

HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis

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Summary

As at 31 July 2014, 27 sub-Saharan African countries had adopted HIV-specific legislation to address the legal issues raised by the HIV and AIDS epidemics. The article provides the first comprehensive analysis of key provisions in these HIV-specific laws. It shows that HIV-specific laws include both protective and punitive provisions. Protective provisions often covered in these laws relate to non-discrimination in general or in specific areas, such as employment, health, housing and insurance. However, these non-discrimination provisions are often not strong enough to fully protect the human rights of people living with HIV and those affected by the epidemic. Punitive or restrictive provisions appear to be a defining feature of HIV-specific laws, both in terms of the number of countries that have adopted them and with regard to the diversity of restrictive provisions provided in these laws. Restrictive provisions often covered in HIV-specific laws include compulsory HIV testing, particularly for alleged sexual offenders, involuntary partner notification and criminalisation of HIV non-disclosure, exposure and transmission. In the great majority of cases, these provisions are overly broad, they disregard best available recommendations for legislating on HIV, fail to pass the human rights test of necessity, proportionality and reasonableness, consecrate myths and prejudice about people living with HIV, and risk undermining effective

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responses to the HIV epidemic. While noting these gaps and concerns in HIV-specific laws, the article calls for ensuring the effective implementation and enforcement of their protective provisions, while devising strategies to address their restrictive stipulations.

Key words: *HIV and AIDS; HIV-specific laws; non-discrimination; criminalisation; non-disclosure; exposure; transmission; human rights norms; Africa*

1 Introduction

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemics remain a serious public health challenge facing sub-Saharan Africa. In 2013, there were an estimated 24.7 million people living with HIV in sub-Saharan Africa, representing some 71 per cent of the global total.¹ In 2012, there were 1.2 million deaths due to AIDS-related illnesses in the region.² As of December 2012, an estimated 15 million children in sub-Saharan Africa had lost one or both parents to AIDS.³ Although important progress has been made in the response to HIV in the region – with a decline in new HIV infections and a significant increase in access to anti-retroviral treatment – the epidemic remains a leading cause of death.⁴ Moreover, serious social, legal and policy issues, such as stigma, discrimination, gender inequality and other negative norms and practices that make people vulnerable to HIV and hinder their access to HIV services, remain largely unchallenged.⁵

The law is considered a structural tool that can shape individual behaviour in the context of public health challenges such as HIV, and orient the manner in which states respond to these challenges.⁶ Consequently, all sub-Saharan African countries⁷ have adopted legislative, policy or other measures to respond to HIV. In their legal responses, many countries in the region (27 out of 45) have resorted to HIV-specific laws, as opposed to other forms of legislation (see annexure). Sometimes referred to as omnibus HIV legislation, HIV-specific laws are legislative texts that address, in a single document, several aspects of HIV, such as HIV-related education and

1 UNAIDS *The gap report* (2014) 26.

2 UNAIDS *Global Report. UNAIDS Report on the Global AIDS Epidemic* (2013) A43.

3 UNICEF *Towards an AIDS-Free Generation. Children and AIDS: Sixth Stocktaking Report 2013* (2013).

4 See UNAIDS *How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response* (2015).

5 See Global Commission on HIV and the Law *HIV and the law: Risks, rights and health* (2012); CI Grossman & AL Stangl (eds) 'Global action to reduce HIV stigma and discrimination' (2013) 16 *Journal of the International AIDS Society* 18881.

6 See, eg, J Hamblin 'The role of the law in HIV/AIDS policy' (1991) 5 *AIDS* s239-s243; L Gable et al 'A global assessment of the role of law in the HIV/AIDS pandemic' (2009) 123 *Public Health* 260-264.

communication, HIV testing, non-discrimination based on HIV status, HIV prevention, treatment, care and support and HIV-related research.⁸ Many countries in sub-Saharan Africa have resorted to HIV-specific laws because these laws make it possible, through a single piece of legislation, to address several aspects of the response to HIV, as opposed to the challenges and delays inherent in the adoption of a multitude of legislative amendments dealing with different aspects of HIV.⁹

Before November 2005, only three countries in sub-Saharan Africa (Angola, Burundi and Equatorial Guinea) had adopted HIV-specific laws. The 2004 development of Model Legislation on HIV/AIDS for West and Central Africa (also known as the N'Djamena Model Law) transformed the legislative landscape on HIV in sub-Saharan Africa and, particularly, in West and Central Africa.¹⁰ Four years later, some 13 West and Central African countries had adopted HIV-specific laws largely based on the N'Djamena Model Law.¹¹ Although presented as

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- 7 This article uses the regional grouping of countries of the Joint United Nations Programme on HIV/AIDS (UNAIDS). Under UNAIDS's regional grouping of countries, there are 45 sub-Saharan African countries, namely, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, South Africa, South Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
- 8 In a few cases, these laws also deal with the establishment of national mechanisms for responding to the HIV epidemic, such as national AIDS commissions. P Eba 'One size punishes all ... A critical appraisal of the criminalisation of HIV transmission or exposure through HIV-specific laws in sub-Saharan Africa' (2008) *AIDS Legal Quarterly* 1.
- 9 Countries such as South Africa, Botswana and Namibia have addressed HIV issues in general legislation without adopting HIV-specific laws. In South Africa, the Law Reform Commission under its Project 85 conducted a thorough review of legal issues relating to HIV, including employment, discrimination in schools, the criminalisation of HIV exposure or transmission and compulsory HIV testing of alleged sexual offenders. The review identified various areas for law reform, through general laws, to better respond to HIV and to protect human rights. See 'South African Law Reform Commission: Reports' <http://www.justice.gov.za/salrc/reports.htm> (accessed 15 November 2014).
- 10 See AWARE-HIV/AIDS 'Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report N'Djamena, 8-11 September 2014' (on file with author).
- 11 See R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12.
- 12 As above; Canadian HIV/AIDS Legal Network 'A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo' 2007 <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1530> (accessed 8 November 2014); 'Africa: "Terrifying" new HIV/AIDS laws could undermine AIDS fight' *Irinnews* 7 August 2008 <http://www.irinnews.org/report/79680/africa-terrifying-new-hiv-aids-laws-could-undermine-aids-fight> (accessed 8 November 2014); 'West Africa: HIV law "a double-edged sword"' *Irinnews* 1 December 2008 <http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword> (accessed 8 November 2014); UNAIDS 'UNAIDS recommendations for alternative language to some problematic articles in the N'Djamena legislation on HIV (2004)' 2008

a model approach to legislating on HIV, it has been criticised for its embrace of coercive approaches that violate human rights and risk undermining the existing response to HIV.¹²

On 31 July 2014, Uganda became the twenty-seventh sub-Saharan African country to enact HIV-specific legislation following assent by the Head of State to the HIV and AIDS Prevention and Control Act.¹³ This Act was criticised on the grounds that it raised both human rights and public health concerns similar to those in the N'Djamena Model Law.¹⁴

More than a decade after the first HIV-specific laws were adopted in sub-Saharan Africa, there is merit in conducting a comprehensive analysis of these laws to examine their key provisions against human rights and public health standards relating to HIV. The present desk research does this by focusing on 26 of the 27 HIV-specific laws that have been adopted in the region as of 31 July 2014.¹⁵ The study first describes global, regional and sub-regional human rights norms and public health recommendations that are relevant to HIV. It then uses these norms and recommendations as the framework for assessing how HIV-specific laws address four key issues, namely, HIV-related discrimination, rights violations in the workplace, HIV testing and the criminalisation of HIV non-disclosure, exposure and transmission. The study concludes with remarks on whether HIV-specific laws advance human rights in the context of HIV and makes specific recommendations for improving them.

2 Human rights norms applicable in the context of HIV

Although no global human rights treaty expressly addresses HIV, there are a wealth of norms and principles in general human rights treaties that are relevant to HIV and to the protection of people living with or affected by the epidemic. In particular, the open-ended grounds for prohibiting discrimination based on 'other status' in the International Covenant on Civil and Political Rights (ICCPR),¹⁶ the International

http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf (accessed 25 January 2015); D Grace 'Legislative epidemics: The role of model law in the transnational trend to criminalise HIV transmission' (2013) 39 *Medical Humanities* 77-84.

13 R Ninsiima 'Uganda: HIV law – After assent, Museveni under fire' *The Observer* 22 August 2014 <http://allafrica.com/stories/201408220430.html> (accessed 8 November 2014).

14 As above.

15 The analysis does not cover the HIV law of Equatorial Guinea. Although research confirmed the existence of HIV-specific law in this country, efforts to secure a copy of this legislation were not successful.

16 International Covenant on Civil and Political Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 52, UN Doc A/6316 (1966), 999 UNTS 171. See art 2.

Covenant on Economic, Social and Cultural Rights (ICESCR),¹⁷ and the Convention on the Rights of the Child (CRC)¹⁸ have been or can be interpreted to include non-discrimination based on health and HIV status.¹⁹ The provisions in these global treaties relating to the rights to liberty, security, equality, health, education, free and fair trial, among others, are also relevant to the HIV epidemic and for people living with or affected by HIV.²⁰ The monitoring bodies established under these treaties have on several occasions in General Comments and Concluding Observations affirmed relevant norms as being applicable to HIV.²¹

Similar to the situation at the global level, regional African human rights treaties – with the exception of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)²² – do not explicitly address HIV. However, key provisions, such as those relating to non-discrimination, liberty and security, health, education, prohibition of torture, inhuman and degrading treatment in the African Charter on Human and Peoples' Rights (African Charter),²³ the African Women's Protocol and the African Charter on the Rights and Welfare of the Child (African Children's Charter)²⁴ are relevant and applicable to HIV.²⁵ For example, in *Odafe & Others v Attorney-General & Others*,²⁶ the High Court of Nigeria invoked article 16 of the African Charter to vindicate the right of access to HIV treatment for prisoners.

In contrast to the silence of global and regional treaties on HIV, there is a wealth of non-binding instruments that assert human rights and public health recommendations in the context of HIV. Chief among these are the international guidelines on HIV/AIDS and human

17 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 49, UN Doc A/6316 (1966), 993 UNTS 3. See art 2.

18 Convention on the Rights of the Child, adopted 20 November 1989, GA Res 44/25, annex, 44 UN GAOR Supp (No 49) 167, UN Doc A/44/49 (1989). See art 2(1).

19 See, in particular, ESCR Committee 'General Comment No 20: Non-discrimination in economic, social and cultural rights (art 2, para 2 of the International Covenant on Economic, Social and Cultural Rights)' 2 July 2009 E/C 12/GC/20; Committee on the Rights of the Child 'General Comment No 3 (2003): HIV/AIDS and the rights of the child' CRC/GC/2003/1.

20 See AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* (2007).

21 As above.

22 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 13 September 2000, CAB/LEG/66.6. Art 14 of the African Women's Protocol explicitly addresses HIV and AIDS under health and reproductive rights.

23 African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc CAB/LEG/67/3 Rev 5; reprinted in C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2013) 29.

24 African Charter on the Rights and Welfare of the Child, adopted 11 July 1990, OAU Doc CAB/LEG/24.9/49; reprinted in Heyns & Killander (n 23 above) 77.

25 See AIDS and Human Rights Research Unit (n 20 above).

26 (2004) AHRLR 205 (NgHC 2004).

rights (International Guidelines) developed by the Second International Consultation on HIV/AIDS and Human Rights convened by UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR) in September 1996.²⁷ In addition, the resolutions adopted by the UN General Assembly Special Session on HIV in 2001,²⁸ the High-Level Meetings on HIV in 2006²⁹ and 2011,³⁰ as well as the resolutions on HIV of the Commission on Human Rights and later the Human Rights Council, also provide specific standards for the protection of human rights in the context of HIV.³¹ Finally, best practice recommendations for legislating on HIV, including those issued by the Inter-Parliamentary Union (IPU), UNAIDS, the United Nations Development Programme (UNDP) and the International Labour Organisation (ILO) are relevant to legal responses to HIV.³²

At regional and sub-regional levels in Africa, several non-binding instruments have been adopted in relation to HIV by the African Union (AU), the African Commission on Human and Peoples' Rights (African Commission), the East African Community (EAC), the Inter-Governmental Authority on Development (IGAD) and the Southern African Development Community (SADC).³³

Finally, general human rights provisions in the constitutions, legislation and case law of many sub-Saharan African countries offer standards for addressing HIV and for ensuring the protection of people living with or affected by the epidemic. For example, in *Banda v Lekha*,³⁴ the Industrial Court of Malawi asserted the applicability of the right to non-discrimination to HIV provided under the country's

27 Commission on Human Rights 'The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)' E/CN.4/RES/1997/33 11 April 1997 http://ap.ohchr.org/documents/all_docs.aspx?doc_id=4480 (accessed 7 March 2015). The International Guidelines were revised in 2002 (Guideline 6) and a consolidated version was published by UNAIDS and OHCHR in 2006. Reference to the International Guidelines in the present article relates to this consolidated version. UNAIDS & OHCHR *International Guidelines on HIV/AIDS and Human Rights, 2006 consolidated version* (2006).

28 UN General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS (A/RES/S-26/2) June 2001.

29 UN General Assembly Political Declaration on HIV/AIDS (A/RES/60/262) 15 June 2006.

30 UN General Assembly Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS UN Doc A/RES/65/277 10 June 2011.

31 For an overview of the resolutions on HIV of the Commission on Human Rights and the Human Rights Council, see <http://www2.ohchr.org/english/issues/hiv/document.htm> (accessed 7 March 2015).

32 See, notably, UNAIDS & IPU *Handbook for legislators on HIV/AIDS, law and human rights: Action to combat HIV/AIDS in view of its devastating human, economic and social impact* (1999); UNAIDS, UNDP & IPU *Taking action against HIV and AIDS: Handbook for parliamentarians* (2007); UNDP *Legal environment assessment: An operational guide to conducting national legal, regulatory and policy assessments for HIV* (2014); International Labour Conference *Recommendation 200: Recommendation concerning HIV and AIDS and the world of work* 99th session, 17 June 2010.

33 AIDS and Human Rights Research Unit (n 20 above).

34 (2005) MWIRC 44.

Constitution. The Court held that '[s]ection 20 of the Constitution prohibits unfair discrimination of persons in any form. Although the section does not specifically cite discrimination on the basis of ... HIV status, it is to be implied that it is covered under the general statement of anti-discrimination in any form.'

3 A human rights analysis of four key areas covered in HIV-specific laws

A review of HIV-specific laws in sub-Saharan Africa shows that these laws cover a broad range of issues, from non-discrimination based on HIV status to HIV education and information, blood and tissue safety, HIV testing and counselling, disclosure and notification of HIV test results and the criminalisation of HIV non-disclosure, exposure or transmission (Table 1). However, this analysis focuses on: HIV-related discrimination, HIV-related protection in the workplace, HIV testing and the criminalisation of HIV non-disclosure, exposure and transmission. Three reasons motivate the selection of these issues. First, they are among those most covered in HIV-specific legislation in sub-Saharan Africa (Table 1) and, as such, allow for a comparative analysis. Second, they are among the most critical to effective HIV responses and to the protection of the rights of people living with HIV. Finally, they have attracted the most criticism and concerns.³⁵

Table 1: Key issues addressed in HIV-specific laws in sub-Saharan Africa

Issue/area	Non-discrimination	Employment	HIV testing and counselling	Criminalisation of HIV non-disclosure, exposure and transmission
Number of HIV-specific laws addressing the issue (out of 26)	26	26	26	24 (except Comoros and Mauritius)

³⁵ See, eg, Pearshouse (n 11 above); Canadian HIV/AIDS Legal Network (n 12 above); 'Africa: "Terrifying" new HIV/AIDS laws could undermine AIDS fight' (n 12 above); C Kazatchkine 'Criminalising HIV transmission or exposure: The context of Francophone West and Central Africa' (2010) 14 *HIV/AIDS Law and Policy Review* 1-11; P Sanon et al 'Advocating prevention over punishment: The risks of HIV criminalisation in Burkina Faso' (2009) 17 *Reproductive Health Matters* 146-153; IPPF *Verdict on a virus: Public health, human rights and criminal law* (2008).

3.1 HIV-related discrimination

Translating international norms into specific guidance on non-discrimination in the context of HIV, the International Guidelines recommend that³⁶

[g]eneral anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face ... Direct and indirect discrimination should be covered, as should cases where HIV is only one of several reasons for a discriminatory act.

In terms of the International Guidelines and other relevant legislative guidance,³⁷ appropriate HIV-related non-discrimination provisions should cover the following: (i) actual or perceived HIV status; (ii) the HIV status of a person and that of others associated with them (eg family members or friends); (iii) indirect discrimination; and (iv) critical areas of protection, such employment, education, health and insurance and credit.

All 26 HIV-specific laws include one or more provisions that prohibit discrimination based on HIV status. In a significant number of countries (19 out of 26), these provisions prohibit discrimination based on both actual and presumed (or perceived) HIV status.³⁸ A handful of countries (five out of 26)³⁹ explicitly prohibit discrimination based on another person's HIV-positive status, and only one country (Chad)⁴⁰ explicitly prohibits indirect discrimination.

In 12 HIV-specific laws, anti-discrimination provisions include both a general prohibition of discrimination as well as specific provisions that prohibit discrimination in particular areas, such as employment, education, health, housing and insurance.⁴¹ Twelve countries prohibit discrimination in specific areas without an overarching non-discrimination provision.⁴² A total of 24 HIV-specific laws address HIV-related discrimination in specific areas. Only two countries (Mauritania and Mauritius) have a general non-discrimination provision without other clauses addressing discrimination in specific areas.⁴³ The areas most covered by the prohibition of discrimination include

36 OHCHR & UNAIDS (n 27 above) 31-32.

37 See n 32 above.

38 Burkina Faso (art 2); Cape Verde (arts 24(1) & 25); Comoros (art 17); Congo (art 27); Côte d'Ivoire (art 18); DRC (arts 10 & 20); Guinea-Bissau (art 29); Kenya (arts 31 & 32); Liberia (art 18(28)); Madagascar (arts 2 & 44); Mali (art 30); Mauritania (art 21); Mauritius (art 3); Niger (art 29); Senegal (art 24); Sierra Leone (art 39); Tanzania (arts 30 & 31); Togo (art 23); and Uganda (art 32).

39 Congo (art 27); DRC (arts 18 & 20); Madagascar (arts 2 & 39); Niger (art 29); and Togo (art 23).

40 Chad (art 28).

41 Benin, Burkina Faso, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Madagascar, Mozambique, Niger, Tanzania and Togo.

42 Angola, Burundi, Cape Verde, DRC, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Senegal, Sierra Leone and Uganda.

43 Mauritania (art 21) and Mauritius (art 3).

employment, education, health care, and access to insurance and credit. All 24 laws covering specific areas of discrimination either explicitly prohibit HIV-related discrimination in employment or forbid HIV testing as a condition for employment. Some 20 countries explicitly prohibit discrimination based on HIV status in education.⁴⁴ A total of 19 countries prohibit HIV-related discrimination in access to health care,⁴⁵ and some 17 countries prohibit HIV-related discrimination in accessing insurance and credit.⁴⁶

The prohibition of discrimination based on actual or perceived HIV status in almost all HIV-specific laws is important to protect individuals who may face discrimination, not because they are HIV positive, but for belonging to a group that is perceived to be at a higher risk of HIV infection, particularly sex workers, men who have sex with men and people who inject drugs. Members of these populations may experience HIV-related discrimination because their lifestyle, behaviour or life circumstances often lead to suspicion that they are living with HIV.

Of concern is the limited number of countries that explicitly cover non-discrimination based on someone else's HIV status. The failure to address this form of discrimination constitutes a gap because the fear and stigma relating to HIV may lead to many individuals being discriminated against, not because of their own HIV status, but because of that of their parents, spouses, relatives or associates. This gap particularly may affect children who could experience discrimination based on their parents' or caregivers' HIV-positive status.⁴⁷ The lack of attention in HIV-specific laws to indirect discrimination is also concerning because only one country explicitly addresses it. Indirect discrimination refers to 'laws, policies or practices which appear neutral at face value, but have a disproportionate impact on the exercise of ... rights as distinguished by prohibited

44 Angola (sec 5(g)); Benin (art 2); Burkina Faso (art 16); Burundi (art 32); Cape Verde (art 25); Chad (art 29); Comoros (art 23); Congo (art 29); DRC (art 16); Guinea-Bissau (art 30(1)); Kenya (art 32); Liberia (art 18(28)(c)); Madagascar (art 39); Mali (art 31); Mozambique (art 17); Niger (art 32); Senegal (art 25); Sierra Leone (art 40); Togo (art 26); and Uganda (art 33).

45 Angola (sec 5(a)); Benin (art 2); Burkina Faso (art 16); Cape Verde (art 29); Central African Republic (art 14); Comoros (art 21); Congo (art 26); DRC (art 10); Guinea (art 15); Guinea-Bissau (art 34); Kenya (art 36); Liberia (art 18(28)(c)); Madagascar (art 62); Mali (art 35); Senegal (art 29); Sierra Leone (art 44); Tanzania (art 29); Togo (arts 39 & 40); and Uganda (art 37).

46 Angola (sec 9); Benin (art 22); Burkina Faso (art 19); Burundi (art 38); Cape Verde (art 28); Chad (art 39); Comoros (art 26); Guinea (art 6); Guinea-Bissau (art 33); Kenya (art 35); Liberia (art 18(28)(c)); Mali (art 34); Niger (art 34); Senegal (art 28); Sierra Leone (art 43); Togo (arts 34 & 36); and Uganda (art 36).

47 See, eg, J Cohen 'Southern Africa: AIDS-affected children face systemic discrimination in accessing education' (2005) 10 *HIV/AIDS Policy and Law Review* 24-25; Human Rights Watch 'Letting them fail: Government neglect and the right to education for children affected by AIDS' October 2005 <http://www.hrw.org/sites/default/files/reports/africa1005.pdf>; PJ Surkan et al 'Perceived discrimination and stigma toward children affected by HIV/AIDS and their HIV-positive caregivers in central Haiti' (2010) 22 *AIDS Care* 803-815.

grounds of discrimination'.⁴⁸ For example, a law or policy requiring a physical medical examination as a pre-condition to enrol in schools could constitute indirect discrimination towards children living with HIV who may not be able to pass the test.⁴⁹

A further weakness in several non-discrimination provisions is that they do not prohibit discrimination generally but rather forbid specific discriminatory acts. For instance, in relation to non-discrimination in education, some HIV-specific laws only prohibit the refusal to allow entry into schools without attention to other measures that could be discriminatory towards HIV-positive learners in the context of education. This is, for instance, the case in the HIV laws of Niger,⁵⁰ Togo⁵¹ and Guinea-Bissau.⁵² Such provisions are too narrow in scope and would leave persons living with HIV, particularly children, without explicit protection in many instances.

In general, provisions in HIV-specific laws relating to non-discrimination in employment are more comprehensive than those dealing with non-discrimination in other areas. While one would understand the importance of devoting specific attention to non-discrimination in employment, there is no reason why areas such as education and health would not merit similar emphasis. Laconic non-discrimination provisions may in particular be problematic in areas such as insurance and access to credit. Most of the 17 HIV-specific laws with provisions relating to insurance and credit merely state that denial of insurance to people living with HIV is prohibited without elaborating on the nature or scope of insurance coverage or providing for subsequent regulations to appropriately address access to insurance and credit for people living with HIV.⁵³ Failure to precisely regulate these issues may, in practice, leave people living with HIV with limited protection against discriminatory practices by insurers.

3.2 HIV in employment

General human rights treaties (such as the ICCPR, the ICESCR and the African Charter) and specific HIV instruments (such as the International Guidelines) provide relevant principles on non-discrimination that apply to HIV and employment.⁵⁴ In addition, norms and principles on HIV in the workplace developed by the ILO

48 ESCR Committee (n 19 above) para 10(b).

49 A Meerkotter *Equal rights for all: Litigating cases of HIV-related discrimination* (2011) 25.

50 Art 32 HIV law of Niger.

51 Art 26 HIV law of Togo.

52 Art 30(1) HIV Law of Guinea-Bissau.

53 See, eg, sec 9 of the HIV law of Angola and art 18(28)(c) of the HIV law of Liberia.

54 In addition to general human rights treaties, all ILO Conventions applicable to the workplace are relevant in the context of HIV. ILO *HIV and AIDS and labour rights: A handbook for judges and legal professionals* (2013) 30-33.

provide frameworks for legislating on HIV in the workplace.⁵⁵ Chief among these is the ILO Recommendation concerning HIV and AIDS and the World of Work No 200 (Recommendation 200), which provides comprehensive guidance on addressing HIV in the context of employment.⁵⁶ Though not binding, Recommendation 200 is a standard adopted by ILO constituents (governments, employers and workers), which sets out key principles and rights relating to HIV in the workplace.⁵⁷

On the basis of Recommendation 200 and other norms applicable to HIV in the workplace, this study identified six areas for assessing the provisions of HIV-specific laws relating to the workplace. The areas for assessment are (i) non-discrimination in employment; (ii) the prohibition of HIV testing as a condition for employment; (iii) privacy and confidentiality in the workplace; (iv) reasonable accommodation for HIV-positive workers; (v) access to post-exposure prophylaxis in case of occupational exposure and compensation in case of occupational HIV infection; and (vi) the requirement for HIV policies and programmes in the workplace.

As discussed in the section on non-discrimination above, all but two HIV-specific laws address HIV-related discrimination in the workplace.⁵⁸ In 11 countries, the prohibition of HIV-related discrimination in employment explicitly addresses both actual and perceived HIV status.⁵⁹ In two countries (Burkina Faso and Burundi), the provisions addressing HIV in the workplace are narrowly drafted and only prohibit HIV testing as a condition for employment.⁶⁰ None of the 26 countries with HIV-specific laws have adopted the full set of six measures that are necessary to effectively address HIV in the workplace. Nineteen countries have provisions that explicitly require governments or employers to put in place HIV employment policies,

55 For a discussion of ILO norms and principles applicable to HIV in the workplace, see ILO *HIV and AIDS and labour rights: A handbook for judges and legal professionals* (2013).

56 International Labour Conference (n 32 above). Also important is the *ILO Code of practice on HIV/AIDS and the world of work* (ILO Code of Practice on HIV) adopted in 2001. Unlike Recommendation 200 which is a standard, the ILO Code of Practice on HIV only sets out practical guidelines for consideration by public authorities, employers and workers. It is not a binding instrument and does not create a particular obligation on states.

57 ILO *Rules of the game: An introduction to international labour standards* Revised edition (2009) http://ilo.org/wcmsp5/groups/public/-ed_norm/-normes/documents/publication/wcms_108393.pdf (accessed 5 November 2014); L Swepston 'The future of ILO standards' (1994) 117 *Monthly Labour Review* 16-23.

58 The two exceptions are Mauritania and Mauritius.

59 Cape Verde (art 24); DRC (art 20); Guinea-Bissau (art 29); Kenya (art 31); Liberia (art 18(28)(b)); Madagascar (art 44); Mali (art 30); Senegal (art 24); Sierra Leone (art 39); Tanzania (art 30); and Uganda (art 32(1)).

60 See art 19 of the HIV law of Burkina Faso and art 30(b) of the HIV law of Burundi.

training and programmes.⁶¹ For example, the HIV law of Tanzania provides that⁶²

[e]very employer in consultation with the Ministry shall establish and coordinate a workplace programme on HIV and AIDS for employees under his control and such programmes shall include provision of gender-responsive HIV and AIDS education, distribution of condoms and support to people living with HIV and AIDS.

Twelve countries have provisions that explicitly provide for access to post-exposure prophylaxis in the workplace, for compensation in case of occupational transmission of HIV, or both.⁶³ For example, the HIV law of Uganda provides that '[e]very health institution shall, within sixty days of the commencement of the Act, ensure that the universal precautions on post exposure prophylaxis ... are complied with'.⁶⁴ Six countries have provisions allowing for reasonable accommodation of people living with HIV to ensure that they remain employed with the necessary adjustments to their work, taking into account their health condition.⁶⁵ Finally, five countries have provisions that protect medical confidentiality in the workplace.⁶⁶

Effective responses to HIV in the context of employment require a broad range of measures, provided under Recommendation 200, that range from the prohibition of discrimination in the workplace to measures aimed at protecting HIV-positive employees and creating an enabling and non-discriminatory environment. The fact that a significant number of HIV-specific laws (19 out of 26) provide for HIV education and programmes in the workplace is positive. These programmes could contribute to create a positive and supportive environment for people living with HIV, provided that they are of sufficient quality and appropriately resourced.⁶⁷

However, the fact that none of the countries with HIV-specific laws has adopted the full set of six measures to address HIV in the workplace raises serious concerns. It is particularly worrying that in two countries, legislative responses to HIV in the workplace are limited to the prohibition of HIV testing as a condition for employment. Such

61 Angola (sec 7(3)); Benin (art 20); Cape Verde (arts 8 & 11); Central African Republic (art 23); Chad (art 40); Côte d'Ivoire (art 34); DRC (art 19); Guinea (art 3); Guinea-Bissau (art 3); Kenya (art 7); Liberia (art 18(7)); Madagascar (art 45); Mali (art 3); Mauritania (art 4); Mozambique (article 43); Niger (art 9); Senegal (art 6); Sierra Leone (art 22); and Tanzania (art 9).

62 Art 9 HIV law of Tanzania.

63 Angola (sec 11); Benin (art 21); Comoros (art 11); Côte d'Ivoire (art 17); DRC (art 23); Kenya (art 6); Madagascar (art 54); Niger (article 25); Senegal (art 10); Sierra Leone (art 26(3)); Tanzania (art 12(2)); and Uganda (art 32(5)).

64 Art 32(5) HIV law of Uganda.

65 Angola (sec 7); Benin (art 19); Chad (art 36); Central African Republic (art 22); Comoros (art 24); and Congo (art 31).

66 Chad (art 35); Côte d'Ivoire (art 31); DRC (art 26); Madagascar (art 49); and Tanzania (art 17(1)).

67 AP Mahajan et al 'An overview of HIV/AIDS workplace policies and programmes in Southern Africa' (2007) 21 *AIDS* 31-39.

narrow provisions are likely to be ineffective in addressing the multifaceted nature of discrimination and other HIV-related human rights violations in the workplace. For instance, employers may become aware of, or suspect, the HIV-positive status of their employees through, for example, the monitoring of sick leave patterns, and may then subject these workers to less favourable treatment in the workplace. Under provisions that only ban HIV testing as a condition for employment, such behaviour will not be deemed discriminatory.

In a number of HIV-specific laws, the prohibition of HIV testing as a condition for employment is relative and may be waived. In Liberia, HIV testing may take place as a condition for employment where 'it can be shown, on the testimony of competent medical authorities, that [an HIV-positive person] is a clear and present danger of HIV transmission to others'.⁶⁸ Because of the widespread fear, stigma and misconception relating to the risks of HIV transmission, such provisions could in practice lead to abusive application that would deny people living with HIV access to employment. This was, for instance, the case when South African Airways refused to hire an HIV-positive person as cabin attendant on 'safety, medical and operational grounds'.⁶⁹ These grounds were ultimately dismissed by the South African Constitutional Court, who ruled that 'the denial of employment to the appellant because he was living with HIV impaired his dignity and constituted unfair discrimination'.⁷⁰

Confidentiality regarding one's health status is a critical element of the right to privacy which should be protected in all settings, including in the workplace.⁷¹ The fact that only five countries explicitly address the protection of medical confidentiality in the workplace is a concern. Although many HIV-specific laws have general provisions on confidentiality regarding HIV test results,⁷² it is unclear whether these general confidentiality provisions pertaining to the obligation of health care workers to maintain patients' confidentiality in the workplace will in practice be interpreted as also applying to non-health care personnel.⁷³

With only six countries explicitly addressing this, the insufficient attention devoted to reasonable accommodation for HIV-positive workers is concerning. This is because, in spite of recent progress, access to anti-retroviral treatment in many sub-Saharan African

68 Art 18(28)(b) HIV law of Liberia.

69 *Hoffmann v South African Airways* (CCT17/00) [2000] ZACC 17 para 7.

70 *Hoffmann* (n 69 above) para 40. For a discussion of this decision, see C Ngwenya 'Constitutional values and HIV/AIDS in the workplace: Reflections on *Hoffman v South African Airways*' (2001) 1 *Developing World Bioethics* 42-56.

71 See, eg, International Labour Conference (n 32 above) paras 24-29; C Ngwenya 'HIV in the workplace: Protecting rights to equality and privacy' (1999) 15 *South African Journal on Human Rights* 513.

72 See, eg, art 25 of the HIV law of Mali.

73 As above.

countries remains limited and the quality of care for people living with HIV remains substandard. In the context of HIV, reasonable accommodation refers to 'any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS to have access to, or participate or advance in, employment'.⁷⁴ The failure to provide for reasonable accommodation leaves HIV-positive employees at the mercy of unfair dismissal. Moreover, in two of the countries that address reasonable accommodation, it is considered an option.⁷⁵ Therefore, employers have no obligation to provide for such measures for HIV-positive employees.

3.3 HIV testing in HIV-specific laws

HIV counselling and testing (HCT) is considered the gateway to HIV-related prevention, treatment, care and support services.⁷⁶ Those who test positive for HIV can be linked to HIV-related treatment and care services and they can receive specific counselling and support that enable them to lead safer and healthier lives. Those who test negative for HIV can also receive information and counselling that may reinforce HIV prevention messages and behaviour.⁷⁷ Despite the importance of HIV testing, more than half the adults living with HIV in sub-Saharan Africa are not aware of their HIV status.⁷⁸ This high percentage of people with an unidentified HIV status often leads to the late diagnosis of HIV infection, which compromises the effectiveness of HIV treatment and increases the odds of HIV-related morbidity and mortality.⁷⁹

Fear of stigma, discrimination and other human rights violations is considered to be among the main determinants of low and delayed HIV testing.⁸⁰ Human rights standards, together with 30 years of public health experience in addressing HIV, recommend that the most effective approaches to encouraging people to test for HIV are those

74 International Labour Conference (n 32 above) para 1(g).

75 Reasonable accommodation is an option in Angola (art 7) and Central African Republic (art 22). However, in Benin (art 19), Chad (art 36), Comoros (art 24) and Congo (art 31), it is an obligation for the employer.

76 UNAIDS 'Treatment 2015' (2013) 17.

77 WHO 'The right to know: New approaches to HIV testing and counselling' 2003 http://www.who.int/hiv/pub/vct/en/Right_know_a4E.pdf?ua=1 (accessed 21 February 2015).

78 UNAIDS (n 1 above) 12.

79 See IM Kigozi et al 'Late disease stage at presentation to an HIV clinic in the era of free anti-retroviral therapy in sub-Saharan Africa' (2009) 52 *Journal of Acquired Immune Deficiency Syndrome* 280; M May et al 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study' (2011) 343 *British Medical Journal* 6016.

80 A Mukolo et al 'Predictors of late presentation for HIV diagnosis: A literature review and suggested way forward' (2013) 17 *AIDS and Behaviour* 5-30.

that protect human rights.⁸¹ Respecting people's rights to liberty, security and privacy, including their rights to informed consent, autonomy and confidentiality, is instrumental in increasing the uptake of HIV testing.⁸² These experiences and best practices led to the adoption of voluntary HIV counselling and testing (VCT), anchored in the principles of confidentiality, pre- and post-test counselling and informed consent, also known as the '3Cs'.⁸³ Over the years, and in an effort to expand access to HCT, global and national public health policies have also endorsed provider-initiated testing and counselling (PITC).⁸⁴ In spite of this shift in policy,⁸⁵ the core principles of confidentiality, counselling and informed consent are still maintained in the context of HIV testing services.⁸⁶

Informed consent to medical procedures is derived from the rights to privacy, liberty and security, dignity, protection against cruel, inhuman and degrading treatment, and to health provided for under global and regional human rights law. As stated by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Special Rapporteur on Health):⁸⁷

Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination. All states parties to [ICESCR] have a legal obligation not to interfere with the rights conferred under the Covenant.

81 UNAIDS & WHO *UNAIDS/WHO Policy statement on HIV testing* (2004) 1; MA Chesney & AW Smith 'Critical delays in HIV testing and care: The potential role of stigma' (1999) 42 *American Behavioral Scientist* 1162-1174.

82 UNAIDS & OHCHR (n 27 above).

83 See UNAIDS & WHO (n 81 above). More recently, WHO and UNAIDS have been referring to '5Cs' by adding 'correct test results' and 'connection/linkage to prevention, care and treatment' to the original '3Cs'. WHO & UNAIDS 'Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing' 2012 http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/ (accessed 8 March 2015).

84 WHO & UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities* (2007). PITC refers to HIV testing and counselling recommended by a health-care provider in a clinical setting. It is defined in contrast to client-initiated testing, where an individual takes the initiative to seek information on his or her HIV status. PITC has now been endorsed by many countries in sub-Saharan Africa; see R Baggaley et al 'From caution to urgency: The evolution of HIV testing and counselling in Africa' (2012) 90 *Bulletin of the World Health Organization* 652-658B.

85 For a presentation on the debates and issues on evolving HIV testing policies, see R Jürgens 'Increasing access to HIV testing and counselling while respecting human rights – Background paper' 2007 <http://www.unaids.org.cn/pics/20120821114907.pdf> (accessed 8 February 2015).

86 See WHO & UNAIDS (n 84 above); UNAIDS & WHO (n 81 above) 1.

87 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/64/272, 10 August 2009 para 19.

Informed consent to HIV testing involves two complementary elements: access to information and knowledge, on the one hand, and full agreement, on the other.⁸⁸ Informed consent by a person to a medical procedure such as HIV testing,⁸⁹ therefore, requires that the person be provided with full information and knowledge, that they understand the information and, as a result, fully and freely agree to undergo HIV testing.⁹⁰ The Special Rapporteur on Health has also stressed that '[i]nformed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of a patient to be involved in medical decision making'.⁹¹ In this regard, the Supreme Court of Namibia has held that 'individual autonomy and self-determination are overriding principles ... require[ing] that in deciding whether or not to undergo an elective procedure, the patient must have the final word'.⁹² A similar patient-centred approach to informed consent was introduced into South African law in *Castell v De Greef*.⁹³

Confidentiality regarding HIV test results, and HIV status in general, is derived from the right to privacy which is enshrined in global and regional human rights treaties, including the ICCPR,⁹⁴ CRC⁹⁵ and African Children's Charter.⁹⁶ In particular, article 17 of the ICCPR provides:

No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

The International Guidelines further note that in the context of HIV, the 'right to privacy encompasses obligations to respect physical privacy, including the need to respect confidentiality of all information relating to a person's HIV status'.⁹⁷ The protection of confidentiality regarding HIV status is also important because of the negative consequences of unwarranted disclosure. As highlighted by the then Appellate Division in South Africa:⁹⁸

88 K Grant & A Meerkotter *Protecting rights: Litigating cases of HIV testing and confidentiality of status* (2012) 11.

89 HIV testing is recognised as a medical procedure. *C v Minister of Correctional Services* 1996 (4) SA 292 (T).

90 The High Court of South Africa concluded that the failure to provide pre-test counselling was an unlawful 'deviation from the accepted norm of informed consent'. *C v Minister of Correctional Services* (n 89 above).

91 Report of the Special Rapporteur on Health (n 87 above) para 9.

92 *Government of the Republic of Namibia v LM* [2014] NASC (3 November 2014) para 106.

93 1994 (4) All SA 63 (c) (S Afr).

94 Art 17 ICCPR.

95 Art 16 CRC.

96 Art 10 African Children's Charter.

97 UNAIDS & OHCHR (n 27 above) para 119.

98 *Van Vuuren & Another NNO v Kruger* 1993 (4) SA 842 (SAA) para 10.

There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

All 26 HIV-specific laws under review include provisions relating to HCT. The three principles of confidentiality, pre- and post-test counselling and informed consent are explicitly provided for in the great majority of these HIV-specific laws. All 26 HIV-specific laws affirm the principle of confidentiality regarding HIV test results, and assert informed consent as a condition for HIV testing or prohibit compulsory HIV testing. Furthermore, all but five countries have provisions on pre- and post-test counselling.⁹⁹ In a number of countries, such as Congo¹⁰⁰ and Guinea,¹⁰¹ specific provisions in the HIV law even detail the content of pre- and post-test counselling.

However, most HIV-specific laws allow for exceptions or limitations to the principles of informed consent and confidentiality. In general, HIV-specific laws allow for informed consent to HIV testing to be waived in three types of circumstances. First, some laws allow health care workers to perform an HIV test without informed consent in the context of access to treatment and care. For example, in Uganda informed consent is not needed if the patient 'unreasonably withholds' it.¹⁰² Similarly, informed consent is not required in Angola if it appears that HIV testing is needed for appropriate medical care.¹⁰³ Second, HIV-specific laws allow for non-consensual HIV testing in the context of personal relationships. For instance, in Burkina Faso, HIV testing is allowed to settle matrimonial disputes.¹⁰⁴ Thirdly, and most commonly, several statutes allow for compulsory HIV testing within the criminal justice system.

Exceptions to confidentiality in HIV-specific laws range from compulsory disclosure of HIV test results within the criminal justice system to the personal realm, with laws allowing the disclosure of HIV status to the parents or guardians of minors (persons below the age of 18) and non-voluntary disclosure to sexual partners. Although many of these exceptions raise concern, the analysis below focuses on two of these, namely, compulsory HIV testing in the context of sexual offences as an exception to informed consent, and non-voluntary

99 The five countries that do not explicitly provide pre- and post-test counselling in their HIV-specific laws are Angola, Burundi, Central African Republic, Madagascar and Niger.

100 Arts 21 & 22 HIV law of Congo

101 Art 1 HIV law of Guinea.

102 Art 11(a) HIV law of Uganda.

103 Art 22(1)(a) HIV law of Angola.

104 Art 19 HIV law of Burkina Faso.

notification of the partners of people living with HIV as an exception to confidentiality.¹⁰⁵

3.3.1 Compulsory HIV testing in the context of sexual offences

In terms of the International Guidelines, any exception to informed consent, including compulsory HIV testing, should be carefully considered. The International Guidelines stress in this regard that 'exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and liberty'.¹⁰⁶ They further point out that 'compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of the person'.¹⁰⁷ Similarly, the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Special Rapporteur on Torture) emphasised that '[f]orced or compulsory HIV testing is also a common abuse that may constitute degrading treatment if it is "done on a discriminatory basis without respecting consent and necessity requirements"'.¹⁰⁸ To meet human rights standards, provisions relating to compulsory HIV testing should satisfy general requirements relating to any limitation of human rights. Compulsory testing provisions should therefore (i) be provided under the law; (ii) be based on a legitimate interest; (iii) be proportionate to that interest; and (iv) constitute the least restrictive measure available and actually achieving that interest in a democratic society.¹⁰⁹

The analysis of HIV-specific laws adopted in sub-Saharan Africa shows that just over one-third of them (eight out of 26) explicitly allow for compulsory HIV testing in the context of sexual offences.¹¹⁰ Of these, five require compulsory HIV testing in the case of rape.¹¹¹ Five countries allow for compulsory HIV testing in the case of prosecution for HIV non-disclosure, exposure or transmission.¹¹² Four countries allow for compulsory HIV testing in case of sexual offences without defining which particular sexual acts fall under their ambit.¹¹³

¹⁰⁵ For a discussion of the other exceptions, see Pearshouse (n 11 above).

¹⁰⁶ UNAIDS & OHCHR (n 27 above) para 20(b).

¹⁰⁷ UNAIDS & OHCHR para 135.

¹⁰⁸ Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment A/HRC/22/53, 1 February 2013 para 71.

¹⁰⁹ See UN Commission on Human Rights *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* 1984 E/CN.4/1985/4; *Media Rights Agenda & Others v Nigeria* (2000) AHRLR 200 (ACHPR 1998); *Enhorn v Sweden* ECHR (Application 56529/00) 25 January 2005.

¹¹⁰ Burkina Faso (art 19); Guinea-Bissau (art 17(3)(a)); Kenya (sec 13(3)); Liberia (sec 18(21)(2)(b)); Mali (art 18(b)); Mauritania (art 15); Tanzania (sec 15(4)(c)); and Uganda (sec 12).

¹¹¹ Burkina Faso (art 19); Cape Verde (art 15(2)(b)); Liberia (sec 18(21)(2)(b)); Mali (art 18(b)); and Mauritania (art 15).

¹¹² Burkina Faso (art 19); Cape Verde (art 15(2)(a)); Guinea-Bissau (art 17(3)(a)); Liberia (sec 18(21)(2)(a)); and Mali (art 18(a)).

¹¹³ Guinea-Bissau (art 17(3)(b)); Kenya (sec 13(3)); Tanzania (sec 15(4)(c)); and Uganda (sec 12).

In addition to these, there are ten countries with provisions allowing for compulsory HIV testing when ordered by a court, which may be applied to sexual offences.¹¹⁴ For example, the HIV law of Mozambique allows for compulsory HIV testing 'when it is required for the purpose of criminal procedures with the prior order of a competent judicial authority'.¹¹⁵

The provisions allowing for compulsory HIV testing in the context of sexual offences raise a number of human rights and public health issues.¹¹⁶ The human rights concerns raised by these provisions relate, first, to the fact that many of the provisions are silent on the nature of sexual offences for which an HIV test is considered compulsory. This implies that compulsory HIV testing can occur in relation to all sorts of sexual offences, whether they involve a risk of HIV infection or not.

Second, many HIV-specific laws allow for compulsory HIV testing of individuals who are *charged* with a sexual offence. Some laws, such as that of Uganda, even allow for HIV testing of a 'person who is *apprehended* for a sexual offence'.¹¹⁷ In either case, the person being subjected to HIV testing has not yet been found guilty of an offence and should consequently benefit from the presumption of innocence. To subject such a person to HIV testing without consent represents an infringement of the right to liberty, security and a fair trial provided for under international human rights law.¹¹⁸ The violation of these rights is particularly acute in the case of persons who are merely 'apprehended' for sexual offences, as is the case under the HIV law of Uganda. There is no justification, under human rights norms and in terms of public health, for blanket HIV testing of all people living with HIV accused of sexual offences. In a case relating to the blanket denial of bail to HIV-positive people alleged to have committed rape, the Botswana Court of Appeal rejected all justifications to such restrictions by noting, among others:¹¹⁹

It is beyond ... comprehension how depriving a person of his liberty merely because he is alleged to have committed rape – not, it must be stressed, because he is found guilty of it – can in any way reduce the crime rate, including rape or serve to contain or restrict the incidence of HIV/AIDS.

Thirdly, most HIV-specific laws that allow for compulsory HIV testing of sexual offenders are generally silent on the conditions, initiator,

114 Angola (sec 22(c)); Burundi (art 11(c)); Chad (art 4); Guinea (art 22(d)); Mozambique (art 25(1)(c)); Niger (art 11); Senegal (art 12); Tanzania (sec 15(4)(a)); Togo (art 6); and Uganda (sec 14).

115 Art 25(1)(c) HIV law of Mozambique.

116 Similar concerns have been raised about the provisions on compulsory HIV testing of sexual offenders under the Sexual Offences Act 2007 of South Africa. See S Roehrs 'Implementing the unfeasible: Compulsory HIV testing for alleged sexual offenders' (2007) 22 *South African Crime Quarterly* 27-32; K Naidoo & K Govender 'Compulsory HIV testing of alleged sexual offenders – A human rights violation' (2011) 4 *South African Journal of Bioethics and Law* 95-101.

117 Sec 12 HIV law of Uganda (my emphasis).

118 Naidoo & Govender (n 116 above) 95-101.

119 See *Attorney-General's Reference: In re The State v Marapo* [2002] 2 BLR 26.

process and timeline for conducting these tests, thus leaving these critical issues open to interpretation by law enforcement agents and courts. This lack of precision is likely to lead to procedural unfairness. There is also uncertainty, in most HIV-specific laws, about the rationale for imposing compulsory HIV testing in the context of sexual offences. Is the HIV test aimed at informing victims of sexual offences? Or is it intended to support a guilty verdict in a criminal law case? Or is the HIV test result expected to serve as an element for the imposition of higher penalties in the context of sexual offences? Who receives the result of the HIV test? Is it only the court? Does the alleged offender also receive it? None of these questions is clearly addressed under these laws.

Several HIV-specific laws in sub-Saharan Africa can also be criticised from a public health perspective because they may lead in practice to (over)focusing on the alleged offender to the detriment of survivors of sexual offences.¹²⁰ Instead of focusing on the alleged perpetrator of a sexual offence, HIV-specific laws should rather ensure that public health authorities and law enforcement agents provide and facilitate access to post-exposure prophylaxis (PEP) and support services for the survivors of sexual offences to prevent the transmission of HIV and other sexually-transmitted infections.¹²¹ In fact, most HIV-specific laws that allow explicitly for compulsory HIV testing of sexual offenders do not provide for PEP and other necessary medical and psychological services for survivors of sexual offences.

Finally, compulsory HIV testing for sexual offenders appears to be unnecessary from a public health perspective.¹²² This is because a negative HIV test result of the alleged offender does not conclusively prove that the survivor of the sexual offence was not exposed to HIV infection. Some alleged offenders might indeed be in the 'window period', during which period the rapid test used in the majority of sub-Saharan African countries will not detect the antibodies that indicate HIV infection.¹²³ Similarly, a positive HIV result of the offender does not mean that the survivor has contracted HIV. It is therefore precarious from a public health perspective to base access to HIV services for survivors of sexual offences on the HIV test results of the alleged offender. Also, by providing for compulsory HIV testing for all sexual offences without any consideration of the nature of sexual acts and the actual risk of HIV that they involve, HIV-specific laws contribute to perpetuating misinformation and prejudice about HIV and its modes of transmission.

120 Roehrs (n 116 above); Naidoo & Govender (n 116 above).

121 See DJ Mcquoid-Mason 'Free provision of PEP and medical advice for sexual offence victims: What should doctors do?' (2008) 98 *South African Medical Journal* 847-848.

122 Roehrs (n 116 above); Naidoo & Govender (n 116 above).

123 As above.

Arguably, provisions relating to compulsory HIV testing of sexual offenders in HIV-specific laws may be deemed to violate human rights because they are overly broad, unnecessary and do not hold any health benefit for survivors of sexual violence.¹²⁴

3.3.2 Partner notification

Partner notification is a public health measure that seeks to reduce the 'burden of asymptomatic disease in the community and to shorten the average period of infectiousness for a given disease' with the expectation that this will reduce the transmission of the disease.¹²⁵ It consists of identifying the sexual partners of people living with HIV and informing them that they may have been exposed to HIV, so as to ensure that they are tested and receive treatment, if required.¹²⁶ Well established in the context of sexually-transmitted diseases (STDs), at least in Western countries,¹²⁷ partner notification raises human rights and ethical concerns in the context of HIV and its utility is often questioned.¹²⁸ Yet, in recent years, the recognition of the prophylactic and prevention benefits of early initiation of anti-retroviral therapy seems to be leading to a renewed consideration of partner notification.¹²⁹

From a human rights perspective, partner notification requires striking a balance between the preservation of the individual right to privacy of the person living with HIV and the protection of public health, particularly in relation to the partner who may be at risk of HIV transmission or who may be HIV positive but may not be aware of it.¹³⁰ Unlike partner notification done with the consent of the person

124 As above.

125 M Adler & F Cowan 'Sexually-transmitted infections' in R Detels et al (eds) *Oxford textbook of public health Volume 3 The practice of public health Fourth edition* (2002) 1449.

126 As above.

127 EP Richards III 'HIV: Testing, screening and confidentiality – An American perspective' in R Bennett & CA Erin (eds) *HIV and AIDS: Testing, screening and confidentiality* (1999) 75-90.

128 See CG Pottker-Fishel 'Improper bedside manner: Why state partner notification laws are ineffective in controlling the proliferation of HIV' (2007) 17 *Health Matrix* 147-179; LA Gostin & JG Hodge Jr 'Piercing the veil of secrecy in HIV/AIDS and other sexually-transmitted diseases: Theories of privacy and disclosure in partner notification' (1998) 9 *Duke Journal of Gender, Law and Policy* 10-88; S Bott & CM Obermeyer 'The social and gender context of HIV disclosure in sub-Saharan Africa: A review of policies and practices' (2013) 10 *Journal of Social Aspects of HIV/AIDS* s5-s16.

129 See, eg, European Centre for Disease Prevention and Control 'Technical report: Public health benefits of partner notification for sexually-transmitted infections and HIV' 2013 <http://www.ecdc.europa.eu/en/publications/Publications/Partner-notification-for-HIV-STI-June-2013.pdf> (accessed 10 February 2015); National AIDS Trust 'HIV partner notification: A missed opportunity?' 2012 <http://www.nat.org.uk/media/files/policy/2012/may-2012-hiv-partner-notification.pdf> (accessed 15 February 2015).

130 S Roehrs 'Privacy, HIV/AIDS and public health interventions' (2009) 126 *South African Law Journal* 381-382; Pottker-Fishel (n 128 above); Gostin & Hodge (n 128 above) 62-68.

living with HIV, it is involuntary partner notification that raises serious ethical, human rights and practical issues.¹³¹ As it overrides the right to privacy of the person living with HIV, involuntary partner notification must be strictly framed so as to prevent abuse.¹³²

In practice, partner notification involves disclosure of confidential information about a patient by the health care worker, either directly to sexual partners or indirectly through public health officers.¹³³ This raises issues about the privileged nature of the relationship between patients and health practitioners.¹³⁴ The protection of the doctor-patient relationship is not just an ethical and legal duty on health care workers. It is also necessary to ensure trust in health care systems so that people come forward to seek HIV and other health services. As noted by the European Court of Human Rights:¹³⁵

Respecting the confidentiality of health data is a vital principle ... It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.

The International Guidelines, therefore, provide narrow circumstances for regulating involuntary partner notification so as to protect human rights, while pursuing public health goals.¹³⁶ On the basis of the International Guidelines and best available recommendations, the following four key elements are highlighted to assess the provisions on involuntary partner notification in HIV-specific laws adopted in sub-Saharan Africa. These are that (i) the opportunity to notify should first be given to the HIV-positive person; (ii) partner notification is an option (not an obligation) for the health care provider; (iii) notification should only occur where there is a risk of HIV infection to another;¹³⁷ and (v) fear of violence and other serious negative consequences should preclude partner notification by health care workers.¹³⁸

The assessment of HIV specific laws in sub-Saharan African countries shows that nearly all of them (21 out of 26) have provisions allowing for involuntary partner notification. In 17 of these countries, involuntary partner notification can occur only after the person living with HIV has first been given the opportunity to inform the sexual partner but did not do so. In a significant number of countries (17 out

131 As above.

132 As above.

133 Richards (n 127 above).

134 Roehrs (n 130 above) 381-382; Pottker-Fishel (n 128 above) 156-157; Gostin & Hodge Jr (n 128 above) 62-68.

135 *I v Finland* ECHR (Application 20511/03) 17 July 2008 para 38.

136 UNAIDS & OHCHR (n 27 above) para 20(g).

137 As above.

138 This element is not part of the provisions on involuntary partner notification of the International Guidelines, but is recommended by UNAIDS because of the serious negative consequences of non-voluntary HIV disclosure, particularly for women. See UNAIDS (n 12 above).

of 21), partner notification is an option (choice) for health care workers who can decide whether to notify the sexual partner. Some 11 countries require the existence of a risk of HIV transmission to the sexual partner as a condition for involuntary notification. Only four countries provide for fear of violence as a reason that precludes involuntary partner notification (see Table 2).

Table 2: Involuntary partner notification in HIV-specific laws

Countries allowing for involuntary partner notification (21 countries)	Opportunity first given to HIV positive person to notify (17 countries)	Option to notify for health care worker (17 countries)	Risk of HIV infection as reason for notification (11 countries)	Fear of violence as reason for not notifying (4 countries)	Timeline for notification (7 countries)
Angola (sec 13(2))	No	Yes	Yes	No	No
Benin (arts 4 & 6)	Yes	Yes	Yes	No	No
Burkina Faso (arts 7 & 8)	Yes	No (obligation)	No	No	Yes (immediately, art 7)
Burundi (art 28)	Yes	No (obligation)	No	No	No
Cape Verde (art 22)	Yes	Yes	No	No	Yes (6 weeks, art 22(1))
Chad (art 51)	Yes	No (obligation)	No	No	No
Central African Republic (art 8(4))	No	Not provided	Yes	No	No
Comoros (art 33)	Yes	Yes	Yes	Yes	No
Cote d'Ivoire (arts 11 & 12)	Yes	Yes	No	No	Yes (3 months, art 12)
DRC (art 41)	Yes	Yes	No	No	Yes (immediately art 41)
Guinea (art 23)	Yes	Yes	Yes	Yes	No
Guinea-Bissau (art 26)	Yes	Yes	No	No	Yes (6 weeks, art 26(1))
Kenya (sec 24(7))	Yes	Yes	No	No	No
Liberia (sec 18(24))	Yes	Yes	Yes	Yes	No
Madagascar (art 63)	Yes	Yes	Yes	No	No
Mali (art 27)	Yes	Yes	No	No	Yes (6 weeks, art 27(1)).
Niger (arts 15 to 17)	Yes	Yes	Yes	No	Yes (6 weeks, art 15)
Senegal (art 22)	Yes	Yes	Yes	No	No

Tanzania (sec 16(2)(c).	No	Yes	No	No	No
Togo (art 10)	Yes	Yes	Yes	Yes	No
Uganda (sec 18(2)(e)	No	Yes	Yes	no	No

There are two positive elements that stem from this analysis. First, a significant number of countries (17 out of 21) allowing for involuntary partner notification give the opportunity to notify others to the person living with HIV. Second, the same number of countries (17) has made involuntary partner notification an option for health care workers, not an obligation (see Table 2). Yet, involuntary partner notification provisions in HIV-specific laws raise several serious human rights, public health and practical concerns. Ten countries allow for involuntary partner notification even in cases where there is no risk of HIV infection to the sexual partner of the person living with HIV (see Table 2). For instance, under these laws, sexual partners with whom the person living with HIV engaged only in protected sex or sexual acts that carry no risk of HIV infection may still be notified. Such provisions are overly broad and unnecessary.

Under the conditions provided in the International Guidelines, there is no set timeline for involuntary partner notification. In view of the complexity of partner notification, the determination of the moment for notifying should be done on a case-by-case basis, taking into consideration the personal circumstances of those involved, including the psychological state of the HIV-positive person and the partner to be notified. The International Guidelines recommend in this regard that 'health-care professionals decide, on the basis of each individual case'.¹³⁹ Despite this recommendation, seven countries set strict timelines after which involuntary partner notification can take place (see Table 2). In DRC and Burkina Faso, people living with HIV must disclose immediately after becoming aware of their HIV status. In Cape Verde, Guinea-Bissau, Mali and Niger, the timeline for disclosure is six weeks. In Côte d'Ivoire, it is three months. Past these periods, involuntary partner notification may take place. There is no scientific or medical rationale for the selection of the six-week or three-month periods as the threshold for involuntary notification. It rather seems that the six-week timeline was replicated from article 26 of the N'Djamena Model Law.¹⁴⁰ In fact, countries that have adopted this period have also adopted several other problematic provisions from this Model Law.¹⁴¹

Involuntary partner notification provisions also pose serious practical and resource issues. It is unclear from most of these

139 UNAIDS & OHCHR (n 27 above) para 20(g).

140 See art 26 of Model Legislation on HIV/AIDS for West and Central Africa; Pearshouse (n 11 above) 6-7.

141 Pearshouse (n 11 above).

provisions which specific category of health workers can conduct partner notification. Is it a doctor, an HIV counsellor, or any person who provides health care services to people living with HIV? The determination of this issue is not a moot point. In sub-Saharan African countries where health care workers and health systems are already overburdened, the implementation of partner notification is likely to create serious additional constraints. In a region where the average density of physician per 1 000 people is less than 0,5,¹⁴² one cannot reasonably expect medical doctors to take on the task of identifying and notifying the sexual partners of persons living with HIV. In fact, the critical issues of training and of human and financial resources to adequately undertake partner notification are eluded in most HIV-specific laws.

Involuntary partner notification can also lead to discrimination, violence and other forms of human rights violations, particularly for women.¹⁴³ Yet, only four out of the 21 countries allowing for involuntary partner notification recognise fear of violence and other serious negative consequences as reasons for not notifying. As noted by the Special Rapporteur on Torture, '[u]nauthorised disclosure of HIV status to sexual partners ... is a frequent abuse against people living with HIV that may lead to physical violence'.¹⁴⁴ By failing to address fear of violence as a limitation to disclosure and partner notification, these HIV-specific laws are likely to expose people living with HIV to violence, but also to the possibility of overly-broad criminal prosecution for HIV non-disclosure, exposure and transmission. These provisions are also likely to have negative public health consequences because fear of involuntary disclosure has been shown to be among the factors that prevent people from seeking HIV testing and other services.¹⁴⁵

Ultimately, only four countries (Comoros, Guinea, Liberia and Togo) have adopted all four key conditions relating to involuntary partner notification under the International Guidelines and UNAIDS recommendations (see Table 2).

142 See WHO 'Health workforce density of physicians (total number per 1 000 population): Latest available year' http://gamapserver.who.int/gho/interactive_charts/health_workforce/PhysiciansDensity_Total/atlas.html (accessed 7 March 2015).

143 KH Rothenberg & SJ Paskey 'The risk of domestic violence and women with HIV infection: Implications for partner notification, public policy, and the law' (1995) 85 *American Journal of Public Health* 1569-1576; JE Maher et al 'Partner violence, partner notification, and women's decisions to have an HIV test' (2000) 25 *Journal of Acquired Immune Deficiency Syndromes* 276-282.

144 Report of the Special Rapporteur on Torture (n 108 above) para 71.

145 A Medley et al 'Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes' (2004) 82 *Bulletin of the World Health Organization* 299-307; S Maman et al 'HIV status disclosure to families for social support in South Africa (NIMH Project Accept/HPTN 043)' (2014) 26 *AIDS Care* 226-232.

3.4 Criminalisation of HIV non-disclosure, exposure and transmission

Under international law, each country can choose which behaviours and practices should be subject to the criminal law.¹⁴⁶ However, there are principles of criminal law and human rights that should guide the definition and content of criminal law offences and related penalties.¹⁴⁷ In the context of HIV, it has been argued that the appropriateness of criminal law provisions applicable to the epidemic can be questioned, and their compliance with criminal law principles and human rights standards interrogated, if it appears that these provisions undermine efforts to address HIV.¹⁴⁸

In particular, serious concerns have over the years been raised about the application of criminal law, through HIV-specific provisions or general criminal law offences, to prosecute individuals who allegedly do not disclose their HIV status prior to sexual relations (HIV non-disclosure), who expose others to HIV (HIV exposure), or who transmit HIV (HIV transmission).¹⁴⁹ These concerns are related to the human rights and public health consequences of such application of the criminal law in the context of HIV.¹⁵⁰ Human rights concerns point to the fact that such criminalisation (i) often ignores the latest scientific and medical knowledge relevant to HIV; (ii) disregards generally-applicable criminal law principles; and (iii) frequently results in disproportionately harsh sentences.¹⁵¹ Public health arguments stress that there is no evidence that criminal law is an effective tool for HIV prevention and points to the possible negative impact on access and uptake of HIV services because of such criminalisation.¹⁵² On their part, proponents of the criminalisation of HIV non-disclosure, exposure or transmission argue that it may help prevent behaviour that leads to HIV transmission, educate the public on HIV and

146 See, eg, J Pradel *Droit penal général* (2007) 24-25.

147 See, eg, C Bassiouni 'Human rights in the context of criminal justice: Identifying international procedural protections and equivalent protections in national constitutions' (1993) 3 *Duke Journal of Comparative and International Law* 235-297.

148 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/HRC/14/20 27 April 2010 15-22; UNAIDS *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations* (2013) 7-10.

149 See S Burris & E Cameron 'The case against criminalisation of HIV transmission' (2008) 300 *Journal of the American Medical Association* 578-581; CL Galletly & SD Pinkerton 'Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV' (2006) 10 *AIDS and Behaviour* 451-461; UNAIDS (n 148 above) 7-10; EJ Bernard *HIV and the criminal law* (2010); Report of the Special Rapporteur on Health (n 148 above).

150 As above.

151 As above.

152 As above.

reinforce social norms against 'reprehensible HIV-related behaviour'.¹⁵³

The UNAIDS guidance note on ending the overly-broad criminalisation of HIV non-disclosure, exposure and transmission (guidance note)¹⁵⁴ is, to date, the most elaborated global document specifically addressing and providing recommendations on the criminalisation of HIV non-disclosure, exposure and transmission. The guidance note expounds on earlier UN recommendations on HIV and the criminal law.¹⁵⁵ It reiterates that there is no evidence that the criminalisation of HIV non-disclosure, exposure and transmission is an effective measure to address HIV, and sets out key principles that should guide any use of the criminal law in this area.¹⁵⁶ Six of these principles will be used here to assess the content of provisions criminalising HIV non-disclosure, exposure and transmission in the HIV-specific laws adopted in sub-Saharan African countries. These principles are (i) to limit criminal liability to cases of intentional HIV transmission (negligent or reckless transmission should not be criminalised); that there is (ii) no criminal liability in cases of mere non-disclosure or exposure where transmission has not occurred; (iii) no criminal liability in cases involving condom use; (iv) no criminal liability where the person living with HIV has a low viral load or is on effective treatment; (v) no criminal liability when the person did not know his or her HIV status; and (vi) no criminal liability in case of disclosure of HIV status prior to a sexual act.¹⁵⁷

The review of HIV-specific laws in sub-Saharan Africa shows that nearly all of the countries (24 out of 26) criminalise HIV non-disclosure, exposure or transmission (see Table 3).¹⁵⁸ Of these, only nine countries restrict criminalisation to cases involving actual transmission of HIV (see Table 3). Eight countries criminalise HIV non-disclosure and 12 countries criminalise HIV exposure where transmission did not occur. Seven countries allow for criminal liability on the basis of negligence or recklessness (see Table 3). Only eight countries exclude criminal liability in cases involving condom use or the practice of safe sex (see Table 3). Seven countries have provisions that could be interpreted to bar criminal liability when a person has a

153 C van Wyk 'The need for a new statutory offence aimed at harmful HIV-related behaviour: The general public interest perspective' (2000) 41 *Codicillus* 2-10; DHJ Hermann 'Criminalising conduct related to HIV transmission' (1990) 9 *Saint Louis University Public Law Review* 351.

154 UNAIDS (n 148 above).

155 UNAIDS *Criminal law, public health and HIV transmission: A policy options paper* (2002); UNAIDS & United Nations Development Programme (UNDP) 'Criminalisation of HIV transmission: Policy brief' 2008 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf (accessed 7 March 2015).

156 UNAIDS (n 148 above) 7-8.

157 UNAIDS (n 148 above).

158 Comoros and Mauritius are the only two countries with HIV-specific laws that do not criminalise HIV non-disclosure, exposure and transmission.

low viral load or is on effective HIV treatment (see Table 3). Finally, seven countries allow for criminal liability only for people who are aware of their HIV status and eight countries recognise disclosure to the sexual partner as a shield against criminal liability (see Table 3).

The fact that almost all countries with HIV-specific laws in sub-Saharan Africa criminalise HIV non-disclosure, exposure and transmission is often cited to epitomise the embrace of coercive approaches in HIV-specific laws in the region.¹⁵⁹ The significant number of countries that allow for prosecution without an intention to transmit HIV and, in the case of HIV non-disclosure and exposure where HIV has not been transmitted, raises serious concerns relating to the fair application of the criminal law.¹⁶⁰ That 16 countries allow for the criminalisation of people living with HIV even when they engage in protected sex is also a major concern as it clearly contravenes HIV prevention efforts based on condom use and introduces a disincentive for protected sex.¹⁶¹ Condom use is a central element of HIV prevention efforts among sexually-active individuals.¹⁶² For people living with HIV, the consistent and correct use of latex condoms is recommended to protect themselves (against the risk of re-infection with HIV or infection with other sexually-transmitted infections) and others (against the risk of onward transmission).¹⁶³ Therefore, allowing the criminal prosecution of individuals who use condoms would not only be unfair, but it also risks undermining HIV prevention efforts.

Although no country explicitly addresses low viral load and effective HIV treatment, the provisions in HIV-specific laws limiting criminal liability to acts involving a significant risk of HIV transmission can be interpreted to cover this situation. This is the case in Congo, Côte d'Ivoire, Guinea, Liberia, Mozambique, Senegal and Sierra Leone (see Table 3). Medical and scientific advances in the context of HIV demonstrate that people with a low viral load or who are on effective HIV treatment pose no significant risk of transmission.¹⁶⁴ Recognising these two elements as excluding criminal liability is, therefore, in line with best scientific and medical evidence relating to HIV. Recently, a number of scientists, public health authorities and courts in Europe

159 Pearshouse (n 11 above); Kazatchkine (n 35 above); Eba (n 8 above).

160 UNAIDS explicitly opposes the application of criminal sanction in cases where people did not know their HIV status and where HIV was not transmitted. See UNAIDS (n 148 above).

161 The failure to promote the use of condoms is also identified as a major flaw in HIV-specific criminal laws adopted in the United States. See Galletly & Pinkerton (n 149 above) 453-456.

162 UNAIDS, WHO & UNFPA 'Position statement on condoms and HIV prevention' July 2004 http://www.unfpa.org/upload/lib_pub_file/343_filename_Condom_statement.pdf (accessed 14 December 2008).

163 When used consistently and correctly, latex condoms significantly reduce the risk of HIV transmission. See SC Weller & K Davis-Beaty 'Condom effectiveness in reducing heterosexual HIV transmission (Review)' (2002) 1 *Cochrane Database of Systematic Reviews* 1-22.

and Canada have concluded that people with a low viral load or who are on effective HIV treatment should not be criminalised for HIV non-disclosure, exposure and transmission.¹⁶⁵ However, in most HIV-specific laws, criminal liability is not limited to acts that carry a significant risk of HIV transmission. In countries such as Mauritania and Guinea-Bissau, HIV transmission is defined as 'any attempt to a person's life by the inoculation of substance infected with HIV, regardless of how these substances were used or employed and independently of the consequences thereof'.¹⁶⁶ This provision is extremely vague and may be used to target a wide range of activities without consideration of the reality of the risk of HIV transmission involved.

In 16 countries, vague criminal law provisions could be invoked to prosecute a woman who transmits HIV to her child during pregnancy, delivery or breast-feeding (see Table 3). In Sierra Leone, the HIV Act of 2007 explicitly provided for such prosecution.¹⁶⁷ The outcry created by this provision and its potential negative impact on women's willingness to come forward for HIV services led to the revision of Sierra Leone's HIV law to explicitly exclude the prosecution of mother-to-child transmission of HIV.¹⁶⁸ Similarly, recently adopted HIV-specific laws in six countries also explicitly exclude the criminalisation of mother-to-child transmission of HIV.¹⁶⁹

The failure to recognise HIV disclosure by the person living with HIV as a barrier to criminal liability in 16 countries is worrying and also paradoxical. In fact, in many of these laws, disclosure is encouraged and the failure to disclose is often punished. The failure to protect those who disclose their HIV status and obtain the informed consent

164 MS Cohen et al 'Prevention of HIV-1 infection with early anti-retroviral therapy' (2011) 365 *New England Journal of Medicine* 493-505; TC Quinn et al 'Viral load and heterosexual transmission of human immunodeficiency virus type 1' (2000) 342 *New England Journal of Medicine* 921-929; J Castilla et al 'Effectiveness of highly active anti-retroviral therapy in reducing heterosexual transmission of HIV' (2005) 40 *Journal of Acquired Immune Deficiency Syndromes* 96-101.

165 See M Loutfy et al 'Canadian Consensus Statement on HIV and its transmission in the context of the criminal law' (2014) 25 *Canadian Journal of Infectious Diseases and Medical Microbiology* 135-140; 'S' v Procureur Général, Arrêt, 23 February 2009 (Chambre pénale) (Genève); P Vernazza et al 'Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle' (2008) 89 *Bulletin des médecins suisses* 165-169.

166 Arts 1 & 23 HIV law of Mauritania and art 37 and 'concept de base' HIV law of Guinea-Bissau.

167 Art 21(2) of the Prevention and Control of HIV and AIDS Act 2007 of Sierra Leone provides that '[a]ny person who is and is aware of being infected with HIV or is carrying and is aware of carrying HIV antibodies shall not knowingly or recklessly place another person, and in the case of a pregnant woman, the foetus, at risk of becoming infected with HIV, unless that other person knew that fact and voluntarily accepted the risk of being infected with HIV'.

168 Sec 37(2)(g) of the HIV law of Sierra Leone of 2011 explicitly excludes the criminalisation of mother-to-child transmission of HIV.

169 Congo (art 42); Côte d'Ivoire (art 51); Guinea (art 37); Liberia (sec 18(27)(b)(viii)); Senegal (art 36); and Togo (art 36).

of their sexual partners before sex further illustrates the conflict between HIV-specific laws and public health messages.¹⁷⁰ Indeed, in spite of its many challenges,¹⁷¹ the disclosure of HIV status to sexual partners is encouraged as a measure of HIV prevention and as an element that may foster support for the person living with HIV and help reduce stigma.¹⁷² Furthermore, disclosure and informed consent to sexual acts are important elements of the sexual and reproductive health rights of people living with HIV who may agree with their partners to have unprotected sex for several reasons, including procreation.¹⁷³ The prosecution of people living with HIV who inform their partners and obtain their consent is unfair and is likely to have a negatively impact on disclosure.

A further problem in HIV-specific laws is what can be termed 'over-criminalisation'.¹⁷⁴ This refers to the fact that, in the same HIV-specific law, several provisions can be used to prosecute HIV non-disclosure, exposure or transmission. A typical example of over-criminalisation can be found in the HIV law of Burkina Faso. This HIV law contains three separate provisions with different constitutive elements that may be applied to the criminalisation of HIV non-disclosure, exposure or transmission. These are article 20, which criminalises the sexual transmission of HIV; article 22, which addresses 'transfer of substances' infected with HIV and could also be used to punish the sexual transmission of HIV; and, finally, article 26, which criminalises any person living with HIV who does not take the necessary precautions to protect his or her partners.¹⁷⁵ This over-criminalisation is likely to be a source of confusion for people living with HIV as well as for those responsible for implementing HIV-specific laws. For instance, on the basis of a provision of the law, a person living with HIV may consistently practise sex with condoms, yet another vague provision in the same law may be invoked to prosecute that person for HIV non-disclosure, exposure or transmission. This problem is also evident in the HIV laws of the Central African Republic and Mauritania which have provisions that prevent the prosecution of people living with HIV who engage in 'protected sex' (which includes the use of condoms).¹⁷⁶ However, these provisions are made irrelevant by the

170 See Galletly & Pinkerton (n 149 above) 453-456.

171 There are several challenges associated with the promotion of disclosure, especially for women who have been reported to face negative reactions ranging from abandonment to violence. See Medley et al (n 145 above); Maman et al (n 145 above).

172 See Chesney & Smith (n 81 above); EN Waddell & PA Messeri 'Social support, disclosure, and use of anti-retroviral therapy' (2006) 10 *AIDS and Behaviour* 263-272.

173 See GNP+ et al *Advancing the sexual and reproductive health and human rights of people living with HIV: A guidance package* (2009).

174 Eba (n 8 above) 5.

175 Arts 20, 21 & 22 HIV law of Burkina Faso.

176 See art 34 of the HIV law of Central African Republic and art 23 of the HIV law of Mauritania.

fact that these laws also contain other provisions that may be used to prosecute people living with HIV even when they use condoms.¹⁷⁷

As described above, the majority of provisions criminalising HIV non-disclosure, exposure and transmission in HIV-specific laws do not meet the standards set in the UNAIDS guidance note. Many ignore basic criminal law principles of legality, foreseeability, intent, causality, proportionality and proof that should serve as the basis for the definition of offences and the imposition of penalties.¹⁷⁸ These criminal law provisions allow for the prosecution for acts that constitute no or very little risk of HIV infection; they fail to recognise condom use, low viral load and effective HIV treatment; and allow for the criminalisation of people who have taken steps to inform their sexual partners and obtain their consent prior to sex. Laws that allow for such use of the criminal law are overly broad, violate criminal law principles, trump human rights and are unfair.¹⁷⁹ These provisions are often based on myths and misconceptions about HIV and its modes of transmission, and they risk undermining effective public health efforts that are based on the use of condoms and on encouraging disclosure. At a time when efforts are being made to end the AIDS epidemic in Africa and to globally focus on expanding access to HIV testing,¹⁸⁰ these overly-broad criminal law provisions are likely to be counterproductive. The provisions will discourage people from coming forward for HIV testing and will negatively impact the patient-doctor relationship.¹⁸¹

4 Conclusion and recommendations

HIV-specific laws are now part of the legal frameworks of a majority of countries in sub-Saharan Africa and the trend in favour of these laws is still increasing.¹⁸² An analysis of these laws shows that they include both protective and punitive provisions. Protective provisions often covered in these laws relate to non-discrimination. Yet, many of these protective clauses, such as general non-discrimination provisions and protection in the context of employment, are often not strong

177 See arts 35, 37, 38 & 39 of the HIV law of Central African Republic and art 23 of the HIV law of Mauritania.

178 UNAIDS (n 147 above) 7.

179 UNAIDS (n 147 above).

180 UNAIDS 'Fast-Track: Ending the AIDS epidemic by 2030' 2014 http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf (accessed 8 February 2015).

181 See Galletly & Pinkerton (n 149 above); P O'Byrne et al 'Non-disclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following non-disclosure prosecution media releases in Ottawa, Canada' (2013) 13 *BMC Public Health* 94.

182 Only in 2014, three countries (Côte d'Ivoire, Comoros and Uganda) have adopted such laws and, at the time of writing, at least one country (Malawi) was working towards the development of an HIV-specific law.

enough to effectively guarantee the human rights of people living with HIV and those affected by the epidemic. Typically, most general non-discrimination provisions cover discrimination based solely on one's actual HIV status. However, many omit critical areas such as discrimination based on another person's status, discrimination based on perceived or presumed HIV status as well as indirect discrimination. The strength of non-discrimination provisions covering specific areas such as education, housing, health and insurance varies greatly. These weaknesses are concerning because a central reason for adopting HIV-specific laws is that they provide clarity and specific protection of the human rights of people living with HIV, rather than leaving it to the courts to guarantee those rights in the context of litigation. The clarity of legislative provisions is also important in sub-Saharan Africa where access to justice remains a serious challenge, particularly for people living with HIV.

Punitive provisions appear to be a defining feature of HIV-specific laws, both in terms of the number of countries that have adopted punitive provisions and with regard to the diversity of restrictive provisions provided in these laws. This situation is paradoxical because a main argument for the adoption of these laws has been the 'need to protect people living with HIV'.¹⁸³ Restrictive provisions often covered in these laws include compulsory HIV testing, particularly for alleged sexual offenders, involuntary partner notification and the criminalisation of HIV non-disclosure, exposure and transmission. In the great majority of cases, these provisions are overly broad, they disregard best available recommendations for legislating on HIV, fail to pass the human rights test of necessity, proportionality and reasonableness, consecrate myths and prejudice about people living with HIV, and risk undermining effective responses to the HIV epidemic. Exceptionally, recently-adopted or revised HIV-specific laws appear to have more evidence-informed and rights-based provisions. In addition, criminal law provisions and limitation of rights under these recent laws are often more narrowly drafted. This is due to the increased scrutiny by, and involvement of, key actors, including civil society, human rights groups and the UN in the development of these laws in recent years following the concerns raised by the N'Djamena Model Law and the laws based thereon.

The study, therefore, concludes that the content of HIV-specific laws in sub-Saharan Africa is generally inadequate. Most of the laws fail to uphold human rights standards and best available public health recommendations relating to HIV. By embracing various coercive and overly-broad provisions against people living with HIV, these laws are unlikely to support efforts to break the stigma and fear that still keep people from seeking HIV services. Furthermore, by failing to adopt enabling provisions for populations such as sex workers, young people and men who have sex with men, who are particularly vulnerable to

183 Eba (n 8 above) 1.

HIV, these laws appear as symbolic responses that do not address critical issues of protection and access to services for key populations in sub-Saharan Africa. It has been argued that, in many instances, HIV-specific laws were adopted in an attempt by parliamentarians and governments to signal to the population that they were taking 'tough measures' to address HIV.¹⁸⁴

While acknowledging the glaring gaps and serious concerns in HIV-specific laws, the study also concludes that these laws do have some merit as they offer some human rights protection, particularly in relation to non-discrimination. The study, therefore, calls for a two-pronged approach in dealing with HIV-specific laws in sub-Saharan Africa. First, the study calls for a thorough analysis of the content of HIV-specific laws in all countries where they exist. The benefit of a general overview, such as the one presented in this study, must be completed by an analysis of each HIV-specific law through a process that involves human rights and public health experts, people living with HIV, HIV programme implementers and parliamentarians, among others. Such an analysis will ensure that the gaps and concerns in HIV-specific laws are outlined and that efforts urgently are put in place to address these concerns. Where possible, these gaps should be addressed through regulations that could clarify the content of the law. In contexts where these issues cannot be addressed through regulations, amendments or legislative reform should be pursued.

Second, this study calls for paying more attention to the enforcement of protective provisions in existing HIV-specific laws. While efforts are to be continued for reforming the most concerning aspects of HIV-specific laws,¹⁸⁵ these efforts should be accompanied by renewed action by civil society, people living with HIV and others to identify and support the implementation of protective provisions under these laws, such as those relating to the prohibition of discrimination in employment or in schools and equal access to health care services. Such an approach seems to have been adopted in Kenya, where civil society organisations have successfully challenged the provisions in the HIV law criminalising HIV transmission,¹⁸⁶ while at the same time playing a critical role in supporting the establishment of the HIV and AIDS Tribunal provided for under this law, as an important mechanism for the protection of the rights of people living with HIV.¹⁸⁷ If effectively pursued, this two-pronged approach could ensure that HIV-specific laws deliver on their stated

184 See Pearshouse (n 11 above); Grace (n 12 above).

185 Efforts to change problematic HIV-specific laws are by their very nature a protracted endeavour. While in countries such as Sierra Leone, Congo and Togo these efforts have succeeded in reforming key punitive provisions, in other countries, such as Burkina Faso, DRC, Mauritania and Niger, reform efforts have stalled.

186 *AIDS Law Project v Attorney General & 3 Others* Kenya High Court [2015] eKLR.

187 See D Njagi 'HIV-positive Kenyans need tribunal to address rights violations' *IPS* 3 August 2010 <http://www.ipsnews.net/2010/08/hiv-positive-kenyans-need-tribunal-to-address-rights-violations/> (accessed 7 March 2015).

objective: the protection of people living with, vulnerable to or affected by HIV.

Table 3: Criminalisation of HIV non-disclosure, exposure and transmission in HIV-specific laws

Country	Criminalises HIV non-disclosure	Criminalises HIV exposure	Criminalises HIV transmission	Limited to intentional acts	Negligent or reckless acts	Applicable to MTCT	Elements that exclude criminal liability		
							Knowledge of HIV infection	Disclosure or informed consent	Condom use and other precautions
Angola (arts 14 & 15)	Yes (art 14)	No	Yes (art 15(1))	Yes (art 15(2))	Yes	No	No	No	No
Benin (art 27)	Yes (art 27)	No	No	No	No	No (specific to sex)	Yes	No	No
Burkina Faso (arts 20, 22 & 26)	Yes (art 20)	No	Yes (art 22)	Yes (art 22)	No	Yes (art 22)	No	No	Yes (arts 20 & 26)
Burundi (art 42)	No	No	Yes (art 42)	Yes (art 42)	No	Yes	No	No	No
Cape Verde (art 30)	No	No	Yes (art 30)	No (arts 30 & 2)	No	Yes	No	No	No
CAR (arts 34, 35, 37, 38 & 39)	Yes (art 39)	Yes (art 37)	Yes (art 35)	Yes (art 35)	Yes	Yes (arts 37 & 38)	No	No	No
Chad (arts 54 & 55)	No	No	Yes	No	Yes (art 55)	Yes	No	No	No
Congo (arts 41 & 42)	No	No	Yes	Yes	No	No (excluded by art 42)	Yes (art 42)	Yes (art 42)	Yes (art 42)

Sierra Leone (secs 37(1) & 37(2))	No	No	Yes (sec 37(1))	Yes (sec 37(1))	No	No (excluded by sec 37(2)(g))	Yes (sec 37(2)(b))	Yes (sec 37(2)(e))	Yes (sec 37(2)(d))	Yes (sec 37(2)(a))
Tanzania (sec 47)	No	No	Yes (sec 47)	Yes (sec 47)	No	Yes (sec 47)	No	No	No	No
Togo (art 61)	No	Yes (art 61)	Yes (art 61)	Yes (art 61)	No	No (excluded by art 61)	Yes	Yes	Yes	No
Uganda (secs 41 & 43)	No	Yes (sec 41)	Yes (sec 43)	Yes (sec 43)	No	Yes (secs 41 & 43)	No	No (sec 41)	No (sec 41)	No

Annex: HIV-specific laws in sub-Saharan Africa

Country	Title of HIV-specific law	Year of adoption
1 Angola	Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Síndrome de Immunodeficiência Adquirida (SIDA)	2004
2 Benin	Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA	2006
3 Burkina Faso	Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA	2008
4 Burundi	Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise	2005
5 Cape Verde	Loi No 19/VII/2007	2007
6 Central African Republic	Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA	2006
7 Chad	Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA	2007
8 Comoros	Loi No 14-011/AU du 21 avril 2014, relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale	2014
9 Congo	Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH	2011
10 Côte d'Ivoire	Loi No 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA	2014
11 Democratic Republic of Congo	Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées	2008
12 Equatorial Guinea	Ley No 3/2005 sobre la prevención y la lucha contra las infecciones de transmisión sexual (ITS), el VIH/SIDA y la defensa de los derechos de las personas afectadas	2005
13 Guinea	Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée	2009, amended HIV Law of 2005
14 Guinea-Bissau	Loi No 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida	2007
15 Kenya	HIV and AIDS Prevention and Control Act, No 14 of 2006	2006
16 Liberia	An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)	2010
17 Madagascar	Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA)	2006

18 Mali	Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA	2006
19 Mauritania	Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA	2007
20 Mauritius	HIV and AIDS Act, No 31 of 2006	2006
21 Mozambique	Lei No 12/2009, estabelece os direitos e deveres da pessoa vivendo com HIV e SIDA, e adopta medidas necessárias para a prevenção, protecção e tratamento da mesma	2009
22 Niger	Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV)	2007
23 Senegal	Loi No 2010-03 du 9 avril 2010 relative au VIH/SIDA	2010
24 Sierra Leone	The National HIV and AIDS Commission Act of 2011	2011, amended HIV Law of 2007
25 Tanzania	HIV and AIDS (Prevention and Control) Act, No 28 of 2008	2008
26 Togo	Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA	2010, amended HIV Law of 2005
27 Uganda	HIV Prevention and Control Act of 2014	2014