

**Mandatory HIV/AIDS testing as an additional precondition for the  
management of the HIV/AIDS pandemic: a South African Women's  
human rights perspective**

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Assignment presented in partial fulfilment of the requirements for the degree of  
Master of Philosophy (HIV/AIDS Management) at Stellenbosch University

Africa Centre for HIV/AIDS Management  
Faculty of Economic and Management Sciences  
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March 2009

## **Declaration**

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Date: 26/01/2009

## **Abstract**

A multitude of articles has been written on HIV/AIDS. In almost every instance, writers tend to draw the readers, interest to the number of people either infected or affected by the disease within a particular year.

While these figures are staggeringly high and the cure still very much elusive, society continues to handle HIV with caution. However the literature review suggests the contrary, that society become more aggressive in their methodology in managing HIV/AIDS, by proposing mandatory HIV/AIDS testing as an additional pre-condition for the management of the HIV/AIDS pandemic. A South African woman's human rights perspective has been evaluated within this context, the rational being that should this type of testing alleviate the effects of the disease on one of the most vulnerable group's women; the benefit on less vulnerable groups would be far greater, while holistically reducing the effects and prevalence of HIV/AIDS in South Africa.

## **Opsomming**

Die Suid-Afrikaanse gemeenskap is steeds uiters versigtig in hulle hantering van die MIV/Vigs pandemie. Die literatuur stel egter voor dat die gemeenskap baie meer aggressief behoort te wees in die bestuur van MIV/Vigs en stel voor dat verpligte toetsing vir MIV/Vigs oorweeg behoort te word.

Hierdie studie ondersoek die literatuur ten opsigte van verpligte toetsing vir MV/Vigs deur middel van 'n omvattende literatuuroorsig. Gevolgtrekkings word gemaak en sekere voorstelle vir die toekomstige bestuur van die pandemie word gemaak.

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## **Introduction**

‘Despite the wide availability of HIV voluntary counselling and testing (VCT) services, it is estimated that less than a quarter of HIV infected people are aware of their HIV status, and less than 1% know their CD4 count. People living with HIV and AIDS are afraid to speak openly about their HIV status this epidemic, in turn, perpetuates secrecy and denial of personal risk as well as the presence and scale of the HIV epidemic’ (Karim, & Karim, 2008).

The number of people infected world wide with HIV and AIDS has increased since AIDS was first identified in 1981, expanding beyond the communities in which it was originally identified (Essex, & Mboup, 2008). In 2007, the United Nations Programme on HIV/AIDS (UNAIDS) reported 5,700 000 million people living with HIV and AIDS in South Africa by the end of 2007. 18.1% adults between ages 15-49 have been living with HIV and AIDS. 59% estimated HIV cases occurred among women ages 15-49. 280 000 estimated children between ages 0-1 are living with HIV and AIDS. 350 000 deaths are due to AIDS (UNAIDS, 2008).

The Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa have concluded that almost half of all deaths in South Africa and a staggering 71% of deaths among those aged between 15 and 49 are caused by AIDS (Pembrey, 2008). ‘By comparing AIDS related deaths with non-AIDS related deaths we can see the impact HIV is currently making on our mortality rates. For instances, statistics show that the number who die from AIDS-related diseases such as tuberculosis or other opportunistic infections is still increasing, whereas the numbers who die from other causes, such as old age, or motor vehicle accidents, has remained steady’ (van Zyl, 2008). The New York Times reported that many people are dying from AIDS, and that in some parts of the country, cemeteries are running out of space for the dead (Pembrey, 2008).

The steady increase in Aids deaths amongst women and children certainly points towards pronounced neglect for human rights ‘at personal and societal levels is also closely linked to individual and collective risk of infection and access to care and support once infected. Preventing HIV transmission, providing good care for people who are already infected and

adequately supporting individuals and communities affected by the HIV epidemic requires attention to human rights on the part of policy makers, program managers, researchers and activists' (Gruskin, & Maluwa, 2002).

Transforming AIDS into a treatable condition has the potential to change community perceptions of people living with AIDS. To realise this potential, the individual patient paradigm that currently exists or treating most medical conditions is inadequate as a modality for treating AIDS. Instead a public health model which integrates both prevention and care for HIV is required. The provision of antiretroviral therapy can save lives and relieve the wide spread suffering due to AIDS. However, providing treatment for AIDS patients is only one piece of the puzzle on changing the course of the epidemic in South Africa. Indeed, a major challenge such as the AIDS epidemic will require much more to secure its defeat. AIDS affects almost every aspect of life. The response to the AIDS epidemic has to be commensurate, involving all sectors of society bound by a common vision (Karim, & Karim, 2008).

Therefore, leaders have to make a concerted effort to curb violations that increase the impact the HIV epidemic has and continues to have on the lives of vulnerable groups in South Africa. Should leaders desire the need to better manage the spread of the epidemic with the consideration of vulnerable groups in mind, bold and unconventional methods have to be considered. South Africa's approach to the epidemic is conservative and pretentious fetid with human right violations. South Africa does not need to spend millions of rands in a second Truth and Reconciliation Commission (TRC) hearing fifty years later gathering apologies for violations that can be avoided now. Appointing Barbara Hogan as the new minister of Health is commendable. However, it will not pacify the epidemic, unless aggressive action is taken. 'The HIV epidemic has had an increasing impact on the lives of adults and children in sub-Saharan Africa. Women, men and children may be infected, affected and/or vulnerable to HIV infection and AIDS. People infected with HIV continue to face marginalisation and discrimination as well as violations of many of their rights, to health, education and social services' (Gruskin, & Maluwa, 2002).

A South African women's human rights perspective is a perspective that is beneficial to all. Human right violations that affect women, affect children and households. Those are the very households that rear male and female children. Values and culture, which are implemented within these households, dictate the lifespan of stigma, discrimination, and perpetual violations as the disease continues to thrive unabated. 19 December 2008 commemorated the anniversary of the death of Gugu Dlamini and the unveiling of her tombstone that bears the prominent red ribbon. Gugu Dlamini was stoned to death when neighbours discovered she was HIV positive (Sayagues, 2008). Gugu, like many other women in South Africa is a victim to the type of human right violation. Gugu died as a result of stigma like many other South African women that are beaten to death, physically and emotionally abused by their partners and communities, because of their status and vulnerability.

The surmounting number of incidences against women goes unrecognised. However, each violation is a human right violation collectively amounting to genocide. 'Stigma devalues and discredits people generating shame and insecurity. Stigma is harmful both in itself, since it can lead to feelings of shame, guilt and isolation of people living with HIV, and because it promotes people to act in ways that directly harm others and deny the access to services and entitlements such as unjust treatment is tantamount to a violation of human rights' (Marumo, 2006). How does one rid society of stigma and violation, by utilising values and inherent characteristic innate in all South Africans? South Africa is a beacon amongst nations for its fight against inequality, racial prejudice and discrimination. Why not make stigma and violation against women a national concern.

Calling for mandatory testing would place every one of Gugu's neighbours in her position. Each would have to be tested in order to decide whether he/she is positive or negative. If the entire South African population is asked to be mandatory tested, every wife, husband, and neighbour would be compelled to deal with the stigma until it no longer exists 'if we [South Africa] started having mandatory testing today, said Dr Moloko from Gauteng, two years from now it would be old hat. 'Everybody would be testing and all this human rights thing would be forgotten' (Smart, 2007). Knowledge of one's status would contribute to South Africa's management of the epidemic, as more individuals take responsibility for their actions. Self-imposed prevention

measures would insure that fewer people are infected by individuals ignorant of their status. Harvey quotes Nieburg and Anderson who support the notion that HIV testing will make a substantial contribution to reducing the number of HIV infections. Data has indicated that the knowledge of one's HIV status reduces the risk of sexual HIV transmission by 68% (Harvey, 2006). Mandatory testing would compel every man, woman and child to be tested, whilst test results remain confidential. No individual would be excluded either by race, sex or financial status, allowing no room for stigma. Individuals found guilty of intentionally infecting another, after being made aware of their status, would be held criminally responsible (Section 2 (2) (b) in the draft version of the Sexual offences and Related Matters Amendment Bill, 2003).

Proposing mandatory testing, as a precondition to the management of HIV and AIDS, would be beneficial in getting society involved in their personal health and the health of fellow South Africans. The benefits derived from such testing would automatically provide rights to vulnerable groups, more especially women who account for 59% of the 5700 000 million infected. Women desperately need the help of legislators and policy makers. Having the state to bear the responsibility for HIV testing would remove a burden from women, by forcing men to learn their status, which could compel men to engage in safer sexual practices (Anderson, 2006).

This study investigates the importance of introducing mandatory HIV and AIDS testing as an additional precondition for the management of the HIV and AIDS pandemic. The study investigates whether mandatory HIV and AIDS testing is compatible with current legislation and whether it is restorative in its application, enabling women to recover rights, previously lost through gender marginalisation.

## **Methodology and scope**

The study is based upon a literature review, in classic qualitative style, whereby the 'researcher considers not only how existing interpretations are constructed, but also how new ones are developed and employed' (Balihar, 2009). The research includes a review of existing materials – reports, position statements, documents, studies, critiques, journal articles and news clippings using electronic databases (Jurgens, 2007). Mandatory HIV and AIDS testing is a concept

conceived by Venter (Venter, 2007) at the 2007 HIV and AIDS Conference held in Durban. Venter's suggestion coupled with the literature has established recommendations that government and donor's, promulgate mandatory HIV and AIDS testing as a measure or a precondition in the management of HIV and AIDS in South Africa.

A South African woman's human rights perspective is an area within mandatory testing that would restore women's rights by asking men, women and children to participate in the testing programme. The study discusses Venter's (Venter, 2007) suggestion and explores legislation that support the concept of mandatory testing, the benefits that would be derived by women and vulnerable groups, concluding with a summary and recommendations.

### **Types of HIV and AIDS testing**

The World Health Organisation (WHO) has set out four types of testing and, more recently, a fifth type. The first four types include voluntary counselling and testing (VCT) which is client –initiated and entails pre- and post- counselling (UNAIDS, 2004). The second type of testing is diagnostic HIV-testing. This form of testing is conducted when a patient shows symptoms that are associated with AIDS-related illness (Richter, 2006). Diagnostic and routine testing allows the patient the right to refuse testing that is to 'opt-out' of testing, a procedure notably made popular in Botswana (Smart, 2007).

The third type of testing that is routine testing is made available to all patients who have sexually transmitted infection, who are pregnant and who are seen in clinical and community based health settings where the HIV prevalence rates are high and where antiretroviral (ARV's) are available (Richter, 2006). The 'opt-in and 'opt-out' routine test, the prescribed model includes an offer of an HIV test which the patient actively has to agree to when the test can be taken. This type of testing usually assumes that the patient accepts the HIV test unless she/he explicitly declines (Richter, 2006). In the fourth type of testing that is mandatory testing; individuals are tested without their consent and without counselling being provided in some instances without their knowledge. This form of testing is also often described as compulsory or involuntary testing (Richter, 2006). The UNAIDS underlines that all HIV-testing should be conducted by respecting the so called '3c's':

counselling, consent and confidentiality. The fifth and more recent type of testing policy, as recommended by World Health Organisation (WHO), is the provider- initiated testing and counselling (PITC). The new UNAIDS guideline was prepared in light of increasing evidence that provider initiated testing and counselling can increase uptake of HIV testing, improve access to health services to people living with HIV, and may create new opportunities for HIV prevention. PITC involves the health care provider specifically recommending an HIV test to patients, at health care facilities. In these circumstances, once specific pre-test information has been provided, test would ordinarily be performed unless the patient declines. PITC has already been implemented in a range of clinical settings in several low-and middle-income countries, including Botswana, Kenya, Malawi, Uganda, Zambia, Thailand, the United Kingdom and the United States (UNAIDS, 2008).

While recent developments give cause for optimism, South Africa is still suffering from one of the most severe AIDS epidemics in the world, and there are no signs that HIV prevalence is declining. Fast, effective action will be needed if progress is to be made. With almost 1 000 people dying from AIDS related illnesses everyday in South Africa, there is no time for hesitation. It has been suggested that, by 2012, around 1, 5 million people will still die from AIDS-related illness, if the treatment scale-up continues at the current rate (Walensky, 2008). If South Africa were hoping to achieve the goal of 27 million people tested for HIV within the next few years, there needs to be an about- turn in attitudes towards the disease (Clark, 2007). Therefore, the scope of the HIV disaster that South Africa is facing may justify a move towards compulsory HIV testing (Smart, 2007).

The type of testing proposed is mandatory testing. However, the type of testing that is proposed is unique and separate from the type of testing defined by Richter. Firstly, every individual would be asked to allow them to be tested. It would be compulsory in that no individual would be excluded from the programme. Tests would need to be concluded at regular intervals that are generally required to renew drivers' licences or passports. Counselling would be provided when individuals present themselves for testing, whilst confidentiality would be upheld at all times. Myths related to mandatory tests would be dispelled as procedure would be compatible with UNAIDS standards, ensuring that counselling, consent and confidentiality are adhered to at all testing sites. Should

leaders neglect to make a conscious effort to address the adverse impact of HIV and AIDS on vulnerable groups, their indifference would ultimately amount to a human right violation.

Human rights are the basic characteristics within individuals because they are human. These rights apply to people everywhere in the world, and they are principally concerned with the relationships between the individual and the state. Human rights can be interpreted in different ways by government, health professionals' activists and researchers (Gruskin, & Maluwa, 2002). 'Human rights are generally invoked as they relate to the responsibility and accountability of governments, and not with respect to the specific actions of individuals' (Gruskin, & Maluwa, 2002). 'A human rights approach to HIV is, therefore based on the states obligations with regard to human rights protection. HIV demonstrates the indivisibility of human rights since the realisation of economic, social and cultural rights, as well as civil and political rights is essential to an effective response. Furthermore a right-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions' (UNAIDS, 2006). Governments are thereby responsible for not violating these rights and enabling individuals to realise their rights as fully as possible.

'Respecting the right means a state can not violate the right directly, protecting the right means a state has to prevent violations of rights by non state actors and offer some sort of redress. Whilst fulfilling the right means a state has to take all appropriate measures including but not limited to legislative, administrative, budgetary and judicial- towards fulfilment of the right' (Eide, 1995). A state could be in violation of the right to health if it fails to incrementally allocate sufficient resources to meet the public health needs of the communities within its borders (Eide, 1995). While 'governments are legally responsible for complying with the range of obligations for each right in every human rights document they have ratified' (Gruskin, & Maluwa, 2002).

An instantaneous restoration of human rights is practically impossible as resources and logistic constraints can hamper the restoration process. 'Therefore realisation of rights is generally understood to be a process of 'progressive realisation' by making steady progress towards a goal (Gruskin, & Maluwa, 2002).

## **Mandatory HIV and AIDS testing and the International guideline on HIV and AIDS and Human Rights**

The International guideline on HIV and AIDS and Human Rights outline human right principles relevant to HIV and AIDS. Each of these rights needs to be upheld to ensure the compatibility of human rights' codes with mandatory testing in order to achieve that progressive goal.

- Right to non-discrimination, equal protection and equality before the law. Mandatory testing would encourage non- discrimination as all citizens would be expected to test irrespective of status. Every 'group suffering from discrimination, which also disables them in the context of HIV, women, children and those living in poverty, minority, indigenous people, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users' (UNAIDS, 2006) would be treated equally and protected against discrimination. 'Prohibition against discrimination this requires the state to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV –related criteria' (UNAIDS, 2006) mandatory HIV testing is one such example.
- The right to life is the crux of what mandatory testing is trying to achieve. With larger numbers tested, the right to life can be preserved. Policy makers would be equipped to plan ahead whilst individuals tested positive would be able to extend their lifespan by being aware of their status. Simultaneously, their right to life can be extended to others as they take greater care when associating with the rest of society, particularly with women where subordination in the family and in public is one of the root causes of the rapidly increasing rate of infection among women (UNAIDS, 2006).
- The right to the highest attainable standard of physical and mental health. Armed with the knowledge of one's status mandatory testing, will allow individuals the opportunity to accept their status, regain a peace of mind should they test negative and address a plan of action if results are positive. Mandatory testing, through routine pre- and post- counselling, would allow women and girls the right to HIV education, to freedom of expression to freely receive and impart HIV-related information and means of prevention and health services. Furthermore,

mandatory testing would empower women who have acquired knowledge of status to leave relationships or employment which threaten them with HIV infection and to cope if they or their family members are infected with HIV (UNAIDS, 2006).

- The right to liberty and security of person. Since every citizen would be expected to be tested irrespective of gender, race or stature. Mandatory testing would not deprive an individual of his/her liberty or security. In fact, individuals plagued by stigma would have the recourse as the perpetrators of stigma would also be expected to be tested.
- The right to freedom of movement. Mandatory testing would not affect the right of movement, freedom of movement would be upheld and encouraged as society would be associating with individuals that have been tested and made aware of their status and counselled in the process.
- The right to seek and enjoy asylum, asylum seekers would have to oblige by the laws of the country they have entered, they would be expected to be tested, a positive test result would not amount to deportation but would rather result in access to health care.
- The right to privacy. The right that attracts the greatest concern. Mandatory testing is about gaining knowledge and awareness about the disease and equipping individuals with the ability to care for themselves and loved ones. Privacy and confidentiality are the fundamental rules of this type of testing, spouses would not be informed, employers or any other interested party would not have access to test results without a court order. Individuals found guilty of divulging information pertaining to another's test results or status would result in criminal prosecution or HIV and AIDS community service (Section 38 (1) (b) Criminal Law Sexual offences and related matters Amendment Act No 32 of 2007). Furthermore the right to privacy and confidentiality means that health care providers must pay special attention to ensuring that people's decision to test for HIV and their HIV test results are not disclosed to third parties, without their consent (Athena Network, 2006).
- The more contentious of rights is the right to freedom of opinion and expression and the right to freely receive and impart information. This right is often infringed when opinion and information

of highly sensitive nature for example, classified information held by states or attorney client privilege, is withheld. This would be a third instance where a right would have to be curtailed for the benefit of another. The ability to limit this right because of the severity of the epidemic and the impact it has on society are crucial reasons for its suppression. Therefore, should individuals refuse to be tested; they would have to consent contrary to their opinion. The right to receive and impart information would only be suppressed as far as disclosure of an individual's status is concerned. Whilst general statistics gathered through this process would be utilised in the management of the disease. Through the development of programmes, roll-out of ARV's, better health care and protection of women and children.

- The right to freedom of association. Mandatory testing can only complement this right as individuals armed with the knowledge of their status would place a minor risk on society than an individual who is unaware of his/her status. Freedom of association would be encouraged as individual's associate, stigma would be reduced as more individuals would be tested resulting in better management of the epidemic. 'Adopting mandatory testing would increase the number of people who know their HIV status finally the stigma associated with HIV would diminish' (Anderson, 2006).
- The right to work. Mandatory testing is confidential, and status can only be disclosed with a court order. The Labour Relations Act 66 of 1995 is supportive of this right. Being tested can only provide better tools in remaining healthy and productive for a longer period ( Hoffman v South African Airways 2001 1 SA 1 (CC) ) of time than not knowing one's status and succumbing to HIV and AIDS and dying prematurely. Often disclosing ones status to an employer can result in better health care for oneself and spouse (Barnett, & Tstsele, 2002).
- The right to marry and to found a family. Mandatory testing would not prevent individuals from marriage, yet it would allow individuals intending to marry to discover their status, allowing both individuals to enter into the marriage aware of their responsibility and status. Knowledge of one's status will allow parties to make the necessary decisions in a relationship. Spouses can plan ahead should they test positive. Unplanned pregnancies can be carefully managed to prevent

mother- to -child transmission, and HIV positive spouses can take adequate precaution not to infect their negative partners.

- The right to equal access to education. Discovering an individual's status through mandatory testing cannot exclude an individual from equal access to education. This type of abuse would be deemed unconstitutional and contrary to the proposal that mandatory testing should become compulsory. Knowledge of another's status cannot be used in a malicious manner that such knowledge deprives an individual of his/her basic human right.
- The right to adequate standard of living is the basic foundation for the proposal in favour of mandatory testing. The purpose of mandatory testing is to educate South Africans as to their status by convincing citizens into becoming responsible for their status. Accurate prevalence figures would allow policy- makers to provide an adequate standard of living. If anything, mandatory HIV testing strives to provide this vital right than prohibit it.
- The right to social security and welfare, is a fundamental right that mandatory testing hopes to restore. With a larger number of people reaching out for help, government would be in a position to help those that seek assistance rather than silently wasting away helplessly.
- The right to share in scientific advancement and its benefits. Being unaware of one's status would not allow one to share in scientific advancement. While the benefit derived by relying on conventional self- medication would not prevent the onset of AIDS, one, therefore, has to rely on antiretroviral therapy and combination therapy to offset the effects of the virus. Mandatory testing would allow for an informed decision and access to treatment and scientific breakthrough as they become available.
- The right to participate in public and cultural life. Stigma would gradually fall away as every individual is asked to be tested. No individual would be discriminated against because of a test, as each individual would be in a similar position. With mandatory testing, more individuals would feel less inhibited from enjoying life in public or in a cultural situation as each would be treated alike. Being tested and discussing one's experience of having a test done or attending

counselling would become a norm, gradually allowing stigma and discrimination to fall away, leading to better management of the epidemic. Mandatory testing would not curtail this right but use this right to the advantage of promoting HIV and AIDS management.

- The right to be free from torture and cruel, inhumane or degrading treatment or punishment. Not to know one's status and to allow oneself to reach progressive HIV is torture, cruel, inhumane and degrading. Not allowing oneself to benefit from health care is an injustice that would be avoided by being tested. Mandatory testing would avoid the silent pain of not knowing the cause and the solution as individuals continue to waste away by being ignorant of their status (UNAIDS, 2006).

### **Mandatory HIV and AIDS testing and the Constitution of South Africa Act no 108 of 1996**

- Section 10 in the South African Bill of Rights speaks of human dignity, the right to have one's dignity respected and protected. Mandatory HIV testing would not expose a person's status in a way that would allow for his/her self respect to be infringed by way of words or actions. Confidentiality of one's status is crucial in allowing this form of testing to be effective ([www.paralegaladvice.org.za](http://www.paralegaladvice.org.za)).
- Section 12 of the Constitution; the right to freedom and security of person, section 14 the right to privacy, section 16 the right to freedom of expression, section 18 the right to freedom of association, section 21 the right to freedom of movement and residence, and sections 22, 23, 24, 25, 27 have been dealt with under a larger title 'The right to social security assistance and welfare' in the International Guideline on HIV and AIDS and Human Rights. These also include section 29, the right of education and section 32, the right to access information. The above-mentioned sections are rights that are present in the international guideline on HIV and AIDS and Human rights and the South African Constitution of 1996. The inclusion of these rights glorifies the South African Constitution in the sense that it is welcoming to know that South African legislation is perfectly compatible with international standards ([www.paralegaladvice.org.za](http://www.paralegaladvice.org.za)).

The South African Constitution, however, does include sections 33, the right to just administration action and section 35, arrested, detained and accused persons, which are sadly excluded from The International Guideline on HIV and AIDS and Human Rights. Section 33, the right to just administration action through mandatory testing would not disallow a person from exercising this right simply because a person has tested positive. In retrospect, it is this very right that can lend a person support if he/she is refused administrative support, because of his/her status ([www.paralegaladvice.org.za](http://www.paralegaladvice.org.za)).

Section 35, arrested, detained and accused persons; act addresses prisoners and persons in general who are detained or in custody. Individuals under these circumstances cannot be discriminated against for being diagnosed HIV positive (C v Minister of Correctional Services 1996 (4) SA 292). Prisoners cannot be discriminated against or treated in an undignified manner just because they have HIV or AIDS ([www.paralegaladvice.org.za](http://www.paralegaladvice.org.za)). With mandatory testing in place, the prison warden as well as the person sentenced to life would have to be tested, including arresting officers. Current case law is in support that prisoners have equal right to health care as would any other person (C v Minister of Correctional Services 1996 (4) SA 292).

Mandatory testing in relation to UNAIDS international guidelines and the South African Constitution of 1996 are compatible. Mandatory testing does not infringe on any of the rights as set out in either document. Mandatory testing, in fact, complements these rights and reinforces areas that were previously seen as discriminatory. At the outset, one would instinctively lean on section 36 of the South African Constitution thereby arguing the limitation clause or guideline 104 of the UNAIDS international guideline on HIV and AIDS and human rights on restrictions and limitations. However, the argument is not necessary as mandatory testing does not require the support of such an argument. From a traditionalist perspective, one would argue that the thought of testing infringes on the right to freedom, liberty, privacy and choice. However, this argument is inaccurate.

However, if every individual, as the Constitution explains, is treated equally with dignity and tested with care, justice would be upheld while the stigma associated with HIV would be diminish.

South Africans, on a regular basis, are being asked to adapt to change. The crisis is such that should aggressive testing not be undertaken, medical practitioners and health care workers would not have the luxury to replace the lives they have lost. Sadly this decision is not in the hands of the practitioners or health care worker but rather in policy makers, who the lack comprehension as to the seriousness of the epidemic.

‘HIV now accounts for half of all deaths in the country. Yet South Africans remain in hopeless denial of their individual risk. AIDS denial by senior leaders has obscured the fact that they are joined by almost the entire population: only 2% of South Africans test for HIV each year. The voluntary and counselling and testing model emphasises choice and free will, which allows people to delay the choice to test, often until that choice is pre-empted by severe illness, pregnancy or insurance. The emphasis on voluntary counselling and testing has allowed individual autonomy to trump public health regardless of the consequences to broader society’ (Venter, 2007).

Opponents of mandatory HIV testing argue that this HIV testing model is largely-ineffective, since if one forces someone into HIV testing, one has not persuaded the person of the benefits of HIV testing and, therefore, one would have to coerce the person into treatment and behaviour change (Jack, 2006). This type of thinking is ludicrous. One cannot imagine how a person drowning in infection would not accept a life line and thereafter decide not to change his or her ways in order to prolong his/her life. The fundamental reason for opposition to this form of testing is the fear of knowing. Denial is far more comforting than being aware of one’s status (Scott, 2007).

### **A South African women’s human rights perspective**

‘In reality, the number of women infected with HIV relative to men infected with HIV increases every year and women more and more are the face of HIV and AIDS, due to gendered and inequalities. HIV prevention strategies, therefore, need to address and promote everyone’s right to equality and non-discrimination, the right to be free from all forms of violence, as well as the right to make sexual and reproductive decisions and the right to security in, and control over, one’s body, if the spread of the pandemic is to be halted. Or as argued by Hamblin & Reid, prevention strategies will only ever be effective in protecting women from the effects of HIV if we embrace a

recognition and active promotion of the human rights of women. 'Human rights must be used proactively in the prevention of HIV' (Elfenbein, 2005).

Gender equality has since been written into the Constitution, but this is not enough to ensure full gender equality. Women cannot breathe a sigh of relief; their struggle for recognition is not over yet. It is up to people who believe in equality to ensure that legislative equality becomes a practical reality and not remain in the law books (Women and the law in South Africa, 1998). 'If we are to be successful in compelling the United Nations to move beyond declarations and into implementation, if we are to transcend the critique that international human right norms coerce culture into a false unity, we must make certain that international legislation reflects and supports advocacy that is taking place at the local and international levels. Despite advances made at the international level, most real gains for women have, in fact, been the result of women's struggles in their own communities (Toro, 1995). AIDS has affected millions of women worldwide. Elizabeth Glaser, Gugu Dlamini, Mpho Motlounge, Susan Teffo, and Rebekka Armstrong are a few of the many women who have become publicly known for their personal stories and contribution in the fight against HIV and AIDS (Spink, 2008).

Toro (1995), states that the popularisation of women's rights is an urgent need. Popularisation is a process whereby we discover ourselves and each other as subjects of human rights, we recognise and claim our dignity by constructing human rights out of own life experiences, and we seek to have those constructs reflected in national and international legislation.

Women's rights are carefully wrapped in legislation and placed on the upmost shelves out of reach. Women's rights need to be placed within reach, where more women need to be informed as to their rights more especially in a crushingly patriarchal South African society that constructs and perpetuates the gender inequalities which influence how HIV and AIDS is spread within the nation (Shull, 2007). Such power inequalities continue to result in the increased vulnerability of powerless, impoverished South African women to HIV infection and effectively constrain their agency as human beings deserving of equal concern and respect (Shull, 2007).

The United Nations has made it clear that violence against women is a violation of basic human rights. The United Nations has promulgated treaties, recommendations and declarations that directly address women's rights and outline government obligations to protect these rights. South Africa has witnessed the birth of a new non-racial and non-sexist democracy. The most significant constitutional protections are found in the South African Bill of Rights, yet these rights are restricted to statutes and text books. 'Violence against women is an internationally recognised human rights violation when either a public official a private person commits the violence' (United Nations Documents that protect women's rights, 2002). The term 'violence against women' means any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations Documents that protect women's rights,2002).

Violence against women and girls is a major contributor to death and illness against women, as well as to social isolation, restrictions on freedom of movement, and loss of personal autonomy. Research confirms that violence, and particularly intimate partner violence, is a leading factor in the increasing 'feminisation' of the global AIDS pandemic resulting in disproportionately higher rates of HIV infection amongst women and girls (Fried, 2007). 'Simultaneously evidence confirms HIV and AIDS as both a cause and a consequence of the gender-based violence, stigma and discrimination that women and girls face in their families and communities , in peace and in conflict settings by state and non-state, and within and outside of intimate partnership' (Fried, 2007). One study of 1366 South African women concluded that those women who were beaten or dominated by their partners were much more likely to become infected with HIV than women who were not (Dunkle, 2004). While Rothschild and Reilly comment that a gender and human rights sensitive approach to HIV and AIDS and gender-based violence are essentially to finding innovative and effective solutions (Rothschild, & Reilly, 2006). Addressing the human rights implications of HIV and AIDS and violence against women requires grappling with gender inequality and other forms of discrimination at all levels- from policy reform to community education. Moreover the links between human rights, HIV and AIDS and violence against women must be made in practical ways that have an immediate impact on women's lives. Women benefit

most when rights-based approaches, including principles of non-discrimination, accountability, transparency, and participation are used in provision of services as well as in advocacy efforts.

‘Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The long standing failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all states and should be addressed’ (United Nations Document that protects women’s rights, 2002). ‘Gender based violence includes and is not limited to violence in the family battering by partners, dowry-related violence, and marital rape, violence against women in the community, rape, prostitution, forced labour. Rape is one of the most pervasive and damaging forms of gender based violence because by definition non consensual, rape has a higher risk of leading to HIV infection including harmful traditional practices: early marriage, wife inheritance and genital mutilation (Women HIV/AIDS and Human rights, 2008).

Sex workers are particularly victimised. ‘They are the informal and often illegal sector of society in which they occupy a low status and marginalised position. They frequently have little control over their working conditions in particular, are exposed to a primary mode. While bisexual women and lesbians often face a double layer of discrimination based both on their gender and sexual orientation, this often makes it even more difficult for these women to have access to health care’ (Women HIV/AIDS and Human rights, 2008).

The former quotation is an extract from the 1995 Fourth World Conference on Women held in Beijing, thirteen years later the plight of women in South Africa has remained unchanged. Creating legislation and hosting conferences has not changed the plight of women in South Africa. Mandatory testing may appear to conflict with legislation, yet its implementation would be far more restorative than current policy.

## **Mandatory HIV/AIDS testing as an additional precondition for the management of the HIV/AIDS pandemic**

Why mandatory HIV and AIDS testing? According to Francois Venter, head of the South African HIV Clinicians Society, confidential HIV testing should be required for all people in South Africa so that those who test positive can begin safeguarding their health immediately (Kaiser Daily HIV/AIDS Report, 2006). ‘With four-fifths of the roughly five million HIV positive people in South Africa not aware of their status, meaning that most HIV-positive people do not receive the care they need in the early stages of the disease and seek medical treatment only when their health has severely deteriorated (Kaiser Daily HIV/AIDS Report, 2006). ‘HIV is treatable current drugs can provide more than 30 years of life or more if started in time. Testing early also allows for the development of support structures, understanding of the complexities of integrating treatment into everyday life, planning for the future and initiation of treatment before the person actually gets sick’ (Venter, 2007).

Mandatory testing can effectively be promulgated by employers who should require proof of an HIV test before making job offers. HIV testing would be required when people apply for bank accounts, health insurance, government grants, drivers’ licences or whenever people deal in any way with bureaucracy (Kaiser Daily Report, 2007). According to Venter, HIV tests would be repeated at regular intervals to ensure that new cases are detected soon after transmission rather than years later. Venter adds that test results would not be available to the government or employers. Other methods of promulgating mandatory testing, as suggested by Venter, include companies being issued testing targets and receiving tax rebates, while HIV testing kits should be made available without prescription.

A further suggestion would include blood banks, welcoming individuals that would like to be tested for HIV rather than donating blood. Mobile blood clinics are clear that their service excludes the opportunity to be tested for HIV. Blood banks would be offered similar incentives by the government for tests conducted. While premarital testing would not be excluded as a method of instilling mandatory testing, spouses/ partners attending antenatal clinics would be asked to be tested with their spouses. Mandatory anonymous testing (MAT) would allow for individuals to anonymously test, safeguarding their results from others whilst acknowledging their status; Venter

advises that testing would always be accompanied by counselling and information about safer sex practices and responsible behaviour.

Anti- mandatory HIV testing activists should not assume that this type of testing suggests a quick fix or a shorter route to voluntary counselling and testing. Every essential element necessary for testing would be present that is pre- and post- counselling, consent and confidentiality. Mandatory testing does not abuse rights. Tests are not performed under duress. Everybody has to test because it is the law. Likewise everybody has to renew their drivers' licences and pay a fee, they may complain but it is the law. The law prevents unlicensed drivers from driving unlicensed and licensed drivers getting an eye test. The overall inconvenience benefits society as a whole. Mandatory testing can be seen as a legitimate inconvenience that necessitates the management of HIV and AIDS.

How does this translate into women's human rights? With more South Africans compelled to test, more men would be prompted to test. 'Recent national studies in South Africa found that only one in five South Africans who are aware of VCT have been tested for HIV, and that men accounted for only 2% of all clients receiving VCT' (Klindera, & Rebombo, 2007). Observations in a recent study conducted in Johannesburg concluded that two thirds of patients were female with 23% of women referred from prevention of mother to child transmission programmes; underscore the need for programmes that target HIV infected men. Similar findings were reported in a study of VCT uptake conducted in the Khayelitsha clinic outside Cape Town, where 70% were women (Klindera, & Rebombo, 2007).

With more men being made aware as to their status and counselled through the process, it is expected that greater responsibility would result from the outcome (Greene, & Derlega, 2003). Men that consider violence against women or seek to accuse women for being HIV carriers will reconsider their actions. As more South Africans begin to test, the burden of stigma would be spread very thinly allowing for transparency and a gradual reduction in stigma and discrimination.

As men become responsible and stigma reduced, more individuals would be treated equally; women's human rights would be restored. Culturally, women would be seen equal to men as both

parties are treated alike when being tested for HIV. An HIV negative woman would have greater reason to negotiate sex if she is aware of her status. The unfaithful spouse, who is aware of his status, would not accuse his faithful wife for being the cause of his infection. HIV positive couples would take additional care should they decide to have a family. Pre- and post-natal precautions can be adhered to prevent mother- to- child transmission. Each scenario would add on a human right previously lost.

Women, who are aware of their status, would have the ability to control their actions when choosing a partner, taking care of their children or deciding on a pregnancy. Men, on the other hand, would also become aware of their actions as they interact with others at the workplace or socially. Discriminating against HIV positive employees would be something of the past. Men would appreciate a woman who suggests the use of a condom. Violating, hurting a women or subjecting her to inhumane treatment because of her vulnerability would be twice considered as men come to realise that they are equally responsible should a spouse, partner or child become infected by the virus.

Tests repeated at regular intervals will ensure that individuals do not take their status for granted. Mandatory testing at repeat intervals would ensure that individuals are constantly kept on track as to their status. Once- off tests would not benefit the person that continues to behave recklessly or not take testing seriously.

As prevalence figures are gathered, government would be better equipped to deal with the influx of accurate prevalence figures. Helen Jackson and Tim Lee have concluded that data collection in South Africa is problematic and incomplete. It does not provide sufficient information to confirm the existence of a pandemic. However, the main data comes from unlinked screening studies of pregnant women without their knowledge or consent. Selected sites screen all clinic attendees for a given period of time until they reach a target sample size, utilising a portion of the blood drawn for syphilis and other tests (Jackson, & Lee, 2002).

The limitation to the quality of the data relate mainly to the representatives of sites selected, small ample size, lack of sufficient repeat surveillance to show trends, and lack of comparability across

sites within and between countries. By definition, such antenatal surveillance only covers females and is skewed toward younger and sexually active women. However, recent studies suggest that, if anything, antenatal data tend to underestimate HIV prevalence in the general adult population when controlled by age (UNAIDS, 1999). ‘The current emphasis by the World Health Organisation on testing in antenatal clinics for statistical purposes and address mother- to- child transmission, only serves to reinforce the view that women bring HIV into the family’ (ICW, 2006). There is a tendency to stigmatise women as ‘vectors of disease’ irrespective of the source of infection. As a consequence, women who are perceived to be HIV-positive, face violation and discrimination in both public and private life (UNAIDS, 2006). Disturbingly, the highest reported rates of disclosure related violence are women, who test for HIV in the context of antenatal care (ICW, 2006). Mandatory HIV testing would allow for a general application of testing, preventing spouses from abuse as each partner would be tested.

Countries also sporadically obtain data from public health services, patients and from men (typically) receiving treatment for sexually transmitted infections (STIS). Blood donors are screened throughout the region. The proportion of AIDS deaths reported is estimated to be low perhaps one –third in the more optimistic assessments (Jackson, & Lee, 2002). Knowing that accurate data do not exist and that mathematical models are only as reliable as the imputed data and the assumption made (Jackson, & Lee, 2002). Mandatory HIV testing would remove the guesswork in data collecting. ‘If we are to control the epidemic of HIV and manage the personal social and economic consequences of AIDS we need numbers. How many people will die in the next ten years, what will the epidemic cost? These are empirical questions and depend primarily on the collection of data’ (Williams, 2008). Mandatory HIV testing can just be such a source of data collection. Better consensus would help isolate problem areas allowing government to step in and effectively resolve areas of concern especially for women. ‘It is crucial that government implement there programmes with a keen awareness of expenses of all women living with HIV and AIDS and with respect for their human rights’ (Fried, 2007).

Hospitals would be better equipped to provide post- exposure prophylaxis (PEP) as Mthembu has found ‘is supposedly available at most state health institutions and yet, very few service providers administer it’ (Mthembu, 2006). Areas that have a higher concentration of HIV patients can be

better equipped with medical facilities that can serve their needs. With more facilities and ARV's available, community health care facilities would be in a position to help vulnerable women who previously would have to consider travelling long distances to have a test done or receive ARV's. Expectant mothers, who typically rely on traditional midwives who are ill equipped to diagnose HIV, would have the opportunity to be tested and cared for prior to delivery at a well- equipped health care facility. The benefits of accurate data collection are numerous each benefit will restore a right most women hoped existed.

As more women are awakened to their status, there would be a rekindling as to their self- worth and dignity. Mandatory premarital testing would reinstate women's human rights enabling women not be seen as commodities that can be transferred from one household to another. Younger women are often married off to older, sexually experienced men with little control over the choice of husband. Mandatory premarital testing would allow younger women the choice not to marry an HIV positive suitor. On the other hand, premarital testing would encourage 'abstinence until marriage', a form of mechanism that discourages premarital sex (Public Health fact sheet, 2008). Women would have the right to know the HIV status of a prospective spouse as 'bride wealth transfer is still part and parcel of modern marriages to some extent it represents an additional yoke that contributes to women's vulnerability to HIV and AIDS' (Madlala, 2006). Further, it is not uncommon for both men and women to justify both domestic and sexual violence on the grounds that a man has paid bride wealth. Bride wealth is frequently made to justify men's control over women and children, and to justify unsafe condom less sex in marriage (Madlala, 2006).

Repeat interval mandatory testing would caution predators of transactional sex. 'Sugar daddy's would have to consider their actions before suggesting gifts or favours in exchange for sex as 'HIV and AIDS is fast becoming a girls epidemic the World Health Organisation (WHO) notes that young people (aged 15-24) account for half of all new HIV infection, and of infected youths, two-thirds are female' (Fried, 2007). 'The combination of money and an expensive car tends to place people at high risk of HIV infection, men's promiscuous behaviour; dominance and economic advantage encourage and perpetuate patriarchy, leading to the pervasive spread of HIV and AIDS' (Marumo, 2006).

Polygamy and wife-inheritance can be defined; where a man may be legally married to one wife but does not preclude the possibility of one or several concurrent partnerships outside of the marriage. Often in a polygamous relationship the man is unhappy with just one wife and seeks to have several other wives. Premarital mandatory testing would alert potential spouses as to the individual's lifestyle. Women would have a choice of whether or not to continue in this cycle of infection. Wife inheritance is often not the choice of the women. Generally, the inherited wife is far older or already infected by the testator. Testing would allow parties to know their status before entering into this type of arrangement.

'Gender inequality and violence against women often inhibits women and girls ability to take full advantage of crucial-even life saving-services' (Fried, 2007). With mandatory testing being applied, women would have the benefit of compulsory pre- and post- counselling at which time vulnerable woman would have the opportunity to benefit from the counsel of trained counsellors who would be able to marginally detect whether a particular women may need additional help for example, a police officer to report rape or a social worker to report child abuse or domestic violence. Mandatory testing would afford women their first step into a secured environment that could assist them in restoring their human right. Facilities that are used or established for the purpose of mandatory testing would be equipped with the infrastructure to provide women with the support needed.

As mandatory testing becomes progressively acceptable, pre- and post- counsellors would be able to assist most women who would not have considered a test unless compelled to do so at antenatal clinics. 'Pre- test counselling is essential not only because it is the only entry point of information for persons who may test HIV negative, but also for people who may test positive for HIV so that messages of HIV prevention, safety treatment availability and adherence are important' (Grover, 2006). Illiterate and older women would not be excluded as this would provide an ideal opportunity to educate those individuals who do not understand the virus or the language that is often used to explain the severity of the disease. Research has shown a 'significant number of women aged 65 to 80 were also raped. The men who did it were confident they could have unprotected sex with them without getting AIDS' (Fried, 2007). Mandatory testing would benefit

victims of rape that silently live with the violence to legitimately receive a test without being stigmatised as a rape victim.

In 2006, UNAIDS decided to shift the age bracket of people infected with HIV from '15-49 years old' to '15 years and over' stating that a substantial proportion of people living with HIV are 50 years and older (Harvey, 2006). 'The 'care giver only' role ties into what seems to be the primary misconception which is simply that people, over 50 years are not at risk for HIV infection' (Harvey, 2006). Recent studies have shown that the number of people over 50 years who have tested HIV positive in South Africa might be as high as 20% (Harvey, 2006). Mandatory testing would dispel these misconceptions and restore human rights previously overlooked as the elderly present themselves to be tested. Better health care programmes can be developed to provide ARV's for the care giver and the infected.

'Generally in South Africa there seems to be a serious lack of vision regarding the design and implementation of HIV and AIDS prevention programmes. The focus on gay and lesbian people is non-existent within mainstream agencies' (Vilakazi, 2006). Sexual minorities are often excluded because of their sexual diversity. Mandatory testing would force health care professionals to educate themselves as to the various sexual minorities, and to become better equipped when dealing with pre- and post- counselling sessions. 'The experience for most has been that the health practitioner will just assume that they are heterosexual, the other extreme is pure homophobic treatment, where people are often asked why they are lesbians' (Vilakazi, 2006). In this instance, mandatory testing would restore a basic human right, the right to dignity.

A second minority group is commercial sex workers. Their lifestyle and vulnerability are indicative of abuse and exploitation. Fear of being accused as 'core transmitters' of the disease often prevents these women from attending clinics or testing for HIV. Fear of knowing their status is far more costly than the health of the person as an HIV positive status would result in the loss of income. The need to survive transcends the right to health. However, the choice of not being tested would only encourage the risk of infecting others. Mandatory testing would grant these women health care options they would not have considered had they not tested at all.

A third minority group is sexually active minors that ordinarily would need to seek the permission of their parents before taking a test. Mandatory HIV testing would also allow sexually-active minors better access to realise their status, since they would be tested for HIV testing without parental permission or notification (Anderson, 2006).

Planning for the future is a right every women, child and man is entitled to enjoy. Knowing one's status would allow for planning, whether the plan includes a new baby or simple insurance. Knowing gives one control over decisions that affect one's life. Knowing gives one control over one's body.

## **Conclusions**

The rationale for mandatory testing, rather than risk-based testing on physician's referral to VCT, is to decrease barriers to testing, to decrease risk-taking behaviour among infected individuals, and to identify HIV infected individuals earlier in their disease so as to provide maximal benefits of therapy.

Routine testing is gaining greater support in South Africa after Botswana introduced the approach in 2004. Routine testing comprises of two primary forms of testing: opt-in and opt-out HIV testing. Opt-in testing is where anyone who enters a health care setting will be informed of the availability of an HIV test, but will only be given a test, if specifically requested. With opt-out HIV testing, anyone who enters a health care setting will be tested for HIV unless the person refuses to consent to the HIV test. The success rate with routine HIV testing has been acclaimed testing in the US improved acceptance of HIV testing in pre-natal clinics, inpatient wards and emergency departments (Ho, & Volberding, 2007). Routine HIV testing at the point of care in out- patient departments (OPD) in Durban identified nearly 5 times as many new cases per week as HIV testing per physician referral to an adjacent hospital-affiliated VCT side (39 v 8 new cases per week) (Ho, & Volberding, 2007). With routine testing producing progressive results it can be concluded that mandatory testing would be far more rigorous as testing would not depend on the ill or pregnant (Smart, 2007).

The WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counselling, but recognise the need for additional, innovative and varied approaches. The uptake of regular VCT has been limited by low coverage of services, fear of stigma and discrimination, and perception by many people that they are not at risk. In an effort to overcome these obstacles, the three United Nations agencies that is the WHO, the United Nations Children's Fund (UNICEF) and the joint United Nations Programme on HIV and AIDS (UNAIDS) are calling for an increase in provider-initiated testing and counselling (PITC) as well as a strengthening of prevention, treatment and care services (People's Daily Online, 2007). 'Provider-initiated HIV testing and counselling (PITC) is an approach in which health care providers specifically recommend an HIV test, when it fits the local epidemiological and social context, it requires that health facilities have the capacity to ensure that patients receive and understand basic information on HIV and have given informed consent prior to the testing' (People's Daily Online, 2007).

PITC, like routine testing, is confined to the health care facility. Should an individual not attend a health care facility he/she would be excluded from the programme? South Africa cannot wait for every attendee to either volunteer or attend a health care facility where the need does not arise. The crux of the concern is to have every individual tested. 'Approximately 80% of people living with HIV in low- and middle-income countries do not know their status' (IRIN Plus News, 2007). Scaling-up access to HIV testing and counselling is both a public health and a human rights imperative (IRIN Plus News, 2007).

Current evidence may suggest that many opportunities to diagnose HIV in clinical settings are being missed (www.who.int, 2007). Yet those missed opportunities only include those individuals that attend a health care facility. These programmes exclude the individuals dying of AIDS who discovered their status only at admission (Venter, 2007). The programme would further exclude the house wife, sugar daddy, the prostitute, the 14 year old school boy, and the one day old new born, the elderly, the 6 year- old molested every night, the list is endless. If we are to focus on a few, how do we save the remaining 80%.

Dr Shigemi Omi, WHO regional Director for the Western Pacific, says knowing his or her HIV status is a public health and human rights imperative, as it leads to life-extending HIV treatment,

care and support services as well as to evidence-based prevention interventions (People Daily Plus, 2007). Zackie Achmat, of South Africa's AIDS lobby group, the Treatment Action Campaign (TAC), confides 'I tested positive for HIV in 1990, and because I had early testing I was able to access treatment early, I have had four sero-negative partners since my diagnosis, and they are still sero-negative, again this is because I got tested and was able to take the necessary precaution' (IRIN Plus News, 2007). These are the rights mandatory testing proposes to establish and further the management of HIV and AIDS in South Africa.

Opponents of mandatory testing claim more HIV positive people in need of treatment in countries with limited resources might create a larger backlog of people with no access to treatment (Medical News Today, 2007). Would this be in line with an individual's right to healthcare, life and dignity? Denying the existence of the ever increasing incidences of HIV would not improve the management of the disease. 'It is a good thing to be concerned with human rights in resource-limited settings but this must be balanced with a sense of urgency about the million of people infected with HIV not receiving care (and dying) because they don't know their status, the status quo or waiting for VCT services to be scaled up everywhere is simply not acceptable' ([www.aidsmap.com](http://www.aidsmap.com) , 2007). 'Studies have shown not every one who tests positive for HIV will need drugs immediately, previous studies have also shown that once people are aware of their HIV positive status they tend to practice safer sex' (Medical News Today, 2007). This type of behaviour change is one of the many examples of change that would support the management of HIV, 'as people become aware of their status and that knowledge-would be in a position to access treatment, and modify their behaviour so as to minimise the risk of onward transmission to others' (Gazzard, 2006).

Kevin De Kock, head of WHO's HIV and AIDS Department, said that HIV diagnosis is an 'essential first step' to curbing the spread of the virus (Medical News Today, 2007). According to the Times, some human rights advocates have said that because of stigma associated with HIV and AIDS, no one should be pressured to receive an HIV test if it could lead to job loss or abandonment by families (Medical News Today, 2007). Activists that fear job losses or abandonment by family do not understand what is being proposed. Mandatory testing is not about militant testing or labelling individuals positive or negative. Mandatory HIV testing is about being

tested, knowing one's status, protecting one's family and being assured that one's status is safe until one is confident to reveal one's status. Mandatory HIV testing is not the holocaust of tests. Individuals that have been tested would not be placed in quarantine or stigmatised. However, as more people test, visibility would be 'vital in overcoming stigma and more unnecessary AIDS-related deaths (Fine, 2006).

A wider circle of people disclosing and living positively has given HIV a human face. Mandatory testing is not about rekindling stigma: it's about liberation and unity where we all have a right to be tested in solidarity. According to Anand Grover all living organisms, including human beings are in a dynamic relationship with their environment. Thus, if the internal environment changes to one of knowledge, empowerment and assertiveness, one will be in the position to participate in HIV prevention. Similarly, if the external environment changes to one which is free of stigma, discrimination and violation of rights, based on one's sex, gender sexuality and or HIV status, one will feel free to access and participate in HIV prevention (van Der Schaff, 2006).

Deane Collie's executive director of International Coalition for Medical Justice (ICMJ), opinion of mandatory testing is far fetched. According to Collie 'this is a Kafkaesque right more that hides human ethics behind a veil of holocaust-like propaganda' (Duluca, 2000).

Does mandatory HIV testing comply with human rights, the South African Constitution Act no108 of 1996 and the International guidelines on HIV and AIDS and human rights? Durojaye quotes Mann who declares that every public health policy, no matter how good it may seem, is potentially a threat to the enjoyment of human rights. Durojaye explains that, in some situations, a public health policy may limit the enjoyment of human rights. This policy can only be allowed in some situations, rights maybe restricted in the interest of society, serves a legitimate public interest, is essentially necessary not arbitrary unreasonable or discriminatory and where a less intrusive means cannot be used to reach the goal (Durojaye, 2008).

Although mandatory testing would satisfy these requirements in terms of guideline/paragraph 104 of the International Guideline on HIV and AIDS and human rights and section 36 of the South African Constitution, restrictions and limitations are unnecessary. Previously discussed relevant

rights, as set out in the Universal Declaration of Human Rights and the South African Constitution, are compatible with mandatory testing. Interpreting human rights can be multifaceted, rights are perceived differently depending on the interpreter. De Luca thinks it is insane to pre- test pregnant women. She has compared it to ‘unparallel likeness to the testing of pregnant Jewish women by the Nazis’ (De Luca, 2000); while TAC has demanded that ARV’s are given to pregnant women. Obviously those women cannot be given ARV’s without being tested.

Libertarians and human right advocates emphasise that the state should not interfere with individuals decisions about their health and that making testing universal would violate autonomy and choice the ‘right not to know’, yet the state imposes benign legislation to assist with individual and public health, seat belts are compulsory , smoking is restricted, immunisation is a prerequisite for school enrolment, vision tested before a driver’s test and cell phones are prohibited when driving (Venter, 2007).

With mandatory testing being compatible with legislation, we are steps ahead in restoring women’s rights. As testing becomes universal, more women would have the right to choose health care, to remain in harmful relations and negotiate sex. Stigma would be reduced as both men and women are expected to be tested. One gender would not be seen greater than the other or less guilty for introducing HIV into the household than the other. Restoration of these basic human rights would assist in the management of HIV and AIDS. As more individuals are tested and counselled, awareness would be delivered to each individual not through a campaign or a poster but through a test. Self- awareness would lead to self- management. Periodic testing would become a measure of adherence and reason to remain negative and healthy. Greater awareness would increase access to ARV’s; as Green adds to have free ARV’s on the shelf while so many are unaware that they need them is a clear human right violation ([www.aidsmap.com](http://www.aidsmap.com) , 2007). In conclusion, the literature review has in many ways supported the implementation of mandatory HIV and AIDS testing as a precondition for the management of HIV and AIDS. Legislation when plainly interpreted is complemented by the suggestion. Human rights principles where supported allowing greater liberty for women once oppressed. The recommendations that follow are based on the literature review supporting the suggestion that mandatory testing of HIV and AIDS as a precondition for the management of HIV and AIDS is well founded.

## **Recommendations**

The emphasis on voluntary counselling and testing has allowed individual autonomy to trump public health regardless of the consequences to broader society (Smart, 2007). To give effect to the consequences of the broader society, it is suggested that mandatory HIV testing come into effect with an emphasis on informed consent, counselling, confidentiality and access to treatment.

Mandatory testing would insist on regular testing for healthy adults, either through incentive-linked systems, tax rebate, medical aid benefit, and reduction in insurance premiums or holiday incentives. Another possible solution, as suggested by Venter, is an 'I know I my status' certificate issued by approved counsellors at regular intervals. The certificate would not record the HIV test result simply that the person knows and understand the results with a date (Venter, 2007).

More importantly 'regular updated certificates may be required for the issuing of all official documents (identity books, driver's licence, bank cards, tax submissions, social grant application) and processing membership of medical aids, applications for new jobs and university entrances, marriage, continuity to receive social grants or pension (Venter, 2007). Furthermore, government must give effect to human rights legislation, particularly dealing with women and children. To have the best policy in place without any effect is futile.

Government donors must fully identify the needs of women when distributing resources. Government donors and service providers must be informed, equipped and sensitive when dealing with attendees at testing sites regarding breaches of confidentiality and rights to privacy, especially in relation to disclosure of HIV status and partner notification policies (Fried, 2007).

Government, with the support of donors, need to increase the level of resources for training. Health care providers must be well-acquainted with human right approaches to service delivery and health policy development regarding mandatory HIV testing. Social service providers must be trained to answer questions regarding mandatory testing, what it entails and what effect it would have once tested.

Government must create or change legislation to promote mandatory testing in conjunction with various other types of testing. Government should make legislation practical and user friendly while committing to programmes equipped to address violence and HIV and AIDS, through education and detailed information about HIV prevention treatment care and support. This includes a focus on the right of women in their own individual rights as citizens (Fried, 2007).

Government must commit themselves to the continued roll- out of ARV's, working towards changing discrimination, rights of women, creating prevention, protection and actions to address gender violence and HIV and AIDS (Fried, 2007). Further, government has to strive to change the stigma in the language that is communicated by removing negative undertones to everything that is AIDS related for example, AIDS orphans, dying of AIDS, AIDS sufferers, and HIV victims (Fried, 2007).

Finally, to give effect to this proposition, it is recommended that a quantitative research be concluded, to gain further insight on the perspective of society, health care professionals and legal minds regarding their views on mandatory HIV and AIDS testing as a precondition for the management of HIV and AIDS in South Africa.

‘History will judge us, and the children of tomorrow won’t ask who it was who did or didn’t act against AIDS, but will know that nothing was done’. (Anonymous, undated)

## **REFERENCES**

1. Abdool Karim, S.S., & Abdool Karim, Q. (Eds), (2008). *HIV/AIDS in South Africa* (2<sup>nd</sup> Ed.). Cambridge University Press Cape Town: South Africa
2. Anderson, B., (2006, September) 'A Human Rights approach to HIV Testing: Voluntary. Mandatory or Routine', *AIDS Legal Network*. P1-7
3. Arbour, L., *United Nations High Commissioner for Human Rights International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version ILO: HIV/AIDS*
4. Aspects of HIV/AIDS and the Law (2007) *Gender Health and Justice Research Unit* University of Cape Town. South Africa
5. Balihar, S. (2009) *Qualitative Research Methods: Documentary Research* www.uk.geocities.com
6. Barnett, T., Tstsele, F., Bekezela, M., Whiteside, A., (2002) *The private sector responds to the epidemic Debswana- a global benchmark*, UNAIDS/02. 52E Geneva, Switzerland
7. C v Minister of Correctional Services 1996 (4) SA 292).
8. Clarke, L., *Will Aids be the Face of SA?* <http://www.iolhivaids.co.za> 5/21/2008 published on the web by HIV/AIDS on the 7 June 2007.
9. Constitution of the Republic of South Africa ( Act no. 108 of 1996 )
10. Criminal Procedure (Act no of 1977)
11. De Luca, J., (2000) 'Mandatory HIV testing for all expectant mothers', *The International Coalition for Medical Justice*.
12. Department of Health Policy Guidelines on Rapid HIV tests and Testing (1999.April)

13. Dunkle, K.L., (2004) 'Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa'. *The Lancet*
14. Durajaye, E., (2008) 'Addressing Human Rights concerns raised by mandatory HIV testing of pregnant women through the protocol to the African Charter on the rights of women', *Journal of African Law*, 52,1 (2008), P43-65 School of Oriental and African Studies, United Kingdom
15. Eide, A., (1995) Economic, social and cultural rights as human rights. In Eide. A, Krause. C, Rosas. A, (Eds). *Economic, social and cultural rights: a textbook* Dordrecht, Martinus, Nijhoff.
16. Elfenbein, R., (2005, November). "'ABC': A gendered look at HIV prevention'. *AIDS Legal Network*, 10-13
17. Essex, M., & Mboup, S. (2003) The Etiology of AIDS. In Essex, M & Mboup, S (Eds), *AIDS in Africa* (2<sup>nd</sup> Ed) Kluwer Academic/Plenum Publishers: New York.
18. Fine, D., (2006, November) HIV prevention and treatment: The power of positive language *AIDS Legal Network* P13-17
19. Fried. S., (2007. March) Rights are too often overlooked *AIDS Legal Network*, P14-23
20. Gazzard, B.G., (2006) Nuffield Council on Bio ethics Consultation on 'Public health: ethical issues' *Expert Advisory group on AIDS*. UK [www.advisorybodies.doh.gov.uk](http://www.advisorybodies.doh.gov.uk)
21. Global Challenges/South African Clinicians Society Head calls for HIV testing in country to be required, confidential, (2006), *Kaiser Daily HIV/AIDS Report*. [www.kaisernetwork.org](http://www.kaisernetwork.org)

22. Greene, K., Derlega, V.J., Yep, G.A., Pretorious, S., (2003) *Privacy and Disclosure of HIV in interpersonal Relationships*, Lawrence Erlbaum Associates, Mahwah, New Jersey.
23. Grover, A., (2006, September) 'Opt-out routine HIV testing a flawed strategy' *AIDS Legal Network* P18-22
24. Harvey, E., (2006, November) Those elderly people HIV prevention messages miss people over 50 *AIDS Legal Network* P18-21
25. Harvey, E., (2006, September) HIV testing: An effective prevention measure *AIDS Legal Network* P23-26
26. Herman, D., (2007) Only 2% of SA Citizens have been tested for HIV <http://www.iolhivaid.co.za>
27. HIV testing and the Rights of Women living with HIV (2006, September),
28. International community of Women living with HIV/AIDS (ICW) June 2006 *AIDS Legal Network*.
29. HIV testing-a rethink need (2007,May) IRIN Plus News, [www.aidscrewatch.org](http://www.aidscrewatch.org)
30. HIV/AIDS and the Bill of Rights [www.paralegaladvice.org.za](http://www.paralegaladvice.org.za) retrieved (2007/03/26)
31. HIV/AIDS in the World of Work 98<sup>th</sup> Session March 2007
32. Hoffman v South African Airways 2001 1 SA 1 (CC)
33. Jackson, H., & Lee, T., (2002) *HIV and AIDS a global view* Green wood Press  
West port Connecticut London
34. Jurgens, R. (2007) *Increasing Access to HIV Testing and Counselling while Respecting Human Rights*, Open Society Institution, Public Health Programme  
[www.soros.org](http://www.soros.org)

35. Klindera, K., Rebombo, D., Levack, A., (2007, March) 'Fear Factor Voluntary Counselling and Testing for HIV and masculinity in South Africa' *AIDS Legal Network*, P40-44
36. Labour Relations (Act no 66 of 1995)
37. Law Reform Examiner Gender, Health and Justice Research Unit May 2008
38. Madlala, S. L., (2006, November) 'What prevents Prevention? An overview of the sociological and gender context of HIV prevention in South Africa' *Aids Legal Network*, P31-34.
39. Marumo, T., (2006, September) 'Women: The transmitters of HIV and AIDS gender, HIV and AIDS and stigma', *AIDS Legal Network* P29-36.
40. Mthembu, M., (2006, November). 'Influences that Taint HIV prevention messaging' *AIDS Legal Network*, P27-30
41. National Health (Act no 61 of 2003)
42. National Patients' Rights Charter
43. Nieburg, P., Connell, T., & Morrison, J., (2005) '*Expanded HIV testing: Critical Gateway to HIV treatment and prevention requires Major resources, Effective Protection*', Washington Post Centre for Strategic and International Studies.
44. Nnaemeka, O., & Ezeilo, J., (2005) *Engendering Human Rights*, Palgrave, Macmillan New York.
45. Pembrey, G., (2008) 'HIV&AIDS in South Africa', *Avert* [www.avert.org](http://www.avert.org)
46. Peters, J., & Wolper, A., (1995) *Women's Rights international feminist perspectives Human Rights* Routledge New York.

47. Richter, M., (2006) '*Different models of HIV testing. What are the considerations in South Africa*' AIDS Law Project Discussion Paper.
48. Robbins, S.P., Odendaal, A., Roodt, G., (2004). *Organisational Behaviour Global and South African Perspectives*, Pearson Education, South Africa.
49. Rothschild, C., Reily, M. A., & Nordstrom, S.A., (2006) *Strengthening Resistance: Confronting Violence against women and HIV/AIDS*. New Jersey, USA Centre for Women's Global Leadership.
50. Routine Voluntary HIV testing in Durban South Africa. The experience from an outpatient department (2007, October) (Eds) Ho, & Volberding, P.A., *Journal of AIDS* volume 46 Number 1
51. Sayagues, M., (2008, December 19). HIV/AIDS death by stigma *Daily News* P.9.
52. Scale-up of HIV counselling and Testing: A call for approaches based on Human Rights and gender equity (2006, September) Anthena Network
53. Scott, C., (2007) Testing times: AIDS' not a disease of ignorance, it's a disease of denial' Science in Africa website.
54. Section 2 (2) (b) in the draft version of the Sexual offences and Related Matters Amendment
55. Sexual Offences Amendment (Act no 32 of 2007)
56. Shull, H., (2007), '*AIDS, Gender and Human Rights. An examination of Human Agency within Post Apartheid South Africa*', Graduate School of International Studies University of Denver.
57. Smart, T., (2007) 'Does the scale of the epidemic in South Africa call for compulsory HIV testing', *AIDS Map News* (2007, June) [www.aidsmap.com](http://www.aidsmap.com)

58. Smythe, D., & Jefthas, D., (2007) Sexual Offences and HIV/AIDS challenges facing Magistrates, *The Law Race and Gender Unit Faculty of Law University of Cape Town and the Gender Health and Justice Research Unit Faculty of Health Sciences University of Cape Town*. South Africa
59. Spink, G., (2008) Women, HIV and AIDS, Avert [www.avert.org](http://www.avert.org)
60. Strode, A., Lewis, M., HIV/AIDS and Human Rights in SADC Namibia. *SIDA Irish AID*.
61. The Health Professions Council Guidelines for the management of Patients with HIV or AIDS
62. The Risk of Human Rights being obscured with more aggressive testing (2007) [www.aidsmap.com](http://www.aidsmap.com)
63. Toro, M. S., (1995). Popularizing Women's Human Rights at the local Level: A Grassroots Methodology for Setting the International Agenda. In Peters. T & Wolper. A, (Eds), *Women's Rights human rights international feminist perspectives* P189-197) Rout ledge. New York.
64. UN agencies call for scaling-up HIV testing and counselling in Asia and the Pacific (2007,June) *People's Daily* Online, [www.english.people.com](http://www.english.people.com) , [www.aidscareswatch.org](http://www.aidscareswatch.org)
65. UNAIDS 2008 Report on the Global AIDS Epidemic [www.who.int](http://www.who.int)
66. UNAIDS,WHO Release New HIV testing guidelines (2007, June) *Medical News Today*, [www.medicalnewstoday.com](http://www.medicalnewstoday.com), [www.aidscareswatch.org](http://www.aidscareswatch.org)
67. UNAIDS/WHO (1999) UNAIDS 1999 Report on the global AIDS epidemic
68. UNAIDS/WHO (2004), HIV testing (2004,June) [www.who.int](http://www.who.int)

69. UNAIDS/WHO (2008), Guidance on provider –initiated HIV testing and counselling health facilities, [www.who.int/](http://www.who.int/)
70. United Nations Document that protect Women’s Rights, Stop Violence against women, (1995), International Law United Nations Systems Fourth World Conference on Women Beijing.
71. Van Der Schaff, G., (2006, November) ‘Provincial Activist Feedback’, *AIDS Legal Network* P24-26
72. Van Zyl, G., (2008). Epidemiology unpublished class notes (Industrial Psychology), University of Stellenbosch
73. Venter, F., (2007, June 3). Make HIV tests compulsory for South Africans. Sunday Times ([www.suntimes.co.za](http://www.suntimes.co.za)).
74. Vilakazi, F., (2006,November) ‘There is no mention of sexual minorities HIV prevention challenges for Lesbian and gay people in South Africa’, *AIDS Legal Network* P10-12
75. Walensky, R. P., (2008) ‘Scaling up antiretroviral therapy in South Africa: the impact of speed on survival’ *Journal of Infectious Diseases*, 197 (2008,May,1)
76. Whiteside. A (2003) ‘Painting the picture-impact of AIDS in development in Africa, Science in Africa website.
77. Williams, B., (2008), Models and Trends, In Abdool Karim, S.S., & Abdool Karim, Q., (Eds), *HIV/AIDS in South Africa* (2<sup>nd</sup> ed), Cambridge University Press Cape Town: South Africa
78. Women and HIV testing Policies, Practices and the Impact on the Health and Human Rights, (2008) *Public Health Fact Sheet* [www.soros.org](http://www.soros.org)

79. *Women and the Law in South Africa Empowerment through enlightenment*, (1998).

Unit for Gender Research in Law UNISA Juta & Co Ltd.

80. 'Women, HIV/AIDS and Human Rights' (2008) *Amnesty International USA*,

[tylcrane@ gmail.com](mailto:tylcrane@gmail.com). AIDS Legal Network P15-17.