

Disentangling illness, crime and morality: Towards a rights-based approach to HIV prevention in Africa

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Summary

An increasing number of African states criminalise HIV transmission. In addition, several states criminalise private conduct traditionally associated with the risk for such transmission, such as homosexuality, sex work and drug use. However, there is increasing evidence that punitive responses to the HIV epidemic are inappropriate and counterproductive. They also fuel stigma and violate individual rights, especially those of members of marginalised groups. Relying on literature canvassing the content and effects of stigma pertaining to HIV, sex, perceived moral deviance and criminality and on studies questioning the effectiveness of criminal law in this context, this article disputes the appropriateness of employing the criminal law in relation to the transmission of HIV, as well as in relation to vulnerable or marginalised groups. Rather, the article argues for a human rights-infused, public health approach to HIV that upholds the rule of law, procedural justice and the principle of proportionality. Ultimately, the article asserts that, given the systemic causes of the African HIV and AIDS pandemic, solutions thereto should be similarly systemic in nature, rather than focused on individual instances of transmission.

1 Introduction

It is probably fair to say that HIV and AIDS have challenged the way in which we think about the relationship between public health, morality and law, more so than any other disease. Indeed, from their arrival on

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the international scene in the early 1980s, HIV and AIDS have highlighted the inadequacies of 'traditional' legal and public health approaches to disease control and prevention, as well as the urgent need to look beyond them.¹ Yet, as health systems around the world continue to buckle under the strain of the pandemic, policy makers seemingly remain tangled in conventional frameworks. In particular, while it is widely accepted that respect for and fulfilment of human rights yield the best results in the battle against HIV,² the rights of those afflicted by and vulnerable to the disease continue to be threatened or infringed by policies steeped in coercion, control and condemnation.

This is especially evident in Africa, which remains the epicentre of the HIV pandemic. On the one hand, there is increasing recognition across the continent that a rights-centred approach to public health is required to stem the tide of HIV. This is reflected, for instance, by the recently-proclaimed SADC Model Law on HIV and AIDS in Southern Africa³ and by the approach to HIV prevention adopted in countries such as South Africa. On the other hand, the African Commission on Human and Peoples' Rights (African Commission) has recently declared that it is 'deeply disturbed by the growing trend by various state parties across Africa towards criminalisation and mandatory testing of [people living with HIV] which leads to greater stigmatisation and discrimination'.⁴ This 'growing trend' has been further mirrored in increasing legal hostility towards social minorities traditionally associated with the spread of HIV, such as legally-sanctioned homophobia in, for instance, Uganda and Malawi.⁵

At this juncture, it is thus appropriate to reflect, once again, upon the manner in which the law responds to HIV and to those social groups most commonly associated therewith. The article takes issue with two related subsets of policy responses to HIV: first, those that employ the criminal law, or related coercive elements of public health law, in their

¹ E Cameron 'Legal and human rights responses to the HIV/AIDS epidemic' (2006) 17 *Stellenbosch Law Review* 47 52-53.

² M Kirby 'The never-ending paradoxes of HIV/AIDS and human rights' (2004) 4 *African Human Rights Law Journal* 163 167-68; M Heneke 'An analysis of HIV-related law in South Africa: Progressive in text, unproductive in practice' (2009) 18 *Transnational Law and Contemporary Problems* 751 754; R Johnson 'The Model Law on HIV in Southern Africa: Third World Approaches to International Law insights into a human rights-based approach' (2009) 9 *African Human Rights Law Journal* 129 141; UNAIDS *Criminal law, public health and HIV transmission: A policy options paper* (2002) (UNAIDS *Criminal law*) 15; UNAIDS *Policy brief on criminalisation of HIV transmission* (2008) (UNAIDS *Policy brief*) 2.

³ SADC *Model Law on HIV and AIDS in Southern Africa* (2008) <http://www.sadcpf.org> (accessed 31 March 2011).

⁴ African Commission on Human and Peoples' Rights *Resolution on the Establishment of a Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV* (2010).

⁵ Uganda published the much-maligned Anti-Homosexuality Bill 18 of 2009, whereas Malawi has been in the news for arresting and detaining a same-sex married couple under public indecency laws.

efforts to prevent and control the spread of the virus and, secondly, those that seek to regulate the lives of individuals or groups who are considered vulnerable thereto. Without conducting a detailed study of the content and application of relevant laws and policies, the article engages with their effect on disease prevention efforts by relying, first, on literature canvassing the content and effects of stigma pertaining to HIV, sex, perceived moral deviance and criminality and, secondly, on a multitude of studies questioning their efficacy. It disputes the appropriateness of employing a punitive paradigm in relation to HIV transmission and argues in favour of a public health approach that emphasises the protection of civil and political rights as well as the fulfilment of socio-economic rights, reflects *ubuntu* and tolerance, and upholds the rule of law, procedural justice and the principle of proportionality. In conclusion, the article warns that criminal and other laws focusing on individual instances of HIV transmission obscure structural and systemic shortcomings in public responses to the HIV epidemic, which ultimately detract from prevention efforts and undermine the realisation of the right to health in Africa.

2 HIV, stigma and marginalisation

The term ‘stigma’ is used to refer to the labelling of persons as different or deviant in relation to certain shared social norms, based on their behaviour or characteristics. Such ‘othering’ then forms the basis of social exclusion, victimisation and discrimination against those who have hence been singled out. As such, stigma is closely related to social power structures and inequality:⁶

Through stigmatisation social distinctions are enhanced. Stigma thus becomes part of the social struggle for power. Difference is transformed into inequality. Moreover, it is used to produce, legitimise and reproduce social inequalities by establishing difference and using difference thus constituted to ascertain where groups of people fit into the structures of power.

Alongside traits such as race, sexual orientation and class, health status has triggered stigma for centuries,⁷ with both the effects of disease and its mode of transmission serving as justification for ‘othering’ and marginalising those who have been afflicted. In particular, disease transmission is often depicted as having been the consequence of socially irresponsible and/or abhorrent behaviour. This construction of disease, as the just deserts of the deviant, has always been particularly prevalent in relation to sexually-transmitted diseases and predominates much social discourse around HIV. Thus, HIV infection is often depicted

⁶ PM Eba *Stigma[ta]: Aids Review 2007* (2008) 12. See also 11.

⁷ See examples discussed by B Bergman ‘AIDS, prostitution, and the use of historical stereotypes to legislate sexuality’ (1998) 21 *John Marshall Law Review* 777 791-92; Eba (n 6 above) 11.

as due punishment for promiscuity, sexual deviance or some other socially abhorrent behaviour.⁸

A significant purpose of stigma in this context is to conceptually separate those who are ill from the 'normal', unaffected population, so as to externalise the threat of the disease and appease public fears of contagion. By dividing society into groups of healthy 'us' and infected 'them' and simultaneously apportioning blame for infection upon those singled out by the fact thereof, members of society can at once reassure themselves that they are safe against infection and justify their lack of compassion with those who have fallen ill.⁹

The close relationship between disease-related stigma and social power structures is illustrated by the fact that such stigma more often than not attaches especially to groups who are in any event socially marginalised, disempowered or stigmatised based on other traits.¹⁰ Accordingly, the 'us/them' distinctions inherent to stigmatisation of HIV status overlap with and reinforces existing social divisions and result in the further labelling and scapegoating of groups who are already socially vulnerable. This is especially the case where existing social marginalisation and stigma relates to sexual practices.¹¹ Think, for instance, of widespread initial depictions of AIDS as a 'gay plague' — a form of divine punishment for the perceived sexual deviance of gay men.¹² Other groups similarly associated with HIV-related stigma include sex workers (who, through the ages, tend to bear the brunt of stigma pertaining to sexually-transmitted diseases),¹³ 'loose women', intravenous drug users, immigrants and prisoners.

Tellingly, while it is true (and arguably especially true in relation to HIV) that social marginalisation and vulnerability exacerbate the threat of disease and that stigmatised members of marginalised groups are therefore particularly vulnerable to infection, disease-related stigma predominantly attaches to such groups regardless of whether their association with an illness is epidemiologically warranted. Hence, gay men, sex workers and injecting drug users continue to bear the brunt of HIV-related stigma even in regions such as sub-Saharan Africa,

⁸ See Bergman (n 7 above) 778; Cameron (n 1 above) 88-89; Eba (n 6 above) 12 38; Kirby (n 2 above) 167; N Nongogo 'HIV testing and voluntary counselling in the context of stigma' in F Viljoen (ed) *Righting stigma: Exploring a rights-based approach to addressing stigma* (2005) 94 97-98; C Visser 'Floundering in the seas of human concern: AIDS, its metaphors and legal axiology' (1991) 108 *South African Law Journal* 619 629-630.

⁹ See Eba (n 6 above) 41-42; M Pieterse 'The interdependence of rights to health and autonomy in South Africa' (2008) 125 *South African Law Journal* 553 556 564 568; F Viljoen 'Stigmatising HIV/AIDS, stigmatising sex? A reply to Professor Van Wyk' (2000) 41 *Codicillus* 11 14 16; Visser (n 8 above) 625 628.

¹⁰ Eba (n 6 above) 12 17-18 24.

¹¹ Visser (n 8 above) 630-631.

¹² See Eba (n 6 above) 24 27-28; Visser (n 8 above) 625-626.

¹³ Bergman (n 7 above) 793; Eba (n 6 above) 38-40.

where the overwhelming mode of HIV transmission is by way of non-transactional, heterosexual sex.¹⁴

Of particular relevance for this article is the extent to which stigma and marginalisation, in relation to HIV and those associated with its spread, are embedded in metaphors of guilt and innocence, crime and punishment.¹⁵

Symbolic stigma is enshrined in the characteristics or behaviours of groups or individuals who are conceived as deviant, amoral and therefore blame-worthy. It derives its strength from the oppositions between good and bad, evil and virtue, punishment and innocence.

Not only do HIV-positive persons and members of marginalised groups who are typically associated with HIV infection tend to be viewed as being responsible for and deserving of their own HIV status, they are also often accused of being vectors of disease who 'deliberately' infect 'innocent victims' through their 'immoral' behaviour.¹⁶ Accordingly, HIV is often seen as due punishment for criminal deviance, while HIV-positive status is itself tainted with perceptions of criminality.

Of course, the very notion of criminality is acutely stigmatised — 'society's power over individuals is nowhere more intrusive, nor its moral condemnation more profound, than when society stigmatises and punishes individuals as criminals'.¹⁷ The label 'criminal' simultaneously triggers, exacerbates and legitimises societal condemnation and marginalisation of those branded thus, thereby providing publicly-sanctioned valorisation for stigma and associated victimisation.¹⁸ Not coincidentally, then, several states criminalise behaviour associated with marginalised groups that bear the brunt of HIV-related stigma, such as sex between men, prostitution, illegal immigration and drug use, despite none of these actions involving 'victims' in the conventional sense. Moreover, an increasing number of states have sought to criminalise certain instances of HIV transmission. Whereas attempts to justify such criminalisation tend to reference social morality and other communal goals such as protection of the public health, their reflection

¹⁴ Eba (n 6 above) 38; Johnson (n 2 above) 156.

¹⁵ Eba (n 6 above) 38. See also Visser (n 8 above) 629-630.

¹⁶ See E Bonthuys 'Women's sexuality in the South African Constitutional Court' (2006) 14 *Feminist Legal Studies* 391 397 399 407; S Burris 'Disease stigma in US public health law' (2002) 30 *Journal of Law, Medicine and Ethics* 179 183; Eba (n 6 above) 12 27-28 38-39; Nongogo (n 8 above) 98; Visser (n 8 above) 629-630.

¹⁷ JK Strader 'Criminalisation as a policy response to a public health crisis' (1994) 27 *John Marshall Law Review* 435 445-446.

¹⁸ Eba (n 6 above) 48; PM Eba 'Pandora's box: The criminalisation of HIV transmission or exposure in SADC countries' in F Viljoen & S Precious (eds) *Human rights under threat: Four perspectives on HIV, AIDS, and the law in Southern Africa* (2007) 13 44-45 47-48 51; N Hunt & J Derricott 'Smackheads, crackheads and other junkies: Dimensions of the stigma of drug use' in T Mason *et al* (eds) *Stigma and social exclusion in healthcare* (2001) 190 191 202; Strader (n 17 above) 446; UNAIDS *Criminal law* (n 2 above) 23-24.

of the interplay between the stigma associated with sexual and social deviance, illness and crime is glaringly apparent.¹⁹

The effects of the matrix of stigma elaborated above on the private and public lives of HIV-positive persons and members of marginalised groups are extensive and profound.²⁰ For purposes of this article, it is important to highlight that feelings of fear, guilt, shame and hopelessness caused and exacerbated by HIV-related stigma prevent members of stigmatised groups, and others at risk of contracting HIV, from seeking testing, treatment, or information on HIV prevention.²¹ This, coupled with general public resistance towards open and effective treatment and support programmes, targeted at marginalised and stigmatised groups,²² severely hampers public health efforts at containing the spread and effects of HIV.

3 HIV, social marginalisation and crime in Africa

Citizens, moreover, thought of punishment. Their minds were in tune with the moralising and stigmatising response that those who had spread the virus were unclean, immoral and dangerous to the community — people who needed to be controlled, checked and sanctioned.²³

Since the early days of the HIV pandemic, states have faced pressure from a fearful public to ‘do something’ to curb the spread of the disease. These calls have escalated where health systems have been unable to cope with the effects of HIV and AIDS or where public efforts to stop its spread have been unsuccessful. In these circumstances, and further fuelled by media reports of individual instances of ‘irresponsible’ and ‘willful’ transmission of HIV, states have tended to resort to ‘politically-safe and intellectually-easy’ options of using the criminal law, or coercive public health powers, in attempts to rein in the epidemic.²⁴ Accordingly, it has been argued that the appropriation of criminal law in this context may be understood as one of a number of ‘structural

¹⁹ Strader (n 17 above) 441.

²⁰ See, generally, Eba (n 6 above); Nongogo (n 8 above).

²¹ Eba (n 6 above) 45-47; Eba (n 18 above) 18; LO Gostin *et al* ‘The law and the public’s health: A study of infectious disease law in the United States’ (1999) 99 *Columbia Law Review* 59 65 92-93; Heneke (n 2 above) 753; Kirby (n 2 above) 176; UNAIDS *Criminal law* (n 2 above) 17.

²² See Eba (n 6 above) 48; D Wikler ‘Personal and social responsibility for health’ in S Anand *et al* (eds) *Public health, ethics, and equity* (2004) 109 125.

²³ Kirby (n 2 above) 167.

²⁴ Quote from Strader (n 17 above) 435. See also Strader 436 447; E Cameron & E Swanson ‘Public health and human rights: The AIDS crisis in South Africa’ (1992) 8 *South African Journal on Human Rights* 200 232; Kirby (n 2 above) 167; Eba (n 18 above) 14-15; M Pieterse & A Hassim ‘Placing human rights at the centre of public health: A critique of *Minister of Health, Western Cape v Goliath*’ (2009) 126 *South African Law Journal* 231; Viljoen (n 9 above) 14; UNAIDS *Criminal law* (n 2 above) 13.

interventions' aimed at reducing the level of health-risk behaviour in the population.²⁵

Africa has been no exception in this regard. Several states across the continent criminalise the wilful or negligent transmission of HIV, either by way of legislation explicitly targeting HIV transmission or through more general public health or criminal statutes that make it illegal and punishable for someone to expose others to dangerous communicable diseases.²⁶ In other states, prosecution of wilful transmission is possible in terms of 'ordinary' criminal law, as either assault or attempted murder, whereas HIV status is also often a factor relevant in the sentencing of rape offenders. In South Africa, for instance, a person convicted of rape while knowing that he is HIV positive must be sentenced to life imprisonment unless exceptional and compelling circumstances justify a lesser sentence, regardless of whether HIV transmission in fact took place.²⁷ There have further been at least one attempted murder conviction in relation to wilful HIV transmission in South Africa,²⁸ as well as instances where delictual claims for damages suffered by the 'victim' of reckless or negligent infection have been successful.²⁹

It is further relevant that a great number of African states criminalise sexual or other high-risk activity associated with marginalised groups. With a number of exceptions, homosexuality, commercial sex and drug use are illegal across the region.³⁰ While the proffered reasons for criminalising private activities of marginalised groups and the extent of their criminalisation extend beyond HIV, protection of the public health tends to be one of the named goals of relevant criminal law measures.³¹ For example, one of the South African government's defences against a constitutional challenge to the criminal prohibition of commercial sex work was that prostitution was associated with increased transmission of HIV and other sexually-transmitted diseases.³²

Indeed, there is sometimes a clearly-articulated link between the criminalisation of HIV transmission and that of marginalised sexual or

²⁵ Z Lazzarini *et al* 'Evaluating the impact of criminal laws on HIV risk behaviour' (2002) 30 *Journal of Law, Medicine and Ethics* 239.

²⁶ States with such legislation include Benin, Botswana, Guinea, Guinea Bissau, Lesotho, Malawi, Mali, Niger, Sierra Leone, Tanzania, Togo, Zambia and Zimbabwe. For a discussion of specific statutes and provisions, see Eba (n 18 above) 29-34; Johnson (n 2 above) 146-147.

²⁷ In terms of sec 51(1) read with sec 51(3) and part 1 of Schedule 2 to the Criminal Law Amendment Act 105 of 1997. See *S v Snoti* 2007 1 SACR 660 (E) and other reported and unreported decisions discussed by Cameron (n 1 above) 71-72 76-77; C van Wyk 'The impact of HIV/AIDS on bail, sentencing and medical parole in South Africa' (2008) 23 *SA Public Law* 50 52-53.

²⁸ See *S v Nyalungu* [2005] JOL 13 254 (T) as well as unreported cases discussed by Cameron (n 1 above) 77; Eba (n 18 above) 24 n 62.

²⁹ See *Venter v Nel* 1997 4 SA 1014 (D) and discussion by Cameron (n 1 above) 79.

³⁰ See Eba (n 15 above) 40 and authorities cited there.

³¹ See Cameron & Swanson (n 24 above) 202 204.

³² See *S v Jordan* 2002 6 SA 642 (CC) para 86.

other private conduct. One particularly egregious example of this is Uganda's current Anti-Homosexuality Bill, which not only deems sex between men a crime punishable with life imprisonment, but goes further to include same-sex activity by HIV-positive persons under the ambit of a crime called 'aggravated homosexuality' which, upon conviction, is punishable by death.³³

Proponents of using the criminal law to regulate HIV transmission typically emphasise the necessity of ensuring that people behave 'responsibly' towards others and of protecting 'innocent' members of the public against the 'wilful', 'reckless' or 'negligent' conduct of certain ('irresponsible') HIV-positive individuals. It is typically advanced that the criminal law would deter high-risk conduct, while sending a clear message that such conduct is not tolerated in society and ensuring accountability for transgressions of this norm.³⁴ However, while acknowledging that it may be appropriate to involve the criminal law in isolated instances where individuals flagrantly and calculatedly infect others with a deadly or harmful disease,³⁵ the overwhelming majority of public health experts and human rights advocates strongly oppose its broader application in this context.

By and large, this opposition relates to the fact that employing the criminal law in order to curb the spread of disease, and in particular HIV, simply does not work. Since HIV is spread predominantly by means of consensual, heterosexual sex, often within stable relationships, it is unrealistic to expect that criminal law will be consistently and uncomplicatedly invoked by the 'victims' of transmission. Unsurprisingly, therefore, there have been precious few prosecutions and even fewer convictions for deliberate or negligent HIV transmission around the world.³⁶ Moreover, where prosecution is attempted under 'ordinary' criminal laws, it is virtually impossible to satisfy all the elements of relevant crimes. This is due, first, to significant problems establishing preconditions for culpability such as intent or causation and, secondly, to the prickly issue of victims' consent to the high-risk activity in question.³⁷ HIV-specific statutes, which tend to contain a range of far-reaching (and often somewhat bizarre) provisions aimed

³³ See secs 2-3 of the Anti-Homosexuality Bill 18 of 2009.

³⁴ See C van Wyk 'The need for a new statutory offence aimed at harmful HIV-related behaviour: The general public interest perspective' (2000) 41 *Codicillus* 2 4-7 10; Van Wyk (n 28 above) 63.

³⁵ See M Brazier & J Harris 'Public health and private lives' (1996) 4 *Medical Law Review* 171 179 188-191; Cameron & Swanson (n 24 above) 220; Eba (n 18 above) 23; F Viljoen 'Verligting of verlustiging: Regshervorming in 'n tyd van VIGS' (1993) 110 *South African Law Journal* 100 110; Viljoen (n 9 above) 13 16; UNAIDS *Policy brief* (n 2 above) 1.

³⁶ Eba (n 18 above) 38; Lazzarini *et al* (n 25 above) 247; Strader (n 17 above) 443.

³⁷ See Eba (n 18 above) 26-27; Strader (n 17 above) 443; UNAIDS *Criminal law* (n 2 above) 22-23.

at circumventing these difficulties,³⁸ are also seldom and inconsistently invoked, with limited success. Apart from a very rare number of cases of flagrant and calculated transmission where preconditions for culpability are clearly satisfied, the consensual and private nature of behaviour likely to lead to HIV transmission together with the fact that transmission does not always result from such behaviour, and that the source of HIV infection cannot always be accurately pinpointed, mean that the mechanism of the criminal law is poorly equipped to detect and prove transgressions.³⁹

Studies further show unequivocally that criminal law, in resting on erroneous assumptions of sex and drug use as rational, free, informed and calculated behaviour, entirely fails to deter high-risk conduct or, consequently, to protect people against HIV transmission.⁴⁰ Indeed, the false sense evoked by the criminal law among HIV-negative people that they are being protected against 'agents of disease' and thus need not themselves take precautions against HIV, may paradoxically increase their vulnerability to infection.⁴¹

Ultimately, it would seem that the only purpose fulfilled by the criminal law in relation to HIV transmission is a symbolic one.⁴² Unfortunately, this symbolism is severely problematic. It fosters and reinforces a discourse of culpability and blame around HIV transmission, which serves to locate the responsibility for HIV prevention solely with HIV-positive people, thereby denying the general responsibility upon everybody to protect themselves from infection.⁴³ Its effect is to label people as criminals, simply by virtue of their being sick or vulnerable to illness. In so doing, it fuels public fear and hysteria surrounding HIV and exacerbates the othering and stigmatising of those affected by or vulnerable to the disease. This, in turn, increases social hostility towards members of marginalised groups and increases their vulnerability to victimisation based on their actual or perceived HIV status.⁴⁴

³⁸ For examples, see Eba (n 18 above) 34-37.

³⁹ Brazier & Harris (n 35 above) 184; Lazzarini *et al* (n 25 above) 251.

⁴⁰ See BD Adam *et al* 'Effects of the criminalisation of HIV transmission in men reporting unprotected sex with men' (2008) 23 *Canadian Journal of Law and Society* 143 157; Cameron & Swanson (n 24 above) 204 207; Eba (n 18 above) 38-39; Eba (n 6 above) 58; LO Gostin & Z Lazzarini *Human rights and public health in the AIDS pandemic* (1997) 106; Strader (n 17 above) 442 445; UNAIDS *Policy brief* (n 2 above) 1 4; UNAIDS *Criminal law* (n 2 above) 21.

⁴¹ Bergman (n 7 above) 816-817; Viljoen (n 9 above) 14.

⁴² Brazier & Harris (n 35 above) 184; Lazzarini *et al* (n 25 above) 252.

⁴³ Adam *et al* (n 40 above) 143-144; Cameron & Swanson (n 24 above) 220; Heneke (n 2 above) 764; UNAIDS *Policy brief* (n 2 above) 5; Viljoen (n 35 above) 111-112; Viljoen (n 9 above) 14.

⁴⁴ Bergman (n 7 above) 818; Bonthuys (n 16 above) 397; Brazier & Harris (n 35 above) 184; Eba (n 6 above) 46 48; Eba (n 18 above) 44; Heneke (n 2 above) 762; Lazzarini *et al* (n 25 above) 247; Viljoen (n 9 above) 13; Viljoen (n 35 above) 113; UNAIDS *Policy brief* (n 2 above) 5.

Indeed, due to the overlap between stigma flowing from HIV status and from membership of marginalised groups, there is a real risk, borne out by preliminary studies, that members of marginalised groups will be selectively targeted for prosecution in terms of HIV-related crimes. This possibility is enhanced where perceived high-risk activities associated with marginalised groups, such as transactional or male-to-male sex, or drug use, are themselves criminalised.⁴⁵ Ironically, epidemiological evidence shows unequivocally that such selective enforcement would misfire severely – whilst members of marginalised groups who are already tainted with perceptions of criminality present useful ‘sitting duck’ scapegoats for criminal campaigns, it is non-stigmatised, ‘everyday’ heterosexual sex that will remain the main driver of the African HIV epidemic, undetected by law enforcement.⁴⁶

The overall effect of the increased stigmatisation and marginalisation of HIV-positive people and members of marginalised groups, occasioned by criminalisation of both HIV transmission and high-risk activity is, first, to hamper HIV-prevention and education efforts (for instance, by complicating AIDS awareness campaigns and condom distribution among prisoners, sex workers and men who have sex with men) and, secondly, to deter people from seeking information, testing, treatment and support for HIV, for fear of exposure, stigma, victimisation and prosecution. Paradoxically, therefore, the effect of criminalising HIV transmission is to fuel the epidemic, by driving it underground and beyond the reach of public health initiatives.⁴⁷

Accordingly, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has strongly cautioned against the creation of HIV-specific crimes. It has recommended that, if the criminal law is to be appropriated at all in the fights against HIV and AIDS, its role should be limited to punishing exceptional cases of actual and deliberate HIV transmission in instances where all elements of existing criminal offences are clearly present.⁴⁸

⁴⁵ Bergman (n 7 above) 816; Cameron & Swanson (n 24 above) 221; Eba (n 6 above) 48; Eba (n 18 above) 40-47; Gostin & Lazzarini (n 40 above) 106; Viljoen (n 35 above) 113; UNAIDS *Criminal law* (n 2 above) 26; UNAIDS *Policy brief* (n 2 above) 4.

⁴⁶ Cameron & Swanson (n 24 above) 207-209.

⁴⁷ Brazier & Harris (n 35 above) 184; Cameron & Swanson (n 24 above) 207-209 220-221; Eba (n 18 above) 42-44 51; Gostin & Lazzarini (n 40 above) 106; Heneke (n 2 above) 763; R Jurgens *et al* ‘People who use drugs, HIV and human rights’ (July 2010) *The Lancet* 97 101; Viljoen (n 35 above) 111; Viljoen (n 9 above) 15; LE Wolf & R Vezina ‘Crime and punishment: Is there a role for criminal law in HIV prevention policy?’ (2004) 25 *Whittier Law Review* 821 869; UNAIDS *Policy brief* (n 2 above) 4-5; UNAIDS *Criminal law* (n 2 above) 24-25.

⁴⁸ UNAIDS *Criminal law* (n 2 above) 27 32 39. See also Johnson (n 2 above) 147.

4 Human rights-infused, public health approach to HIV prevention

Public health measures tend to be mooted as the obvious alternative to criminalisation when it comes to combating HIV.⁴⁹ This is because disease prevention or health-maximisation efforts grounded in public health law, unlike criminal law, tend to focus on minimising vulnerability to disease rather than on assigning and punishing culpability for its spread.⁵⁰ Yet, public health law is also steeped in a tradition of coercion and control⁵¹ and its most readily-appropriated measures, such as mandatory testing, quarantine and isolation policies, have proved as controversial and potentially counterproductive in combating HIV and other serious diseases as has criminal law.⁵²

In recent years, however, there has been a shift in emphasis in public health law, away from control and towards protection and fulfilment of individual human rights.⁵³ In particular, the infiltration of human rights discourse into public health law has led to the elevation of the rule of law and adherence to the proportionality principle in the formulation and implementation of public health policies.⁵⁴ Today, public health policies are typically evaluated for human rights compliance by inquiring into the proportionality between their purpose and their human rights impact, with particular emphasis placed on the extent to which the measures succeed in achieving their purpose and on whether the purpose could be achieved through measures that are less restrictive of individual rights.⁵⁵

⁴⁹ See Eba (n 18 above) 51; UNAIDS *Criminal law* (n 2 above) 28.

⁵⁰ See, eg, arguments advanced in favour of a public health approach to HIV prevention in the context of intravenous drug use by D Wolfe & K Malinowska-Sempruch 'Seeing double: Mapping contradictions in HIV prevention and illicit drug policy worldwide' in C Beyrer & HF Pizer (eds) *Public health and human rights: Evidence-based approaches* (2007) 330 335-336 345-346.

⁵¹ See, in a different context, L London 'Confinement in the management of drug-resistant TB: The unsavoury prospect of balancing individual human rights and the public good' (June 2008) 1 *SA Journal of Bioethics and Law* 11 12.

⁵² See Brazier & Harris (n 35 above) 184-185; Eba (n 18 above) 54; UNAIDS *Criminal law* (n 2 above) 29-30.

⁵³ See Cameron (n 1 above) 54-55; Cameron & Swanson (n 24 above) 202; Gostin & Lazzarini (n 40 above) 43; London (n 51 above) 12; Pieterse & Hassim (n 24 above) 232 245.

⁵⁴ See London (n 51 above) 13-14; C Ngwenya 'Responses to AIDS and constitutionalism in South Africa' (2003) 24 *Obiter* 299 300-301 305.

⁵⁵ See Cameron & Swanson (n 24 above) 212-213; JF Childress & RG Bernheim 'Beyond the liberal and communitarian impasse: A framework and vision for public health' (2003) 55 *Florida Law Review* 1191 1202-1203; L Gostin & JM Mann 'Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies' (1994) 1 *Health and Human Rights* 58-80; Gostin & Lazzarini (n 40 above) 57-57; London (n 51 above) 13; Pieterse & Hassim (n 24 above) 232-233. This mirrors the inquiry, under various constitutional systems, into the legitimacy of justifications offered in favour of restrictions of individual rights.

It should be clear from the discussion above that, save in isolated instances of deliberate and actual infection, criminal law measures aimed at controlling the spread of HIV are not proportional to the significant human rights burden that they impose, not least because of their complete lack of effectiveness. Similarly, 'traditional', coercive public health measures such as isolation or quarantine tend to impose a human rights burden on HIV-positive persons that is entirely disproportionate to the (limited) public health gains associated with their implementation. They are therefore generally regarded as being inappropriate for the prevention and control of HIV, except in exceptional circumstances.⁵⁶

Apart from highlighting the shortcomings of criminal or coercive laws in combating disease, human rights principles also provide the blueprint for a more appropriate approach to public health. Indeed, as reflected by the experience in countries such as South Africa, respect for and protection, promotion and fulfilment of human rights (including rights to liberty, dignity, equality, freedom from discrimination, access to information and access to health care services) can significantly enhance public health objectives. This is because adherence to these rights reduces stigma, increases public trust and voluntary participation in public health programmes and directs people who become infected with communicable diseases towards (rather than away from) the health system, in order to obtain appropriate care.⁵⁷ As Wolf and Vezina have noted:⁵⁸

Co-operative approaches to preventing transmission are far more successful than coercive approaches when dealing with a disease characterised by social stigma, misunderstanding, fear, and personal shame. Messages recognising the diverse circumstances of HIV-infected people, the difficult and imperfect prospects of changing private sexual behaviors, and the pressing needs of people living with HIV, are ultimately more effective than threats of prosecution and incarceration.

Given, first, that members of marginalised social groups bear the brunt of HIV-related stigma, secondly, that the extent of their marginalisation and vilification increases their vulnerability to HIV infection and, thirdly, that the combination of marginalisation and stigma have the effect of driving them away from the health system in much the same way as with the criminalisation of HIV transmission, it is also necessary

See, eg, the limitation clause in sec 36 of the 1996 South African Constitution.

⁵⁶ Cameron & Swanson (n 24 above) 212-217; Wolf & Vezina (n 47 above) 831; UNAIDS *Criminal law* (n 2 above) 17-18.

⁵⁷ See Cameron (n 1 above) 52-55; Cameron & Swanson (n 24 above) 202 212-213; Childress & Bernheim (n 55 above) 1197 1207; CT Cook & K Kalu 'The political economy of health policy in sub-Saharan Africa' (2008) 27 *Medicine and Law* 29 36; Gostin & Mann (n 55 above) 75 77; Gostin & Lazzarini (n 40 above) 43 47; Kirby (n 2 above) 167-168; London (n 51 above) 12; Pieterse & Hassim (n 24 above) 232; Wolf & Vezina (n 47 above) 830-831.

⁵⁸ Wolf & Vezina (n 47 above) 831.

to consider the manner in which criminal and coercive laws impact on the lives of vulnerable and marginalised groups. As with the criminalisation of HIV, the general consensus appears to be that subjecting already stigmatised minority groups to the further stigma and sanction of the criminal law is both highly inappropriate and utterly counterproductive from a public health perspective.

For this reason, UNAIDS has recommended that states decriminalise all forms of consensual adult sexual activity.⁵⁹ This recommendation pertains particularly to homosexuality and adult sex work, the continued widespread criminalisation of which appears to serve little purpose other than to enforce antiquated moral values and has been singled out as the main obstacle for HIV prevention and control measures, particularly in Africa.⁶⁰

While the broader human rights arguments in favour of decriminalising sex work and homosexuality are different (in that criminalising homosexuality impacts on identity and personhood in a manner that criminalising sex work arguably does not, whereas the criminalisation of sex work overlaps more visibly with the oppression of women), the public health reasons for doing so are identical. In both cases, the moral goals of criminalisation are ethically questionable whereas the public health goals are remote and somewhat spurious. In both cases, criminalisation fails dismally to either deter the sexual conduct in question or to alleviate the health risks associated therewith and appears to have little effect other than to fuel stigma and legitimise victimisation. Finally, in both cases, criminalisation increases vulnerability to HIV infection by increasing vulnerability to sexual violence, by complicating access to condoms and sexual health services and information, and by deterring HIV testing and treatment seeking.⁶¹

Yet, in the face of public demand for scapegoats for health and social problems, state responses to calls for the decriminalisation of sex work and homosexuality have been disappointing, particularly in Africa. In relation to homosexuality, South Africa's Constitutional Court has led the way by declaring criminal prohibitions on male-to-male sex unconstitutional, because they unjustifiably violated the rights to equality, dignity and privacy of men who have sex with men. The Court acknowledged the links between the stigmatisation, criminalisation and victimisation of gay men and held that there was no legitimate government purpose

⁵⁹ UNAIDS *Criminal law* (n 2 above) 22.

⁶⁰ As above. See also C Boudin & M Richter 'Adult, consensual sex work in South Africa: The cautionary message of criminal law and sexual morality' (2009) 25 *South African Journal on Human Rights* 179 192; Johnson (n 2 above) 141; Kirby (n 2 above) 169; Viljoen (n 35 above) 113.

⁶¹ See Bergman (n 7 above) 823; Boudin & Richter (n 60 above) 192 196-197; Eba (n 18 above) 53; Johnson (n 2 above) 156; J Stadler & S Delany 'The "healthy brothel": The context of clinical services for sex workers in Hillbrow, South Africa' (2006) 8 *Culture, Health and Sexuality* 451 452 458; Viljoen (n 35 above) 113.

which could justify their continued criminalisation.⁶² Unfortunately, this judgment has not impacted elsewhere on the continent, where the trend has been towards increased criminalisation, as evidenced by Uganda's draconian draft legislation alluded to above.

As to sex work, the general trend towards criminalisation across Africa has, regrettably, been mirrored by a much less progressive judgment from the South African Constitutional Court. In *S v Jordan*, the majority of the Court upheld the criminal prohibition of adult sex work in South Africa, finding that criminalisation served 'important and legitimate' public purposes such as combating violence, drug use and exploitation of children, that sex workers were themselves partly responsible for the diminution of their dignity and that the social stigma attached to sex work was unrelated to its legal prohibition.⁶³ Apart from its deplorable reliance and reinforcement of gendered stereotypes pertaining to sexual expression, the majority judgment has been criticised for its conservative moralism, for perpetuating gendered discourses that blame sex workers (and women, generally) for the spread of sexually-transmitted diseases and for insinuating that individuals can forfeit the protection of the law by virtue of their 'private' lifestyle choices, all of which are inimical to a human rights-based approach to health-promotion.⁶⁴

Beyond sexual marginalisation, there have in recent years also been increased calls for the decriminalisation of drug use for public health and human rights reasons. Just like the criminalisation of sex work or homosexuality, criminal prohibitions on drug use are largely ineffective, and have the effect of increasing users' vulnerability to HIV and other health risks, by forcing them to conceal themselves, by hindering their access to appropriate health services and safer modes of drug injection, and by significantly complicating health systems' ability to reach them.⁶⁵ Unlike men who have sex with men or sex workers, however, drug users lack social visibility and their human rights tend to be denied or overlooked.⁶⁶ Predictably, there have been few moves towards decriminalising drug use worldwide, even in regions where the HIV epidemic is intravenous drug use-driven.

Instead of criminalisation, experts argue for the public health regulation of drug use. This would involve widespread education about the HIV and other health risks associated with 'unsafe' drug use, access to drug substitution therapy and other voluntary rehabilitative services, as well as the wide-scale implementation of harm-reduction measures

⁶² *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 1 SA 6 (CC). See specifically paras 23, 26-28 & 37.

⁶³ *S v Jordan* (n 32 above). See specifically paras 10, 15-16 & 24.

⁶⁴ See Bonthuys (n 16 above) 392 400 403 399; Boudin & Richter (n 60 above) 186 194; Pieterse (n 9 above) 568.

⁶⁵ See Hunt & Derricott (n 18 above) 192; Jurgens *et al* (n 47 above) 98 101-102; Wolfe & Malinowska-Sempruch (n 50 above) 336.

⁶⁶ Jurgens *et al* (n 47 above) 98; Wolfe & Malinowska-Sempruch (n 50 above) 335.

such as needle exchange programmes, which have empirically been proven to be effective in minimising the transmission of HIV, among other diseases.⁶⁷ Criminalising drug use at best complicates, and at worst prohibits, the implementation of such measures. This notwithstanding, 'most countries with injection-driven epidemics continue to emphasise criminal enforcement and demand for abstinence over the best practices of public health'.⁶⁸ Accordingly, UNAIDS has recommended that criminal laws, at the very least, should not hinder the implementation of needle exchange programmes,⁶⁹ while the international scientific community and participants at the 2010 World AIDS Conference in Vienna have recently called for 'the acknowledgment of the limits and harms of drug prohibition, and for drug policy reform to remove barriers to effective HIV prevention, treatment and care', for the decriminalisation of drug users and for the 'reorienting [of] drug policies towards evidence-based approaches that respect, protect and fulfil human rights [of drug users]'.⁷⁰

Overall then, an approach to public health law that foregrounds human rights requires the jettisoning of the criminal law, both in relation to HIV transmission and to the activities of marginalised groups whose social vulnerabilities tend to place them at increased risk of contracting HIV. While the practice in many African states remains to opt instead for a punitive approach to HIV prevention, the recently promulgated SADC Model Law on HIV and AIDS in Southern Africa presents a welcome step towards such a human rights-based approach.

Recognising 'the importance of a human rights-based and gender-sensitive approach, and the involvement of those vulnerable to and living with HIV, on adopting effective legislation',⁷¹ the Model Law aims to:⁷²

- (a) provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human rights law standards;
- (b) promote the implementation of effective prevention, treatment, care and research strategies and programmes on HIV and AIDS;

⁶⁷ See J Chalmers *Legal responses to HIV and AIDS* (2008) 80-83 86; LO Gostin & Z Lazzarini 'Prevention of HIV/AIDS among injection drug users: The theory and science of public health and criminal justice approaches to disease prevention' (1997) 46 *Emory Law Journal* 587 644 648 677-682; Jurgens *et al* (n 47 above) 97.

⁶⁸ Wolfe & Malinowska-Sempruch (n 50 above) 335.

⁶⁹ UNAIDS *Criminal law* (n 2 above) 22.

⁷⁰ Vienna Declaration (2010) <http://www.viennadeclaration.com> (accessed 31 March 2011). On the systemic advantages of a 'public health' rather than criminal justice approach to drug use, see further Gostin & Lazzarini (n 67 above) 590-592 642; RA Weisheit & JM Klofas 'The public health approach to illicit drugs' (1998) 23 *Criminal Justice Review* 197-207.

⁷¹ Preamble Model Law. See http://www.chr.up.ac.za/images/files/research/ahrru/news/ahrru_news_08_model_law_hiv_southern_africa.pdf (accessed 30 April 2011).

⁷² Sec 1 Model Law.

- (c) ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected and realised in the response to AIDS; and
- (d) stimulate the adoption of specific measures at national level to address the needs of groups that are vulnerable and marginalised in the context of the AIDS epidemic.

The Model Law contains detailed provisions on HIV-related education and information campaigns,⁷³ prevention measures,⁷⁴ standards pertaining to HIV testing and counselling,⁷⁵ research and clinical trials,⁷⁶ as well as a substantial number of provisions elaborating the rights of HIV-infected and affected persons to, for instance, equality and non-discrimination, access to health care services, treatment, care and support, insurance, social security, education and work.⁷⁷

Importantly, the Model Law consistently reflects the intention to improve the position of marginalised groups in society in the context of HIV. For instance, it provides that HIV education and information campaigns must both include and promote acceptance of HIV-positive people as well as members of marginalised and vulnerable groups,⁷⁸ and requires that such people be included in male and female condom distribution programmes.⁷⁹ An entire chapter of the Law is devoted to HIV prevention in prisons. Suggested prevention measures include that prisoners be provided with condoms, lubricant and clean drug-injecting equipment.⁸⁰ The Model Law further recommends that members of vulnerable and marginalised groups be involved in 'the design, development and implementation of a national plan for the realisation of universal access to treatment, care and support services'.⁸¹

Crucially, the Model Law further requires states to 'ensure access to effective harm reduction programmes for drug users, including needle exchange and drug substitution therapy'⁸² and to consider decriminalising both adult sex work and consensual sexual relationships between persons of the same sex.⁸³ Unfortunately, this suggestion has not been phrased more imperatively. More disturbingly, the Model Law is silent on the criminal prohibition of intentional or negligent transmission of the HIV virus. While these omissions are lamentable, it is hoped that the African Commission's expressed concern over the increasing trend

⁷³ Secs 4-7 Model Law.

⁷⁴ Secs 9-11 Model Law.

⁷⁵ Secs 13-16 Model Law.

⁷⁶ Secs 37-39 Model Law.

⁷⁷ Secs 17-28 Model Law.

⁷⁸ Secs 4(2)(f)-(g) Model Law.

⁷⁹ Sec 11(1) Model Law.

⁸⁰ Sec 29(1) Model Law. See further secs 29-35.

⁸¹ Sec 36(5) Model Law.

⁸² Sec 11(3) Model Law.

⁸³ Sec 11(4) Model Law.

towards criminalisation in Africa, together with the recommendations of UNAIDS in this respect, will enter states' deliberations when they attempt to give effect to the provisions of the Model Law in their domestic health and legal systems.

5 Conclusion: Systemic responses to systemic problems

The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its ... spheres and the panoply of resources and skills of civil society are marshalled, inspired and led.⁸⁴

The constitutional right of the appellant not to be unfairly discriminated against cannot be determined by ill-informed public perceptions of persons with HIV.⁸⁵

The extent and scale of the havoc wreaked by the African HIV and AIDS epidemics and by associated diseases like tuberculosis are ascribable, first, to the widespread poverty and associated living conditions on the continent and, secondly, to the inability of antiquated, under-resourced and under-capacitated health systems to cope with a public health challenge of this magnitude. By focusing on individual behaviour and characteristics in their responses to the epidemic, states divert focus from these systemic causes.⁸⁶ Blaming and punishing marginalised social groups for systemic failures is not only blatantly unfair, but also detracts attention and resources from what is necessary to address the crisis.⁸⁷

The article has underlined that faith in criminal law to address public health problems is largely misplaced. Elevating illness to crime exacerbates stigma and accordingly undermines the achievement of public health goals. For the most part, criminalising individual behaviour perceived to involve a (public or private) health risk is similarly counterproductive. Instead of criminalisation, the article reiterates calls for public health laws to foreground adherence to human rights and associated public law principles. Doing this has the effect of strengthening health systems by showing up fault lines in existing arrangements, enhancing accountability, ensuring meaningful patient participation, redirecting wasteful expenditure from counterproductive punitive measures and highlighting public obligations in relation to health care service delivery.

⁸⁴ *Minister of Health v Treatment Action Campaign (No 2)* 2002 5 SA 721 (CC) para 123.

⁸⁵ *Hoffmann v South African Airways* 2001 1 SA 1 (CC) para 36.

⁸⁶ Cook & Kalu (n 57 above) 30 49; Johnson (n 2 above) 148; Kirby (n 2 above) 172 175; London (n 51 above) 12; Pieterse (n 9 above) 556 564 568 572; Pieterse & Hassim (n 24 above) 244-245; Strader (n 17 above) 447; Viljoen (n 9 above) 14.

⁸⁷ UNAIDS *Criminal law* (n 2 above) 17.

Responses to public health threats are most effective when grounded in science and in respect for individual rights. The HIV epidemic in Africa has for too long been fuelled by a lack of such grounding. African states have a legal obligation to 'take the necessary steps to protect the health of their people and to ensure that they receive medical attention when they are sick'.⁸⁸ In relation to HIV, this requires a commitment to health prevention policies that reduce stigma and vulnerability, while ensuring unencumbered access to prevention measures as well as to appropriate anti-retroviral treatment.⁸⁹ To the extent that health system strengthening is required to deliver on this commitment, that, rather than the scapegoating of those who are ill and vulnerable as a result of commitment failure, should be the focus.

⁸⁸ Art 16 African Charter on Human and Peoples' Rights.

⁸⁹ Cook & Kalu (n 57 above) 36; Kirby (n 2 above) 172 175.