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ISSN 1727-3781

2012 VOLUME 15 No 1

http://dx.doi.org/10.4314/pelj.v15i1.7

REALISING EQUALITY IN ACCESS TO HIV TREATMENT FOR VULNERABLE AND MARGINALISED GROUPS IN AFRICA

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1 Introduction

> States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines… (Revised Guideline 6 of the International Guidelines on HIV and Human Rights 2002)

Almost thirty years into the HIV/AIDS pandemic its negative effects (including loss of health, income and a source of living) have continued to threaten lives in most parts of the world, particularly sub-Saharan Africa. Although recent figures tend to show that the spread of the epidemic is declining or stabilising in many countries, the devastating effects of the epidemic have not abated. UNAIDS[1] has reported that at the end of 2009 there were about 33 million people living with HIV worldwide. Of this figure, Africa accounts for about 23 million, that is, 68 percent of the people living with HIV.[2] The report indicates that across the world, particularly in the hardest hit regions such as Africa, efforts targeted at reducing the spread of HIV are beginning to yield positive results. According to the report, HIV incidence has fallen by 25 percent between 2001 and 2009 in 33 countries, of which 22 are in sub-Saharan Africa.[3] An estimated 2.6 million people were infected with HIV worldwide in 2009, about one fifth fewer than the 3.1 million people infected in 1999. In sub-Saharan Africa it is estimated that 1.8 million people were newly infected with HIV in 2009, fewer than the 2.2 million people newly infected in 2001.

More importantly, there have been remarkable achievements with regard to the number of people receiving HIV treatment worldwide. It is estimated that about 1.2

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1 UNAIDS *Global AIDS Epidemic Report* 16.

2 UNAIDS *Global AIDS Epidemic Report* 25.

3 UNAIDS *Global AIDS Epidemic Report* 16.

million people received HIV treatment in 2009 alone, representing an increase of about 30 percent in a single year.[4] Overall, the number of people receiving HIV antiretroviral therapy in low and middle income countries has now increased to 5 million.[5] This translates to about 35 percent of people in need of HIV treatment in the world. When compared with the about 230, 000 people receiving treatment in 2001, this is no doubt a significant improvement in ensuring access to treatment for those in need. This expansion in access to HIV treatment has led to about a 19 percent decrease in HIV-related deaths among children worldwide between 2004 and 2009.[6] As the region hardest hit by the epidemic, sub-Saharan Africa recorded the greatest increase in the number of people receiving antiretroviral therapy in 2009, from 2.9 million people at the end of 2008 to 3.9 million people as at December of 2009, representing an increase of about 33 percent in a single year.[7] Interestingly, the average number of people receiving treatment in sub-Saharan Africa is put at 37 percent (41 percent in Eastern and Southern Africa, and 25 percent in Western and Central Africa) compared with only 2 percent few years back.[8] In some countries such as Botswana the antiretroviral therapy coverage has almost exceeded 90 percent, thus leading to sharp decline in AIDS-related deaths from 18, 000 in 2002 to 9, 100 in 2009.[9]

Despite these achievements, however, more efforts are still needed in Africa to realise universal access to HIV treatment for those in need. When compared with other regions (42 percent in Central and South America, 51 percent in Oceania, 48 percent in Caribbean and 19 percent in Eastern Europe and Central Asia), the number of people on ARV in Africa is still one of the lowest.[10] More particularly, there is a need for African governments to improve access to HIV treatment for vulnerable and marginalised groups such as children, people living in rural areas, sex workers, men having sex with men (MSM) and prisoners.

4 WHO *Towards Universal Access* 11.
5 UNAIDS *Global AIDS Epidemic Report* 95.
6 UNAIDS *Global AIDS Epidemic Report* 19.
7 WHO *Towards Universal Access* 11.
8 WHO *Towards Universal Access* 11.
9 Stover *et al* 2008 *PLoS ONE* 3:e3729.
10 UNAIDS *Global AIDS Epidemic Report* 96.

Against this background, this article examines the relevance of the concept of equality in improving access to HIV treatment for vulnerable and marginalised groups in Africa. The article argues that though modest achievements have been made in expanding access to HIV treatment for those in need in Africa, this expansion has concentrated on the general population without focus on the needs of those most vulnerable and marginalised in society, especially children and sex workers. In conclusion, it is argued that if the aim of realising universal access to treatment for all by 2015 is to be achieved, it is imperative to ensure equal access to HIV treatment for disadvantaged groups such as children and sex workers.

2 The importance of equality in accessing health care services

Equality, like most legal terms, is incapable of a generally acceptable definition. This is because the term could mean different things to different scholars. However, it has been recognised that equality is tantamount to non-discrimination. Hence, an act of discrimination will lead to the violation of the right to equality.[11] The principle of non-discrimination has been well recognised in most human rights instruments. For instance, article 2 of the *African Charter on Human and Peoples' Rights* (the *African Charter*) provides that every individual shall be entitled to enjoy all the rights guaranteed in the Charter without distinction as to race, sex, political belief, religious belief and other status.[12] Furthermore, article 3 provides that all individuals shall be equal before the law and that they shall be entitled to equal protection of the law. In a number of cases the African Commission on Human and Peoples' Rights (the African Commission) has shed light on the importance of these provisions. For instance, in the *Legal Resource Foundation v Zambia*[13]*,* the Commission explained that the right to equality is important because people are expected to be treated equally before the law and are entitled to equal enjoyment of the rights available to other citizens. Moreover, the Commission noted that "equality or lack of it affects the capacity of one to enjoy many other rights".[14] Similarly, the Human Rights

11 Shalev 2000 *Health and Human Rights* 39.

12 Article 2 *African Charter on Human and Peoples' Rights* (1981); see also a 3 of the African Charter, which provides for equality before the law and the equal protection of the law.

13 *Legal Resource Foundation v Zambia* 2001 AHRLP 84 (ACHPR) para 63.

14 For instance, the rights to dignity and to be free from inhuman and degrading treatment. See *Legal Resource Foundation v Zambia* 2001 AHRLP 84 (ACHPR).

Committee[15] responsible for monitoring the implementation of the International Covenant on Civil and Political Rights (ICCPR) has noted that non-discrimination, together with equality before the law and equal protection of the law, forms a basic principle relating to the protection of human rights.

The classical conception of the notion of equality is often traced to Aristotle,[16] who argues that likes should be treated alike and unlikes in proportion to their unalikeness. This has given rise to a distinction being made between formal and substantive equality. Formal equality - often referred to as mathematical, absolute or numerical equality - merely treats all members of society in the same way without taking into cognisance their specific differences. This approach is said to be blind to the socio-economic disparities that may exist in every society. Adherence to formal equality in the real sense does not guarantee true equality. Instead, it entrenches disparity. Dworking[17] warning Americans that sameness of treatment does not ensure true equality and expresses the opinion that "we must take care not to use the Equal Protection Clause [of the 14th Amendment of the *American Constitution*] to cheat ourselves of equality". Implicit in this statement is that the mere assurance of (formal) equality may not address social injustice. On the other hand, the notion of substantive equality implies that every individual is treated in the same manner, taking into consideration each one's peculiar circumstances. In other words, substantive equality, differently from formal equality, aims at promoting social justice and egalitarianism in a society, particularly for the marginalised or vulnerable groups.[18] The non-discrimination provisions guaranteed in the *Convention on the Eliminations of All Forms of Discrimination against Women* (*CEDAW*)[19] and the *Protocol to the African Charter on the Rights of Women* (*African Women's Protocol*)[20] are good examples of the notion of substantive equality.

15 Human Rights Committee *General Comments 18*; see also Möller 'Article 7' 115.
16 Aristotle *Nichomachaen Ethics* para III.
17 Dworking *Taking Rights Seriously* 209.
18 Rawls *Theory of Justice*.
19 *Convention on the Elimination of All Forms of Discrimination Against Women* (1980). According to ar1 of *CEDAW* discrimination is widely defined to embrace any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women of their rights on an equal basis with their male counterpart.
20 The *Protocol of the African Charter on Human and People's Rights on the Rights of Women in Africa* (2003) entered into force on 25 November 2005. A 1 of the *African Women's Protocol* defines discrimination against women as "any distinction, exclusion or restriction or any

Following from the above discussion, it is clear that realising equal access to health care for the disadvantaged groups in society requires that health care institutions must take into consideration the peculiar circumstances of these groups. In essence, a substantive equality approach in health care services is imperative to meeting the special needs of vulnerable and marginalised groups.[21] Reinforcing this argument, Loenen has noted as follows: [22]

> a meaningful and convincing interpretation of the concept of discrimination starts from its historical genesis as principle directed at protecting groups, which have suffered from structural disadvantage, from patterns of exclusion, and not just from one negative incidental impact… Sensitive groups thus need stronger protection against classification with a negative impact… Such an asymmetrical conception of discrimination acknowledges harm caused by measures which disadvantage vulnerable and subordinate groups is, indeed, a greater evil which merits more suspicion than measures which disadvantage power and otherwise privilege groups.

It should be noted that the enjoyment of the right to health guaranteed in various human rights instruments[23] can be realised only in the absence of any form of distinction or discrimination. For instance, article 12 of the *International Covenant on Economic, Social and Cultural Rights* (the *ICESCR*), the most comprehensive provision on the right to health, guarantees the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. According to the Committee on ESCR,[24] the enjoyment of the right to health is dependent on other rights such as rights to life, privacy, dignity and non-discrimination. The Committee has further noted that an essential minimum core of the right to health includes realising access to health care services to all on a non-discriminatory basis. In the Committee's view, the Covenant proscribes: [25]

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differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life".

21 For a detailed discussion on this see Ngwena 2000 *Medical Law International* 111.

22 Leonen 1997 *SAJHR* 408.

23 See for instance, a 12 of *International Covenant on Economic, Social and Cultural Rights* (1966) (*ICESCR*); a 12 of *CEDAW*; a 24 of the *Convention on the Rights of the Child* (1989) (*CRC*); a 16 of the *African Charter* and a 14 of the *African Women's Protocol*.

24 Committee on ESCR *General Comment 14* para 12.

25 Committee on ESCR *General Comment 14* para 18.

> any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status which has the effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

More importantly, the Committee has reasoned that in realising the right to health for all, the equality of access to health care must be emphasised. Furthermore, with regard to access to health care services, states are obliged to eliminate discrimination on internationally prohibited grounds, especially the core content of the right to health. Undoubtedly, these explanations of the Committee tally with the notion of substantive equality in health care services.

With regard to the historically disadvantaged position of women, Cook and Howard have argued that developing an anti-discrimination theory can be useful in addressing the neglect of women's reproductive health and the detrimental impact of such neglect on the status of women in society.[26] This is particularly true of the patriarchal nature of African society, where women's rights are accorded little or no respect, thus compromising their sexual and reproductive health needs. The decision of the South African Constitutional Court in the *Minister of Health v Treatment Action Campaign and Others*[27] provides an indication of the relevance of equality to having access to health care services. In that case, the Court held that the failure of the South African government to provide antiretroviral therapy in public institutions to prevent mother-to-child transmission constituted a breach of its obligation under the national constitution and international law. Although the Constitutional Court did not directly apply the notion of equality in its judgment, nonetheless, the Court held that the failure of the South African government's policies to meet the need of those in dire need (HIV-positive pregnant women) rendered those policies unreasonable and constituted a breach of the government's obligation to realise the right to health of its citizens. This decision of the court would seem to lean towards the application of the principle of substantive equality in health care services.

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[26] Cook and Howard 2007 *Emory Law Review* 1041.

[27] *Minister of Health v Treatment Action Campaign* 2002 10 BCLR 1033 (CC).

More specifically, the Canadian Supreme Court has demonstrated the importance of substantive equality in access to health care services for vulnerable groups in *Eldridge v British Columbia (Attorney-General)*[28]. In that case, some of the issues before the Court were premised on whether or not sections 3, 5 and 9 of the *Hospital Insurance Act* and the Regulations infringed section 15(1) of the Canadian Charter of Rights by failing to require hospitals to provide medical interpreter services for the deaf. If the answer was in the affirmative, the Court wished to establish if the impugned provisions were saved under section 1 of the Charter. The Court held that the failure to make money available for sign-language interpretation that would equip hearing-impaired patients to communicate with health-service providers in the same way that unimpaired patients can, constitutes discrimination in violation of the Canadian Charter on Rights and Freedoms. According to the Court, the adverse effects of discrimination are relevant in the context of people with disabilities. The Court further explained that: [29]

> In the present case the adverse effects suffered by deaf persons stem not from the imposition of a burden not faced by the mainstream population, but rather from a failure to ensure that deaf persons benefit equally from a service offered to everyone. Once it is accepted that effective communication is an indispensable component of the delivery of a medical service, it is much more difficult to assert that the failure to ensure that deaf persons communicate effectively with their health care providers is not discriminatory. To argue that governments should be entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits bespeaks a thin and impoverished vision of s. 15(1). It is belied, more importantly, by the thrust of this Court's equality jurisprudence.

The relevance of this case is that it clearly requires states to do more than meeting the needs of the general population. They need also to take into cognisance the peculiar needs of some members of society who are vulnerable, disadvantaged or marginalised. This reasoning of the court is crucial to our discussion relating to ensuring equal HIV treatment for children, sex workers and men who have sex with men (MSM) in Africa. The discussion that follows will show that it is imperative for African governments, using the substantive equality approach, to improve access to HIV treatment for vulnerable and marginalised groups such as children and sex

28 *Eldridge v British Columbia (Attorney-General)* 1977 151 DLR (4th) 577.
29 *Eldridge v British Columbia (Attorney-General)* 1977 151 DLR (4th) 577.

workers as a matter of obligation and in order to meet the target of universal access to health care for all by 2015.

3 Applying a rights-based approach to the access to HIV treatment for vulnerable and marginalised groups in Africa

It is widely agreed that realising access to treatment for all constitutes an integral part of the right to health. Echoing this position, the UN General Assembly has noted that access to treatment in the context of HIV/AIDS is one of the fundamental elements required if the world is to "achieve progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[30] This presupposes that a human rights approach must be adopted in the provision of health-related services, including access to HIV treatment. The question may then be asked: what does a rights-based approach to health services mean? Adopting a rights-based approach to health related services implies that all health policies, plans and programmes must be grounded on respect for people's fundamental.[31] Moreover, it presupposes assessing and addressing the likely human rights implications of health decisions, plans or programmes. More importantly, a rights-based approach requires making human rights an integral part of the design, implementation, monitoring and evaluation of health-related policies and programmes.[32]

Some essential elements of a rights-based approach to health services include safeguarding human dignity, ensuring the provision of a health care system that is accessible to all, giving attention to gender-related issues, removing advertent or inadvertent discrimination in the ways in which services are rendered, and paying special attention to the rights of vulnerable and marginalised groups in society.[33] As regards the last point, it is imperative to recognise and act upon the characteristics of those likely to be affected by health-related decisions, policies and programmes. In this regard, groups such as children (both male and female), adolescents, women and men, indigenous people, refugees, prisoners, immigrants and migrants, people

30 *Declaration of Commitment on HIV/AIDS* (2001) para 15.
31 WHO *25 Questions and Answers* 16.
32 WHO *25 Questions and Answers* 16
33 WHO *25 Questions and Answers* 16, 17.

with disabilities, sex workers and economically disadvantaged and other marginalised groups must be given special attention.

In many societies, vulnerable and marginalised groups are often disproportionately affected by health problems. While in some cases this situation may not be envisaged, it is generally agreed that overt or implicit discrimination will violate the fundamental rights of individuals.[34] Although not all discrimination amounts to a violation of rights, an unjustified and unfair differential treatment will no doubt amount to a violation of human rights.[35] Over the years, grounds for non-discrimination in the context of health-related services have evolved to include proscribing "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national and social origin, property, birth … and other status".[36]

Mann has argued that most public health programmes and policies are replete with "inadvertent discrimination" to the extent that public health policies and programmes should be deemed discriminatory until otherwise proved.[37] In other words, public health policies are potentially a threat to the enjoyment of human rights. This is often so because policymakers scarcely ever consider the human rights implications of public health policies or programmes. As stated above, while African governments have made positive efforts to realise access to HIV treatment for the general population, gaps still exist with regard to the position of vulnerable and marginalised groups. The next section of this article focuses on the situation of children and sex workers.

3.1 Children

Globally, there are indications that the number of children newly infected with HIV is decreasing. In 2009 an estimated 370, 000 children were newly infected with HIV, a

34 Cook, Bennard and Fathalla *Reproductive Health and Human Rights* 197.
35 Gruskin and Tarantola "Health and Human Rights" 314.
36 Committee on ESCR *General Comment 14.*
37 Mann 1997 *Hasting Center Report* 9.

decrease of about 24 percent from 5 years earlier.[38] Also, in the same year an estimated 260, 000 children died worldwide of AIDS-related illnesses, about 19 percent fewer that the estimated 320, 000 who died in 2004.[39] This is an indication that that there have been tremendous improvements in preventing the mother-to-child-transmission of HIV worldwide, particularly in sub-Saharan Africa. According to the World Health Organization (WHO),[40] worldwide about 360, 000 children younger than 15 years of age were receiving HIV treatment at the end of 2009, up from the 275, 000 in 2008, representing an increase of about 29 percent. Despite the progress made so far, however, only 6.8 percent of children are receiving HIV treatment worldwide as against about 8.7 percent in need of treatment.[41] With regard to antiretroviral coverage among children, it is estimated that of about 1.2 million children in need, only 28 percent had access to treatment compared with 35 percent of adults worldwide.[42] Although while sub-Saharan Africa accounts for about 87 percent of pediatric needs, only 26 percent coverage (less than the 28 percent for worldwide coverage) has been achieved in the region.[43] This could be construed as an indication that it is not yet time to celebrate the modest progress made in realising access to HIV treatment for the world's children.

Moreover, the fact that more adults than children have access to antiretroviral therapy is an indication that African governments are giving more priority to the needs of adults than those of children. For instance, the estimated number of children receiving treatment compared with adults in some African countries is put at 11 percent of children as against 30 percent of adults in Cameroon, 12 percent of children as against 32 percent of adults in Mozambique, and 18 percent of children as against 42 percent of adults in Uganda.[44] This may amount to an act of discrimination prohibited under numerous international and regional human rights instruments, including articles 2 and 3 of the *Convention on the Rights of the Child* (*CRC*) and the *African Charter on the Rights and Welfare of the Child* (*African Children's Charter*) respectively. As noted above, the Committee on ESCR has

38 UNAIDS *Global AIDS Epidemic Report* 19.
39 UNAIDS *Global AIDS Epidemic Report* 19.
40 WHO *Towards Universal Access* 11.
41 WHO *Towards Universal Access* 11.
42 WHO *Towards Universal Access* 14.
43 UNAIDS *Global AIDS Epidemic Report* 99.
44 UNAIDS *Global AIDS Epidemic Report* 99.

stated that the right to health must be guaranteed to all on a non-discriminatory basis, paying attention to the needs of the vulnerable and marginalised groups in society. In addition, this situation can be said to be contrary to the principle of the best interests of the child, which principle is recognised under the *CRC* and the *African Children Charter*.

It is estimated that in 2009 130, 000 children were newly infected with HIV in Africa, 32 percent fewer than in 2004, when about 190, 000 children were newly infected with HIV.[45] Also, the death toll as a result of AIDS-related illnesses among children in the region was estimated at 90, 000 in 2009, compared with 120, 000 deaths in 2004. An important factor contributing to this decline in the death toll is the pronounced progress made in the prevention of the mother-to-child transmission of HIV. Thus, the infection rates among children born to mothers living with HIV have dropped significantly from about 500, 000 to 320, 000 worldwide.[46] Indeed, many countries across the world, particularly in Africa, have made great strides in this regard.

On average, Africa has achieved about 54 percent coverage of antiretroviral therapy for pregnant mothers. In some countries in the region, such as South Africa, Botswana, Namibia and Swaziland, coverage of about 80 percent has been achieved.[47] Despite this improvement, a disparity still exists from one sub-region to another. For instance, while about 68 percent of pregnant mothers in East and Southern Africa received antiretroviral medication to prevent the mother-to-child transmission of HIV in 2009, only about 23 percent was recorded in Western and Central Africa.[48] The shortfall in the provision of antiretrovirals for the prevention of mother-to-child transmission is widest in a country such as Nigeria. This is a sad development, considering the fact that about 90 percent of the children living with HIV are infected through mother-to-child transmission.

Moreover, given the modest cost involved, there is no reason while African countries should not scale up treatment to prevent the mother-to-child transmission of HIV. A

45 WHO *Towards Universal Acces* 11.
46 UNAIDS *Global AIDS Epidemic Report* 78.
47 UNAIDS *Global AIDS Epidemic Report* 99.
48 UNAIDS *Global AIDS Epidemic Report* 99.

conclusion that can be drawn from this is that African governments are not committing enough resources to meeting the health needs of the people in general and children in particular. This is sometimes reflected in the weak infrastructure and acute shortage in basic amenities such as gloves, syringes and medication in the health care institutions.

It should be noted that a failure to realise the health care needs of children will amount to a violation of their right to health guaranteed in articles 24 and 14 of the *Convention on the Rights of the Child* (*CRC*)[49] and the *African Charter on the Rights and Welfare of the Child* (*African Children Charter*)[50] respectively. Article 24 of the *CRC* recognises the right of children to the enjoyment of the highest attainable standard of health. More importantly, article 24 (f) requires states parties to develop preventive health care guidance for parents and family planning services. Article 14 of the *African Children's Charter* provides that every child shall be entitled to the best attainable standard of physical and spiritual health. The Committee on the CRC has noted that failure on the part of states to ensure access to HIV treatment care and services for children will result in the violation of their rights to health and life.[51] In particular, the Committee has noted that discrimination against children in the context of HIV may be construed as a denial of services to them.

The Committee has further noted that policies and programmes have been developed in the context of HIV mainly for adults without a focus on the needs of children. In the Committee's view, this is inconsistent with the principle of the best interests of the child guaranteed under article 5 of the Convention.[52] According to the Committee, this principle requires that in all actions relating to children, the best interests should be a paramount consideration. Thus, the Committee urges states to place children at the centre of all actions and steps taken with regard to addressing the impact of the HIV pandemic.[53] In some of its concluding observations to states parties, the Committee has advocated for a sufficient allocation of resources to meet

49 *Convention on the Rights of the Child* (1989).
50 *African Charter on the Rights and Welfare of the Child* (1990).
51 Committee on CRC *General Comment 3* para 5.
52 Committee on CRC *General Comment 3* para 10.
53 Committee on CRC *General Comment 3* para 10.

the health needs of children in the context of HIV/AIDS[54] and has urged governments to incorporate a "youth-friendly" approach in the delivery of reproductive health services, including HIV/AIDS care services.[55] The call for the adoption of "youth-friendly" health care services would seem to cover the plight of children, given that under international law children are persons under the age of 18, while young persons have been described as persons between the ages of 15 and 24 years.[56]

At the regional level, the Africa Union in its *Abuja Declaration* expresses grave concern about the high incidence of the mother-to-child transmission of HIV and requests member states to take appropriate measures with a view to addressing the special needs of children in the context of the epidemic.[57] Moreover, African governments agreed to: [58]

> [M]obilize all the human, material and financial resources required to provide care and support and quality treatment to our populations infected with HIV/AIDS, Tuberculosis and Other Related Infections, and to organize meetings to evaluate the status of implementation of the objective of access to care.

While it is noted that the *Abuja Declaration* is not binding on African governments, nonetheless it constitutes a moral obligation requiring African governments to fulfill the commitments made during the Declaration.

In the *Treatment Action Campaign*[59] case the South African Constitutional Court held that the failure on the part of the South African government to ensure access to antiretroviral therapy at public health institutions to prevent the mother-to-child transmission of HIV was a violation of the right to health guaranteed under the constitution. The Court in that case rejected the argument of the South African

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54 Committee on CRC *Concluding Observations: Benin* para 25; see also Committee on CRC *Concluding Observations: Lesotho* para 46.

55 Committee on CRC Concluding *Observations: Central Africa Republic* para 61; see also Committee on CRC *Concluding Observations: Ethiopia* para 61.

56 UNDP, UNFPA, WHO & World Bank Special Programme of Research, Development and Research Training in Human Reproduction Progress in *Reproductive Health Research.*

57 *Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and other Related Diseases* (2001) paras 5 and 6.

58 *Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and other Related Diseases* (2001) para 30.

59 *Minister of Health v Treatment Action Campaign* 2002 10 BCLR 1033 (CC).

government that its inability to provide such services was due to a lack of resources. According to the Court, such an excuse was untenable given the importance of preventing HIV transmission from pregnant mothers to their unborn children. Although this case dealt specifically with the prevention of the mother-to-child transmission of HIV, there is no reason why the principles of law enunciated thereto should not apply, to hold a state accountable for its inability to meet the health needs of children generally.

Experience has shown that, access to health care services for children in general and HIV treatment in particular is difficult in most African countries due to the existence of a number of challenges including a lack of access to accurate sexual and reproductive health information, cultural and religious factors, the need for parental consent, poor funding, gender inequality and the unfriendly nature of the health care setting.[60] In most African countries, honouring their cultural and religious norms, parents avoid discussing issues relating to sex with their children, particularly their daughters. The result is that most children lack adequate information regarding sexual matters, including the prevention and treatment of HIV/AIDS. Even when they possess the necessary information regarding their health, children often face difficulty in seeking treatment because of the demand for parental consent or the judgmental attitudes on the part of health care providers. Thus most children shun seeking help or treatment for sexual and reproductive health issues, including HIV/AIDS. This not only violates the rights of children but also endangers their health and lives.

The Committee on CRC has urged states to ensure that health care centres are sensitive and respectful of the rights of children and young persons.[61] In one of its Concluding Observations of the CRC: Nigeria, the Committee recommendesthat respect for the rights of the child should form the fulcrum of all governments' policies and programmes relating to HIV/AIDS.[62]

60 See for instance, Biddlecom *et a*l *Protecting the Next Generation in Sub-Saharan Africa* 17; Munthali *et al Adolescent Sexual and Reproductive Health in Malawi* 14.

61 Committee on CRC *General Comment 4.*

62 Committee on CRC *Concluding Observations: Nigeria* para 717.

It should be noted that during the 2001 Declaration of Commitment the governments of the world agreed to address non-discrimination against children infected with HIV, including those orphaned by it, and to ensure them equal enjoyment of fundamental rights, including access to health care services.[63]

3.2 Sex workers

Sex work is regarded as one of the oldest profession in the world. However, in many countries, particularly in Africa, engaging in sex work or other activities related to it is criminalised. Moreover, sex workers are often viewed as morally depraved persons and experience discrimination and violations of their rights. Thus, many people who engage in sex work operate secretly, in a very difficult environment. This makes them vulnerable. However, the truth remains that in many countries of the world, including sub-Saharan Africa, a significant number of new HIV infections occur among sex workers daily.[64] For example, it has been reported that new HIV infection rates among female sex workers in Ethiopia, Zambia, South Africa and Ghana are about 75 percent.[65] This underlines the need for prevention and treatment, care and support efforts to be improved among sex workers.[66]

Due to the stigma attached to and the criminalisation of sex work in most parts of Africa, sex workers are less likely than the general population to access public health services, and may not know about or be able to afford treatment for sexually transmitted infections (STIs), including HIV/AIDS. In addition, organisations promoting the rights and health of sex workers or led by sex workers often experience difficulty in accessing funds to carry out HIV-related programmes that are likely to be beneficial to sex workers.[67] Narrating the experience of sex workers in Uganda, Ray notes as follows: [68]

63 *Declaration of Commitment on HIV/AIDS* (2001) paras 65 and 66.
64 See for instance, Durojaye, Okeke and Oluduro 2009 *Indian Journal of Human Rights and the Law* 13.
65 UNAIDS *Progress Report* 75.
66 UNAIDS *Handbook for Parliamentarians* 187.
67 Fried and Kowalshi-Morton 2008 *Health and Human Rights* 127.
68 Ray *The Guardian* 6.

> Health clinics that offer HIV testing and treatment services in Uganda regularly deny sex workers access to care and withhold anti-retroviral medications on the grounds that there are other people, whose jobs are legal and who aren't engaged in immoral activities, who are more deserving of treatment. Some healthcare workers regard time and HIV/Aids resources spent on sex workers as a waste.

Generally, people living with HIV encounter discriminatory attitudes on a daily basis. Studies have shown that socially marginalised groups already tend to suffer the most severe forms of HIV-related stigma and discrimination.[69] As for HIV-positive sex workers, the situation is compounded due to the negative attitudes of most communities to sex work. Access to health care services, particularly HIV-related services, may be difficult for sex workers as a result of their inadequate access to counseling and testing, care and support services. It is important that sex workers living with HIV have access to HIV prevention, care and support services, including assistance to leave sex work if they so wish, counseling support to assist with partner notification, access to antiretroviral therapy and the treatment of opportunistic infections, and social support.[70] Without access to this comprehensive seet of support services, sex workers are not only at great risk of infection but are also a threat to society. This fact underlies the importance of addressing the stigma and discrimination associated with HIV, especially as regards marginalised groups such as sex workers.

While there are no accurate figures relating to the number of sex workers accessing HIV treatment worldwide, it is believed that a small percentage of HIV positive sex workers currently have access to antiretroviral therapy. This is often the case because of the fact that sex work is criminalised in most countries. The criminalisation renders sex workers vulnerable to violence and abuse and thus exposes them to HIV infections. Punitive measures against the activities relating to sex work reinforce the stigma and discrimination against sex workers and push them further out onto the margins of society. This further leads to an environment than condones the exploitation of sex workers. In some cases, systematic police violence and the harassment of sex workers becomes the norm.[71] Unfortunately, due to the criminalisation of sex work, most countries in Africa do not include sex workers in

69 See for example, Visser, Markin and Lehboye 2006 *Journal of Community & Applied Social Psychology* 42-58.
70 UNAIDS *Guidance Note* 7.
71 Canadian HIV/AIDS Legal Network *Sex, Work, Rights* 14.

prevention and treatment programmes on HIV/AIDS. The result is that a significant number of sex workers lack access to HIV treatment. A report has shown that less than a third of sex workers in need of HIV prevention receives it.[72] Worse still, less than this figure received appropriate HIV treatment, care and support.[73] Reports from some African countries such as Lesotho, Mozambique and Senegal have revealed that the stigma and discrimination against sex workers and other sexual minorities constitute great barriers to access to HIV treatment, care and support.[74] This is a violation of the rights to health and life of sex workers. More importantly, it violates the right to non-discrimination of sex workers.

The Committee on ESCR has noted that health care services must be provided to all without discrimination against vulnerable and marginalised groups. Obviously, this necessarily includes sex workers, who are daily subject to stigmatisation and abuse. The Committee has reiterated this in some of its concluding observations to states parties. For instance, in one of its concluding observations to the government of Dominican Republic, the Committee emphasised that the forced prostitution of women and the trafficking of women and girls may lead to serious health consequences not only for these groups but for the country's population at large.[75] Thus, the Committee has enjoined the government to take the necessary steps to ensure that these women's right to health is protected.

Although the Committee on CEDAW has not been very consistent in its statements and comments regarding the advancement of the rights of sex workers,[76] nonetheless it has occasionally made important comments relating to access to health care for them. For instance, the Committee has noted that women, girls and sex workers generally are vulnerable to HIV infections and that states must take the necessary steps to ensure that they have access to the health care services they

72 UNFPA, UNAIDS and Government of Brazil *Report of the Global Technical Consultation.*
73 UNFPA, UNAIDS and Government of Brazil *Report of the Global Technical Consultation.*
74 UNAIDS *Country Progress Reports* 12.
75 Committee on ESCR *Concluding Observations: Dominican Republic* para 16.
76 For instance, in Committee on CEDAW *Concluding Observations: China* paras 288-289 the Committee asked the state party to take necessary steps with a view to decriminalising sex work, whereas at other times the Committee has expressed concerns about the unintended consequences of the legalisation of sex work, as this may result in the perpetration of further violence against them. See Committee on CEDAW Concluding Observations: Georgia para 101; Committee on CEDAW *Concluding Observations: Netherlands* paras 209-210.

require without prejudice or discrimination.[77] In one of its concluding observations to the government of Armenia, the Committee has expressed concern about the increasing number of sex workers in that country, owing mainly to the limited economic options available to women. The Committee has further noted the "lack of access of women engaging in prostitution to appropriate health services, including for the prevention and care of HIV/AIDS".[78] At some other times the Committee has advocated for access to health care services for sex workers.[79] This will no doubt include ensuring them access to HIV treatment, care and support.

It should be noted that meeting the prevention, care and treatment needs of sex workers in the context of HIV/AIDS requires taking a wide range of actions including expanding the knowledge base on the nexus between sex work and HIVAIDS, embarking on advocacy campaigns, building partnerships, and enhancing service provisions for sex workers. More specifically, it will be necessary to integrate HIV services into general primary health care dealing with STIs, tuberculosis, hepatitis, family planning and prevention of mother-to-child transmission of HIV.[80] Additionally, it will be necessary to strengthen the programmes that provide care and treatment for HIV-positive sex workers, including unrestrained access to antiretroviral therapy and the treatment of opportunistic infections. Also, there will be a need to empower sex workers to negotiate safer sex and refuse a client where necessary.[81]

A holistic approach is required from African governments to improve the health needs of marginalised groups such as sex workers. In this regard, it has been rightly suggested as follows: [82]

> Greater attention must be paid to how the interplay between law and social values may impede access to essential health services and compromise the effectiveness of HIV programmes. The criminalization of HIV transmission, same-sex relations, sex work and drug use impedes effective interventions to prevent HIV transmission among these groups and makes them significantly less likely to seek life-saving

77 Committee on CEDAW *General Recommendation 24* para 18.
78 Committee on CEDAW *Concluding Observations: Armenia* para 59.
79 See for instance, Committee on CEDAW *Concluding Observations: Cameroon* para 52; Committee on CEDAW *Concluding Observations: Democratic Republic of Congo* para 289.
80 UNAIDS *Guidance Note* 8.
81 UNAIDS *Guidance Note* 8.
82 UNICEF 2010 www.unicef.org.

treatment and care. Many of these issues are compounded further by poverty and social marginalization.

4 Conclusion

As seen from the above discussion, it is imperative that African governments adopt a comprehensive approach to HIV treatment and care, which must take into cognizance the peculiar needs of vulnerable and marginalised groups such as children and sex workers. Such an approach must be based on the notion of substantive equality, ensuring that all those in need of treatment, particularly the vulnerable and marginalised groups, have access to prevention, treatment and care services. There is a need to address the stigma attached to and the discrimination against vulnerable and marginalised groups such as children, sex workers and MSM, which often drive them to live on the margins of society, beyond the reach of health care services.[83] Efforts must be made to address the interplay between law and social values, which may hinder access to health care services and derail promising HIV programmes.[84] As the UN Secretary General correctly observed, universal access to HIV prevention, treatment, care and support represents an essential bridge towards achieving the full range of the Millennium Development Goals (MDGs).[85]

Laws that punish certain sexual behaviours fuel discriminatory practices against certain groups in society, especially in the context of HIV/AIDS. Such laws must be revised or repealed and more concrete efforts must be made towards upholding the human rights of all, particularly the vulnerable and marginalised groups in society. Moreover, African governments will need to create an enabling environment where marginalised groups are protected from violence and human rights abuse that may impede access to HIV treatment and other forms of health care. It will be recalled that during the UN Declaration of Commitment in 2001, governments across the world agreed to reduce the stigma attached to and discrimination against people living with HIV and those vulnerable to HIV infection.[86]

Furthermore, during the Political Declaration on HIV/AIDS in 2006, the international community agreed to the scaling up of programmes to achieve universal access to

83 WHO *Towards Universal Access* 16.
84 WHO *Towards Universal Access* 16.
85 United Nations *Report on the Progress Made*.
86 *Declaration of Commitment on HIV/AIDS* (2001).

HIV prevention, treatment, care and support, recognised the harmful effects of stigma and discrimination in addressing the HIV pandemic, and made commitments to reduce them.[87] The recent move by the South African government to consider the decriminalisation of sex work is a welcome development. Decriminalisation wouldl go a long way toward advancing the human rights of sex workers.[88] This would enable sex workers to be reached easily by government's intervention and prevention programmes on HIV/AIDS.

It is also important that African governments engage with vulnerable and marginalised groups in the design and implementation of HIV prevention and treatment policies and programmes. More importantly, African governments must recommit themselves to the promise they made in the Abuja Declaration, where they agreed to allocate 15 percent of their annual budgets to the health sector in order to address the impact of the HIV pandemic[89]. There is no better time than now to fulfill this promise. Given that Africa is the region hardest hit by the epidemic, increasing spending on the health of the people will go a long way towards improving the access to health care of infected and affected person, especially members of vulnerable groups such as children and sex workers.

87 *Political Declaration on HIV/AIDS* (2006).
88 Department of Health 2006 www.info.gov.za.
89 *Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and other Related Diseases* (2001).

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List of abbreviations

African Charter	African Charter on Human and Peoples' Rights
African Children's Charter	African Charter on the Rights and Welfare of the Child
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
SAJHR	South African Journal on Human Rights
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
UNFPA	United Nations Programme on Population and Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization