (BMA) guidance- *Confidentiality: Protecting and Providing Information,* June 2000, online <www.gmc-uk.org>, accessed: 17 April 2005; see also BMA guidance, *Confidentiality & Disclosure of Health Information*, October 1999, online <www.bma.org.uk>, accessed: 17 April 2005.
57 D.W. Webber, *AIDS and the Law,* 3rd ed., Wiley Law Publications, New York, 1997, p. 149.
58 For the meaning of 'adverse personnel action' see E3.2 Enclosure 3 'Limitation on the Use of Information obtained in the Epidemiological Assessment Interview', US *DoD Policy, op. cit.* n. 20.

of HIV/AIDS infection, has been upheld.[59]

One aspect of concern in the privacy provisions, however, is that the policy does not stipulate the use to which those who need to know can put medical reports of infected soldiers. The doubt or fear over to what use the military authority can put medical information, may still discourage some soldiers from going for HIV testing. Therefore, the confidentiality provision in the Military HIV/AIDS Policy may not have the desired effect of encouraging voluntary testing. It is recommended that there should be clear-cut assurance that the result of any voluntary test would not be used for any disciplinary purposes against soldiers.

Mandatory HIV Testing for Foreign Missions

Serving personnel slated for foreign courses or postings, as part of their medical examination processes, need to undergo HIV screening.[60] Those who test positive can still be eligible, subject to their physical fitness as determined by further medical examination, nature of the activities they are to be undertaken and, in case of foreign operations, the laws of the recipient nations or institutions relating to HIV infection. Whatever the case, HIV positive personnel would receive counseling. Whether HIV positive or not, all personnel chosen for foreign assignments, before departure, need to undergo training and education on HIV prevention; which are also repeated on return from such missions.

The policy position on the eligibility of HIV positive personnel for foreign missions is laudable. It is another indication that soldiers living with HIV would not suffer unwarranted discrimination because of their HIV positive status. Furthermore, with condition of fitness being a determinant of eligibility, infected soldiers would be encouraged to maintain healthy life styles in order to reduce the likelihood of full-blown AIDS.

Mandatory Testing at Point of Enlistment: Exclusion of HIV Positive Applicants

At the point of enlistment, the medical examinations of applicants for military service include mandatory HIV screening. Those who test positive will be disqualified.[61] The disqualification is summary and without any reference to the health or ability of such applicants to perform military duties. The basic implication of this provision is that people living with

59 *JRB et al.* v. *Ministry of Defence*, Case No. 14000, Supreme Court of Justice of Venezuela (Political-Administrative Bench) (1998). A summary and commentary on this case is available in R. Elliott *et al.*, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV,* Canadian HIV/AIDS Legal Network & Joint United Nations Programme on HIV/AIDS (UNAIDS), Toronto & Geneva, 2006, from which the case is adapted here.
60 Nigerian Military HIV/AIDS Policy, pp. 6-7.
61 *Ibid.*, p. 16.

HIV/AIDS (PLWHA) cannot serve in the Nigerian Armed Forces, simply because of their HIV status. This raises questions on discrimination against HIV positive applicants, and the welfare and human rights orientations of the Policy.

In the overall public interest, there can be legitimate encroachment on some basic rights in certain situations.[62] Along this course, the justifiability of exclusion of infected applicants from the armed forces can be examined. In the absence of any Nigerian cases on the issue, three cases from Namibia, Canada and Australia offer pertinent illustrations.[63] The cases of *X* v *The Commonwealth, Canada (Attorney General)* v *Thwaites* and *Nanditume* v *Minister of Defence* raise important issues with respect to employment discrimination based on HIV positive status. The cases relate to judicial interpretation of legal provisions designed to prevent undue discrimination in employment based on grounds including health status. The fundamental principle flowing from the cases is that mere HIV positive status is not a justifiable basis to disqualify summarily, an applicant from military service. Rather, the basis for disqualification should be whether the HIV infection would impair the applicant from being able to carry out the *inherent requirements* of his particular employment as a soldier.[64] It is submitted that the provision on summary disqualification should be reviewed. Considerations should be based on the health condition and fitness of an applicant *vis-à-vis* likely duties, and the extent to which the applicant constitutes a *real* risk to others in the course of employment.

Care and Support for Infected Military Personnel

The policy recommends continuous care and counseling for military personnel infected with HIV as well as their families.[65] Anti-retroviral drugs (ARVs), post-HIV exposure prophylaxis, drugs to manage opportunistic infections and adequate nutritional support are to be provided for infected personnel. There shall be equality in access to care and treatment. In some parts of the world, rights of HIV positive military personnel to health care and non-discrimination have received legal recognition.[66]

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62 See Gostin and Lazzarini, *op. cit.* n. 3, p. 57.

63 See generally, the Namibian case of *H.N. Nanditume* v *Minister of Defence,* Case No. LC 24/98, Labour Court of Namibia (2000); the Canadian case of *Canada (Attorney General)* v *Thwaites* (1994) 3 FC 38, Federal Court of Canada - Trial Division, 1994. Summaries and commentaries on these cases are available in R. Elliott *et al.*, *op. cit.* n. 59, from which the cases are adapted here; and the Australian case of *X* v *The Commonwealth of Australia* (1999) HCA 63, 2 December, B53 1998.

64 For a discussion of the concept of 'fitness for task', see e.g., S.B. Odunsi, 'When can HIV/AIDS legally disqualify a person from Employment? Reflections on Fitness for Task', Ahmadu Bello University, Zaria, *Journal of Private and Comparative Law*, Vol. 1, No.1, 2006, pp. 1-18.

65 Nigerian Military HIV/AIDS Policy, pp. 21-22.

66 See *e.g. XX* v *Ministry of National Defence (General José María Córdova Cadet School*), Case No. T-707205, Third Appeal Bench of the Constitutional Court, 2003. Summary and Commentaries on this case are available in R. Elliott *et al., op. cit.* n. 59, from which the case is adapted here.

Human Rights Impact Assessment of the Nigerian Military HIV/AIDS Policy

The policy, by its nature, is a public health policy with members of the Nigerian military constituting the targeted population. Public health policies need to strike a balance between the desired public health goals and human rights. This approach would engender a better chance of success than where human rights are summarily sacrificed in the interest of public health.[67] 'Human Rights Impact Assessment' has evolved as a device of ensuring that public health policies constitute beneficial health strategies without restricting human rights unduly.[68] At this point the Nigerian Military HIV/AIDS Policy is assessed to determine whether it strikes the appropriate balance. This paper adopts the 'seven-step process' impact assessment methodology[69] to appraise the policy.

The first step of the assessment is to *find the facts.* In HIV/AIDS, the modes of transmission in a particular society are crucial factors. Closely related to the first step is the second, which is to *determine if the public health policy is compelling.* In determining the compelling nature of the health policy, the policy makers must display sufficient understanding of, and state clearly the specific health goals of the policy. A policy needs to have specific and definite goals,[70] which should take cognizance of the factors responsible for HIV/AIDS spread among the targeted population. Based on its content, the Nigerian Military HIV/AIDS policy, in some respects, satisfies the requirements of steps 1 and 2. With respect to the mode of transmission, the policy identifies risky heterosexual behaviors of military personnel as the principal cause of HIV/AIDS in the Nigerian military.[71] Research and writings, relating to HIV/AIDS in the armed forces, corroborate the position of the policy makers as to the epidemiology of HIV/AIDS in the Nigerian military.[72] In expressing its goal, the policy states:

> [t]he goal of the Armed Forces Policy on HIV/AIDS is to reduce the spread and transmission of HIV within the military to the point where it is no

67 S. Spencer, 'AIDS: Some Civil Liberty Implications', in P. Byrne, *Ethics and Law in Health Care and Research,* John Wiley & Sons, Chichester, 1990, pp. 105-106; see also Gostin and Lazarini, *op. cit.* n. 3, p. 69.

68 Gostin and Lazarini, *ibid.,* p. 57. Also see Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, (UN Doc. E/CN.4/1984/4 91984), which reflect commonly applied tests for assessing the legitimacy of limitations on human rights.

69 See Gostin and Lazarini, *ibid.,* pp. 57-58.

70 An example of such definite goals is "initiating specific behavioral changes (e.g. decreasing unprotected homosexual or heterosexual intercourse, or the sharing of contaminated drug injection)", *ibid.,* p. 59.

71 Nigerian Military HIV/AIDS Policy, p. 6, clauses 2 and 3.

72 See e.g. Nwokoji and Ajuwon, *op. cit.* n. 9.

longer of public health concern nor a threat to the security of the country through its impact on the Armed Forces.[73]

On the surface, it may appear that the policy does not meet the *step 2* requirement of definiteness. However, a deeper look at the relevant policy provisions highlight the central goal of the policy, that is effecting change in the sexual behavior of soldiers to curtail HIV spread in the Nigerian military. It is in line with this goal that the policy places premium on HIV/AIDS prevention education, emphasising the beneficial effect of education that motivates behavioural change.[74]

Step 3 requires that policy makers should evaluate how effectively the policy would achieve the public health purpose.[75] This criterion simply requires that prescribed or adopted control measures have a reasonable prospect of attaining the desired goal. In the present context, this connotes that the measures should be the best means of achieving behavioural change in military personnel and curtailing spread of HIV/AIDS. The military policy satisfies step 3. Subject to effective implementation, the Nigerian military HIV/AIDS policy has the prospect of attaining its goals.

The fourth step is to determine whether the public health policy is well-targeted and aimed at the appropriate population.[76] Demonstrably, the Nigerian Military HIV/AIDS policy meets this requirement. The Nigerian military is a predominant vector of the means of HIV/AIDS spread in Nigeria, which needs to be curtailed in the country. Further, the threat which the disease poses to Nigeria's security also necessitates that cogent efforts be made to control the disease in the military. The following extract from the policy touches on the point:

> In June 2001, the United Nations General Assembly adopted the Declaration of Commitment on HIV/AIDS, whereby Member States committed themselves to developing and/or strengthening national programs targeting the uniformed services to address HIV/AIDS awareness, prevention, care and treatment.
>
> This HIV/AIDS Control Policy Guidelines for the Nigerian Armed Forces represents the commitment and determination of the leadership to stem the tide of this epidemic and mitigate its impact on its personnel.[77]

Step 5 requires that policy makers, in adopting a policy should examine for possible human rights burdens - there should be a principled as well

73 Nigerian Military HIV/AIDS Policy, p. 13.
74 *Ibid.*, pp. 15-16.
75 Gostin and Lazarini, *op. cit.* n. 3, p. 59.
76 *Ibid.*, p. 62.
77 Nigerian Military HIV/AIDS Policy, p. i.

as pragmatic balance between public health interests and human rights protection in the drive to control HIV/AIDS. While it is true that public health necessities may justify some restriction of human rights in some cases, the latter should only occur when inevitable; any infraction should also be minimal. Generally, the Nigerian Military HIV/AIDS policy embraces protection of the human rights of soldiers along with preventing spread of HIV/AIDS.[78]

The sixth step requires that policy makers reflect whether the policy to be put in place is, in terms of encroachment on human rights, the least restrictive of different options in achieving the public health objective. Related to this, the seventh step states that if a human rights restricting policy is the most viable option in HIV/AIDS control, it should be formulated in such a way that it would still be fair to those whose rights are affected. There is clearly correlation between steps 5, 6 and 7. The core of these three steps taken together is that policy makers must strike a proper balance between the public health benefits of a policy and encroachment on human rights.[79]

In sum, the Nigerian military HIV/AIDS policy has endeavoured to give reasonable attention to the need to safeguard human rights in its drive to control HIV/AIDS among military personnel. Similarly, the policy does not rely on coercive measures. Rather, in different ways, it adverts to the welfare of soldiers in the context of HIV/AIDS. Generally, the policy qualifies as a non-restrictive one.

Along this line, even if the policy does not qualify as a rights-based policy in every sense, the recognition of human rights protection as a necessary component of the fight against HIV/AIDS coupled with protection of human rights in some respects is noteworthy. In this context, the policy has manifested reasonable conformity with globally prescribed guidelines with respect to HIV/AIDS control.[80]

Rights-Based Policy and HIV/AIDS in the Military

Rights-Based Policy as a Means of Controlling HIV/AIDS in the Military

Evidently, there is significant awareness among Nigerian military personnel on the causes and modes of preventing HIV/AIDS infection.[81] The awareness, coupled with efforts by the military authorities and

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78 *Ibid.,* p. 16 clauses 5 – 8; p. 22; see also above, 'The Nigerian Military HIV/AIDS Policy – An Overview'.

79 See Gostin and Lazzarini, *op. cit.* n. 3, pp. 65-67.

80 See Office of the United Nations High Commissioner for Human Rights and UNAIDS, *HIV/AIDS and Human Rights: International Guidelines,* Geneva, 1998. [hereinafter 'UN Guidelines']

81 Egbewunmi, *op. cit.* n. 31, p. 2. See also Nwokoji and Ajuwon, *op. cit.* n. 9, p. 1.

the government, ought to have resulted in drastic reduction of HIV/AIDS incidence in the Nigerian military. However, the rate of HIV in the Nigerian military grew to a point where, Nigeria is now threatened by an exponential and explosive growth of the epidemic.[82] This scenario raises the question whether the Nigerian military has been adopting the appropriate methodology in its fight against HIV/AIDS. More contextually, it raises a question whether the *welfare* or rights-based approach, which the current policy still embraces, is an effective method of controlling HIV/AIDS in a military setting.

The Nigerian military has been adopting a non-coercive approach with an inherent appreciation of the importance of human rights protection in HIV/AIDS control. Considering the rather limited success of this approach it may seem attractive that the Nigerian military should instead confront HIV/AIDS as a military issue. After all, as some sources have argued, the only way to run an effective military force is the summary imposition of draconian punishments for the slightest infraction.[83] Seemingly hinting at the need for such a tough approach, Commander in Chief of the Nigerian Armed Forces who is also Nigeria's President, at a forum on HIV/AIDS, once directed military authorities to "*warn* [military personnel] against *illicit* sexual relationship".[84] Moreover, this thinking would be in line with the widespread perception of soldiers as people whose human rights can be summarily encroached upon by the authorities. This paper seeks to engage this question in the discussion that follows.

Perception of the Military

The customs and nature of military activities may have influenced the way non-military members of society perceive military men. A brief reference to the history and nature of the military is considered appropriate at this point. Prior to the modern system of keeping standing armies, the practice was for the community or the ruler to mobilize able-bodied men on *ad-hoc* basis to prosecute battles when necessary.[85] When men of different backgrounds, temperaments and ideas were brought together to undertake sensitive projects like wars, it was important that they were made to blend as a disciplined fighting force under the command of a leader. In attaining this goal, stringent coercive measures, some of which would appear inhuman to non-military minds, were adopted to make the warriors obey the leader and other authorities.

Different countries now maintain standing armies to protect and ward off foreign aggression and maintain security generally.[86] For an army to

82 Military HIV/AIDS Policy, p.5.
83 Blair, *op. cit.* n. 32, at p. 237.
84 *Pro Ques*t, *op. cit.* n. 51, at 1.
85 McDonald, *op. cit.* n. 28, p. 1.
86 Glenn, *op. cit.* n. 29, pp. 1-2, 7-12. See also section 217(1) of Nigerian Constitution.

be effective, soldiers must be healthy, fit and disciplined.[87] In that light, discipline of personnel and obedience of superior orders or commands remain fundamental and inherent features in the armed forces. It is therefore customary for military forces in modern times to adopt strict coercive measures in controlling soldiers under military law.[88]

The courts, at different times, have highlighted the importance of obedience and discipline in the armed forces. For example, in the early case of *Heddon* v *Evans,*[89] McCardie J. held:

> I conceive that the compact or burden of a man who enters the army, whether voluntary or not, is that he will submit to military law…He must accept the Army Act and Rules and Regulations and Orders, and all that they involve. These (which I may call army legislations) define his status, indicate his duties, express his obligations, and announce his military rights. To the extent permitted by them his person and liberty may be affected and his property touched.[90]

The law has clearly recognized the approach as being within the scope of the armed forces to regulate its affairs in its peculiar way, without interference from non-military quarters.[91] In the case of *Parker* v *Levy* [92] the US Supreme Court reiterating its stand that the military is a specialized society further noted that the fundamental necessity for obedience, and the consequent necessity for imposition of discipline, may render permissible within the military that which would be impermissible outside it.[93]

With a nature as described above, it is pardonable if some people regard military duties and human rights as incompatible. Therefore, 'welfare approach' methodology in an organization used to coercion and force, would appear to be a wrong and potentially ineffective step. However, coercive military measures or force may not be effective or advisable tools for controlling HIV/AIDS in the military because of certain inherent factors. Firstly, notwithstanding the perception of soldiers as 'rightless' persons, there is a limit to which military can encroach on the rights of soldiers. Secondly, apart from the legal limitation, coercion does not necessarily guarantee proper conduct or compliance with laws and regulations.

87 Egbewunmi, *op. cit*. n. 65; Blair, *op. cit*. n. 32, p. 237.
88 See McDonald, *op. cit*. n. 28, p. 1; see also generally Part xii, Armed Forces Act.
89 (1919) 35 TLR, 642.
90 *Ibid.*, p. 643.
91 See Glenn, *op. cit*. n. 29, at 54: "…so far as its laws and the correlative rights of its members are concerned the functioning of the army should be a matter of self-control. The commission of offenses against the law and custom of the army, on the part of persons who are members of it, is to be judged by the governing powers of that organization, sitting in that respect in a judicial capacity; and the sanction of such laws is a matter entirely within the control of the organization".
92 417 U.S 733 (1974).
93 *Ibid.,* at 743.

Furthermore, it may be difficult to sustain or enforce coercive measures in the context of HIV/AIDS control. These issues are further examined below.

Status of Military Personnel and Scope of Nigerian Military Law

By opting for military service, a person enters into a service with the armed forces, which involves an obligation to subject himself to military law. Under the common law, this evolving contractual relationship became known as *compact.* [94] The essence of compact is that any one who submits himself to military service is bound by military law and discipline and, invariably, some of his rights could be encroached upon for military effectiveness.[95] The modern military practice of effecting compact is by means of standard forms and oaths of allegiance.

From the old judicial authorities on compact,[96] one may have the impression that enlistment in the military literally wipes off all the basic rights of a soldier. However, the acceptable position is that enlistment in the military does not *ipso facto* turn military personnel to persons without any rights as citizens.[97] That military personnel largely retain certain rights as citizens has been long acknowledged in different jurisdictions. For example, in the Australian case of *Linday* v *Lowell*[98] Hood J stated, "A man by becoming a soldier does not cease to be a citizen. He changes his status as he does on marriage and thereby assumes new liabilities".[99] In the comparatively more modern Nigerian case of *Ladejobi* v *Attorney General of the Federation*[100] the Nigerian Court of Appeal held that, subject to relevant conditions guiding their services, military personnel, as citizens, have access to civil courts to have their grievances addressed. Inferably, what soldiers give up on enlistment in the military are such rights that may be incompatible with the effective performance of their military duties.

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94 See the case of *Grant* v *Gould* (1792) 2 Henry Blackstone Rep. 69. See the case of *Dawkins* v *Lord Rokeby* (1866) 4 F & F 806, where Willes J at p. 831, stated: "But with respect to persons who enter into the military state, who take His Majesty's pay, and who are consent to act under his commission, although they do not cease to be citizens in respect of responsibility, yet they do by a *compact* which is intelligible and which requires only the statement of it to the consideration of any one of common sense, become subject to military rule and discipline".

95 See *Grant* v *Gould and Dawkins* v *Lord Rokeby, ibid.*

96 *Ibid.*

97 See *Burdett* v *Abbott* 4 Taunt Rep. 450.

98 (1917) VLR 734.

99 *Ibid.,* p. 746. The Armed Forces Act recognizes and upholds the dual legal status of military personnel. While primarily subjecting soldiers to military law, the Act equally provides for the application of non - military laws to military personnel in different respects- see e.g. section 170 of the Armed Forces Act.

100 (1982) 3 NCLR 563.

While there are no express statutory provisions setting out the human rights of soldiers in Nigeria, the Act which vests the Nigerian military authorities with the power of self regulation is subject to the Nigerian constitution.[101] Based on this analysis, subject to the encroachment permitted by the Nigerian constitution for the effective performance of military duties, Nigerian military personnel are entitled to all constitutional rights as citizens.

HIV/AIDS, Military Personnel and High-Risk Sexual Activities: Human Rights and Military Law Perspectives

A combination of high-risk heterosexual behaviours, beliefs in paranormal immunity against infection and in magical cure contribute to the spread of HIV/AIDS among Nigerian soldiers. Logically, the solution lies in behavioural change in these areas. The fundamental question is whether the military approach would be more effective than a rights-based approach/rights-oriented approach in achieving the solution.

The Nigerian military personnel can be held guilty in non-military courts for crimes, like other citizens; convictions for crimes are grounds for further military actions against affected soldiers.[102] This network of criminal and military laws is a useful tool for the Nigerian military to check illicit sexual activities. Ostensibly, when culpable soldiers face stiff sanctions for rape or other sexual offences, it is expected that others would be deterred from engaging in sexual abuses in the course of operations.

Leaving aside arguments over the deterrent power of sanctions, this option may still not have much impact in HIV/AIDS control in the Nigerian military. Not all sexual activities of soldiers are unlawful. Soldiers, more often, engage in *consensual* sexual activities with sex workers and other partners,[103] who could be male or female. While some of these behaviours may be morally and socially reprehensible, that does not transform them to criminal conduct that attracts sanctions under civil or military law. Therefore, even if we assume that military sanctions can discourage *unlawful* high-risk sexual activities by military men, other high-risk sexual activities, which are *not* unlawful under Nigerian laws, would still fall outside the purview of the provisions. In this vein, the option of punitive military law sanction faces obvious legal limitations.

At another level, we may consider how the Nigerian military can use its *self-regulating* mechanism to check high-risk sexual behaviours, which are not inherently *unlawful*. The military is vested with the power of self-regulation.[104] As a self-regulating body, with seemingly boundless powers over its personnel, it would seem acceptable that the Nigerian military

101 Section 1 of the Nigerian Constitution.
102 See sections 77-81 together with 88-99 of the Armed Forces Act.
103 See Nwokoji, Ajuwon, *op. cit.* n. 9, p. 1.
104 See sections 4-6, Armed Forces Act.

can summarily *order* its soldiers to desist from behaviours conducive to HIV/AIDS spread. For example, to extract proper sexual behaviours on the part of military personnel, military authorities may issue a standing order that no military personnel should have sexual intercourse with sex workers or other groups considered prone to HIV/AIDS. Perhaps, to imagine some extreme cases, an order could also be made barring soldiers from having multiple sexual partners, or directing that they *must* use condoms when engaging in sexual intercourse with persons whose HIV status they are uncertain of. To give effect to such drive, stiff sanctions could be put in place as a means of ensuring compliance. Any of these imagined orders, assuming they are made, undoubtedly, would be difficult to enforce. More importantly, such orders will be in conflict with basic human rights principles. There are human rights limits to the steps the military can take with regard to its personnel. This issue is best discussed by analysing the factors responsible for HIV/AIDS spread in the Nigerian military in the context of relevant constitutional provisions.

Sexual intercourse, choice of sex partners and the mode of undertaking sexual activities fall within the scope of certain fundamental human rights guaranteed under the Nigerian constitution and international human rights law. The human rights that are primarily relevant in the context of sexual behaviors and paranormal beliefs are the rights to privacy and association. Section 40 of the Nigerian constitution guarantees, among others, the right to 'associate with other persons',[105] while section 37 guarantees the right to privacy. The right to 'associate with other persons' manifestly extends to having interpersonal and sexual relationships with others. These rights are also guaranteed under international human rights law.

The right to privacy encompasses the right of a person to be free from intrusion into his seclusion, solitude or private affairs,[106] and the right of every citizen to live his life free from arbitrary interference by public authorities or the government.[107] The right to privacy encompasses the liberty to establish and maintain relationships with persons, particularly in the emotional and physical/sexual realms.[108] Sexual intimacy constitutes a component of the right to privacy. Based on this, it can be concluded that any military order that dictates the mode of heterosexual sex,[109] or the choice of partners with which soldiers should have *legitimate*[110]

105 Section 40- Every person shall be entitled to assemble freely and *associate with other persons*....[emphasis added]

106 W. Prosser, *Handbook of the Law of Torts*, 4th ed., West Publishing Co., St. Paul, Minnesota, 1971, p. 814.

107 See *Belgian Linguistics Case*, Judgment of the European Court of Human Rights (ECHR) (1968) 1 EHRR 252.

108 See *Dudgeon* v *United Kingdom*, Judgment of ECHR (1981) 4 EHRR 149.

109 That is, in terms of seeking to compel the use of condoms.

110 'Legitimate' here connotes sexual practices that are not regarded as unlawful under an existing law. In this light, conventional sexual intercourse between consenting adults within the confines of existing law would qualify as legitimate sexual intimacies.

sexual intercourse constitutes a violation of this basic right.[111] This same reasoning can be extended to the decision to use or not use condoms or engage in protected sex by other means. It can hardly be disputed that in the exercise of their right to association and privacy, two consenting adults can legitimately decide to engage in unprotected sex with full appreciation of the likely risks and a readiness to be exposed to such risks. It is true that the conduct of such persons may be unreasonable; this however does not nullify the fact that they operate within the scope of their basic rights. In the context of unprotected sex, compulsion to use condoms or engage in sex in a particular manner, arguably, would amount to transgression of rights.

Extent to which Military can Abridge Fundamental Rights of Personnel

It can be argued that unfettered exercise of the rights to privacy and association in the realm of sexual practices is inimical to the effectiveness of the military. A compact entails a soldier giving up some basic rights, necessitated by the effective performance of duties. The Armed Forces Act empowers the Army Council to control or regulate the Nigerian military with respect to "discipline and administration of, and for all other matters relating to the Armed Forces".[112] Seemingly, the Nigerian military, on that basis, would be justified in abridging the exercise of any rights of its members if deemed necessary for military effectiveness. Such a measure would particularly seem to find support in section 45(1) of the Nigerian constitution, which provides:

111 See generally, the case of *Post* v *State* 715 P.2d 1105 (Okla. Crim. App.), 479 U.S 890 (1986), see also, *Bowers* v *Hardwick* 478 US 186 (1986).
In the cases, the courts rejected contentions that the government could not intrude into the practice of consensual same-sex sodomy. From the facts and circumstances of the cases, it appears that the determinant of whether the government could intrude into sexual conduct was whether the sexual practices, by either statute, or other means, were legally acceptable in the jurisdictions. Therefore, probably, if same-sex sodomy was legal the cases could have been decided differently, with the courts probably invalidating government intrusion into the right of the parties' sexual inclinations. According to a commentator, "[p]erhaps the Supreme Court's decision in *Hardwick* can be made consistent with a view of treating privacy as an aspect of autonomy by limiting the autonomy at stake to *states of affairs in which society already recognizes a certain degree of privacy.* In this view, autonomy is protected only if there is a pre-existing state of affairs (such as marriage) in which the autonomy is expressed". [Emphasis added] see V.J. Samar, *The Right to Privacy, Gays, Lesbians, and the Constitution*, Temple University Press, Philadelphia, 1991, p. 37. Building on the above reasoning, inasmuch as sex without condoms is not illegal, it would seem unlawful intrusion for the Nigerian military as a public institution to interfere with the failure of military personnel to use condoms.

112 Section 5(1), Armed Forces Act.

> [n]othing in sections 37, 38, 39 and 41 of this Constitution[113] shall invalidate any law that is reasonably justifiable in a democratic society-
> (a) in the interest of *defence*, public safety, public order, public morality or public health.[114]

While the foregoing proposition may be attractive, the reality, however, is that the Nigerian military can only encroach on the rights of military personnel to certain prescribed limits. The military is a creation of statute, which determines the ambit of its powers. Therefore, any regulation or orders the military make, *vis-à-vis* the sexual behaviors of Nigerian military personnel, must be within the confines of its enabling statute as well as the constitution and other relevant laws applicable in Nigeria.[115]

To start with, section 45(1) does not provide for the making of just any law in the interest of defence. Before any law can find protection under the provision, the law must be 'reasonably justifiable in a democratic society'. Assuming that the regulations on sexual behaviour for military personnel, qualify as 'laws', the issue arises whether such regulations can pass the test of *reasonable justifiability*. In the absence of any Nigerian case law, the European Court of Human Rights offers a useful guide on the scope of the 'reasonable justifiabilty' in the context of article 8 of the European Convention on Human Rights,[116] which is substantively similar to section 45 of the Nigerian constitution. For clarity, article 8 of the European Convention on Human Rights provides, "[e]very one has the right to respect for his private and family life, his home and his correspondence…"…"[t]here shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is *necessary in a democratic society*".[117] According to the Court, for a right-encroaching measure to be necessary or justifiable, there must be a 'pressing social need' for the encroachment,[118] and the encroachment must correspond proportionately to the aim to be achieved by it.[119] Moreover, it must be determined whether there would be any adverse consequences to society if the rights were not restricted or if any existing restriction is discontinued.[120]

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113 Sections 37, 38 and 41 relate to the rights to privacy, association and worship discussed above.
114 Emphasis added.
115 Glenn, *op. cit.* n. 29, p. 59.
116 Convention for the Protection of Human Rights and Fundamental Freedoms, Rome, 4.XI. 1950, Council of Europe, European Treaties ETS No. 5,<http://www.pfc.org.uk/legal/echrtext.htm >, accessed 12 August 2005.
117 Emphasis added.
118 *The Handyside Case*, Judgment of the ECHR (1976) 1EHRR, 737 para 48; see also *The Sunday Times Case*, Judgment of the ECHR (1979) 2 EHRR 245, para 59.
119 *The Handyside Case*, *ibid.*, [para 48], *The Sunday Times* Case *ibid.,* para 59.
120 See *The Sunday Times Case, ibid.*, para 60.

Based on the above stated principles, an encroachment on the rights of military personnel beyond the constitutionally permitted extent cannot satisfy the justifiability condition for certain reasons. In one aspect, it is debatable whether interfering with soldiers' rights would deter them from high-risk sexual behaviours. With soldiers scattered in different locations within and outside the country, it is inherently difficult to monitor what every soldier does in his private time outside the direct supervision of commanders. Enforcing the 'safe sex' regulations may not be practicable. Also, since sexual activities tend to occur in a state of passion clouded in sentiments, with little room for rational thinking, it is debatable what impact any 'safe sex' regulations would have on soldiers in such circumstances. Moreover, civilian spouses and other sexual partners of soldiers would not be bound by the sexual conduct regulations, so there is still the possibility of soldiers being infected through their partners.

It is thus obvious that encroaching on the rights of military personnel is not likely to have any impact in curtailing their high-risk sexual behaviours. Without the likelihood of achieving the desired goal, a coercive sex code in the Nigerian military would have no effect apart from simply depriving soldiers of their fundamental rights. Such regulations cannot be regarded as necessary or reasonably justifiable in a democratic society.

In another vein, encroaching on the rights of soldiers for HIV/AIDS control would be contrary to worldwide recommendations that protection of the rights of targeted populations is the best approach to HIV/AIDS control.[121] According to the International Guidelines:[122]

> [o]ne aspect of the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. In particular, people will not seek HIV-related counselling, testing, treatment and support if this would mean facing discrimination, lack of confidentiality or other negative consequences…[C]oercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support.[123]

In that sense, it would be also difficult to justify a rights encroaching rule or measure which conflicts with recommendations of well recognized international bodies.

121 See UNAIDS, *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*, 2nd. reprint, UNAIDS & IPU, Geneva, 1999, pp. 24 - 25.
122 OHCHR and UNAIDS, *op. cit.* n. 80.
123 *Ibid.*, at para 74.

Examining Likelihood of Soldiers' Compliance with Restrictive Regulations

Apart from the legal or constitutional limitations previously considered, some other factors can still make rights-encroaching measures ineffective in the drive to control HIV/AIDS in the Nigerian military. One crucial factor is that such measures may not have the co-operation of soldiers as the targeted population.

Any measure that unduly transgresses on the rights of soldiers is likely to encounter resistance from them. While soldiers may be perceived as unthinking robots, as insinuated in the centurion's speech, the reality is that "a soldier…is not an automaton but a reasoning agent".[124] Therefore, notwithstanding the Spartan dispensation in the military, it is important that orders imposed or measures taken with respect to their rights and interests are credible and fair. Otherwise, it will not receive the co-operation of the soldiers.[125] The observation of a commentator made in reference to the Canadian military throws some light on the point being made in this respect:

> The question of credibility is perhaps the most important question of all. If troops stop believing in fair and effective military justice, the breakdown of discipline and ultimately of military efficiency will follow. Remember, the force is an all-volunteer force in which recruiting and retention can be quickly and adversely affected by dissatisfaction. It is not in the interests of the Canadian Forces to operate a disciplinary system which is characterized by the imposition of unthinkingly severe punishments…The old idea that when you sign up in the military you give up your civil rights is long dead and buried. The members of the Canadian Forces have all undertaken a contingent commitment of absolute personal liability in the defence of Canadian constitutional values. It would be truly ironic if they were not allowed to enjoy the benefit of those values.[126]

Though the above statement was made in the context of the Canadian armed forces, in view of the similarity in the nature of military, it can be applied to the Nigerian military. A measure that has the impact of literally obliterating rights of soldiers will not receive their full cooperation.

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124 *US* v *Kinder* (1953) 14 CMR. 742, at 776.

125 Weber, *op. cit.* n. 57, p. 149, illustrates this scenario by the non-cooperation of US soldiers for epidemiological interview, due to lack of protection against 'adverse personnel action'.

126 Blair, *op. cit.* n. 32, at pp. 238-239.

Soldiers as Stakeholders in the War Against HIV/AIDS

To reiterate, measures that encroach on the rights of soldiers are not likely to have any meaningful impact in curtailing high-risk sexual behaviours, and control of HIV/AIDS in the military. Such measures could even be counterproductive and harmful to the efforts to control HIV/AIDS. Herein lies the answer to the question of the preferable choice between rights based or 'tough' military approaches in the battle against HIV/AIDS in the military.

Notwithstanding the apparent shortcomings of the *welfare* approach of the Nigerian military in the battle against HIV/AIDS, that approach still offers a better hope of effective solution to the crisis than a tough military approach. In confronting HIV/AIDS, the military needs the maximum co-operation of its soldiers who are important stakeholders in the HIV/AIDS control drive. A feasible approach would thus be one that can motivate the co-operation of soldiers and encourage them, as the targeted population, to participate diligently in the drive. A rights-based/welfare approach is more likely to induce a spirit of 'it is *our* battle', while a tough military approach may propel a feeling of 'it is *their* battle'. Military authorities need to appreciate the important roles that soldiers can play in the success or failure of the war against HIV/AIDS. Safeguarding the rights of soldiers would be an important indication that military authorities count on the support of the soldiers as *comrades* in the battle against HIV/AIDS. This, expectedly, would infuse in the soldiers a collective sense of responsibility to make the control efforts successful. As Osiel noted:

> Hegel famously observed that the "slave" cannot give the master what the master wants-recognition as a superior being- without the master's recognizing the slave's capacity to accord that recognition, thereby acknowledging the slave's humanity. Within an army, in similar fashion, a superior needs to give his subordinates enough responsibility credibly to hold them (rather than himself) accountable for certain kinds of failure.[127]

The Nigerian military HIV/AIDS policy evidently recognizes the need for co-operation of soldiers in the battle against HIV/AIDS. Pragmatically, the policy seeks to attract this co-operation by tacitly *requesting,* instead of *compelling* it. 'Elevating' the soldiers to a level of important voluntary role players, in an organization where they normally have to be coerced, should be an impetus to make them strive for success in the HIV/AIDS control drive along with the military authorities.

127 Osiel, *op. cit.* n. 4, p. 234.

Conclusion

The importance of adapting HIV/AIDS policies and control measures to blend with human rights law cannot be overemphasized. It is generally acknowledged that efforts to control the pandemic are more likely to succeed when the policies and measures promote and safeguard human rights. The military, notwithstanding the predisposition to use coercion and force to control personnel, remains a part of the larger society. It therefore cannot take a route radically different from that of the larger society in the war against HIV/AIDS. It is necessary that HIV/AIDS control measures in the military should attune with the overall policies of their respective countries. Similarly, the military should be mindful of the commitments of their countries to human rights protection at domestic and international levels.

The imposition of draconian military orders and concomitant punishments for engaging in risky sexual behaviors might create the impression that a military organisation is getting tough in the war against HIV/AIDS. However, such measures in the long run will be unproductive. Coercion and sanctions, the major military tools for controlling personnel management, it is submitted, may not be feasible means of controlling the spread of HIV/AIDS in the military. The Nigerian military, apparently recognizing this fact, has avoided the 'military route' and remains committed to an approach which could be deemed a rights-based approach, which it has been using for a relatively long time. This scenario highlights a conviction: that whatever may be the perceived shortcoming of the approach in past efforts, the rights-based approach rather than coercive military measures, has a good possibility of achieving control of HIV/AIDS in the military.

HIV/AIDS AND EMPLOYMENT LAW IN BOTSWANA

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Introduction

The HIV/AIDS epidemic has presented and continues to present unprecedented challenges in almost all spheres of human life. These challenges of the epidemic are to a large extent felt in the work place. It is beyond doubt that Botswana has made positive strides towards reducing and/or mitigating the impact of HIV/AIDS by introducing comparatively good programmes in the health sector. Despite this fact, this paper seeks to explore the plight of employees living with HIV in the workplace, who, it is argued, are more vulnerable and disadvantaged because of the absence of protective laws. This paper will specifically deal with the current status of HIV/AIDS and Employment law as it pertains in Botswana. In the end, the paper will examine the related law that obtains elsewhere in the Southern African region. The reason for this examination is that these jurisdictions are arguably progressive in law reform and their laws and practices serve as best practices that Botswana could, and ideally should follow.

In Botswana, there is no specific statutory provision dealing with the issue of HIV/AIDS and the world of work. This notwithstanding, there are several issues that have been and continue to be the subject of debate and litigation in Botswana. Significant amongst them are the legality of pre-employment HIV testing of job applicants, continuity of employment and termination of employment of persons living with HIV/AIDS. These issues are central to this paper and they will accordingly be dealt with individually.

The Legality of Pre-Employment HIV Testing in Botswana

Employers may and do sometimes require job applicants to undergo an HIV test as a pre-condition to employment. This requirement is enabled and exacerbated by the absence of specific law regulating employment of HIV infected job applicants. It is termed Pre-Employment HIV Testing. If diagnosed as infected with HIV, the job applicant will almost certainly be denied the employment opportunity. This requirement is, it is submitted, unfortunate, devoid of rationality and unjustifiable. This is particularly so because being HIV-positive is not in any way synonymous with incapacity to perform functions of one’s job requirements. An employee can productively work for many years without any impairment on his capacity to perform.

Is Pre- Employment HIV Testing Legal in Botswana?

The Employment Act[1] provides for pre- employment medical examination but does not state the medical conditions to be examined and the purpose/s of such tests. One irresistible inference that can be deduced is that medical examinations are by their nature intended to assess the fitness or unfitness, of a job applicant to work. The permissibility or otherwise of this requirement/practice was considered by both the Botswana Industrial Court and Court of Appeal in the authoritative *Rapula Jimson* v *Botswana Building Society (BBS)* case.[2]

The said courts came to the conclusion that there is nothing in the present labour laws prohibiting employers from requiring job applicants to undergo an HIV test as a precondition to employment. The courts conclusively said that there is no restraining legislation and that it must be emphasized that Parliament, not the courts, enact laws specifically prohibiting HIV testing as a pre-condition for employment. As the common law stands today, employers have the right to make decisions regarding recruitment and requirements thereof. Such requirements may include pre-employment HIV testing.

It is important to note however, that the Industrial Court and the Court of Appeal arrived at different conclusions in so far as determining whether the HIV test that *Jimson* was required to undergo amounted to pre-employment medical examination or not, with the Court of Appeal holding that the HIV test was part and parcel of the pre-employment medical examination.[3]

The brief facts of *The Jimson Case* were that, the applicant, Rapula Jimson, passed the pre-employment medical examination, and 19 days later received a letter requiring him to undergo a *'further pre-employment medical examination'* for an HIV test. He consented to such a test, which showed that he was HIV positive. The respondent thereupon wrote to the applicant informing him that his probationary employment with the respondent will be terminated at the end of that month and enclosed a copy of the results of the HIV test.

The Industrial Court found that the second test, for HIV, was not part of the pre-employment examination but a compulsory post employment HIV testing, which was in breach of the contract of employment entered into between the parties. The court consequently found that the applicant's dismissal was substantively and procedurally unfair and he was awarded

1 Section 46 (1): Subject to subsection 3, every employee who enters in to a contract of employment to which this part applies shall be examined by a medical officer.
2 Industrial Court 35/03 and Civil Appeal 37/03 respectively.
3 Botswana Network on Ethics, Law and HIV/AIDS, *Challenging HIV-related Discrimination – Protection for Employees in the Workplace*, BONELA, Gaborone, 2004.

compensation of a sum equal to six months' wages, being the maximum permissible compensation at the time.[4]

On appeal, the Court of Appeal found that it was evident that the applicant, Rapula Jimson, was dismissed because of the result of the HIV test. The court further found that the required further HIV test was not an additional post-employment requirement by the employer, but part and parcel of the pre-employment medical examination.

It is clear from the above, that the two courts are in agreement on the legality of pre-employment HIV testing. In fact Judge President of the Industrial Court, Justice Legwaila had this to say:

> The Botswana Building Society made a decision with regard to the recruitment of people with HIV. In the absence of any legal stipulation forbidding the making of that policy, this Court cannot assume the role of a lawmaker…The Applicant lost his employment because of an indiscriminate policy of the employer who took advantage of the absence of restraining legislative instruments. It was not that at that point in time the Applicant was found to be incapacitated but simply because he was HIV positive. This is not the type of prejudice that can be left to the courts to tackle. The courts can only fill gaps, clear doubts or give meaning where there is a lack of clarity.[5]

Evidently the court was advising parliament to pass restraining laws. This decision was handed down in May 2003, and to date the legislature has done nothing in this regard. Be that as it may, one cannot confidently say that the courts would have arrived at the same decision if constitutional human rights arguments were raised and ably canvassed. The Constitution of Botswana recognizes and confers certain rights such as the right to privacy, the right to be free from discrimination and also the right to liberty, to mention but a few. The cumulative effect of these rights, it can be argued, would be to declare pre-employment HIV testing unconstitutional.

Pre-employment HIV testing in the Public Service is however different and clear, in that the Public Service Code of Conduct on HIV/AIDS and the Work Place, specifically prohibits pre-employment HIV testing as a precondition for employment. This prohibition however does not extend to non citizens as they are required to undergo an HIV test before employment in the public service or before their contracts could be considered for renewal.

4 The ceiling for compensation has since been removed by the Trade Disputes Act, which gave judges the discretion to award any monetary compensation they deem just and apt.
5 Industrial Court 35/03, p. 19.

Continuation of Employment of an HIV Positive Employee

The effects of the HIV/AIDS pandemic can be so enormous in the workplace that existing employees are sometimes dismissed for their being HIV positive and some are forced to test for HIV when the employer suspects that the employee is infected. This is termed post-employment HIV testing.

Post-employment HIV testing is where employees, not job applicants, are required to undergo HIV testing during the currency of their employment. It is important to note that the Employment Act does not provide for such existing employment medical examination and regard is therefore placed on common law for guidance, and the agreement of the parties to the employment contract. The Industrial Court in the case of *Sarah Diau* v *Botswana Building Society*[6] has clearly and unequivocally held that unilateral demand by an employer to an employee to test for HIV is unlawful as it is in violation of the contractual agreement or common law.[7]

In *The Diau Case*, which illustrates the issue of post-employment testing, the applicant was employed by the respondent on six months' probation on condition that she underwent and passed a full medical examination, which she did. Six months later a further medical examination was required. She was asked to submit a certified document of her HIV status. She thought about it for a while and then informed the respondent that she was not going to submit a document on her HIV status. The respondent then informed the applicant that she would not be confirmed to the permanent and pensionable service of the respondent, without giving any reasons for such decision. The court found that the reason for her dismissal was that she had refused to submit a document on her HIV status, since she was not judged on her performance.

The court, agreeing with the findings of the *court a quo* in the Jimson case, however further approached this dispute from a different angle, namely from a Constitutional point of view. The court first examined the question of whether, at the time of her dismissal, Diau had completed her probationary period, thus bringing her within the ambit of employment law. The court decided that she had done so and was, therefore, a permanent employee of the respondent at the time she was dismissed. The reason for this finding was based on the fact that she was tacitly confirmed at the end of her probationary period.

6 2003 (2) Botswana Law Reports (BLR) 409 (IC).

7 See C. Stegling, 'Employment Rights and HIV/AIDS', in *Managing HIV and AIDS in the World of Work: Experiences from Southern Africa*, SAFAIDS and HIVOS, Harare, 2007, pp. 13-21.

In terms of the Employment Act, probationary periods for unskilled employees should not exceed three months. However, in the case of Diau, the employer required a six month probationary period.

The following passage from the judgment of Justice Dingake in *Diau* v *BBS*[8] illustrates this point clearly:

> In terms of the common law, before the expiry of the probationary period, the employer must confirm the employee as a permanent employee or the employer can extend the probationary period. This choice must be exercised and conveyed to the employee at the latest on the last day of the probationary period. Should an employer fail to exercise such choice and the employee is allowed to carry on working after the expiration of the probationary period, it would be deemed that the employer had tacitly confirmed the contract of employment.
>
> The employer cannot therefore after the expiration of the probationary period extend such period, nor can he thereafter decide to terminate the contract of employment without giving a valid reason for so doing and or complying with a fair procedure. This is what the respondent did in this case.
>
> The respondent allowed the applicant to carry on working, and after close to two months, following the expiration of the 'three months probationary period', it writes the applicant a letter purporting to end her contract of employment by not confirming her.
>
> I must stress here that the applicant having completed her probationary period was no longer subject to S 20(2) of the Employment Act. Consequently the respondent could not dismiss her without a valid reason.

The court found that the conduct of the respondent, in terminating the applicant's contract of employment for refusing to undergo an HIV test, was an unjustifiable violation of the applicant's right to liberty, as contemplated by section 3(a) of the Constitution of Botswana, as well as section 7(1), which outlaws inhuman or degrading treatment.
Judge Dingake posited that:

> To punish an individual for refusing to agree to a violation of her privacy or bodily integrity is demeaning, undignified, degrading and disrespectful to the intrinsic worth of being human... where even the remotest suspicion of being HIV/AIDS can breed intense prejudice, ostracisation and stigmatisation.[9]

8 2003(2) BLR 409, p. 420 E-G.
9 *Ibid.*, at p. 433.

Furthermore, the court decided that Diau was entitled to disobey the instruction to undergo an HIV test as it was "irrational and unreasonable to the extent that such a test could not be said to be related to the inherent requirements of the job". The court consequently found the dismissal of the applicant to be substantively and procedurally unfair. The respondent was ordered to reinstate the applicant and to pay her compensation equal to four months' salary. Regrettably, the court decision does not address whether pre-employment HIV testing is constitutional under Botswana law, especially in the light of the fact that weighty constitutional arguments were placed before it for consideration and determination.

An exception to the general rule that prohibits unilateral post-employment HIV testing is when an employee is not performing his/her contractual duties optimally owing to ill health. In this case the employer needs to be concerned and can then justifiably require an employee to undergo a medical examination to assess his/her fitness or lack-of fitness to perform. The difficulty with that is that it is not clear what tests could be carried out, as a result of this uncertainty. Some employers are inclined to take advantage of this uncertainty and include HIV testing. In the light of the above arguments, an employer can require an employee to undergo HIV testing only if there is a justifiable need to do so. This need can only be based on the employees' apparent unfitness to perform, as being HIV positive is not by itself indicative of the capacity or incapacity of an employee to perform.

Some employees face discriminatory practices by employers and sometimes misinformed co-employees. The said discrimination manifests itself in many ways, for example, arbitrary dismissals and creation of intolerable working conditions which compel the affected employee to leave his/her employment. In law the latter example amounts to constructive dismissal. This discrimination is further exacerbated by the absence of specific and unambiguous restraining laws.

Termination of Employment of an Employee Living with HIV/AIDS

The Industrial Court, in the case of *Nelson Lemo* v *Northern Air Maintenance,*[10] had occasion to deal with this issue and decided authoritatively, that it is incompetent, wrongful and unfair for the employer to dismiss an employee purely or solely on the basis of his or her HIV positive status. The background to *The Lemo Case* is that, the applicant, Mr. Lemo, alleged that he was dismissed on the grounds that he was HIV positive. The evidence presented to court revealed that the applicant had been dismissed one day after having disclosed his status. The reason for the dismissal was stated to be the long absences from work on sick leave (about 191 days) that had been the trend of the applicant' performance for the past three years.

10 2004 (2) BLR 317 (IC).

The court noted that the employer had shown the highest level of compassion and care in accommodating the employee throughout the long periods of sick leave he had taken. It further noted that the employer had tolerated the applicant's absenteeism for about three years and that it had to be questioned what event triggered the dismissal of the employee. The court went on to say that at no stage had the employee been warned that his job was in jeopardy due to his repeated absences. It proceeded to note that the fact that the employee was dismissed the day after he disclosed his status was not incidental. It raised the inference that he was dismissed because he was HIV positive. The court accordingly held that the employer was not competent to dismiss an employee solely on that ground and that the employee's dismissal was not preceded by the appropriate consultation and discussion and was accordingly procedurally unfair.

Again Justice Dingake had occasion to preside over this matter and stated:

> To exclude an HIV/AIDS positive employee from employment through dismissal solely because he is HIV positive and without having established that he is incapacitated, as in this case, lacks a rational foundation and is unfair. The view I hold is that once an employee is dismissed because he is HIV positive, as in this case, the Constitution is immediately implicated, in particular section 7(1) which prohibits inhuman and degrading treatment. This is so because to dismiss an employee because he is HIV positive is a violation of his right to dignity. The value of dignity as a core value of our Constitution cannot be overemphasized. Recognizing the right to dignity is an acknowledgement of the intrinsic worth of a human being. It is therefore plainly impermissible to dismiss an employee because he is HIV positive, when such a status has not been shown to incapacitate him. The era of routine dismissals because an employee is HIV positive, if ever there was, is now past. It is offensive to modern thinking and must not be tolerated. The courts need to assert and enforce this right, so as to inform the future, and invest in our legal and constitutional order the intrinsic worth of all human beings.[11]

We need not say more because this quotation encapsulates the issue of discrimination neatly and perfectly.

On the other hand, the employer should not be saddled with an employee who is incapacitated to perform his duties owing to deteriorated health caused by the HI virus. The process for terminating an employee who is such situated has been prescribed by the Labour courts and has been held to be akin to termination on the basis of incapacity owing to ill health. The process of termination will be discussed later on in this paper.

11 *Ibid.*,at p. 328.

Reasonable Accommodation in Botswana

Reasonable accommodation simply means any modification or adjustment to a job or to the workplace environment that is reasonably practical to enable a person with a medical condition, including HIV or AIDS to have access to or to enjoy the benefits and privileges of employment equal to those enjoyed by employees not suffering from such condition. In essence the concept seeks to ensure that those with peculiar needs are not disadvantaged to access jobs or to retain jobs. The rationale for this is to ensure that employees continue to work for as long as they are medically fit to do so.[12]

The law at present does not compel employers to reasonably accommodate employees with special circumstances and needs such as attending to monthly medical treatment like antiretroviral drugs. This is especially so after the employee exhausts all his/her annual sick leave days. The law in the private sector allows for a minimum period of 14 days as paid sick leave. This usually applies only if one has a doctor's note, which one does not get for travel days from remote areas and for sitting around a hospital all day waiting for ARV medication. In the end, workers living with HIV are torn between the choice of adhering to treatment or keeping their work. Some end up completely abandoning their treatment which is provided free by the government, for fear of the risk of losing their jobs.

The situation in the public service is by far more accommodative in that the employee can go on six months sick leave on full pay and on half pay for any period in excess of six months. This position is reasonable and makes it uneasy for employees in the public service to be dismissed. It also ensures that those who are on sick leave do not run the risk of having their salaries cut on the basis of the no work no pay principle. In the private sector as indicated, if an employee exceeds his/her sick leave quota, the employer is not obliged to continue paying the employee salary or wages not earned.

Termination due to Incapacity Based on Ill Health

In terms of the Industrial Court decisions, including *The Lemo Case,* before dismissing an employee because of his/her incapacity arising from ill health, an employer is required to have regard to the following principles:

- The illness must be such that the employee can no longer, as a result of the illness, perform the duty for which he was employed.
- Temporary absence from work because of illness is not a valid reason for termination of a contract of employment.

12 P.J. Petesch, 'Expert Perspectives Dealing with HIV/AIDS in the Work Place', available at: www.hivatwork.org/resource/expert/petesch.htm, accessed 03.04.2008.

- The employer must first assess what the illness is, then the seriousness of such illness and then make a prognosis. This must be done in consultation with the employee and if possible also with a medical practitioner.
- If the employer is thereafter satisfied that the employee is not capable of performing the work for which he was employed and there is no available alternative work, the employer will be justified in dismissing the employee for incapacity to perform his duties.
- Such termination which is not due to misconduct, must be carried out with due notice.

The issue that often arises with respect to ill health resulting in incapacity is as to whether an employer can impose a particular medical practitioner of choice to make a prognosis, or simply disregard medical opinion by any doctor. The Industrial Court has taken the view that the employer is not entitled to dictate on the choice of a medical practitioner. In *The Lemo Case,* Justice Dingake[13] articulated the right of an employee to consult a medical practitioner of his own choice as follows:

> After all the respondent has no right to dictate to the applicant who he should consult. The patient being the master of his body is entitled to a medical practitioner of his choosing and it would be unreasonable for the employer to take a dim view of the applicant's refusal to consult a medical practitioner of its choice. It would be a different story if the applicant had refused to see any medical practitioner.

In August 2007, the Botswana Department of Civil Aviation, (BDCA) held a conference in Gaborone intended to find ways of invoking an International Civil Aviation Organisation (ICAO) requirement that makes it mandatory for aviation personnel such as air traffic controllers and pilots to be declared unfit for duty if they test HIV positive or have AIDS but proffered no medical evidence supporting the intended standard.[14] In the absence of restraining laws, this standard may easily be invoked by the BDCA without many legal impediments.

HIV/AIDS and Employment Law in Southern Africa: A Comparative Perspective

Most countries in the Southern African region have enacted laws which serve as best practices, and the focus here is on Namibia, Angola, South Africa and Zimbabwe. In these arguably progressive jurisdictions pre-employment HIV testing is prohibited, albeit not absolutely in some, like South Africa and Namibia.

13 *Op. cit.* n. 10, p. 327 D-E.

14 For the article covering the story, see http://news.bbc.co.uk/2/hi/africa/6950240.stm

In South Africa, the employer should seek and obtain a court order allowing him or her to require a job applicant to undergo an HIV test as a precondition to employment. The employer can only obtain this order after advancing justifiable reasons supporting the need for the test.[15] At least this process allows for checks and balances thus curbing or averting needless and capricious demands for HIV tests.

The Labour Court in Namibia, in a case involving the Namibian Defence Force, held that it is unjustifiable to require an HIV test on job applicants for the army. The HIV test was said to be sensible and fair only if it is to be followed by CD4 and viral load tests as HIV status on its own does not show a person's fitness or unfitness to work. The court went on to say that if the viral load is high and the CD4 count is low, then it will make sense to deny a job applicant the job opportunity.[16]

The principle of non discrimination is also entrenched in these jurisdictions as it is statutorily explicitly stated that discrimination on the basis of HIV status alone is impermissible. In another related case that arose in South Africa, *Hoffman* v *South African Airways,*[17] the Constitutional Court held that South African Airways had unfairly discriminated against Hoffman and that this was a violation of the equality clause of the Constitution of the Republic of South Africa.

The facts of the case were briefly that Hoffman applied for a position as a cabin attendant with South African Airways. He successfully completed a four stage interview process and a medical examination, and was found to be a suitable candidate for the position. However, when the results of an HIV test were positive, his medical report was changed to read 'HIV Positive' and 'unsuitable' and he was as a result denied the position of cabin attendant.

Certain countries in the region have statutory provisions conferring protection on persons living with HIV/AIDS against arbitrary and insensitive tendencies and practices by employers.

In Angola there is a specific Act called *Legislation on Human Immuno-Deficiency Virus – HIV and Acquired Immuno-Deficiency Syndrome – AIDS.* This Act specifically and comprehensively addresses issues of HIV and the workplace. Section 5 thereof states: "Every person infected with HIV/ AIDS has the right to work, employment and professional training".[18] In terms of section 7 of the said legislation, no employee may see his/her labour status prejudiced due to his/her health status in relation to HIV/

15 Section 7(2) of the Employment Equity Act.
16 See *Haindongo Nghidipohamba Nanditumbe* v *Minister of Defence* (1998) LC 24/98.
17 (2002) 21 ILJ 2357 (CC).
18 Legislation on Human Immuno-Deficiency Virus – HIV and Acquired Immuno-Deficiency Syndrome – AIDS.

AIDS. Under section 8, an employee sick with AIDS who absents himself/herself from the work place for 180 days whether consecutive or not, has the right to receive his/her full salary as long as the absence is justified by a medical document. This is a fairly reasonable provision which recognizes and entrenches the principle of reasonable accommodation. In Zimbabwe[19] the sick leave period is 90 days as opposed to Botswana's 14 days. The Angola position is clearly commendable and a welcome development as it entrenches job security of employees living with HIV/AIDS.

The Zimbabwe Labour Relations (HIV & AIDS) Regulations 1998[20] deals with issues of HIV and employment and provides that: "No employer shall require, whether directly or indirectly, any person to undergo any form of testing for HIV as a precondition to the offer of employment". In terms of section 5 of the Regulations, it shall not be compulsory for any employee to undergo, directly or indirectly, any testing for HIV. Here post-employment HIV testing is left to the discretion of the employee as it is not compulsory. This position is similar to that set by Botswana's courts in *The Jimson Case*.

Lastly, and of profound importance, section 6 entrenches job security, when it dictates that "no employer shall terminate the employment of an employee on the grounds of that employee's HIV status alone".[21]

These robust provisions should be celebrated and not taken for granted as they are wanting in other jurisdictions, for instance Botswana. In Botswana, there currently exists a National Policy on HIV/AIDS which deems HIV testing for purposes of recruitment unnecessary and further discourages it. The main disadvantage here is that this is merely a policy and not law as it lacks the necessary legal force for enforcement or compulsion. One can decide to disregard it and still escape with impunity. There is therefore an urgent need to transform this policy into law.

The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) subscribes fully to the ILO Declaration on Fundamental Principles and Rights at Work, adopted in June 1998.[22] This Declaration sought to reaffirm the constitutional principle of the elimination of discrimination at the workplace. Although Botswana has not ratified the above declaration, she has ratified Convention no. 111 (Discrimination Employment and Occupation Convention, 1958)[23] that is consistent with it. One would therefore expect Botswana to take positive steps that will demonstrate

19 The Zimbabwe Labour Relations (HIV & AIDS) Regulations, 1998.
20 Section 4 (1).
21 *Op. cit.* n. 19.
22 See http://ilo.law.cornell.edu/public/english/employment/skills/recomm/instr/decla/htm, accessed 04/04/2008.
23 http://www.unhcr.ch/html/menu3/b/d_ib111.htm

her full commitment towards significantly actualizing the aforementioned convention.

Conclusion

It is abundantly clear that HIV/AIDS does present huge challenges in the workplace and consequently employees with HIV are placed in precarious circumstances. The absence of clear and specific laws further compounds this situation especially in the area of pre-employment HIV testing. The courts must be commended for also developing the jurisprudence that protects employees with HIV as witnessed in the case of *Lemo*. BONELA is firmly of the view that being HIV positive will not immediately adversely alter one's capacity to work especially in the upsurge of effective treatment in the market, which is available free in Botswana to citizens and non citizens married to citizens. The enactment of the law on HIV and Employment remains necessary especially since some people living with HIV have lost faith in the legal system and do not assert their causes of action. Some for fear of further discrimination from the community decide not to report their cases, as cases are heard in open court and therefore become matters of the public domain. As a result, BONELA and its stakeholders, mostly unions, have embarked on an initiative billed 'HIV Employment Law Campaign'.

The central purpose of the campaign is to prompt parliament to pass protective and supportive laws for people living with HIV/AIDS in the workplace. A petition signed by over 13 000 Batswana was presented to the Minister of Labour and Home Affairs in 2007. The campaign is still ongoing as to date no positive and concrete feedback has been received.

IMPLICATIONS OF INDIAN INTELLECTUAL PROPERTY LAW ON SUB-SAHARAN AFRICAN COUNTRIES

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Introduction

Over the past decade, acrimonious relations characterised by threats of legal action, retaliation, Trade Related Aspects of Intellectual Property Rights (TRIPS) plus provisions in Free Trade Agreements (FTAs) and other bilateral treaties have taken centre stage in the international trade arena. Irrespective of the fact that the World Trade Organisation (WTO) members recognized the health plight of its developing and least developed member countries,[1] the health situations in these countries remain far from satisfactory. This is especially due to the fact that the majority of the citizens of the said countries cannot afford to buy life saving medicines. This in part could be explained by the coming into force of TRIPS. The Agreement introduced important new dimensions to the field of intellectual property (IP) with far reaching implications for health delivery, in particular access to essential medicines.[2] By accepting to be bound by the requirements of the TRIPS Agreement, developing and least developed countries in particular undertook to substantially review, expand and strengthen their IP legislation.[3] The strengthened and expanded patent protection covering pharmaceutical products, has meant that with the emergence of new diseases such as HIV/AIDS and the growing resistance to drugs of old diseases such as malaria and tuberculosis, effective medicines are increasingly patent protected by international intellectual property regimes which makes it difficult for developing countries.[4] Increasing commercialization of bio-medical research, and the drive of pharmaceutical companies for making profits which largely contributed to the emergence of TRIPS, constitute a broad context to this discussion.

Intellectual Property refers to a creation of the mind including: inventions, literary and artistic works, symbols, names and images used in commerce.[5]

1 This is evident in the enactment of paragraph 6 of the Doha Declaration subsequently followed by the WTO 30 August 2003 Deal on Medicine.
2 S. Musungu, 'The Right to Health in the Global Economy: Reading Human Rights Obligations into the Patent Regime of the WTO-TRIPS Agreement', LLM Thesis, University of Pretoria, November 2001.
3 *Ibid.*
4 *Ibid.*
5 See www.wipo.int accessed 24 September 2004.

A patent is a legal right granted to the applicant upon fulfillment of certain conditions, which grants them the monopoly on making, using or selling an invention, for a fixed period of time, in the countries in which the patent has been granted.[6]

Recent unsavoury developments have not been helpful to the global Intellectual Property climate. These developments were: pending litigation against Intellectual Property regimes in countries allowing the production of generic versions of certain drugs; criticisms and threats meted against countries authorizing compulsory licenses and the proliferation of bilateral investment treaties with TRIPS plus provisions. These have aggravated the tension. This is especially true with the legal challenge to the Indian patent law filed by Novartis, a Swiss pharmaceutical company. This paper aims at analyzing the possible implications of India implementing intellectual property protection as well as the outcome that *The Novartis Case* (on appeal) could have on the public health systems of developing and least developed countries (LDCs) particularly those in sub-Saharan Africa. It argues that the potential outcome could be very detrimental to most sub-Saharan African countries which not only lack the capacity to produce generic medicines, but also sufficient financial resources to purchase patented versions of these medicines from large pharmaceutical companies. This paper is premised on the hypothesis of Novartis winning the appeal of the case it lost against the Indian patent regime.

The paper commences by analyzing the health care situation in Namibia, a sub-Saharan African country, followed by an overview of the TRIPS Agreement. India's role as an important source of generic medicines to African countries is highlighted. An analysis of the recent case wherein Novartis challenged the Indian Patent Act for not being constitutional and WTO compliant, as well as the refusal by India to grant a patent to one of the medicines it produces - *Glivec* - follows. Finally, the consequences on African countries, of India strengthening its IP laws as well as the outcome of *The Novartis Case* with regard to the patentability of *Glivec*, are examined.

6 See Swansea University, *A Glossary of Library, Information and Computing Terms*. Available at: http://www.swan.ac.uk/lis/helpandtraining/resource_guides/GlossaryM-Z/ accessed on 17 February 2008.

Analysis of the Health Situation in an African Country: Namibia in Focus

Though sub-Saharan Africa is home to about 10% of the world's population, it accounts for more than 70% of all cases of HIV/AIDS.[7] Other pandemics still rampant in the region include malaria, tuberculosis and typhoid.

Of the estimated one million deaths that occur in the world as a result of malaria, approximately 90% are in Africa, with young children being the most vulnerable to the disease.[8]

Namibia is one such sub-Saharan African country severely hit by these diseases. According to statistics from the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), adult (15-49 years) prevalence of HIV/AIDS ranges from 18.2% - 24.7%.[9] Furthermore, Namibia has the highest tuberculosis (TB) notification rate in the world. According to the WHO, an average of 717 cases of TB is recorded for every 100,000 Namibians, putting the country at the top of the world ranking for this disease.[10] Malaria is endemic in the northern regions of the country. Approximately 1,090,000 people live in malarious areas. It is the leading cause for outpatient consultations and hospital admissions in Namibia, the leading cause of illness and death amongst Namibia's under five year olds, and the third most prolific reason for adult mortality.[11]

Sexually Transmitted Infections (STIs) are among the most common illnesses in Namibia and have far reaching health, social and economic consequences. The HIV/AIDS epidemic further highlighted the importance of Sexually Transmitted Disease (STD) control and management. At the same time, resistance to several sexually transmitted pathogens and to some anti-microbial treatments has emerged, which has made it more difficult to treat certain STDs.[12] Other common diseases include diabetes, cervical and breast cancer for females, and prostrate cancer for males. In 2000, about 25,000 Namibians were diagnosed with diabetes, and the number is expected to increase to 60,000 by 2013.[13] Breast cancer is the most common cancer among Southern African women

7 T. Avafia, 'TRIPS and Public Health: The Unresolved Debate', tralac Trade Brief, No 2, 2005, p. 1, available at: http://www.tralac.org/scripts/content.php?id=3144; accessed 1 February 2007.
8 *Ibid*.
9 Available at http://www.who.int/hiv/HIVCP_NAM.pdf; accessed 8 February 2007.
10 TB country profile - Namibia. Available at http://www.who.int/NAM_2004_Brief.pdf; accessed on 8 February 2007.
11 C. Diwouta, 'Women's Access to HIV, and AIDS Health Care in Namibia: A Situation Analysis', (unpublished), December 2005, p. 18.
12 K. Shangula cited in C. Diwouta, *ibid*. at p. 22.
13 Available at http://www.who.int/diabetes/facts/world_figures/en/index1.html; accessed on 10 February 2007.

and cervical cancer is the third most common cancer amongst women in Namibia.[14] It should be noted that as of June 2005, there were 34 district hospitals and 77 health centers and clinics throughout Namibia.[15] The total number of doctors, nurses, pharmacists, community counselors and social workers was 2424.[16]

43.49% of medicines and clinical supplies at the central medical store came from India while 28.17%, 5.66% and 2.97% came from South Africa, the United States of America and France respectively.[17] These statistics clearly demonstrate the importance of Indian and South African manufacturers of generic medicines, to Namibia. This implies that any changes effected in Indian intellectual property law (especially with regard to patent) would have a direct bearing on Namibia.

Overview of TRIPS and the Public Health Debate

> We consider HIV/AIDS as a state of emergency in the continent. To this end, all tariff and economic barriers to access to funding of AIDS-related activities should be lifted.[18]

The struggles between private interest and public interest, competition law and intellectual property law, individual rights and collective rights, and national public policy and patent protection are not new.[19] Until recently, a large number of developing countries did not provide patent protection with respect to pharmaceuticals. From the same perspective, there were countries which provided protection only to pharmaceutical process patents while refuting the same protection in respect of pharmaceutical products. This led to a long standing debate in the Uruguay Round, culminating in the adoption of the TRIPS, which provided, *inter alia*, laws/rules that WTO Member States had to implement at national level. Virtually since TRIPS entered into force as part of a newly created WTO in 1995, WTO Members and interested observers have recognized that significant gaps exist in the Agreement with respect to patent protection and access to life saving medicines in developing and least developed countries; but finding and agreeing on

14 *Ibid.*
15 C. Diwouta, Power Point Presentation on Status of Health Care in Namibia on the occasion of the launching of the Parliamentarians for Women's Health Project in Windhoek, Namibia, 6 October 2005.
16 *Ibid.*
17 See N $ Value of Net Receipt of Medicines and Clinical Supplies at the Central Medical Store for the financial year 2005/2006, per country of origin, obtained from the Ministry of Health and Social Services, Namibia, on 20 February 2007.
18 Statement from OAU/Heads of State and Government, African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, held at Abuja, Nigeria, 25-27 April 2001.
19 T. Kongolo, 'Public Interest Versus the Pharmaceutical Industry's Monopoly in South Africa', 4:5, *Journal of World Intellectual Property*, 2001, p. 609.

improvements to the system has proven to be a much more controversial topic.[20]

The current debate on access to medicine on the one hand and the stringent protection of intellectual property rights (hereafter 'patents') on the other could be traced back to the entry into force of TRIPS. This agreement was one of the most astonishing outcomes of the Uruguay round of multilateral trade talks, which saw the establishment of the WTO.[21] Before and during the Uruguay round, developed countries pressed and lobbied hard for the incorporation of an agreement on intellectual property within the multilateral trading system. They were concerned that the products protected by intellectual property rights in developed countries could not be protected in developing and least developed countries where there was often no equivalent intellectual property system. In the area of drugs and medicines, pharmaceutical companies were concerned that they would lose their competitive advantage as the knowledge behind the invention was utilized without a profit to them. Thus, developed countries responded by introducing TRIPS as a means of ensuring that developing and least developed countries provided an intellectual property system to complement their own.[22]

Within a few years of its existence, concerns were raised that the TRIPS Agreement was inequitable to developing and least developed countries, especially as it made it difficult for countries in chronic health crises to grant compulsory licenses for the production of generic versions of certain drugs. The need to address this issue arose from concerns related to Article 31(f) of the TRIPS Agreement, which requires that production under compulsory licensing must be primarily for the supply of the domestic market. Such concerns reached their climax in 1998 when multinational pharmaceutical companies filed a law suit against the South African Government for seriously breaching TRIPS provisions as well as certain sections of the South African constitution, when the latter enacted the controversial Medicines Amendment Act of 1997. The ensuing protests and criticisms caused WTO Members to revisit the TRIPS Agreement and make certain inroads aimed at relaxing the rigidity of some of its articles. Thus, in Qatar, (2001) WTO Members came up with the Doha Declaration. Paragraph 6 of this declaration on public health noted the particular problems faced by countries with insufficient manufacturing capacities and economies of scale in making effective use of one of the key flexibilities afforded by the TRIPS agreement, the

20 T. Kongolo, 'Towards a New Fashion of Patent Protection in Africa', 33/2 *International Journal of Technology Transfer and Commercialisation*, 2001, p. 185.

21 A. Capling, 'Intellectual Property' in B. Hocking and S. McGuire (eds.), *Trade Politics: International, Domestic and Regional Perspectives,* Routledge Press, London, 1999, p. 79.

22 K. Weston, 'The Impact of TRIPS on Agricultural Economies in the Developing World', *Murdoch University Electronic Journal of Law,* Vol. 10, No 3, September 2003, p. 3, www.murdoch.edu.au; accessed on 10 February 2007.

right to undertake compulsory licensing, for some or all drugs.[23] It has been maintained that in cases of emergency such as HIV/AIDS, countries should be given the authority to produce, import or export generic anti-retroviral drugs to save lives of people.

However, the unresolved question has been how countries lacking manufacturing capacity to produce anti-retroviral drugs to fight HIV/AIDS would benefit from the compulsory license regime provided under TRIPS.

On 30 August 2003, the WTO announced that it had resolved the issue of giving poor countries access to essential medicines without breaching its own law on intellectual property.[24] The decision settled the one remaining piece of unfinished business on intellectual property and health from the WTO Ministerial conference in Doha, November 2001.[25] It set out conditions under which patents could be waived to allow developing country members to issue compulsory licenses to import cheap generic drugs to fight critical diseases such as AIDS, tuberculosis and malaria. This agreement recognizes that compulsory licensing is necessary to serve the interests of public health in developing countries. In the WTO Hong Kong Ministerial meeting of December 2005, the August 2003 Decision was adopted as part and parcel of the TRIPS Agreement. Regrettably, to date, only Rwanda has notified the WTO of using the August 2003 Decision. Many reasons could be advanced for the piecemeal developments with regard to using the August 2003 Decision. They include the following:

- Administratively cumbersome procedure and requirements leading to a pragmatically unworkable solution, more so for developing countries especially those across sub-Saharan Africa;
- Fear at the local level, that the issuing of compulsory licences might have an adverse impact on Foreign Direct Investment (FDI) or even on donor aid and;
- The lack of capacity at the domestic level, to completely comply with the 30th August Decision. As a practical example, a number of countries have expressed doubts about the ability of customs officials to prevent re-exportation.[26]

23 R. Weissman, 'Paragraph 6 Implementation Recommendations', www.cptech.org; accessed on 12 October 2004.

24 Decision Removes Final Patent Obstacle to Cheap Drug Imports', available at: www.wto.org; accessed on 12 October 2004.

25 *Ibid.*

26 T. Avafia, *op. cit.* n. 7, at p. 72.

Importance of India's Pharmaceutical Companies to Developing and Least Developed Countries

Often described as the 'Pharmacy for the Developing World',[27] India is the main supplier of essential medicines for developing countries with about 67% of medicines produced in India being exported to developing countries.[28]

Furthermore, many of the main procurement agencies for developing countries' health programmes purchase their medicines in India, where quality products are available at low prices,[29] for example:

- Approximately 50% of the essential medicines that UNICEF distributes in developing countries come from India;
- 75-80% of all medicines distributed by the International Dispensary Association (IDA)[30] to developing countries are manufactured in India;
- In Zimbabwe, 75% of tenders for medicines for all public sector health facilities come from Indian manufacturers;
- Furthermore, 43.49% of medicines and clinical supplies at the central medical store in Namibia come from India.[31]

In addition, India is the world's primary source of affordable Anti-Retrovirals (ARVs), as it is one of the few countries with the capacity to produce these newer medicines as generics.[32] Therefore, most AIDS programmes use India as their main source of drugs, for example:

- 80% of ARVs used by *Médecins Sans Frontières* are purchased in India and are distributed in treatment projects in over 30 countries;
- Globally, 70% of the treatment for patients in 87 developing countries, purchased by UNICEF, IDA, The Global Fund (GFATM) and the Clinton Foundation since July 2005 has come from Indian suppliers;
- PEPFAR, the US President's AIDS initiative also purchases ARVs from India for distribution in developing countries, thus resulting in cost-savings of up to 90%. 89% of the generic ARVs approved by the US Food and Drug Administration for PEPFAR are from India;

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27 'Examples of the Importance of India as Pharmacy of the Developing World', available at: http://www.accessmed-msf.org/prod/publications.asp?scntid=29120071111256&contenttype=PARA accessed on 11 February 2007.

28 *Ibid.*

29 *Ibid.*

30 The International Dispensary Association is a medical supplier operating on a not-for-profit basis for distribution of essential medicines to developing countries.

31 *Op. cit.* n. 27.

32 *Op. cit.* n. 17.

- 90% of the ARVs used in Zimbabwe's national treatment programme come from India.[33]
- The state procurement agency in Lesotho states that it buys nearly 95% of all ARVs from India.[34]

In addition, raw materials are exported from India to other countries, such as Brazil, to facilitate the local production of affordable medicines.[35] This has been crucial in enabling national AIDS programmes to provide universal free access to ARVs.[36]

It is worthy to note that before India enacted its new intellectual property law (which is discussed below), India's pharmaceutical majors like *Cipla* and *Ranbaxy* were spearheading the manufacture of AIDS drugs and exporting them to African nations at a very low cost when compared to multinational pharmaceutical majors.[37] For example, in Africa, exports by Indian companies helped to drastically reduce the annual price of Anti Retroviral Treatment (ART) from US$ 1,400 a decade ago to US$ 200.[38] They also simplified the therapy by making combination pills containing 3 AIDS drugs.

India's New Intellectual Property Regime

India is amongst the developing countries leading the production of generic versions of patented drugs and has traditionally been the primary provider of drugs to African countries.[39] In March 2005, India passed a Patent Bill (Bill No. 32-C of 2005) to replace her Patent Ordinance of 2004. By passing this Bill, India was merely fulfilling her TRIPS obligations which required conformity with the WTO's intellectual property agreement by 2005.[40] For purposes of this article, only Article 2(1) of India's Patent Act will be examined.

India's Patents Ordinance of 2004 defined 'inventive step' to mean a 'feature that makes the invention not obvious to a person skilled in the art'. This definition was in compliance with the explanatory note to Article 27(1) of the TRIPS Agreement which states that 'inventive step' is synonymous with non-obviousness. However, article 2(1) (ia) of the 2005 Bill re-defines inventive step as:

33 *Op. cit.* n. 27.
34 *Ibid.*
35 *Op. cit.* n. 27.
36 *Ibid.*
37 H.S. Nanda, 'Health Groups Slam India's New Patent Law', available at: www.washingtontimes.com/upi-breaking /20050324-105633-9090r.htm; accessed on 5 February 2007.
38 *Ibid.*
39 T. Avafia, 'Comments on the Latest Amendments to the Indian Patent Legislation and the Impact on African Countries', available at www.tralac.org; accessed 9 February 2007.
40 *Ibid.*

> A feature of an invention that involves technical advances as compared to the existing knowledge or having economic significance or both and that makes the invention not obvious to a person skilled in the art.[41]

The inclusion of the phrase 'an invention that involves technical advances as compared to the existing knowledge' in the definition of inventive step was, probably, to stop 'ever-greening'.[42] Drug patent ever-greening is the single most important strategy that multinational pharmaceutical companies have been using since 1983 in the US (and since 1993 in Canada) to retain profits from high sales volume drugs for as long as possible.[43] When the original patent over the active compound of a brand-name drug is due to expire, these drug companies often claim large numbers of complex and often highly speculative patents. As required by the laws of some countries (USA for example), manufacturers have to notify the original brand-name patent holders of their intention to market copies at the expiry of the original patent. The original patent holders can then threaten these potential generic competitors with breaching their now 'evergreened' patents and seek a court order preventing their marketing approval.

Ever-greening has recently become a very contentious issue. Many pharmaceutical companies are now suing manufacturers of versions of generic medicines. For instance in 2002, 75 per cent of new drug applications by generic drug manufacturers were the subject of legal actions under patent laws by the original brand-name patent owner.[44] The trends could continue if appropriate measures are not taken, especially with the proliferation of Free Trade Agreements having ever-greening provisions.[45]

Thus, one can safely say that the intended outcome of Article 2(1) (ia) of the 2005 Indian Intellectual Property Act is to henceforth stop companies which make slight improvements on a drug from demanding patent on it.

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41 Section 2(1) (ja) of India's Patents Bill, 2005.

42 This is a process of slightly improving formulations of existing drugs and applying for a patent for them.

43 T Faunce, 'The Awful Truth about Evergreening', available online at: http://www.theage.com.au/articles/2004/08/06/1091732084185.html; accessed on 13 February 2008.

44 *Ibid.*

45 Article 17.10.of the US-Australia FTA requires that the Therapeutic Drug Administration (the drug safety and efficacy body) drug marketing approval be 'prevented' indefinitely (not for the 30-month and 24-month periods as in the US and Canada) whenever any type of patent (including a speculative evergreening patent) is merely 'claimed'.

The Novartis Case and its Possible Implications on Sub-Saharan Africa

Novartis, a Swiss Pharmaceutical company, applied for a patent in India on a modified form of the cancer drug *imatinib mesylate*, which the company markets under the brand name '*Gleevec/Glivec*' in many countries.[46] The patent was rejected in India in January 2006 on the grounds that the drug was a new form of an old drug, and therefore was not patentable under Indian Law.

Under the above mentioned Indian law, patents are only granted on medicines that are truly new and innovative. This means that companies should not be able to obtain patents for drugs that are not really new, such as for combinations or for slightly improved formulations of existing drugs. This part of the law was specifically targeted at preventing a common practice of drug companies of trying to get patents on insignificant minor improvements of existing drugs, in order to extend their monopolies on drugs as long as possible.

Novartis actually filed two separate challenges, but both were heard at the High Court in Chennai concurrently by the same judges. The first case challenged the very decision made by the Chennai patent office to reject the patent application.

The Patent Controller had concluded that *Glivec* was merely a new form of an existing patented substance rather than a new invention that merited a patent, as defined in Indian patent law. Novartis disagreed, however, on the basis that Indian patent law states that a patent cannot be granted for "the mere discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance". Novartis said the *Glivec* patent application was rejected despite the fact that it demonstrated a 30 percent increase in bio-availability, the amount of drug absorbed in the body, over the original substance.[47] The Appellate Board is therefore expected to deliberate over exactly what measure of efficacy would demonstrate that the substance was a new chemical entity that merits a patent, rather than just a new form of a known substance.The second and more controversial case, directly challenged the Indian law in issue. Specifically, Novartis claimed that section 3(d) of the 2005 Indian Patents Act, which defines exactly what a new invention should consist of, is not in compliance with Article 27 of the TRIPS Agreement as it was apparently discriminatory. Thus the

46 For more details of the facts of this case see: http://www.maketradefair.com/en/index.php?file=a2m_novartis_01292007.htm accessed on 2 February 2007.

47 T. Anderson 'Novartis Case Against Indian Patent Law Resumes this Week', available at http://www.ip-watch.org/weblog/index.php?p=657&res=1024&print=0 accessed on 17 September 2007.

company submitted that it was unconstitutional, arbitrary, illogical and vague.

The Court dismissed the petition on the grounds that treaty law only becomes national law and capable of violation in India when specifically domesticated by Indian Parliament. In this light, one can only litigate violations of Indian law in Indian courts.[48] As such the appropriate forum for such a petition was the WTO, not the local Indian court. On page 25 of the judgment, the court held that "when domestic law is challenged on the ground of it being in violation of an international treaty, the domestic court would have no jurisdiction".[49]

On the ground that the law was unconstitutional, the court was of the view that Article 3(d) of the Indian Patent Law was in essence, constitutional because by enacting the said piece of legislation, the Indian Parliament was in fact and in law, exercising its legislative power.[50]

Novartis has not taken the verdict lightly. After the decision was made public, it stated in a press release that: "A decision issued today in an Indian court would have long term negative consequences for research and development into better medicines for patients in India and abroad".[51] A decision on Article 3(d) is not subject to appeal.

However, the outcome of the appeal challenging the decision not to grant a patent on *Glivec* is still awaited. The potential implications of the outcome of this appeal (if it is successful) on sub-Saharan African countries are many and varied. They could be examined from the following perspectives.

If Novartis wins on appeal, it would lead to an amendment of India's patent law and patenting could spread to several other drugs, currently produced by India in generic form. This would be a significant development, as over half the medication currently used for HIV/AIDS treatment in developing countries reportedly comes from India. Drugs produced by companies in India are among the cheapest in the world.[52] As it only recently introduced patent measures, many of the ARVs India produces are not patented, making the country a key source of affordable

48 S. Musungu, 'Of Trivialities and Fallen Skies: A Look at the Decision in *Novartis Case* in India', available at http://mail.kein.org/pipermail/incom-l/2007-August/001729.html; accessed on 17 September 2007.
49 For more details of the facts of this case see: http://www.maketradefair.com/en/index.php?file=a2m_novartis_01292007.htm; accessed on 2 February 2007.
50 S. Musungu, *op. cit.* n. 48.
51 *Ibid.*
52 Y. Shantharam: 'Botswana: Drug Patents and Their Implications on ARV Therapy Access', available online at: http://allafrica.com/stories/200702070946.html accessed on 10 February 2007.

antiretroviral medicines.[53] A direct consequence of an amendment of India's patent law would be an increase in prices of most drugs. This could cause untold hardship to many sub-Saharan African countries. Namibia, for instance, would particularly be affected as the government uses only 11% of her budget for health services. The government and other individuals would thus be unable to afford generic versions of drugs. The amendment would add further constraints to the already limited budgets of sub-Saharan African countries and they would be forced to redirect resources meant for the development of other sectors of the economy in order to procure expensive medicines, especially ARVs. Arguably, there would be an increase in the country's death toll as patients with no means to afford expensive drugs they could hitherto afford, would have no other option but to wait for the day death shall come knocking on their doors.

Another ramification of Novartis winning the appeal is that it would open the floodgates to litigation, nationally or at the level of the WTO. Other pharmaceutical companies would be motivated by this case to bring legal challenges against other patent regimes. Judges in other countries may be inclined to follow the outcome of the *Novartis Case*. If this happens, then patents could be given in relation to many other drugs. As such, patients and Governments of developing and least developed countries, would be left to bear the brunt of paying exorbitant prices for certain drugs.

Furthermore, a successful outcome for the company in this appeal could impact negatively on the patent regimes of certain developing countries, especially those having the capacity to produce versions of generic drugs. These countries may be pressurized to tighten their patent regimes so as to either discourage production of generic drugs or tighten the granting of compulsory licenses. The pressure recently meted on Thailand when it announced in late January 2007, a decision to issue new compulsory licenses for the medicines *lopinavir/ritonavir (Kaletra)* and *Plavix* is still very fresh. A likely explanation why Brazil, which like Thailand has a major HIV/AIDS treatment program, but has not actually used a compulsory license to compel generic production of on-patent medicines, could be the pressure that may ensue from developed countries like the USA. In a situation like this, countries like Namibia, with little or no manufacturing capacity and a significant vulnerability to external pressure, will suffer.

In addition to this, a decision in favour of Novartis would make most sub-Saharan African countries increasingly dependent on donor aid to fight their current HIV/AIDS and other pandemics, which may not be sustainable. Firstly, most donor agencies procure medicines from Indian

53 *Ibid.*

generic producers.[54] A tightened patent regime would limit their sourcing of these drugs from generic producers. Secondly, the cost of procuring these medicines from pharmaceutical companies in the developed world would be enormous and as such, very few patients in countries facing endemic health crises would benefit from donor agencies' largesse, if at all the drugs are procured. Thirdly, donor funding alone is not sustainable.

What becomes of countries benefiting from donor aid when such aid dries up, especially if such countries are confronted with a health crisis at some future stage?

The outcome of this case could negatively affect the right to health. This right has been enunciated in several international instruments to which the majority of states are signatory. Article 25 of the Universal Declaration of Human Rights provides that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family..." The preamble to the constitution of the WHO conceptualises health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[55] The United Nations Committee on Economic, Social and Cultural Rights *General Comment* has maintained that international agreements should not adversely affect the right to health. Thus, this case could seriously undermine important right to health provisions, encapsulated in major international conventions. There is certainly a degree of tension between TRIPS and cases like Novartis on the one hand, and the right to health on the other. There is a conflict of interests between the economic rights and interests of pharmaceutical companies to make profits from their businesses/inventions, and the health rights of the poor to access essential medicines. The human rights implications of both the *Novartis Case* and the TRIPS regime are thus central to the context of HIV/AIDS.

Conclusion

The *Novartis Case* is yet another example of a pharmaceutical company challenging a patent regime. Though the case the company brought challenging the Indian Patent Act's compatibility with TRIPS was unsuccessful, the potential negative implications of its challenge to India's refusal to grant a patent to *Glivec,* on sub-Saharan African countries in particular, and other developing and least developed countries in general, are wide and varied. If it is successful, it would mean a victory for ever greening processes. As such, pharmaceutical companies would slightly improve an existing drug and demand that a patent be granted for it. If this becomes the case, access to medicines

54 *Op. cit.* n. 27.
55 The Constitution of the World Health Organisation, 14 UNTS 186 reproduced in *Basic Documents of the WHO* (1981).

would be greatly hampered. There will not only be a significant increase in the prices of medicines as discussed above, but also a severe health crisis in countries which depend greatly on generic drugs from Indian manufacturers. It is suggested here that domestic and international lobbying should continue in order to stop Novartis from pursuing the appeal as in the case of *Pharmaceutical Manufacturers' Association* v *The President of South Africa.*[56] Here, 42 pharmaceutical companies which had been challenging the constitutionality of the provisions embodied in a South African statute, the Medicines Amendment Act 90 of 1997 via a legal suit, announced a withdrawal of their action as a result of three years of intense national and international lobbying. Civil society, both at home and abroad, played a critical role, and this experience highlights the part that civil society can play in similar situations worldwide, especially in the context of developing countries. Only when such a course of action is taken, will developing and least developed countries finally see some relief. However, though the implications of the outcome of the *Novartis case* could negatively affect access to medicines, there are other factors that restrict access to medicines in sub-Saharan African countries. Inadequate resources to finance health activities, shortage of health personnel, absence of effective regulatory mechanisms and inadequate health facilities are some of the factors that undermine access to medicines. Thus, there is a real need for policy makers to put in place structures and policies that would fill this void. One example would be through implementing the Abuja Declaration and the Plan of Action[57] which calls for the allocation of at least 15% of national budgets to health care, but the effort needs to address all factors in a holistic manner.

56 *Notice of Motion in the High Court of South Africa* (Transvaal Provincial Division) Case No. 4183/98, available at <www.cptech.org/ip/health/sa/pharmasuit> accessed on 30 January 2007.

57 WHO/CDS/RBM/2000.17, Abuja, Nigeria, 25 April 2001, http://www.rbm.who.int/docs/abuja_declaration_final.htm

REALIZATION OF HUMAN RIGHTS: A PATH TOWARDS THE REDUCTION OF VULNERABILITY TO HIV/AIDS BY THE GOVERNMENT OF BOTSWANA

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Introduction

HIV continues to spread throughout the world, posing increasing challenges to human rights, at both national and global levels. The epidemic continues to be marked by discrimination against certain population groups; those who live on the fringes of the society or who are assumed to be at risk because of their behavior, race, ethnicity, sexual orientation, gender, or social characteristics that are stigmatized in a particular society.[1] As the number of people living with HIV and AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more noticeable, but also increasingly diverse.

From a global perspective, Botswana is among the countries hardest hit by HIV and AIDS. In 2005, there were an estimated 270,000 people living with HIV.[2] This, in a country with a total population below two million, gives Botswana an adult HIV prevalence rate of 24.1%, the second highest in the world after Swaziland.[3] However, Botswana's comprehensive response to the epidemic may finally be bearing fruit. According to Botswana's draft 2008 Sentinel Surveillance surveys HIV prevalence has significantly declined from 37.4% in 2003 to 32.4% in 2006 in the 15-49 age group.

The UNGASS report has highlighted that the most remarkable drop was among 40-49 year olds from 30.4% to 27.4% in 2005 and 2006 respectively, while the least reduction was among 15-19 year olds (17.8% to 17.5%).[4] Preliminary country estimates indicate that approximately

1 Joint United Nations Programme on HIV/AIDS (UNAIDS), Report of the Secretary-General, Second International Consultation on HIV/AIDS and Human Rights, UN, Geneva, September 1996.

2 The Population Reference Bureau, World Population Data Sheet, USAIDS, Washington, 2007, available at: http://www.prb.org/pdf07/07WPDS_Eng.pdf

3 UNAIDS, World Health Organization (WHO), *Report on the Global AIDS Epidemic*, UNAIDS, WHO, Geneva, May 2006.

4 Ministry of State President, National AIDS Coordinating Agency (NACA), *Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS*, NACA, Gaborone, 2008, p. 11.

113 000 people had advanced HIV infection in Botswana in 2007. 91 780 persons (81.2%) were on treatment as of 30th November 2007.[5]

While Botswana is blessed with comparatively sufficient financial resources from both domestic and external sources, it faces several important challenges that need to be overcome if it is to rapidly and effectively scale up its HIV prevention portfolio.[6] HIV/AIDS is a real and major threat directly linked to the continued protection and promotion of human rights in Botswana. With the initial understanding of the HIV/AIDS and human rights relationship, centered on the concept of vulnerability, this paper attempts to analyze the specific human rights responsibilities of the Government of Botswana and their actual accomplishment in the context of HIV/AIDS.

The Perception of Vulnerability, HIV/AIDS and Human Rights

It is now a quarter of a century since the Acquired Immune Deficiency Syndrome (AIDS) was recognized. The knowledge that has been gained since then has been far-reaching, and the velocity at which basic research has been translated into life-saving treatment is commendable. The reasons HIV/AIDS is being treated differently from other diseases include among others its impact not only on the physical health of individuals, but also their social identity and mental condition. The stigma and discrimination surrounding HIV/AIDS can be as destructive as the disease itself. Lack of recognition of human rights not only causes unnecessary personal suffering and loss of dignity for those living with HIV/AIDS but it contributes directly to the spread of the epidemic. It also appears that the spread of HIV/AIDS is disproportionately high among groups that already suffer from a lack of human rights protection, social and economic discrimination, or marginalization in terms of legal status.[7] To illustrate, the inequality evident in gender relations that provides men with greater access to economic resources, is often replicated in heterosexual interactions. Male pleasure supercedes female pleasure. The balance of power in any sexual interaction determines its outcome. Another disturbing outcome of the emphasis of sexual and physical domination of women is violence against women.

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5 *Ibid.*

6 'Setting the Stage for Scaling-Up Access to HIV Prevention in the Context of Increased Treatment Access in Botswana', Discussion paper to rapidly scale up HIV prevention in Botswana, Brainstorming Meeting, African Comprehensive HIV/AIDS Partnerships (ACHAP), Botswana , 2-3 March 2006.

7 UNAIDS, *HIV/AIDS and Human Rights: Young People In Action*, UNESCO, UNAIDS, Geneva, 2001; see also T. Bruyn, 'HIV/AIDS and Discrimination: A Discussion Paper', Canadian HIV/AIDS Legal Network and Canadian AIDS Society, Montréal, 1998; 'Canadian Human Rights Commission Releases Revised Policy on HIV/AIDS', *Canadian HIV/AIDS Policy & Law Newsletter,* 1996, Issue 3 (1), pp. 7-8.

These factors have significant implications in the spread of HIV and its prevention programs.[8]

In the 1980s, the relationship between HIV/AIDS and human rights was only understood as it involved people infected with the virus and the discrimination to which they were subjected.[9] By the end of the decade, however, the call for human rights and for compassion and solidarity with people living with HIV/AIDS (PLWHA) had been explicitly embodied in the World Health Organization's (WHO) first global response to AIDS. The approach here was motivated by moral outrage and also by the recognition that protection of human rights was a necessary element of a worldwide public health response to the emerging epidemic.[10]

The implications of the WHO call were across the board. Its public health strategy in human rights terms became anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions toward people living with HIV/AIDS. The most important contribution of this phase was the recognition of the applicability of international law to HIV/AIDS and thereby, to the ultimate accountability of the State for issues relating to the health and well-being of its subjects.[11]

The concentration on the human rights of people living with HIV/AIDS in the 1980s led to increased understanding in the 1990s, of the importance of human rights as a factor in determining people's vulnerability and risk to the HIV infection. The problems relating to their accessing appropriate care and support were also acknowledged.[12] Vulnerability is the susceptibility to physical or emotional injury or attack.[13] It also means to have one's guard down, to be open to censure or criticism and to be assailable.[14] The term 'vulnerable population' is broad and can apply to a large number of groups who find themselves marginalised, different from the majority and under-represented: commonly understood to mean fragile, subject to hurt and harm usually from external sources, but sometimes by internal ones; a self-appraisal fashioned to justify

8 G.R. Gupta, 'Vulnerability and Resilience: Gender and HIV/AIDS in Latin America and the Caribbean', International Center for Research on Women (ICRW), August 2002, pp. 4 - 6.
9 World Health Organization, World Health Assembly, *Avoidance of Discrimination against HIV-Infected Persons and Persons with AIDS*, Preamble, Resolution WHA, WHO, Vol. 41.24, 13 May 1988.
10 World Health Organization, World Health Assembly, *Global Strategy for the Prevention and Control of AIDS*, Geneva, Resolution WHA , WHO Vol. 40.26, 5 May 1987.
11 M.L. Gostin , S. Gruskin *et al.,* 'Human Rights and AIDS: The Future of the Pandemic', *Health and Human Rights*, Vol. 1, Issue 1, 1994, pp. 6-23.
12 D. Tarantola, 'Risk and Vulnerability Reduction in the HIV/AIDS Pandemic', *Current Issues in Public Health*, Vol. 1, 1995, pp. 176-179.
13 V.J. Carlos, 'Vulnerability: A Conceptual and Methodological Review', *Source,* Vol. 14, Issue 44, Bonn, Germany, February 2006.
14 G. Bankoff, G. Frerks and D. Hilhorst, *Mapping Vulnerability*, Earthscan, 2004.

negative emotions and negative orientations to sentiments such as fear, doubt, anger, withdrawal, blame, lovelessness, hostility.[15]

The vulnerability of people with HIV/AIDS affects practically every one of their human rights, be it health, unfair discrimination, violation of privacy or inhumane or degrading treatment.[16] The application of the human rights approach to vulnerability is a relevant concept for elucidating risk-taking processes and designing intervention programs by concerned stakeholders. People infected with HIV may suffer from violations of their rights when, for example, they face government-condoned marginalization and discrimination in the realms of health, education, employment and social services.[17] Freedom from discrimination can have a strong impact on the ability to enjoy the right to work, the right to be free from inhuman and degrading treatment and the right to education. This applies, albeit in different ways, to women, men, and children infected with, and vulnerable to HIV.[18]

Vulnerability to HIV basically is the lack of power of individuals and communities to minimize or modulate their risk of exposure to HIV/AIDS infection and, once infected, to receive adequate care and support. Women are, in general, for instance, more vulnerable than men to HIV infection in heterosexual relations.[19] The reasons for this are not only biological and epidemiological, but importantly also socio-economic and related to inequalities. A woman's safety in sexual relations may be compromised by, for example, the perceptions that men (and her partner in particular) have about using condoms, the potential for violence or abuse in the relationship, and the extent to which the woman depends economically or socially on her partner.[20] The gender roles within intimate relationships, families, friendships and communities depend greatly on how HIV is understood and talked about, how it is spread and how PLWAs are treated or vice versa.

15 http://www.soulprogress.com/html/Glossary/VulnerabilityGlossary.html

16 The Botswana Network on Ethics, Law and HIV/AIDS, *Human Rights and HIV: A Manual for Action*, BONELA, Gaborone, 2005.

17 Human Rights Internet, *Human Rights and HIV/AIDS: Effective Community Responses*, International Human Rights Documentation Network, Ottawa, 1998; R. Cohen and L. Wiseberg, *Double Jeopardy-Threat to Life and Human Rights: Discrimination Against Persons with AIDS,* Human Rights Internet, Cambridge, Massachusetts, 1990.

18 New South Wales Anti-Discrimination Board, Discrimination - The Other Epidemic-Report of the Inquiry into HIV and AIDS Related Discrimination, Anti-Discrimination Board, Australia, 1992, p. 5.

19 L Sherr, 'Tomorrow's Era: Gender, Psychology and HIV Infection' in L Sherr *et al.* (eds.,) *AIDS as a Gender Issue: Psychological Perspectives*, Taylor and Francis, London, 1996, p. 46 - 63, at 48, cited in Bruyn, *op. cit.* n. 7

20 . *Op.cit.* n. 8

Hence, prevention, treatment, care and support programs and policies must take gender-based experiences and differences into consideration in order to be effective.[21]

Similarly, disadvantaged racial/ethnic minorities, groups which are socially or economically marginalized on the basis of sexual orientation, age, refugee status, occupation (e.g. commercial sex workers) or location (remote area dwellers) often have a higher incidence of HIV/AIDS, due to restricted access to resources, including education, adequate medical services, and political power.[22] As the pandemic progressed, it became apparent that human rights law is relevant not only to the treatment of infected individuals but also to the wider populace, vulnerable to HIV/AIDS.

Protection of Human Rights to Reduce the Vulnerability to HIV/AIDS: The Case of Botswana

There is strong political commitment to fight HIV/AIDS in Botswana. It was one of the first few countries to adopt the '*Three Ones*', key principles for co-ordinating and guiding national authorities in responding to HIV/AIDS.[23] In alliance with development partners, it has developed policies, strategies and institutions, and is in the process of implementing a national multisectoral HIV/AIDS response with the goal of zero new HIV infection by 2016. The strategy was developed to enable effective implementation of a comprehensive and integrated approach in tackling the epidemic. [24]

The 2006 Report on the Global AIDS Epidemic shows that the world is at a defining moment in its response to the AIDS crisis.[25] International human rights law, indeed, is serving as a powerful mechanism to influence domestic law and policy regarding HIV/AIDS. It is also one of the few avenues the international community can use to examine what goes on within a state's borders. This scrutiny by outside actors applies pressure on governments to change their practices and is one mechanism through which international consensus on the content of each right is built.[26] A number of international human rights treaties

21 G.M. Wingood and R.J. Di Clemente, 'Application of the Theory of Gender and Power to Examine HIV-related Exposures, Risk Factors, and Effective Interventions for Women', Vol. 27, Issue 5, *Health, Education, and Behavior,* 2000, pp. 539-565.

22 *Op. cit.* n. 16, Vol. 3, pp.16-20.

23 *Op. cit.* n. 6.

24 Botswana National Policy on HIV/AIDS, approved and adopted by the Government of Botswana through Presidential Directive CAB: 35/93, 17 November 1993; see also UNAIDS, WHO, *op. cit.* n. 3; 'The Power of Partnership:Third Annual Report to Congress on PEPFAR', Bureau of Public Affairs, US State Department, March 2007, available at http://www.pepfar.gov/press/c19573.htm

25 *Op. cit.* n. 3.

26 Centre for Human Rights, Report of an International Consultation on AIDS and Human Rights, Geneva, 26-28 July 1989; UN, New York, 1991, p. 10.

further elaborate the rights set out in the Universal Declaration of Human Rights, 1948, a document of widest significance, serving in its field as the conscience for the world and a standard against which the attitude of societies and Government can be measured. These include the following conventions to which Botswana too is a member: International Covenant on Civil and Political Rights (accession 2000); Convention on the Rights of the Child (accession 1995); Convention on the Elimination of Racial Discrimination (accession 1974);[27] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (accession 2000) and the Regional Treaty, the African Charter on Human and Peoples' Rights (accession 1986). By signing an international human rights treaty, Botswana accepts obligations at the international level, to protect the rights of all people within its territory.

Unfortunately, Botswana has not yet ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Covenant deals with *'positive'* rights, such as the right to food, to health care, to education and to cultural life.[28] None of the international human rights treaties specifically mentions HIV or the rights of individuals in the context of HIV/AIDS, yet all the international human rights mechanisms responsible for monitoring government action have expressed their commitment to exploring the implications of HIV/AIDS for governmental obligations.[29] This may be of critical importance for fusing HIV/AIDS and human rights in practical and concrete ways.

International treaties, however, need to be supplemented by national legislation and training for advocates of rights of minorities and vulnerable groups. Converting promises to reality could be the best medicine in the fight against HIV/AIDS.[30] Proper implementation of a treaty ensures that its laws and policies are consistent with the terms of the treaty. In some cases, the courts have shown respect to the rights contained in the treaty.[31] Laws and constitutions cannot create human rights, as they are a reflection of our common humanity. But when human rights are included in the constitution and the law, it is more likely they will be protected and people will be able to protest if they are violated.[32] Vulnerability to HIV reflects (an individual or community's) inability to control the risk of infection. HIV/AIDS is not only a health issue; rather it has huge social and economic implications that require

27 See CERD/C/BWA/CO/16, 21 March 2006.

28 Central Intelligence Agency, The World Fact Book - Botswana, USA, November 2006, available at: https://www.cia.gov/library/publications/the-world-factbook/goes/bc.htm

29 UNESCO and UNAIDS, *Advocacy Beyond Borders: Introduction to the International Human Rights Machinery,* UNAIDS, Geneva, 2001, p. 13.

30 UNGASS Declaration of Commitment 2001, para. 98.

31 *Attorney General* v *Unity Dow* (1992) Botswana Law Reports (BLR) 119 (CA).

32 D.D. Nsereko, *Constitutional Law in Botswana,* Pula Press, Gaborone, 2002 , p. 259.

multi-sectoral responses. Poverty, gender inequality and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can increase vulnerability to the infection. Both risk and vulnerability need to be addressed in planning comprehensive responses to the epidemic.[33] Recently, in a Progress Report (2008) the Ministry of State President has acknowledged that in Botswana, there are laws that present obstacles to effective HIV prevention, treatment, care & support for most-at-risk groups.

It has been accepted that gaps exist in service delivery for vulnerable groups. The report has clearly acknowledged that there is lack of human rights monitoring & enforcement mechanisms.[34]

Although HIV/AIDS eradication has been accorded the highest priority in various ways at the national and local levels, very few laws have been passed by Parliament to specifically address the consequences of the epidemic in Botswana. It has been a common contention among the human right activists and organizations working in the concerned field, that HIV/AIDS policies and programs do not address the human rights dimension adequately.[35] Nevertheless, some general provisions of the existing law, including the constitution, are relevant to HIV and AIDS.[36] The human rights protections listed in Section 3 through 15 of the Constitution clearly have implications for the HIV/AIDS epidemic.[37] However, the actual legal protection they afford to those affected remains uncertain because the courts have not yet resolved many cases involving the Constitution and HIV/AIDS.[38]

The right to health is not mentioned in the Constitution even though the Government of Botswana has gone to great lengths to provide free medical care and anti-retroviral therapy to its citizens. Botswana was the first African country to provide free anti-retroviral treatment to all its citizens in need of it.[39] The health care system in Botswana is guided by the Public Health Act, 1981(amended in 2006)[40] which aims to prevent and control epidemics in Botswana. The enactment of the Health Act is the government's initiative to promote health through the provision of hospitals, clinics and skilled health personnel. However, there is no specific provision for HIV and AIDS in the Act. In addition, section 5 of the Act makes notification of certain specific diseases by a health officer to

33 *Op. cit.* n. 3, Chapter 5.
34 *Op. cit.* n. 4, Table 3: National Composite Policy Index, Trend Analysis, Human Rights, NACA, Gaborone, 2007, p. 16.
35 *Op. cit.* n. 16, Vol. 3; K.D. Ogile, *HIV/AIDS and the Law*, Printing and Publishing Company, Gaborone, 1999, p. 5.
36 *Op. cit.* n. 4, p. 24.
37 Constitution of Botswana, Part-II.
38 Industrial Court case no. 35 of 2003; see also Court of Appeal Civil Appeal no.37 of 2003 pp. 6-7; *op. cit.* n. 16, Vol. 4, pp. 12-13.
39 *Op. cit.* n. 28.
40 Chapter: 63.01.

the Ministry of Health, compulsory. HIV/AIDS, however, is not classified as a disease which requires notification. Moreover, anti-retroviral drugs are being administered to the infected without strict legal regulation in place.[41]

As the law in Botswana currently stands, it does provide for the general right to life under the Constitution which includes the right to live with dignity, freedom and safety.[42] The Constitution further prohibits subjecting any person to inhuman or degrading treatment. People living with HIV/AIDS have the right to be treated with respect and dignity like any other person in the society. The laws permit prosecution for the wilful transmission of infectious diseases, but this can be difficult to prove. It requires proof that the individual knew his/her own HIV status and may also require proof that the individual was aware of the high risk of infection and had vile intent to infect others.[43]

The National Policy on HIV and AIDS represents the Government of Botswana's plan to control the spread of HIV/AIDS and reduce its negative impact on society. While promoting personal responsibility, it recognizes the need for respect of human rights, privacy and self-determination; it expressly provides for counseling, consent and confidentiality and envisages non-discrimination in relation to HIV/AIDS.[44] It also provides guidelines for protecting human rights in a variety of contexts.

So far as vulnerability is concerned, the policy has established that some groups such as children, young people, women and sexual minorities are at greater risk. It highlights children's right to education as well as to appropriate health care and prevention information. It notes that women are particularly vulnerable to infection '*because of a complex mix of discrimination, economic deprivation, cultural and biological factors'*.[45]

It mentions that people involved in same-gender sexual activity may be particularly vulnerable; homosexual activity is still illegal in Botswana.[46] It is thus difficult for public health managers and policy-makers to reach out to homosexuals with proven means of prevention like condoms.

41 D. Ntseane, K. Solo, *Social Secuirty and Social Protection in Botswana*, Bay Publishing, Gaborone, 2007, p. 113.

42 Section 4 of the Constitution of Botswana; see also *Sarah Diau v Botswana Building Society* IC 50/2003 (unreported); *Rapula Jimson v Botswana Building Society* IC 35/2003 (unreported); *Botswana Building Society v Rapula Jimson*, Civil Appeal No 37, 2003. (unreported)

43 Constitution of Botswana Sec. 5 (g); Penal Code of Botswana Sec. 142(2); Public Health Act Sec. 11.

44 S. Puvimanasinghe, 'Lest We Do Not See The Wood For The Trees: Human Rights and Routine HIV Testing', *The Botswana Review of Ethics, Law and HIV/AIDS*, Vol. 1, No. 1, 2007, p. 67; see also *op.cit.* n. 24, para. 1.7 and para 6.

45 *Op. cit.* n. 24, *Ibid.* (1998-2004).

46 Sections 164-167 of the Penal Code of Botswana.

In relation to the rights of people who are gay, lesbian and transgendered, there are no policy provisions that specifically accommodate the reproductive health rights of such people so far.[47]

Equality means equal concern and respect across differences; it does not pre-suppose the elimination or suppression of differences. It is further submitted that respect for human rights requires the affirmation of self, not the denial of it.[48] Differences, therefore, should not be the basis for exclusion, marginalisation and stigma. Thus, it is important to stop discriminating against marginalised sexualities and include them in the national fight against HIV/AIDS.

As for the right to employment and allied rights, according to the HIV/AIDS Policy, people with HIV/AIDS should have the right to confidentiality in all aspects of their employment, be it pre-employment or workplace testing.[49] The Industrial Court of Botswana has considered a few cases involving HIV.[50] These cases give us some idea of how current employment law and the court's equity jurisdiction treat HIV/AIDS issues in the workplace. However, since there is no law in Botswana that specifically addresses HIV/AIDS and employment, it is unclear how the courts may treat other HIV related issues in the future.

The policy also notes that no restriction should be placed on HIV-positive travellers into Botswana and that no HIV test should be required for entry. The guidelines under section 6.5 aim to protect the rights to freedom of movement, non-discrimination, health, education and information.[51] However, while the National Policy on HIV/AIDS is a document of national importance, being only a policy statement, it does not have the strength and enforceability of law.[52]

There is no law in Botswana that specifically targets social security and HIV/AIDS. The need for social security is more pertinent to those already affected by the disease. The National Policy underscores the need to utilize the social protection system to address the consequences of the pandemic but the idea of social protection is still underdeveloped and fragmented, with no underlying policy to guide its implementation. Conversely, no law has been passed so far that encompasses social security, particularly for those more vulnerable to the epidemic.[53]

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47 *Kanane* v *The State* (6) 2003 BLR 2.

48 I. Currie, J. De Waal, *The Bill of Rights Handbook*, Juta and Co.,Wetton, SA, 2005, Chapter 9: *Equality*, pp. 229-272.

49 *Op.cit.* n. 24, ss. 6.2-6.4; see also Central Statistics Office, *Botswana AIDS Impact Survey (BAIS II)* (2004); DITSHWANELO/The Botswana Centre for Human Rights and The Botswana Red Cross Society, Botswana HIV/AIDS & Human Rights Charter, adopted in Kasane, 15 September 1995; revised in Gaborone, 13 September 2002, p. 5.

50 *Op. cit.* n. 42, IC Case No. 35, 50 and 68/87 of 2003.

51 *Op. cit.* Section – 6.5, HIV/AIDS and Travellers.

52 *Op. cit.* n. 35, vol. 3, pp. 22-24.

53 *Op. cit.* n. 41, p. 113; *op. cit.* n. 35.

Besides policy, there are a number of agencies of the government of Botswana which are working "to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within the scope of Vision 2016" and:

> to provide clear guidance for Ministries, districts, NGOs, and the Private Sector to enable them to work in a collaborative manner in achieving the intended goal of the National Response to HIV/AIDS: to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana.[54]

Botswana's National Strategic Framework for HIV/AIDS makes provision for a 'Strengthened Legal and Ethical Environment' as one of its main goals through creation of a supportive human rights-based environment conforming to international standards for the implementation of the national purpose.[55] The Botswana HIV/AIDS and Human Rights Charter,[56] though not a legal document which seeks to assert a set of legally enforceable or actionable claims, is a statement of the aspirations of a particular group, namely PLWHAs. The Charter emphasizes that the group have legal, civil, political, social and economic rights.

Little doubt exists with regard to Botswana's status as an exceptional case of political and economic success in post-independent Africa. However, the fact that Botswana has acceded to only a few International Human Rights instruments and its failure to ratify several conventions that it is a signatory to, and bring its domestic legislation in line with them, impacts negatively on its achievement of international standards of human rights. Although the Bill of Rights enshrined in the Constitution of Botswana incorporates international human rights instruments, the country's national law and its application and enforcement by the courts have not been consistent. The country has excelled in establishing a workable relationship with the international community and organisations, in drafting promising policies to deal with the HIV/AIDS pandemic. In this scenario, however, the major challenges confronting Botswana are issues related to effective implementation of the basic rights of all concerned. There appears to be a gap between the international, regional and national commitments and Botswana's legal policies.[57] The most significant challenge in the HIV/AIDS pandemic is to bring about behavioral change to reduce the rate of new infections.

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54 NACA, Botswana National Strategic Framework for HIV/AIDS, 2003-2009, 2003, pp. 8, 9.

55 Puvimanasinghe, *op.cit.* n. 44, p. 67.

56 *Op. cit.* n. 49. See also S.Puvimanasinghe, *op.cit.* n. 44.

57 Statement from *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland - A Report by Physicians for Human Rights,* Physicians for Human Rights, Cambridge, 2007, available at http://physiciansforhumanrights.org/library/report-2007-05-25.html

To elaborate further, there is ample research[58] which provides evidence that socio-cultural factors influence men's and women's views on sexuality. Their access to information and health services affects reproductive health and well-being, including protection from HIV infection.

Additionally, in Botswana traditional culture dictates that women have little control over their bodies, and that men are 'in control' of sexual life; women's social position and traditional attitudes have blocked efforts to empower them to combat the disease. Early on, HIV/AIDS programs in Botswana focused on women in preventing transmission of the disease, especially to children. But the challenges women face in society are long term and require cultural change, access to education, economic empowerment and reform of the legal system.[59] A landmark change occurred early in 2005, when in an outstanding effort to empower women, the Government of Botswana approved the Abolition of Marital Power Bill which abolished the unwritten rule that gives a man control over his wife. However, the percentage of women (out of marriage) in the country is considerably higher than married women, who seek the protection of the Bill. So a larger section of women remain susceptible to *transactional* sex, for money or status, and often have no choice but to comply with a partner's wishes even in risky situations, for instance in relation to use of condoms when she is unsure of his positive status. Migration also plays a role in exposing women to the risk of HIV infection.

It is unfortunate that there are no specific laws that address HIV/AIDS in relation to any group that is most vulnerable to the disease despite the fact that research reports have clearly established the link. Recommendations to the concerned authorities have been made from time to time. DITSHWANELO, the Botswana Centre for Human Rights made the following Press Statement in 2005:

> In traditional Botswana society children are still perceived as the 'property' of their parents. Consequently, children are largely subject to the arbitrary exercise of power in unequal adult-child relationships, increasing their vulnerability and heightening the need to develop a rights-based culture and legislation. Creating child-centred laws which are in line with Botswana's international obligations will enable children, in the spirit of *Botho*, to actively participate and contribute to the fulfillment of the goals and aspirations of Vision 2016.[60]

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58 *Op. cit.* n. 20; see also R.D. Mueller, 'The Sexuality Connection in Reproductive Health', *Studies in Family Planning,* Vol. 24 Issue 5, 1993, pp. 269-82.

59 Botswana Institute for Development Policy Analysis (BIDPA), *Study on Knowledge, Attitude and Behaviour toward HIV/AIDS in The Vocational Training Sector*, BIDPA, Gaborone, June 2005.

60 DITSHWANELO, Press Statement on the Commemoration of the Day of the African Child, DITSHWANELO, Gaborone,16 June 2005.*Botho* is a Setswana word, conveying the Botswana cultural concept of humanity and respect for all.

Despite all efforts made in this area, the fact remains that human rights abuses in the form of rejection, humiliation, stigma, fear, exclusion, marginalisation, and discrimination associated with HIV/AIDS are still a harsh reality in many communities. It is a well documented fact that lack of respect for human rights at personal and societal levels is directly associated to individual and collective risk of exposure and to availing of post-infection care and support as in the case of commercial sex workers for instance. Discrimination against people living with HIV/AIDS is counter-productive to public health efforts.[61] A study report[62] released very recently by Physicians for Human Rights (PHR) connects widespread discriminatory views against women in Botswana and Swaziland to sexual risk-taking and, in turn, to very high HIV prevalence.

A statement by Karen Leiter, lead investigator of the study says:

> According to the PHR research, the very fear of being subject to HIV-related stigma (as opposed to the actual experience of it), being abandoned by friends or shunned at work was pervasive. For instance in Botswana, 30% of women and men believed that testing positive and disclosure would lead to the break up of their marriage or relationship.[63]

The authors of this paper fully support the observations of Leiter, that HIV/AIDS interventions focused solely on individual behaviour will not address the factors creating vulnerability to HIV for women and men in Botswana, nor protect the rights and assure the wellbeing of those living with AIDS. Further, leaders, with the assistance of donors, are obligated under international law to change the inequitable conditions faced by women, people living with HIV/AIDS and other vulnerable groups.

Conclusion

The fundamental linkages between HIV/AIDS and human rights have been well understood by all stakeholders, whether those directly affected, their governments, policy-makers at the international level, or the public at large. The importance of bringing HIV/AIDS policies and programs in line with international human rights law is generally acknowledged but, unfortunately, rarely carried out. Planners, program managers and service providers need to become more comfortable in using human rights norms and standards to guide the actions taken by governments in all matters relating to HIV/AIDS.

61 *Op. cit.* n. 56.
62 *Ibid.*, p. 641.
63 Physicians for Human Rights, *op. cit.* n. 57, presented in the Journalists' Telephone Conference Call, University of Botswana, 28 May 2007.

Governments are responsible for safeguarding rights directly, as well as for ensuring that favorable conditions exist for people to realize their rights. So far as Botswana is concerned, on the one hand, people infected and affected by HIV/AIDS need to be informed about those human rights that are provided within the country's national and international framework, and on the other, there is a dire need to identify areas where there is a gap and to lobby for change. Finally, there is a need to initiate change in an effort to move concretely towards a rights-based approach to HIV/AIDS. Both the government and the people of Botswana should recognize that the nation is presently facing a crisis of unprecedented proportions in the form of HIV/AIDS. If no major steps are taken forthwith, this crisis threatens to negate much of the development achieved in the country since independence in 1966. Adhering to progress trends towards achieving all the Millennium Development Goals, and ensuring that there is adequate progress in crucial areas, is a major challenge facing Botswana, today.

REVIEW OF BOOKS AND ARTICLES

Books Review:
Helen Epstein, *The Invisible Cure. Africa, the West and the Fight Against AIDS*, New York, FSG, 2007, 326 pp.

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The Invisible Cure is the story of Helen Epstein's desperate attempt to tackle extremely sensitive issues surrounding the fight against AIDS in Uganda and other African countries, particularly Eastern and Southern Africa, including Botswana. In this new, important and thought provoking book, Epstein relates to us her own story since she began working on AIDS in Uganda in 1993 as a biologist on a vaccine project. The book is the outcome of years of personal involvement in AIDS research, in which Epstein shares her encounters, experiences, struggles, and testimonies. She reveals interesting insights on the Ugandan experience in fighting the AIDS epidemic, to address the most disturbing and sensitive questions when looking at the AIDS epidemic in Africa: How and why did the HIV virus begin in Africa? Why has the Southern African region been so severely affected by HIV/AIDS when sero-prevalence rates had been kept at very low levels in western countries? Clearly there cannot be one single answer to these questions, especially the latter. For the author, the more compelling answer revolves around the concept of concurrency, which is the central argument in the book. Using the case of Uganda, Epstein gives us a concrete illustration of what might work to tackle AIDS and in the meantime she provides us with a severe critique of international public health experts and their continuous misunderstanding of the dynamics of the AIDS pandemic. This, she argues, together with powerful American investments and positions in favour of abstinence, overlapping with religious interests, have created a situation where fighting AIDS effectively has become almost impossible.

Why Africa?

Why did Helen Epstein come to work in Africa? The story begins in 1993 when Epstein decided to abandon California-based post doctoral work on the sexual organs of insects to collaborate on a vaccine research project by a bio-technology company, Chiron. She moved to Uganda for this purpose, but the project did not last long. The project was deemed a failure after the blood samples she analysed were 'lost' because her findings – that the HIV virus in Uganda had many different strains – did not seem to satisfy the objectives of the company. After moving to England to study public health, Epstein would often come back to Uganda and many other places in Africa to work on several different projects and above all to pursue her own research goals on AIDS.

To account for 'The Mysterious Origins of HIV', in Chapter Two, Epstein explains how the virus was transmitted to human beings from chimpanzees. She takes the position of Opendra Narayan, a virologist at the University of Kansas, who explains the transmission as 'serial passaging': If a weak virus is passed from one monkey to another in a lab, it is transformed into a very deadly one. In other words, "if you pass a virus to new species often enough, eventually you get a more pathogenic virus" (p. 45). Strains of HIV1 and HIV2 emerged in the 1930s. One of these strains (HIV1) gave rise to the global AIDS pandemic. Epstein suggests that this 'serial passaging' of HIV might have occurred through the large scale medical campaigns which used highly unsafe practices (with just a few syringes to treat thousands of people) that were carried out during colonial times. This, together with poor blood transfusions, "might have been enough to kick-start the virus. [...] It might have become sexually transmissible and deadly" (p. 47).

Why is the African continent so severely affected by AIDS? To this end, Epstein reviews most of the controversial theories about the so-called 'African sexuality' which purport to explain why the virus has developed so quickly and has got out of control in Africa. Among them, and perhaps the most famous, is the theory of the Australian demographer John Caldwell postulating the existence of "a distinct and internally coherent African system embracing sexuality, marriage and much else" arguing that there is in Africa, 'a unique sexual system' characterized by higher rates of casual and premarital sex.[1] Epstein distances herself from those culturalist theories that were very common at the beginning of the epidemic. But it is certainly not an easy task because those stereotypes about an 'African sexuality' have not completely disappeared despite many anthropological, sociological and other types of research showing how inept this concept is. While not arguing of a distinct African sexuality, Epstein is nonetheless supporting an explanation in terms of sexual behaviours – even if understood in a broader social and cultural context.

Concurrency: The Key-Word?

In 1991 the epidemiologist Roy Anderson developed the 'mixing theory' about a 'sexual mixing' between 'high-risk groups' and everybody else; where sex crosses social boundaries more frequently than in the West. He was followed by the sociologist Martina Morris who gave a lecture in Uganda in 1993 that sparked off Epstein's interest. At that time, Morris

1 For those interested in the text and the following controversies, see : J.C. Caldwell, P. Caldwell and P. Quiggin, 'The Social Context of AIDS in Sub-Saharan Africa', *Population and Development Review*, Vol. 15, No. 2, June 1989, pp. 185-234 and a response by M.-N. Le Blanc, D. Meintel and V. Piche, 'The African Sexual System: Comment on Caldwell *et al.*', *Population and Development Review*, Vol. 17, No. 3, September 1991, pp. 497-505.

explained that "a relatively high proportion of African men and women had ongoing relationships with a small number of people – perhaps two or three – at a time. These 'concurrent' relationships might overlap for months or years, or even, in the case of polygamous marriages, a lifetime. Such behaviour is normative in many African societies […]" (p. 55). Epstein finds crucial explanations of why faithful partners are infected with HIV or why even the monogamous couples maybe at risk, because from the moment one partner is involved in this 'sexual network', all others taking part in this 'concurrency network' are at great risk of contracting HIV: "In this way, concurrent sexual relationships link people up into a web of sexual relationships that can extend across huge regions. If one member contracts HIV, then everyone in the web is immediately placed at very high risk as well" (p. 59).

This 'multiple concurrent sexual relationships' theory is thought-provoking and somehow disturbing because it postulates a fundamental cultural gap between Africa and the rest of the world but Epstein does not fall into the trap of the stereotype about 'sexual promiscuity' because her writing is cautious: "Africans are not more promiscuous than heterosexual people in other world regions […]. Generalizing about sexual culture is always difficult; social life everywhere is complicated and constantly changing" (p. 73). That is why reading her ideas about "concurrency sexual relationships" can make one feel dissatisfied particularly because long term unfaithful relationships are clearly a pattern occurring in other parts of the world. This can do damage to the argument in Epstein's book as a whole. Being seduced by that explanation, Epstein seems to give more importance to it to the detriment of other more pertinent issues that she herself writes about in other parts of the book, for example, the social and economic issues, the inadequate policies, the insufficient care and management of Sexually Transmitted Infections (STI), unsafe blood transfusions etc.

Indeed, reading the book as a whole, 'concurrency' appears to be just one of the numerous factors that contribute to the severity of the AIDS crisis in Southern Africa. Other factors include: inequality, poverty, – and 'transactional' sexual relationships (pp. 77-79); the consequences of gender imbalances and domestic violence (pp. 79-83); and inadequate international health programmes and insufficient national policies. She is cautious enough, for example, to report important social and political patterns fundamental to the understanding of the development of the AIDS epidemic in Southern Africa especially the migrant labour system. Millions of mine workers have been sent to South Africa in the past century from nearly all its neighbouring countries. This system "has been blamed for many of the region's ills, including disruption of family life and underdevelopment. Now it was also being blamed for the spread of HIV" (p. 90). Long absences from home, dangerous work, very poor living conditions in hostels surrounded by bars are among the important aggravating factors. But most illuminating is the writer's experience of

what she discovered in Uganda.

The Ugandan Success-Story

Epstein warns in the preface of the book (p. xvi): "What I didn't know when I was in Uganda in the early 1990s was that something remarkable was happening there. Between 1992 and 1997, the HIV infection rate fell by some 60 percent in the arc of territory along the northern and western shores of Lake Victoria [...] It was not attributable to a pill or a vaccine or any particular public health programme but to a social movement in which everyone [...] was extraordinarily pragmatic and candid about the disaster unfolding in their midst". This maybe what guides the author to continue her struggle because Uganda is a sign of hope despite the many obstacles. Epstein argues that HIV decline is a matter of self and collective responsibility relayed by nationwide discussion, open conversations, gossip, etc., which spread public health messages more efficiently than any specific programme. "Behaviour change then became a matter of common sense. Maybe foreign public health officials missed this at the time because such 'social mobilisation' is actually quite hard to programme. It is a spirit that flourishes when people come together to face a common threat" (p. 167). In 2003, Uganda was the only African country with a nationwide decline in HIV prevalence, and Ugandans have shown that by coming together in a spirit of solidarity and responsibility, one can see the light at the end of the tunnel.

Epstein does not pay much attention to Zimbabwe, but she could have benefited a lot from a comparative analysis of the Ugandan case with a study conducted under the direction of Simon Gregson, (Department of Infectious Disease Epidemiology, Imperial College London, UK) on the reasons for HIV prevalence decline in the Manicaland region of Zimbabwe. This study also came up with findings that were quite similar in terms of the combined effects of behaviour change, condom use and fewer casual relationships being at the core of the prevalence decline.[2] What about Botswana where high sero-prevalence rates do not show significant signs of decline? Epstein has visited Botswana and makes several references to this country. But what she found there differs notably from what she witnessed in Uganda. On pages 167-169, she explains that in spite of the democratic and efficient government and the provision of free antiretroviral drug treatment for all citizens since 2002, she didn't find any sign of this collective answer like in Uganda.

"Even though Botswana seemed to have all the elements of the 'package' recommended by public health experts", Epstein believes that many in

2 S. Gregson, 'HIV Decline Associated with Behavior Change in Eastern Zimbabwe', *Science,* Vol. 311. No. 5761, 3 February 2006, pp. 664 - 666.

Botswana lacked the simple messages found in Uganda and instead relied on mass-media campaigns, distribution of condoms and hospital-based services. She even says that in Botswana "no one talked about AIDS" (p. 168). Perhaps she did not stay long enough in Botswana, to capture a more precise picture of the AIDS issue there. Epstein even makes the hypothesis that because patients are now going to hospitals, the home-based care system has not had a chance to really flourish although it is a way of bringing people closer to the reality of AIDS and thus stirring the nation's conscience. This might be interpreted as a quick and rather simple conclusion. Thinking about HIV/AIDS prevention and care together with the question of social mobilisation would need further documentation, inquiries and discussion in order to account for the complexity of the AIDS question in Botswana.

AIDS Experts and Programmes: A Critique

Based on her experience in Uganda and the remarkable success she reports in her book, Epstein develops a strong critique of international AIDS programmes. Firstly she shows how 'social marketing' has failed to address the real questions. 'AIDS Inc.' is the expression she has created to critique media campaigns such as the 'Love Life' campaign in South Africa, where the original idea was – according to its director, "to create a brand of positive lifestyle, [...] a brand so strong that young people who want to be hip and cool and the rest of it want to associate with" (p. 128). These 'social marketing' campaigns drew much of their inspiration from marketing campaigns for soft drinks, depicting small, well dressed families clearly promoting a glamorous western style of consumption. Epstein shows how unrealistic it was: "[a] more realistic HIV prevention programme would have paid less attention to aspirations and dreams unattainable for so many young people and greater attention to the real circumstances in people's lives that make it hard for them to avoid infection" (p. 139). Secondly, Epstein argues that in Uganda the government preferred to launch big information campaigns at the very beginning of the epidemic and she regrets that the 'Zero grazing campaign' (no sex outside a single partner relationship) which proved to be crucial in fighting the virus, never gained favour with international AIDS donors and experts who instead gave preference to campaigns for condom use, abstinence and testing.

Epstein is in a position to provide us with such a severe critique of international public health because of her own background as a public health specialist and that is perhaps the strongest element of the book. For example, when she explains why initiatives such as partner reduction campaigns were neglected. Even the Bush administration's 'ABC' (Abstain, Be Faithful, Use Condoms) was weak in effecting partner reduction and the President's Emergency Plan for AIDS Relief (PEPFAR) overwhelmingly emphasized abstinence for unmarried youths. Furthermore, she

suggests that UN and USAID officials responsible for the design of AIDS programmes in Africa "feared the topic implied racial stereotyping and moral judgments; perhaps they also felt it would be futile to try to change deeply rooted patterns of behaviour" (p. 178). She goes on to state: "[i]t is possible that the implication of the findings from Uganda – that Africans had fought this epidemic on their own through frankness and common sense, compassion for the afflicted, and a shift in sexual norms and attitudes surrounding sexual relationships and the rights of women – were the last thing UN bureaucrats would have wanted to hear. It meant that fighting AIDS would require an approach with which they were quite unfamiliar, and for which their existing expertise might not be paramount" (p. 181).

The international sphere of experts and money flourishing around the AIDS crisis for more than two decades is something that upsets Epstein. Early in the 1990's Ugandans were already talking about the difference between slim aids and fat aids: "People with slim AIDS will get slimmer and slimmer and slimmer until they finally disappear. Fat AIDS afflicts doctors, bureaucrats, and foreign-aid consultants with enormous grants and salaries; they fly around the world to exotic places and get fatter and fatter and fatter" (p. 27). Throughout the book, she constantly shows the many gaps between the experts' conceptions and practices and what is really happening on the ground.

There is also an entire chapter on the situation and politics of AIDS in South Africa (Chapter Six: 'A President, A Crisis, A Tragedy') where she tries to make sense of the complex and incomprehensible discourses and policies around AIDS in South Africa. In the end, she could not, as she confesses "[w]hy had this otherwise sensible president, who had done so much to fight for the dignity and rights of his people, been so wrong on AIDS? […] I knew I would never figure it out, but at the turn of the century, he seemed to embody all the tortured pride and shame of his conflicted continent" (p. 125). For those interested, French anthropologist Didier Fassin and South African public health specialist Helen Schneider have together studied this complex and difficult topic and have succeeded in giving a clear interpretation.[3] South Africa is also the focus of Chapter Fourteen where the author introduces the issues of violence and rape.

Many other questions are debated in this book. Among them the question of circumcision and its role in preventing HIV transmission informed by recent studies; the very important issue of the religious implications with regards to HIV prevention[4] and the question of AIDS orphans. American politics, with a very good insight into PEPFAR, is also addressed in this

3 D. Fassin and H. Schneider, 'The South African Politics of AIDS. Beyond the Controversies', *British Medical Journal*, No. 326, pp. 495-497.
4 On religion and AIDS see also H. Epstein, 'God and the Fight Against AIDS', *The New York Review of Books*, available at: http://www.nybooks.com/articles/17963 Accessed 6 September 2007.

book.

Perhaps Epstein attempts to address too many questions, and readers may sometimes feel that it is too short, but this book remains a rich testimony. It is also a good and well written introduction for persons who have not yet worked on the AIDS epidemic, especially for the good historical, biological and medical insights. The author gives preference to the theory of 'multiple concurrent sexual relationships' but she also clearly argues that the social and political contexts are keys to understanding the AIDS pandemic in contexts where social and political rights are violated, where gender relations are unequal and violent, and where poverty leads many people to have transactional sex to earn money. For further insights into these issues, there is a very good report entitled *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana and Swaziland*,[5] edited by Physicians for Human Rights.

Epstein's book ends with recommendations for the UN and USAID agencies in the form of a plea: "The African AIDS epidemic is partly a consequence of patterns of sexual networking that have evolved in response to the insecurity of living in a rapidly globalizing world that is leaving the continent behind. Therefore, the industrialized countries should also re-examine their policies in trade and foreign investment so that African nations can compete on fairer terms in the global economy" (p. 255).

5 *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana and Swaziland. An Evidence-Based Report on the Effects of Gender Inequity, Stigma and Discrimination*. This report is available at: http://physiciansforhumanrights.org/library/report-2007-05-25.html Accessed 6 September 2007.

RECENT DEVELOPMENTS AND EVENTS

TWO RECENT EVENTS AT BONELA

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This paper presents a commentary on two events recently hosted by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA). The first section highlights key issues raised at the organization's Annual General Meeting (AGM) under the theme 'Turning Up the Volume – Amplifying Community Voices'. This was a deliberate effort by BONELA to emphasize, acknowledge and advance 'The Peoples' Voice' in response to the HIV/AIDS pandemic in Botswana. The second event was the BONELA Membership Forum where members were updated on the work that the organization has been doing.

Annual General Meeting 2007

Duma Boko the current chairperson of BONELA emphasized that human rights were important, 'Now More Than Ever', because treatment and care will never be accomplished without the promotion and protection of human rights, especially for the girl child and women.[1] He further argued that to protect human rights is to protect the general public. Boko however highlighted that real action remains lacking in the fight against HIV/AIDS.

The guest speaker Sisonke Msimang, the HIV/AIDS programme officer of the Open Society Institute of Southern Africa (OSISA), stated that human rights are fundamentally a human concept. She noted that the primary challenge to human rights is the state, and argued that the state is a big violator of human rights despite its claim to having laws that protect people. Msimang contended that in fact there is a high element of discrimination. She noted that it is a challenge to advocate for the humanity and existence of all people including those who are frowned upon such as homosexuals, sex workers and prisoners. This she argued is because what they do is often criminalised.

Commending BONELA for its contribution to the fight for human rights, Msimang said that we cannot run away from the fact that homosexuality exists, and should therefore not criminalise its existence. BONELA was further commended for its work in that it took a chance to work with those groups of people mentioned above as minority groups. She noted that by so doing, BONELA showed love. She argued that if our society is driven by love and not hatred, we could shape our society into something we can be proud of.

1 Reference can be made to the recent participation of BONELA in the discussion of the Domestic Violence Bill.

With this background in mind, the AGM proceeded to give a platform to a diversity of stakeholders such as civil society groups, the media and the general public to discuss HIV/AIDS and human rights issues in-depth. BONELA staff shared their experiences on how far they have come in the fight against HIV/AIDS. After the organisational presentations, a new board was elected from amongst BONELA members for a two year term.

The Treatment Literacy Department

The Treatment Literacy Co-ordinator, Cindy Kelemi, during her presentation on the Treatment Literacy Department talked about the Treatment Literacy Coalition which was formed in 2006 with the aim of guiding the project along the lines of the needs of the community. She also explained why it is important for BONELA to have a Treatment Literacy Department. Kelemi stated that "[t]reatment is both a human right and development issue", arguing that it is about the right to health and access to treatment. The programme also empowers communities with information about Treatment and will continue to empower communities on Treatment Literacy and intensify advocacy for improved health care delivery. One of the emerging issues in Treatment Literacy is Tuberculosis (TB). The Princess Marina Hospital Head of Disease Control, Dr. Julius Mboya recently disclosed that there are some cases of drug resistant tuberculosis in Botswana.[2] The department will therefore continue to provide information on TB through the development of Information, Education and Communication (IEC) and to advocate for better services through the use of existing health education programmes.

The Prevention and Research Initiative for Sexual Minorities (PRISM)

The Prevention and Research Initiative for Sexual Minorities (PRISM) Coordinator, Felistus Motimedi, used her presentation to explain the reason behind PRISM. The project started with a needs assessment intended to identify existing gaps in service delivery and health needs for sexual minorities (Lesbians, Gays and Bisexuals). This assessment provided the basis for a proposal to run a relevant and targeted HIV/STI Prevention programme at BONELA. This programme is conceptualised jointly with the Dutch Schrarer Foundation. In addition, the Johns Hopkins School of Public Health and OSISA in collaboration with NGOs from African countries (Namibia, Malawi, South Africa and BONELA in Botswana) are in the process of getting permission to do research on men who have sex with men (MSM) and HIV/AIDS including an HIV Prevalence Survey. Taking part in the study affords BONELA an opportunity to establish evidence based data to support its argument for the provision of condoms in prisons, and decriminalisation of same sex practices.

2 *Sunday Standard*, 20-01-2008, p. 2.

The Sexual and Reproductive Health Rights of Women Living with HIV

The presentation by Advocacy Officer, Nthabiseng Nkwe, on this subject, highlighted the challenges women living with HIV in Botswana face when it comes to their reproductive health rights. These include: increasing pressure on People Living with HIV and AIDS (PLWHA) to disclose their HIV status, HIV discordance, limited safer-sex strategies and family planning, pregnancy and societal attitudes discouraging couples living with HIV from having children. BONELA visited 15 sites in the country and held discussions/interviewed 228 participants living with HIV. These were conducted in order to understand the challenges and difficulties that this particular group faces in exercising their sexual and reproductive health rights relating to pregnancy - planned and unplanned. People living with HIV continue to have satisfying sexual lives and have plans to have families. The most alarming outcome of the fact finding missions was that most of the women living with HIV (70% interviewed) were not aware of Pap Smears and had never undergone a screening. From the 21% who knew of such a service and had actually undergone a screening, only a handful (38.9%) had received the results and a disturbing 61.1% who underwent the screening had not received their results. BONELA as a result is now airing community messages in the form of radio jingles making women aware of the importance of going for a pap smear – the sooner, the better.

BONELA Membership Forum

A key strategy borne out of BONELA's recent strategic planning process has been to focus on strengthening and extending the membership base to enable a critical mass of socially conscious individuals and groups driving advocacy on rights-based approaches to HIV. The BONELA Membership Forum was held to update BONELA members on the activities, programmes and advocacy strategies that have been implemented during the year (2007). The forum comprised of a panel discussing best methods or practices in which community voices can be amplified in the fight for human rights within an HIV/AIDS context. A panellist, Beata Kasale from the *The Voice* newspaper spoke about 'The Role of the Media' in trying to combat HIV/AIDS. In her words:

> Accuracy is not only critical but crucial since important personal and policy decisions may be influenced by media reports. Journalists should be particularly careful to get scientific and statistical information right. The bottom line is that media has a role to play in fostering development through communication, and reporting HIV/AIDS effectively is one way of playing its part in ensuring that there is creation of a new AIDS free generation.

Members at the Forum got the opportunity to engage in dialogue with the BONELA Programme Officers (staff) on human rights and HIV/AIDS issues and how best they can participate in this sphere. For the purpose of the discussions, the members were divided into small groups addressing different issues related to HIV/AIDS, including emerging issues. The topics discussed included HIV testing, employment law, stigma, sexual minorities, sexual and reproductive health rights, and criminalisation, all in relation to HIV/AIDS. At the end of the forum, members were given a form to complete in order to assess and evaluate the impact of BONELA's activities and programmes.

ACTIVITIES OF BONELA

BONELA stands for the Botswana Network on Ethics, Law and HIV/AIDS, founded in 2001 and formally registered in 2002 to support human rights initiatives in the area of HIV/AIDS and to facilitate mainstreaming and integration of ethical, human rights and legal approaches into the country's response to the HIV epidemic. It does so by educating people on their rights relating to HIV and also advocating for policy formulation and legislative reforms. It is a national network of concerned organisations and individuals deeply committed to protecting and promoting the rights of all persons affected and/or infected by HIV/AIDS. Its ultimate aim is to consequently promote transparency, de-stigmatisation and respect for humanity.

The organisation is staffed by 16 full-time staff, a development worker and at any given time a number of international and local interns and volunteers. BONELA is governed by an Executive Board comprising seven people whose responsibilities include among others, the governance of the secretariat and the staff. It has over 120 members with diverse backgrounds. The membership of BONELA is open to individuals, organisations, groups, businesses and trade unions, and extends throughout the country.

In order to effectively achieve its stated aims and objectives, work is divided into six thematic programme areas, namely:

Education and Training

BONELA operates a fully fledged education and training programme aimed at building capacity among community stakeholders to respond to HIV/AIDS in the context of human rights in their communities, with the view of making human rights part of the national response to HIV. Key topics covered in these trainings include: HIV and the workplace; HIV testing and confidentiality; the right to health; wills and inheritance; and legal literacy and treatment literacy, which form a critical part of the education and training programme.

Media

In order to engage more effectively with the public, BONELA operates a very comprehensive media programme and has in the past two years run a successful media campaign under the slogan 'Making your Human Rights a Reality' which includes posters and radio jingles. Additionally, BONELA produces a quarterly newsletter that is distributed to members, partners and the public aiming at fostering debate on HIV and human rights.

Research

BONELA is actively engaged in action oriented research on issues relating to human rights and HIV/AIDS in Botswana. This research is very instrumental in informing advocacy and training programmes of the organization. In late 2005, BONELA completed its most comprehensive and ground breaking research project to date, titled: *Human Rights and HIV: A Manual for Action*. This fourteen-module, bilingual (English and Setswana) resource and training manual is the first of its kind in Botswana, addressing a wide range of topics such as basic facts about HIV/AIDS and understanding human rights concepts. *The Botswana Review of Ethics, Law and HIV/AIDS* was launched in mid 2007. This is a bi-annual journal, intended to provide a participatory forum for research and reflection, critical and analytical discussion on a broad range of issues and debates surrounding HIV and AIDS.

Advocacy

An integral part of BONELA's work lies in its continuous and deliberate efforts to facilitate discourse around HIV and human rights issues in the public arena. BONELA regularly holds discussions engaging the public and policymakers on a range of current and timely topics. In 2007, BONELA's advocacy focus areas were reproductive health rights of people living with HIV, condom distribution in prisons, HIV/AIDS and sex workers, and the HIV/AIDS employment law campaign. This campaign seeks to have employment legislation that confers protection to potential employees and/or current employees from discriminatory practices based on their actual or perceived HIV status. One of BONELA's ongoing efforts has been to advocate for and demand legislative changes of laws and policies in particular in the area of employment.

Treatment Literacy

This department is newly created and seeks to educate and enhance awareness on antiretroviral treatment. Several issues pertaining to treatment such as adherence and effects and consequences thereof are addressed in-depth and at length. It must be noted that this initiative reinforces or complements government efforts which are already in place.

Legal Aid

Lastly, BONELA operates a legal aid project which aims at providing free legal services to people who are discriminated against on the basis of their HIV status. The legal aid project is an integral aspect of the organisation and it is through this project that BONELA provides direct services to individuals and their families who might be subjected to discrimination on the basis of their known or perceived HIV status. The legal aid ranges from offering legal advice and mediating cases, to engaging in litigation. Apart from offering these services free of charge, the in-house lawyer also conducts sensitisation workshops across the country raising awareness with community groups and people living with HIV. The focus of the workshops is on HIV/AIDS and the law, and topics covered include employment law, family law and inheritance. The workshops usually run for three days. These workshops have been implemented since June 2006 and presently, 260 people have been sensitised on the law and HIV/AIDS across the country. The department also runs a call-in radio show on national radio, educating the public on HIV and the law.

PUBLICATIONS OF BONELA

Human Rights and HIV Resource Manual

BONELA's *Human Rights and HIV – A Manual for Action* was conceptualized as a tool for local activists, government officers, health care workers and people living with HIV/AIDS to pursue a human rights approach to the epidemic. Made in Botswana for Botswana's unique context, and conceptualized and written entirely by BONELA staff, the manual is partially translated into Setswana. Aware that human rights are often perceived as a foreign concept, BONELA embarked on this exciting project to explain and analyse a human rights approach to HIV within the cultural, political and social framework that is understood in Botswana society in the 21st century. Because no local information had previously been comprehensively collected on this issue, BONELA chose to cover the broadest possible range of topics and involved the participation of a variety of key local groups. Launched in November 2005, the training manual has caught the attention of diverse audiences from the highest level of government to grassroots community groups and the general public. The 14-book training kit covers the following topics:

- Understanding HIV and AIDS
- Human Rights and our Common Humanity
- Human Rights, HIV and AIDS
- HIV/AIDS and the Law in Botswana
- Right to Health
- Confidentiality
- Testing for HIV
- Your Rights at Work
- Sexuality and Human Rights
- Women, HIV/AIDS and Human Rights
- Men, HIV/AIDS and Human Rights
- Youth, Children, HIV/AIDS and Human Rights
- Wills and Inheritance
- Research

The Botswana Review of Ethics, Law and HIV/AIDS (BRELA)

The Botswana Review of Ethics, Law and HIV/AIDS was launched in mid 2007. This peer-reviewed journal is published bi-annually and is intended to create a participatory forum for analytical and critical discussion on a range of issues and debates surrounding HIV/AIDS. BRELA provides a platform for research on HIV/AIDS-related ethical, legal and human rights issues, which can inform BONELA's advocacy programmes.

BOOKLETS

Realising Botswana's Vision to Stop HIV/AIDS by 2016: The Need for a Pragmatic Approach to Provide Condoms in Prisons

In order to realize Botswana's vision of stopping HIV/AIDS by 2016 – effective means of treatment and prevention should be provided to all population groups in Botswana. The publication on 'condoms in prisons' emphasizes the need to pay "realistic attention to HIV/AIDS in the prisons in terms of provision of effective treatment and means of prevention, including condoms for prisoners who, due to confinement, are more prone to HIV infection than unconfined members of society".

Human Rights are Children's Rights

This publication takes the form of a story-book. It is an interactive 'children friendly' training tool that aims to educate children about human rights in the context of HIV/AIDS. The publication was created for children, their teachers and parents. It is also available in Setswana.

Human Rights and HIV/AIDS - 'Now More Than Ever'

This publication, which was endorsed by 24 non-governmental organizations and networks from around the world including BONELA, affirms that 'now more than ever', human rights should occupy the centre of the global struggle against HIV and AIDS. In 2006 world leaders at the UN High Level Meeting reaffirmed that "the full realization of all human rights and fundamental freedoms for all is an essential element in

the global response to the HIV/AIDS pandemic". The booklet gives 'Ten reasons why human rights should occupy the centre of the global AIDS struggle', and is published by the Open Society Initiative of Southern Africa (OSISA).

BONELA Guardian – Quarterly Newsletter

The BONELA newsletter – published quarterly - continues to be an informative tool used predominantly to disseminate information on BONELA's advocacy issues. The newsletter accommodates all issues related to HIV/AIDS and human rights, giving them prime space to which they would not have access in mainstream media. Previous editions showcase examples and the nature of cases received by BONELA's Legal Aid Department. The latest issue of the Newsletter features articles on recent developments in the Treatment Literacy Department. For example, the effect of the combination of Tuberculosis and HIV infection, and the burden of disease on People Living with HIV/AIDS resulting from such combination.

LEAFLETS

Children's Rights

The leaflet outlines the three groups of children's rights - protection, provision and participation. Children need to be protected and treated fairly; they need to be provided with help and everything they need for their well-being; and they need an enabling environment to participate in decisions affecting their lives, particularly in the era of HIV/AIDS. Children have the right to privacy, the right to dignity and the right to access treatment. The leaflet is available in Setswana and English.

BONELA Organizational Activities

The leaflet, which is bilingual (Setswana and English) and interactive, summarizes what BONELA does and advocates for – rights in the workplace, rights around HIV testing, right to health, children's rights, women's rights, reproductive health rights, rights for prisoners, rights for sex workers, rights for people with non-heterosexual identities, and rights

for people living with disabilities. The leaflet also explains the services that BONELA offers such as training and free legal advice for people who have been discriminated against based on their HIV status.

Legal Aid Department (LAD)

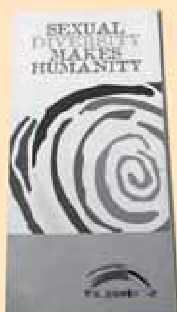
The BONELA Legal Aid Department has a mandate to assist clients with cases involving discrimination on the basis of their actual or perceived HIV positive status in all spheres of life including the workplace and the community. The leaflet promotes the slogan, 'Know your rights and assert them'. This bilingual leaflet answers frequently asked questions about the law and how it relates to HIV/AIDS, for example, criminal law and HIV/AIDS; HIV/AIDS and Employment law; and post-employment HIV testing. The leaflet also attempts to answer questions such as: can the law punish someone for the intentional transmission of HIV/AIDS? Do we have a duty to disclose our HIV status to employers? Can one be dismissed because he or she is HIV positive? What is reasonable accommodation?

Cervical Cancer

Women living with HIV are at a greater risk of developing cervical cancer due to their suppressed immune system. Women's consultations with BONELA reveal that most women living with HIV are usually unaware of Pap smears. The leaflet serves to educate and remind women (regardless of their HIV status) to seek a Pap smear test, at least once a year. The bilingual leaflet also outlines the signs and symptoms to look out for.

Routine HIV Testing

"Be sure to ask your healthcare worker what you are being tested for". This is the slogan that the leaflet carries to remind people of their right to the three 'C's namely: counseling, confidentiality and consent. The leaflet points out what people need to know regarding these rights. Consent- one has the right to information required in choosing, refusing or accepting an HIV test. Confidentiality- one has the right to control who knows his or her HIV status, even among health care workers. Counseling- one has the right to pre- and post-test counseling, even if he or she decides not to take the HIV test. This bilingual leaflet was primarily produced for training purposes as well as for increasing the visibility of BONELA.

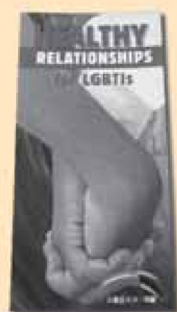


'Sexual Diversity Makes Humanity'

This was the initial leaflet produced by the 'informal' Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) organization which is housed under BONELA. There is a high risk of HIV infection among the Lesbian, Gay, Bisexual, Transgendered and Intersexed (LGBTI) community because of a tendency to think that since falling pregnant is out of the question among same gender sexual relationships, protection during intercourse is not necessary. This leaflet, therefore, serves to correct the aforementioned misconceptions as well as to dispel all myths about LGBTI's, by way of providing clarifications including the terms/names used, such as intersexed – when a person is born with full or partial sexual organs of both sexes.

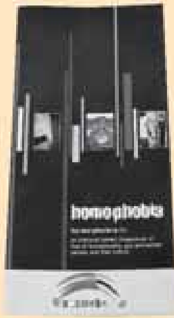
Play it Safe

This leaflet was produced for the LGBTI community offering and illustrating tips on how to practice safer sex. The leaflet outlines the signs and symptoms of sexually transmitted diseases or infections and how, and where to seek treatment. Specifically produced for LGBTI, this leaflet raises awareness on the various 'barrier' methods that can be used to avoid infection such as dental dams, glide dams, saran wraps and surgical gloves. Most importantly, the leaflet demonstrates how these barriers can be used to avoid infection while enjoying the pleasure.



Healthy Relationships for LGBTIs

The leaflet looks at what makes a healthy relationship, within the context of LGBTIs. The most basic elements of a healthy relationship are good communication, respect, trust and acceptance. The leaflet touches on the issues of choosing a partner, staying healthy, relationships and protection, roles in same sex relationships, why people lie in a relationship and rules of healthy relationships.



Homophobia

This leaflet was produced by Gays, Lesbians and Bisexuals of Botswana (LeGaBiBo), and attempts to answer questions such as: What is homophobia? How do I know if I am homophobic? What are the different types of homophobia? Where does homophobia manifest itself? How does one overcome homophobia? How can one cope with homophobia? What are some of the effects of homophobia?

Support HIV Prevention in Prisons

"Protecting public health includes protecting prisoners' health". Around the world, HIV prevalence among prisoners is comparatively higher than in the general population. While there are no statistics available for Botswana, 41% of the South African prison population is estimated to be HIV positive. For a variety of reasons, inmates are particularly vulnerable to HIV infection. Among these are the absence of condoms in prisons, incidents of voluntary and forced sex, violence, harmful prison conditions and ineffectual HIV education. The leaflet encourages people to be proactive about this concern and make it their cause by contacting their local Members of Parliament (MP's) about the issue; or writing letters to the media about their views on this subject. An accompanying poster was produced to increase visibility of the subject.

CALL FOR PAPERS

HIV/AIDS raises many issues because of its complex, all embracing and multi-dimensional nature. It therefore needs to be understood in relation to numerous scientific, social, legal, political, economic, cultural and other parameters. *The Botswana Review of Ethics, Law and HIV/AIDS* welcomes contributions on a wide variety of relevant issues from a broad range of disciplinary backgrounds, including but not limited to Ethics, Philosophy, Law, Medicine, Sociology, Psychology, Anthropology, Development Studies, Gender Studies, Pharmacology, Political Science, Economic Policy, Cultural Studies, African Studies, Social Work and Communication. Contributions from practitioners and activists from all relevant fields are welcome. As an advocacy organisation, BONELA champions human rights for all sections of society and accordingly, *BRELA* is intended to reach as wide an audience as possible. To this end, papers that can be of interest to a diverse audience consisting of many levels of readership are encouraged.

SUBMISSION GUIDELINES

Every contribution submitted with the view to publication in *BRELA* will be peer reviewed by at least two anonymous reviewers. Comments will be communicated to contributors within a reasonable time to enable revision of papers accordingly. *BRELA* will only publish papers that meet the required standards.

Format and Length:

- Contributions should include the name(s), professional details (including affiliation) and contact information of the author(s).
- Articles: short articles should be up to 5,000 words and long articles should be up to 10,000 words.
- Reviews of Books and Articles should be up to 2,500 words.
- Recent Developments and Events should be up to 2,500 words.
- Contributions must be in English, typed in font type Times New Roman, font size 12, and 1.5 spacing, with page numbering on the bottom, centre of the page.

The style of referencing is that of the American Psychological Association (APA). For more information on style, visit:
http://www.apastyle.org/styletips.html

Submission:

Submission should be via e-mail as an MS Word document attachment to: bonela.journal@gmail.com
Find out more about *The Botswana Review of Ethics, Law and HIV/AIDS* on the website of the Botswana Network on Ethics, Law and HIV/AIDS:
http://www.bonela.org

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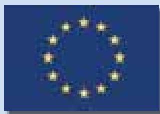

European Union

Ministry of Finance and Development Planning

Government of Botswana

BONELA

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