

HIV and Human Rights in Southern and East Africa

2014 Report



ARASA
AIDS & Rights
Alliance
for Southern Africa

HIV and Human Rights in Southern and East Africa

2014 *Report*





about ARASA

Who are we?

Established in 2003, the AIDS and Rights Alliance for Southern Africa (ARASA) is a regional partnership of over 70 non-governmental organisations (NGOs) working together in 18 countries to promote a human rights approach to HIV, AIDS and tuberculosis (TB) in Southern and East Africa (SEA) through capacity building and advocacy. ARASA partners comprise a diverse mix of more and less well-established organisations including networks of people living with HIV, legal support services, human rights, women's, sex workers', LGBTI, youth and other AIDS service organisations across SEA. The basis of the partnership is solidarity and shared responsibility for advancing social justice in the region, with a focus on the realisation of the right to health. Since its inception in 2003, the partnership has remained the only alliance of organisations that have come together to address human rights responses to issues of HIV and TB in SEA.

Our vision

A Southern and East Africa in which all are able to access and enjoy their fundamental human right to health.

What do we do?

The work of ARASA is structured in 2 programme areas:

Training and Capacity Strengthening: ARASA strengthens the capacity of its partners and the communities that they serve to promote a human rights-based response to TB, HIV and AIDS in their own countries. The Training and Capacity Strengthening Programme facilitates human rights training at both regional and national levels, assists to strengthen skills and develop training resource materials related to HIV, TB and human rights programming.

Advocacy and Lobbying: ARASA strengthens and supports partner organisations to promote a human rights based response to TB, HIV and AIDS through technical assistance to them and the communities that they serve. This programme is aimed at enabling partners and communities to monitor and analyse the efforts of national governments to protect, respect and uphold human rights in the context of national responses to AIDS and TB; and engage in effective advocacy initiatives on rights issues that are identified as relevant at both the national and regional levels.

Central to both programme areas is the recognition that the protection of human rights remains critical to a successful response to HIV, AIDS and TB. HIV-related stigma and discrimination remain major obstacles to meeting the target of universal access to HIV prevention, care and treatment. Protection of human rights, both for those vulnerable to HIV infection and those living with HIV, is not only a right, but also produces positive public health results against HIV. The denial of human rights such as the rights to non-discrimination, gender equality, information, education, health, privacy and social assistance both increases vulnerability to infection, and increases the impact of the epidemic.

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abbreviations

ARASA	AIDS and Rights Alliance for Southern Africa
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine
AU	African Union
CEDAW	Convention for the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
DRC	Democratic Republic of Congo
EAC	East African Community
eMTCT	Elimination of Mother to Child Transmission of HIV
FDC	Fixed Dose Combination
FGM	Female Genital Mutilation
GARPR	Global AIDS Response Progress Reports
GBV	Gender-Based Violence
GCHL	Global Commission on HIV and the Law
GFATM	Global Fund to fight AIDS, TB and Malaria
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex Persons
MMP	Methadone Maintenance Programme
MSM	Men who have sex with men
NAC	National AIDS Council
NCPI	National Commitments and Policies Instrument
NGO	Non-Governmental Organisation
NSP	National Strategic Plan on HIV and AIDS
PEP	Post-Exposure Prophylaxis
PEPFAR	President’s Emergency Plan for AIDS Relief
SADC	Southern African Development Community
SEA	Southern and East Africa
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations International Children’s Emergency Fund
UNGASS	United Nations General Assembly Special Session
VSU	Victim Support Units

1. Introduction: About the Report

1.1 Aim of the 2014 Report

The HIV & Human Rights in Southern and East Africa 2014 report examines the legal and regulatory framework for responding to HIV and AIDS in countries in Southern and East Africa (SEA) in order to determine whether:

- Laws, regulations and policies protect and promote the rights of all people, including key populations at higher risk of HIV¹, in the context of HIV and AIDS, and
- Populations are aware of their rights, are able to access justice and are able to enforce their rights in the context of HIV and AIDS.

The 2014 Report identifies and analyses both national and regional findings to identify significant developments in creating enabling legal and regulatory frameworks for key and emerging human rights issues (such as the criminalisation of HIV transmission, gender inequality, gender-based violence (GBV) and protection of the rights of key populations). In addition, the report provides country snapshots for 18 countries, updating information on universal access and human rights.

1.2 Background

Following the publication of the 2006 and 2009 reports, the AIDS and Rights Alliance for Southern Africa (ARASA) and its partners considered this an opportune time to reflect on the process of developing both reports and the value that they have added to the discourse and advocacy on HIV and human rights in SEA. The following issues emerged during the process for purposes of designing the 2014 Report:

- The 2006 and 2009 reports provide a solid baseline for further reporting on HIV and human rights in SADC. However, given the length of time since the first report, it would be useful to move back to looking at a full report on HIV and human rights issues across countries, looking at law review and reform, access to justice and law enforcement issues, for this 2014 Report.
- However, since much of the information from the 2006 and 2009 reports remains relevant, this 2014 Report updates the HIV & human rights situation in countries in 2014, as well as assessing the development of protective legal frameworks for certain key populations and women and their impact on universal access to HIV prevention, treatment, care and support.
- The reports have been widely used as a resource for research and have been extensively quoted in publications on HIV, law and human rights. In many respects, the 2006 and 2009 reports represented one of the few attempts to systemically evaluate HIV and human rights in the SADC region. However, in terms of advocacy, it is not clear whether the reports have been as useful for ARASA partners. Concerns were expressed about whether the reports, which were envisaged primarily as an advocacy tool for partners, have been adequately promoted to partners and whether the format and structure of the reports have been useful in promoting advocacy. The 2014 report ensures that it is useful for advocacy purposes, in terms of its format and content.
- The focus on national human rights issues is important for supporting country-based advocacy initiatives and has been strengthened in the 2014 Report. However it is still important to identify key regional issues of concern for regional advocacy: this has been included in the 2014 Report.

¹Including LGBTI, men who have sex with men, sex workers, people who use drugs and prisoners

Table 1: Key findings of the 2006 and 2009 HIV and Human Rights in SADC reports

2006: HIV/AIDS and Human Rights in SADC: An evaluation of the steps taken by countries in the Southern African Development Corporation (SADC) region to implement the International Guidelines on HIV/AIDS and Human Rights ²	2009: HIV/AIDS and Human Rights in Southern Africa ²
Main focus	
Used the International Guidelines on HIV/AIDS and Human Rights, then in their 10th year, to examine the steps taken by SADC counties to put in place and implement a human rights framework as part of national responses to the HIV epidemic. The report evaluated the extent to which SADC countries had implemented the recommendations of the Guidelines in key areas	Adopted a narrower focus and investigated two key focus areas, namely laws and policies that: (1) promoted equality and non-discrimination for people infected and affected by HIV and (2) promoted access to health care
Methodology	
<ul style="list-style-type: none">• Key informant questionnaires distributed to non-governmental organisations (NGOs)• Telephonic and face-to-face interviews with ARASA partners• A limited desk review of literature, including grey material, on HIV and human rights in SADC	<ul style="list-style-type: none">• Key informant questionnaires distributed to ARASA partners and other NGOs and government institutions responsible for HIV and AIDS in SADC countries• Face-to-face interviews with ARASA partners• A limited desk review of all literature, including grey material, on HIV and human rights in SADC• The 2009 report adopted new strategies based on lessons learnt from the 2006 report, including:• Distributing questionnaires to a wider range of civil society organisations as well as to National AIDS Commissions (NACs)• Using ARASA staff, familiar with civil society organisations and issues at country level, to obtain feedback from questionnaires• Translating questionnaires into Portuguese and French
Main findings	
<ul style="list-style-type: none">• Stigma and discrimination were key obstacles to people living with HIV) accessing health, legal and other available services• Most countries introduced legal and policy reforms relating to HIV and human rights, which helped to create a more protective legal environment for those infected and affected by HIV and AIDS• In terms of criminal law, coercive responses were finding their way onto the legislative agenda and these initiatives highlighted the lack of legal protections available to vulnerable groups	<ul style="list-style-type: none">• Law reform identified in the 2006 report had continued, with all SADC countries undertaking law reform to respond to HIV and AIDS as a human rights issue• In many countries, this involved the adoption of an HIV-specific public health law and the report cautioned that the HIV-specific nature of such legislation could undermine a more appropriate, multi-sectoral response to HIV and AIDS• Anti-discrimination provisions had not been extended to vulnerable and key populations at higher risk of HIV exposure• The majority of countries continued to criminalise same sex relationships, women remained second class citizens under customary laws and practices, and migrants and displaced populations were marginalised from communities and services• The provision in law, policy and programmes to ensure access to treatment showed signs of progress, notably those relating to elimination of mother-to-child transmission (eMTCT) and post-exposure prophylaxis (PEP). Progress had been made towards the rolling out of treatment, care and support programmes; however, only 14 % of SADC countries had reached 70 % of those who needed ARV treatment

²Available at <http://www.arasa.info/index.php/reports/124-hiv-and-human-rights-in-southern-africa>

³Ibid.

Conclusions	
<ul style="list-style-type: none"> • Researchers were unable to reach any conclusions on the effectiveness of the law and policy reforms. The report recommended that further research was needed to establish if reforms had reduced human rights abuses against people living with HIV • The report noted the limited availability of legal support services, including awareness, education and training, legal advice and the monitoring of HIV-related complaints, and therefore the lack of support for access to justice for people infected and affected by HIV • Particular concerns were expressed about the failure of SADC countries to promote the right to health, with 50% of SADC countries having ART treatment coverage of less than 15%.⁴ • The report concluded that the right to health was being undermined by the slow progress in rolling out and scaling up ART 	<ul style="list-style-type: none"> • Many of the key challenges identified in the 2006 report remained and stigma and discrimination was again highlighted as a key concern • The limited legal protections for women against gender based violence (GBV) in many countries, pre-employment HIV testing in the armed forces and the criminalisation of same sex relationships were also highlighted, along with the lack of specific legal protections for children • The report concluded that the SADC region was moving into a new phase in which legal and policy frameworks were largely in place and that there was therefore a greater need to focus on monitoring the implementation of reforms. In addition, enforcement mechanisms would need to be strengthened so that people infected and affected by HIV could enforce their existing and new rights

1.3 Overview

This report is divided into this and 5 additional sections:

- Section 2 provides the background and context for the report, including the most recent statistics on HIV incidence and prevalence.
- Section 3 sets out the progress made removing laws that criminalise HIV-related conduct and developing protective legal frameworks in Southern and East African countries; it identifies the major gaps in the legal, regulatory and policy framework across the region in particular for key populations and women.
- Section 4 looks at access to justice and the extent to which the legal framework currently in place is being enforced.
- Section 5 contains country reports that provide country level information about all the countries under review.

1.4 Methodology

The information in this report was obtained from the following sources:

Desk Review

A desk review of current information on HIV and human rights in ARASA partner countries (namely SADC countries, Kenya, and Uganda) was conducted, including both primary sources (e.g. laws, regulations, policies, plans) and secondary sources (research reports, annual reports, newspaper articles). Information was accessed from ARASA partners, country reports to UN and other agencies, the internet, journals, NGO publications and newspapers.

In addition, where helpful, the authors also used information provided in the assignments submitted by ARASA Training of Trainers (ToT) Programme trainees on HIV and human rights in their respective countries as a requirement for their successful completion of the ToT Programme.

Key Informant Interviews

Key informant interviews were conducted with ARASA partners identified by ARASA based on their knowledge of priority HIV and AIDS and human rights issues. The key informants were drawn from national organisations in partner countries, including:

- Organisations of people living with HIV
- Organisations providing legal support services to people living with HIV and key populations
- HIV and human rights advocacy organisations
- Women’s rights and HIV organisations
- Children’s rights and HIV organisations
- Organisations of people with disabilities
- Organisations representing the interests of key populations at higher risk of HIV (e.g. organisations of men who have sex with men, LGBTI, sex workers and prisoners)
- Organisations focused on health rights relating to HIV and/or TB

1.5 Strengths and Limitations

The research was limited by a number of factors:

Language

The authors were unable to conduct in-depth interviews with organisations in Franco- and Lusophone countries, nor were they able to obtain translations of all relevant documentation. The information in the report therefore shows a bias towards Anglophone countries.

Relatively poor response to requests for interviews

Although 22 organisations were approached to participate in key informant interviews, only 11 responded and were interviewed. The relatively poor response meant that we were not able to interview representatives from each country under review in the report.

2. HIV, AIDS and Human Rights in Southern and East Africa

“Clearly, Africa remains the most affected region of the epidemic. It has, however, made historic progress in its AIDS response. In 2011, the number of people newly affected with HIV in Africa south of Sahara was 25% lower than in 2001, while AIDS-related deaths declined by 32% from 2005 to 2011”⁵

2.1 HIV and AIDS in Southern and East Africa

The most recent update on the HIV epidemic released by the United Nations Joint Programme on HIV /AIDS (UNAIDS) in 2013 continues to demonstrate significant progress towards universal access to prevention, treatment, care and support in Southern and East Africa.

In Southern and East Africa the rate of overall new HIV infections has been reduced by 30% and has halved in children since 2001. In 2011, the number of adults who became newly infected with HIV in Southern and East Africa was at its lowest level since 2001. Rates of new HIV infections among adults have declined significantly in SADC countries since 2001 – by more than 50% in Botswana, Malawi, Namibia, Zambia and Zimbabwe and by between 25% and 49% in Mozambique, South Africa and Swaziland. Although the number of new HIV infections in countries of the East African Community (EAC) have remained more stable, Kenya has also seen a decline in new HIV infections of between 25% and 49%.

AIDS-related mortality has also declined rapidly with the dramatic increase in the provision of antiretroviral therapy (ART) and the improved integration of HIV and tuberculosis (TB) diagnosis and treatment; as a result, fewer children are being orphaned because of AIDS. Since 2005 the number of people receiving life-saving ART had increased tenfold at the end of 2012, with Botswana, Namibia, Swaziland and Zambia achieving treatment coverage of at least 80% of people eligible for treatment by the end of 2011 and Kenya, Malawi, South Africa and Zimbabwe on track to achieve this goal.⁶ A larger proportion of people eligible for ART were receiving it in the SADC sub-region in 2011 compared with East Africa.

Key Points⁷

- 17.1 million people are living with HIV in Southern and East Africa
Home to just over 5% of the global population, the region accounts for close to 50% of all people living with HIV in the world and almost two-thirds of the worldwide TB cases amongst people living with HIV.
- 8.6 million of the 14.9 million adults living with HIV in the region are women
The HIV epidemic continues to disproportionately affect women, who make up 58% of adults living with HIV.
- 800 000 people died of AIDS-related deaths in 2011
This reflects a 38% reduction in AIDS-related deaths since 2005. Both AIDS and TB claimed fewer lives in 2011 than they have done since 1998.
- New infections continue to decline
1.2 million people were newly infected with HIV in 2011, a 30% reduction in new HIV infections since 2001. New infections amongst children declined by 50% since 2001.
- 690 000 pregnant women living with HIV received ART to prevent HIV transmission to their babies
Countries in Southern and East Africa achieved 72% coverage of services to eliminate new HIV infections among children (eMTCT).
- 6.3 million people living with HIV received ART in Southern and East Africa in 2012
The number of people on ART continued to increase in 2012, up from 5.2 million in 2011 and 625 000 in 2005. An estimated 64% of those eligible for treatment were receiving it in 2011, up from 16% in 2005.

⁵UNAIDS, Abuja +12: Shaping the future of health in Africa, 2013 at p7. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2524_Abuja_report_en.pdf

⁶ UNAIDS Getting to Zero: HIV in Eastern & Southern Africa, 2013

⁷As at end of 2011; see UNAIDS, Getting to Zero: HIV in Eastern and Southern Africa 2013.

Despite dramatic progress, sub-Saharan Africa continues to bear the brunt of the epidemic. Nearly one in 20 adults (4.9%) is living with HIV and they account for 69% of all people living with HIV.⁸ SADC is particularly hard-hit, with at least four countries⁹ having over a million people living with HIV. Almost two thirds (65%) of the estimated 1.1 million worldwide TB cases amongst people living with HIV in 2011 were in Southern and East Africa. Kenya, Mozambique, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe together account for approximately 59% of the global burden of HIV-positive TB cases.

Table 2: HIV Prevalence in Countries of Southern and East Africa¹⁰

Country	Adult (15 to 49) prevalence in %	Numbers of people living with HIV	New HIV infections	Young people (15–24) prevalence in %	
				F	M
Angola	2.1	230 000	23 000	1.6	0.6
Botswana	23.4	300 000	9 000	9.0	4.10
Comoros	<0.1	<500	<100	<0.1	<0.1
DRC*	1.1	480 000			
Kenya	6.2	1 600 000	100 000	3.5	1.6
Lesotho	23.3	320 000	26 000	15.4	6.4
Madagascar	0.3	34 000	4 300	<0.1	0.2
Malawi	10.0	910 000	46 000	4.9	2.1
Mauritius	1	7 400	<500	0.4	0.6
Mozambique	11.3	1 400 000	130 000	8.2	2.8
Namibia	13.4	190 000	8 800	6.5	2.7
Seychelles*					
South Africa	17.3	5 600 000	380 000	11.9	5.3
Swaziland	26	190 000	13 000	15.3	6.3
Tanzania	5.8	1 600 000	150 000	4.0	1.8
Uganda	7.2	1 400 000	150 000	5.3	2.4
Zambia	12.5	970 000	51 000	7.0	3.1
Zimbabwe	14.9	1 200 000	74 000	7.6	3.6

*Information for the DRC and Seychelles was not included in the referenced publication. Information for the DRC was extracted from UNAIDS 2012 AIDS Update.

In order to create effective and rights-based HIV responses, it is important to understand how and where HIV transmission occurs. Studies in the region show that the majority of adults living with HIV in the region acquire HIV infection during unprotected sex in multiple partnerships or in stable discordant relationships.¹¹ However, certain populations are recognised as being at higher risk of HIV infection, discussed further below.

Women

Women continue to be disproportionately infected and affected: in almost all countries in the region, the number of women, especially young women, with HIV is significantly higher than those of men. Women and girls aged between 15 – 24 years constitute 58% of all people living with HIV in sub-Saharan Africa¹² and HIV is the leading cause of death among women of reproductive age.¹³ Young women aged 15-24 years have double the HIV prevalence of young men the same age in the majority of countries and in some countries in Southern Africa (including Lesotho, Swaziland and South Africa), HIV prevalence among young women is still greater than 10%.¹⁴

⁸ UNAIDS, *Global Report: UNAIDS report on the Global AIDS Epidemic 2012*, 2012 at p.8. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf
⁹ Mozambique, South Africa, Tanzania and Zimbabwe. South Africa has the highest number of people living with HIV, with 5.1million.
¹⁰ UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013
¹¹ *Ibid* at p.12
¹² UNAIDS, *Update: How Africa Turned AIDS Around*, 2013 at p.32. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf
¹³ UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013 at p.68
¹⁴ *Ibid*.

High infection rates amongst women, especially young women, are associated with a number of factors including physiological and social vulnerability, gender inequalities, GBV and inter-generational sex in the case of young women. It is estimated that in Kenya, Malawi and Uganda more than 80% of all unprotected sex acts involving people living with HIV occur with spouses or cohabiting partners and a recent modelling study has suggested that women are at greater risk than men of acquiring HIV in such relationships.¹⁵ Studies from Lesotho and Swaziland show that many young women appear to have been infected by men who are several years older. The power imbalances in these relationships can create challenges for women who insist on practicing safer sex. Violence against women is also associated with a heightened risk of HIV infection, with studies from South Africa and Uganda showing that adolescent girls who had been subjected to violence from a partner or who are in relationships with low levels of equality are at an increased likelihood of acquiring HIV.¹⁶ In addition, it appears that women living with HIV are more vulnerable to physical, sexual and psychological violence.¹⁷ Violence and the fear of violence and rejection can discourage women and girls from disclosing their HIV status and accessing HIV-related health care services.

Key Points

- A young woman is newly infected with HIV every minute and they account for 22% of new infections¹⁸
- Women who are vulnerable to gender based violence appear to be particularly vulnerable to HIV: they are 55% more likely to have HIV if they have experienced intimate partner violence¹⁹
- Young women have inadequate access to comprehensive and accurate information about HIV and face stigmatizing attitudes when they seek health care for their sexual health²⁰

Children

In 2011, 330 000 children were newly infected, with 90% of them living in sub-Saharan Africa.²¹ Significant progress has been made in reducing the number of new infections in children through provision of programmes to eliminate mother-to-child transmission of HIV (eMTCT): a decline of almost 50% in new infections has been noted between 2001 and 2011 in Southern and East Africa.²² Only one SADC country, Angola, showed an increase in new infections, while the number of new HIV infections in children fell by more than 50% in Botswana, Malawi, Namibia, South Africa and Zambia and by 30 to 49% in Kenya, Mozambique, Swaziland, Tanzania and Zimbabwe.²³

Sex workers

While the overall size of sex work populations may be small, the most recent UNAIDS update on the global HIV epidemic provides a stark illustration of their higher risk of HIV infection, reporting that female sex workers are 13.5 times more likely to be living with HIV than other women.²⁴ Data on the sizes, HIV prevalence and related behaviours of sex workers across Southern and East Africa are very limited; median HIV prevalence rates amongst sex workers are estimated at 22% in Southern and East Africa, from data provided by eight countries.²⁵ Although some countries have observed a reduction in HIV prevalence among female sex workers, high HIV prevalence is still reported in countries with available data including Mauritius (32%), Swaziland (70%) and Zimbabwe (50%).²⁶ In Kenya and South Africa, sex workers accounted for 33% and 26% of new HIV infections;²⁷ HIV transmission among sex workers, their clients and the regular partners of clients

¹⁵ *Ibid*. at p.69
¹⁶ *Ibid* at p.71
¹⁷ UNAIDS, *Stigma Index Review, East and Southern Africa: A Rapid Assessment of the Stigma Index studies conducted in Ethiopia, Malawi, Rwanda, Swaziland, United Republic of Tanzania and Zambia: Preliminary Report*, 2013
¹⁸ UNAIDS, *Women Out Loud: How Women Living With HIV Will Help the World Ends AIDS*, 2012, p. 10 available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20121211_Women_Out_Loud_en.pdf
¹⁹ UNAIDS, *Unite with Women Unite Against Violence and HIV*, 2014, at p.4, available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2602_UniteWithWomen_en.pdf
²⁰ UNAIDS, *Women Out Loud*, at p.63
²¹ UNAIDS, *Global Report: UNAIDS report on the Global AIDS Epidemic 2012*, at p.42; available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf
²² UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013 at p.10
²³ UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013 at p.7
²⁴ UNAIDS, *Global Report: UNAIDS report on the Global AIDS Epidemic 2012*, 2012 at p.21 Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf
²⁵ UNAIDS, *Global Report: UNAIDS report on the Global AIDS Epidemic 2013*, 2013 at p.20
²⁶ UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 at p.21
²⁷ Although these estimates are associated with wide levels of uncertainty; see UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013 at p.21

are estimated to account for between 7% -11% of new infections in Uganda, Swaziland and Zambia.²⁸ UNAIDS indicates that there has been a significant increase in the number of countries tracking and reporting on epidemiological trends and services for sex workers since 2006, and interprets this as an indication of greater recognition of the needs of this key population. Despite these encouraging trends, sex workers in Southern and East Africa remain a highly stigmatised population with little access to prevention, treatment, care and support and with limited understanding of prevalence data or programmatic needs of the population across the region. The criminalisation of aspects of sex work in almost all countries in Southern and East Africa further stigmatises sex work and limits access to HIV prevention, treatment and care services.²⁹

Transgender women who engage in sex work are more likely than other sex workers to be living with HIV.³⁰ They also report that “they often face additional risks because some clients react violently when they discover that the sex worker is a transgender woman.”³¹

Men who have sex with men

Historically countries in Southern and East Africa have had limited information on HIV prevalence amongst men who have sex with men. However, in 2012, according to national Global AIDS Response Progress Reports (GARPR), the highest median HIV prevalence among men who have sex with men across regions of the world was reported in Western and Central Africa (19%) and Southern and East Africa (15%). Studies confirm that HIV prevalence amongst men who have sex with men is generally higher than among men in the general population with studies showing 10 to 50% prevalence amongst men who have sex with men in South Africa, 11 to 25% in Kenya, 21% in Blantyre and Lilongwe, Malawi, 20% in Gaborone, Botswana and 12% in Tanzania.³² The HIV epidemic amongst men who have sex with men is linked to the epidemic in the wider population, since studies show that many men who have sex with men in the region also have heterosexual sex.

Specific HIV health services for men who have sex with men remain limited and many governments are unwilling to provide HIV-related health interventions, such as prevention programmes, for men who have sex with men even at times where their national strategic plans (NSPs) on HIV commit to doing so. Same-sex sexual activity, sex between men or sodomy is criminalised in almost all countries in the region and men who have sex with men remain stigmatised, socially marginalised and vulnerable to violence and abuse in the region.

Lesbian, gay, bisexual, transgender and intersex

For same sex practising people in Southern and East Africa, as in other parts of the world, HIV and AIDS research and programming has focused on men who have sex with men. The belief that women who have sex with women are at no or low risk of HIV infection has led to the exclusion of women who have sex with women from HIV prevention efforts, access to health care services, education, treatment and research. Specific groups of women are more affected by this exclusion than others, such as women who have sex with women and are living with HIV, including those who do not identify themselves as lesbian or bisexual. There is also a widespread misconception, characterised by exclusion from research or programming, by both women who engage in same sex relations and other stakeholders that women who have sex with women are not at risk of HIV and AIDS.³³ Same sex practising women in the region – and in South Africa in particular – continue to experience sexual violence in the form of ‘corrective’ rape, and this form of violence increases their vulnerability to HIV and AIDS. Transgender people are especially marginalised and at increased risk of HIV. Although there is limited data about the prevalence of HIV among transgender people, a review of studies from 15 countries shows that 19% of transgender women globally are living with HIV.³⁴ Transgender women are particularly vulnerable to violence, with between 21 – 68% experiencing rape in their lifetime.³⁵

People who inject drugs

Although injecting drug use accounts for a fraction of the HIV epidemic in Southern and East Africa, it appears to be increasing in the region. It is a particular concern in Indian Ocean island countries such as Mauritius, Seychelles and

Madagascar and recent studies indicate increasing drug use in other countries such as Mozambique, South Africa and Tanzania. In addition, existing studies show that people who inject drugs in these countries have very high HIV prevalence rates. In Mauritius it was estimated that 52% of people who inject drugs were living with HIV in 2011; in a recent study in Dar es Salaam, participants who injected drugs had HIV prevalence rates of 35% and a study in Kenya showed HIV prevalence of 18% among people who inject drugs in Nairobi and Mombasa with 45% prevalence among women who inject drugs.³⁶ In addition to the risk of HIV transmission through needles, there is also evidence of low condom use, multiple sexual partners and transactional sex among people who inject drugs, increasing the risk of exposure to HIV.

The criminalised and stigmatised nature of drug use in the region further complicates the issue, discouraging people who inject drugs from accessing services and making governments unwilling to address drug use as a public health issue. However, countries such as Mauritius, Seychelles, Madagascar and Tanzania have begun to develop prevention and harm reduction programmes for injecting drug users (such as needle exchange programmes and methadone maintenance programmes). There are positive signs of progress: in Mauritius in 2011, it was estimated that around 75% of people who inject drugs were being reached with harm-reduction services. However, countries will need to increase efforts to scale up prevention and harm reduction programmes.³⁷

2.2 HIV and Human Rights in Southern and East Africa: Achievements and Challenges³⁸

At an international level and increasingly so in Southern and East Africa, HIV, AIDS and to a lesser extent, TB are recognised as human rights issues. National and regional responses to HIV and AIDS recognise the need to integrate rights-based approaches to managing HIV and TB effectively, in order to protect rights, reduce stigma and discrimination and increase universal access to HIV prevention, treatment, care and support. In this section we give a broad overview of some of the achievements as well as the remaining challenges in Southern and East Africa in promoting the health rights of all people in the context of HIV, AIDS and TB.

Signs of renewed commitment to HIV and AIDS

As indicated, almost 6.3 million people living with HIV were receiving ART in Southern and East Africa at the end of 2012, reducing AIDS deaths dramatically and improving the quality of life of affected people and their families. Coverage of services to eliminate mother-to-child transmission (eMTCT) in this region increased from 61% [55–67%] in 2010 to 72% [64–80%] in 2011.³⁹

An increase in funding support, both domestically and at an international level, and the scale-up of key programmes such as ART and eMTCT may be seen as indications of the renewed commitment to tackling the HIV epidemic in Southern and East Africa. UNAIDS considers the commitment and mobilisation of leaders, including people living with HIV, their communities and political leaders at national, regional and continental level, to be the driving force behind many of the recent achievements.⁴⁰

In 2011, African leaders from government and civil society organisations (CSOs) came together to deliberate an African Common Position on HIV and AIDS. The voice of African representatives at the United Nations (UN) High Level Meeting helped to inform and shape the United Nations General Assembly Special Session (UNGASS) *Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS*⁴¹ adopted on 10 June 2011. The 2011 declaration, building on the 2001 and 2006 declarations, set new targets and re-committed the international community to scale up efforts to achieve universal access to prevention, treatment, care and support. Since then, countries in the region have resolved to take specific steps to implement the recommendations by, amongst other things, updating HIV treatment guidelines to ensure that four million people are on ART by 2015, strengthening the human rights response to HIV and integrating HIV into broader health sector initiatives.⁴²

²⁸Ibid.

²⁹Global Commission on HIV and the Law, Risks, Rights & Health, 2012

³⁰UNAIDS, *United with Women, Unite Against Violence and HIV*, 2014 at p.9

³¹Ibid.

³²UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa, Regional Report*, 2013 at p.22

³³UN Women, *OSISA: Silenced and Forgotten*, 2013 at p.6-7

³⁴UNAIDS, *United with Women, Unite Against Violence and HIV*, 2014 at p.9

³⁵Ibid.

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³⁶UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa, Regional Report*, 2013 at p.27

³⁷UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa, Regional Report*, 2013 at p.27-29

³⁸The 2006 and 2009 reports provided a comprehensive overview of the global and regional responses to HIV and human rights. This section of the report sets out recent developments.

³⁹UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013 at p.7

⁴⁰Ibid. at p.2

⁴¹Available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf

⁴²SADC, *Communique of the NAA directors' meeting on "Implementing the High Level Meeting of AIDS Outcomes in the SADC Region"*, Johannesburg, 27 October 2011.

Targets and elimination commitments: 2015

The 2011 Political Declaration set out 10 new targets and commitments to help achieve universal access by 2015:

- Reduce sexual transmission of HIV by 50% by 2015
- Reduce transmission of HIV amongst drug users by 50% by 2015
- Eliminate new HIV infections amongst children and substantially reduce AIDS-related maternal deaths
- Reach 15 million people with life-saving anti-retroviral therapy (ART) by 2015
- Reduce TB deaths amongst people living with HIV by 50% by 2015
- Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries
- Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
- Eliminate stigma and discrimination against people living with and affected by HIV through the promotion and laws and policies that ensure the full realisation of all human rights and fundamental freedoms
- Eliminate HIV-related restrictions on entry, stay and residence
- Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

In July 2012 the African Union (AU) Heads of State adopted the *Roadmap on shared responsibility and global solidarity for AIDS, TB and malaria in Africa* to build on previous continental commitments set out in the 2001 *Abuja Declaration* and the *Kampala Declaration* of 2010. The Roadmap sets out concrete guidance to countries to encourage effective responses to the three diseases in Africa. From a human rights perspective it is significant that the Roadmap makes specific reference to the need for investment in programmes that support people and communities to prevent HIV, to know and claim their rights and to enable effective participation in planning and evaluating programmes, as well as the need for ensuring legislative environments that make full use of TRIPS flexibilities. Also of significance is the fact that it proposes to increase the impact of basic programme investments by overcoming barriers to the adoption of evidence based HIV policies and addressing factors that limit uptake.

Funding Challenges

Funding for responses to HIV in Southern and East Africa remains an ongoing challenge. For instance, while domestic spending on HIV has increased in some countries in the region, many are still dependent on international aid. At least seven SADC countries (Malawi, Mozambique, Zimbabwe, Madagascar, Lesotho, Swaziland and Namibia) rely on international donor funding for more than 40% of their expenditure on HIV, with Malawi funding all its HIV programming through donor funds, and Mozambique receiving 97% of its HIV expenditure from international donors.⁴³

International donor funding for HIV had significant increases⁴⁴ in 2002 – 2008, and yet has ‘flattened’ post this period. The Global Fund to Fight AIDS, TB and Malaria (GFATM) cancelled its 11th round of funding as a result of a \$2.2billion shortfall. While several donors suspended payment to the Global Fund as a result of allegations of mismanagement, the global economic downturn also played a role in several countries not fulfilling their pledges. Subsequently, some donors have resumed funding and the New Funding Model includes a strong emphasis on addressing human rights and gender equality with national responses. Despite this, the total amount of funding for human rights programming in the context of HIV in 2012 was only USD 137 million, which represents less than 1% of the total spending on HIV in 2012.⁴⁵

In addition to the impact on universal access, reduced international aid has also had a negative impact on CSOs. The Treatment Action Campaign (TAC) issued a statement following the cancellation of round 11 of the Global Fund, explaining that it was largely dependent on Global Fund money and could not survive without it.⁴⁶ The increase in domestic funding has not improved this situation, in that domestic funding is often not available for or accessible to civil society organisations working on a human rights response to HIV and AIDS.

⁴³UNAIDS, *Update: How Africa Turned AIDS Around*, p.13 available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf

⁴⁴Kaiser Family Foundation, *Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2012*, available at <http://kff.org/global-health-policy/press-release/kaiserunaids-study-finds-no-real-change-in-donor-funding-for-hiv/>

⁴⁵UNAIDS, *Sustaining the Human Rights Response to HIV: An Analysis of Funding Trends*, 2014 (draft)

⁴⁶Irin Global, *Global Fund cancels funding*, Johannesburg, South Africa, 24 November 2011 Available at <http://www.irinnews.org/report/94293/hiv-aids-global-fund-cancels-funding>

Stigma, Discrimination and Human Rights Abuses

In June 2013, the Secretary General of the UN reported to the UN General Assembly on progress made towards meeting the global commitments in the 2011 Political Declaration. The report highlighted that more than 30 years since the first HIV cases were detected, stigma and discrimination against people living with HIV continue to “undermine effective responses”⁴⁷ to the epidemic. The report expressed concern about failure to pay “adequate attention”⁴⁸ to women’s inequality and the impact on their HIV-related needs. The Global Commission on HIV and the Law’s comprehensive investigation into HIV, law and human rights across the globe found substantial evidence of how bad laws, policies and practices continue to create barriers to universal access to health care services for people affected by HIV.⁴⁹

Table 3: Key human rights issues identified by the HIV & Human Rights Report 2014

Country	Stigma and discrimination against key populations ⁵⁰	Stigma and discrimination against people living with HIV	Women	Children	Access to treatment
Angola	X				
Botswana	X	X	X		
Comoros	X		X		
DRC	X		X	X	X
Kenya	X	X	X		
Lesotho	X		X	X	
Madagascar	X		X		
Malawi	X	X	X	X	
Mauritius	X	X		X	
Mozambique	X	X	X		
Namibia	X	X	X		
Seychelles	X	X	X		
South Africa	X		X	X	
Swaziland	X	X	X		
Tanzania	X	X	X		X
Uganda	X	X		X	
Zambia	X	X	X	X	
Zimbabwe	X	X	X	X	

HIV-related stigma and discrimination emerged as a critical human rights concern in previous ARASA reports on HIV and human rights in SADC in 2006 and 2009. Recent findings suggest that stigma and discrimination remain a significant challenge to national HIV responses in the region, affecting not only people living with HIV but also key populations at higher risk of HIV such as men who have sex with men and sex workers. The increase in coercive laws, such as **laws criminalising HIV transmission**, was noted in previous ARASA reports. This Report notes that laws which criminalise HIV transmission remain on the books in many countries, despite the increasing evidence and international recommendations against their use. UNAIDS has recently released further guidance to countries to end overly broad criminalisation of HIV transmission and to limit criminal prosecution to the ‘truly blameworthy’ cases where it achieves justice.⁵¹ The Global Commission on HIV and the Law (GCHL) recently confirmed that laws criminalising HIV transmission are ineffective, unjust in their formulation and application, and may serve to exacerbate stigma and discrimination against people living with HIV and key populations at higher risk of HIV exposure.⁵²

⁴⁷UN General Assembly, *Accelerating the AIDS Response: achieving the targets of the 2011 Political Declaration*, 3 April 2013, p. 17, available at http://www.un.org/ga/search/view_doc.asp?symbol=A/67/822

⁴⁸Ibid.

⁴⁹UN General Assembly, *Accelerating the AIDS Response: achieving the targets of the 2011 Political Declaration*, 3 April 2013, p. 17, available at http://www.un.org/ga/search/view_doc.asp?symbol=A/67/822

⁵⁰Ibid.

⁵¹GCHL, *Risks, Rights & Health*, 2012.

⁵²These included sex workers, men who have sex with men, migrants, people who use drugs and prisoners.

⁵³UNAIDS, *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations*, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf

⁵⁴GCHL, *Risks, Rights & Health*, 2012

There is an increasing awareness of the importance of understanding the nature, extent and causes of stigma and discrimination and the multiple and intersecting forms of stigma and discrimination experienced by key populations in SEA. The People living with HIV Stigma Index, an Index developed by the Global Network of People living with HIV (GNP+), UNAIDS and ICW and carried out by and for people living with HIV, is designed to identify stigma and discrimination experienced by people living with HIV within countries.⁵³ Kenya, Uganda and around 10 countries in SADC, including the DRC, Lesotho, Malawi, Mauritius, Mozambique, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe are using or have used the People Living with HIV Stigma Index to assess HIV-related stigma and discrimination at national level, thus increasing baseline information on HIV-related stigma and discrimination within countries.

In addition to this, a number of countries in SEA are also seeking to increase their understanding of whether people know their rights and how people living with HIV experience access to justice and law enforcement. This is particularly important in contexts where, as was noted in the ARASA 2006 and 2009 Reports, protective HIV laws are now in place: other reasons for ongoing stigma and discrimination need to be explored.

It has now become increasingly important to not only monitor violations but furthermore identify why protective laws have failed to adequately limit HIV-related stigma and discrimination. Various countries are currently reviewing their legal and regulatory frameworks in the context of HIV and AIDS, in order to determine how laws and policies protect, or act as barriers to the HIV response as well as how affected populations experience law enforcement and whether they are able to access justice for human rights violations. This includes reviewing the availability of programmes to increase awareness, education and training on HIV, law and human rights issues for affected populations as well as service providers; access to legal support services and legal advice for HIV-related complaints and mechanisms to monitor human rights violations and provide redress.

These findings are particularly important for the **rights of key populations at higher risk of HIV**, such as sex workers, men who have sex with men, transgender persons and people who inject drugs. As was noted in previous ARASA reports, HIV laws that protect people living with HIV from discrimination often fail to include protection for key populations. Furthermore, evidence suggests that the impact of discriminatory and punitive laws, policies and practices is felt most keenly by already marginalised populations in the region, creating barriers to access to HIV-related health care services.

For instance, countries in Southern and East Africa use criminal law to prohibit various aspects of sex work. **Sex workers** remain a highly stigmatised group in the region, vulnerable to discrimination and abuse. The Global Commission on HIV and the Law's (GCHL) Africa Regional Dialogue on HIV and the Law highlighted the impact of criminal laws on sex workers, with first-hand experiences of the humiliation, sexual and physical violence, theft, extortion and harassment sex workers are subjected to by their communities, clients and law enforcement officials.⁵⁴ The GCHL recommended the repeal of all laws that criminalise the consensual exchange of sex for money between adults.⁵⁵

Africa has a particularly "hostile and punitive legal environment" for **men who have sex with men**.⁵⁶ Sex between men remains a criminal offence in almost all countries and recent years have seen increasing efforts to broaden same-sex criminal offences, increase criminal penalties and strengthen law enforcement against sex between men in countries in the region.⁵⁷ As a result, men who have sex with men report increasing fear of violence, harassment and discrimination, forcing many to remain invisible in society and limiting their access to support, including health services. In addition, governments in the region often cite the existence of criminal laws as justification for their failure to provide specific health services, such as HIV prevention programmes tailored to meet the needs of men who have sex with men.⁵⁸ Men who have sex with men report that health services are not only inadequate, but that they receive discriminatory treatment from health care workers.⁵⁹

⁵³See <http://www.stigmaindex.org/> for more information on the Stigma Index.

⁵⁴GCHL, *Africa Regional Dialogue Report*, 2012 at p.35. Available at <http://www.hivlawcommission.org/index.php/ard-dialogue-documentation>

⁵⁵Global Commission on HIV and the Law, *Risks, Rights and Health*, 2012. Available at <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>

⁵⁶GCHL, *Africa Regional Dialogue Report*, 2012 at p.37

⁵⁷For instance, the case of *Republic v Steven Monjeza Soko and Tionge Chimbalanga Kachepa*, 2009 in Malawi which sentenced two men to 14 years imprisonment in terms of Section 156 of the Penal Code prohibiting 'indecent practices between males' and the arrest and charging of Paul Kasonkomona, National Coordinator of Engender Rights-Zambia, under section 178(g) of the Zambian Penal Code for 'soliciting in a public place for an immoral purpose' after he spoke publicly about the need for respect of the rights of sexual minorities, are two examples of more recent 'crackdowns' on the rights of men who have sex with men.

⁵⁸See, for instance, Government of Malawi and UNDP, *Assessment of the Legal, Regulatory and Policy Environment for HIV and AIDS in Malawi*, July 2012.

⁵⁹GCHL, *Africa Regional Dialogue Report*, 2012.

Countries across the region make individual drug possession and use a criminal offence. Furthermore, almost 70% of countries in Southern and East Africa also have punitive laws on drug use that make it difficult and in many cases criminal, to provide harm-reduction services such as needle exchange programmes for **people who inject drugs**.⁶⁰ This means that people who inject drugs fail to receive services to prevent their high risk of HIV exposure. In addition, they are a marginalised population, living in constant fear of police action and avoiding services that may expose them to arrest or detention. When people who inject drugs are arrested and confined, whether in prison or drug detention centres, they are often at even higher risk of HIV infection with no access to harm reduction services or related treatment.⁶¹

ARASA partners identified **gender inequality and GBV** as an ongoing human rights concern in the region and a key driver of HIV infection amongst women in the region. A number of countries have made efforts to review and reform laws that discriminate against women and to strengthen legal protection against GBV. However, there is still much more that needs to be done to counteract customary laws, underlying gender norms and social relations that place women and girl children at risk for HIV. Countries such as Madagascar, Tanzania and the Seychelles still have inadequate laws to tackle domestic violence, and in other countries the implementation and enforcement of existing laws is weak. Research shows that the widespread violence against women in the region, especially in their homes, places women at heightened risk of HIV infection.⁶²

There is increasing evidence that lesbians and transgender men and women are **targeted for sexual violence** because of their sexual orientation and/or gender identity. A submission to the GCHL stated that "most of the violence amongst lesbians, gay and bi-sexual persons focuses on transgender persons. Male-female persons are more likely to be jailed with other men and become the objects of sexual gratification. Female-male transgender are subjective to corrective rape."⁶³ Sexual violence increases their risk of contracting HIV, and they face barriers when seeking care in connection with sexual violence, including post-exposure care (PEP) for HIV.

Gender-based Violence (GBV) in Conflict

The UN Security Council's *Resolution 1983* of 2011 recognises that HIV "poses one of the most formidable challenges to the development, progress and stability of societies"⁶⁴ and notes that the impact of HIV and AIDS may be "felt more profoundly in conflict and post conflict situations." It underlines the need for urgent and co-ordinated international action to address the needs of those infected and affected by HIV in conflict and post-conflict societies, urging Member States to intensify efforts to prevent conflict-related sexual violence which disproportionately exposes women and girls to HIV transmission.

In addition, women living with HIV continue to face discriminatory treatment in their homes, communities and in access to services, such as sexual and reproductive health care services. Access to eMTCT services has been scaled up dramatically, with coverage of effective ART prophylaxis to prevent mother to child transmission at 72% in Southern and East Africa in 2011, up from 61% a year earlier. Five countries (Botswana, Namibia South Africa, Swaziland and Zambia) achieved coverage of above 80% and coverage of effective regimens ranged from 50% and 79% in Kenya, Lesotho, Malawi, Mozambique, Tanzania and Zimbabwe.⁶⁵ However, a recent review of the People living with HIV Stigma Index studies in countries in the region suggest that women with HIV still experience discrimination and coercion in accessing sexual and reproductive health services. For instance, they report forced or coerced sterilisation, receiving limited or inadequate information on birthing and feeding options and being discouraged from having children.⁶⁶

Significant progress has been made in reducing the number of new infections in children, as set out above. However, children and young people continue to face limitations in their ability to access sexual and reproductive health information and services independently of parents and guardians, limiting their ability to protect themselves from HIV infection. In addition, there are still reports of stigma and discrimination against children living with or affected by HIV (such as children orphaned as a result of AIDS or children living with an HIV-positive carer or family member) continue.⁶⁷

⁶⁰*Africa Regional Dialogue Report*, p.39 available at <http://www.hivlawcommission.org/index.php/ard-dialogue-documentation>

⁶¹GCHL, *Risks, Rights & Health*, 2012

⁶²UNAIDS, *Getting to Zero: HIV and AIDS in Eastern and Southern Africa*, 2013 at p.71

⁶³At p.39

⁶⁴UN Security Council, *Resolution 1983* (2011), June 2011

⁶⁵UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 at p.33

⁶⁶UNAIDS, *Stigma Index Review Eastern and Southern Africa (draft)*, 2013

⁶⁷Global Commission on HIV and the Law, *Risks, Rights & Health*, 2012

Finally there has been progress in access to the right to affordable treatment, which has “dominated the agenda of human rights activists in Southern Africa for the past decade”⁶⁸ and was seen as the priority challenge facing the region in 2009. Significant progress has been made to expand access to treatment and there has been an 805% increase in the number of people in Africa receiving treatment in less than a decade.⁶⁹ Southern and East Africa has scaled up access to treatment particularly rapidly, more than doubling the numbers on treatment between 2006 and 2012.⁷⁰

Recent data illustrates the impact of treatment on AIDS-related deaths: AIDS-related mortality declined by over 50% since 2005 in several countries including Botswana, Kenya, Namibia, Zambia and Zimbabwe.⁷¹ According to the 2010 World Health Organisation (WHO) treatment eligibility criteria, an estimated 64% of the 8.1 million people who were eligible were receiving ART in the region in 2011.⁷²

Table 4: Access to treatment and coverage for 2012⁷³

	Estimated number of people needing antiretroviral therapy	Estimated coverage (%)	Reported number of people on antiretroviral therapy
Angola	120 000	36	42 607
Botswana	210 000	≥95	204 298
Comoros			
DRC	220 000	29	64 219
Kenya	830 000	73	604 027
Lesotho	170 000	56	92 747
Madagascar			
Malawi	580 000	70	404 905
Mauritius			
Mozambique	690 000	45	308 577
Namibia	130 000	90	116 687
Seychelles			
South Africa	2 6000 000	83	2 150 880
Swaziland	110 000	82	87 534
Tanzania	710 000	61	432 293
Uganda		54	313 117
Zambia	590 000	81	480 925
Zimbabwe	720 000	79	565 675

While progress has been made in increasing access to treatment, the number of people eligible for treatment will increase substantially with the revised 2013 WHO ART guidelines. ARASA partners who participated in the research for this report cautioned that vigilance was needed to ensure that progress was not eroded. For example, while Zimbabwean activists welcomed steps by the government to introduce third-line ART to address HIV drug resistance, they expressed concerns about how the government would pay for costlier treatments and whether the procurement of the third-line regimen would divert resources from other HIV programmes, including prevention. In South Africa, activists feared that stock-outs would undermine the rollout of fixed-dose combination (FDC) ART. The rollout, which started on 8 April 2013 in Pretoria, will initially benefit new patients and breast-feeding women.

Treatment coverage for children aged 0 to 14 years living with HIV in Southern and East Africa is still unacceptably low.⁷⁴ Key populations also experience unique barriers to treatment, with reports showing extremely low treatment coverage rates for men who have sex with men, sex workers, transgender individuals and people who inject drugs.⁷⁵

⁶⁸ARASA 2009 report, at p.12

⁶⁹UNAIDS, *Special Report: How Africa Turned AIDS Around*, p.15 available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf

⁷⁰UNAIDS, *Access to Antiretroviral Treatment in Africa: Status report on progress towards the 2015 targets*, 2013, p.3, available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131219_AccessARTAfricaStatusReportProgressTowards2015Targets_en.pdf

⁷¹*Ibid.* p.8; see also UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 at p.7

⁷²UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 at p.40

⁷³UNAIDS, *Access to Antiretroviral Treatment in Africa: Status report on progress towards the 2015 targets*, 2013, p.3, available at p.16; available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130630_treatment_report_en.pdf

⁷⁴UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 at p.42

⁷⁵UNAIDS, *Global report on the AIDS Epidemic 2013*, 2013 at p.48

3. Developing legal frameworks to protect human rights in the context of HIV

3.1 Introduction

The *International Guidelines on HIV/AIDS and Human Rights* emphasise the key role that the law and human rights play in protecting the rights of people living with HIV and advancing access to prevention, treatment, care and support. Both the 2006 and 2009 ARASA reports examined the development of protective laws and policies, concluding that the countries under review were making progress towards developing rights-protecting legal frameworks.

The ARASA 2009 report found that all 14 countries under review⁷⁶ had laws and/or national policies prohibiting discrimination against people living with HIV. The report concluded that “significant progress has been made in ensuring legal protection for people living with HIV within SADC”⁷⁷. A 2010 UNAIDS report confirmed that continuing progress was being made, finding that in Southern and East Africa, 14 countries had protective laws and only six did not. ⁷⁸ This positive trend would however be undermined by on-going criminalisation of HIV-related conduct which undermines universal access to prevention, treatment, care and support.

The ARASA 2009 report also warned that while progress had been made in protecting the rights of people living with HIV, anti-discrimination laws and HIV-specific laws had failed to protect the rights of all vulnerable and marginalised populations, leaving them vulnerable to violations of their human rights that would place them at higher risk of HIV infection.

Research conducted for this report confirms that insufficient progress has been made in developing legal frameworks to protect key populations, undermining their human rights and their access to prevention, treatment, care and support and in removing or amending laws that inappropriately criminalise HIV transmission or exposure. In addition, there are also significant gaps in existing legal frameworks that seek to protect the rights of women and girls. These gaps exacerbate their vulnerability and increase their risk of HIV.

3.2 Criminalisation of HIV-related conduct

Criminalisation of HIV-related conduct emerged as a key concern in both the 2006 and 2009 ARASA reports, with a large number of SADC countries either introducing specific legislation to criminalise HIV transmission and/or exposure or indicating that existing legal provisions could be used to criminalise transmission and/or exposure. Six countries⁷⁹ introduced legislation requiring courts to impose harsher sentences on HIV positive rapists and Botswana and Lesotho introduced legislation providing for compulsory HIV testing of all sex offenders. Legislation in Angola, Mozambique, South Africa and Tanzania gave the courts authority to order HIV testing in certain circumstances, including of alleged sex offenders. The report concluded that many of these laws were poorly drafted and couched in broad language, lowering the standards of proof and widening the net of liability in a way that is legally unacceptable.⁸⁰ It also raised grave concerns about how continued criminalisation would reinforce stigma and undermine universal access to prevention, treatment, care and support.

In 2014, Africa, although not the continent with the most HIV-related convictions, remains the continent with the most countries that have broad and vaguely worded laws criminalizing various aspects of HIV transmission. The GCHL confirms concerns that where countries word statutes very broadly, these are “inconsistent with international human rights law as they result in criminalisation of a wide range of negligent or reckless acts by persons who may even be unaware of their HIV status”.

The table below provides updated information on the Southern and East African countries that have criminalised HIV transmission and/or exposure and provides information, where available on HIV-related prosecutions and convictions.

76The countries included in the 2009 report were Angola, Botswana, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe
77ARASA 2009 report, at p.39
78UNAIDS, *Making the Law Work for the HIV Response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support*, 2010
79Botswana, DRC, Lesotho, Namibia, South Africa and Zimbabwe
80Global Commission on HIV and the Law, *Regional Issue Brief: Criminal Law and HIV*, 2011, Pretoria, p 10, available at <http://www.hivlawcommission.org/index.php/regional-dialogues-main?task=document.viewdoc&id=72>, p.10

Table 5: Criminalisation of HIV transmission or exposure in Southern and East African countries⁸¹

Country	Criminalised HIV transmission/ exposure	Prosecution	Conviction
Angola	Law 8/04	2	Unknown
Botswana	Public Health Act 2013 ⁸²	2	1 acquittal 1 pending case
Comoros	No HIV specific criminal law		
Democratic Republic of Congo	Law 08/11 Protection of People living with HIV and Those Affected	Unknown	Unknown
Kenya	HIV Prevention and Control Act 2006	None known	
Lesotho	No HIV specific criminal law		
Madagascar	Law 2005- 04 Fight Against HIV and AIDS and the Protection of People living with HIV	None known	
Malawi	Criminalisation provision has been excluded from the most recent draft HIV and AIDS Prevention and Management Bill. ⁸³		
Mauritius	No HIV-specific criminal law		
Mozambique	Act on Defending Rights and the Fight Against the Stigmatisation and Discrimination of People living with HIV and AIDS, 2009	None known	None known
Namibia	No HIV specific criminal law		
Seychelles	No HIV-specific criminal law		
South Africa	No HIV specific criminal law	Unknown	1 conviction
Swaziland	No HIV specific criminal law		
Tanzania	HIV and AIDS Prevention and Control Act 2008	None known	
Uganda	HIV and AIDS Prevention and Control Act ⁸⁴		
Zambia	HIV-specific provision in penal code	None known	
Zimbabwe	Criminal Law 2004	3	3

No laws have been repealed since 2009, as recommended in the ARASA report. Botswana adopted new legislation in September 2013. The law, the Public Health Act, has been criticised as “vague and overly broad”.⁸⁵ In addition to the criminalisation provisions, the law also allows for forced HIV testing, mandatory disclosure of HIV status and limitations on the freedom of movement of people living with HIV. ⁸⁶ The current version of the Malawi draft HIV law no longer contains provisions on criminalisation.⁸⁷ The Uganda HIV and AIDS Prevention and Control Act, also criticised for being too broad,⁸⁸ was passed by Parliament in May 2014 and is pending assent by the President. It contains other problematic provisions including mandatory HIV testing of pregnant women and their partners, victims of sexual offences and people convicted of a sexual offence, drug use and prostitution; and the disclosure of HIV status without consent by medical practitioners.⁸⁹

81Information for this table was extracted from the Global Criminalisation Scan website available at <http://criminalisation.gnpplus.net/> and the Global Commission on HIV and the Law, *Regional Issue Brief: Criminal Law and HIV*, 2011, Pretoria, p.10, available at <http://www.hivlawcommission.org/index.php/regional-dialogues-main?task=document.viewdoc&id=72>
82The Bill was approved by Parliament in September 2013
83Mbewe, Safari (MANET+), *Advancing HIV Justice: Achievements and Challenges in Global Advocacy against HIV Criminalisation*, ICASA 2013, available at <http://www.hivjustice.net/news/african-hiv-criminalisation-achievements-and-challenges-highlighted-at-icasa-2013/>
84The Bill was passed by Parliament in May 2014 and remains to be signed by the President at the time of writing
85Bernard and others, *Advancing HIV Justice: Achievements and Challenges in Global Advocacy against HIV Criminalisation*, 2013, available at <http://www.scribd.com/doc/190880968/Advancing-HIV-Justice-Achievements-and-challenges-in-global-advocacy-against-HIV-criminalisation-African-update-ICASA-2013>
86Ibid
87Ibid
88Ibid
89Ibid

Implementation of laws is inconsistent and generally weak, and there are few known prosecutions in the countries under review. However, research for this report suggests that there has been an increase in the number of prosecutions and convictions since 2012, with cases in Botswana, Uganda, Zimbabwe and South Africa:

- Botswana: in 2013, a Zimbabwean woman was charged with deliberate HIV transmission after she breastfed her neighbour's baby. At the time of writing, the case was still pending. A man was acquitted of the same offence (deliberate transmission) earlier in the same year.⁹⁰
- Uganda: in May 2014, a woman was convicted of criminal negligence and sentenced to three years imprisonment in a case stemming from allegations that she attempted to infect a child patient with HIV. She was accused of exposing the child to the virus by administering an injection with a needle that had been contaminated with her own blood.⁹¹
- South Africa: 2013 saw the first successful prosecution of HIV exposure. The case was prosecuted under ordinary criminal law and the accused was convicted of attempted murder.⁹²
- Zimbabwe: there were two convictions of "deliberate" HIV transmission in 2012. Zimbabwe also convicted a woman of the same offence in 2008, for infecting her husband.⁹³

Although it is too soon to judge whether these convictions represent a new trend, they do give cause for serious concern. A further concern is that, far from protecting women from HIV, these statutes appear to disproportionately affect women, with the majority of those being prosecuted being women.⁹⁴

The public push for criminalisation continues, with members of parliaments from various countries who attended the Africa Regional Dialogue of the Global Commission on HIV and the Law⁹⁵ stating that they were "constantly under pressure from the public to do something about the intentional spread of HIV."⁹⁶

As mentioned in the first chapter of this report, UNAIDS issued new guidance on criminalisation in 2013. The guidance states that the overly broad application of the criminal law to non-disclosure, exposure and transmission of HIV causes significant human rights and public health concerns and urges countries to review provisions in light of the most recent, legal, medical and scientific evidence.⁹⁷

New guidance on using the criminal law to prosecute HIV-related offences:⁹⁸

The 2013 UNAIDS guidance on the use of criminal law states that a criminal law response to HIV should:

- Reflect the best and latest available scientific, legal and medical knowledge relating to HIV
- Treat HIV proportionately to similar harms and risks – HIV should not be specifically singled out
- Require that all generally applicable criminal law principles be applied to cases involving HIV. This would include requiring harm to another person, mental culpability, evidence to support a guilty verdict and proportionality between the offence and penalty

⁹⁰GNP+, *Global Criminalisation Scan: Botswana*, available at <http://criminalisation.gnpplus.net/country/botswana> [accessed 9 April 2014]

⁹¹GNP+, *Global Criminalisation Scan: Uganda*, available at <http://criminalisation.gnpplus.net/country/uganda>, [accessed 9 April 2014], see also <http://www.news24.com/Africa/News/Uganda-nurse-gets-3-yrs-for-spreading-HIV-20140519>

⁹²Bernard and others, *Advancing HIV Justice: Achievements and Challenges in Global Advocacy against HIV Criminalisation*, 2013, available at <http://www.scribd.com/doc/190880968/Advancing-HIV-Justice-Achievements-and-challenges-in-global-advocacy-against-HIV-criminalisation-African-update-ICASA-2013>

⁹³Bernard and others, *Advancing HIV Justice: Achievements and Challenges in Global Advocacy against HIV Criminalisation*, 2013, available at <http://www.scribd.com/doc/190880968/Advancing-HIV-Justice-Achievements-and-challenges-in-global-advocacy-against-HIV-criminalisation-African-update-ICASA-2013>

⁹⁴Mbewe, *Safari (MANET+)*, *Advancing HIV Justice: Achievements and Challenges in Global Advocacy against HIV Criminalisation*, ICASA 2013, available at <http://www.hivjustice.net/news/african-hiv-criminalisation-achievements-and-challenges-highlighted-at-icasa-2013/>

⁹⁵Pretoria, 4 August 2011

⁹⁶Global Commission on HIV and the Law, *Report of the African Regional Dialogue of the Global Commission on HIV and the Law*, p.14 available at <http://hivlawcommission.org/index.php/regional-dialogues-main?view=category&id=6>

⁹⁷UNAIDS, *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations*, p.12; available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf, at p.2

⁹⁸UNAIDS, *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations*, p.12; available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf

Recommendations:

- Build and strengthen the capacity of civil society to continue advocacy to remove laws that inappropriately criminalise HIV-related conduct.
- Monitor courts to identify cases where individuals are being prosecuted for HIV-related offences in order to assist litigants, identify strategic litigation to challenge over-broad, vague and inappropriate legislation, and undertake public awareness around the human rights dimensions of cases.
- Identify public interest lawyers, build their capacity to undertake strategic litigation to challenge over-broad, vague and inappropriate legislation.
- Undertake training for parliamentarians and law-makers to educate them about the negative impact of criminalisation on universal access to HIV prevention, treatment, care and support in line with new guidance from UNAIDS.
- Build alliances with public health specialists and scientists in order to ensure that the 'best and latest' information is readily accessible to criminal justice officials such as police officers, prosecutors, judges and magistrates.

3.3 Sexual orientation and gender identity

Lesbians, women who have sex with women, gay men, men who have sex with men, bi-sexual men and women, transgendered and intersex persons living in the countries under review, face increasingly high levels of discrimination, violence and abuse that undermine their human rights, including their right to health and access to HIV-related treatment, care and support. Amnesty International (AI) reports that violations against LGBTI are 'increasingly visible' on the continent, and include rape and murders of lesbians, transgender women and men, and gay men; arrests, harassment and violence against LGBTI; extortion and threats against LGBTI activists and organisations and attempts to criminalise same sex sexual conduct even further.⁹⁹

The 2009 ARASA report found that nearly two-thirds of the 14 SADC countries surveyed had laws that criminalised consensual sex between men. As the table below shows, the situation has not improved and almost every country under review has some legislative measure that criminalises same sex sexual conduct for both men and women. Uganda adopted a new law, the Anti-Homosexuality Law, in February 2014. Same sex sexual conduct was already criminalised by the Penal Code, but the new law goes much further, criminalizing, amongst others, "touching with the intent to commit homosexuality", and "promotion of homosexuality". Under the new law, the penalty for engaging in same sex sexual conduct is life imprisonment.

The only countries that do not criminalise all same sex conduct are DRC, Madagascar and South Africa. Even so, men in the DRC may be prosecuted under indecency laws.

Few countries have laws that promote equality and non-discrimination on the basis of sexual orientation or gender identity, and those that do tend to prohibit discrimination on the grounds of sexual orientation in the workplace and not in other settings. The Seychelles, Mozambique, Mauritius and Botswana prohibit discrimination on the grounds of sexual orientation or have removed discriminatory provisions from existing employment laws.¹⁰⁰ South Africa appears to be the only county that promotes equality on the grounds of gender identity: in 2003, the South African Parliament passed a law that permits individuals to change their sex in the population registry. The law applies to people who have undergone sex reassignment surgery, those whose sex characteristics have evolved naturally and intersex persons.

⁹⁹Amnesty International (2013), *Making Love a Crime: Criminalisation of Same Sex Conduct in Sub-Saharan Africa*, p.9

¹⁰⁰Seychelles (2006), Mozambique (2007), Mauritius (2008), Botswana (2010). See: Amnesty International, *Making Love a Crime: Criminalisation of Same Sex Conduct in Sub-Saharan Africa*, 2013, p.8

Table 6: Overview of key laws affecting people living with HIV and key populations

Country	Criminalise same sex sexual conduct between men	Criminalise same sex sexual conduct between women	Laws prohibiting discrimination and promoting equality
Angola	X	X	
Botswana	X	X	X only on the basis of sexual orientation
Comoros	X	X	
Democratic Republic of Congo			
Kenya	X	X	
Lesotho			
Madagascar			
Malawi	X	X	
Mauritius	X	X	
Mozambique	X	X	X only on the basis of sexual orientation
Namibia	X		
Seychelles	X		X only on the basis of sexual orientation
South Africa			X Alteration of Sex Description and Sex Status Act 2003
Swaziland	x		
Tanzania	X		
Uganda	X	X	
Zambia	X	X	
Zimbabwe	X		

Almost all of the respondents interviewed for this report identified stigma and discrimination against gay men and other men who have sex with men as major human rights concerns. They identified the criminalisation of sodomy as a key driver of stigma and discrimination and a barrier to prevention, treatment, care and support for many men. The African Dialogue succinctly summarised the impact of criminalisation on universal access to prevention, treatment, care and support:

“A number of negative consequences flow from the criminalisation of same-sex relationships including that service providers report that it is extremely difficult to openly provide services for people in same-sex relationships; state media messages on HIV and AIDS ignore same-sex issues and men who have sex with men are publicly persecuted so they do not self-identify as men who have sex with men. In a number of countries, political leaders have suggested that same-sex relationships are not part of African culture, making those in same-sex relationships an invisible group in society. Also, the criminalisation of men who have sex with men enables governments to deny condoms to prisoners on the basis that the sexual acts are unlawful.”¹⁰¹

Although data is not available for all countries under review in this report, where comparative data has been obtained, it confirms that men who have sex with men have significantly higher levels of HIV than men in the general population in countries where same sex sexual conduct is illegal.

Examples of stigma and discrimination against men who have sex with men from key respondent interviews

- Medical personnel say that they will treat men who have sex with men, but they will not discuss prevention with them (Zambia)
- HIV prevalence amongst men who have sex with men is very high in Malawi, and they experience barriers in relation to accessing information and also when trying to access health services. (Malawi)
- The law prevents this community from being visible, from being open and this has implications for their health – they cannot disclose their sexual orientation to a health care provider without fear of being reported to the police. (Malawi)
- There is lots of stigma about homosexuality – I am attacked when I talk about it. (Zambia)

Table 7: Comparison of HIV prevalence between men who have sex with men and in the general population in countries where sex between men is illegal

Country	%HIV prevalence in men who have sex with men	%HIV in general male population
Angola ¹⁰²	8	2.1
Madagascar	1 in 7 is living with HIV	
Malawi ¹⁰³	21.4	11.4
Mauritius	5.8	≥1
Tanzania ¹⁰⁴	12.4	5.88
Zambia ¹⁰⁵	32.9	15.72

Some progress has been made in recognising men who have sex with men as a key population in need of HIV-related services, and the majority of countries under review for this report have either explicitly identified men who have sex with men as a key population in their most recent National Strategic Plans (NSP) or they have incorporated them elsewhere in policy and/or programming. However, as table 8 indicates, a significant number of countries indicated that existing laws and policies, including those that criminalise consensual sexual conduct, create barriers to access.

Table 8: Inclusion of LGBTI in NSPs on HIV and AIDS¹⁰⁶

Countries	Does the multi-sectoral strategy include LGBTI?	What LGBTI groups are identified as key populations for HIV programming?	Are there laws and policies that are obstacles to effective prevention, treatment and care interventions?
Angola	Yes; men who have sex with men, transgender	No data provided	No data provided
Botswana	Yes; men who have sex with men, transgender	Men who have sex with men	Yes, impacts on men who have sex with men, transgender
Comoros	Yes; men who have sex with men	None included	No data provided
Democratic Republic of Congo	No	None included	No
Kenya	Yes; men who have sex with men	Men who have sex with men	No

¹⁰²See UNGASS Angola Country Progress Report, 2012. Available at www.unaids.org/en/regionscountries/countries/angola/ [Accessed 9th September 2012].
¹⁰³Godwin, J Legal environments, human rights and HIV responses amongst men who have sex with men and transgender people in Asia and the Pacific: an agenda for action, 2010
¹⁰⁴Ibid.
¹⁰⁵Ibid.
¹⁰⁶This information was extracted from the 2012 country National Commitments and Policies Instrument (NCPI) available at <http://www.unaids.org/en/region-scountries/countries/>

Lesotho	Yes; men who have sex with men, transgender	Men who have sex with men	Yes, impacts on men who have sex with men, transgender
Madagascar	Yes; men who have sex with men, transgender	Men who have sex with men	Yes, impacts on men who have sex with men
Malawi	Not included	Not included	Yes, impacts on men who have sex with men, transgender
Mauritius	Yes; men who have sex with men, transgender	Men who have sex with men	Yes, impacts on men who have sex with men, transgender
Mozambique	Yes; men who have sex with men	Men who have sex with men, transgender	No data provided
Namibia	Yes; men who have sex with men	Men who have sex with men	No data provided
Seychelles	Yes; men who have sex with men	Men who have sex with men	No data provided
South Africa	Yes; men who have sex with men, transgender	Men who have sex with men, transgender	No
Swaziland	Not included	None included	Yes, transgender
Tanzania	Yes; men who have sex with men	Men who have sex with men	Yes, impacts on men who have sex with men, transgender
Uganda	Yes; men who have sex with men, transgender	None included	Yes, impacts on men who have sex with men, transgender
Zambia ¹⁰⁷			
Zimbabwe	Not included	None included	Yes, impacts on men who have sex with men, transgender

While some progress has been made with regard to men who have sex with men; lesbians, transgender and intersex people remain to a large extent invisible in national AIDS responses.

Conclusions and recommendations

The inclusion of men who have sex with men in a large number of NSPs suggests that it may be possible to advocate for states to take some measures to recognise men who have sex with men and their health needs in policies and programmes in the context of the HIV epidemic, while maintaining ongoing efforts towards the decriminalisation of same-sex sexual activity. It is not clear the extent to which this has been seen as a viable strategy by civil society. New legal and advocacy strategies are required to effect genuine change. In particular it is critical for civil society to foster and strengthen broad coalitions of a range of faith based, labour, women’s and other civil society organisations to advance an agenda of equal rights for all, regardless of sexual orientation or gender identity, from the ground up and to engage with influencers in communities such as traditional healers and traditional leaders.

The recommendations contained in the 2009 report remain relevant and are largely unchanged:

- Advocate for the decriminalisation of laws that prohibit same sex relations between consenting adults
- Although some progress has been made to provide HIV and AIDS and health care services that are acceptable and accessible to men who have sex with men, it is necessary to continue to advocate for the continuation and expansion of these services, including to lesbians, transgender men and women and intersex persons
- Advocate for condom distribution in prisons
- Advocate for the inclusion of key populations in NSPs and AIDS programming

¹⁰⁷The 2012 NCPI is not available on the UNAIDS website

3.4 Sex Workers

The 2006 and 2009 reports both identified sex workers as a vulnerable population. Respondents interviewed for this report identified sex workers as a highly stigmatised population who are disproportionately vulnerable to HIV. This view is confirmed by data that shows that female sex workers are 13.5 times more likely to be living with HIV than other women.¹⁰⁸

Respondents expressed significant concerns about how criminalisation drives sex workers away from HIV prevention, treatment, care and support. They also report that sex workers are subject to violations of their human rights that increase their exposure to HIV.

Examples of stigma and discrimination against sex workers

- Sex workers are usually arrested for loitering. Arrests are fairly common and they just lock them up for the night. (Zambia)
- The police really abuse sex workers: our clients tell us that they ask for bribes, they want sex and sometimes they rape them. (South Africa)
- People think that if you have HIV, you must be a prostitute or you have misbehaved. (Mozambique)

The 2012 UNAIDS Global Update on HIV and AIDS reports that greater attention is being paid to sex workers in national AIDS responses – there is better data available about how they are affected by the epidemic and there is greater and more consistent service coverage.¹⁰⁹ The report also notes increased spending on HIV prevention programmes that target sex workers. However it is concerning that the majority of countries under review failed to include information on sex workers in 2012 in their National Commitments and Policies Instrument (NCPI) reports.

Table 9: Sex work in countries in the region

Countries	HIV prevalence (%) sex workers	Coverage of HIV prevention programmes for sex workers	Provided information on sex workers in 2012 reporting cycle
Angola	Not available	Between 75 - 100	
Botswana	Not available	Not available	Did not report
Comoros	Not available	Not available	Did not report
Democratic Republic of Congo		Between 25 – 49	
Kenya	Not available	Not available	Did not report
Lesotho	Not available	Not available	Did not report
Madagascar	Not available	Not available	Did not report
Malawi		Between 25 - 49	
Mauritius	Not available	Not available	Did not report
Mozambique		Between 75 - 100	
Namibia	Not available	Not available	Did not report
Seychelles	Not available	Not available	Did not report
South Africa	Not available	Not available	Did not report
Swaziland	Not available	Not available	Did not report
Tanzania	Not available	Not available	Did not report
Uganda	Not available	Not available	Did not report
Zambia	Not available	Not available	Did not report
Zimbabwe	Not available	Not available	Did not report

¹⁰⁸UNAIDS Global Update on HIV and AIDS 2012 at p.21 http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf

¹⁰⁹Global Update at p.21 http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf

Only Madagascar does not criminalise sex work. Other countries use various legal mechanisms to criminalise all aspects of sex work and related activities.

Sex workers have been recognised by the majority of countries as a key population in HIV policy and programming. However, a significant number of countries indicated that existing laws and policies created barriers to universal access for sex workers.

Table 10: Inclusion of sex workers in NSPs and policies¹¹⁰

Country	Does the multi-sectoral strategy include sex workers?	Are sex workers identified as key populations for HIV programming?	Are there laws and policies that are obstacles to effective prevention, treatment and care interventions?
Angola	Yes	Unable to ascertain – report in Portuguese	No data provided
Botswana	Yes	Yes	Yes
Comoros	Yes	No	No data provided
Democratic Republic of Congo	Yes	Yes	No data provided
Kenya	Yes	Yes	Yes
Lesotho	Yes	Yes	No
Madagascar	Yes	Yes	No data provided
Malawi	Yes	Yes	Yes
Mauritius	Yes	Yes	Yes
Mozambique	Yes	Yes	No data provided
Namibia	Yes	Yes	No data provided
Seychelles	Yes	Yes	No data provided
South Africa	Yes	Yes	Yes
Swaziland	Yes	No	Yes
Tanzania	Yes	Yes	No
Uganda	Yes	Yes	Yes
Zambia	report not available	report not available	report not available
Zimbabwe	No	No	Yes

Conclusions and recommendations

Sex workers are at high risk of HIV transmission and they experience many barriers to access HIV prevention, treatment, care and support, including violations of their human rights. Law reform is “critical to facilitate access to HIV prevention, treatment, care and support for these key populations”.¹¹¹

- Decriminalise the selling and buying of sex by consenting adults
- Ensure that sex workers whose rights have been violated have access to justice through the provision of legal services and by holding perpetrators accountable for abuse
- Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health
- Programmes should be put in place to sensitize and educate health-care providers on non-discrimination and sex workers’ right to high-quality and non-coercive care, confidentiality and informed consent
- Sex workers’ groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services
- Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of sex workers, and held accountable if they violate the rights of sex workers, including the perpetration of violence

¹¹⁰Information from 2012 NCPi
¹¹¹Global Commission on HIV and the Law, Report of the Africa Regional Dialogue of the Global Commission on HIV and the law, p.40 available at <http://www.hivlawcommission.org/index.php/ard-dialogue-documentation>
30 HIV and Human Rights in Southern and East Africa 2014 Report

3.5 Gender inequalities and GBV: HIV and women

Globally, women make up half of those living with HIV. In sub-Saharan Africa however, women continue to be disproportionately affected, with 1.4 times more adult women than men living with HIV in 2010. Women make up 58%¹¹² of people living with HIV in this region, as they have for most of the preceding decade. ¹¹³ They also account for 53% of all adult AIDS deaths.¹¹⁴

The African Dialogue on HIV and the Law received more submissions on women than any other focus area¹¹⁵ and almost all the respondents for this research identified human rights violations against women as a key challenge, confirming that they remained at high risk of HIV and that violations of their human rights exacerbated the impact of HIV on their lives.

Examples of stigma and discrimination against women and girls from key informant interviews

- Women are most often the users of health services, especially expectant mothers – they are tested without their consent sometimes... we know of some who have been refused access to services. (Lesotho)
- We have examples of families that play a significant role in enforcing traditional practices that are harmful and can make people vulnerable to HIV – women cannot protect themselves even if they know about condoms and they want to use them because of family pressure to get pregnant. (Lesotho)
- Women are not protected from harmful customary practices – we have one bad law that supports widow inheritance. (Zambia)

Violence against women

Key Data¹¹⁶

- 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence
- 30% of all women in a relationship have experienced physical and/or sexual violence by their intimate partner
- Women who have been physically or sexually abused by their partners are 1.5 times more likely to acquire HIV compared to women who have not experienced partner violence

The Global Commission confirms that GBV is “one of the most pervasive threats to the physical well-being of women in Africa”. ¹¹⁷

The ARASA 2009 report pointed out two-thirds of SADC countries had legislation protecting women against GBV. At the time of the report, Swaziland and Zimbabwe were in the process of reviewing existing laws and introducing reforms.¹¹⁸ No information was available from Angola, Mozambique and Tanzania. Countries under review continue to make progress

¹¹²2012 Global Aids Review http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf p.70
¹¹³WHO, UNAIDS & UNICEF, Global HIV Response: Epidemic Update and health sector progress towards Universal Access. Progress Report 2011; p. 19; available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_UA_Report_en.pdf
¹¹⁴UNAIDS, Getting to Zero: HIV in east and southern Africa, Regional Report 2013; p.68 available at <http://www.zero-hiv.org/wp-content/uploads/2013/08/Getting-to-Zero-2013.pdf>
¹¹⁵SGCHL, Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law, 2011 at p. 18
¹¹⁶WHO et al., Global and Regional estimates of Violence Against Women: prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013, p.2 Available at http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf
¹¹⁷African Regional Dialogue of the Global Commission on HIV and the Law, Regional Issue Brief: Women, HIV and the Law, 2011, p.22 Available at <http://www.hivlawcommission.org/index.php/regional-dialogues-main?task=document.viewdoc&id=73>
¹¹⁸ARASA 2009 report at p.50

towards developing laws that criminalise and punish GBV: Angola and Kenya passed new laws on domestic violence in 2011 and 2013 respectively. Mozambique also has a domestic violence law. Swaziland and Lesotho have however still not finalized their legislation and the DRC and Comoros do not have specific laws on domestic violence.

Table 11: Criminalisation of marital rape and domestic violence legislation¹¹⁹

Countries	Marital rape is criminalised	Marital rape is not criminalised	Domestic violence laws
Angola	X		Domestic Violence Law 2011
Botswana		X	Domestic Violence Law 2008
Comoros		X	
DRC		X	
Kenya	Marital rape is criminalised in limited circumstances		Draft Domestic Violence Bill
Lesotho		X	Protection Against Domestic Violence 2013
Madagascar		X	Law 2000 - 12
Malawi		X	Protection Against (Prevention of) Domestic Violence Act
Mauritius	X		Protection from Domestic Violence Act 1997 (as amended)
Mozambique	X		Law on Domestic Violence Perpetrated Against Women
Namibia	X		Combating of Domestic Violence Act 2003
Seychelles	X		Family Violence (Protection of Victims) Act 2000
South Africa	X		Domestic Violence Act 1998
Swaziland		X	Draft Domestic Violence and Sexual Violence Bill 2007
Tanzania	Marital rape is criminalised in limited circumstances		No dedicated domestic violence legislation, but aspects of domestic violence are criminalised through the Penal Code
Uganda		X	Domestic Violence Act 2009
Zambia		X	Anti-Gender Based Violence Act 2011
Zimbabwe	X		Domestic Violence Act 2007

Despite the progress made, a key protection gap in the legal frameworks remains the failure to criminalise marital rape. It is estimated that in Kenya, Malawi and Uganda more than 80% of all unprotected sex acts involving people living with HIV occur with spouses or cohabiting partners and a recent modelling study has suggested that women are at greater risk than men of acquiring HIV in such relationships. HIV transmission in long term relationships is becoming an increasing concern and there is a critical need for long-term partners to be able to negotiate safe sex.¹²⁰ Protecting women from marital rape and ensuring women who experience sexual violence in marriage can access PEP, emergency contraception (EC) and other health services are critical HIV prevention interventions.

Even where adequate laws exist, implementation remains weak: police and health care workers are poorly trained and cultural and social barriers prevent women from reporting violence and accessing justice. The GCHL raised particular concerns about the on-going failure to make programmatic linkages between survivors of sexual and domestic violence and HIV services.¹²¹

¹¹⁹Information extracted from the Secretary-General of the UN's database on violence against women. Available at <http://www.un.org/womenwatch/daw/vaw/v-database.htm>
¹²⁰*Ibid.* p.69 Getting to Zero
¹²¹African Regional Dialogue of the Global Commission on HIV and the Law, Regional Issue Brief: Women, HIV and the Law, 2011, p.23. Available at <http://www.hivlawcommission.org/index.php/regional-dialogues-main?task=document.viewdoc&id=73>

Child and early marriage¹²²

Young women are particularly disproportionately at risk of HIV infection: they are infected at almost double the rates of young men in almost all countries under review, except for Madagascar and Mauritius (there are no figures for the DRC and Seychelles).

Table 12: Women and HIV¹²³

Country	Estimated women (15+) living with HIV	Young women (15 – 24) prevalence (%)	Young men (15- 24) prevalence (%)
Angola	120 000	1.6	0.6
Botswana	160 000	9.0	4.1
Comoros	<100	<0.1	<0.1
DRC	no data	no data	no data
Kenya	800 000	3.5	1.6
Lesotho	170 000	15.4	6.4
Madagascar	9 500	<0.1	0.2
Malawi	430 000	4.9	2.1
Mauritius	2 200	0.4	0.6
Mozambique	750 000	8.2	2.8
Namibia	100 000	6.5	2.7
Seychelles	no data	no data	no data
South Africa	2.900 000	11.9	5.3
Swaziland	100 000	15.3	6.3
Tanzania	760 000	4.0	1.8
Uganda	670 000	5.3	2.4
Zambia	460 000	7.0	3.1
Zimbabwe	600 000	7.6	3.6

One in three girls in the developing world is married before she reaches 18, the majority of these living in sub-Saharan Africa and Asia.¹²⁴ Four of the countries included in this survey are in the top 20 most affected countries: Mozambique¹²⁵, Malawi¹²⁶, Madagascar¹²⁷ and Zambia¹²⁸. In these four countries, a significant proportion of child brides are married before they reach 15: 21% in Mozambique, 14% in Madagascar, 12% in Malawi and 9% in Zambia.

Table 13: Early marriage¹²⁹

Country	Married by 15 (%)	Married by 18 (%)
Angola	No information available	No information available
Botswana	No information available	No information available
Comoros	No information available	No information available
DRC	9	39
Kenya	6	26
Lesotho	2	19
Madagascar	14	48
Malawi	12	50
Mauritius	No information available	No information available

¹²²A marriage in which one spouse is younger than 18 years of age
¹²³UNAIDS, Getting to Zero: HIV in east and southern Africa, Regional Report 2013; p.101 available at <http://www.zero-hiv.org/wp-content/uploads/2013/08/Getting-to-Zero-2013.pdf>
¹²⁴See: <http://www.girlsnotbrides.org/where-does-it-happen>
¹²⁵Mozambique is ranked no.10th
¹²⁶Malawi is ranked 9th
¹²⁷Madagascar is ranked 11th
¹²⁸Zambia is ranked 16th
¹²⁹The information in this table was extracted from UNICEF statistics, quoted on the Girls Not Brides website, available at <http://www.girlsnotbrides.org/>
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Mozambique	21	56
Namibia	2	9
Seychelles	No information available	No information available
South Africa	1	6
Swaziland	1	7
Tanzania	7	37
Uganda	10	40
Zambia	9	42
Zimbabwe	4	31

Child marriage affects many aspects of girls’ and women’s health, including increasing their vulnerability to HIV. Many become pregnant as a result of marital rape and forced sex, without understanding what is happening to their bodies. They are unable to negotiate how and when sex takes place or whether condoms will be used.

Girls must then care for their own children while they are still children themselves. Often, married girls drop out of school or are expelled, limiting their ability to learn skills to work later in life and limiting their access to information, including on HIV and reproductive health. A 2007 study in Kisumu, Kenya showed that 33% of married girls were living with HIV, compared to 22% of their unmarried, sexually active counterparts.¹³⁰ Many suffer violence and face barriers in accessing justice and available legal protections.

A critical aspect of eradicating child marriage is developing and enforcing laws that set a minimum age of marriage of 18, which is the internationally accepted standard, protecting girls from marital rape and prosecuting perpetrators of child and early marriage.

Table 14: Minimum age of marriage

Country	Minimum age	No minimum age
Angola	18, but permissible at 15 for girls and 16 for boys with parental consent	
Botswana	18	
Comoros	18	
DRC	18 for boys, 14 for girls	
Kenya	18	No minimum age for marriages performed in terms of sharia and customary laws.
Lesotho	The Child Protection and Welfare Act defines a child as below the age of 18 and prohibits child marriage, but the Marriage Act which is still in force allows girls of 16 and boys of 18 to marry. There is no minimum age for customary marriages.	
Madagascar	18	
Malawi	18, but permissible at 15 with parental consent Conflicting ages in legislation: the Constitution sets 18, but permissible at 15 with parental consent;	
Mauritius	The Marriage Act sets 21 as the minimum age.	
Mozambique	18, but between 16 – 18 with parental consent	
Namibia	21 but permissible at 18 with parental consent	
Seychelles	18	
South Africa	15 for girls and 18 for boys	
Swaziland	18 but between the ages of 15 – 18, with parental consent	

¹³⁰Population Council, *Child marriage in the context of the HIV epidemic*, New York, September 2007, p.2

¹³¹See: <http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>

Tanzania	18	
Uganda	15 for girls, 18 for boys	
Zambia	16	No minimum age for marriages concluded under customary law
Zimbabwe	18	

As the table above indicates, the majority of countries included in this report have set the minimum age of marriage at 18. It is clear from the statistics included in the country reports about the prevalence of child marriage, that there are significant challenges in implementing these laws.

In December 2013, Ministers of Health and Education from 21 countries¹³² met in Cape Town to commit to the provision of quality, comprehensive sexuality education and reproductive health services. They committed to review and amend existing laws and policies on age of consent to sex and child protection and they set a target of eradicating child marriage by 2020.

Conclusions and recommendations

- Ensure the inclusion of marital rape in domestic violence and sexual offences legislation
- Develop awareness campaigns against child marriage on the harms the practice causes, including exposure to HIV
- Support programmes to help end violence against women and girls

3.6 Access to affordable medicines

As this report shows, access to HIV treatment continues to increase in Southern and East Africa and the number of people receiving ART increased from 625 000 in 2005 to approximately 6.3 million in 2012.¹³³ However, access and adherence to treatment for HIV as well as TB, including multi-drug resistant (MDR) and extensively drug resistant TB, continues to be a priority in the region. Despite significant progress in the scale-up of ART, another 2.9 million people (including 0.87 million children) who were eligible for ART in 2011 were not yet receiving it. Treatment coverage for children is still unacceptably low and access to treatment for key populations remains problematic.¹³⁴ The number of people eligible for treatment will also increase with the revised WHO ART treatment guidelines for 2013 with a focus on providing ART for both treatment and prevention (‘treatment as prevention’).

Further reducing the costs of HIV treatment, especially for second and third line treatments, as well as for effective TB treatments, is essential. However, resources to fund HIV prevention, treatment and care programming are at risk of declining. Southern and East African governments have increased their domestic spending on HIV treatment and care, with domestic financing (from public and private sources) in Angola, Botswana and South Africa responsible for 80% of funding for their ARV treatment.¹³⁵ In Southern Africa, the reported domestic financing for treatment and care is 83%, and while this is high, it is largely due to South Africa which represents almost half of all HIV treatment and care spending in Africa. Despite the increase in domestic funding, UNAIDS, governments and civil society have expressed concerns about the sustainability of treatment and care programmes in the medium and long term, partly because of the reliance on foreign and donor funding, but also because of the high costs of medicines and health-related commodities. A working paper of the Global Commission on HIV and the Law indicated that in low-income countries as the need for second- and third-line regimens increases, costs will increase: the annual price per person will increase from US \$136 to US \$243 for first-line regimens and from US \$572 to US \$803 for second-line regimens.¹³⁶ The Global Commission on HIV and the Law described treatment affordability as a “crisis”.¹³⁷

¹³²Including Angola, Botswana, DRC, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe

¹³³UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa*, 2013.

¹³⁴*Ibid.*

¹³⁶UNAIDS, *Access to Antiretroviral Therapy in Africa: Status report on progress towards the 2015 target*, p. 8 available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131219_AccessARTAfricaStatusReportProgresstowards2015Targets_en.pdf

¹³⁵So, A. and Oh, C., *Approaches to Intellectual Property and Innovation That Meet the Public Health Challenge of AIDS: Working Paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law*, 7-9 July, 2011

¹³⁸Global Commission on HIV and the Law, *Risks, Rights and Health*, 2012, at p. 77 available at <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf>

The high cost of medicines not only contributes to the costs of sustaining large treatment and care programmes, it also has detrimental consequences for health: people in the most affected countries often have access to a much smaller pool of ARV combinations, even when they experience severe side effects or treatment failure. High costs also affect the speed at which countries are able to introduce new and better treatment options.¹³⁸

TRIPS and access to medicines

The TRIPS Agreement put in place a global intellectual property regime that “elevated the international standards of intellectual property protection by imposing standards of protection far stricter than those prevailing in developing countries at the time of its adoption.”¹³⁹ The implementation of these standards has undermined access to affordable medicines in many parts of the developing world, including those most affected by HIV as few countries, India being a notable exception, chose to exercise the flexibilities that would allow them to increase access to antiretrovirals and “obviate the shortages of affordable medicines that TRIPS itself has contributed to creating”.¹⁴⁰

Although the Doha Declaration on TRIPS and Public Health re-affirmed the right of developing countries to exercise flexibilities, including the use of compulsory licensing, only a small number of countries have chosen or been able to do so.¹⁴¹ Some of those that did use TRIPS flexibilities to promote affordable access met with retaliation from some high-income countries and corporations.¹⁴² Some of the public health safeguards that were extended to countries under the Doha Declaration will expire in January 2016; beyond that time, the patenting situation of HIV-related medicines will become more complex, restrictive and inevitable.¹⁴³

The Global Commission on HIV and Law recommended that the UN Secretary-General convene a neutral, high-level body to recommend a new intellectual property regime for pharmaceutical products. It explicitly recommended that such a system be consistent with both international human rights and public health considerations. In the interim, it recommended the suspension of TRIPS for essential pharmaceutical products and that middle- and low-income countries use TRIPS flexibilities.¹⁴⁴

The African Union’s (AU) *Roadmap on Shared Responsibility and Global Solidarity for the AIDS, Tuberculosis and Malaria Response in Africa* recognizes the urgent need to ensure the sustainability of national responses to AIDS, TB and malaria, given the dependence of many national responses on both external funding and foreign produced medications. The roadmap is intended to provide a set of practical solutions around three key issues: diversified funding, access to medicines and enhanced health governance. It includes goals to be met by 2015.

The African Roadmap and Access to Medicines

The roadmap identifies four priority actions that can be taken to ensure accelerated access to affordable and quality assured medicines and health-related commodities:

1. Promote and facilitate investing in leading medicines hub manufacturers in Africa – focusing initially on AIDS, TB and malaria medicines;
2. Accelerate and strengthen regional medicines regulatory harmonization initiatives and lay foundations for a single African regulatory agency;
3. Acquire essential skills through technology transfers and south-south cooperation and create incentives to ensure that new capabilities are truly embedded in Africa; and
4. Create a legislative environment that incorporates the full use of the Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) flexibilities and develops awareness to avoid the incorporation of “TRIPS-plus” measures in trade agreements.

The Roadmap recommends the creation of an enabling legislative environment that “incorporates the full use of TRIPS flexibilities” to allow for enhanced access to affordable medicines and that raises awareness about the need for countries to avoid incorporating TRIPS-plus provisions in new trade agreements.¹⁴⁵ In particular, the Roadmap recommends that the waiver to be TRIPS compliant for the least developed countries should extend beyond 2016.

At a regional level, some progress has been made towards building pharmaceutical capacity in Africa and harmonising the regulation of medicines, through the Pharmaceutical Manufacturing Plan for Africa and the AU/NEPAD African Medicines Regulatory Harmonisation Programme.¹⁴⁶ Kenya, South Africa, Uganda and Zimbabwe are already producing WHO pre-qualified ARVs and Mozambique and Tanzania are soon expected to do so.¹⁴⁷ A draft AU Model Law on Medical Products Regulation and Harmonisation was developed in 2013.

At a national level, a number of countries have engaged in policy reforms to incorporate public health flexibilities in 2013. Government and civil society actors in Swaziland, Malawi, Zambia and Botswana held workshops in 2013 to strengthen capacity to engage in law and policy reform by developing action plans for the incorporation or use of TRIPS flexibilities. Uganda passed an Industrial Property Act in 2014 which incorporates a number of public health sensitive flexibilities. The Kenyan government commenced a review process in 2013 of its anti-counterfeiting legislation to ensure its compliance with the constitutionally-affirmed right to health, including to essential medicines. Civil society organisations in that country have been active to ensure this mandate is effectively fulfilled by the review process.¹⁴⁸ However, ongoing work is required to encourage countries to strengthen their laws and policies, including making use of TRIPS flexibilities and ensuring they do not adopt restrictive intellectual property laws, in order to facilitate access to affordable and effective medicines for HIV and TB.

Conclusions and recommendations

- Strengthen review of laws and measures to fully incorporate and use public health related flexibilities and to avoid restrictions on the use of public health related TRIPS flexibilities
- Continue regional advocacy for strengthened pharmaceutical production and regulation of medicines in Africa

¹³⁸*Ibid.*

¹³⁹*Ibid.*

¹⁴⁰*Global Commission on HIV and the Law, Risks, Rights and Health, 2012, at p.81*

¹⁴¹*Ibid.*

¹⁴³*Global Commission on HIV and the Law, Risks, Rights and Health, 2012, at p.84*

¹⁴³UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa, 2013.*

¹⁴⁴*Global Commission on HIV and the Law, Risks, Rights and Health, 2012, at p.86*

¹⁴⁵*African Union, Roadmap on Shared Responsibility and Global Solidarity for the AIDS, Tuberculosis and Malaria Response in Africa* http://www.au.int/en/sites/default/files/Shared_Res_Roadmap_Rev_F%5B1%5D.pdf

¹⁴⁶*African Union Commission, A report on progress towards achieving law and human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Responses in Africa 2012-2015, Report for AWA Consultative Experts Committee Meeting, Nouakchott, May 2014.*

¹⁴⁷UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa, 2013.*

¹⁴⁸AUC, *A report on progress towards achieving law and human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Responses in Africa 2012-2015, Report for AWA Consultative Experts Committee Meeting, Nouakchott, May 2014.*

4. Access to justice and challenges in implementing the protective legal framework

Inadequate implementation of existing laws and policies and access to justice when rights are infringed emerged as major issues during the research for this report. Many of the respondents expressed concerns about the large disparity between the good laws and policies that had been developed, and the lack of knowledge amongst people living with HIV and key populations about their rights. In almost all the countries under review for this report, the primary enforcement mechanism is the courts, and respondents highlighted the many barriers that prevent or limit access, including the costs of litigation, the lack of legal representation and for people living in rural areas, distance and expense. As one respondent stated, “the courts are not very accessible. Many people don’t have the fees for filing documents and people generally don’t know what the process is for litigation”.¹⁴⁹

Women face particular challenges in implementing their rights both through law enforcement mechanisms and formal and customary courts and tribunals.¹⁵⁰ Information provided to the CGHL indicated that even where protective legal frameworks are put in place to protect women’s rights, entrenched gender inequality and patriarchy undermined their ability to enforce these rights.¹⁵¹

Key populations such as sex workers, people who inject drugs and LGBTI persons also struggle to enforce their rights, including because they frequently experience human rights violations at the hands of law enforcement officials.¹⁵²

4.1 Know Your Rights?

The ARASA 2009 report concluded that Know Your Rights campaigns were a crucial aspect of empowering people living with HIV. However, *lack of information about rights is a major barrier to claiming and enforcing rights*. Many respondents indicated that there have been few national, government-led campaigns to make people living with HIV aware of their rights and what to do if these are infringed. In addition, there are no national, government-led campaigns which provide key populations with accessible and relevant information about their rights.

Examples of impact of lack of information about rights

- Based on our work with people living with HIV, some do know their rights, but generally people don’t. It’s usually the people who belong to support groups who get some training on their rights. (Zambia)
- There is a lack of awareness of what people’s rights are – people just generally don’t know what their rights are and not enough has been done to make sure that key populations know their rights. (Lesotho)
- One of the big weaknesses is that people still don’t know their rights; there have been some materials that were developed, but this really needs to be improved. We need more legal literacy programmes for people living with HIV and for other groups. (Mauritius)
- We still have a lot to do raising awareness about HIV and human rights. (Malawi)

4.2 Law enforcement

Law enforcement mechanisms

Kenya is the only country that has adopted HIV-specific legislation which creates a dedicated HIV-dispute resolution process. The ARASA 2009 report showed that other countries have chosen to give specific courts the jurisdiction to hear matters involving HIV-related discrimination.

¹⁴⁹Communication with Malala Mwendela, ZARAN, 6 September 2012

¹⁵⁰Global Commission on HIV and the Law, Regional Issue Brief: Women, HIV and the Law, p. 12 available at <http://www.hivlawcommission.org/index.php/ard-dialogue-documentation>

¹⁵¹Ibid.

¹⁵²Global Commission on HIV and the Law, Report of the African Regional Dialogue of the Global Commission on HIV and the Law, 4 August 2011, available at <http://www.hivlawcommission.org/index.php/ard-dialogue-documentation/edocman-page-1>

Conclusions	Key recommendations	Follow up to 2009 report
SADC countries that have adopted HIV-specific laws have also created offences for failure to abide by the laws. In most cases, these offences are dealt with the courts	• Advocate for courts to hear HIV-related disputes	It appears that courts are hearing some HIV-related cases
	• Advocate for training for the judiciary and law enforcement staff to increase their capacity to enforce HIV-related laws	Some training has taken place, but it is by no means systemic or widespread
	• Alternatively advocate for HIV-related dispute mechanisms	No additional mechanisms have been created

While there has been an increase in the number of cases that courts have been hearing, it appears that relatively few cases dealing with HIV-related discrimination are being litigated.

Legal aid

Given that courts are the primary venue for dispute resolution in almost all the countries under review, the availability of legal aid services is a critical aspect of access to justice for those whose rights have been violated. The 2009 report recommended that civil society advocate for the provision of legal services to people living with HIV and members of vulnerable and marginalised groups in the form of legal aid, strategic litigation and community dispute resolution.

Examples of the lack of legal aid

- Government legal aid programmes are over-whelmed – they don’t have enough lawyers and they focus on criminal cases. (Zambia)
- People can use the courts when they need to, but this is not always possible for people living with HIV – lawyers are expensive and cases can take a long time to be finalized. (Seychelles)

Case study – providing legal aid for prisoners, Zambia

Zambian prisons are heavily congested: there are 17 000 prisoners, including awaiting trial detainees, in prisons that are designed to hold only 5 000. As Godfrey Malembeka from PRISSCA, an NGO promoting the rights of prisoners, states, they are “a breeding ground for TB and other opportunistic infections”.

PRISSCA, with funding from the Open Society Institute of Southern Africa (OSISA), has developed a programme in conjunction with three law firms to identify and take up cases that have been delayed in the courts. The programme focuses on identifying cases involving petty offences and trying to get these through the courts, advocating non-custodial sentences with the aim of alleviating overcrowding.

Other dispute mechanisms

Although only Kenya has developed an HIV-specific dispute resolution mechanism, other human rights institutions do exist and may be able to address HIV-related complaints. These include national human rights institutions and ombudspersons. Many respondents indicated that these institutions and representatives existed in their countries, but did not take up HIV-related complaints. Many expressed concerns about the lack of capacity within these institutions and their lack of resources.

Providing support to traditional mechanisms to hear and adjudicate on HIV-related complaints is another important potential mechanism for resolving disputes, which requires further exploration across the region. For example in Kenya,

the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN)’s work with traditional dispute mechanisms to resolve issues relating to women and property ownership and inheritance has successfully protected women’s rights to property in a number of cases.

Table 15: Existence of national human rights institutions

Country	Human rights commissions	Other
Angola	X	An inter-ministerial committee meets regularly to report to UN bodies on human rights
Botswana	None	Ombudsman- investigates maladministration and human rights violations in the public sector
Comoros	None	
DRC	In October 2012, the DRC adopted a law to establish a human rights commission and it is currently before the Supreme Court for review of constitutionality ¹⁵³	Inter-ministerial committee on human rights that meets on ad hoc basis
Kenya	X ¹⁵⁴	
Lesotho	The senate passed an amendment to the Constitution in 2011 to allow for establishment of a human rights commission but to date not yet been established ¹⁵⁵	Office of the Ombudsman ¹⁵⁶
Madagascar	X ¹⁵⁷	Ombudsman ¹⁵⁸
Malawi	X	X
Mauritius	X	X Equal Opportunities Commission Ombudsman
Mozambique	X ¹⁵⁹	X ¹⁶⁰
Namibia		X
Seychelles	X	
South Africa	X	X
Swaziland	X ¹⁶¹	
Tanzania	X	
Uganda	X	
Zambia	X	
Zimbabwe ¹⁶²		X

¹⁵³US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Republic of Congo, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁵⁴In 2011, the government passed legislation transforming the Kenya National Commission on Human Rights from an autonomous body to a constitutional commission, stripping the commission of significant power and independence. US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Kenya, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 18 May 2014]

¹⁵⁵US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Lesotho, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁵⁶Although the office is independent, it is few resources and there is a lack of awareness about its existence: US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Lesotho, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁵⁷Inactive since 2002. The de facto government adopted legislation on 4 Dec 2012 establishing an independent national human rights commission

¹⁵⁸Minimally active: US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Madagascar, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁵⁹Although the law establishing the commission was enacted in 2009, the first commissioners were only appointed in September 2012. By the end of 2012, the commission had no budget and was not operational. Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Mozambique, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁶⁰The law was enacted in 2005, but the first ombudsman only elected in 2012. Ibid

¹⁶¹The commission is nearly inactive due to lack of staff and no budget: Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Swaziland, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 20 August 2013]

¹⁶²A bill has been drafted for the establishment of a commission

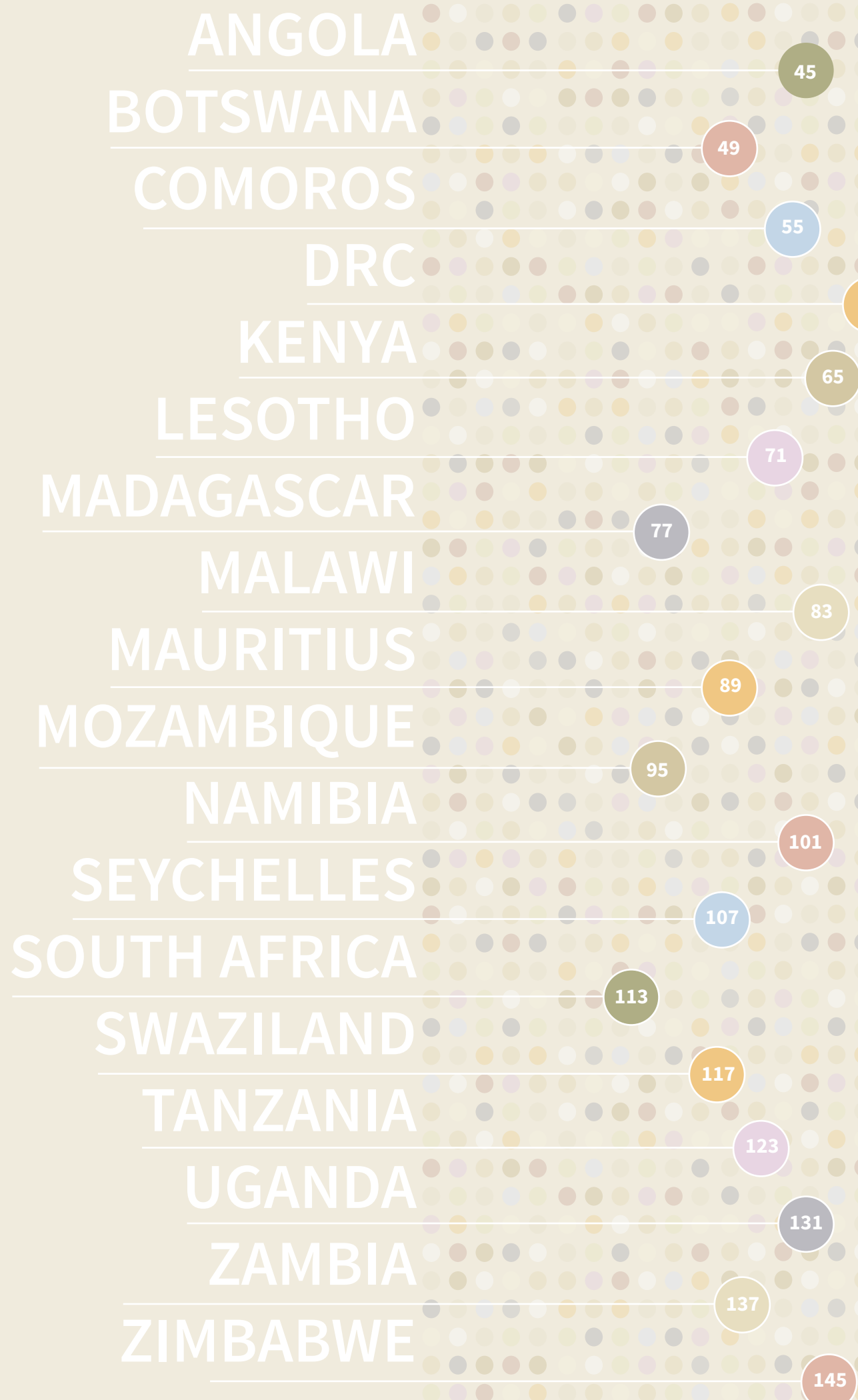
Recommendations

Across the region, countries need to continue efforts to strengthen access to justice for people living with HIV and to ensure that such efforts take measures to prioritise the particular needs of key populations. Strengthening access to justice and law enforcement will support populations in accessing protection for human rights violations. Additionally, in situations where populations are criminalised or where there are no protective laws for people living with HIV and key populations, it may also help to sensitise key stakeholders to the importance of protecting rights, pending law review and reform.

Programmes may include, amongst others:

- Developing stigma and discrimination reduction programmes to encourage understanding and tolerance towards all affected populations
- Expanding 'Know Your Rights' campaigns to ensure that all vulnerable and key populations know their rights and how to claim access to justice for human rights violations
- Increasing access to legal support services for people living with HIV and key populations to support affected populations to claim redress for rights
- Sensitising health care workers and other relevant service providers on the rights of people living with HIV and key populations
- Sensitising members of the judiciary as well as law enforcement on the rights of people in the context of HIV, with a particular focus on the rights of key populations
- Working with human rights institutions and other alternative dispute resolution mechanisms, including traditional mechanisms, to strengthen responses to HIV-related complaints for all affected populations

5. Country snapshots



ANGOLA

Key data and modes of transmission

According to UNAIDS, 190 000 people (being 2.1% of adults aged 15 to 49 years) in Angola are living with HIV, the majority of whom are women (120 000). There have been an estimated 12 000 deaths from AIDS annually. There are 34 000 children below age 15 living with HIV and there are 140 000 orphans.¹⁶³

Limited research exists on HIV incidence and prevalence amongst key populations such as sex workers, men who have sex with men and people who inject drugs. In research studies conducted for purposes of the UNGASS Country Report 2012, higher levels of HIV prevalence were found amongst sex workers (around 7% testing positive for HIV) and men who have sex with men (around 8%).¹⁶⁴ Heterosexual transmission is said to account for around 80% of all new infections, and vertical transmission for 6% of new infections.¹⁶⁵

Background to HIV, Law and Human Rights

The 2009 ARASA report identified key HIV and human rights concerns in Angola:

- a) Discrimination against soldiers living with HIV;
- b) Limited access to condoms for prisoners;
- c) Limited access to legal protection for women to reduce vulnerability to HIV;
- d) Criminalisation of HIV transmission; and
- e) Lack of access to ART.

Key Human Rights Concerns in 2014

The National Strategic Plan (NSP), the *Plano Estratégico Nacional de Resposta às ITS/VIH/SIDA, Angola, 2011 – 2014 (PEN IV)* identifies the following populations as key populations at higher risk of HIV exposure:

- Sexually active people aged 15-29 years
- Pregnant women
- Sex workers
- Migrant populations
- Prisoners
- Men who have sex with men
- Members of the uniformed services
- Truckers and sailors

It also includes programmatic responses for other populations identified as vulnerable such as orphans and vulnerable children and people with disabilities.

Women's rights: Submissions to the GCHL's Africa Regional Dialogue on HIV and the Law raised concerns about the inequitable rights of women to property and

¹⁶³UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013, 2013.*

¹⁶⁴See UNAIDS Angola Country Progress Report, 2012. Available at www.unaids.org/en/regionscountries/countries/angola/

¹⁶⁵See www.unaids.org/en/regionscountries/countries/angola/



190 000
people are
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Heterosexual
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infections

inheritance, and to sexual and reproductive health services in Angola. Although a domestic violence law was passed in 2011, domestic violence remains a serious problem in both rural and urban areas. There is limited prosecution of domestic and sexual violence.¹⁶⁶

Rights of LGBTI: The submissions also cited examples of discrimination against sexual minorities as a key issue.¹⁶⁷

Prisoner’s rights: The 2012 US State Department report highlighted severe over-crowding in prisons and limited access to health care, sanitation, food and water.¹⁶⁸ There are also reports of sexual abuse of female prisoners by prison guards. Female migrants appear to be particularly vulnerable to sexual abuse when they are in the custody of officials or being expelled from Angola.¹⁶⁹

Legal framework for HIV and AIDS

Constitution

Discrimination is prohibited on the grounds of ancestry, sex, race, ethnicity, colour, disability, language, place of birth, religion, political, ideological or philosophical beliefs, level of education or economic, social or professional status.

The Constitution of the Republic of Angola is the overarching law and includes protection of the human rights and dignity of all people. In 2010, the National Assembly of Angola approved a new Constitution, which entered into force in February 2012.¹⁷⁰

Article 23 of the 2010 Constitution provides for equality before the law and also contains a substantive equality clause: discrimination is prohibited on the grounds of ancestry, sex, race, ethnicity, colour, disability, language, place of birth, religion, political, ideological or philosophical beliefs, level of education or economic, social or professional status. Although HIV is not specifically mentioned as a prohibited ground of discrimination, people living with HIV are entitled to the protections contained in the Constitution. The Constitution also provides for equality between women and men in marriage.

Article 77 requires the state to take steps to promote and guarantee measures that will ensure a universal right to medical and health care.

National Laws and Policies

Angola has a number of laws, regulations and policies that protect human rights in the context of HIV and AIDS, including an HIV-specific law that protects people living with HIV from HIV-related discrimination, workplace protection for employees as well as laws protecting women from sexual violence. Angola enacted an HIV-specific law in 2004, Law 8/04 on HIV and AIDS (2004). The law aims to protect and promote the health of all people, through the provision of HIV-related health care and to provide for the rights and duties of people affected by HIV. It contains a number of important protections.

HIV-specific protections:

- Protection of the right to confidentiality
- Protection of the rights of employees and a prohibition against HIV-related discrimination in the workplace
- A prohibition against compulsory HIV testing for purposes of employment (including within the defence and security forces) and for purposes of credit
- Protection of the rights of prisoners (e.g. to protection from compulsory HIV testing and access to health services)
- The provision of HIV and AIDS education in schools, learning institutions and workplaces¹⁷¹
- The provision of ART to people living with HIV
- In the employment sector, Order No. 43/03 (July 2003) contains the Regulations of HIV/AIDS in Employment and Professional Training, regulating HIV and AIDS in employment

The Regulations contain detailed protection for HIV-related employment rights including non-discrimination; confidentiality; ensuring safety in the workplace, compensation for occupational infection and an express prohibition on HIV testing in employment.

Although women enjoy equal rights under the Constitution and national laws, they continue to experience discrimination, an especially serious problem in rural areas. Sexual offences laws protect women from rape, including marital rape. There is a minimum age of marriage of 18 years, protecting girls from early marriage, although girls may marry “exceptionally” at the age of 15 and boys at 16.¹⁷² In 2011 a law was enacted to protect women from domestic violence¹⁷³ The law stipulates a wide range of crimes relating to violence against women including physical and mental violence, sexual abuse, withholding food from pregnant women and children, misappropriation of an heir’s property and promoting early marriages of children under 14 years. It generates various forms of support services for people whose rights are violated including psychological, social, medical and legal support.¹⁷⁴

Ratification of International and Regional Human Rights Instruments

- Angola has ratified:
- African Charter on Human and Peoples’ Rights, 1990
 - African Charter on the Rights and Welfare of the Child, 1999
 - Convention on the Rights of the Child (CRC), 1990
 - Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1986
 - International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
 - International Convention on Civil and Political Rights (ICCPR), 1992
 - Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2007

Angola has not ratified the Convention on the Rights of People with Disabilities.

Access to Justice and Law Enforcement

There are said to be programmes in place to reduce stigma and discrimination, increase awareness and understanding of rights amongst populations and service providers, and provide legal support services. There are also said to be general mechanisms in place to record, document and address cases of stigma and discrimination, such as the national human rights commission, as well as organisations working on HIV, law and human rights issues such as the National Network of People living with HIV or AIDS. The government reported having run awareness campaigns at the end of 2011 to raise awareness about violence against women and girls. However, generally awareness and understanding of rights is said to

¹⁶⁶US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Angola [Accessed on 22 August 2013]

¹⁶⁷Global Commission on HIV and the Law, Submissions to the Africa Regional Dialogue on HIV and the Law, 2011 at p299. Available at www.hivlawcommission.org

¹⁶⁸US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Angola

¹⁶⁹Human Rights Watch submission on Angola to the UN Human Rights Committee, February 2013, available at <http://www.hrw.org/news/2013/02/15/hrw-submission-angola-un-human-rights-committee>

¹⁷⁰See: <http://www.wipo.int/wipolex/en/details.jsp?id=5622>

¹⁷¹Section 18

¹⁷²See: <http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>

¹⁷³UNAIDS, Angola National Commitments and Policies Instrument (NCPI) Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Angola%20NCPI%202012.pdf>

¹⁷⁴Ibid.

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be weak and attempts are being made to increase awareness of the provisions of the Law 08/04 on HIV and AIDS.¹⁷⁵

Gaps and Challenges

Law No 8/04, the HIV law, does not deal with the rights of key populations and those especially vulnerable to the impact of HIV such as women, children, sex workers and men who have sex with men, amongst others. It does not provide for social assistance for those affected by HIV.

In addition, the HIV law contains coercive and punitive provisions relating to disclosure and criminalisation of HIV transmission: Section 14 requires people living with HIV to use condoms when they have sex and inform health personnel who attend to them, their sexual partners or spouses about their HIV status. The provision fails to recognise the particular difficulties women (who have higher HIV prevalence than men) may face in negotiating safer sex and disclosing their HIV status; women across Southern Africa report instances of violence, abandonment and being evicted from their homes when they disclose their HIV status to partners.¹⁷⁶ Section 15 of the Law 8/04 makes the intentional as well as the negligent transmission of HIV a crime punishable in terms s353 and 368 of the Penal Code.

Other punitive provisions that impact on key populations include the criminalisation provisions within the Penal Code (1886) and Draft Penal Code (2011) including the criminalisation of aspects of sex work such as procuring and living off the earnings of sex work and prohibiting public acts of indecency (s176 and 178 of the Penal Code); the criminalisation of same-sex relationships for both men and women and highly punitive laws for people who inject drugs.¹⁷⁷

Recent law reform initiatives include a comprehensive 2011 law on domestic violence that has improved protection for women as well as a Preliminary Draft National Policy on Human Rights which includes issues relating to HIV and AIDS.¹⁷⁸ The domestic violence law has however not been fully implemented as the by-laws necessary to fully implement the law have not yet been written.¹⁷⁹

Recommendations

- While the HIV law of 2004 offers some human rights protections to people living with HIV, it also contains provisions that undermine universal access. The law should be reviewed to ensure that it is consistent with international human rights standards, and in particular that punitive provisions are removed and protections for key populations included
- The criminalisation of both same sex relations and aspects of sex work also undermines universal access for Lesbian, Gay, Bisexual, Transgender and Intersex persons (LGBTI), sex workers and their clients. Law reform to decriminalise all aspects of sex work and same sex relations by and between consenting adults should be undertaken
- In addition, efforts should be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms as well as law enforcement officials
- The government should also ensure that the provisions of the new domestic violence laws are fully implemented
- Angola should ratify the Convention on the Rights of People with Disabilities (CRPD) to enhance protection for people with disabilities, including those living with HIV

¹⁷⁵UNAIDS, Angola NCPI Report, 2012.

¹⁷⁶See, for instance, submissions to the Global Commission on HIV and the Law, Africa Regional Dialogue, 4 August 2011. Available at www.hivlawcommission.org [Accessed 10 September 2012].

¹⁷⁷ARASA, HIV and Human Rights in Southern Africa, 2009; UNAIDS, Making the law work for the HIV Response: A Snapshot of Selected Laws that Support of Block Universal Access to HIV Prevention, Treatment, Care and Support, July 2010

¹⁷⁸UNAIDS, Angola NCPI Report, 2012

¹⁷⁹Human Rights Watch submission on Angola to the UN Human Rights Committee, February 2013, available at <http://www.hrw.org/news/2013/02/15/hrw-submission-angola-un-human-rights-committee>

Key data and modes of transmission

According to UNAIDS, in 2012 280 000 adults, that is 23.4% of adults aged 15 to 49 years, were living with HIV, with more women affected than men (160 000 women have HIV compared to 120 000 men).¹⁸⁰ Around 4 200 people died of AIDS; while still unacceptably high, the number of deaths due to AIDS has declined over the last eight years due to increased access to anti-retroviral treatment and prevention of mother to child transmission of HIV. There are 15 000 children below the age of 15 living with HIV, and 100 000 orphans.¹⁸¹

Botswana's epidemic continues to be fuelled by heterosexual sex and the country's 2012 Global AIDS Response report shows that the largest proportion of new infections, 57%, are expected to occur amongst "supposedly low risk heterosexual populations which include married couples and those living together". Men who have sex with men will contribute 6% of new infections and sex workers, their clients and partners of clients will contribute 7%.¹⁸²

Background to HIV, Law and Human Rights

The ARASA 2009 report identified the criminalisation of sex between men, pre-employment HIV testing in the military and routine HIV testing as key human rights concerns in Botswana.

Key Human Rights Concerns in 2014

Botswana's Second National Strategic Framework for 2010-2016 includes human rights and gender equality issues within its strategic priorities, and the country identifies a number of key populations and populations vulnerable to the impact of HIV and AIDS such as women and girls, orphans and other vulnerable children, men who have sex with men, migrants and mobile populations, people with disabilities, young men and women, and adolescents.

Stigma and discrimination: HIV-related stigma and discrimination remains a key concern impacting on people living with HIV within their families, communities and workplaces and particularly on vulnerable and key populations. Provisions for mandatory HIV testing¹⁸³ and disclosure¹⁸⁴ under certain circumstances as well as the assessment, restriction, isolation and detention of a person who places another at risk of HIV infection¹⁸⁵ have been included in the recently enacted Public Health Act 2013, with the potential to increase HIV-related stigma and discrimination and impede access to HIV-related health care. The Act also contains a broad offence criminalising exposing the public to a communicable disease, which could be open to various interpretations.¹⁸⁶

¹⁸⁰See www.unaids.org/en/regionscountries/countries/botswana/ [Accessed 8 August 2013].

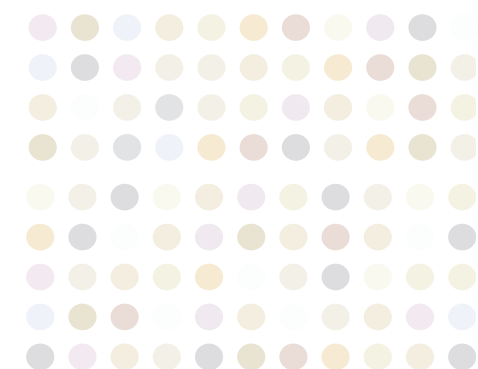
¹⁸¹UNAIDS, Botswana Country Progress Report, 2012. Available at [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BW_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BW_Narrative_Report[1].pdf); UNAIDS, Getting to Zero: HIV in Eastern and Southern Africa 2013, 2013 (Annexures).

¹⁸²Botswana, Country Progress Report 2012 at p.9

¹⁸³For example, where a Director of Health Services considers it "necessary and reasonable" in terms of section 104(3)(b) and where a person undergoes a surgical or dental procedure in terms of s109(3) of the Public Health Act 2013.

¹⁸⁵Section 116(9) and (10).

¹⁸⁶Section 58(1) of the Public Health Act 2013.



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Women’s rights: Botswana has a dual legal system and discriminatory customary laws entrench inequality, increasing women’s vulnerability to HIV. In addition, GBV and harmful practices such as widow cleansing¹⁸⁷ place women at higher risk of exposure to HIV. Law reform efforts have improved women’s legal status, but implementation of some of these reforms is inconsistent and sometimes weak. It remains unclear whether the Domestic Act of 2008 criminalises marital rape.

Rights of young people: Adolescents and young people struggle to access health care services; they also complain of being denied access to HIV tests in the absence of parental involvement.¹⁸⁸

Rights of sex workers: Sex workers report that they face marginalisation, stigma and discrimination and that the prejudice and judgmental attitudes of health care workers limit their access to health care services.¹⁸⁹ In 2013, the government’s *Draft Strategies to Address Key Populations* was reported to include a recommendation to detain sex workers and deport “foreign sex workers”, leading to increased crackdowns and rights violations against sex workers by the Botswana Police Services and Department of Immigration in 2013.

Rights of LGBTI: Same sex sexual conduct is also criminalised and LGBTI people face particularly high levels of stigma and discrimination.

Rights of non-citizens: Non-citizens are prohibited from accessing state health care services; this means that migrant populations (including migrant sex workers) are at increased risk of HIV exposure and unable to access HIV-related prevention, treatment, care and support services.¹⁹⁰ In prisons only prisoners who are residents of Botswana are provided with ART, CD4 counts and viral load tests;¹⁹¹ non-citizen prisoners only have access to HIV tests and peer counselling.¹⁹² A March 2014 High Court default court order obliged government to provide HIV treatment to non-citizen prisoners; the matter is currently before the court again.¹⁹³

Botswana is planning to conduct a People Living with HIV Stigma Index survey in 2014 which will provide more detailed information on the nature and extent of HIV-related stigma, discrimination and human rights violations in the country.

Legal framework for HIV and AIDS

Constitution

Sections 3 to 19 of the Constitution of Botswana, 1966 (as amended) protect the fundamental human rights and freedoms of all people, which would include people living with HIV. It includes protection for key human rights relevant to HIV such as the rights to non-discrimination,¹⁹⁴ privacy,¹⁹⁵ liberty,¹⁹⁶ the rights to freedom of expression and association¹⁹⁷ and the right not to be subjected to cruel, inhuman or degrading treatment or punishment.¹⁹⁸

National Laws and Policies

There are a number of protections against discrimination in various statutes and within the common law. There is no comprehensive, rights-based HIV law in Botswana.

The Public Health Act was signed in to law in September 2013. While the Act contains some protective provisions, including prohibiting pre-employment HIV testing and expanding access to HIV testing for children, it also permits forced

and mandatory HIV testing under certain circumstances,¹⁹⁹ allows for non-consensual disclosure of HIV status,²⁰⁰ places obligations²⁰¹ followed by severe restrictions on a person living with HIV who is believed to have “knowingly or recklessly placed another person at risk of infection²⁰² and makes HIV a notifiable disease.²⁰³ The Act has been widely criticised.

In the employment sector, the Botswana National Code of Practice on HIV/AIDS and Employment, and the Code of Good Practice: HIV/AIDS and Employment (Trade Disputes Act) protect the rights of employees with HIV.²⁰⁴ There is protection from discrimination and unfair labour practices in labour legislation that applies equally to employees living with HIV. For instance, the Public Service Act, 2008 protects public service employees from discrimination on various grounds including sex, race, tribe, place of origin, national extraction, social origin, colour, creed, political opinion, marital status, health status, disability, pregnancy or other grounds.²⁰⁵ The Employment Act (Amendment), 2012 provides for non-discrimination on the basis of health status.

These broad rights have been used by the courts to protect people living with HIV from discrimination and from unlawful HIV testing in the workplace. In the case of *Diau v Botswana Building Society*²⁰⁶ the Botswana Industrial court ordered the reinstatement of an employee who had been dismissed by the Botswana Building Society for refusing to undergo an HIV test. The dismissal was found to be an unconstitutional violation of the employee’s right to liberty and the right not to be subjected to inhuman and degrading treatment.²⁰⁷ The right to protection from cruel, inhuman and degrading treatment has been widely interpreted to include protection from stigma and discrimination.²⁰⁸ In the 2005 case of *Jimson v Bostwana Building Society*²⁰⁹ the Botswana Industrial Court ruled that the termination of the employee’s contract was both substantively and procedurally unfair. Of particular note in this case is the Courts exhortation of the legislature to address compulsory HIV testing.²¹⁰

The new Children Act, 2009 has increased protection for the rights of all children.

There are laws, policies and plans to protect women’s access to HIV-related prevention, treatment, care and support (including eMTCT services)²¹¹ and broader sexual and reproductive health rights²¹² including a Penal Code provision allowing a woman to terminate a pregnancy where it is the result of rape, defilement or incest, where there is a risk to the physical or mental health of the woman.²¹³

There is also legislation protecting women from inequality and harmful gender norms relating to marriage. The Marriage Act was amended in 2001 to specify 18 years as the minimum age for marriage and the Abolition of Marital Power Act 34 of 2004 gave women and men married in community of property equal powers in relation to disposing of assets of the joint estate, contracting debts and administering the joint estate.²¹⁴ A 2012 judgment of the High Court²¹⁵ further strengthened women’s rights by striking down discriminatory customary laws that did not permit women to inherit property. The Botswana Court of Appeal upheld the judgment in September 2013, stating that the exemption of personal status laws from the constitutional prohibition on discrimination was subject to two limitations: that the discrimination is in the public interest and that it did not prejudice the rights and freedoms of others.

¹⁹⁹For example, where a Director of Health Services considers it “necessary and reasonable” in terms of section 104(3)(b) and where a person undergoes a surgical or dental procedure in terms of s109(3) of the Public Health Act 2013.

²⁰⁰Sections 115 to 122 of the Public Health Act

²⁰¹Section 116(1)(a) and (c)

²⁰²Section 116(9) and (10).

²⁰³HIV and AIDS are included in the Section 2 definition of a “notifiable disease”.

²⁰⁴Interview with Nthabiseng Nkwe of Bonela, in Johannesburg, October 2006

²⁰⁵Global Commission on HIV and the Law. Regional Dialogue Submissions.2011. 3 – 4 August South Africa: Botswana: University of Botswana at 219

²⁰⁶(BBS) 2003 (2) BLR 409 (BwIC)

²⁰⁷AIDS and Human Rights Unit, Centre for the Study of AIDS and Centre for Human Rights. Compendium of Key Documents Relating to Human Rights and HIV in Eastern and Southern Africa, 2008 at p. 212

²⁰⁸UNAIDS, NCPI Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Botswana%20NCPI%202012.pdf>

²⁰⁹(2005) AHRLR 3 (BwIC 2003)

²¹⁰AIDS and Human Rights Unit, Centre for the Study of AIDS and Centre for Human Rights, Compendium of Key Documents Relating to Human Rights and HIV in Eastern and Southern Africa, 2008 at p.212

²¹¹Global Commission on HIV and the Law. Regional Dialogue Submissions. August 3 – 4, 2011, Pretoria: Botswana Submission: Ethical and Human Rights dimensions in prenatal HIV/AIDS Testing: Botswana in a Global Perspective, at 158

²¹²E.g. the Strategy and Programme of Action for Male Involvement in Sexual and Reproductive Health and Rights 2007-2012

²¹³International, African and country legal obligations on women’s equality in relation to sexual and reproductive health, including HIV & AIDS. Gerntholtz, L and Grant, C. 2010 at 35

²¹⁴Section 7 of the Act. UNDP Compendium of Key Documents relating to human rights and HIV in ESA at 171.

²¹⁵Edith Mmusi and others v Molefi Ramantele and others, MAHLB 000836-10

¹⁸⁷A practice in terms of which a widow must have sex with a male relative of her deceased husband

¹⁸⁸GCHL, Risks, Rights and Health, 2012 at p. 141

¹⁸⁹Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. Botswana: Sisonke Botswana at 276

¹⁹⁰Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. Pretoria, South Botswana: Sisonke Botswana at 276

¹⁹¹Global Commission on HIV and the Law. 2011. August 3 – 4. Pretoria, South Africa. Final

Rights Risks and Health at 134

¹⁹²US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Botswana, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

¹⁹³More information available at www.southernafricalitigationcentre.org

¹⁹⁴Articles 3 and 15

¹⁹⁵Article 9

¹⁹⁶Article 5

¹⁹⁷Articles 12 and 13

¹⁹⁸Article 7

The Domestic Violence Act 10 of 2008 has also strengthened women’s protection from various forms of domestic violence.²¹⁶ However, the Act fails to explicitly criminalise marital rape.²¹⁷

Some of the major achievements since 2009:

- The establishment of an HIV, ethics, law and human rights office in the national AIDS commission
- Representation of civil society organisations on the national AIDS commission
- Sensitization of the media, law-makers, the judiciary and law enforcement officers on HIV, law and human rights
- Increased research on key populations within Botswana ²¹⁸

Ratification of International and Regional Human Rights Instruments

Botswana has ratified:

- African Charter on Human and Peoples’ Rights, 1986
- African Charter on the Rights and Welfare of the Child, 2001
- Convention on the Rights of the Child (CRC), 1995
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1996
- International Convention on Civil and Political Rights (ICCPR), 2000

Botswana has not ratified:

- Convention on the Rights of Persons with Disabilities
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa
- International Convention on Economic, Social and Cultural Rights (ICESCR)

Access to Justice and Law Enforcement

There are efforts within the country to implement and enforce existing protections in law through various mechanisms and institutions as well as through the work of CSOs. There is access to the courts of justice and the judiciary has extended rights protection to employees with HIV in the workplace in various judgments.²¹⁹ However, this has been dependent on individual members of the judiciary and is not necessarily reflective of a coordinated and coherent government response.²²⁰ Additionally, access to courts is limited for many populations due to the exorbitant costs of private law firms and distance from services. Some populations may be able to access free legal aid provided by the government in partnership with civil society organisations.²²¹

There is an Ombudsman tasked with monitoring violations. The office, however, is not well resourced and has suffered from staff shortages. It is not considered to be particularly effective.²²² Civil society organisations such as the Botswana Network on Ethics, Law & HIV/AIDS (BONELA) document cases of HIV-related discrimination and provide assistance for seeking redress for rights violations.

Awareness and understanding of human rights and legal literacy is low across all levels of society including amongst communities, as well as service providers who have limited capacity and skills to deal with human rights violations.

However, it is clear that there are issues with law enforcement practices and access to legal support services for key populations. For instance, sex workers report being unlawfully arrested and detained for longer periods than required

²¹⁶Global Commission on HIV and the Law. *Regional Dialogue Submissions*. 2011. 3 – 4 August South Africa: Botswana: University of Botswana at 219

²¹⁷Global Commission on HIV and the Law. 2011. 3-4 August. Pretoria, South Africa. *Final Rights Risks and Health* at 137

²¹⁸UNAIDS, Botswana Country Progress Report, 2012

²¹⁹See, for instance, *Diau v Botswana Building Society (BBS) 2003 (2) BLR 409 (BwIC)*; *Jimson v Botswana Building Society (2005) AHR LR 3 (BwIC 2003)*

²²⁰UNAIDS, Botswana NCPI Report, 2012.

²²¹*Ibid.*

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by law on spurious prostitution- related charges. They report being prohibited from speaking, not being questioned and being unable to access legal support services.²²³

Gaps and Challenges

A comprehensive assessment of the Botswana legal and regulatory environment was undertaken a number of years ago and was due to be updated in 2012. However, to date there has been limited HIV-related law review and reform despite ongoing legislative review processes in the country. New laws have not incorporated HIV and human rights issues and a comprehensive stand-alone HIV law has not been developed. Currently, a legal assessment of the extent to which the Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities have been incorporated into Botswana’s intellectual property laws and related regulations and policies is taking place with the aim of improving Botswana’s intellectual property (IP) laws and increasing access to cheaper medicines.

Some of the major gaps and challenges include:

- Provisions within the Public Health Act allowing for forced HIV testing and disclosure, placing obligations on HIV-positive persons, allowing for restrictions, possible isolation and detention of HIV-positive persons who place a person at risk of HIV infection and providing for a broad offence of exposure to a communicable disease.
- A provision in the Penal Code requiring a person convicted of rape to undergo an HIV test before sentencing by the court and punishment by life imprisonment where a rapist is found to be knowingly HIV-positive. ²²⁴ Importantly, in a number of cases such as in *Nquibi v The State 2001 BLR 154 (BwCA)*, *Lenoy v The State 2000 (2) BLR 145 (BwCA)* and *Makuto v The State 2000 (2) BLR 130 (CA)*²²⁵ the courts have refused to accept the results of an HIV test conducted at the time of sentencing as evidence of a convicted rapist’s HIV status at the time of the offence.
- A provision in the Penal Code (Amendment) Act 5 of 1998 which provides that any person who unlawfully or negligently performs an act likely to spread a disease dangerous to life is guilty of an offence.²²⁶
- Limited constitutional protection of socio-economic rights, including the right to health, and limited protection for the rights of non-citizens²²⁷ including migrants, refugees and foreign prisoners.²²⁸ The national ART guidelines prescribe access to free ART for citizens only.
- Limited protection for the rights of vulnerable populations (e.g. women, children) and key populations such as sex workers, men who have sex with men, migrant populations, prisoners and people who inject drugs.
- Criminal laws that create barriers to access to health care: While sex between men is not explicitly criminalised in the Penal Code, s164, 165 and 167 (which refer to unnatural offences and indecent acts) are used to prohibit homosexuality. The prison health policy prohibits the distribution of condoms to prisoners. Chapter 8 of the Penal Code criminalises a wide range of acts associated with sex work including procurement²²⁹ , living off the earnings of sex work²³⁰ , brothel keeping²³¹ , solicitation²³² , idle or disorderly public conduct²³³ and ‘rogue and vagabond’ laws.²³⁴
- Inadequate protection for women including the failure to criminalise marital rape as well as the continued application of customary laws and practices that discriminate against women (such as customary laws of inheritance that only permit men to inherit from a parent’s estate regardless of the particular circumstances of each situation) and that place women at higher risk of HIV exposure.²³⁵
- Inadequate enforcement of laws protecting children from sexual abuse.

²²³Global Commission on HIV and the Law. *Regional Dialogue Submissions*, Pretoria, 3-4 August, 2011: Botswana Submission: *Ethical and Human Rights dimensions in prenatal HIV/AIDS Testing: Botswana: Sisonke Botswana* at p.275

²²⁴Penal Code (Amendment) Act 5 of 1998, s142

²²⁵AIDS and Human Rights Unit, Centre for the Study of AIDS and Centre for Human Rights. 2008. *Compendium of Key Documents Relating to Human Rights and HIV in Eastern and Southern Africa*. Pretoria University Law Press (PULP) at 247 to 250

²²⁶Section 184

²²⁷Molathegi & Associates: *Attorneys, Notaries, Conveyancers, Regulatory and International Trade Law Consultants*. NAC Sector on Ethics, Law and Human Rights. *Final Report: Consultancy services for review for laws and policies relating to HIV/AIDS*. 2005. At 9

²²⁸UNAIDS, Botswana NCPI Report, 2012 although see the discussion regarding the March 2014 court case, above

²²⁹Penal Code, s146

²³⁰Section 155 and 156

²³¹Sections 157 and 168

²³²Section 155

²³³Section 179

²³⁴Section 182

²³⁵Global Commission on HIV and the Law, *Regional Dialogue Submissions*. Pretoria, 3 – 4 August 2011: Southern African Litigation Centre at p.297

Recommendations

Various recommendations for strengthening the legal and regulatory framework have been made in Botswana and include:

- Reviewing the Constitution to incorporate social and economic rights such as the right to health and to work, as well as an express prohibition of discrimination on the basis of HIV status, sexual orientation, health and/or nationality
- Ratifying the ICESCR to commit to protecting, respecting, promoting and fulfilling socio-economic rights
- Ratifying the Maputo Protocol to enhance protection for women's rights
- Ratifying the Convention on the Rights of Persons with Disabilities to enhance protection for people living with disabilities
- Developing a National Policy on Children and HIV and amending the Children Act to include protection against sexual abuse, child trafficking, strengthening of children's right to sexual reproductive information and other children's specific human rights such as the right to child friendly sexual and reproductive health services
- Strengthening the Employment Act and other relevant employment laws to ensure specific, statutory protection against pre-employment HIV testing, non-discrimination on the basis of an employee or potential employee's HIV status and reasonable accommodation of employees with HIV
- Amending the Education Act to provide a rights-based approach by the heads of school in carrying out their functions
- Reviewing the Penal Code to clarify that 'acts against the order of nature' do not include consensual sex between adults of the same sex
- Decriminalising all aspects of sex work by consenting adults
- Reviewing and repealing overly broad provisions criminalising HIV transmission such as those set out in the Penal Code and Public Health Act
- Reviewing the Public Health Act for purposes of repealing punitive and discriminatory provisions, such as those allowing for mandatory HIV testing, disclosure, isolation and detention of people living with HIV
- Strengthening access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms as well as law enforcement officials

Key data and modes of transmission

According to UNAIDS, there are less than 500 people aged 15 to 49 years in Comoros living with HIV, which is less than 0.1% of adults 15 – 49 years. There have been less than 100 deaths due to AIDS. There is no information about the numbers of children below the age of 14 who are infected, and there are less than 100 children orphaned by AIDS.²³⁶

However, due to increasing levels of poverty and sex work, low levels of knowledge about prevention, low condoms use rate and poor quality of sexual transmitted infection (STI) care services, the government recognises the need to respond to HIV as a priority.²³⁷

Background to HIV, Law and Human Rights

Comoros was not included in the ARASA 2009 report.

Key Human Rights Concerns Relating to HIV in 2014

The National Strategic Plan for HIV and AIDS 2011 - 2015 recognises a number of key populations at higher risk of exposure and factors increasing risk and vulnerability amongst populations.

Key populations identified by the country's NSP include:

- Men who have sex with men
- Sex workers
- Migrants
- Young women and men

Factors affecting risk and vulnerability include migration, gender inequality and gender-based violence. Gender disparities give women little role in decision-making including within national government and the legislature, where only one or two women hold positions.²³⁸

Stigma and discrimination: HIV-related stigma and discrimination has been described as a major obstacle to achieving universal access to HIV prevention, treatment, care and support; although some work has been done around HIV related stigma and discrimination, further work is required. Stigma and discrimination against sex workers, men who have sex with men and transgender people is also said to be high.²³⁹

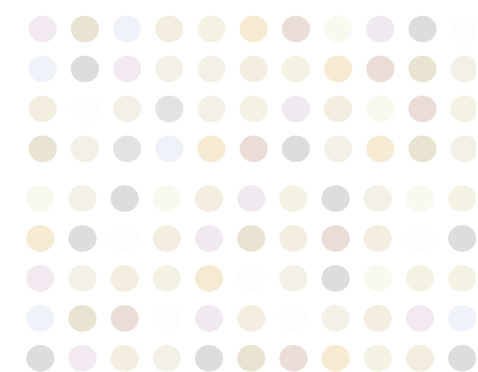
Children's rights: Violence and abuse of children has also been highlighted as a key concern in the first report of the Indian Ocean Child Rights Observatory (Observatoire des droits de l'enfant de la région de l'Océan Indien (ODEROI)), published in October

²³⁶See <http://www.unaids.org/en/regionscountries/countries/comoros/> [accessed on 9 August 2013]; see also UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013.

²³⁷See www.unaids.org/ctrysa/AFRCOM_en.pdf [Accessed 12th September 2012]

²³⁸National Strategic Plan for HIV and AIDS. Union of the Comoros. 2008 – 2012. April 007 http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf. At 25 - 27

²³⁹www.unaids.org/ctrysa/AFRCOM_en.pdf [Accessed 12 September 2012]



less than
100 deaths
due to AIDS

Factors affecting
risk and
vulnerability
include
migration,
gender
inequality and
gender-based
violence.

2006. It highlighted disturbing trends in increased sexual assaults; GBV and abuse; exploitation of children for economic reasons; rising juvenile crime; and increased school drop-outs. Although the legal age of marriage is 18 years for both boys and girls, earlier marriage is still common.²⁴⁰

Legal Framework for HIV and AIDS

Constitution

The Constitution of Comoros, adopted on 23 December 2011, provides for “equality for all persons irrespective of sex, origin, race, religion and belief”.²⁴¹

The Constitution also provides a framework for the protection of children and health policies;²⁴² health policies prioritise the needs of both children and young people in terms of providing youth friendly services and access to information and education inside and outside of schools.²⁴³

National Laws and Policies

While there is no specific anti-discrimination legislation, the broad protection of rights provided for by the Constitution and human rights commitments apply to all people.²⁴⁴

A major recent initiative in the Comoros is the development of a draft HIV Bill, the Bill on the Rights of Persons Living with HIV and their Involvement in the Fight against AIDS.

The Bill aims to protect people affected by HIV, provide universal access to prevention, treatment, care and support for people in need and protect the rights of women, children, youth and other vulnerable populations.²⁴⁵

It provides for protection against stigma and discrimination,²⁴⁶ including within the working environment, and a prohibition against HIV testing for purposes of employment or accessing services and unfair dismissals based on an employee’s HIV status.²⁴⁷

The Bill provides protection for the reproductive health and rights of women in the context of HIV including access to prevention (including eMTCT) services, treatment services, access to a termination where medical reports show a danger to the life of the foetus or the mother and provision for shared decision-making regarding reproduction in the case of a discordant couple.²⁴⁸ Article 5 provides for strengthened awareness and education programmes to promote gender equality and discourage harmful gender norms and gender-based violence.²⁴⁹ The Bill protects the fundamental rights of children living with HIV and orphaned by AIDS, including their rights to privacy, health, education, awareness and access to information and protection against all forms of violence and abuse that could harm them.²⁵⁰

However, the Bill also contains punitive provisions. Article 36 provides for criminalisation of HIV transmission.²⁵¹

Women are protected in law from sexual violence and domestic violence, but the law is often poorly enforced and does not explicitly criminalise marital rape.²⁵² Few cases of domestic violence ever enter the judicial system.²⁵³ The Family

²⁴⁰UNICEF: Country Programme Document. 2008- 2012. September 2007 http://www.unicef.org/about/execboard/files/Comoros_final_approved_CPD.pdf. At 3

²⁴¹HIV, Law and Rights. Country Snap shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support. Comoros. Southern Africa. June 2011. (UNPUBLISHED)

²⁴²HIV, Law and Rights. Country Snap shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support. Comoros. Southern Africa. June 2011. (UNPUBLISHED)

²⁴³HIV, Law and Rights. Country Snap shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support. Comoros. Southern Africa. June 2011. (UNPUBLISHED)

²⁴⁴Viljoen, F and Precious, S. A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in ESA, 2007 at p.30

²⁴⁵Article 3

²⁴⁶Article 19

²⁴⁷Article 26 and 27

²⁴⁸Article 13

²⁴⁹Bill on the Rights of Persons Living with HIV and their involvement in the fight against HIV. (aka Comoros Draft Bill for PLWH)

²⁵⁰Article 14

²⁵¹Bill on the Rights of Persons Living with HIV and their involvement in the fight against HIV. (aka Comoros Draft Bill for PLWH)

²⁵²US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Comoros, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed on 12 August 2013)

²⁵³Ibid.

Code, adopted by Parliament in 2006 recognises the central role of women.²⁵⁴ Inheritance and property rights do not generally discriminate against women and give men and women equal rights.²⁵⁵ In addition health policies ensure access to HIV prevention, treatment, care and support for women outside of the context of pregnancy and child birth,²⁵⁶ and the National Health Policy guarantees equal access to preventive health care for men and women and gives specific attention to the needs of vulnerable populations. The minimum age of marriage is 18.

There are laws that criminalise both sex work and sex between men.²⁵⁷

Ratification of International and Regional Human Rights Instruments

Comoros has ratified:

- African Charter on Human and Peoples’ Rights, 1986
- African Charter on the Rights and Welfare of the Child, 2004
- Convention on the Rights of the Child (CRC), 2003
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1994
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

Comoros has not ratified:

- Convention on the Rights of Persons with Disabilities (signed in 2007)
- International Convention on Economic, Social and Cultural Rights (ICESCR) (signed in 2008)
- International Convention on Civil and Political Rights (ICCPR) (signed in 2008)

Access to Justice and Law Enforcement

There are various initiatives to reduce stigma and discrimination and strengthen access to justice in Comoros by community groups such as youth theatre groups,²⁵⁸ radio programmes as well as community women’s groups co-ordinated by the National Network on Women and Development (RNFD).²⁵⁹ However, it appears that there is a need to increase training with service providers, such as HIV counsellors, on HIV and human rights issues. HIV testing is frequently conducted without counselling.²⁶⁰

Gaps and Challenges

Stigma and discrimination remain key challenges to universal access to HIV prevention, treatment, care and support in Comoros.²⁶¹ Stigma and discrimination affects people living with HIV as well as key populations at higher risk of HIV such as sex workers and men who have sex with men. Harmful gender norms and GBV place women, children and young people at risk of HIV infection.

The development of a protective draft HIV bill is an opportunity for strengthening a protective legal and regulatory framework. Significantly, the bill contains not only protections against HIV-related discrimination but also provision for programmes to reduce stigma and discrimination and to increase access to justice. The inclusion of a punitive provision criminalizing HIV transmission may pose challenges for the future.

²⁵⁴Union of the Comoros, National Strategic Plan for HIV and AIDS 2008-2012 http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf. at 18

²⁵⁵HIV, Law and Rights. Country Snap shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support. Comoros. Southern Africa. June 2011. (UNPUBLISHED)

²⁵⁶UNAIDS National Composite Policy Index. 2010. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/comoros_2010_ncpi_fr.pdf. at 30

²⁵⁷HIV, Law and Rights. Country Snap shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support. Comoros. Southern Africa. June 2011. (UNPUBLISHED)

²⁵⁸National Strategic Plan for HIV and AIDS. Union of the Comoros. 2008 – 2012. April 2007. http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf. At 25 -27.

²⁵⁹National Strategic Plan for HIV and AIDS. Union of the Comoros. 2008 – 2012. April 2007. http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf. At 25 - 27.

²⁶⁰Union of the Comoros, National Strategic Plan for HIV and AIDS 2008-2012 http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf. at 25 - 27.

²⁶¹UNAIDS Comoros: Country Situation 2009. National Response. www.unaids.org/ctrysa/AFRCOM.en.pdf. [Accessed 06 August 2012]

Recommendations

- Law review and reform initiatives should be supported to ensure that a protective, rights-based HIV law is developed which includes protection for all key populations and those vulnerable to the impact of HIV and AIDS and excludes provision for the criminalisation of HIV transmission. Consensual same sex relations and all aspects of sex work by consenting adults should be decriminalised
- Support ongoing efforts to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms as well as law enforcement officials
- Comoros should ratify the Convention on the Rights of Persons with Disabilities, ICESCR and the ICCPR to enhance protection for human rights, including for people living with HIV and key populations

Key data and modes of transmission

According to UNAIDS more than 1% of adults aged 15 to 29 years are living with HIV in the DRC, with more women than men being HIV-positive.

Background to HIV, Law and Human Rights

Violence against women and the lack of legal protections for women were identified as key human rights issues in the ARASA 2009 report.

Key Human Rights Concerns in 2014

A new national strategic plan is currently in draft format. The current national strategic plan on HIV and AIDS for 2010-2014 identifies the following populations as populations at higher risk of HIV exposure or as particularly vulnerable in the context of HIV and AIDS:

- Youth
- Women of childbearing age
- Men in uniform
- Sex workers
- Prisoners
- People living with HIV and their families
- Migrants
- Orphaned and vulnerable children
- Miners
- Truckers
- Populations living near border areas²⁶²

Others that have been identified as vulnerable include women in uniform, women in prison, married women, women in border areas, widows, poor women, men who have sex with men, men who abuse alcohol and men who inject drugs.²⁶³ Some of the key legal and human rights issues facing these populations are set out below:

Rights of sex workers: Sex work is not criminalised in the DRC, but sex workers are highly stigmatised. Physical and sexual assault and other forms of abuse against sex workers, perpetrated by the police and security forces, have been reported and moral attitudes and the prevailing culture of impunity has reinforced the idea that violations of sex workers' rights (including rape) are not crimes worthy of reporting and enforcement.²⁶⁴

Rights of LGBTI: Sexual minorities in the DRC also face high levels of discrimination and abuse.²⁶⁵ While homosexuality is not specifically criminalised, men having sex with men may be prosecuted under public indecency laws. Homosexuality is highly stigmatised and men who have sex with men are targets of harassment, including by



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²⁶²UNAIDS, NCPI Report, 2010 Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/democraticrepublicofcongo_2010_ncpi_fr.pdf

²⁶³UNDP DRC, Report of Proceedings of Workshop on HIV, AIDS and the Law. Kinshasa, DRC, 30 March 2011

²⁶⁴This was recently reinforced by the findings of risk-mapping pilot studies in South Kivu

²⁶⁵Submission to the GCHL African Regional Dialogue, Pretoria, 3-4 August, 2011: Southern African Litigation Centre

state security forces.²⁶⁶ Recent attempts by a Member of Parliament in late 2013 and 2014 to introduce a new draft bill to explicitly criminalise and severely punish homosexuality in DRC indicate the need for ongoing vigilance in the DRC.

Women’s rights: Women in the DRC face high levels of gender inequality and sexual violence, including conflict-related sexual violence²⁶⁷ making them at higher risk of HIV and increasingly vulnerable to the impact of HIV. They have inequitable access to property and inheritance,²⁶⁸ limiting their economic power. Harmful practices such as incision, traditional tattoos and widow inheritance also place women at risk.²⁶⁹ Women have limited information, decision-making power in relation to and access to sexual and reproductive health care services,²⁷⁰ often requiring their husbands’ permission to access services, including contraception and health services are not gender-sensitive.²⁷¹ Additionally, women living with HIV appear to be more stigmatised than men living with HIV;²⁷² they complain of being thrown out of their homes, divorced and deserted due to their actual or perceived HIV status.²⁷³

“Women are often the first to take the test as part of their pregnancy and therefore often regarded as having [brought] the HIV into the family. This exposes them to stigma from their families and spouses and [they are] often totally rejected. They find themselves alone with the disease and without means or home. This will often lead them to remain in hiding, even taking the risk of breastfeeding for fear of rejection.”²⁷⁴

There are an estimated 2.4 million internally displaced people in the DRC. Displaced women and children are at risk of sexual exploitation and abuse and they have limited access to health services, including HIV prevention, treatment and care. There is also emerging documentation that suggests that men and boys are targeted for conflict-related sexual violence.

Children’s rights: Children are vulnerable for various reasons: sexual abuse of children is a concern and places children, especially girl children, at higher risk of HIV exposure. Children cannot independently access health care services, and require a parent to consent on their behalf to services, limiting access to HIV prevention services. Additionally, children with HIV experience discrimination within their communities and are deprived of inheritance rights.²⁷⁵ Children living in conflict-affected provinces, such as North and South Kivu, remain at risk of forcible recruitment as child soldiers and girls are at risk of sexual abuse.²⁷⁶

Access to treatment: Access to treatment is another major issue of concern. There is poor access to health services, including treatment, for HIV. People are forced to travel large distances to access testing and treatment services, health criteria limit access to ART and there is insufficient psycho-social support for those testing HIV-positive, amongst other things. There are insufficient qualified health personnel, and those who are available lack adequate training and often adequate medical equipment.²⁷⁷

Prisoners’ rights: Conditions in prisons are described as “severe and life threatening”²⁷⁸ Prisons are over-crowded and there are serious staff shortages. There is also inadequate access to food, sanitation, medical treatment and water. Both male and female prisoners are subject to sexual violence.

Legal Framework for HIV and AIDS

Constitution

The Constitution protects fundamental human rights such as the right to equality and non-discrimination, the right to privacy and the right to freedom and security of the person. These rights apply equally to all populations including those affected by HIV and AIDS. Importantly, there is constitutional protection for women’s rights.²⁷⁹

National Laws and Policies

Law 08/011 of 14 July 2008 on Protecting the Rights of People living with HIV/AIDS and those Affected (*Loi no. 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées*) includes a number of protective provisions including protection of the rights of people living with HIV to equality,²⁸⁰ the right to marry and have children,²⁸¹ to reproductive health care,²⁸² to non-discrimination on the basis of HIV and AIDS including in public and private health care²⁸³ and to access to education.²⁸⁴ The HIV law also contains specific protection for the rights of employees with HIV²⁸⁵ and the rights of prisoners with HIV.²⁸⁶ Protection of patients’ rights includes provision for HIV testing only with voluntary consent and counselling,²⁸⁷ the right to confidentiality,²⁸⁸ and protection of a child’s right to confidentiality.²⁸⁹

Other protections in law include Law 06/018 of 20 July 2006 relating to sexual violence. This law amended and supplemented the Penal Code in order to strengthen protection for women from violence, including sexual slavery, sexual mutilation and forced pregnancy (often resulting from sexual violence in the eastern DRC perpetrated by armed groups following the conflict in the Great Lakes area.)²⁹⁰ Although domestic violence is criminalised, marital rape is not. Women and girls who have been sexually assaulted experience high levels of stigma and discrimination and many are pressurised by families and communities not to lay charges against perpetrators. Adultery remains a criminal offence, and although both men and women are criminalised, women are more likely to be prosecuted and may be sentenced to up to one year’s imprisonment.

Women, including married women, are subject to various forms of legal discrimination. They are prohibited from engaging in various legal transactions without the permission of their husbands, examples being when purchasing or selling land, opening bank accounts or applying for a passport.

Law 09/001 of 10 January 2009 on Child Protection prescribes penalties for child trafficking. The Family Law Code of 1987 prescribed different minimum ages of marriage for boys (18) and girls (14), but now article 48 of the 2009 law prohibits child marriage (that is, marriage below 18 years of age).²⁹¹ There are cases of girls below the legal age of consent who are however forced into marriage.

Ratification of International and Regional Human Rights Instruments

The DRC has ratified:

- African Charter on Human and Peoples’ Rights, 1987
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1986

²⁶⁶US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Republic of Congo, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

²⁶⁷Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: ASADHO, DRC; *Okapi pour les Droits de l’Homme* (OKDH), DRC,

²⁶⁸Submissions to the GCHL African Regional Dialogue, Pretoria, 4 August, 2011: Southern African Litigation Centre

²⁶⁹Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: OKDH, DRC,

²⁷⁰Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: Réseau des PVV en RDC (UCOP+), DRC

²⁷¹Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: Southern African Litigation Centre.

²⁷²Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: UCOP+.

²⁷³Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: Network of NGOs on human rights of people living with HIV, DRC.

²⁷⁴Submissions to the African Regional Dialogue, Pretoria, 4 August, 2011: UCOP+, DRC

²⁷⁵Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: Network of NGOs on human rights of people living with HIV, DRC

²⁷⁶US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Republic of Congo, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed on 12 August 2013)

²⁷⁸Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: Association Africaine de Défense es Droits de l’Homme, ASADHO.

²⁷⁹US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Republic of Congo, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

²⁷⁹Preamble, Articles 5, 14 and 15

²⁸⁰Article 7

²⁸¹Article 8

²⁸²Article 9

²⁸³Article 10

²⁸⁴Article 16

²⁸⁵Articles 20 to 26 protect employees’ rights to non-discrimination in the workplace on the basis of HIV status, a prohibits compulsory HIV testing and protects the rights of employees to confidentiality, amongst other things

²⁸⁶Articles 28 to 30 protects the rights of prisoners to health care and protection from compulsory HIV testing

²⁸⁷Article 36

²⁸⁸Article 39

²⁸⁹Article 17

²⁹⁰Submissions to the Africa Regional Dialogue on HIV and the Law, 4 August, 2011: ANAMED, DRC

²⁹¹<http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>

- International Convention on Economic, Social and Cultural Rights (ICESCR), 1976
- International Convention on Civil and Political Rights (ICCPR), 1976
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2008
- Convention on the Rights of Persons with Disabilities

The DRC has not ratified:

- African Charter on the Rights and Welfare of the Child

Access to Justice and Law Enforcement

Civil society organisations have some ongoing programmes to try to strengthen access to justice including awareness-raising, training of the judiciary and the provision of legal support through legal clinics. ALCIS concentrates on awareness-raising of the rights of sex workers, documents human rights violations, does advocacy with lawmakers and provides legal assistance through a legal clinic set up for sex workers living with HIV and survivors of sexual assault.²⁹² A network of civil society organisations on human rights and HIV have conducted advocacy around the HIV law, conduct awareness-raising and training of people living with HIV on their rights in relation to HIV, sexual violence and child protection issues.²⁹³

In 2011, the National Assembly adopted a law to create a national human rights institution and the appointment of the Commissioners is underway. There is currently an inter-ministerial Human Rights Committee that meets to discuss human rights but it is largely ineffective.²⁹⁴ There is generally a limited implementation of laws and access to justice and enforcement of HIV-related complaints is problematic. Problems with access to justice include the following:

- High levels of stigma, including self-stigma, prevents access to justice
- Populations have a limited awareness of the law and their rights and there is limited targeted communication on HIV, law and human rights; key populations in particular are not well organised to claim their rights
- Service providers (such as health care workers, welfare workers, police and even judges, activists and lawyers) have limited understanding and capacity in HIV, law and human rights issues
- There is also insufficient information regarding and access to legal support services – there are limited pro bono legal services available. The judicial system is expensive to access and has lengthy and cumbersome procedures and people are not aware of other services (e.g. mediation) outside of the courts
- There is limited political commitment to HIV and human rights, weak implementation and enforcement of laws and inadequate oversight by parliamentarians²⁹⁵

Gaps and Challenges

There are gaps and challenges within the legal framework that allow HIV-related stigma and discrimination to continue and that increase vulnerability to HIV.

Civil society organisations report that the HIV and AIDS law, Law 08/011 is not adequately implemented or enforced. The HIV law also includes coercive and punitive provisions. Article 45 criminalises HIV transmission; it provides for “5 to 6 years of penal servitude and a fine of 500,000 Congolese francs” for anyone who deliberately transmits HIV. The Law 08/011 also includes provision for a person to disclose his or her HIV status to a partner ‘promptly’ and, where he/she has failed to do so, for the disclosure of a patient’s HIV status by a doctor.²⁹⁶ People living with HIV have expressed concern over Article 41 due to the discrimination they have experienced as a result of disclosures of their HIV status.²⁹⁷ The provision does not emphasise psychosocial support to people living with HIV to support them with disclosures, nor is there any consideration for women who report experiencing abuse, discrimination, abandonment and even violence when disclosing their results.²⁹⁸ This provision is also linked to Article 45 suggesting that failure to disclose may result in

criminal charges in terms of the ‘deliberate transmission’ provision. A number of organisations have conducted advocacy initiatives to amend the HIV Law and to remove punitive provisions, but to date no changes have been made.²⁹⁹

The Penal Code criminalises running a brothel, placing sex workers in a vulnerable position in society. Sex workers experience human rights violations including stigma, discrimination, violence and sexual assault. They struggle to access prevention, treatment and care services because of the stigmatising attitudes towards rape, HIV status and sex work. Government’s decision to close mobile treatment centres impacted harshly on sex workers who cannot access ART.³⁰⁰ Societal discrimination and oppressive law enforcement has driven sex workers underground and caused them to operate in secret, making it difficult for them to access health, social and legal services and making prevention and treatment programmes for HIV virtually impossible to implement, increasing their social isolation and worsening their living and working conditions.³⁰¹ ALCIS has conducted advocacy campaigns for reform of laws and policies at local level including a proposed bill submitted to the provincial parliament specifically for the recognition of human rights of sex workers and for their health protection.³⁰²

In 2013, a private members’ bills criminalising homosexuality was submitted to Parliament by a Member of Parliament, reviving concerns among men who have sex with men who are already a stigmatised population. Order No. 344 of 17 September 1965 governs the prison system and an older order from the colonial system prohibits the distribution of condoms in prisons.

With regard to women’s rights, weaknesses exist in a range of laws and their implementation and enforcement such as laws affecting: the right to privacy, confidentiality and the right to be protected against violence, sexual assault and rape during and outside marriage, during and outside conflicts and emergencies; as well as laws relating to inheritance, property ownership, access and control of land ownership; family law and other political and practical women’s rights.³⁰³ Customary laws and practices undermine the status of women and the Family Code reinforces inequality by not recognising the capacity of women and children, despite the protection afforded to women in the Constitution. They have inequitable access to property and inheritance in terms of these laws and practices, and widows are often dispossessed of their property.

The Family Code previously allowed for early marriage – girls being permitted to marry at 14 years.³⁰⁴ The Child Protection Code now prohibits the marriage of children. UNICEF estimates that in 2012 9% of girls were married before they reached 15, and 39% by the age of 18.³⁰⁵

Violence and sexual assault of women remains a major issue in the DRC. Despite the reform of the Congolese Penal Code in 2006, implementation and enforcement of these laws (by police, prosecutors and the courts) is limited and often weak.³⁰⁶ Law enforcement officials rarely intervene in domestic disputes and rape laws are not well enforced. Although assault is a crime, domestic violence by a spouse is not specifically mentioned. Law No. 06/018 of 20 July 2006, which increased protection against sexual violence, provides in Article 174 for the criminalisation of “wilful transmission of incurable sexually transmitted infections” which would include HIV, and further provides for a punishment of life imprisonment or a fine.³⁰⁷ Likewise, Article 177 of the Act of 10 January 2009 on child protection provides for life imprisonment for a person who deliberately infects a child with an incurable sexually transmitted infection, including HIV. Criminalisation provisions, while often enacted to protect women, often impact disproportionately upon women, since they are more likely to be aware of their HIV status and thus able to be prosecuted for transmission of HIV. They target people living with HIV and, in their implementation and enforcement, may conflate simply being HIV-positive with having the intention to commit the crime of transmission.

Laws, policies, plans and programmes need to increase access to health care services to ensure that the state’s obligation to provide HIV-related services is clear and enforceable across all sectors. Current laws and policies also

²⁹²Submission by Action Pour La Lutte Contre L’ignorance Du Sida (ALCIS), DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

²⁹³Submission by Network of NGOs on Human Rights and HIV/AIDS, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

²⁹⁴US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Democratic Republic of Congo, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 12 August 2013]

²⁹⁵UNAIDS, DRC NCPI Report, 2010

²⁹⁶Article 41

²⁹⁷Submission by Avocats au ruban rouge, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011.

²⁹⁸Submission by ASADHO, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

²⁹⁹E.g. see submission by Association Africaine de Défense es Droits de l’Homme (ASADHO), DRC, Africa Regional Dialogue on HIV and the law, 4 August, 2011

³⁰⁰Submission by ALCIS, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

³⁰¹Submission by Southern African Litigation Centre, DRC, African Regional Dialogue, Pretoria, 4 August, 2011.

³⁰²Submission by ALCIS, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

³⁰³Submission by ASADHO, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

³⁰⁴Submission by Réseau des PVV en RDC (UCOP+), DRC, Africa Regional Dialogue on HIV and the Law, Aug 4, 2011; see also SALC, DRC, African Regional Dialogue, Pretoria, 4 August, 2011

³⁰⁵See: <http://www.girlsnotbrides.org/where-does-it-happen/>

³⁰⁶Submission by OKDH, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

³⁰⁷ANAMED, DRC, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

prohibit children below 18 years from accessing condoms – this creates a barrier to HIV prevention for young people below 18 years of age.

Recommendations

Recommendations have been made in the DRC for strengthening the legal and regulatory framework, including the following:

- Decriminalise all aspects of sex work by consenting adults, review and amend the HIV law to remove the punitive and coercive provisions and reject the passing of the anti-homosexuality bill
- Review, reform and enforce laws and legislation to eradicate discrimination against women and girls
- Establish socio-legal protection and support for women and children with HIV
- Improve the integration of HIV into sectoral policies and laws in certain key sectors including for the social protection of widows and orphaned and vulnerable children
- Develop a policy of prevention and treatment of HIV and AIDS in prisons and train prison guards and support staff on HIV and AIDS
- Implement the protective provisions of the 2008 HIV law
- Strengthen the capacity of parliamentarians on HIV and human rights and on the negative impact of punitive laws such as criminalisation of HIV transmission
- Disseminate laws to the broader population (e.g. by developing brochures in local languages) as well as to the judiciary
- Sensitise judges, activists and lawyers on HIV, law and human rights; in particular the judicial system must protect women's rights regarding inheritance and ownership, access and control of land rights, and rights to sexual and reproductive health
- Train service providers on HIV law and human rights issues
- Structure and organize networks of key populations (e.g. men who have sex with men, sex workers)
- Provide financial support for legal clinics
- Integrate access to justice issues into funding proposals, including those of the Global Fund
- Improve access to HIV testing services, as well as treatment, care and support and social protection for all, and in particular for orphaned and vulnerable children and widows and in eastern DRC³⁰⁹
- Ratify the African Charter on the Rights and Welfare of the Child to enhance protection for children's rights, including by raising the minimum age of marriage for girls to 18

³⁰⁹Submission by ANAMED, DRC to African Regional Dialogue, Pretoria; Submission by OKDH, DRC to African Regional Dialogue, Pretoria; Submission by ASADHO, DRC to African Regional Dialogue, Pretoria, 3-4 August 2011.

Key data and modes of transmission

According to UNAIDS, 1.4 million adults aged 15 – 49 years, that is 6.2%, are living with HIV, almost 60% of whom are women aged 15 years and older (there are 800 000 women living with HIV). There are 220 000 children below the age of 15 living with HIV and there are estimated to be 1.1 million orphans due to AIDS. There are estimated to be around 62 000 annual deaths from AIDS.³¹⁰

Kenya reports that an estimated 44% of new HIV infections occur through heterosexual transmission within a union or primary partnership. Several populations have been especially heavily affected by HIV. Urban dwellers have historically been more likely to become infected than people living in rural areas. Key populations, namely sex workers, men who have sex with men and people who inject drugs account for around 1 in 3 new HIV infections. HIV prevalence exceeds 18% among both men who have sex with men and people who inject drugs, while 29.3% of all female sex workers are living with HIV. Various social factors – such as gender inequality, sexual violence and HIV-related stigma and discrimination are reported to increase HIV risk and vulnerability.³¹¹

Background to HIV, Law and Human Rights

Key Human Rights Concerns in 2014

The Kenya National HIV and AIDS Strategic Plan for 2009/10–2012/13 (KNASP III) identifies various vulnerable and key populations and factors driving the epidemic in Kenya:

Women's rights: Women account for almost 60% of adults living with HIV in Kenya. Factors increasing women's vulnerability and risk include social, economic and legal inequality, sexual violence, inter-generational and transactional sex and limited access to sexual and reproductive health information and services. Young girls and young women, are nearly four times more likely to be infected than males. One in five Kenyan women have experienced sexual violence, most of which goes unreported.³¹² Traditional practices such as wife inheritance and female genital mutilation (which continues to take place despite a 2011 law prohibiting FGM) reinforce gender inequality and place women at risk of HIV exposure. Women living with HIV report various forms of discrimination including being thrown out of family homes. In the case of *Midwa v Midwa*³¹³ a husband brought proceedings to have his HIV-positive wife vacate their jointly-owned matrimonial home on the ground that she posed a grave risk to his life and the life of the children; the court ordered that she be permitted to move back into the matrimonial home. Discrimination in access to sexual and reproductive health care services is a concern, including reports of HIV testing without consent when accessing antenatal health care, for purposes of prevention of mother-to-child transmission programmes, as well as reports of coerced sterilisation.³¹⁴

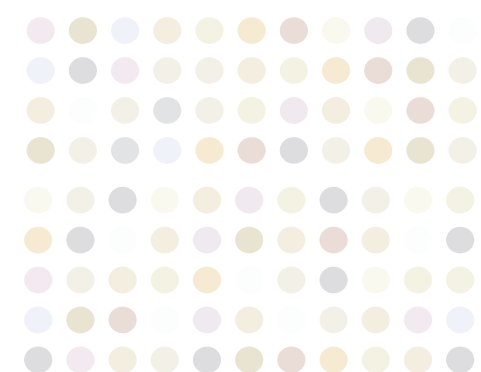
³¹⁰UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013, 2013 (Annexures)*; NACC and NASCOP, *Kenya AIDS Epidemic Update 2011, Nairobi, 2012*.

³¹¹NACC and NASCOP, *Kenya AIDS Epidemic Update 2011, Nairobi, 2012*.

³¹²*Ibid.*

³¹³[2000] 2 EA 453

³¹⁴NEPHAK *The PLHIV Stigma Index Study: Kenya, Nairobi, 2011*; KELIN and others *National Symposium on HIV, Law and Human Rights, Nairobi, October 2012*



1.4 million
adults aged 15
to 49 are living
with HIV

Women account
for almost 60%
of adults living
with HIV in
Kenya.

Rights of sex workers: The sale of sex is criminalised in Kenya and sex workers are highly stigmatised. Sex workers report various human rights violations from clients and law enforcers including harassment, physical and sexual violence and being forced to have unprotected sex.³¹⁵

Rights of men who have sex with men: Research has shown extremely high rates of HIV prevalence amongst men who have sex with men in Kenya. Sex between men is criminalised in Kenya and men who have sex with men in Kenya are highly stigmatised and discriminated against. This results in public humiliation, harassment and even physical and sexual violence against men who have sex with men. Men who have sex with men also report discrimination in the health sector; as a result they are often unwilling to seek treatment for STIs for fear of embarrassment or stigmatisation. They also report inadequate interventions to meet their specific health needs.³¹⁶

Rights of people who inject drugs: Drug use is criminalised in Kenya, which is reported to create barriers to access to health care for people who inject drugs.³¹⁷ Studies in Kenya have shown high rates of HIV prevalence amongst people who inject drugs.³¹⁸

Prisoner’s rights: Kenya’s Modes of Transmission study indicated that around 10% of prisoners were living with HIV. Prisoners are vulnerable to HIV due to unprotected sex including sex between men, sexual assault, violence as well as the spread of tuberculosis and other infectious diseases, and poor nutrition. They are not provided with access to condoms in prisons.

Stigma and discrimination: HIV-related stigma and discrimination, despite being prohibited by national law and reported to be decreasing, persists in Kenya.³¹⁹ The recent People Living With HIV Stigma Index study found that people living with HIV reported most instances of stigma and discrimination within their families and communities, at the workplace and in the health sector (e.g. HIV testing and disclosure without consent and denial of health care services), with 56% of respondents reporting verbal abuse or harassment and 38% reporting physical abuse as a result of their HIV status.³²⁰ Discrimination in access to insurance and mortgages is also reported,³²¹ as well as discrimination in schools and prisons.

Legal Framework for HIV in Kenya

Constitution

Chapter 4 of the Constitution of Kenya, 2010 protects the human rights, dignities and fundamental freedoms of individuals and communities.

Article 27 protects the right to equality and freedom from discrimination. It provides that “every person is equal before the law and has the right to equal protection and equal benefit of the law” and that “the State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.” The Constitution’s Bill of Rights protects a range of further rights that are important for people living with HIV and other affected populations such as the right to freedom and security of the person, privacy, right to marry and found a family, freedom of expression, right to property, right of access to information, freedom of movement and residence, right to work and to fair labour practices and economic and social rights such as the right to “the highest attainable standard of health, which includes the right to health care services, including reproductive health care”.³²² Article 159 of the Constitution allows for customary practices, and for alternative forms of dispute resolution, but only insofar as they do not contravene the Bill of Rights and the Constitution. The Constitution 2010 also recognises international treaties, to which Kenya is a signatory, as valid sources of law.

³¹⁵GCHL Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law, Pretoria, 4 August 2011

³¹⁶Ibid; see also KELIN and others, National Symposium of HIV, Law and Human Rights, Nairobi, October 2012

³¹⁷Kenya National Commitments and Policies Instrument (NCPI) Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Kenya%20NCPI%202012.pdf>

³¹⁸Ibid.

³¹⁹KANCO Study on Human Rights Violations Against People living with HIV and AIDS in Kenya, Nairobi, 2012

³²⁰NEPHAK, The People living with HIV Stigma Index: Kenya, Nairobi, 2011

³²¹KELIN and others, National Symposium of HIV, Law and Human Rights, Nairobi, October 2012

³²²Section 43(1) of the Constitution of Kenya, 2010

National Laws and Policies

In 2006, Kenya enacted the HIV and AIDS Prevention and Control Act. The law includes various protections for people living with HIV including promoting equality and non-discrimination in employment, education, travel or choice of lodging; promoting non-discrimination in the workplace; promoting ethics in research; providing for HIV testing only with voluntary and informed consent and confidentiality and prohibiting mandatory HIV testing (including for employment, marriage, education, travel or health insurance) and promoting measures to educate, prevent and treat affected persons. Importantly, section 25 of the Act creates an HIV and AIDS Tribunal to hear HIV-related complaints, the only one of its kind in the world. However, the law does not specifically address vulnerable populations, such as women, children and young people, people with TB, or key populations at higher risk such as men who have sex with men, sex workers and people who inject drugs.

The courts have upheld the rights of people living with HIV, including the right to privacy for people living with HIV. In the 2010 case of *D.N. and Anor v Attorney-General*³²³ the High Court found that the imprisonment of patients with TB, for defaulting on their treatment, was unconstitutional and contrary to the Public Health Act. The court found that imprisonment was in fact “the worst of choices”, the length of imprisonment was unreasonably long and was not backed by medical evidence.

Other important laws that strengthen protection for affected populations include the following:

- Various newer laws protect women and men from harmful gender norms, gender-based and sexual violence and exploitation. The Sexual Offences Act 2006 prohibits various forms of sexual violence offences committed against men and women including rape, sexual assault and sexual exploitation of children. The Counter-Trafficking in Persons Act 2010 prevents, suppresses and punishes trafficking in persons, especially women and children, and it provides for various offences aimed at eliminating sexual exploitation. The Prohibition of Female Genital Mutilation Act 2011 prohibits FGM, although its implementation has been slow to take effect.
- The recently enacted Marriage Act of 2014 and Matrimonial Property Act reinforce equality rights in marriage and on divorce and in terms of matrimonial property. The Marriage Act brings together customary, Islamic, Christian and Hindu laws relating to marriage under one statute and creates uniform recognition of all forms of marriage (including, however, polygamous marriage). It sets the age of marriage at 18 years. The Acts give a spouse equal rights to matrimonial property and provide safeguards to protect the property rights of a first wife in a polygamous union.
- The Children’s Act of 2001 protects the rights of children and prohibits any child from being discriminated on any ground including sex, religion, creed, custom, language and other status among others. All children, boys and girls, are entitled to enjoy the right to education and to be protected from harmful cultural practices like FGM. As a result of the case of *Nyumbani Children’s Home v the Ministry for Education and the Attorney General*³²⁴ challenging the exclusion of children with HIV from public schools, the public schools in Kenya abolished their admission policy prohibiting the enrolment of HIV-positive children.
- The Employment Act in Kenya protects employees’ rights, including employees with HIV, to fair labour practices. Section 5 protects employees from discrimination on the grounds of HIV status and section 46 provides that HIV or AIDS does not constitute a fair reason for an employee’s dismissal or for the imposition of a disciplinary penalty on an employee. The courts have upheld an employee’s right to be protected from pre-employment HIV testing and from unfair discrimination on the basis of HIV status in Kenya.³²⁵ The Public Sector workplace policy on HIV and AIDS 2010 (as amended) emphasises the need for mainstreaming HIV into the core activities of all public sector organisations and prohibits discrimination, sexual harassment and abuse.
- Kenya has taken important steps to review the legal and regulatory environment for access to treatment for HIV and AIDS and the availability of affordable ART under the Industrial Property Act is reported to have enhanced the life and health of people living with HIV. A judicial review of the constitutionality of sections 2, 32 and 34 of Kenya’s Anti-Counterfeit Act 2008 in *Patricia Asero Ochieng and Ors v Attorney General*³²⁶ found that these sections, which were broad enough to outlaw the production of generic drugs, were unconstitutional and in conflict with the right to life, dignity, and health. This will help to strengthen ongoing access to generic medicines for people living with HIV.

³²³Petition No. 3 of 2010, HC Eldoret

³²⁴Application No. 1521 of 2003 (OS)

³²⁵See, for instance, *VMK v CUEA, Industrial Court Cause No 1161 of 2010; J.A.O v Homepark Caterers Ltd and Ors, Civil Case 38 of 2003*

³²⁶Petition No 409 of 2009

Ratification of International and Regional Human Rights Instruments

Kenya has ratified:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1999
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004
- Convention on the Rights of Persons with Disabilities, 2008
- Convention on the Rights of the Child (CRC), 1992
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1995
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1992

Access to Justice and Law Enforcement

Civil society have undertaken various initiatives to increase awareness and understanding of HIV-related human rights and gender equality amongst communities, law and policy-makers, lawyers, the judiciary and law enforcers to increase access to justice. However, CSOs report that there is still a need for ongoing monitoring and documentation of rights violations, and awareness-raising and capacity building to ensure that all law and policy makers and enforcers are sensitized and affected communities, including key populations, know their rights and how to access justice and enforce rights. People living with HIV still report feeling unable to access the formal justice system easily and, although aware of institutions to enforce rights, they are unsure of how to use them.³²⁷

Alongside a strong civil society, there are a number of institutions in Kenya that are able to investigate and adjudicate upon human rights violations, to enforce rights. They include the HIV-specific forum, the HIV and AIDS Tribunal, the Kenya National Commission for Human Rights with the power to investigate and hear all human rights violations, the National Gender & Equality Commission which is tasked with promoting gender equality and the Office of the Ombudsman (Commission on Administrative Justice), which is a public ‘watchdog’. The HIV and AIDS Tribunal can make a range of orders; it can enforce its own orders and its decisions can be executed by the High Court. To date, cases heard by the Tribunal have primarily been concerned with HIV discrimination in the workplace.

Gaps and Challenges

While the HIV and AIDS Prevention and Control Act, 2006 contains numerous protective provisions that prohibit discrimination against people living with HIV, it contains gaps and challenges. Key populations such as men who have sex with men, sex workers and people who inject drugs are not protected from discrimination in terms of the HIV and AIDS Act. In addition:

- Section 24 of the HIV and AIDS Prevention and Control Act 2006 contains a provision that criminalises the intentional transmission of HIV. Similarly, the Sexual Offences Act, 2006 criminalises the deliberate transmission of HIV and AIDS.
- Kenya criminalises sex between men in terms of Articles 162, 163 and 165 of the Penal code (which criminalises unnatural offences and indecent practices between males) with severe penalties of up to 14 years imprisonment.
- The Penal Code criminalises living off the earnings of sex work and the Sexual Offences Act 2006 criminalises the ‘exploitation of prostitution.’
- Many laws and practices continue to reinforce gender inequality including laws regulating land ownership and inheritance. Property-grabbing remains a major concern for women living with HIV and even where laws are protective, enforcement of laws such as the Laws of Succession Act Cap 160 is weak, particularly in communities where customary laws prevail.
- Marital rape is not recognised as a criminal offence in either the Sexual Offences Act 2006 or the Protection against Domestic Violence Bill, 2013 (which is yet to be passed).

Recommendations

The KNASP III has called for a legal and policy review in Kenya to review the HIV and AIDS Prevention and Control Act and review corresponding laws and policies. It has also called for various measures to strengthen access to justice and law enforcement such as the implementation of stigma and discrimination reduction initiatives, steps to ensure the enforcement of anti-discrimination provisions as well as steps to improve access to legal support services.

In addition, Kenya should:

- Strengthen anti-discrimination protection in law for all vulnerable and key populations
- Review provisions in law criminalising HIV transmission
- Address remaining laws (e.g. the Protection Against Domestic Violence Bill), policies and practices, including the implementation and enforcement of existing laws, to address gender inequality, harmful gender norms and gender-based violence
- Decriminalise all forms of consensual adult sex, including consensual sex between men and all aspects of sex work
- Review laws criminalising drug use and decriminalise possession for own use to protect people who use drugs from the risk of HIV exposure and to promote access to health care
- Review prisons policy to ensure access to condoms in prisons

In addition, efforts should be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials.

NACC and NASCOP, Kenya AIDS Epidemic Update 2011, Nairobi, 2012; KELIN and others National Symposium on HIV, Law and Human Rights, Nairobi, October 2012; KANCO Study of Human Rights Violations Against People living with HIV and AIDS in Kenya, Nairobi, 2012



Key data and modes of transmission

According to UNAIDS, 280 000 adults aged 15 – 49 years, that is 23.3%, are living with HIV, most of whom are women aged 15 years and older (there are 170 000 women living with HIV). There are around 14 000 annual deaths from AIDS. 41 000 children below the age of 15 are living with HIV and there are estimated to be 140 000 orphans due to AIDS.³²⁸

Lesotho's Global AIDS Response Country Progress Report for 2011 indicates that multiple and concurrent sexual partnerships are a significant driver of the HIV epidemic in Lesotho. In a 2009 survey, 45% of all sexually active adult males reported that they had had more than two sexual partners in the preceding twelve months.³²⁹ Nearly 26% of sexually active adult women reported similarly.

Background to HIV, Law and Human Rights

The ARASA 2009 report identified the disproportionate impact of HIV and AIDS on women, the large numbers of orphans, discrimination against soldiers living with HIV, and the lack of access to condoms in prison as key human rights concerns.

Key Human Rights Concerns in 2014

The Lesotho National HIV and AIDS Strategic Plan 2011-2016 defines four key populations:

1. Sex workers
2. Men who have sex with men
3. Migrant labourers
4. Inmates

It also defines six vulnerable groups:

1. People with Disabilities
2. Orphans and vulnerable children
3. Herd boys
4. Women and girls
5. People living with HIV
6. Mobile populations

The primary structural drivers of the epidemic include social and cultural factors affecting women and girls, poverty and food, insecurity and barriers to access to health care services.³³⁰

Stigma and discrimination: Research reports a growing awareness and acceptance of HIV and AIDS throughout the country, with declining levels of stigma and discrimination.

³²⁸See: <http://www.unaids.org/en/regionscountries/countries/lesotho/> [Accessed on 9 August 2013] see also UN-AIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 (Annexures).

³²⁹UNAIDS, *Lesotho Country Progress Report, 2012*, Available at [http://www.unaids.org/en/dataanalysis/knowyour-response/countryprogressreports/2012countries/ce_LS_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyour-response/countryprogressreports/2012countries/ce_LS_Narrative_Report[1].pdf), p.28

³³⁰UNAIDS, *Lesotho Country Progress Report, 2012*.

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However, the same research still indicates that around 50% of people would not willingly disclose the presence of an HIV-positive member in the family.³³¹ An ARASA partner interviewed for the report advised that people living with HIV in rural communities, especially women, were at higher risk of discrimination and continued to experience violations of their rights including breaches of confidentiality and abandonment by families. Findings from a draft legal assessment found that discrimination against people living with HIV may simply have become more ‘covert’. HIV testing and discrimination in the military continues and many respondents reported fearing HIV testing and disclosure and being unwilling to access health care, due to stigma and discrimination.³³²

There is a growing recognition that sexual minorities, prisoners, sex workers and other key populations experience high and perhaps escalating levels of discrimination, abuse and human rights violations from communities and service providers, such as health care workers, all of which are in need of being addressed.³³³

Rights of LGBTI: Sex between men is criminalised in Lesotho as part of the common law offence of sodomy, and there are high levels of stigma and discrimination against men who have sex with men. Until recently there was limited information on HIV and human rights issues experienced by men who have sex with men; however a recent study on sexual minorities in Lesotho has helped to increase visibility and to increase awareness of, and advocate for the recognition of the human rights of sexual minorities.³³⁴ The first gay pride march took place in Maseru in May 2013. Despite these steps, LGBTI populations in Lesotho continue to experience stigma and discrimination and “official insensitivity to this discrimination.”³³⁵

Rights of sex workers: Various aspects of sex work are also criminalised, as set out below. Sex workers live lives of “secrecy and violence”³³⁶ placing them at higher risk of HIV exposure and making it difficult for them to access services.

Prisoner’s rights: A 2011 Lesotho Correctional Services (LCS) study showed escalating HIV prevalence amongst prisoners, with 17% of those assessed identifying themselves as HIV-positive. Recent research noted that prisoners complained of inadequate access to uninterrupted ART, as well as inadequate protection from the risk of HIV infection.³³⁷

Women’s rights: Despite recent protections in statutory law, with dual legal systems applying, women in Lesotho are still not accorded equality in laws and practice.³³⁸ They have inequitable access to property and inheritance, and property grabbing remains a serious issue. GBV is recognised as a grave concern in Lesotho, placing women and girl children at higher risk of HIV exposure.³³⁹ Research suggests that women living with HIV are particularly affected by discrimination in their homes, communities and when accessing services.³⁴⁰ Civil society reports that pregnant women living with HIV experienced discrimination in accessing antenatal health care and were subjected to pressure to undergo HIV testing.³⁴¹

Children’s rights: There are estimated to be over 200,000 orphaned and vulnerable children, of which around 67% are children orphaned by AIDS. These children have various basic needs for food, clothing and assistance with school fees. They also need protection for their rights such as their rights to birth registration and to protection of their property and inheritance.³⁴³ A large number of adolescents and young people are out of school.³⁴⁴

“Although recognition of the rights and entitlements of women and girls has changed significantly within the legal system in Lesotho, these changes have not yet influenced ongoing social and cultural practices regarding female roles in marriage and sexual relationships. Lesotho continues to have troubling trends in discriminatory attitudes towards women and girls which fuel GBV.

For women themselves, in 2009, 37.1% agreed that there could be at least one reason for a husband to legitimately beat his wife. In the lowest wealth quintile, this rose to 55%. Amongst men, 47.9% agreed that there could be at least one reason to beat their wives. This view was shared by 59% of men in the lowest wealth quintile. If a woman refused to have sex with her husband, 62.5% of men felt it was acceptable to get angry and to threaten their spouse; 26.3% felt it was acceptable to deny financial support; 16.5% felt it was acceptable to force sex on their spouse; and, 28.7% felt it was acceptable to have sex with another woman. For women, 14.6% stated that a woman was never justified in refusing to have sex with her husband; for men it was 16%. For a wife to refuse sexual contact with her husband when she knows he has other partners was supported by 52% of women and 53% of men.”³⁴²

Legal Framework for HIV in Lesotho

Constitution

Lesotho has a Constitution that protects the human rights and freedoms of all people and prohibits discrimination on “any ground whatsoever” which should include HIV or AIDS. Article 4 provides that every person in Lesotho is entitled, whatever their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status to fundamental rights and freedoms including the right to life, personal liberty, freedom of movement and residence, freedom from inhumane treatment, the right to respect for private and family life, freedom from discrimination and equality before the law and the equal protection of the law. Article 24 of the Constitution sets out the state’s commitment to protecting the health of all people, as a Principle of State Policy, through the prevention, treatment and control of epidemic, endemic, occupational and other diseases, and creating conditions to assure medical services and attention to all in the event of a sickness.

National Laws and Policies

Lesotho does not have an HIV-specific law³⁴⁵ but does have a number of protective laws for vulnerable and key populations, including the following:

- The recently enacted Lesotho Children’s Protection and Welfare Act, 2011 has strengthened protection of the rights of children, including the right of children to non-discrimination on various grounds, protection from sexual violence, protection of the right to reside with a parent and grow up in a caring environment, and specific protection of children living with HIV. The Education Act, 2010 makes primary education free and compulsory.³⁴⁶
- Women’s equality rights within marriage were strengthened in the Legal Capacity of Married Persons Act 9, 2006. Section 5 of the Act gives equal powers to spouses married in community of property to dispose of assets of the joint estate, contract debts for which the joint estate is liable and administer the joint estate. This law, however, is said not to be adequately implemented.³⁴⁷ Inheritance may still be regulated through customary laws with customary inheritance rights only applying to men. In addition to discriminatory inheritance laws, there are also several customary practices which discriminate against women and increase their risk of HIV e.g. forced elopement.

³³¹Ibid.
³³²UNDP Assessment of the Legal Environment for HIV and AIDS in Lesotho (Draft Two), March 2014.
³³³UNAIDS, Lesotho NCPI Report, 2012. UNDP Assessment of legal and regulatory environment for HIV and AIDS in Lesotho (Draft Two), March 2014.
³³⁴Ibid.
³³⁵US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Lesotho, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed on 12 September 2013)
³³⁶Ibid.
³³⁷UNDP Assessment of legal and regulatory environment for HIV and AIDS in Lesotho (Draft Two), March 2014
³³⁸Ibid.
³³⁹UNAIDS, Lesotho Country Progress Report, 2012. Available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_LS_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_LS_Narrative_Report[1].pdf)
³⁴⁰UNDP Assessment of legal and regulatory environment for HIV and AIDS in Lesotho (Draft Two), March 2014
³⁴¹Key informant interview, S Shale, DPE, 6 August 2012
³⁴²UNAIDS, Lesotho Country Progress Report, 2012
³⁴³Ibid.
³⁴⁴Ibid.

³⁴⁵An HIV and AIDS Bill was drafted a number of years ago, but has never been finalized.
³⁴⁶UNAIDS, Lesotho NCPI Report, 2012.
³⁴⁷AIDS and Human Rights Unit, Centre for the Study of AIDS and Centre for Human Rights. 2008. Compendium of Key Documents Relating to Human Rights and HIV in Eastern and Southern Africa. Pretoria University Law Press (PULP) at 172

- The Sexual Offences Act, 2003 strengthens protection against sexual violence. It prohibits various forms of sexual assault and read with the Penal Code it criminalises marital rape in specific circumstances, including where the accused spouse is suspected to have a sexually transmitted infection (STI).³⁴⁸ Sexual harassment is also criminalised. There are programmes targeting women, girls, families and communities on GBV and the rights and entitlements of women and girls and legal aid is available to support enforcement of rights.³⁴⁹
- New statutes protect children from abuse (the Children’s Welfare and Protection Act, 2011) and women and girls from human trafficking (the Anti-Trafficking in Persons Act, 2010).³⁵⁰ There is a revised National Action Plan for Women, Girls and HIV and AIDS 2012-2016. The NSP provides for post-exposure prophylaxis for survivors of sexual violence.³⁵¹
- The Lesotho Correctional Services’ HIV Policy and the new Strategic Plan on HIV and AIDS provide for the management of HIV in the prisons, including for prevention, treatment and care. Notably, the policy provides for condom distribution in prisons.
- In the working environment, Article 30 of the Constitution states that Lesotho shall adopt policies aimed at securing just and favourable conditions of work and in particular policies directed to achieving equality for men and women within the working environment. The Lesotho Labour Code Amendment Act 5, 2006 prohibits HIV testing of a job applicant or an employee in all types of employment with the exception of the military,³⁵² prohibits compelling an employee to disclose his or her HIV status or that of any other³⁵³ and prohibits discriminating against an employee on the basis of his or her HIV status.³⁵⁴

Ratification of International and Regional Human Rights Instruments

Lesotho has ratified:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1999
- Convention on the Rights of the Child (CRC), 1992
- Convention on the Rights of Persons with Disabilities, 2008
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1995
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1992
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

Access to Justice and Law Enforcement

There have been various initiatives to reduce HIV-related stigma and discrimination, increase awareness and understanding of rights and increase access to justice in the context of HIV and AIDS.³⁵⁵ There is also access to legal support services in Lesotho, and the courts are the mechanism for protection of constitutional rights. Special children’s courts, and Child and Gender Protection Units are tasked with addressing discrimination involving children.³⁵⁶

However, there is not a strong constitutional law tradition. Discrimination cases are rarely if ever brought to court due to lack of a clear process and an enabling environment.

The key challenge identified by civil society is the lack of information and awareness about rights.³⁵⁷ In the view of ARASA

partners, not enough has been done to educate people about their rights and how to seek redress. Courts remain the main vehicle for enforcing rights, but they remain inaccessible to many people and few cases of discrimination have been brought to court.

Gaps and Challenges

Lesotho developed a draft HIV Bill many years ago, but this has never been finalised or promulgated. Lesotho’s NSP has committed to reviewing the legal and regulatory framework, including the implementation and enforcement of laws that impact negatively on people living with HIV and other vulnerable and key populations, in order to create an enabling legal and policy environment that protects human rights and gender equality. A legal review is currently taking place, with support from UNDP and the involvement of a range of partners. HIV and AIDS issues are enshrouded within other laws, making legal action difficult. There are also a number of punitive and discriminatory laws that arguably pose barriers to access to health care services, as well as other gaps within law and policy.³⁵⁸

- Lesotho criminalises sex between men through the common law crime of sodomy which is defined as the “unlawful and intentional sexual relationship through the anus between two human males.”³⁵⁹ The Penal Code 2010 also prohibits “public indecency” and the Criminal Procedure and Evidence Act provides that sodomy is one of the offences for which an arrest may be made without a warrant.³⁶⁰ Sex between women is not criminalised. There is no legal recognition of the rights of transgender people as persons within the law.³⁶¹ There are high levels of stigma and discrimination against men who have sex with men and transgender people and they face difficulties creating support organisations.³⁶²
- Various aspects of sex work are criminalised in the Penal Code, including procurement,³⁶³ solicitation,³⁶⁴ living off the earnings of prostitution³⁶⁵ and committing indecent acts in public.³⁶⁶ Sex workers are vulnerable to physical and sexual abuse by police and are subject to discrimination in provision of health services and in the courts.³⁶⁷ Similarly to sexual minorities, sex workers may not establish and legally register sex worker organisations for advocacy and health support.³⁶⁸
- Section 52 of the Penal Code criminalises the non-disclosure of HIV status; it provides that failure to disclose HIV-positive status prior to sex amounts to an unlawful sexual act. In addition, Section 30 of the Sexual Offences Act 2003 provides for mandatory HIV testing in cases of unlawful sexual acts³⁶⁹ with the results of the test to be used for purposes of sentencing.³⁷⁰
- Many laws and practices continue to reinforce gender inequality, harmful gender norms and GBV against women and girl children. Women have inequitable access to property and inheritance in terms of customary law. Section 10 of the Chieftainship Act of 1968 provides for only male succession to chieftainship.³⁷¹ There are still high rates of GBV and domestic violence is not separately recognised as a criminal offence. The laws on age of marriage are contradictory and allow for early marriage: although the Child Protection and Welfare Act defines a child as anyone under the age of 18, the Marriage Act, enacted in 1974 and still in force, sets the minimum age of marriage for girls at 16 (it is 18 for boys) and there is no minimum age of marriage for customary unions. UNICEF reported that in 2012, 19% of girls were married by the age of 18.³⁷²

³⁴⁸International, African and country legal obligations on women’s equality in relation to sexual and reproductive health, including HIV&AIDS. Gertholtz, L and Grant, C. 2010 at 36

³⁴⁹<http://www.unaids.org/en/regionscountries/countries/lesotho/>

³⁵⁰UNAIDS, Lesotho Country Progress Report, 2012.

³⁵¹Gertholtz, L and Grant, C. International, African and country legal obligations on women’s equality in relation to sexual and reproductive health, including HIV&AIDS, 2010 at p.36

³⁵²Section 235 C

³⁵³Section 235 D

³⁵⁴Section 235 E

³⁵⁵UNAIDS, Lesotho NCPI Report, 2012.

³⁵⁶Ibid.

³⁵⁷Key informant interview with S Shale, DPE, 6 August 2012

³⁵⁸UNAIDS, Making the Law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support, July 2010

³⁵⁹Amnesty International, Making Love A Crime: Criminalisation of Same-Sex Conduct in Sub-Saharan Africa, April 2013, at p.84

³⁶⁰Schedule 1 Part II

³⁶¹Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. Lesotho: Matrix Support Group. Pretoria, South Africa. At 176; see also UNAIDS, Lesotho NCPI Report, 2012

³⁶²UNAIDS, Lesotho NCPI Report, 2012

³⁶³Section 55(2)

³⁶⁴Section 55(3)

³⁶⁵Section 55(4)

³⁶⁶Section 56

³⁶⁷UNAIDS, Lesotho NCPI Report, 2012 available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Lesotho%20NCPI%202012.pdf>

³⁶⁸Ibid.

³⁶⁹Section 30 (1) of the Sexual Offences Act of 2003

³⁷⁰Section 30 (3) and (4) of the Sexual Offences Act

³⁷¹Submissions to the Global Commission on HIV and the Law Africa Regional Dialogue on HIV and the Law, Pretoria, 3 – 4 August 2011: Matrix Support Group at 176; South Africa: South African Litigation Centre at 297

³⁷²See: <http://www.girlsnotbrides.org/where-does-it-happen/>

- Despite labour protection, herd boys work outside of the traditional ‘labour’ environment and are not protected by laws or policies.³⁷³ Their isolated working conditions, limited access to education and services and high risk of HIV exposure makes them particularly vulnerable and in need of protection.³⁷⁴
- Pre-employment HIV testing of applicants to the armed forces is not prohibited by the Labour Code.³⁷⁵
- Miners are vulnerable to HIV and to TB; many are migrant workers working in South Africa who receive no continuation of care on their return to Lesotho.
- In addition, as set out above, access to justice and law enforcement is weak. For instance, efforts to protect girls and women have led to some improvements and increased prosecutions. However, these efforts are often undermined by the judiciary systems that are not equipped to prosecute sexual offences. This undermines the willingness of women and girls to report sexual abuse, given that the mechanisms of addressing cases, from reporting up to the courts, still shift the blame on the females and is not protective towards women. In the case of HIV and AIDS, the lack of HIV-specific legislation and the high costs of litigation in Lesotho mean that for the majority of people, legal action is impossible.³⁷⁶

There are still very few responsive and effective mechanisms to address discrimination in Lesotho. Although there has been discussion about establishing a Human Rights Commission, there is no indication when this will move forward to be established.³⁷⁷

Recommendations

Lesotho is currently undertaking a comprehensive review of the legal and regulatory frameworks that impact on the rights of people living with HIV and key populations. Additional gaps in protection and specific recommendations will be identified through this assessment. In addition, Lesotho should:

- Strengthen anti-discrimination protection in law for people living with HIV and all vulnerable and key populations
- Address a range of laws, policies and practices that allow for gender inequality, harmful gender norms and gender-based violence and increase women and girls’ vulnerability to HIV
- Increase the minimum age of marriage to 18 for girls to ensure equality between boys and girls
- Decriminalise all forms of consensual adult sex, including consensual sex between men
- Decriminalise all aspects of sex work by consenting adults
- Strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials

³⁷³UNAIDS, Lesotho NCPI Report, 2012.

³⁷⁴UNAIDS, Lesotho Country Progress Report, 2012.

³⁷⁵ibid.

³⁷⁶UNAIDS, Lesotho NCPI Report, 2012.

³⁷⁷UNAIDS, Lesotho NCPI Report, 2012

Key data and modes of transmission

According to UNAIDS, there are around 31 000 adults aged 15 - 49 years in Madagascar living with HIV – less than 1% of the population.³⁷⁸ Unlike other SADC countries, less than one third of those infected are women (9 500 women are living with HIV). UNAIDS does not have accurate data relating to the numbers of children living with HIV, but there are estimated to be 12 000 orphans. In 2011, there were estimated to be 2 600 AIDS-related deaths.³⁷⁹

Certain populations appear to be at higher risk of HIV exposure; according to research 1 in 7 men who have sex with men are believed to be HIV-positive and one in seven sex workers tested positive for sexually transmitted infections.³⁸⁰ Other key populations that have been identified include clients of sex workers, prisoners, people living with HIV and TB, pregnant women, people who abuse alcohol, orphaned and vulnerable children, people with disabilities and homeless people.³⁸¹ Girls under 18 years of age, living in areas frequented by tourists, may be at particularly high risk of HIV exposure.³⁸²

Background to HIV, Law and Human Rights

Key Human Rights Concerns in 2014

Stigma and discrimination: HIV-related stigma and discrimination is a priority human rights issue in Madagascar, with people experiencing discrimination in various sectors, including within the working environment and the health care sector (including testing without consent, breaches of confidentiality and a denial of care). This causes people to avoid HIV testing services, for fear of testing HIV-positive.³⁸³ An ARASA partner indicated that the most common forms of stigma and discrimination cited by people living with HIV is within families, relationships and their communities. They also reported that women experience coercive sterilisation.³⁸⁴

Research conducted in Madagascar identified specific areas within the country which were said to have higher HIV prevalence rates, with common risk factors being the prevalence of sex work within the community, socio-economic activities such as mining, cattle markets (labour mobility) and tourism as well as the presence of traditional rites and customs.³⁸⁵

Rights of key populations: Men who have sex with men, people who inject drugs and sex workers report high levels of stigma and discrimination, violence, rape, unlawful arrests and prosecution.

³⁷⁸<http://www.unaids.org/en/regionscountries/countries/madagascar/> [Accessed 13 August 2013]

³⁷⁹UNAIDS, Getting to Zero: HIV in Eastern and Southern Africa 2013, 2013 (Annexures)

³⁸⁰UNAIDS, Madagascar Country Progress Report, 2012. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MG_Narrative_Report.pdf

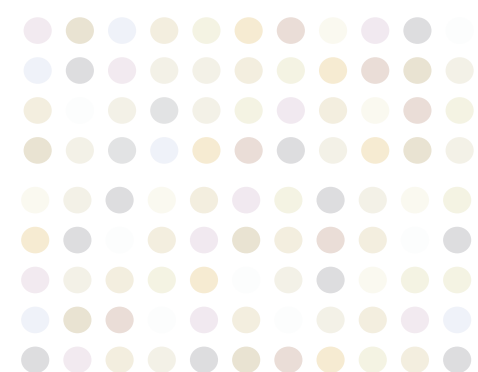
³⁸¹UNAIDS, Madagascar NCPI Report, 2012. Available at <http://www.unaids.org/en/regionscountries/countries/madagascar/>

³⁸²Correspondence from SISAL, August 2012.

³⁸³Submissions to the GCHL Africa Regional Dialogue, Pretoria 3-4 August 2011: Madagascar Independent submission at 42; correspondence from SISAL, August 2012

³⁸⁴Correspondence from SISAL, August 2012

³⁸⁵UNAIDS, Madagascar Country Progress Report, 2012; See also World Bank HIV/AIDS M&E Getting Results: Results Orientation Monitoring: A successful Transition: Madagascar, www.worldbank.org/aids [Accessed 27 July 2012]



31 000
adults aged 15
to 49 are living
with HIV

one in seven
sex workers
tested positive
for sexually
transmitted
infections

Prisoner’s rights: A report on human rights in Madagascar described prison conditions as “harsh and life-threatening”.³⁸⁶ Prisons are severely over-crowded and malnutrition and a lack of hygiene make prisoners vulnerable to disease.³⁸⁷

Rights of girl children: Madagascar has high levels of child marriage, and is ranked 11th out of the list of 20 global hotspots for child marriage. A 2012 UNICEF report states that 14% of girls are married before they reach 15 and 48% by the time they reach 18.

Legal framework for HIV and AIDS

Constitution

The Malagasy Constitution, 1992 (as amended) protects the fundamental rights and freedoms of all people on a number of grounds such as sex, education, wealth, origin, race and religious belief or opinion.³⁸⁸ It protects the right of every person to dignity and privacy.³⁸⁹ In addition, it provides for a range of socio-economic rights including the individual’s right to the protection of his or her health³⁹⁰ and the right to free public education.³⁹¹

National Laws and Policies

Madagascar has an HIV-specific law - the Madagascar Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People living with HIV (2005). The law provides a wide range of protections for people living with and affected by HIV and AIDS including:

- Protection from all forms of discrimination and stigmatisation (such as a distinction, restriction or exclusion on the basis of a person’s HIV status) and promotion of all rights and fundamental freedoms in accordance with international human rights instruments.³⁹²
- Provision for HIV testing services that are free, voluntary, anonymous and confidential and undertaken with informed consent of the person to be tested.³⁹³
- Provision for offers of voluntary HIV testing to pregnant women during antenatal consultations.³⁹⁵
- Protection from discrimination in terms of access to life or health insurance.³⁹⁶
- Protection from discrimination against children affected by HIV or AIDS on the basis of the child’s real or presumed HIV status, the status of the child’s partners, parents, legal guardians or relatives.
- Protection from any form of discrimination or stigmatisation in the working environment³⁹⁷ including protection from pre-employment HIV testing,³⁹⁸ being refused employment or the termination of employment on the basis of HIV status.³⁹⁹
- Protection from discrimination, isolation and compulsory HIV testing within prisons.⁴⁰⁰
- Protection from discrimination and from breaches of the right to confidentiality within the health care sector.⁴⁰¹

The law acknowledges ‘vulnerable populations’, specifically naming sex workers, youth, women, children, people who inject drugs, men who have sex with men and mobile populations. It provides for special measures to be taken to ensure that they are sufficiently protected from HIV,⁴⁰² and for condoms to be made available in highly frequented places and to be freely distributed in prisons.⁴⁰³

³⁸⁶US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Madagascar*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [Accessed on 22 September 2013]

³⁸⁷Correspondence, SISAL, August 2012

³⁸⁸Article 8

³⁸⁹Article 13

³⁹⁰Article 19

³⁹¹Articles 23 and 24

³⁹²Articles 1 and 2

³⁹³Articles 5 and 7

³⁹⁴Article 20

³⁹⁵Article 31; See also Centre for the Study of AIDS and Centre for Human Rights, *Compendium of Key documents relating to human rights and HIV in Eastern and Southern Africa, 2008* at p.139

³⁹⁶Article 36

³⁹⁷Article 44

³⁹⁸Article 11

³⁹⁹Article 46

⁴⁰⁰Article 59

⁴⁰¹Articles 62 and 63

⁴⁰²Article 26

⁴⁰³Centre for the Study of AIDS and Centre for Human Rights, *Compendium of Key documents relating to human rights and HIV in Eastern and Southern Africa, 2008* at p.140

A Decree of 2006-092 on the enforcement of the Law 2005-040 set down various regulations for the implementation and enforcement of the HIV law. A National Ethics Committee was set up to advise on matters relating to HIV and human rights and to review all laws, policies and plans that impact on HIV and AIDS to ensure they integrate rights-based principles. Recommendations and obligations for special monitoring of the rights of key populations were also set out in the Decree, although people who inject drugs were not specifically mentioned.⁴⁰⁴

The Labour Code Act 2003-044 of 28/07/04 protects the rights of every employee to human dignity at work and punishes any act of discrimination based on age, sex, origin, religion, nationality and disability, amongst other things. This general protection may extend to protection for employees living with HIV or AIDS.⁴⁰⁵ A tripartite declaration in 2005 committed the state, employers and employees to responding to HIV and AIDS and labour inspectors have been trained to receive HIV-related workplace complaints.⁴⁰⁶

Women are protected from sexual violence by the Penal Code (as amended by Act 2000-021 of 30/11/2000). The Penal Code severely punishes rape, attempted rape, indecent assault⁴⁰⁷ and incest,⁴⁰⁸ but does not explicitly criminalise marital rape. Although the minimum age of marriage is set at 18 for boys and girls, there are still high levels of child and forced marriage.

Law No 68-012 of 07/04/1968 relates to inheritance and protects women’s rights to inherit in the absence of a will; Article 16 provides for gender equality in intestate succession.⁴⁰⁹ However customary laws of succession discriminate against some widows: widows with children are entitled to half the joint property, but widows without children are passed over in favour of the deceased husband’s family.

Ratification of International and Regional Human Rights Instruments

Madagascar has ratified:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 2005
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1989
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1971
- International Convention on Civil and Political Rights (ICCPR), 1971

Madagascar has not ratified:

- Convention on the Rights of Persons with Disabilities, 2008 (although it has signed the convention)
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

Access to Justice and Law Enforcement

There are many weaknesses in terms of implementation of laws, access to justice and enforcement of laws. There has been some progress in increasing knowledge and understanding of HIV, law and human rights issues amongst populations, civil society organisations as well as key individuals within state institutions. For instance:

- Media has been distributed to employers regarding HIV, law and human rights within the working environment.
- There has been some work to sensitise health practitioners on HIV, law and human rights issues.
- Recent initiatives to strengthen awareness and understanding of the HIV law amongst lawmakers and law enforcers have taken place. The HIV law has been distributed to parliamentarians, the Ministry of Justice and the Ministry of the Interior. Training for HIV focal point persons in various sectors and for human rights commissioners has taken place.

⁴⁰⁴UNAIDS, *Madagascar NCPI Report, 2012*.

⁴⁰⁵UNAIDS, *Madagascar NCPI Report, 2012*.

⁴⁰⁶*Ibid.*

⁴⁰⁷Article 331

⁴⁰⁸Article 333

⁴⁰⁹Article 16. UNAIDS, *Madagascar NCPI Report, 2012*.

- There are currently plans underway by the government to introduce legal support services across Madagascar.⁴¹⁰

However, many challenges remain and an ARASA partner identified lack of knowledge about rights as a major concern.

Access to justice for HIV-related human rights infringements is still weak, despite these initiatives and the inclusion of penalties for discrimination within the HIV law. In particular the following issues have been raised:

- There are limited funds available for HIV-related interventions and as a result civil society interventions primarily focus on HIV prevention services and social mobilization to increase access to and use of health services.
- Some work has been done to increase awareness and understanding of HIV, law and human rights issues amongst the broader public as well as amongst AIDS service organisations and key service providers (such as health care workers), but in general the HIV law has not been widely popularized. People are generally unaware of their rights and how to access and enforce them. As a result, patients seldom challenge discrimination or limited access to services within the health care sector.⁴¹¹

Gaps and Challenges

The HIV law, although generally protective, contains punitive provisions criminalising both intentional and negligent HIV transmission, including transmission by a health care worker.

Article 67 provides that “in the event of transmission of HIV by recklessness, carelessness, inattentiveness, negligence or in violation of regulations, the offender shall be punished with imprisonment of 6 months to 2 years and a fine of from 100 000 ariary to 400 000 ariary. The penalty shall be doubled if the act was committed by a health worker or a traditional healer.” This provision places onerous responsibilities on people living with HIV as well as health care practitioners, particularly given the limited access to services for people in the context of HIV and AIDS.

Law No 97-039 of 11/04/1997 deals with drug control and criminalises the provision of any equipment that may facilitate the use of drugs.⁴¹² This provision creates a barrier to the provision of harm reduction services (such as needle-exchange programmes) for people who inject drugs.⁴¹³

Homosexuality is not explicitly criminalised, but the Penal Code does criminalise same-sex sexual activity where participants are below the age of 21. The age of consent for heterosexual sex is 14.

Procuring sex, living off the earnings of sex work, brothel keeping and solicitation are criminalised in terms of the Penal Code.⁴¹⁴

Recommendations

Recommendations to strengthen the legal and regulatory framework in Madagascar include:

- Madagascar should review its HIV law to remove provisions that criminalise HIV transmission and other punitive provisions.
- Madagascar should also review laws that criminalise same sex sexual relations under the age of 21 to align ages of consent for same sex sexual relations and heterosexual sex and decriminalise all aspects of sex work by consenting adults and drug possession for own use
- Ongoing steps should be taken to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials
- Madagascar should also ratify the Convention on the Rights of People with Disabilities (CRPD) and the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa, to enhance the protection of people with disabilities and women

⁴¹⁰Submissions to the GCHL Africa Regional Dialogue, Pretoria, 3-4 August 2011: Madagascar Independent submission, at p.42; UNAIDS, Madagascar NCPI Report, 2012

⁴¹¹Correspondence, SISAL, August 2012; UNAIDS, Madagascar NCPI Report, 2012

⁴¹²Article 105

⁴¹³UNAIDS, Madagascar NCPI Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Madagascar%20NCPI%202012.pdf>

⁴¹⁴Sections 334, 335 and 336 of the Penal Code



Key data and modes of transmission

According to UNAIDS, 10% or 740 000 adults aged 15–49 years in Malawi are living with HIV, more than half of whom are women (430 000 women have HIV); there are currently estimated to be over 44 000 deaths from AIDS. 170 000 children are living with HIV and there are 610 000 orphans.⁴¹⁵

Populations at higher risk of HIV exposure and most vulnerable to HIV and AIDS, as defined by government, include people living with HIV, women, children (especially girl children), men who have sex with men, sex workers, people with disabilities and employees.⁴¹⁶

Background to HIV, Law and Human Rights

Key Human Rights Concerns in 2014

Information from the Stigma Index study concluded in 2011, the Global Commission on HIV and the Law's Africa Regional Dialogue in 2011 and from a recent assessment of the legal and regulatory framework for HIV and AIDS in Malawi in 2012 provides a useful baseline for key HIV, law and human rights issues of concern:⁴¹⁷

Stigma and discrimination: People living with HIV are stigmatised and discriminated against in their communities, families and homes. They are isolated, marginalised and thrown out of their homes. They may be denied access to resources at community level, such as agricultural subsidies. They also experience discrimination in the health care sector, including breaches of confidentiality, being tested for HIV without their voluntary and informed consent, being treated with indignity and in the case of pregnant women with HIV, being forced to test for HIV, coerced to undergo sterilisation and to terminate pregnancies. In the workplace they report pre-employment HIV testing, exclusion from appointments on the basis of HIV as well as dismissals due to their HIV status.

Women's rights: Women experience gender inequality in their relationships and are subjected to harmful cultural practices that increase the risk of HIV exposure such as wife inheritance, widow cleansing and early marriage. Women with HIV experience many forms of discrimination within the health sector, as detailed above, and are also discriminated against in their communities through property-grabbing. There are high levels of GBV, including sexual violence, within the country.

Children's rights: Children with HIV report discrimination on the basis of their HIV status in their communities and in schools. They also complain of difficulties in independently accessing health care services to prevent and treat HIV and AIDS. Malawi has very high rates of child marriage and is ranked 10th out of 20 hotspots for

740 000
adults aged 15
to 49 are living
with HIV

People with
disabilities
are amongst
the poorest
populations with
limited access to
opportunities,
resources and
services.

⁴¹⁵<http://www.unaids.org/en/regionscountries/countries/malawi/> [Accessed 13 August 2013] UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013

⁴¹⁶UNDP, Department of Nutrition, HIV and AIDS and Ministry of Justice, *Malawi Legal Environment Assessment*, 2012.

⁴¹⁷See UNDP, Department of Nutrition, HIV and AIDS and Ministry of Justice, *Malawi Legal Environment Assessment*, 2012; www.stigmaindex.org; www.hivlawcommission.org

child marriage. Approximately 50% of girls are married before they reach the age of 18, and 12% are married before the age of 15.⁴¹⁸

Rights of men who have sex with men: Men who have sex with men experience high levels of stigma and discrimination in all aspects of life including within their families, communities and in public. They experience violence, abuse, extortion and harassment, including from law enforcement officials. Health care services do not meet their specific needs, they are treated with indignity and disrespect by health workers and discouraged from accessing health care services. An ARASA partner confirmed that HIV prevalence amongst men who have sex with men is very high, and they also experience barriers in relation to accessing information.

Rights of sex workers: Sex workers, like men who have sex with men, also report very high levels of stigma and discrimination on the basis of their criminalised and marginalised status. They frequently report violence, including sexual violence, theft and extortion from their clients as well as from law enforcement officials and have limited access to justice for fear of police action. Sex workers also experience discrimination from health care providers. Stigma and discrimination as well as fear of criminal action isolate sex workers from HIV-related health care services, placing them at higher risk of HIV exposure.

Rights of people with disabilities: People with disabilities are amongst the poorest populations with limited access to opportunities, resources and services. They are stigmatised and marginalised due to their disabilities, are vulnerable to sexual abuse and have limited access to appropriate health care services to meet their specific needs. This places them at higher risk of HIV exposure and makes them particularly vulnerable to the impact of HIV and AIDS.

Workplace rights: Employees are discriminated against in the working environment in various ways including through pre-employment HIV testing, denial of employment and dismissals on the basis of their HIV status. Domestic workers are particularly vulnerable to human rights violations. Applicants to the armed forces are required to test for HIV, in terms of the Defence Force’s policy, and are denied employment if testing HIV-positive.

Legal Framework for HIV and AIDS

Constitution

The Republic of Malawi (Constitution) Act, 1994 as amended contains a Bill of Rights in Chapter IV protecting the basic human rights of all people. It includes protection for a number of human rights that are important in the context of HIV and AIDS such as the rights to equality and non-discrimination,⁴¹⁹ privacy,⁴²⁰ liberty and security,⁴²¹ life,⁴²² work,⁴²³ freedom of expression and information,⁴²⁴ women’s rights,⁴²⁵ children’s rights⁴²⁶ and the rights of people with disabilities.⁴²⁷ The right to health is not specifically protected under Chapter IV of the Constitution but it is a Principle of National Policy⁴²⁸ and is also included in the right to development⁴²⁹ which enjoins the state to take measures to promote development, including equality of access to health care. It is notable that recent amendments to the Constitution have strengthened the rights of vulnerable populations such as children and people with disabilities.

National Laws and Policies

Malawi does not have an HIV-specific law protecting the rights of people living with HIV or AIDS, despite the 2008 *Report of the Law Commission on the Development of HIV and AIDS Legislation* recommending the enactment of a specific law. There have, however, been recent initiatives to revise the Law Commission’s recommendations to develop a new HIV and

AIDS Bill. There are also various protections in other laws that protect people living with HIV and other key populations from discrimination, from exposure to HIV and from the impact of HIV and AIDS:

- Labour legislation in Malawi, including the Employment Act, Labour Relations Act and the Occupational Safety, Health and Welfare Act) is broadly protective of employee’s rights, although it does not deal specifically with HIV and AIDS.
- The Child Care, Justice and Protection Act has strengthened children’s rights, and in particular the rights of orphaned and vulnerable children to care. However, it does not deal with children’s health rights broadly or specifically in the context of HIV and AIDS. The Constitution states that the minimum age for marriage is 18 for both boys and girls, but it permits marriage between the ages of 15 – 18 with parental consent.⁴³⁰
- Women’s rights have been strengthened by various new laws and proposed laws. The Prevention of Domestic Violence Act, 2005 has increased protection for women from domestic violence in all relationships, including from sexual abuse within their domestic relationships (although it fails to specifically criminalise marital rape). The Penal Code criminalises sexual offences such as rape,⁴³¹ defilement⁴³² and incest. Notable is that recently the age to consensual sex has been raised from 13 years to 16 years to provide further protection to girl children.
- More recently, the Deceased Estate (Wills and Inheritance) Act 2011 criminalises property grabbing and provides improved inheritance rights for women upon death of a spouse. In addition, the Marriage, Divorce and Family Relations Bill, when it is passed, will strengthen the equality rights of women within their relationships and create a uniform system of rights and responsibilities in all relationships. The Gender Equality Act was also passed into law in February 2013. The new law prohibits discrimination on the basis of sex and harmful, social, cultural and religious practices and sexual harassment. It specifically promotes access to sexual and reproductive health services. The Malawi Human Rights Commission is tasked with ensuring that the law is enforced.
- The Disability Act was finally passed in April of 2012. Although it makes no specific mention of HIV and AIDS, it does increase protection for the rights of people with disabilities.

Ratification of International and Regional Human Rights Instruments

Malawi has ratified:

- African Charter on Human and Peoples’ Rights, 1989
- African Charter on the Rights and Welfare of the Child, 1999
- Convention on the Rights of the Child (CRC), 1991
- Convention on the Rights of Persons with Disabilities, 2009
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1987
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1993
- International Convention on Civil and Political Rights (ICCPR), 1993
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2005

Access to Justice and Law Enforcement

Although Malawi has run several campaigns to reduce stigma and discrimination, it still faces challenges in raising awareness about HIV and human rights. Key populations face significant challenges in accessing information about their rights and identifying non-discriminatory and accessible services and no public awareness campaigns have targeted their needs.

ARASA partners indicated that the criminalisation of sex between men stops men who have sex with men from accessing services and from disclosing their sexual orientation to health care workers and also appears to discourage service

⁴¹⁸See: <http://www.girlsnotbrides.org/country/malawi/>

⁴¹⁹Section 20

⁴²⁰Section 21(1)

⁴²¹Sections 18 and 19

⁴²²Section 16

⁴²³Section 31

⁴²⁴Sections 34, 35 and 27

⁴²⁵Section 24

⁴²⁶Section 23

⁴²⁷Section 20

⁴²⁸Section 13 enjoins the State to provide adequate health care for all people

⁴²⁹Section 30

⁴³⁰See: http://www.girlsnotbrides.org/wp-content/uploads/2013/04/Minimum-age-of-marriage-in-Africa-March-2013.pdf?utm_source=GNB+Members+Newsletter+English&utm_campaign=bae7fef4ff-GNB_Members_Newsletter_April20134_26_2013&utm_medium=email

⁴³¹Section 132

⁴³²Section 137

providers from providing services to men who have sex with men. The criminalisation of same-sex sexual conduct also inhibits men from pursuing criminal charges when they have been harassed, attacked or victimised, as they fear the risk of being arrested themselves.

The government has provided limited training on stigma and discrimination for service providers and NGOs have also provided some training. The training is however yet to be scaled up and has not yet had a significant impact on attitudes, according to an ARASA partner.

Gaps and Challenges

Issues for law review and reform in Malawi include the following:

- There is no specific protection in law for the rights of people in the context of HIV and AIDS. The Malawi Law Commission’s *Report on the Development of HIV and AIDS Legislation*, 2008 recommended the enactment of an HIV law, and proposed a draft HIV and AIDS Prevention and Management Bill in its report (with both protective and punitive provisions), which has yet to be enacted. Punitive provisions within the original bill included provision for disclosure of HIV status by a health care worker, compulsory HIV testing of specified populations (e.g. sexual offenders, pregnant women, sex workers, partners to polygamous union), pre-employment HIV testing for applicants to the armed forces and for domestic workers and the criminalisation of HIV transmission. The proposed HIV bill was also criticised for its failure to deal with issues affecting vulnerable populations and key populations at higher risk of HIV. In April 2013, the Department of Nutrition HIV and AIDS, the Law Commission and the Ministry of Justice met with civil society and other technical stakeholders to review the bill to ensure that it conformed to rights-based recommendations. A revised Bill which excludes provisions for mandatory testing and criminalisation is currently in the final stages of development and may be enacted into law in the near future.
- Health legislation such as the Public Health Act; Pharmacy, Medicines and Poisons Act and the Patents Act are outdated. These laws fail to deal adequately with HIV and AIDS or to protect patient’s rights. They also fail to promote the use of TRIPS flexibilities to increase access to treatment for HIV and provide inadequate protection against ‘counterfeit’ medicines. The Public Health Act is currently being reviewed by the Malawi Law Commission. In addition, the Penal Code allows for the quarantine and/or prohibition from employment of persons with specified illnesses, and also criminalises transmission of infectious diseases. Section 192 of the Penal Code⁴³³ creates a serious offence in the event that any person “negligently or recklessly does something which he or she knows or has reason to believe is likely to spread an infection dangerous to life”. The maximum sentence for the offence is 14 years in prison.
- There is no specific provision in criminal law for marital rape. Although the Penal Code criminalises rape, rape is defined ‘outside’ of marriage and consent to rape is considered to be implied upon marriage. “For most Malawians it is conceptually impossible for rape to occur amongst married couples. Malawian women are under the mindset that they have to have sex with their husbands even when they do not want to.”⁴³⁴ In addition, women are still subjected to harmful gender norms such as early marriage, placing them at higher risk of HIV exposure. The Constitution fails to prohibit early marriage.
- The Penal Code criminalises sex between men and, in a recent amendment,⁴³⁵ sex between women.⁴³⁶ In the recent case of *Republic v Steven Monjeza Soko & Tionge Chimbanga Kachepa*,⁴³⁷ two men were sentenced to 14 years imprisonment when they openly held a commitment ceremony, evidencing government’s commitment to enforcing the criminalisation of same-sex activities. In late 2013, a review of convictions under the Penal Code provisions,

including a review of the constitutionality of provisions themselves, was brought before the Blantyre High Court by various organisations and individuals.⁴³⁸

- The Penal Code also criminalises aspects of sex work;⁴³⁹ these laws are used to arrest and harass sex workers, along with other ‘nuisance’ laws, such as ‘rogue’ and ‘vagabond’ laws⁴⁴⁰ despite a court ruling in the case of *Bridget Kaseka et al v Rep*⁴⁴¹ that it was sex based discrimination where the police had arrested and prosecuted women suspected of sex work while allowing their male counterparts to go free.
- There is no HIV-specific protection in law for the rights of employees with HIV and the National Workplace HIV Policy has yet to be formally adopted.
- The Immigration Act refuses entry to prohibited persons which include those with specified infections, sex workers and men who have sex with men who are not citizens of Malawi.⁴⁴²
- Populations have a limited awareness and understanding of their rights in relation to HIV and AIDS. There are ad hoc programmes by civil society organisations aimed to reduce stigma and discrimination and to increase awareness of HIV, law and human rights issues; however civil society organisations are reliant on dwindling donor funding and there is no evidence of systematic government-led national campaigns to increase legal literacy and reduce stigma and discrimination. In particular, issues affecting vulnerable populations and key populations at higher risk of HIV require increased attention.
- Legal aid services are available to people but they are not available at district level and are under-resourced to meet the massive demands. Private lawyers are beyond the reach of most people.
- The courts are not accessible to the majority of the population due to the high costs, distance to courts (which operate in a few urban areas) and the time delays involved in litigation. Other mechanisms (such as the Ombudsman and Human Rights Commission) are overstretched. There is limited use of health mechanisms to resolve HIV-related complaints in the health care sector.
- Victim Support Units (VSU) set up by the police services to strengthen complaints mechanisms at district levels, appear to have strengthened access to justice for some. The VSUs are not ideal, however, and users report various complaints such as the need for improved training of staff and the limited awareness of human rights issues.
- Many people use traditional systems to access and enforce their rights. These traditional systems tend to apply customary law principles and have limited understanding of human rights issues.
- Vulnerable and key populations seem most affected by limited access to justice. They are least likely to feel able to use services and most likely to receive discriminatory treatment (e.g. women, men who have sex with men, sex workers etc.).

⁴³³Section 192 of the principal Act was amended (a) by deleting the words “or negligently” and substituting them with the words “negligently or recklessly” (b) by deleting the words “shall be guilty of a misdemeanour” and substituting them for the words “shall be guilty of an offence and shall be liable to imprisonment for fourteen years.”

⁴³⁴Submission by MANERELA, Malawi to Africa Regional Dialogue, Pretoria, 3-4 August, 2011

⁴³⁵Penal Code (Amendment) Act 1 of 2011

⁴³⁶Section 137A, Sections 153 and 156

⁴³⁷Criminal Case No 359 of 2009 (Unreported)

⁴³⁸R v Mussa Chiwis and R v Matthew Bello and R v Amon Champyuni, Confirmation Cases Nos. 22, 411 and 662 of 2011

⁴³⁹Sections 145 to 147 criminalise procuring women, solicitation, living off the earnings of prostitution

⁴⁴⁰Section 180 of the Penal Code criminalises ‘idle and disorderly conduct’ and section 183 criminalises offences likely to cause a breach of the peace

⁴⁴¹Criminal Appeal No 2, 1999

⁴⁴²Section 4

Recommendations

Various recommendations have been made to strengthen the legal and regulatory framework for HIV and AIDS in Malawi including the following:

- Enacting a protective HIV law that includes the protections against HIV-related discrimination in the current HIV bill, includes protection for vulnerable and key populations and excludes coercive and punitive provisions
- Enacting the National HIV and AIDS Workplace Policy to strengthen protection in the working environment for employees living with HIV and to encourage the development of workplace HIV programmes to promote universal access to HIV prevention, treatment care and support for all employees
- To decriminalise same-sex sexual relations and all aspects of sex work by and between consenting adults, in order to reduce stigma and discrimination, protect rights and strengthen access to HIV-related health care services for criminalised populations such as sex workers and men who have sex with men
- To strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials

Key data and modes of transmission

According to UNAIDS, less than 1% of adults aged 15 - 49 years in Mauritius are living with HIV, which equates to 7 400 adults. Similar to Madagascar, less women than men are infected, with 2 200 women living with HIV. There have been less than 1000 AIDS-related deaths. UNAIDS does not have accurate statistics for the number of children infected, but there are 2 700 orphans.⁴⁴³

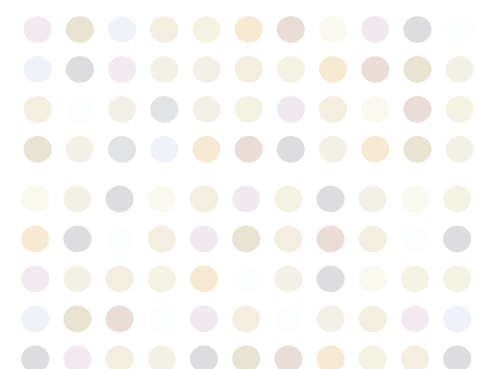
The HIV epidemic is “concentrated” in Mauritius as the HIV rate in the general population is low (0.19%). However, the prevalence in key populations at higher risk of HIV (such as sex workers, people who inject drugs and prisoners) is around 15% to 20%.^{444,445} The main route of HIV infection has remained constant with an average 73% of HIV transmission taking place through injecting drug use.⁴⁴⁶ Baseline data on HIV prevalence amongst men who have sex with men and sex workers is limited. However, it is important to note that many sex workers also inject drugs.⁴⁴⁷

Background to HIV, Law and Human Rights

Key Human Rights Concerns In 2014

The National Strategic Plan 2012-2016 identifies a number of key populations at higher risk and vulnerable populations, although people who inject drugs are most at risk. Others include sex workers, men who have sex with men, seafarers, migrant workers, street children, prisoners, women and young girls and young people.

Stigma and discrimination: HIV-related stigma and discrimination remains high in Mauritius, despite protective laws.⁴⁴⁸ Discussions with CSOs and the recent People Living with HIV Stigma Index Study show that people living with HIV, especially people with HIV who inject drugs, complain most of stigma and discrimination within health care settings. Examples include being refused medicines or access to facilities, poor or inadequate services, stigmatizing treatment from health care providers, HIV testing without consent and in particular, breaches of the right to confidentiality, often fuelled by ignorance on the part of doctors, midwives, nurses and hospital staff of HIV transmission routes. The Study found that 28% of respondents reported being denied access to health services due to HIV, 40.5% reported discriminatory or very discriminatory responses to disclosures of their HIV status to health care workers and 26.8% of respondents said that health care workers had disclosed their HIV status without their consent. A number of respondents reported being tested for HIV on admission to an institution – 23.5% were tested for HIV on admission into prison and 12.2% were tested on admission to hospital. Respondents also reported relatively low levels of access to ART.⁴⁴⁹



7400
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to 49 are living
with HIV

The main route
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HIV transmission
taking place
through
injecting drug
use

⁴⁴³<http://www.unaids.org/en/regionscountries/countries/mauritius/> [Accessed 17 September 2012] see also UN-AIDS, *Getting to Zero: HIV in Eastern and Southern Africa 2013*, 2013 (Annexures).

⁴⁴⁴Source: AIDS Unit, M.O.H. & Q.L.

⁴⁴⁵National Strategic Framework 2007-2011, p.5

⁴⁴⁶UNAIDS. *Mauritius Country Progress Report, 2012*. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MU_Narrative_Report.pdf

⁴⁴⁷Submission by Chrysalide, Mauritius, *Africa Regional Dialogue on HIV and the Law*, Pretoria, 3-4 August, 2011

⁴⁴⁸National AIDS Secretariat, *People living with HIV Stigma Index Report*, Mauritius, 2013

⁴⁴⁹Ibid.

Workplace rights: Employees living with HIV are discriminated against in the working environment. Complaints of unfair dismissals on the basis of HIV status or drug use (where employees using methadone replacement therapy are dismissed) are reported, although the general attitudes of stigma towards HIV and drug use discourage employees from seeking legal remedies.⁴⁵⁰

Rights of sex workers: Sex work is criminalised and highly stigmatised and sex workers report various forms of discrimination including verbal and physical abuse from the general public; assault, sexual violence and rape, harassment, theft and extortion from brothel owners, clients and law enforcement officials and discriminatory treatment, denial of access to health care, degrading treatment and breaches of the right to confidentiality within the health care setting. Sex workers note being unable to report these violations since there is a general perception that due to the criminalised nature of their work they are not deserving of protection. They are unable to register sex worker organisations because of their criminalised status.⁴⁵¹

“Years of discrimination and marginalisation, physical and verbal abuses have had many consequences on sex workers’ living and working conditions. Because this violence is enforced by representatives of the law, sex workers are convinced that they are not entitled to any rights, and not protected by the law, which leads them to pass over the atrocities they face in silence. It has developed in them self-stigma to such an extent that they have resigned from challenging clear injustice. Criminalisation has a psychological impact on them, affecting every aspect of sex workers’ lives.”⁴⁵²

Children’s rights: There are some reports of discrimination against children affected by HIV – such as being denied access to education on the basis of a child’s perceived HIV status.⁴⁵³

Legal Framework for HIV and AIDS

Constitution

The Constitution prohibits discrimination on the grounds of race, caste, place of origin, social status, political opinion, colour, gender, disability, language and sexual orientation.

National Laws and Policies

Mauritius has a number of protections for fundamental human rights, including provisions specifically relating to HIV and AIDS, in the legal framework. In many respects the laws, regulations and policies for HIV and AIDS are strong. Recent legal developments of note are the passing of the Equal Opportunities Act and the Employment Rights Act.

The Equal Opportunities Act of 2008 prohibits any form of discrimination, directly or indirectly, on the basis of a number of grounds including physical state or sexual orientation, amongst others. The Act does not refer to HIV but the definition of ‘impairment’ in the act includes the presence in the body of organisms that cause disease.

In the workplace, the Employment Rights Act 31, 2008 prohibits screening for HIV for purposes of employment⁴⁵⁴ and prohibits harassment in the workplace based on a person’s HIV status or sexual orientation.⁴⁵⁵

The Mauritius HIV and AIDS Act 2006 contains a number of protections for people living with HIV. Also, although there is no specific recognition in the Act of vulnerable populations or key populations at higher risk of HIV, there is provision for syringe and needle exchange programmes. Additionally, the Act is one of the few in the region that does not include criminalisation of HIV transmission.

⁴⁵⁰Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

⁴⁵¹Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011

⁴⁵²Ibid.

⁴⁵³Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

⁴⁵⁴UNAIDS, Mauritius NCPI Report, 2010 Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Mauritius%20NCPI%202012.pdf>

⁴⁵⁵Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

Key protections include:

- A prohibition against requiring a person to test for HIV – for example as a condition of employment, services, application for immigration, citizenship, defence or public safety – and provision for HIV testing only with informed consent save for exceptional circumstances⁴⁵⁶
- Protection of the right to confidentiality, with disclosure of a person’s confidential HIV status only permitted under exceptional circumstances⁴⁵⁷
- Provision for access to non-discriminatory HIV related treatment, care and support⁴⁵⁸
- Provision for syringe and needle exchange programmes and exemption from prosecution under the Dangerous Drugs Act if in possession of syringe or needle in compliance with Act⁴⁵⁹

The Civil Status Act and immigration laws were amended to align with the HIV and AIDS Act, allowing a foreigner living with HIV to marry a Mauritian citizen, which was previously not permitted.⁴⁶⁰

There are various protections in law for women’s equality rights in Mauritius including within the family and with regard to inheritance. The Mauritian Civil Code provides both spouses with the same rights and obligations with regard to parental authority and inheritance laws grant women equal rights to inherit.⁴⁶¹ Women and girl children are also protected from violence, including sexual violence and exploitation, by a number of new laws including the Combating of Trafficking in Persons Act, 2009 and the Protection from Domestic Violence (Amendment) Act 11 of 2004. The amendment has provided better protection for women from domestic violence and has strengthened enforcement mechanisms provided for under the Act (such as protection orders, occupancy orders and tenancy orders). However, the Act does not prohibit all forms of gender-based violence and fails to criminalise marital rape. The Sexual Offences Bill, tabled recently in Parliament, which attempts to criminalise marital rape as well as decriminalise all forms of consensual sex between adults, including anal sex, is yet to be passed.⁴⁶²

Children are protected in law and in policy. They are recognised as a vulnerable population in need of support including through social assistance. For example, education is free at primary and secondary level and there is a universal social aid scheme for all orphans irrespective of their socio-economic status.⁴⁶³

Ratification of International and Regional Human Rights Instruments

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1992
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Rights of Persons with Disabilities, 2010
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1984
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1973
- International Convention on Civil and Political Rights (ICCPR), 2005

Mauritius has signed but not yet ratified the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2005.

Access to Justice and Law Enforcement

Mauritius has a democratic government, an independent legal system, a human rights commission, an Ombudsperson for children and strong civil society organisations including HIV-specific human rights organisations.

PILS and other civil society organisations undertake various programmes to strengthen access to justice including a National Candlelight Memorial, monitoring all forms of HIV-related stigma and discrimination and providing legal

⁴⁵⁶Sections 6 and 7

⁴⁵⁷Section 13

⁴⁵⁸Section 12

⁴⁵⁹Sections 14-16

⁴⁶⁰UNAIDS, Mauritius NCPI Report, 2012

⁴⁶¹Social Institutions and Gender Index (see UNAIDS Snapshot reports)

⁴⁶²Gender Links (see UNAIDS Snapshot reports); Key Informant Interview, Nicolas Ritter, PILS, 24th August 2012

⁴⁶³Mauritius NCPI Report, 2010.

support services for people affected by HIV and AIDS. There are also programmes to reduce HIV-related stigma and discrimination and to increase awareness of HIV, law and human rights issues amongst the broader population as well as within key sectors such as the health care sector, education and the workplace and for the judiciary and law enforcement officials.⁴⁶⁴ The People Living with HIV Stigma Index Study showed that, compared with other countries in the region, people living with HIV in Mauritius have relatively strong awareness of the HIV law and their rights.⁴⁶⁵

A new development which may strengthen access to justice is the establishment of the Equal Opportunities Commission and Equal Opportunities Tribunal, in terms of the Equal Opportunity Act. The Commission is mandated to receive and investigate complaints of discrimination and to take steps to mediate between the affected parties or, where matters remain unresolved, to refer matters to the Equal Opportunities Tribunal. The Commission is also tasked with preparing and publishing guidelines promoting non-discrimination. The Equal Opportunities Tribunal is mandated to hear and determine complaints of discrimination referred to it by the Equal Opportunities Commission and to appropriate declarations, orders and awards as it thinks fit.⁴⁶⁶

Gaps and Challenges

In general, there has been a strong commitment towards protecting rights in the context of HIV and AIDS. However, there are remaining gaps and challenges within the legal and regulatory framework.

Despite the generally protective nature of the Mauritius HIV and AIDS Act, 2006, it fails to adequately promote children’s rights to independent access to health care services. Children under the age of 18 years do not have independent access to HIV testing unless a specific request is made by the minor in writing and the person undertaking the test is convinced that the minor understands the nature of the request, in terms of s7(5) of the Act. In all other instances HIV testing of a child under the age of 18 may only take place with the consent of the legal administrator or guardian,⁴⁶⁷ who received counselling for such testing.⁴⁶⁸ In these cases the decision to consent to any disclosures of the child’s HIV status lies with the legal administrator or guardian.⁴⁶⁹ This is inconsistent with sexual offence laws that set the legal age for consent to sex at 16 years.⁴⁷⁰

In addition, children under 18 years of age cannot access harm reduction programmes⁴⁷¹ even with the consent of an adult.⁴⁷² The Dangerous Drugs Act prohibits the possession of dangerous drugs, illegal drug trafficking and illegal drug consumption. Needle exchange programmes conflict with the provisions of the Act since possession of needles for purposes of injecting drug use contravenes the Act. The Act is said to act as a barrier to access to both harm reduction and HIV-related health care services.⁴⁷³ The provision in the HIV and AIDS Act, 2006 for needle exchange programmes is thus in conflict with the provisions of the Dangerous Drugs Act and if this provision is to be effectively implemented the two pieces of legislation should be harmonised.

Criminal laws criminalise sodomy. Given the protection against discrimination on the basis of sexual orientation in the new Equal Opportunities Act, 2008, civil society is planning to advocate for the repeal of the sodomy laws on the basis that they are discriminatory on the basis of sexual orientation. In 2009, Mauritius committed to finalizing the Sexual Offences Bill which would decriminalise sodomy.⁴⁷⁴ The bill has however not yet been adopted.

Sex work is also criminalised in Mauritius in terms of the Penal Code, 1930 (as amended).⁴⁷⁵ People involved in the sex trade are prosecuted for various offences such as: ‘brothel keeping’, ‘soliciting’, ‘performing an indecent act in public’, ‘rogue and vagabonding behaviour’, ‘pornography’, ‘being a pimp’, and ‘being a common prostitute’. Clients are used as witnesses instead of being charged⁴⁷⁶ and being in possession of condoms may be used by law enforcement officials as

evidence of the offence.⁴⁷⁷ These criminal laws pose barriers to the provision of and the access to health services for men who have sex with men, transgender people and sex workers.⁴⁷⁸

All persons convicted of and imprisoned for a crime require a ‘morality’ certificate in order to apply for employment, once released. This creates barriers to access to employment for criminalised populations such as people who inject drugs and sex workers. HIV positive migrant workers are also not allowed to work in Mauritius.⁴⁷⁹ Migrants are required to test for HIV in order to apply for a work permit; if they test HIV-positive, they are denied a permit to work legally within the country.⁴⁸⁰

Despite strengths within the legal framework, access to justice and law enforcement remains problematic, particularly for key populations.⁴⁸¹ There is still a need for greater awareness about human rights, law and HIV with people living with HIV and key populations. People are also unaware of the services available when their rights are violated. In addition, mechanisms such as the courts and Human Rights Commission are not effective redress mechanisms for most people. The National Human Rights Commission has limitations and does not deal with complaints relating to economic, social and cultural rights such as the right to work, the right to an adequate standard of living, the right to education, the right to health services and the right to social security, amongst others. Sex workers report brutal treatment at the hands of police officers which they are unable to challenge due to their criminalised status.⁴⁸²

Mauritius does not have a consolidated law dealing with children, but there are a number of laws and codes that deal with issues relating to children. The law prohibits child prostitution and pornography, and in 2012, the government identified it as a law enforcement priority.

Recommendations

In terms of law review and reform, the Dangerous Drugs Act and HIV and AIDS Act should be reviewed to limit harassment of people who use drugs. They should be harmonised to ensure that there is a comprehensive, rights-based response to drug use that provides for decriminalisation of possession for own use and that needle exchange programmes are permitted in law, as set out in the HIV and AIDS Act, and not subject to prosecution.

Efforts should also be made to increase access to justice and improve law enforcement, particularly for key populations, through various efforts including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms as well as law enforcement officials. Specific interventions that have been called for in Mauritius include:

- Decriminalising same sex sexual relations and all aspects of sex work by and between consenting adults
- Increasing awareness and education on HIV, law and human rights for the general public, government agencies, service providers within key sectors (such as health care providers and teachers) and law enforcement officials
- Providing dedicated HIV and human rights training and services for key populations such as people who inject drugs, sex workers and men who have sex with men
- Disseminating and popularizing the HIV and AIDS Act
- Creating an accessible police complaints system to handle complaints of abuse from law enforcement officials⁴⁸³

⁴⁶⁴UNAIDS, Mauritius NCPI Report, 2012.

⁴⁶⁵National AIDS Secretariat, People living with HIV Stigma Index Report, Mauritius, 2013.

⁴⁶⁶UNAIDS, Mauritius NCPI Report, 2012

⁴⁶⁷Section 7

⁴⁶⁸Section 11

⁴⁶⁹Section 13(4)

⁴⁷⁰Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

⁴⁷¹Ibid.

⁴⁷²Ibid. This is currently being challenged by PILS

⁴⁷³Ibid.

⁴⁷⁴Amnesty International, Making Love a Crime,: Criminalisation of Same-Sex Conduct in Sub-Saharan Africa, 2013, p.17

⁴⁷⁵Mauritius NCPI Report, 2012

⁴⁷⁶Submission by Chrysalide, Mauritius, African Regional Dialogue, Pretoria, 3-4 August, 2011

⁴⁷⁷UNAIDS, Mauritius NCPI Report, 2012

⁴⁷⁸Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

⁴⁷⁹UNAIDS, Mauritius NCPI Report, 2010

⁴⁸⁰Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

⁴⁸¹Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, 4 August, 2011

⁴⁸²Submission by Chrysalide, Mauritius, African Regional Dialogue, Pretoria, 4 August, 2011

⁴⁸³Submission by Chrysalide, Mauritius, African Regional Dialogue, Pretoria, 4 August, 2011

Key data and modes of transmission

According to UNAIDS the adult prevalence rate is 11.1%, so 1 400 000 adults aged 15 - 49 years in Mozambique are living with HIV, with more women than men living with HIV (810 000 women have HIV). 77 000 people have died from AIDS-related causes. 180 000 children have HIV, and there are 7400 000 orphans.⁴⁸⁴

Mozambique has a heterosexual epidemic. There are significant regional differences in prevalence, with an estimated adult prevalence rate in the southern region of 17.8%, 12.5% in the central region and 5.6% in the northern region.⁴⁸⁵

Background to HIV, the law and human rights

The ARASA 2009 report identified the following issues as priority human rights concerns in Mozambique:

- Lack of infrastructure
- Access to treatment issues including lack of access to ARVs, short supplies of ARVs, the expense of ARVs and treatment illiteracy
- Conflicts between traditional medicine and conventional medicine
- Mandatory HIV testing proposed in HIV bill
- Discrimination against HIV positive soldiers
- Lack of access to condoms in prisons
- Lack of legal protection to reduce vulnerability of women to HIV
- Use of criminal law to ‘punish’ people living with HIV
- No prevention and treatment programmes by government, only those initiated and maintained by NGOs
- No protection for vulnerable populations

Key Human Rights Concerns in 2014

The National Strategic Plan (NSP) 2010-2014 aims to “provide an effective response to HIV and AIDS, on a national and regional scale, by striving to comply with ratified global and regional commitments.” Its guiding principles include the principles of respect for human rights, multi-sectoralism and the involvement of people living with HIV.

The NSP recognises populations that are vulnerable as well as those that are at high risk of HIV “due to socio economic, cultural and behavioral factors.” It identifies a range of vulnerable populations as well as key populations at higher risk of HIV, including sex workers, men who have sex with men, military personnel, people who inject drugs, prisoners, refugees, migrants, people with disabilities and the elderly. HIV programmes also identify others such as women, young girls and boys, truck drivers, teachers, mobile populations, informal traders, orphans and vulnerable children.⁴⁸⁶ It notes the limited data on and the limited prioritisation these populations have received in programmatic responses to HIV, and calls for an increased focus on vulnerable

⁴⁸⁴Submission by Chrysalide, Mauritius, African Regional Dialogue, Pretoria, 4 August, 2011

⁴⁸⁵<http://www.unaids.org/en/regionscountries/countries/mozambique/> [Accessed on 18 May 2014]

⁴⁸⁶Republic of Mozambique National AIDS Council, GAPRP (2012 Global AIDS Response Progress Report), p 7, available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MZ_Narrative_Report[1].pdf)



1 400 000
adults aged 15 to
49 are living with
HIV

Stigma and
discrimination is
acknowledged
as one of the
factors impeding
the national
response to HIV

populations. It aims to provide equitable access to health for all people, by amongst other things, reducing the risk and vulnerability of key populations and by prioritising these populations in its prevention, treatment and care and impact mitigation strategies.⁴⁸⁷

Stigma and discrimination is acknowledged as one of the factors impeding the national response to HIV in Mozambique and resulting in barriers to access to HIV-related health care services, including in the NSP.⁴⁸⁸ People living with HIV report discriminatory treatment when accessing HIV testing and counselling.⁴⁸⁹ A Stigma Index survey was completed by the National Network of People living with HIV/AIDS (RENSIDA) in 2012. The report⁴⁹⁰ indicates that the most commonly cited cases include “eviction cases and isolation from family, alienation from neighbours and others, support when sick, verbal insults, associations of witchcraft, cases of scorn and discrimination because of appearance and prejudice”.⁴⁹¹

Women’s rights: The NSP notes the impact of discrimination, gender inequality and GBV on women’s vulnerability to HIV in Mozambique. Customary practices such as purification, whereby a widow must have unprotected sex with a male relative of her deceased husband, continue to expose women to HIV, especially those living in rural areas. Despite a minimum age of marriage (see below), customary practices permit underage marriage and Mozambique is ranked 6th out of the 20 hotspots for child marriage, with 56% of girls marrying before they reach the age of 18. Some 21% of girls are married before the age of 15.⁴⁹² Women with HIV report discrimination on the basis of their HIV status, including being evicted from their homes and abandoned by their husbands when their HIV status becomes known.⁴⁹³

Rights of sex workers: Sex workers are highly stigmatised in Mozambique since they transgress strict gender norms regarding women’s role in society. Sex workers complain that they are regarded as ‘non-citizens’ and as ‘sub-human’ and face public discrimination.⁴⁹⁴ They also experience violence from law enforcement officials and discrimination within the health care sector.⁴⁹⁵

Rights of sexual minorities: Sexual minorities are discriminated against and are denied the right to form support organisations with legal status, despite constitutional protection of the right of association.⁴⁹⁶ Sexual minorities report being denied public health services when they disclose their sexual orientation or practices or being discouraged from using the services and disclosing their health needs due to the attitudes and practices of health care providers (e.g. during HIV testing and counselling sessions).⁴⁹⁷

The US State Department’s annual human rights report for Mozambique confirms that “discrimination against women ... lesbian, gay, bisexual and transgender (LGBTI) persons and persons with HIV”⁴⁹⁸ are major problems.

Prisoner’s rights: Mozambique’s prisons are severely over-crowded and prisoners face potentially life threatening conditions, including a lack of access to health care and inadequate nutrition. Malaria, TB, cholera and HIV are “commonplace among prisoners in nearly all prisons”.⁴⁹⁹ In 2012, the Maputo Central Prison reported treating 580 of 2096 inmates for HIV. HIV testing in prison is voluntary, so actual rates of infection may be higher.⁵⁰⁰

Legal Framework for HIV and AIDS

Constitution

The Constitution of the People’s Republic of Mozambique, 1990 protects the fundamental human rights and freedoms of all people. Article 36 provides that men and women shall be equal before the law in all spheres of political, economic, social and cultural affairs. The Constitution also protects socio-economic rights such as the right to education⁵⁰¹ and the right to health.⁵⁰² Article 116 states that health care shall be provided through a national health system which is to benefit all Mozambican people; the state is to promote the equal access of all citizens to the enjoyment of this right.

National Laws and Policies

Mozambique enacted an HIV-specific law in 2009, Law 12/2009 on Defending the Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS. It contains a number of protections for affected people:

- The Act prohibits any form of discrimination against people living with HIV
- It provides for HIV testing only with informed consent (except in emergency cases related to the patient’s care, to test blood products, or if it is ordered by a court in sexual offence cases) and prohibits HIV testing linked to employment
- The Act provides for minors to be tested for HIV with the permission of their parents or guardian only where an HIV test is in the best interests of the child, and allows minors to consent independently to an HIV test at age 16 years
- The Act protects confidentiality rights, prohibiting health workers from disclosing a person’s HIV test results to a third party without consent from the patient, spouse, parent, or guardian
- The Act creates penalties for acts of discrimination against people affected by HIV in access to health care, employment, housing, transportation, education, culture, sports or other public or private services and for breaches of the right to confidentiality.

A new draft of the Penal Code, not yet in effect, provides for a prison sentence of between 8 – 12 years for any person convicted of deliberately infecting his or her partner with HIV.⁵⁰³

In the workplace, the Labour Act protects all employees from discrimination in terms of employment, training, promotion and career progression.⁵⁰⁴ In addition, Act 5/2002 of 5 February 2002 provides for non-discrimination for employees with HIV within the formal sector, prohibits HIV testing without consent and prohibits dismissal of an employee on the grounds of HIV status. It protects, inter alia, the right to confidentiality, the right of equal opportunity in employment, education, and promotion, and the right to compensation and appropriate medical treatment in the event of occupational infection with HIV.⁵⁰⁵

Women’s equality rights are protected in the Constitution.⁵⁰⁶ There are a number of laws that protect women from inequality, harmful norms and GBV including:

- The Family Law provides protection for the property rights of women in customary marriages; it establishes a minimum age of marriage of 18 for boys and girls if they have parental consent and 21 if they do not.
- The Law on Domestic Violence improves protection for women against domestic violence.⁵⁰⁷
- The Penal Code contained a number of problematic provisions that discriminated against women – these included a provision that allowed alleged rapists to escape prosecution if they marry their victims or that suspended their sentences if they married, and remained married to their victims. The code also failed to explicitly criminalise marital rape. In April 2014, the Legal and Constitutional Affairs Commission recommended that the provisions allowing

⁴⁸⁷UNAIDS, *Mozambique Country Progress Report, 2012* Available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_MZ_Narrative_Report[1].pdf)

⁴⁸⁸http://www.unaids.org/ctrysa/AFRMOZ_en.pdf; See also GCHL Africa Regional Dialogue, Pretoria, 3-4 August 3: MONASO: Rede Mocambicana de Organizadoes Contra a SIDA at p.82; National Strategic Plan 2010-2014

⁴⁸⁹Submission to GCHL Africa Regional Dialogue, Pretoria, 3 – 4 August 2011: LAMBDA Mozambique at 425

⁴⁹⁰Currently only available electronically in Portuguese

⁴⁹¹Information taken from <http://www.stigmaindex.org/454/press-releases/in-mozambique-plhiv-are-helping-themselves-2012.html> [accessed on 20 August 2013]

⁴⁹²See: <http://www.girlsnotbrides.org/where-does-it-happen>

⁴⁹³Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Mozambique*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed 12 August 2013)

⁴⁹⁴Submission to Global Commission on HIV and the Law. *Africa Regional Dialogue Submissions*, Pretoria, 3 – 4 August 2011: African Alliance of SW (ASWA) at p.79 – 80

⁴⁹⁵Submission to Global Commission on HIV and the Law *Africa Regional Dialogue*, Pretoria, 3 – 4 August 2011: African Alliance of SW (ASWA) at p.81

⁴⁹⁶Article 52

⁴⁹⁷Submission to Global Commission on HIV and the Law *Africa Regional Dialogue*, Pretoria, 3 – 4 August 2011: LAMBDA Mozambique at p.425

⁴⁹⁸Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Mozambique*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed 12 August 2013)

⁴⁹⁹Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Mozambique* (accessed 12 August 2013)

⁵⁰⁰*Ibid.*

⁵⁰¹Article 88(1)

⁵⁰²Article 89

⁵⁰³See: *allafrica: Mozambique: Offensive Articles Removed from New Draft of Penal Code*, 7 April 2014, available at <http://allafrica.com/stories/201404080228.html>

⁵⁰⁴Article 42

⁵⁰⁵*Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law. 2007. AIDS and Human Rights Research Unit. Pretoria University Law Press. Pretoria. At 152*

⁵⁰⁶Article 36

⁵⁰⁷http://www.unaids.org/ctrysa/AFRMOZ_en.pdf

rapists to marry their victims be removed from the Code and recommended the explicit criminalisation of marital rape.⁵⁰⁸

Efforts have been made to increase access to sexual and reproductive health care for women in the context of HIV, such as through the integration of provider-initiated, op-out HIV testing, CD4 testing, ART and eMTCT programmes into existing maternal and child health services.⁵⁰⁹

Ratification of International and Regional Human Rights Instruments

Mozambique has ratified:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1992
- Convention on the Rights of the Child (CRC), 1994
- Convention on the Rights of Persons with Disabilities, 2012
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1997
- International Convention on Civil and Political Rights (ICCPR), 1993
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2005

Mozambique has not yet ratified the International Convention on Economic, Social and Cultural Rights.

Access to Justice and Law Enforcement

There are a number of initiatives to increase access to justice in the context of HIV and AIDS including stigma and discrimination reduction programmes, legal literacy programmes, legal support services, programmes for the judiciary and law enforcement officials on HIV and human rights issues as well as programmes in different sectors such as the health care sector and the workplace. Civil society has played an important role in the dissemination of information, stigma and discrimination reduction campaigns (e.g. amongst health care workers and community volunteers working with HIV and TB patients) and in providing legal and para-legal support services for people living with HIV.^{510,511} As a result there is an increased awareness amongst Mozambicans of the protections within law for HIV and human rights. However, there is limited implementation and enforcement of the laws.

Gaps and Challenges

Despite protections in law, gender inequality, harmful gender norms and gender-based violence remains a key concern. The NSP notes the negative impact of customary laws, such as laws limiting women’s property and inheritance rights, as well as socio cultural factors that support and maintain gender inequality. It furthermore recognises the on-going high levels of GBV and discrimination against women.

While sex between men is not explicitly criminalised in the Penal Code, it does contain provisions that allow for imprisonment for any person who routinely practice ‘vices against nature’.⁵¹² The new draft of the Penal Code has removed references to crimes against nature but does not specifically criminalise discrimination on the basis of sexual orientation or gender identity.

The criminalisation of sex work leads to various forms of discrimination against sex workers, as detailed above.⁵¹³

The HIV Law 12/2009 contains a number of gaps and challenges:

- Although it recognises people who inject drugs as a key population, it fails to recognise and protect other key populations at higher risk of HIV such as sex workers and men who have sex with men.⁵¹⁴
- The Law provides for HIV testing at the discretion of a physician (i.e. without the consent of the patient) where “the patient’s clinical condition requires such a test exclusively for the treatment and care of the patient.” It is also ambivalent with regard to disclosures to a patient’s sexual partner.⁵¹⁵
- The HIV Law 12/2009 criminalises the intentional transmission of HIV, despite international and regional guidance recommending against the specific criminalisation of HIV transmission. Article 52 of the Act provides that “any person who knowing his/her positive serological state, transmits HIV to another person, shall be punished with a prison term higher than two and up to eight years.”
- Article 40 of the Act allows a court to order HIV testing of a person convicted of a sexual offence. However, the legislation does not detail the circumstances in which a court is competent to order HIV testing of offenders, nor does it state how the results of the HIV test will be used, leaving the provision open to abuse.

A key issue regarding the law is the lack of regulations detailing implementation mechanisms for the provisions within the law and the fact that its provisions have not, as a result, been adequately implemented.⁵¹⁶ Currently, there are efforts underway to review HIV laws within the country with the aim of consolidating all HIV-related protections within one law, ensuring protection for the rights of key populations at higher risk of HIV and populations vulnerable to HIV. In April 2013, the government submitted an amended draft to Parliament for consideration.⁵¹⁷ The amendments, if enacted, will remove punitive criminalisation provisions from Law 12/2009 and consolidate a rights based approach in Law 5/2002.

Access to justice and law enforcement for protection of HIV-related rights remains inadequate in Mozambique.⁵¹⁸ People still need more information and education on their rights. There are insufficient mechanisms to monitor and enforce human rights. There is limited access to legal support services in order to increase access to justice for people living with HIV and key populations. Health care providers are not adequately trained on the rights of patients with HIV and access to justice for those whose rights are violated.⁵¹⁹ Law enforcement officials and members of the judiciary also require increased sensitisation to reduce stigma and discrimination and other rights violations and to improve law enforcement.⁵²⁰

“Civil society organizations that provide free legal assistance have been playing a key role in the protection of the rights of people living with HIV. Victims approach such organizations and they take the matter through the legal system. Generally, there are not effective mechanisms to implement such laws. However, the Civil Society has been playing an important role in the dissemination of the laws and in other interventions such as the training of community-based paralegals. Nevertheless access to judicial services is still deficient and a significant part of the population do not have the ability and resources needed to navigate in this system.”⁵²¹

⁵⁰⁸See: *allafrica*: Mozambique: Offensive Articles Removed from New Draft of Penal Code, 7 April 2014, available at <http://allafrica.com/stories/201404080228.html>

⁵⁰⁹Strode, A and Gertholtz, L. 2009. *HIV/AIDS and Human Rights in Southern Africa*. ARASA. www.arasa.info. at. 79

⁵¹⁰UNAIDS, Mozambique NCPI Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Mozambique%20NCPI%202012.pdf>

⁵¹¹Human Rights Protected? *Nine Southern African Country Reports on HIV, AIDS and the Law*. 2007. AIDS and Human Rights Research Unit. Pretoria University Law Press. Pretoria. At 152

⁵¹²Articles 70 and 71 punish those engaging in sexual intercourse ‘against the order of nature’ to labour camps. See also: See: *allafrica*: Mozambique: Offensive Articles Removed from New Draft of Penal Code, 7 April 2014, available at <http://allafrica.com/stories/201404080228.html>

⁵¹³ASWA, Mozambique, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁵¹⁴*Submissions to the Global Commission on HIV and the Law Africa Regional Dialogue*, Pretoria, 3-4 August 2100: MONASO: Rede Mocambicana de Organizadoes *Contra a SIDA* at p.82

⁵¹⁵Strode, A and Gertholtz, L. *HIV/AIDS and Human Rights in Southern Africa*, 2009 at p.14

⁵¹⁶UNAIDS, Mozambique NCPI Report, 2012.

⁵¹⁷<http://www.hivlawcommission.org/index.php/africa-follow-up-activities/184-the-government-of-mozambique-submits-amended-hiv-law-to-parliament> [accessed on 20 August 2013]

⁵¹⁸AIDS Alliance, *Desk Review of the NSPs of Countries in ESA*, 2011

⁵¹⁹*Submissions to the Global Commission on HIV and the Law Africa Regional Dialogue*, Pretoria, 3-4 August 2100: MONASO: Rede Mocambicana de Organizadoes *Contra a SIDA* at p.82

⁵²⁰AIDS Alliance, *Desk Review of the NSPs of Countries in ESA*, 2011

⁵²¹UNAIDS, Mozambique Country Progress Report, 2012

Recommendations

Various recommendations have been made to strengthen the legal and regulatory framework in Mozambique, including:

- Increasing information and data on HIV-related stigma, discrimination and human rights violations against all affected populations
- Review and reform laws such as the HIV Law 12/2009 and 5/2002 to strengthen protection for all key populations, remove punitive provisions in the draft Penal Code and HIV law of 2009 and enact regulations to strengthen the implementation of the law;⁵²² and to strengthen protection for women from discriminatory inheritance practices.
- Decriminalise all aspects of sex work by consenting adults
- Efforts should also be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials. Specific interventions which have been recommended in Mozambique include:
- Improving gender equity and reducing harmful gender norms through ongoing community sensitisation campaigns, peer education of men and women and economic empowerment of women.
- Strengthening protection for sexual minorities through various means including through allowing the registration of civil society organisations to support sexual minorities.⁵²³
- Providing additional training and awareness campaigns with health care providers to reduce stigma and discrimination against affected populations, including 'criminalised' populations such as sex workers.⁵²⁴
- Improving the quality of law enforcement (e.g. through continued education and training programmes) to reduce human rights violations against key populations such as sex workers and men who have sex with men.⁵²⁵
- Mozambique should ratify the International Convention on Economic, Social and Cultural Rights

⁵²²UNAIDS, Country Progress Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Namibia%20NCPI%202012.pdf>

⁵²³Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. LAMBDA Mozambique. At 425

⁵²⁴Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. ASWA at 81

⁵²⁵Global Commission on HIV and the Law. Regional Dialogue Submissions. 2011. August 3 – 4. African Alliance of SW (ASWA) Mozambique. At 79 – 80.

Key data and modes of transmission

According to UNAIDS, around 13.3% of adults aged 15 - 49 in Namibia are living with HIV, which means that 200 000 adults have HIV, the majority of whom are women (120 000 women have HIV). There are around 5 000 annual deaths from AIDS. 18 000 children have HIV and there are 76 000 orphans.⁵²⁶

The National Strategic Framework 2010/11-2015/16 and the National Policy on HIV recognises that, although Namibia has a generalized epidemic, there are groups that are more at risk because of behaviours placing them at higher risk of exposure or lack of access to services, as well as those who are especially vulnerable due to poverty, gender inequality, age, legal status and other socio-economic and cultural circumstances. The NSF and Policy identify a number of key populations and vulnerable populations including people living with HIV, women, orphans and vulnerable children, poor people, sex workers, men who have sex with men, members of the uniformed services, mobile populations, refugees and displaced people, people with disabilities and prisoners.⁵²⁷ Despite research which confirms the increasing incidence of injecting drug use in a number of countries, including Namibia, people who inject drugs are not specifically recognised as a key population by the NSF.⁵²⁸

Background to HIV, Law and Human Rights

The ARASA 2009 report identified a number of priority human rights issues:

- Discrimination against HIV positive soldiers: while Namibia does not automatically dismiss soldiers with HIV and they have access to treatment and prevention services, it excludes those who are positive from entering the NDF and then from being deployed.
- Discrimination against key populations.

Key Human Rights Issues in 2014

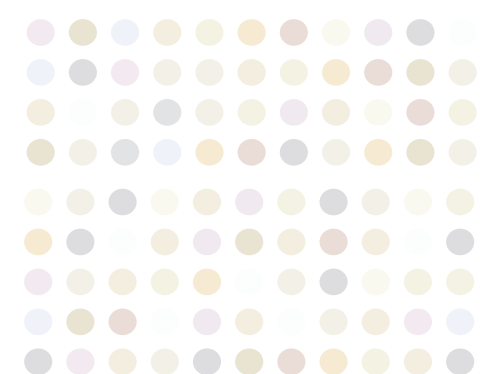
Both the NSF and the Policy recognise the importance of protecting human rights and reducing stigma and discrimination against those affected by HIV as well as the need to target key populations.⁵²⁹

⁵²⁶Available at <http://www.unaids.org/en/regionscountries/countries/namibia/> [Accessed 15 May 2014]

⁵²⁷UNAIDS, Namibia NCPI Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Namibia%20NCPI%202012.pdf>; National Policy on HIV/AIDS. Republic of Namibia. 2007, April. http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Namibia_2007.pdf [Accessed August 2012]; National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16 Available at http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Namibia_2011-2016.pdf

⁵²⁸Godwin, J. 2010. Enabling legal environments for effective HIV responses: A leadership challenge for the Commonwealth. 2010. at 40

⁵²⁹UNAIDS, Namibia NCPI Report, 2012; National Policy on HIV/AIDS. Republic of Namibia. 2007, April http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Namibia_2007.pdf [Accessed August 2012]; National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16 Available at http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Namibia_2011-2016.pdf



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Key issues relating to HIV and human rights include the following:

Stigma and discrimination: People living with HIV report various forms of stigma and discrimination including being denied employment on the basis of their HIV status - e.g. within the armed forces. Stigma and discrimination marginalises people living with HIV.⁵³⁰

Women’s rights: Women in Namibia experience various forms of gender inequality, harmful gender norms and GBV that impact on their vulnerability to HIV. Harmful customary practices affecting women and children remain in practice in Namibia, despite constitutional protection against discrimination. Practices such as property-grabbing, initiation ceremonies for children, arranged marriages between cousins, and widow inheritance increase the vulnerability of women and children and place them at risk of HIV exposure.⁵³¹ Women with HIV have reported forced and coerced sterilization as a result of their HIV status; they report being provided with insufficient information to give proper consent to the procedures, giving consent under coercive circumstances or being denied access to HIV and health services unless they agree to abortion or sterilization.⁵³²

Rights of LGBTI: Sexual minorities are highly stigmatised in Namibia. Men who have sex with men face stigma, discrimination and human rights abuses in their everyday lives, including being denied housing and healthcare, being afraid to walk down the streets of one’s community, or being afraid to seek health care and other services.⁵³³ There is a culture of denial of their existence,⁵³⁴ which reinforces their invisibility as a population in need of protection. Transgender people face ridicule, sexual assault and rape and are not assisted by the police when reporting violations, despite their risk of HIV exposure.⁵³⁵

Rights of sex workers: Sex workers report various human rights violations exacerbated by the government’s failure to recognise their rights in Namibia. They are stigmatised and marginalised within the country. They are vulnerable to violence, exploitation and abuse. As a result of stigmatisation and fear of abuse, they struggle to access sexual and reproductive health care services, including HIV-related health care services.⁵³⁶

Legal Framework for HIV and AIDS

Constitution

Chapter 3 of the Constitution of Namibia protects the fundamental human rights and freedoms of all people. It provides for the right to equality and freedom from discrimination of all people.⁵³⁷ It also provides for the right to respect for human dignity⁵³⁸ and the privacy of all people.⁵³⁹ Article 66(1) of the Constitution recognises the validity of both the customary law and the common law of Namibia to the extent that they do not conflict with the Constitution or any other statutory law.

National Laws and Policies

Although there is no HIV-specific statute, there are a number of protective laws, regulations and policies such as those set out below:

- The National Policy on HIV/AIDS includes a rights-based response to HIV.⁵⁴⁰ It recognises that “respect for the rights of people living with HIV/AIDS is an essential and central component of an effective response. Discrimination against people living with HIV/AIDS violates their rights and is counterproductive to an effective response to HIV/AIDS in that it constitutes a significant disincentive for voluntary counseling and testing, threatens voluntary disclosure of HIV status and increases vulnerability to HIV infection, thereby undermining efforts in response to the epidemic.” The Policy provides for protection of the rights and dignity of people living with or affected by HIV and for non-discrimination in access to health care and related services, education, employment and related services.
- The Namibia Labour Act 11 of 2007 prohibits HIV-related discrimination in the workplace. It provides that no person may discriminate in any employment practice, directly or indirectly against any individual on a number of grounds, including HIV status.⁵⁴¹ The National Code on HIV/AIDS in Employment, 2000 prohibits discrimination and pre-employment HIV testing and provides for workplace responses to HIV and AIDS.⁵⁴² In *Nanditume v Minister of Defence* (2002) AHRLR 119 (NaLC 2002) the Namibian Labour Court found that pre-employment HIV testing for purposes of excluding a person from employment in the armed forces was unreasonable and unfairly discriminatory. The court held that a person’s HIV status alone could not be a reasonable ground for exclusion from the Namibian Defence Force, since an HIV test was not able to assess an applicant’s fitness to perform the job requirements.
- Women’s rights are protected in law. Their equality rights within marriage and with regard to property are protected by the Married Persons Equality Act and the Communal Land Act. The Married Persons Equality Act 1 of 1996 abolishes a husband’s marital power over his wife and her property and grants men and women equal rights in marriage and on the termination of a marriage for spouses married in community of property. The Communal Land Reform Act 5 of 2002 regulates inheritance rights with regard to customary land; it grants equal rights to women applying for access to communal land and protects the rights of a widow to continue using her deceased husband’s land.
- Laws that protect women from GBV include the Combating of Rape Act 8 of 2000, which criminalises various forms of sexual assault, including marital rape⁵⁴³ and provides for harsher sentences for rapists infected with a serious sexually transmitted infection; it provides penalties for perpetrators and compensation for survivors. The Combating of Domestic Violence Act 4 of 2003 criminalises a range of acts amounting to domestic violence including ‘sexual abuse’ in domestic relationships (effectively prohibiting marital rape), as well as child abuse and incest.⁵⁴⁴
- In the 2012 court case of *LM, MI, NI v The Government of the Republic of Namibia* Case No I 1603/2008 the court took note of various factors in determining whether adequate informed consent was provided to three women with HIV who were sterilised. They noted factors such as inadequate information provided to the plaintiffs, including information regarding the risks and alternatives to the procedure, poor written records regarding the nature and extent of information provided to the plaintiffs and their consent to the procedure as well as consent forms signed during labour. The court held that the plaintiffs, three women with HIV, had not provided adequate informed consent to be sterilised and that the sterilisation procedures were an unlawful invasion of their rights. The court, however, failed to find on the evidence that the forced sterilisations had been unfairly discriminatory and taken place as a result of the women’s HIV status.
- Children are protected from sexual exploitation by the Children’s Act 33 of 1960; it prohibits any person or guardian or any person having the custody of a child from causing or allowing the seduction, abduction or prostitution of a child or the commission by that child of immoral acts.⁵⁴⁵
- Health rights are set out in various laws and policies. The Charter of Rights on HIV/AIDS, 2000 sets out the various health rights of people living with HIV or AIDS, including the right to confidentiality and HIV testing only with informed consent.⁵⁴⁶ Although it does not refer specifically to HIV and AIDS, the National Policy for Reproductive Rights of July 2001 recommends that people should not be denied services based on prejudice.⁵⁴⁷ The National Policy on HIV/AIDS provides for protection of various rights, including the right to voluntary HIV testing with voluntary, informed consent and pre- and post-test counselling.
- Notably, Namibia recently repealed laws imposing travel restrictions on entry for people living with HIV.

⁵³⁰Submission to GCHL Africa Regional Dialogue, Pretoria, 3-4 August 2011: Legal Assistance Centre, Namibia at p.430

⁵³¹GCHL Risks, Rights and Health, July 2012 at p.66; see also Submissions to the Global Commission on HIV and the Law Africa Regional Dialogue, Pretoria, 3-4 August 2011 at p.194

⁵³²International Community of Women Living with HIV/AIDS, *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*, available at <http://www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf>

⁵³³Baral, S, Trapence, G, Motimedi, F, Umar, E, Ipinge, S, Dausab, F, Beyrer, C, HIV Prevalence, Risks for HIV infection and Human Rights Among Men who have Sex with Men in Malawi, Namibia and Botswana, 2009. Plosone. www.plosone.org. at p.4 – 7

⁵³⁴Submissions to the Global Commission on HIV and the Law, Africa Regional Dialogue, Pretoria, 3-4 August 2011: Out Right Namibia at p.274

⁵³⁵Ibid.

⁵³⁶Godwin, J, *Enabling legal environments for effective HIV responses: A leadership challenge for the Commonwealth*, 2010 at p.25; see also Submission to GCHL Africa Regional Dialogue, Pretoria, 3-4 August 2011: Rights not Rescue Trust of Namibia at p.215 – 216

⁵³⁷Article 10

⁵³⁸Article 8

⁵³⁹Article 13(1)

⁵⁴⁰UNAIDS, Namibia NCPI Report, 2012

⁵⁴¹Article 5(2)(f)

⁵⁴²UNAIDS, Namibia NCPI Report, 2012

⁵⁴³Article 2(3)

⁵⁴⁴Godwin, J, *Enabling legal environments for effective HIV responses: A leadership challenge for the Commonwealth*, 2010 at p.20; Viljoen, F and Precious, S, *A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in ESA*, 2007; UNAIDS, Namibia NCPI Report, 2012

⁵⁴⁵Viljoen, F and Precious, S, *A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in ESA*, 2007

⁵⁴⁶Ibid.

⁵⁴⁷Ibid.

Ratification of International and Regional Human Rights Instruments

Namibia has ratified:

- African Charter on Human and Peoples’ Rights, 1992
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- Convention on the Rights of the Child (CRC), 1990
- Convention on the Rights of Persons with Disabilities, 2007
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1992
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1994
- International Convention on Civil and Political Rights (ICCPR), 1994
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

Access to Justice and Law Enforcement

There are a number of institutions, services and programmes set up to promote access to justice in Namibia. There are programmes to educate people about their rights in relation to HIV and AIDS and programmes to reduce HIV-related stigma and discrimination, including amongst service providers such as health care workers and within various sectors such as the workplace. There are some civil society organisations working on HIV and human rights issues and providing legal support services as well as legal aid; however there are still insufficient legal support services and limited pro bono services from private law firms.⁵⁴⁸ Rights may be enforced through the judiciary, the Office of the Ombudsman, the Labour Commissioner and the Employment Equity Commissioner and it has been reported that members of the judiciary and law enforcement have been sensitised on HIV and human rights issues. However the extent to which institutions such as the Ombudsman recognise and implement HIV as a human rights issue is unclear.⁵⁴⁹

Gaps and Challenges

Gaps and challenges within the Namibian legal framework include:

- Provisions within the common law that criminalise sodomy effectively criminalise men who have sex with men and create barriers to their access to services. This law also poses a barrier to the distribution of condoms within prisons.
- The Combating of Immoral Practices Act, 21 of 1980, currently criminalises the following activities associated with sex work:
 - Keeping of a brothel (section 2) ;⁵⁵⁰
 - Procuration (section 5);
 - Enticing the commission of immoral acts, including soliciting or indecent dress in public (section 7);
 - Committing of immoral acts in public (section 8);
 - Permitting of offence in terms of this Act by owner or occupier of premises (section 9);
 - Living on the earnings of prostitution and assistance in relation to the commission of immoral acts (section 10).⁵⁵¹

Notably, the act does not criminalise the selling or buying sex. Some municipalities have adopted loitering by-laws that make specific reference to sex work and facilitate the arrest of street workers.⁵⁵² New draft Traffic Regulations for the City of Windhoek have recently been developed that will further criminalise sex work by criminalising the act of sex for reward by both clients and sex workers and will, if passed, have the effect of significantly hindering the ability of sex workers

and their clients to access HIV prevention and treatment programmes and thus undermine the effectiveness of HIV and sexual health programmes in Namibia.

- Laws relating to children are currently being reviewed with the intention of consolidating laws in a single bill, the Child Care and Protection Bill. The Ministry of Gender Equality and Child Welfare convened a task team to examine the proposed legislation and it was hoped that the bill would be tabled in Parliament in 2012. Currently children below the age of 16 may not consent to an HIV test without the permission of their parents.
- The Defence Act 1 of 2002 sets out the qualifications of Defence Force members. It is broad enough to allow for the interpretation that people living with HIV are people with a ‘disease status’ that prevents them from enlisting in the Defence Force.⁵⁵³ This was raised as a serious concern in the 2009 ARASA report and has yet to be resolved. The NDF continues to exclude recruits on the basis of HIV status.

Although there are strong laws and policies, many are not adequately implemented and enforced and populations, in particular vulnerable and key populations, are not adequately protected in law and policy and experience difficulties accessing justice.⁵⁵⁴

Recommendations

- Namibia should decriminalise same sex relations and all aspects of sex work by and between consenting adults – the existing laws exacerbate stigma and discrimination and prevent sex workers and men who have sex with men from accessing services due to fears of prosecution
- As recommended in previous reports, Namibia should remove discriminatory criteria for entry into the National Defence Force and ensure that applicants with HIV who meet fitness and health requirements are no longer excluded from serving in the NDF
- Efforts should also be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials. In particular, work with law enforcement officials is critical to ensure sex workers do not continue to be harassed, pending law review and reform

⁵⁴⁸Viljoen, F and Precious, S, *A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in ESA*, 2007 at p.49 – 51; see also Nair, P, *Litigating against forced sterilization of HIV Positive Women : Recent Developments in Chile and Namibia*, 2010 at p.231

⁵⁴⁹UNAIDS, *Namibia NCPI Report*, 2012

⁵⁵⁰In the case of *Hendricks and others v Attorney-General, Namibia* (High Court, Case 140/2000, judgment 20 August 2002), the court ruled that some sections of the Act were overly broad, such as a portion of the definition of a brothel that included places people “visit for the purpose of having unlawful carnal intercourse” and unconstitutional.

⁵⁵¹In the case of *S v H 1986 (4) 1095 (T)*, the South African High Court considered the meaning of this offence, and held that the offence does not apply to sex workers, but to persons who trade in or benefit from a sex worker’s activities. The same was said in the case of *Hendricks and others v Attorney-General, Namibia* (High Court, Case 140/2000, judgment 20 August 2002).

⁵⁵²Godwin, J. 2010. *Enabling legal environments for effective HIV responses: A leadership challenge for the Commonwealth*. 2010. at 25

⁵⁵³Article 7(1)(c)(i)(ii)(iii)

⁵⁵⁴UNAIDS, *Namibia NCPI Report*, 2012; Republic of Namibia, Ministry of Health and Social Services, *Global AIDS Response Country Progress Report*, 2012.

⁵⁵⁵UNAIDS, *Namibia NCPI Report*, 2012; see also Viljoen, F and Precious, S. 2007. *A Review of Regional and National Human Rights Based on HIV and AIDS. Policies and Frameworks in ESA*. UNDP

Key data and modes of transmission

UNAIDS does not provide data on HIV prevalence in Seychelles.

By the end of 2012, 502 people (290 men and 212 women) had tested positive for HIV. Ninety four people had died of HIV related causes.⁵⁵⁶

The country has a concentrated HIV epidemic with high levels of HIV amongst certain populations, including youth aged between 15 and 24 years, people who inject drugs, men who have sex with men and sex workers. Sex between men is believed to account for around 15 to 25% of HIV transmissions and, while data on HIV incidence and prevalence amongst men who have sex with men is limited, there is a recent recognition of men who have sex with men as a key population with growing HIV incidence. Injecting drug use is recognised as a matter of increasing concern, with more recent information available on HIV amongst people who use drugs. The HIV prevalence among people who inject drugs and men who have sex with men is estimated to be about 5.8% and 13.2% respectively and about 53.5% of people who inject drugs were found to be infected with Hepatitis C in a study conducted in Mahe, Praslin and La Digue Islands. While sex work is suspected to have increased significantly over the recent years, no systematic study has been conducted to estimate HIV prevalence among this population group.⁵⁵⁷

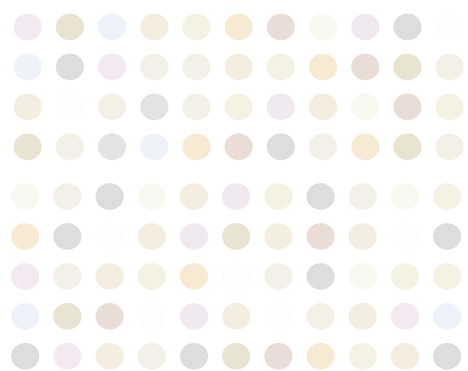
Background to HIV, the law and human rights

The Seychelles was not included in the ARASA 2009 report.

Key Human Rights Concerns in 2014

Stigma and discrimination: Civil society organisations report that stigma and discrimination are still key challenges and the review of the National HIV Policy and the NSP 2005-2009 showed that stigma and discrimination towards people affected by HIV were still important issues to be addressed.⁵⁵⁸ The review of the NSP 2005-2009 reported that patients had limited confidence in the health care system, in terms of protecting their confidentiality rights, impacting on their willingness to return for HIV test results and treatment. VCT centres are said to be ill-equipped to handle confidential counseling and testing, and populations at higher risk of HIV exposure report being asked about their HIV status and treated with indignity.⁵⁵⁹ In addition, HIV testing as a condition of entry is required by various institutions including banks, insurance companies, educational institutions as well as the armed forces.⁵⁶⁰

Rights of key populations: Injecting drug use, sex work and sex between men are all criminalised in the Seychelles. Civil society organisations report difficulties in accessing



By the end of 2012, **502** people (290 men and 212 women) had tested positive for HIV.

Injecting drug use, sex work and sex between men are all criminalised in the Seychelles.

⁵⁵⁶UNAIDS, *Country Progress Report 2012*, available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SC_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SC_Narrative_Report[1].pdf), p.6

⁵⁵⁷ UNAIDS, *Country Progress Report, 2012*; see also *country situation analysis* available at http://www.unaids.org/ctrysa/AFRYSYC_en.pdf [Accessed 25 September 2012]; see also Ministry of Health: Epidemiology Department, *Respondent Driven Sampling study*, 2011

⁵⁵⁸Key Informant Interview, Justin Freminot, HASO, Seychelles, 27 August 2012; NSP Review

⁵⁵⁹Key Informant Interview, Justin Freminot, HASO, Seychelles, 27 August 2012

⁵⁶⁰Ibid

criminalised populations like sex workers and men who have sex with men.⁵⁶¹ There are also reports of harassment of sex workers by law enforcement officials.⁵⁶² The National Strategic Framework 2012 – 2016 has prioritised the needs of key populations “in response to the limited prioritisation within the previous national plan”⁵⁶³. The new plan includes specific programmes for people who inject drugs, men who have sex with men, sex workers, pregnant women and young people.

However, in general there is limited research on the impact that criminalisation has on key populations and how it impacts on stigma and discrimination and/or blocks universal access to HIV prevention, treatment, care and support.

The recent Respondent Driven Sampling (RDS) survey with people who inject drugs and men who have sex with men reported situations of stigma and discrimination:

*“Sixty eight % of IDU reported that they had received verbal insults and 2.0% reported being hit, kicked or beaten in the past 12 months because someone believed respondent has sex with other men. Twelve % of IDU reported being forced to have sexual intercourse when they did not want to at some point in their lives and, among those, 83.4% reported having been forced to have sexual intercourse in the past 12 months. Fifty-four % of men who have sex with men reported being arrested in the past 12 months.”*⁵⁶⁴

Legal Framework for HIV and AIDS in Seychelles

Constitution

Article 27 of the Constitution of Seychelles provides that “every person has a right to equal protection of the law including the enjoyment of the rights and freedoms set out in this Charter without discrimination on any ground except as is necessary in a democratic society.”⁵⁶⁵ This protection extends to all people, including people living with HIV and other key populations at higher risk of HIV. The Seychelles government is currently considering to what extent legislation could be amended to make it more accessible and to better guarantee the equality rights of sexual minorities.⁵⁶⁶

All persons have the right to free primary health care in terms of the Constitution and health policy.

Article 31 of the Constitution protects children’s rights. It states that “the State recognises the right of children and young persons to special protection in view of their immaturity and vulnerability and to ensure effective exercise of this right.”Children are provided with HIV-related services, such as HIV and AIDS information and education; however their right to access services independently of a parent or guardian is limited.

National Laws and Policies

Seychelles does not have an HIV-specific law. However, the legal and policy framework contains protection for the rights of all people and includes specific protection for people affected by HIV and AIDS in the workplace.

It also has broad anti-discrimination protection including the Constitution, the Employment Act, Public Order Bill and Education Policy Statement as well as rights-based protection for HIV and AIDS in the national HIV policy and HIV/AIDS Workplace Policy, 2007.⁵⁶⁷

Women are protected in law from inequality, harmful norms and gender-based violence in law and in policy. There is an Action Plan dealing with gender-based violence and a recent National Gender Policy, 2012 shows a strong commitment to achieve gender equality for all women and to eradicate poverty and achieve long-term social change. Girls are protected from early marriage by laws that set the minimum age of marriage at 18 years without parental consent. Women are

protected from violence in terms of the 1996 Amendment to the Penal Code and The Family Violence (Protection of the Victims) Act, 2000.

There are state policies in place to provide HIV-related prevention, treatment, care and support, including targeted services for key populations. The Public Health Act also specifically prohibits HIV-related discrimination in the provision of care and treatment.⁵⁶⁸ The state and civil society are also collaborating to ensure the provision of health care services, including HIV-related health care, for people who inject drugs despite the criminal laws regarding drug use.⁵⁶⁹

Ratification of International and Regional Human Rights Instruments

The Seychelles has ratified:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1992
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1992
- Convention on the Rights of people with disabilities, 2009
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1992
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2006

Access to Justice and Law Enforcement

According to civil society and country reports to UNAIDS and UNGASS, there are various programmes to raise awareness on HIV and human rights issues, reduce stigma and discrimination and increase understanding amongst affected populations as well as amongst the judiciary and law enforcement. There are also legal support services to support people to access justice as well as mechanisms (such as the courts, National Human Rights Commission and the Office of the Ombudsman, a family tribunal and an employment tribunal) to enforce rights.⁵⁷⁰ The US State Department report for 2012 reports that although the National Human Rights Commission is adequately resourced, there is a public perception that it is too closely aligned to government and it is therefore rarely used.⁵⁷¹

However, these programmes and services are clearly not reaching all populations, particularly populations at higher risk of HIV, since many people are unaware of their rights and how to access justice to enforce their rights. Lawyers are expensive, legal aid is available but difficult to access and court processes are lengthy. Also, high levels of stigma and discrimination are believed to dissuade people from accessing justice.⁵⁷²

“Perceptions of national efforts to address human rights related to the key populations vary but scores just above average in overall. Notable also is the varying views about existence of programmatic actions to reduce HIV-related stigma and discrimination. Some respondents disagree they even exist. This is subject to varying interpretation but it may be important to explore it further with stakeholders. It is important to find out what these programmes (if they exist) have in terms of content, delivery and design.”

In summary, the overall observation is that there are general laws on non-discrimination (as in the country’s Constitution, Employment Act and Public Order Bill) which may be used by anybody (through different mechanisms like the Ombudsman office, the National Human Rights Commission and the courts) to seek legal redress. The real issue may be access to these existing mechanisms and their effectiveness to enable people to seek redress for alleged violation of their rights. However, considering the significant number of non-responses on some of these fundamental questions, it may be assumed there is low awareness of stakeholders about existing laws that relate to discrimination in general among different population groups.⁵⁷³

⁵⁶¹Ibid

⁵⁶²Ibid.

⁵⁶³Ministry of Health, National AIDS Council, UNDP, *Situational Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles. Final Report* 2013, p.14

⁵⁶⁴UNAIDS, *Country Progress Report, 2012*

⁵⁶⁵UNAIDS, *Country Progress Report, 2012*

⁵⁶⁶Ibid.

⁵⁶⁷UNAIDS, *Seychelles NCPI Report, 2012* Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Seychelles%20NCPI%202012.pdf>; see also NCPI Report, 2010

⁵⁶⁸Ibid; UNAIDS NCPI Report, 2010

⁵⁶⁹Key Informant Interview, Justin Freminot, HASO, 27 August 2012

⁵⁷⁰UNAIDS, *Country Progress Report, 2012*; UNAIDS, *Seychelles NCPI Report, 2012*; Key Informant Interview, Justin Freminot, HASO, 27 August 2012

⁵⁷¹Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Seychelles*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 18 September 2013]

⁵⁷²Ibid.

⁵⁷³UNAIDS, *Country Progress Report, 2012*

Gaps and Challenges

There are a number of remaining gaps and challenges within the legal framework that impact on the rights of key populations at higher risk of HIV and vulnerable populations:

- The Public Health Act criminalises the ‘wilful spreading’ of HIV, despite international recommendations against criminalising HIV transmission.
- Children’s rights are not harmonised in law and conflicting provisions create uncertainty regarding children’s rights to access services, as mentioned above. For instance, the legal age of consent to sex is 15 years, yet children may not access medical treatment, including HIV testing, counselling and a range of sexual and reproductive health services including contraception, independently until they are 18 years or over. Children under the age of 18 years require the consent of a parent or guardian to access health care services.⁵⁷⁴
- Criminal laws impact on key populations such as people who inject drugs, sex workers and men who have sex with men. The criminalised nature of drug use makes it difficult to initiate harm reduction measures to reduce the risk of HIV transmission amongst people who use drugs. Laws criminalise sex work, despite the fact that “denial of the activities of sex work increases their risk of HIV infection and its spread.”⁵⁷⁵
- Criminal laws also criminalise sex between men, making it difficult to provide services to men who have sex with men and in prisons⁵⁷⁶ and reinforcing the ‘invisibility’ of men who have sex with men in society.⁵⁷⁷ In 2011, the Seychelles committed to repealing all provisions that criminalising consensual sex between men.⁵⁷⁸
- There is also need for clear guidance in law in relation to HIV testing, confidentiality and disclosure to deal with issues such as the limited guidance in law on the right to confidentiality and disclosures of HIV status with respect to sexual partners.
- The provisions of the Immigration Act which require HIV testing in the event of a proposed marriage between a Seychellois and a foreign national and for foreigners who apply for permission to enter or remain in Seychelles. Applicants for dependents, visitors, residence or gainful occupation permits must submit a medical fitness certificate to accompany their application and include the results of the HIV test. Applicants with HIV have been refused entry to Seychelles or asked to leave.
- The policies of some financial institutions and insurance companies which require HIV testing for approval of loans and life insurance.⁵⁷⁹
- In the workplace, despite the existence of a workplace HIV policy, employees with HIV are discriminated against. There is limited awareness of the HIV workplace policy and due to its non-binding nature, employers are not obliged to implement the provisions.

Seychelles recently conducted a review of its National Strategic Plan on HIV and AIDS (prior to the development of the new plan) and National Policy on HIV. The review noted the gaps and challenges within the legal and regulatory framework. It prioritised the need for a thorough review of all laws and policies impacting on affected populations in the context of HIV and AIDS, with a view to law review and reform, harmonization of conflicting laws and policies and strengthening awareness of HIV and human rights and access to justice for human rights violations.⁵⁸⁰

Recommendations

There are a number of challenges in the legal and regulatory framework, particularly in relation to populations already vulnerable in the context of HIV and AIDS such as young people, people who inject drugs, sex workers, men who have sex with men, prisoners and migrants. Furthermore, due to the relatively concentrated epidemic within the country, HIV is highly stigmatised, and people living with HIV and affected by HIV face severe discrimination within their families, communities and within key sectors such as employment and health care. For this reason, the creation of a strong and protective legal and regulatory framework for HIV and AIDS is crucial to ensure a successful response to HIV in Seychelles. Recommended actions include:

- Clearly identifying all gaps and challenges within the legal and regulatory framework, including laws and policies, access to justice and law enforcement, and how these impact on a range of populations
- Reviewing and reforming health laws to protect the rights of patients to HIV testing only with voluntary and informed consent and confidentiality, to remove provisions that criminalise HIV transmission and to improve access to health care services for all populations including young people
- Reviewing and harmonising children’s laws to ensure children’s rights to access health care services are promoted
- Reviewing and reforming criminal laws (such as laws regarding drug control, sex work and same sex sexual relations) and policies (such as prisons policies) that create barriers to the provision of health care services for people who inject drugs, sex workers and men who have sex with men, including within prisons
- Decriminalising same sex relations and all aspects of sex work by and between consenting adults and possession of drugs for own use
- Reviewing and reforming laws and policies that discriminate against people on the basis of their HIV status
- Strengthening access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials• In particular, recommendations have been made for increasing training and sensitization of existing enforcement mechanisms to increase access to justice and law enforcement for HIV-related human rights violations and for GBV⁵⁸¹

⁵⁷⁴NSP Review; see also NCPI Report, 2010

⁵⁷⁵National Strategic Plan, 2005-2009

⁵⁷⁶UNAIDS, Global AIDS Response Country Progress Report, 2012. NCPI Report, 2012 and 2010; see also Revised draft concept: Situational Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles

⁵⁷⁷Key Informant Interview, Justin Freminot, HASO, Seychelles

⁵⁷⁸Amnesty International, Making Love a Crime: Criminalisation of Same-Sex Conduct in Sub Saharan Africa, 2013, p.17

⁵⁷⁹Ibid.

⁵⁸⁰UNAIDS, Country Progress Report, 2012; NCPI Report, 2012.

⁵⁸¹ AIDS Alliance, Desk Review of NSPs in ESA; Seychelles NSP Review; Key Informant Interview, Justin Freminot, HASO, 27th August 2012; les indicated that stigma was a significant barrier to the reporting of rape; see Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Seychelles [accessed 18 September 2013]

Key data and modes of transmission

According to UNAIDS, 5.7 million people between the ages of 15 - 49 are living with HIV in South Africa, which is 17.9% of the population. There are 3.4 million women living with HIV and 410 000 children. There are 2.5 million children who have been orphaned by AIDS and 240 000 AIDS related deaths.⁵⁸²

HIV in South Africa is transmitted predominantly heterosexually between couples. Mother-to-child transmission is the main infection route for children.⁵⁸³

According to the NSP, drivers of the epidemic in South Africa are intergenerational sex, multiple concurrent partners, low condom use, excessive use of alcohol and low rates of male circumcision. The epidemic is generalized among the population, but the subset of groups referred to as key populations is at particularly higher risk for HIV transmission. The new National Strategic Plan for STIs HIV, and TB for 2012-2016 identifies key populations that are most likely to be exposed to or to transmit HIV as including young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; people with disabilities and mental disorders; sex workers and their clients; people who abuse alcohol and illegal substances; men who have sex with men and transgender individuals.

Key populations for TB infection are identified by the NSP as including healthcare workers; miners; prisoners; prison officers and household contacts of confirmed TB patients. In addition, populations vulnerable to progressing from TB infection to disease include children; people living with HIV; diabetics; smokers; alcohol and substance users; people who are malnourished or have silicosis; mobile, migrant and refugee populations; and people living and working in poorly ventilated environments.⁵⁸⁴

Background to HIV, the law and human rights

The ARASA 2009 report identified the lack of adequate oversight mechanisms to ensure the implementation of HIV-related legislation and the failure to prioritise HIV prevention as major human rights concerns.

Key Human Rights Concerns In 2014

The NSP recognises the importance of protecting human rights and reducing stigma and discrimination against those affected by HIV as well as the need to target key populations. Key issues relating to HIV and human rights include the following:

Stigma and discrimination: HIV-related stigma and discrimination remains an issue of concern, despite the fact that national research as well as reports from civil society suggest that it has declined over the years. People affected by HIV report discriminatory treatment ranging from stigmatisation within communities, denial of



17.9%
of the
population are
living with HIV

drivers of the
epidemic in
South Africa are
intergenerational
sex, multiple
concurrent
partners, low
condom use,
excessive use of
alcohol and low
rates of male
circumcision.

⁵⁸²Available at <http://www.unaids.org/en/regionscountries/countries/southafrica/> [Accessed 18 May 2014]

⁵⁸³UNAIDS, *Country Progress Report, 2012*. Available at <http://www.unaids.org/en/regionscountries/countries/southafrica/>

⁵⁸⁴Ibid.

basic services from services providers, including sexual and reproductive health services, through to violence. Stigma and discrimination fuels silence, self-stigma and shame and often targets those who are most vulnerable.⁵⁸⁵ A Stigma Mitigation Framework has been put in place by the national government and a People Living with HIV Stigma Index has been undertaken by the national network of people living with HIV in the Eastern Cape and is currently being rolled out nationwide.

Women’s rights: Women in South Africa continue to experience high levels of gender inequality and gender-based violence placing them at risk of HIV. GBV is a major concern across South African society. Although women’s rights in most marriage situations are now protected in law, women in cohabiting relationships and religious marriages are still not fully protected.

Rights of sex workers: Sex workers report various human rights violations exacerbated by the government’s failure to recognise their rights. They are stigmatised and marginalised within the country, and thus vulnerable to violence, exploitation and abuse. This creates barriers to access to health care services.

Rights of people with disabilities: People with disabilities have had limited protection from national responses relating to HIV and AIDS due to various reasons, including on-going discriminatory and stereotypical beliefs towards people with disabilities which makes mainstreaming of disability considerations in planning, service delivery and monitoring processes difficult, across all sectors at all levels, built environments and communication systems which continue to exclude people with disabilities and lack of capacity within the disability sector to effectively advocate for the rights of people with disabilities.⁵⁸⁶

Prisoner’s rights: Despite the existence of protective prison policies on HIV and AIDS, prisoners struggle to access HIV-related health care and the failure to prioritise prisoners as a vulnerable population within health care policies exacerbates the problem. Prisons remain severely over-crowded and over-crowding, along with sexual violence and poor conditions generally, contributes to the spread of HIV amongst prisoners. The Department of Correctional Services does undertake HIV prevention in prisons, including the distribution of condoms and prisoners have access to HIV testing and ART.

Legal Framework for HIV and AIDS

Constitution

The Constitution of the Republic of South Africa, 2006 is the supreme law in the country and protects the values of dignity, right to freedom, and equality for all. The Constitution has a well -developed equality provision that outlaws unfair discrimination on a number of grounds, but does not specifically include HIV status.

National Laws and Policies

South Africa has a variety of laws and regulations that provide for the security of human rights and protect individuals against discrimination in education, employment, correctional facilities and in health care (both public and private). Some specifically include provisions for vulnerable sub-populations such as women and girls, young people, men who have sex with men, sex workers, prisoners and migrant populations. They also protect the rights to privacy, dignity, life, freedom and security of the person, access to information and access to health care services, amongst others.

The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 provides further protection and promotes equality, with a special focus on equality on the grounds of race, gender and disability. Although the anti-discrimination law does not specifically mention HIV and AIDS, the courts have extended protection to people living with HIV under these provisions.⁵⁸⁷

The Labour Relations Act protects all employees from discrimination. The Employment Equity Act 55 of 1998 provides for the measures to eliminate discrimination and promote affirmative action in the workplace; it prohibits unfair

discrimination in any employment policy or practice on various grounds including HIV status and also prohibits HIV testing (such as pre-employment HIV testing) in the workplace.

The Children’s Act 5 of 2010 provides comprehensive protection for the rights of children; it includes protection for a child’s right to non-discrimination as well as the rights to provide independent consent to HIV testing from 12 years of age and the right to confidentiality regarding his or her HIV status, provided they have the maturity to understand the implications of their decisions. Children above the age of 12 also have a right to access contraception and to access abortion without parental consent.

The Social Assistance Act, 2004 and Amendment Act, 2010 provide for social assistance, including for people living with HIV who are unable to work and to caregivers of children (including children orphaned by AIDS)

There are also various protections in law to provide for the equality of women, to protect them from violence and to promote their sexual and reproductive health rights, including the Choice on Termination of Pregnancy Act, 1996 which provides women with the right to termination of pregnancies based on choice.

Various sectors have enacted a range of protective policies for HIV, including the Departments of Health, Education, Correctional Services, and the Defence Force, amongst others.

Ratification of International and Regional Human Rights Instruments

South Africa has ratified:

- African Charter on Human and Peoples’ Rights, 1996
- African Charter on the Rights and Welfare of the Child, 2000
- Convention on the Rights of the Child (CRC), 1995
- Convention on the Rights of people with disabilities, 2007
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1995
- International Convention on Civil and Political Rights (ICCPR), 1998
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

South Africa has not ratified the International Convention on Economic, Social and Cultural Rights (ICESCR).

Access to Justice and Law Enforcement

There are a number of institutions, services and programmes set up to promote access to justice in South Africa. There are programmes to educate people about their rights in relation to HIV and AIDS and programmes to reduce HIV-related stigma and discrimination, including amongst service providers such as health care workers and within various sectors such as the workplace. There are some civil society organisations working on HIV and human rights issues and providing legal support services as well as legal aid; however there are still insufficient legal support services and limited pro bono services from private law firms.

Mechanisms in place to ensure the implementation of laws include the SA Human Rights Commission, to promote and protect human rights; the Commission for Gender Equality, with the responsibility to promote and protect gender equality; the Judicial Inspectorate of Prisons, to uphold the standards of prisons; the Medicines Control Council, which approves medicines and clinical trials and various Parliamentary Committees, to monitor the implementation of laws and policies. Systems of redress to ensure that laws are upheld and that they are having the desired effect include the court systems, the Commission for Conciliation, Mediation and Arbitration (CCMA) for workplace disputes; the Health Professions Council of SA (HPCSA) to regulate the conduct of health professionals and the Judicial Inspectorate of Prisons to uphold the standards of prisons and the National Health Research Ethics Council with the authority to grant or deny permission to carry out research on human subjects.⁵⁸⁸

⁵⁸⁵NAPWA People Living with HIV Stigma Index, 2013.

⁵⁸⁶*ibid.*

⁵⁸⁷See, for instance, *Hoffman v SAA (CCT 17/00) [2000] ZACC 17*

⁵⁸⁸ UNAIDS, *Global AIDS Response Country Progress Report*, 2012

Gaps and Challenges

Gaps and challenges within the South African legal framework include:

- The ongoing criminalisation of sex work in terms of the Sexual Offences Act 23 of 1957 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007. Criminalisation increases sex workers' vulnerability and risk of HIV. The South African Law Commission's Project 107 has been reviewing the legal barriers to sex work for the past seven years but has yet to report conclusively on the matter.
- Failure to provide for harm reduction for people who inject drugs in law (the Prevention of and Treatment for Substance Abuse Act, 2008) or in policy, such as needle syringe exchange (NSE) and opioid substitution therapy (OST) programmes as part of a holistic prevention package. Current drug laws and policies should be aligned with the recommendations of the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC).
- Failure to specifically address comprehensive health care programmes and services for key populations and concentrated epidemics within the country including men who have sex with men, sex workers, mobile populations and refugee populations.
- Inadequate provision for legal support services to strengthen access to justice for HIV and AIDS. Legal aid services are available on a limited basis, and although government funds some, capacities and resources are insufficient to address the need.
- Inadequate provision for monitoring and documenting HIV-related human rights violations. While individual councils and commissions work on HIV-related discrimination cases or record human rights abuses, oversight bodies lack sufficient resources to act in accordance with their regulatory responsibilities, and problems with financing and appointment procedures have undermined their efficacy. The NSP does explicitly provide for the promotion and protection of human rights and attempts to create benchmarks for compliance with human rights standards and the reduction of stigma. Unfortunately, South Africa lacks one overarching body that gathers and centralises the information around human rights, including that pertaining to HIV and AIDS.⁵⁸⁹

Recommendations

Recommendations for law review and reform include:

- Ongoing review of the criminalisation of sex work with a view to decriminalising all aspects of sex work by consenting adults
- Review of drug law and policy to specifically provide for harm reduction programmes for people who inject drugs to protect them from HIV
- Ongoing review of health policies, plans and programmes to ensure protection of the rights and needs of key populations at higher risk of HIV exposure
- Enactment of laws to provide for equality between men and women in domestic partnerships and religious marriages, including Islamic marriages
- Strengthened access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials.
- Ratification of the ICESCR

⁵⁸⁹Ibid.

SWAZILAND

Key data and modes of transmission

Swaziland currently has the highest HIV prevalence in the world. According to UNAIDS, around 26.5% (190 000) of adults aged 15-49 years in Swaziland are living with HIV, with significantly more women infected than men (31% and 20% respectively, with 110 000 women living with HIV). There are currently around 5 500 deaths from AIDS each year. There are 22 000 children below the age of 15 living with HIV and 78 000 orphans.⁵⁹⁰

Two thirds of new adult infections occur amongst people above 25 years of age mainly in long-term stable relationships. Multiple concurrent partnerships are one of the key drivers of the epidemic; others are low levels of male circumcision, low levels of condom use, age-disparate sex, mobility and migration, gender inequalities and sexual violence, alcohol and drug use and early sexual debut.⁵⁹¹

The National Multi-Sectoral HIV and AIDS Framework 2009-2014 identifies a number key populations including women, girls and youth, pregnant women, migrant populations and people with disabilities.⁵⁹² National programmes have also recognised the need and made efforts to reach other populations such as sex workers, prisoners and men who have sex with men.⁵⁹³

Background to HIV, the law and human rights

The ARASA 2009 report identified a range of human rights concerns related to HIV and AIDS:

- HIV testing – there was a lack of clarity on whether informed consent was necessary for HIV testing and pre- and post-test counselling was not consistently provided.
- Draft laws relating to violence against women had not been enacted. In addition, despite guarantees of gender equality in law, women's legal status continued to be undermined by customary laws and practices, including early marriage.
- LGBTI populations experienced high levels of stigma and discrimination and civil society organisations working on LGBTI issues were forced to disband.

Key Human Rights Concerns In 2014

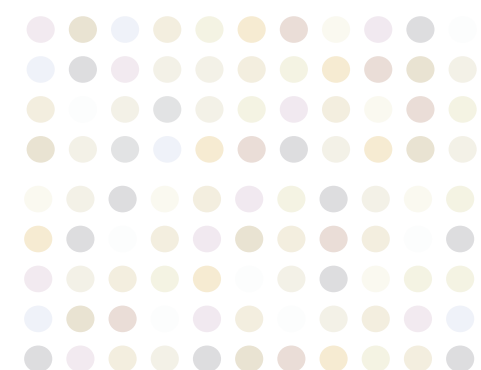
Stigma and discrimination: A recent Stigma Index Study conducted by the Swaziland National Network of People living with HIV and AIDS (SWANNEPHA) shows that while progress has been made in managing stigma and discrimination against people living with HIV, it nevertheless continues to be an issue of concern, affecting people living with HIV of all sexes, age and location and contributing to self-stigma. Stigma and discrimination occurs at family and community level where people living with HIV report being physically assaulted, gossiped about, verbally insulted, harassed, threatened, excluded from their families and social gatherings. In the working

⁵⁹⁰Available at <http://www.unaids.org/en/regionscountries/countries/swaziland/> [Accessed 18 May 2014]

⁵⁹¹UNAIDS, Country Situational Analysis, 2012 Available at http://www.unaids.org/ctrysa/AFR/SWZ_en.pdf [Accessed 26 September 2012]

⁵⁹²UNAIDS, NCPI Report, 2012 Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Swaziland%20NCPI%202012.pdf>

⁵⁹³UNAIDS, Country Progress Report, 2012 Available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report[1].pdf)



26.5%
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world.

environment, people living with HIV experience discrimination and there are also indications of denial of dental, family planning and sexual and reproductive health services. Other issues that emerged in the health sector were HIV testing without voluntary consent and/or pre-test and post-test counselling, and unlawful disclosure HIV status.⁵⁹⁴

Women’s rights: Significantly more women than men are HIV-positive in Swaziland and of particular concern is the increase in prevalence in younger women aged 15 to 24 years. Gender inequality places women in a subordinate position, with limited legal status in terms of common and customary law and limited rights in relation to marital property, including on the death of their spouse. Women have limited social, economic and general decision-making power within their families and communities, including in relation to sexual decision-making. Harmful norms such as inter-generational sex as well as GBV place women at higher risk of HIV.⁵⁹⁵ Women with HIV report discriminatory treatment including forced or coerced sterilization.

Rights of sex workers: Sex workers are vulnerable to violence and abuse, with limited powers to claim redress for violations of their rights.⁵⁹⁶

Rights of men who have sex with men: Sodomy, defined as anal intercourse between men, is a prohibited common law offence.

Legal Framework for HIV and AIDS

Constitution

The Constitution of the Kingdom of Swaziland protects the rights of all people. It includes specific protection for a number of rights relevant to HIV and AIDS including the rights to equality and freedom of movement⁵⁹⁷ and protection from harm such as human trafficking and sexual abuse. It obliges the state to take all practical measures to ensure the provision of basic health care services to the population.⁵⁹⁸

Women’s rights are protected in the Constitution. Section 28 guarantees women’s right to equality and places a duty upon the state to support women’s realization of their property rights through, for instance, equal opportunities in political, economic and social activities and to provide facilities and opportunities to enhance women’s development.⁵⁹⁹ It furthermore protects women from harmful cultural norms, providing “a woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed.”⁶⁰⁰ In addition, the Constitution provides for the property rights of spouses to ensure that a surviving spouse is entitled to a reasonable provision out of the estate of the other spouse whether the other spouse died having made a valid will or not and whether the spouses were married by civil or customary rites.⁶⁰¹

Despite the existence of a Constitution that appears to protect human rights, Swaziland remains an absolute monarchy, with King Mswati III maintaining authority over all arms of government. The US State Department 2012 human rights report on Swaziland indicated that discrimination and abuse of women and children is one of the main human rights concerns for Swaziland. The report also noted that government did little to address human rights violations and perpetrators were not held accountable.⁶⁰²

National Laws and Policies

There is no HIV-specific law. However, the national HIV policy includes strong protection for the rights of people in the context of HIV and AIDS, prohibits HIV-related discrimination including discrimination in access to services such as education, health care and employment and calls for the enactment of HIV specific laws to address key issues such as discrimination.⁶⁰³ Parliamentarians have also recently adopted a Parliament Strategy on HIV and AIDS, 2011 which outlines how parliamentarians will engage with constituencies on HIV and AIDS issues.

Women and girl children are protected from sexual abuse by the Girls and Women Protection Act. The recently enacted People Trafficking and People Smuggling (Prohibition) Act, 2009 seeks to prevent human trafficking and smuggling and to enable the judicial system to prosecute perpetrators. This legislation came into effect in March 2010. In addition, there is pending legislation, the Sexual Offences and Domestic Violence Bill, 2010, which will address the increasing rates of domestic violence in the country when it becomes law. The bill however does not explicitly criminalise marital rape. The Bill has been passed in Parliament and is awaiting the King’s assent.⁶⁰⁴ The draft Marriage Bill which addresses inequality in marriage has also not yet been passed into law. The Gender Policy, 2010 provides a clear commitment to strengthening gender equality in Swaziland.

In the employment sector, Swaziland has an Employment Act Cap 268 and Industrial Relations Act Cap 269 to protect workers against discriminatory practices. The Employment Act was recently amended to make provision for non-discrimination for employees in any contract of employment based on sex, race, colour, religion, marital status, national origin, tribal or clan extraction, political affiliation or social status.⁶⁰⁵ Although the provisions are not HIV specific, they do contain anti-discrimination protection that should protect the rights of people living with HIV.⁶⁰⁶ Part X makes provision for the protection of women, children and young persons in the workplace. The public sector has also recently developed a Public Sector Workplace Policy and Wellness Programme, 2011 to co-ordinate the management of HIV within the public sector.

Recent developments in children’s protection include the Education Sector Policy, which integrates HIV and AIDS and addressing harmful gender norms under the schools care and support programmes, and the Child Protection and Welfare Act, endorsed by King Mswati in September 2012, which is a comprehensive law addressing all issues affecting children, including protection for orphaned and vulnerable children. It also prohibits child marriage and sets the age of majority at 18. In the health sector, a number of recent health policies have been updated to strengthen HIV programmes for all people. The National HIV Prevention Policy, 2011 seeks to strengthen efforts in prevention and create an enabling environment for the prevention response; the National Palliative Care Policy, 2011 provides for quality and affordable palliative care services in Swaziland; the revised National eMTCT Guidelines, 2010 strengthens a comprehensive approach to eMTCT, including through prevention of HIV infection amongst women of child-bearing age, prevention of unintended pregnancies amongst women with HIV and regular HIV retesting during pregnancy and finally the revised National Antiretroviral Treatment (ART) Guidelines, 2010 to bring the guidelines in line with World Health Organization (WHO) recommendation of early enrolment into care.⁶⁰⁷

A review of intellectual property laws has taken place to strengthen access to treatment for HIV and AIDS.

Ratification of International and Regional Human Rights Instruments

Swaziland has ratified:

- Convention on the Rights of the Child (CRC), 1995
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 2004
- Convention on the Rights of people with disabilities, 2012
- International Convention on Economic, Social and Cultural Rights (ICESCR), 2004
- International Convention on Civil and Political Rights (ICCPR), 2004

⁵⁹⁴Swaziland Network of People living with HIV/AIDS, *People Living with HIV Stigma Index Report: Swaziland*, 2011, available online at www.stigmaindex.org. [accessed 27 July 2012]; Molathegi & Associates: Attorneys, Notaries, Conveyancers, Regulatory and International Trade Law Consultants, *Final Report: Consultancy services for review for laws and policies relating to HIV/AIDS*, 2005 at p.118

⁵⁹⁵UNAIDS, *Country Situation Analysis*, 2012. Available at http://www.unaids.org/ctrysa/AFRSWZ_en.pdf [Accessed 26 September 2012]; *National Multi-Sectoral Framework on HIV and AIDS 2009-2014*

⁵⁹⁶GCHL, *Risks, Rights & Health*, 2012 Available at www.hivlawcommission.org

⁵⁹⁷Section 26

⁵⁹⁸AIDS and Human Rights Research Unit, University of Pretoria, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, 2007 at p.295

⁵⁹⁹AIDS and Human Rights Research Unit, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, 2007 at p.299

⁶⁰⁰Section 28(3)

⁶⁰¹Section 34(1)

⁶⁰²Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Swaziland*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 21 August 2013]

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⁶⁰³Gertholtz, L and Strode, A, *ARASA HIV & Human Rights in Southern Africa*, 2009 at p.36; AIDS and Human Rights Research Unit, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, 2007 at p.306

⁶⁰⁴UNAIDS, *Country Progress Report*, 2012.

⁶⁰⁵Article 29

⁶⁰⁶Gertholtz, L and Strode, A. 2009. *ARASA Human Rights Report*. 2009. At 36

⁶⁰⁷*Ibid.*

Swaziland had signed, but not yet ratified:

- African Charter on Human and Peoples’ Rights
- African Charter on the Rights and Welfare of the Child
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa

Access to Justice and Law Enforcement

There are institutions and mechanisms in place to provide access to justice for human rights violations in Swaziland, including the police, social welfare officers, public prosecutors and the courts, the Human Rights Commission and the Gender Desk in the Deputy Prime Minister’s Office. Some of these mechanisms (e.g. the Human Rights Commission and Gender Desk) are relatively new and still becoming established.⁶⁰⁸ The Human Rights Commission is reported to be weak and under-funded.

There are reported to be programmes to reduce HIV-related stigma and discrimination for health care workers, the media, employers and employees and others. There are also programmes to educate, raise awareness among people living with HIV and key populations concerning their rights as well as programmes for members of the judiciary and law enforcement officials on HIV and human rights issues that may come up in the context of their work. Civil society organisations such as Women and Law in Southern Africa, SWAPOL and SWANEPWHA, amongst others, support rights protection for women and for people living with HIV. However, there are inadequate legal aid systems for HIV case work, university based centres and private sector law firms to provide free or reduced-cost legal services to people living with HIV and limited recording and documenting of HIV-related stigma and discrimination (up until the recent Stigma Index study).⁶⁰⁹

Gaps and Challenges

The lack of HIV-specific protection in law means there is no clear guidance on the rights of people in the context of HIV and AIDS. Despite reports of programmes to increase awareness and understanding, the Stigma Index Study found that many people are still unaware of their rights (e.g. their rights to non-discrimination within the working environment or their rights protection provided in terms of the national HIV policy) and of how to access and use mechanisms to enforce their rights. Likewise, many service providers are not fully sensitised on HIV-related human rights issues.⁶¹⁰ In addition, although there are efforts to enforce legislation and other measures to eliminate all forms of discrimination, the enactment and implementation of laws and policies is slow and inadequately resourced.⁶¹¹

Although the Constitution specifically protects women’s rights and promotes equality between men and women, under Swazi common law and customary law women are still considered to be minors, which affects their property ownership and inheritance rights. This inconsistency between civil and customary laws means that some women may still have to obtain permission from their husbands or guardians in all legal matters or important interactions. Swazi inheritance law prevents a woman from inheriting anything from their deceased husband’s estate in their own right. Rural women can have access to land only through a husband if she is married, or through a male relative if she is single.⁶¹² There is currently a review of inheritance law in terms of the Administration of Estates Bill, 2009.⁶¹³

Laws that criminalise injecting drug use, sex between men (in terms of the common law crime of sodomy) and sex work create barriers to the HIV response. Providers are not able to offer services and these populations are unable to access targeted health services, including HIV prevention services, as a result of the criminalisation of their activities. For instance, sex workers are not protected in law; they face violence and abuse and do not report violations for fear of arrest.⁶¹⁴ Section 3 (3) of the Swaziland Girls and Women’s Protection Act creates a defence to the charge of “carnal knowledge of a girl child under 16” if, “at the time of the commission of the offence the girl was a prostitute.” This means

that while a girl under the age of 16 cannot consent to sex (regardless of whether she is a sex worker) she also cannot claim protection from the law if someone has sex with her against her will. By granting her neither agency nor security, the law effectively renders her a non-person.⁶¹⁵

Currently, there are no laws criminalizing HIV transmission in Swaziland. However, disturbingly this was noted by government as a gap in Swaziland’s most recent report to UNAIDS on *National Commitments and Policies Instruments*, 2012. While the need to protect people from sexual abuse is important, it is equally important to ensure that broad laws that unnecessarily discriminate against and target people living with HIV with criminalisation of HIV transmission, in the absence of knowledge of HIV status, intent or consideration of mitigating factors (such as a women’s real fear of violence on disclosure of HIV status) be avoided.

Recommendations

Recommendations have been made for the development of HIV and AIDS legislation in Swaziland to protect all key sectors and populations and deal with a wide range of issues.⁶¹⁷ Criminal laws that create barriers to access to services for key populations, such as sex workers and men who have sex with men, require review. All aspects of sex work and same sex relations by and between consenting adults should be decriminalised. Additionally, laws to strengthen women’s equality rights, their rights to own and inherit property and to protect them from violence should be finalised, enacted and enforced.⁶¹⁸

Efforts should also be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials. The Stigma Index study makes the following specific recommendations to strengthen access to justice and law enforcement in the context of HIV and AIDS including:

- Increasing mass media programmes to reduce stigma and discrimination amongst all populations
- Strengthening legal literacy amongst people living with HIV and AIDS
- Developing mechanisms to monitor and document HIV-related human rights violations
- Strengthen training and sensitisation of service providers to improve HIV-related health care, including counselling and psycho-social support⁶¹⁹

There is a need to introduce legislation to ensure that the Human Rights Commission becomes fully operational.⁶²⁰

⁶⁰⁸UNAIDS, Swaziland NCPI Report, 2012

⁶⁰⁹Ibid; see also NCPI Report, 2010

⁶¹⁰SWANNEPHA, Stigma Index Report: Swaziland, 2011. Available at www.stigmaindex.org [Accessed 27 July 2012]

⁶¹¹UNAIDS, Country Progress Report, 2010 at 20

⁶¹²Molathegi & Associates: Attorneys, Notaries, Conveyancers, Regulatory and International Trade Law Consultants, Final Report: Consultancy services for review for laws and policies relating to HIV/AIDS, 2005 at p.118

⁶¹³UNAIDS, Country Progress Report, 2010

⁶¹⁴UNAIDS, Swaziland NCPI Report, 2012.

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⁶¹⁵GCHL, Risks, Rights & Health at 38

⁶¹⁶UNAIDS, Swaziland NCPI Report, 2012

⁶¹⁷Ibid.

⁶¹⁸Ibid.

⁶¹⁹Stigma Index Report: Swaziland. June 2011. Swaziland Network of People living with HIV/AIDS. Available online at www.stigmaindex.org. accessed 27 July 2012

⁶²⁰UNAIDS, Swaziland NCPI Report

Key data and modes of transmission

According to UNAIDS, around 5.1% of all adults aged 15-49 years (1 200 000 people) in Tanzania are living with HIV, the majority of whom are women (730 000 women are living with HIV). Currently there are around 80 000 annual deaths from AIDS. There are 230 000 children living with HIV and 1 200 000 orphans.⁶²¹

The HIV epidemic on the Tanzanian mainland is a generalized epidemic, while in Zanzibar, the epidemic is believed to be concentrated amongst key populations. Although reliable data on the magnitude of the epidemic in key populations is scarce, some studies show that the point prevalence is larger than 12% in Zanzibar.⁶²²

Tanzania's National Multi-Sectoral Strategic Framework on HIV and AIDS 2008-2012 recognises a number of populations that are at higher risk of HIV and/or are vulnerable in the context of HIV and AIDS including women, people with disabilities, orphaned and vulnerable children, migrant populations, sex workers, men who have sex with men, prisoners and people who inject drugs.⁶²³ The NSP notes that "recent studies indicate that in some parts of the country, transmission through anal sexual intercourse (heterosexual or among men who have sex with men) as well as HIV infection through drug abuse are occurring and may be important factors for the further spread of HIV," although it acknowledges that the dimension of these infection routes is not known. According to Tanzania's 2012 NCPI report, it has not yet updated its NSP or multi-sectoral framework.

Background to HIV, Law and Human Rights

The ARASA 2009 report identified the following priority human rights issues:

- Discrimination against HIV positive people seeking employment in the military;
- Lack of access to condoms in prisons;
- Lack of legal protection to reduce the vulnerability of women to HIV;
- Use of the criminal law to "punish" people living with HIV
- Lack of access to ARV treatment; and
- Lack of legal aid to people living with HIV.

Key Human Rights Concerns In 2014

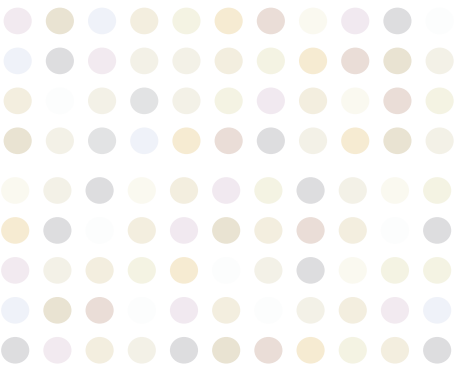
Stigma and discrimination: People living with HIV report stigma and discrimination at the family, workplace and community level and in terms of accessing health care and social services. The National Strategic Framework recognises that this creates a barrier to the response for people living with HIV; it also identifies stigma and discrimination (to a lesser extent) as impacting on key populations, and in particular on women and girls.⁶²⁴

⁶²¹Available at <http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania/> [Accessed 4 May]

⁶²²UNAIDS, Country Situation Analysis Available at <http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania/> [Accessed 27th September 2012].

⁶²³UNAIDS, Tanzania NCPI Report, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Tanzania%20NCPI%202012.pdf>. See also submission by EALCO Advocates, Africa Regional Dialogue on HIV and the Law, 4 August 2011. Available at www.hivlawcommission.org [Accessed 14 August 2012]

⁶²⁴National Strategic Multi-Sectoral Framework on HIV and AIDS 2008-2012



1 200 000
of all adults aged
15-49 years are
living with HIV.

A recent study in
Dar es Salaam
estimated HIV
prevalence
amongst people
who inject drugs
to be around
42%

“The stigma associated with HIV as well as discrimination against and denial by people living with HIV remains one of the strongest barriers against successful interventions. They prevent open and informed discussion about issues related to sexuality and transmission of HIV. They marginalise and exclude people from communities and families, creating unnecessary suffering by those infected. Stigma, denial and discrimination also appear to be major drawbacks to access HIV services, including lifesaving antiretroviral treatment”⁶²⁵

People living with HIV have access to ART, but those who are poor have limited access to food for nutrition; this impacts on their health outcomes. Government employees are provided with food allowances alongside ART, which has resulted in an outcry amongst the broader population.⁶²⁶

Women’s rights: Women in Tanzania are vulnerable to HIV and AIDS because of gender inequality, limited rights to land, property and inheritance in terms of religious and customary laws and practices, harmful gender norms such as early marriage, widow cleansing, wife inheritance, polygamy and FGM as well as gender-based violence, including sexual violence.⁶²⁷ The National Strategic Framework recognises that due to their subordinate social, cultural and economic position, women are often unable to protect themselves from HIV exposure due to unsafe sex and survival sex.⁶²⁸ They are also often unable to refuse practices such as wife inheritance despite the fact that the practice may increase the risk of HIV transmission.⁶²⁹

Women with HIV also report HIV-related discrimination and human rights violations. They report being tested for HIV without their consent and being stigmatised and abused by partners, including being evicted from their homes, as a result of their HIV status; women complain of being unable to access justice for these violations from the courts.⁶³⁰

“Women may be aware of risk reduction measures but often lack realistic capacity to put them in practice...The socio-cultural reality where men control sexual decision making, often resulting in coercive sex and sexual violence and necessitates interventions to strengthen women’s sexual negotiation skills be conducted concurrently with men, or for girls and boys”⁶³¹

Rights of people who inject drugs: A recent study in Dar es Salaam estimated HIV prevalence amongst people who inject drugs to be around 42%. Despite their high risks of HIV exposure, there is limited provision for harm reduction measures and rehabilitation of people who use drugs.⁶³² The Tanzanian government has allowed Medicines du Monde to establish a needle exchange programme in Dar es Salaam and to train police officers about harm reduction. The government has also established two methadone clinics in Dar es Salaam. There are currently no similar initiatives in Zanzibar, although recently the President of Zanzibar has spoken publicly about the need to better support drug users and provide them with services⁶³³. Criminal laws continue to create barriers to the development of organisations to support people who inject drugs as well as the provision of services, including HIV-related prevention, treatment, care and support services.⁶³⁴

Rights of sex workers: Sex workers are at high risk of HIV as a result of unprotected sex, yet there are limited programmes targeting their specific HIV-related health needs. Living off the earnings of sex work is prohibited in Tanzania and as a result sex workers are stigmatised and discriminated against.⁶³⁵ A recent study funded by the World Bank reported high levels of abuse and violence against sex workers.⁶³⁶

⁶²⁵Ibid.

⁶²⁶EALCO Advocates Company Ltd, Tanzania; LAHR Consult Company Ltd, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011.

⁶²⁷See, for instance various submissions made to the Global Commission on HIV and the Law including LAHR Consult Company Ltd, Tanzania; EALCO Advocates Company Ltd, Tanzania; Tanzania Women Lawyers Association, Tanzania; Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011. Available at www.hivlawcommission.org [Accessed 14 August 2012]

⁶²⁸AIDS Alliance, Desk Review of NSPs in East and Southern Africa, 2011

⁶²⁹Submission by the Tanzania Women Lawyers Association to the Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011.

⁶³⁰Submissions by Tanzania Network of Women Living with HIV or AIDS, Tanzania; HUVUMAFO, Tanzania; LAHR Consult Company Ltd, Tanzania; Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011. Available at www.hivlawcommission.org

⁶³¹National Strategic Multi-Sectoral Framework on HIV and AIDS 2008-2012

⁶³²National Strategic Framework on HIV and AIDS 2008-2012

⁶³³Human Rights Watch, Treat Us Like Human Beings: Discrimination against SW, Sexual and Gender Minorities and People Who Use Drugs in Tanzania, June 2013, available at <http://www.hrw.org/reports/2013/06/18/treat-us-human-beings-0> p.7

⁶³⁴Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011. Available at www.hivlawcommission.org

⁶³⁵Submission by Studio Calabash Ltd, Tanzania; Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011.

⁶³⁶Kerrigan, The Global HIV Epidemics Amongst SW, 2012

Rights of men who have sex with men: Tanzania has strict laws criminalizing consensual sex between men, with penalties of up to 30 years imprisonment. Zanzibar criminalises consensual sex between men, and also “unions” between same sex partners.⁶³⁷ Human Rights Watch reported that “arrests, violence and harassment of LGBTI people are common, especially of men who have sex with men”⁶³⁸

Workplace rights: Employees report HIV-related discrimination within the working environment including pre-employment HIV testing and dismissals, without reasonable accommodation, when ill.⁶³⁹

Rights of other marginalised populations: Refugees, displaced persons, people with disabilities and prisoners are all recognised as being vulnerable to HIV yet they have limited access to services. Prisoners are not provided with HIV prevention, treatment, care and support services; they do not have access to HIV testing services and there are no prison policies or programmes to deal with HIV and AIDS in prisons.⁶⁴⁰

Prison conditions are poor, with severe over-crowding, inadequate food and lack of access to health care. The most common health complaints for prisons include malaria, TB and HIV.⁶⁴¹

Legal Framework for HIV and AIDS

National Laws and Policies

Tanzania is characterized by a pluralistic legal system where statutory, Islamic, Hindu and customary laws operate simultaneously.

There are various protections in law for the equality rights of people in the context of HIV and AIDS. The Constitution of the Republic of Tanzania, 1977 recognises that all people are equal and that nobody should be discriminated against.⁶⁴²

Specific protection of the rights of people in the context of HIV and AIDS is furthermore provided for in law and in policy. The National HIV Policy of 2001 and the National Multi-Sectoral Strategic Framework for HIV and AIDS both recognise the importance of rights-based responses to HIV and AIDS. The HIV and AIDS Prevention and Control Act, 2008 specifically protects people from HIV-related human rights violations in Tanzania.

In Zanzibar⁶⁴³ the HIV and AIDS Prevention and Management Bill (2011) is largely supportive of the human rights of people living with HIV but has not yet become law. It includes a general prohibition on discrimination (direct or indirect) on the grounds of HIV status, including perceived status. Part V of the bill elaborates on this general prohibition and includes sections that elaborate on the forms of discrimination occurring in employment, educational and health care settings, in relation to access to credit and insurance services and with regard to travel into and out of Zanzibar, and explicitly outlaws such conduct.

The Bill provides for confidential HIV testing, informed consent and prohibits unlawful disclosure of HIV status. It provides special protection for the rights of children and permits children above the age of 15 to undergo HIV testing without parental consent, providing they are mature enough to understand the consequences of their decision.

It is not yet clear when the Bill will become law.

In the health sector, the National Health Policy, 2001 protects the right to HIV testing only with voluntary and informed consent and health policy provides for access to HIV-related prevention, treatment, care and support services, including ART.

⁶³⁷Human Rights Watch, Treat Us Like Human Beings: Discrimination against SW, Sexual and Gender Minorities and People Who Use Drugs in Tanzania, June 2013, available at <http://www.hrw.org/reports/2013/06/18/treat-us-human-beings-0>

⁶³⁸Ibid. p 7

⁶³⁹Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011

⁶⁴⁰Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August 2011

⁶⁴¹Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Tanzania, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [Accessed on 23 September 2013]

⁶⁴²Article 2

⁶⁴³Zanzibar is a semi-autonomous part of Tanzania with its own government. It is permitted to make laws.

Employees with HIV are protected from HIV-related discrimination in terms of the Employment and Labour Relations Act, 2004. The HIV policy reiterates that no person should be denied employment on the basis of his or her HIV status.⁶⁴⁴

Women are protected in law in various ways:

- The enactment of the Land Act, 2002⁶⁴⁵ provides for gender equality in ownership, access and control over land.
- The Law of Marriage Act 5, 1971 prohibits corporal punishment of a spouse (although the Penal Code fails to create corresponding punishments and legal redress for domestic violence).
- The Sexual Offences Sexual Provisions Act (SOSPA)⁶⁴⁶ contains various protections for women against harmful gender norms and gender-based violence. It increases the age of consent to sex to 18 years (although the Law of Marriages Act provides for a 15 year old to consent to marriage), protects women against marital rape by a husband whom they are separated from, recognises sexual harassment as a punishable offence and includes protection of children by their guardians.
- The Penal Code (as amended by Section 5 of the Sexual Offences Special Provisions Act) makes it an offence to rape a girl or woman who is not the offender's wife or who is separated from the offender at the time of the sexual intercourse and does not provide consent.⁶⁴⁷ In addition, the Law of Evidence Act and the Criminal Procedures Act were amended in 1998 to protect women and children's rights in respect of sexual related issues, including sexual harassment.
- The Penal Code criminalises female genital mutilation.
- The Anti-Trafficking in Persons Act, 2008 protects people from human trafficking.
- The National Strategic Framework on HIV and AIDS includes a strong focus on the needs of women and girls, and makes provision for various strategies to promote equitable access to prevention, treatment, care and support and to provide for the sexual and reproductive health rights of women and girls including programmes aimed at addressing gender inequality and gender-based violence, information and education on HIV, sexuality and reproductive health targeting women and young girls; the provision of PEP, emergency contraception and the presumptive treatment of STIs and eMTCT, amongst others.⁶⁴⁸

Other key populations at high risk of HIV are specifically provided for in the National Multi-Sectoral Strategic Framework on HIV and AIDS. It includes programmatic interventions for all recognised affected populations and in particular for people who inject drugs and prisoners. In particular, it provides for increased access to HIV prevention information and services for vulnerable populations, targeted prevention services for sex workers and men who have sex with men, to make condoms available for and to address sexual abuse amongst prisoners, and to develop a comprehensive strategy for prevention with people who inject drugs including education, condom provision, harm reduction programmes such as needle exchange and rehabilitation services.⁶⁴⁹

Children are recognised as a vulnerable population by the NSF which includes strategies to review and strengthen legal and social protection for orphaned and vulnerable children as well as strategies to mitigate the impact of HIV. The National Health Policy, 2001 makes provision for youth friendly services to provide access to reproductive health information and services in and out of schools, voluntary HIV testing and pre-and-post-test counselling of the parents or guardians of minors and protection for the confidentiality and privacy rights of adolescents.

Ratification of International and Regional Human Rights Instruments

Tanzania has ratified:

- African Charter on Human and Peoples' Rights, 1984
- African Charter on the Rights and Welfare of the Child, 2003
- Convention on the Rights of the Child (CRC), 1991
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1985
- Convention on the Rights of people with disabilities, 2009

⁶⁴⁴UNAIDS, NCPI Report, 2012.

⁶⁴⁵Cap 113 R.E.

⁶⁴⁶Cap 4 of Revised Edition of the Laws of Tanzania, 2002

⁶⁴⁷Section 130

⁶⁴⁸AIDS Alliance, Desk Review of NSPs in East and Southern Africa, 2011

⁶⁴⁹Ibid.

- International Convention on Economic, Social and Cultural Rights (ICESCR), 1976
- International Convention on Civil and Political Rights (ICCPR), 1976
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2007

Access to Justice and Law Enforcement

There are various mechanisms, institutions and organisations to provide for access to justice and law enforcement in Tanzania. There are national institutions to protect and promote human rights, programmes to reduce stigma and discrimination, gender inequality and GBV, programmes to educate and raise awareness amongst people living with HIV and key populations as well as programmes for members of the judiciary and law enforcement on HIV and human rights. In general, there appears to be an increased understanding of the basic HIV, human rights and gender issues amongst populations.

There are also university-based legal aid systems for HIV-related case work and other legal support services as well as various civil society organisations that support access to justice in the context of HIV and AIDS.

However, there is a limited understanding of the HIV-related human rights of key populations. There is also no right to legal assistance in Tanzania and free legal assistance is usually provided by a few independent non-governmental organisations. The Tanzanian government has no legal assistance scheme and does not provide financial support to those organizations providing this service.⁶⁵⁰ Vulnerable populations like women report being unable to use the system to access justice for human rights violations⁶⁵¹ and to enforce laws. In addition, the Basic Rights and Duties Enforceability Act enforces some, but not all constitutional rights.⁶⁵²

Religious and cultural belief, norms and values towards basic human rights principles create barriers to access to justice for human rights violations.⁶⁵³

Gaps and Challenges

Challenges in access to justice have been discussed above. Other challenges in law and policy include the following, set out below.

Although the HIV and AIDS Prevention and Control Act contains protections against HIV-related discrimination, it also contains various challenges:

- The Act criminalises the wilful transmission of HIV. It provides that whoever wilfully transmits HIV to another person intentionally commits an offence. The negative impact of this provision on the response to HIV was noted in a number of recent submissions to the GCHL in 2011 in terms of discouraging access to HIV testing and health care, targeting populations such as people living with HIV and sex workers and disproportionately impacting on women who test for HIV more often than men.⁶⁵⁴
- The HIV and AIDS Act, 2008 contains no provision for the economic social and cultural rights of people living with HIV or AIDS.
- The Act does not protect women from abuse on disclosure of their HIV status to their spouse.⁶⁵⁵

Despite protection in law for women's rights, there are still numerous inadequacies and challenges remaining. In particular, women are not adequately protected from discriminatory customary and religious laws and practices that place them at higher risk of HIV exposure and that deny them equal rights to own and inherit property. The most discriminatory laws in Tanzania are inheritance laws which are governed by statutory, Islamic and customary laws.

The majority of the population is subject to customary laws of inheritance that discriminate against women by depriving them of their rights to inherit properties or allowing them to inherit only the use of or a small share of the estate in

⁶⁵⁰Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011.

⁶⁵¹Submission by Tanzania Network of Women Living with HIV or AIDS, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁶⁵²Submission by EALCO Advocates Company Ltd, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁶⁵³Ibid. See also UNAIDS, NCPI Report, 2012

⁶⁵⁴Submission by Legal Aid Clinic, Tanzania; EALCO Advocates Company Ltd, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁶⁵⁵Submission to African Regional Dialogue, Pretoria, 3-4 August 2011; available at www.hivlawcommission.org

preference to male heirs. Despite judges having declared the Customary Law (Declaration Order) to be discriminatory and unconstitutional in the case of *Bernado Ephrahim vs Holaria Pastory and Gervas Kaizilege* (1989)HC (PC) Case No 10 1980, the law remains unchanged. In the case of *Elizabeth Stephen & Salome Charles V Attorney General*⁶⁵⁶ the court found the customary Law of the Sukuma people to be discriminatory but failed to declare it unconstitutional.

A widow may retain some rights to the marital home (but without control over the landed property) if she agrees to be inherited in terms of Rule 62; this was confirmed by the courts in the case of *Scolastica Benedict v Martin Benedict* (1978) LRT No.49 where the court ordered the widow to vacate the matrimonial home if she was not inherited. Rule 20 provide for that a woman can inherit in terms of usufruct only until she remarries or dies. Wife inheritance, while originally aimed to protect the deceased’s family, is recognised as a harmful practice that not only degrades women but also places them at higher risk of HIV exposure.⁶⁵⁷

Islamic laws of inheritance apply to those who follow the Islamic religion during their life and intend that Islamic law be applicable in the administration of their estate. These laws also discriminate against women and girl children. The widow’s share of the deceased estate is 1/8 if the deceased left children and ¼ of the estate if no children are left by the deceased. The remaining share of the estate is divided between heirs in the ratio of 1 share to females and 2 shares to males.⁶⁵⁸

Criminal laws such as those that criminalise same-sex sexual behaviour, sex work and injecting drug use create barriers to access to services for affected populations. The Tanzania Penal Code criminalises sex between men and makes it illegal for people to live on the earnings of prostitution. Laws criminalising drug use make needle exchange programmes difficult to implement and create fear amongst drug users in accessing services. As a result, user-friendly services are not available for criminalised populations and the stigma and discrimination they experience discourages them from coming forward.⁶⁵⁹

Even though Tanzania labour laws guarantee people living with HIV the right not to be discriminated against in the world of work, the law does not fully protect their right to remain at work. The law gives employers the right to terminate an employee’s employment provided that they pay them proper terminal benefits and does not address “reasonable accommodation” of employees with HIV.⁶⁶⁰

Tanzania’s Child Development Policy (CDP) emphasises the basic rights of the child. It outlines various causes of vulnerability amongst children including poverty, access to essential services, gender discrimination, the denial of girl’s human rights, exploitation and abuse including sexual exploitation and abuse. The policy proposed a review of existing legislation to ensure all children’s laws were aligned to promote the rights of the child. In 2009, Tanzania passed the Children’s Act, and Zanzibar followed suit in 2011, passing its own legislation on children’s rights. Although both acts have introduced positive reforms to protect children, gaps remain, including the fact that child marriage is still recognised in the Tanzania law (where girls may marry at the age of 15 with the consent of parents or guardian, except if they are orphaned in which case, no consent is required).

The NSF recognises the need to strengthen the legal and regulatory framework and emphasises the need for a legislative review of all HIV-related laws and policies. It provides for law review and advocacy for the enactment of laws and regulations (e.g. inheritance rights, gender based violence, property laws, marriage laws, workplace regulations, employment laws, child welfare laws and insurance laws) aimed at enhancing a gender sensitive approach to and human rights for people infected and affected by the epidemic. It identifies various laws and policies in need of review and possible reform including:

- The decriminalisation of the activities of sex workers and men who have sex with men
- Land and housing laws, to allow women, children and orphans greater access to security of tenure
- Socio-cultural practices (e.g. circumcision, mourning days and wife inheritance) to enhance prevention efforts
- Welfare laws to protect orphaned and vulnerable children and to enable effective impact mitigation strategies
- Workplace laws to protect workers

⁶⁵⁶High Court Misc. Civil Cause No. 82 of 2005

⁶⁵⁷Tanzania Women Lawyers Association, Tanzania; Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁶⁵⁸Ibid.

⁶⁵⁹UNAIDS, NCPI Report, 2012.

⁶⁶⁰Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011

- Marriage laws to reduce gender inequality
- Laws to protect women from gender-based violence
- Harmonisation of laws relating to children
- Investigating a means to expand insurance coverage and the range of insurance services for those who are HIV positive in the formal sector.⁶⁶¹

Recommendations

Review all laws and policies identified for review in the NSF to strengthen the legal and regulatory framework for HIV and AIDS including, amongst others:

- Review the Law of Marriages Act to harmonise provisions on age of consent to marriage with those set out in the SOSPA Act
- Strengthen protection against marital rape
- Provide for post-exposure prophylaxis (PEP), emergency contraception, presumptive treatment of STI, counseling, legal support and protection for those who have been raped, including for sexually abused children and for women in abusive and forced marriages
- Review laws criminalizing key populations to ensure they are protected and able to access HIV-related health care services
- Decriminalise same sex relations and all aspects of sex work by and between consenting adults
- Decriminalise possession of drugs for own use
- Review the provisions within the HIV and AIDS Act criminalizing HIV transmission
- Review inheritance laws that discriminate against women and sensitise the judiciary on the impact of discriminatory inheritance laws on women’s development
- Review employment laws to provide for reasonable accommodation of people who are ill, such as employees with HIV with opportunistic infections
- Include protection in law and policy for access to education for orphaned and vulnerable children
- Strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials⁶⁶²

⁶⁶¹AIDS Alliance, Desk Review of NSPs in ESA, 2011

⁶⁶²AIDS Alliance, Desk Review of NSPs in ESA, 2011; Legal Aid Clinic, Tanzania; Tanzania Women’s Lawyers Association, Tanzania; Studio Calabash Ltd, Tanzania; Africa Regional Dialogue on HIV and the Law, 4 August 2011



Key data and modes of transmission

UNAIDS states that 7.2% of adults in Uganda between the ages of 15 – 49 are living with HIV. This includes 780 000 women, more than half of adults living with HIV. The HIV prevalence rate amongst women between the ages of 15 – 49 is 7.7% while in men of the same age, it is 5.6%.⁶⁶³ There are 1 million orphans and 190 000 children living with HIV. There were 63 000 AIDS related deaths.⁶⁶⁴

Uganda has a predominantly heterosexual epidemic, with 80% of infections attributable to heterosexual transmission. Mother to child transmission accounts for 20% of new HIV infections; this is a significant portion of transmission. Risk factors for HIV include multiple concurrent partnerships, HIV sero-discordance, inconsistent condom use, sexually transmitted infections and lack of male circumcision.

Background to HIV, Law and Human Rights

Uganda was not included in the ARASA 2009 report.

Key Human Rights Concerns in 2014

The revised National Strategic Plan 2011/12 – 2014/15 identifies vulnerable populations as including internally displaced persons (IDPs), fishing communities, sex workers, prisoners, uniformed forces, mobile populations and migrant populations, people with disabilities and motor cycle riders. Men who have sex with men, people who inject drugs and sex workers are not specifically targeted for HIV intervention because they are criminalised in law.⁶⁶⁵ The revised NSP is guided by a set of principles to inform HIV programming – these include non-discrimination in access to HIV/AIDS services, GIPA, a human rights based approach and gender sensitivity.

Key human rights issues include:

Stigma and discrimination: Stigma and discrimination against people living with HIV is common.⁶⁶⁶ Uganda launched its first Stigma Index in October 2013, the People living with HIV Stigma Index Report 2013, which surveyed over 1000 people living with HIV in 18 districts in Uganda. Nearly half the respondents state that they experienced verbal abuse, harassment and threats as a result of their HIV status. The report showed that the most common form of stigma included gossip, verbal insults and threats, with 60% of respondents “convinced that they had been gossiped about at least once in the preceding year”.⁶⁶⁷ The index showed high levels of discrimination in the workplace, with respondents reporting experiencing discrimination at the hands of co-workers

7.2% of adults aged 15-49 years are living with HIV.

Uganda has a predominantly heterosexual epidemic, with 80% of infections attributable to heterosexual transmission

⁶⁶³UNAIDS, Country Progress Report, Uganda, Jan 2010 – Dec 2012; p 2

⁶⁶⁴Available at <http://www.unaids.org/en/regionscountries/countries/uganda/>; [Accessed on 11 April 2014]

⁶⁶⁵UNAIDS, NCPI 2012 p 8 available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Uganda%20NCPI%202012.pdf>

⁶⁶⁶Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Uganda, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [Accessed on 24 April 2014]

⁶⁶⁷All Africa, Uganda: People with HIV Reveal Rampart Stigma in New Study, 6 November 2013 available at <http://allafrica.com/stories/201311071365.html>

and employers, losing their jobs and income and changes to their job descriptions. In 2012, a primary school teacher, Florence Najjumba, was fired when she disclosed her HIV status.⁶⁶⁸

Respondents also reported high levels of stigma in their personal lives, with 21% experiencing sexual rejection in the previous year and 41% being excluded from various family activities. Over 20% report being assaulted.

The Stigma Index concludes that stigma and discrimination are major barriers to HIV testing and disclosure of HIV status.

Gender-based violence: GBV is a significant problem in Uganda and includes sexual abuse of children, rape, intimate partner violence, defilement, incest, sexual assault and harassment and trafficking of women and girls. The 2011 Uganda Demographic Health Survey found that 27% of women and girls between the ages of 15 and 49 had experienced some form of domestic violence in the year prior to the survey and 56% of married women reported experiencing some form of domestic violence during their marriage. Women and girls who have experienced sexual violence often face stigma from their families and communities,⁶⁶⁹ and rape and other forms of sexual violence remain seriously underreported.⁶⁷⁰ A 2012 report from the Centre for Basic Research confirmed the high levels of violence against women and also found that 23% of their respondents had been forced into marriage.

Women’s rights: Female genital mutilation is prohibited by law, but some groups continue to practice it. The US State Department’s Annual Human Rights Report indicated that 120 women were cut in 2012.⁶⁷¹

Although the Constitution provides for equality between men and women, women experience discrimination in many areas of their lives, including in marriage, divorce, child custody and inheritance. Customary, religious and traditional practices such as widow inheritance and polygamy discriminate against women and increase their risk of HIV transmission.

Rights of LGBTI: Uganda’s President Museveni signed the controversial Anti-Homosexuality Law in February 2014. The law increases the penalty for same-sex sexual conduct to life imprisonment. It also criminalises “attempts” to commit homosexuality, which carries a 7 year terms of imprisonment. The law includes far-reaching provisions that criminalise the “promotion of homosexuality”.

LGBTI persons experience high levels of stigma and violations of their human rights at the hands of government and individuals. A prominent LGBTI activist, David Kato was murdered in 2011. In November 2012, the government banned 38 NGOs accused of promoting homosexuality and the police broke up a workshop on LGBTI rights in the same month. Since the passage of the bill into law, LGBTI people have reported an increase in rights abuses, including arbitrary arrests, police abuse and extortion, loss of employment and eviction. Many have had to flee the country.⁶⁷² Activists also report the deliberate outing of gay men in the media leading to their loss of employment, assaults and verbal abuse.⁶⁷³

LGBTI persons are subject to human rights violations that increase their risk and vulnerability to HIV: lesbians report being subjected to sexual violence to “make them straight”⁶⁷⁴, and “LGBTI persons were subject to societal harassment, discrimination, intimidation, and threats to their well-being and were denied access to health services”.⁶⁷⁵

Prisoner’s rights: Prison conditions, including severe over-crowding and inadequate access to health care, undermine the rights of prisoners living with HIV. Prisons outside the capital, Kampala, lack food, water and medical care and sanitation conditions are inadequate. NGOs reported that many HIV-positive inmates in prison did not have adequate access to antiretroviral medication, especially in rural areas, and that prison officials sometimes subjected HIV-positive inmates to hard labour.⁶⁷⁶

⁶⁶⁸ Ibid.

⁶⁶⁹ Mukasa, Stella and others, *HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment*, 2008, p.25

⁶⁷⁰ Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Uganda*,

⁶⁷¹ Ibid

⁶⁷² See for example: Human Rights Watch, *Anti Homosexuality Act’s Heavy Toll*, 15 May 2014, available at <http://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-act-s-heavy-toll>

⁶⁷³ See for example: CBC News, *WorldPride 2014: A gay rights activist on being outed in Uganda*, 20 June 2014, available at <http://www.cbc.ca/news/canada/worldpride-2014-a-gay-rights-activist-on-being-outed-in-uganda-1.2681185>

⁶⁷⁴ Mukasa, Stella and others, *HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment*, 2008, p.24

⁶⁷⁵ Department of State, Bureau of Democracy, Human Rights and Labour, *Uganda*

⁶⁷⁶ Department of State, Bureau of Democracy, Human Rights and Labour, *Uganda*

Rights of Sex workers: Sex work is illegal in Uganda. As a result sex workers are abused and exploited and although many criminal acts are committed against them, they have limited access to justice. Sex workers report being subjected to arbitrary arrests, sexual and exploitation and extortion at the hands of police officials. Sex work in Uganda is a highly stigmatized occupation and cultural attitudes towards sex work and sex workers are predominantly negative and conservative. According to the 2009 report of the Uganda AIDS Commission, the rate of infections among sex workers significantly higher than in the general population. Sex workers lack information concerning where to go for treatment of HIV and other STIs, the skills to negotiate with their clients for safer sex, or an adequate supply of condoms. Sex workers also do not seek services, because of the criminalised nature of their work and the negative attitude of the health workers towards them. More than 90% of female sex workers in Uganda report having been raped in the past year. The illegal status of sex work makes it difficult to punish perpetrators of violence.⁶⁷⁷

Legal framework for HIV and AIDS

Constitution

The Constitution of the Republic of Uganda (1995) does not explicitly mention HIV and AIDS, despite the country recognising the gravity of the AIDS epidemic a decade before the Constitution was adopted.⁶⁷⁸ The Constitution prohibits discrimination on the grounds of sex, race, colour, ethnic origin, tribe, birth, creed, religion, social or economic standing, political opinion and disability. Health and HIV status are not included amongst the prohibited grounds for discrimination. The Constitution provides for the protection of the rights to life, personal liberty and privacy of the person, home and property. Torture and cruel, inhuman and degrading treatment is also prohibited. Article 23 of the Constitution provides for the limitation of the right to personal liberty in the interests of public safety, including for “the purpose of preventing the spread of an infectious or contagious disease”.

National Laws and Policies

Uganda’s Parliament passed the HIV Prevention and Control Act on 13 May 2014 and at the time of writing it is awaiting assent by the President. The Act been criticized by AIDS activists⁶⁷⁹ and the Uganda AIDS Commission has written to the President to ask him not to assent to the act in its current form.⁶⁸⁰ Provisions that have raised particular concerns are those that provide for compulsory HIV testing and disclosure and criminalisation of HIV transmission.⁶⁸¹ The Act places an obligation on every person “to take reasonable steps and precaution to protect him or herself and others from HIV transmission”.⁶⁸² Failure to comply with these provisions constitutes a criminal offence. The Act makes provision for voluntary testing⁶⁸³ although consent may be dispensed with where it is unreasonably withheld. Compulsory testing is mandated of any person convicted of a drug abuse or in possession of drug paraphernalia; charged with a sexual offence or convicted of sex work.⁶⁸⁴ Routine testing, which is not defined, is provided for victims of sexual offences and pregnant women and their partners. The Act also criminalises intentional HIV transmission and imposes a life sentence on anyone who is found guilty of such an offence. Use of a condom constitutes a defence in cases of wilful transmission.⁶⁸⁵ Finally, the Act prohibits discrimination on the basis of HIV status in the workplace,⁶⁸⁶ schools,⁶⁸⁷ health institutions⁶⁸⁸ and in access to credit and insurance.⁶⁸⁹ It also outlaws restrictions of travel and habitation.⁶⁹⁰

The first Stigma Index report for Uganda showed that discrimination in the workplace is a significant concern. The Equal Opportunities Act (2007) and the Employment Act (2006) provide some protection for employees living with HIV.

⁶⁷⁷ *Submission to Africa Regional Dialogue on HIV and the Law: Alliance for Integrated Development and Empowerment-AIDE*, Pretoria, 3-4 August 2011. Available at www.hivlawcommission.org

⁶⁷⁸ Mukasa, Stella and others, *HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment*, 2008, p.24

⁶⁷⁹ See: Human Rights Watch, *Uganda: Deeply Flawed HIV Bill Approved*, 14 May 2014, available at <http://www.hrw.org/news/2014/05/13/uganda-deeply-flawed-hiv-bill-approved>

⁶⁸⁰ All Africa, *Opposition Against Uganda HIV Bill*, 16 June 2014, available at <http://allafrica.com/stories/201406170061.html>

⁶⁸¹ The New Vision, *Activists want HIV/AIDS Bill 2010 amended*, 16 January 2014, <http://www.newvision.co.ug/news/651503-activists-want-hiv-aids-bill-2010-amended.html>; IPS, *Uganda Passes Another Repressive Law – This Time Criminalising HIV Transmission*, 15 May 2014, <http://www.ipsnews.net/2014/05/uganda-passes-another-repressive-law-time-criminalising-hiv-transmission/>

⁶⁸² HIV Prevention and Control Bill 2010, article 3

⁶⁸³ Article 10

⁶⁸⁴ Article 13

⁶⁸⁵ Article 40

⁶⁸⁶ Article 32

⁶⁸⁷ Article 33

⁶⁸⁸ Article 37

⁶⁸⁹ Article 36

⁶⁹⁰ Article 34

Although the Equal Opportunities Act does not specifically include HIV as a prohibited ground of discrimination, it outlaws discrimination on the grounds of health status which could include HIV and AIDS. The Employment Act explicitly prohibits discrimination on the grounds of HIV/AIDS. The act also prohibits sexual harassment in the workplace, but only between employer and employee.

The Penal Code was amended in 2006, introducing a new offence of aggravated defilement. The offence includes situations where a victim is below the age of 14, and the accused was aware of his HIV status. The Code also criminalises being “idle and disorderly”, a provision that is often used to arrest sex workers.

The Anti-Homosexuality Act was passed into law in February 2014. The act does not explicitly refer to HIV, but it increases the penalties for same-sex sexual conduct and introduces new offences such as the promotion of homosexuality. There are serious concerns that the new law will undermine access to universal treatment, care and support for LGBTI persons and drive them away from critical prevention interventions.

The Public Health Act Cap 281 does not specifically mention HIV, but has provisions on infectious diseases. Uganda passed an Industrial Property Act in 2014 which incorporates a number of public health sensitive flexibilities to increase access to medicines in Uganda. It also has a range of HIV-specific policies, several of which go further than the laws described above to promote a human rights based approach to the national response:

- The National Health Policy (1999) recognises HIV as a major cause of morbidity in Uganda. The prevention and control of HIV/AIDS is included in the minimum health care package.
- The National Policy Guidelines for Voluntary HIV Counselling and Testing⁶⁹¹ provide that consent should be required for HIV testing, regardless of the reason for testing, and testing should be accompanied by a package of supportive services, including counselling. The guidelines contain special provisions for the testing of children, emphasizing the best interests of the child and their human rights. These guidelines were amended and integrated into the National Policy Guidelines for HIV testing in 2005. The policy includes VCT, but also provides guidance on routine testing and home-based counselling and testing.
- The Antiretroviral Treatment Policy⁶⁹² takes a human rights based approach to treatment and is guided by the principle of universal access. It makes provision for certain groups to be prioritised for free ARV treatment, including pregnant women with HIV and their families, infants and children, people living with HIV and enrolled in support and care activities and people living with HIV involved in research.
- The Policy for Reduction of the Mother-to-Child HIV Transmission (2003) includes provisions on treatment, VCT, breastfeeding and STI diagnosis and treatment. It states that women should receive non-judgemental and non-directive support, but does not explicitly address stigma against pregnant women in health settings.
- The National Policy on HIV/AIDS and the World of Work (2003) is guided by human rights and provides for non-discrimination on the basis of actual or perceived HIV status in recruitment, termination, deployment, transfers, grievance and disciplinary measures and payment of benefits. It prohibits employment related testing and protects the confidentiality of employees.
- The National Safe Male Circumcision Policy (2010) is guided by human rights principles and promotes circumcision for men with informed consent, privacy, non-discrimination, confidentiality and absence of coercion.

Ratification of International and Regional Human Rights Instruments

Uganda has ratified:

- African Charter on Human and Peoples’ Rights, 1986
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1985
- Convention on the Rights of People with Disabilities, 2008
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1987
- International Convention on Civil and Political Rights (ICCPR), 1995
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2010
- African Charter on the Rights and Welfare of the Child, 1994

⁶⁹¹Developed in 2003

⁶⁹²2003

Access to Justice

Uganda’s 2012 National Commitments and Policies Instrument acknowledges that implementation of laws and policies is weak.⁶⁹³ The major institutions responsible for implementation are the courts and the police and the NCPI describes their response as “inadequate”.⁶⁹⁴ Illiteracy and poverty are also barriers to enforcement and access to justice.⁶⁹⁵

Other justice mechanisms include:

- Uganda Human Rights Commission – the commission is largely independent from government, although the President appoints the seven member board. The commission is empowered to investigate human rights violations and award compensation to victims. The US State Department’s Human Rights Report for Uganda stated that the commission’s resources were inadequate to investigate all complaints received.⁶⁹⁶ The commission did intervene in the case of the teacher who was dismissed when she disclosed her HIV status.
- Programmes to educate and raise awareness amongst people living with HIV and key populations about their rights in the context of HIV;
- Training for the judiciary and law enforcement on HIV and human rights;
- Legal aid programmes for HIV case work;
- Private law firms and university law clinics that offer free or reduced cost legal services in connection with HIV.

A country assessment of HIV, human rights and legal services, conducted in 2008, concluded however that the “vast majority of cases of human rights abuses linked to the HIV epidemic in Uganda are endured in silence and ultimately coupled with the denial of justice.”⁶⁹⁷ Research conducted for this report confirms that access to justice remains a major challenge for victims of HIV-related human rights violations.

Gaps and Challenges

The passing of the Anti-Homosexuality Act in 2014 represents a fundamental challenge to protecting the human rights of LGBTI persons and ensuring that they are able to access appropriate HIV prevention, treatment and care. The further criminalisation of same sex sexual conduct and the significantly increased penalties for those convicted will drive LGBTI persons underground and away from services and support. The criminalisation of the “promotion of homosexuality” will prevent civil society from providing health related information to LGBTI persons. Given the current lack of information about HIV prevalence amongst men who have sex with men and other key populations, the law represents a serious setback in the national response to HIV and AIDS.

The HIV Prevention and Control Act will also require significant revision if it is to be passed into law in a version that will advance human rights and universal access.

Although rape, including marital rape, is criminalised, laws are “inconsistently”⁶⁹⁸ enforced, and rape remains a seriously under-reported crime. The police lack the capacity to investigate sexual violence, including the collecting and analysing of forensic evidence.⁶⁹⁹ Domestic violence laws are also inadequately enforced. In 2013, 154 cases of domestic violence were reported, despite the high levels of violence reported in the 2011 DHS.⁷⁰⁰ In addition to gender based violence, women also face widespread discrimination, especially in rural areas. Although the Constitution guarantees gender equality, customary laws and practices undermine women’s equality, especially in relation to marriage, divorce, child custody and inheritance. Polygamy and widow inheritance are legal under customary and Islamic laws.

Uganda has high levels of child abuse and similar to gender based violence, laws are not adequately implemented and cases of sexual violence against girls are under-reported. Birth registration also remains a challenge: only 29% of rural births and 38% of urban births are registered.⁷⁰¹ Although lack of registration does not undermine children’s access to

⁶⁹³NCPI 2012 p 17

⁶⁹⁴Ibid.

⁶⁹⁵Ibid.

⁶⁹⁶Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Uganda

⁶⁹⁷Mukasa, Stella and others, HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment, 2008, p.29

⁶⁹⁸Department of State, Bureau of Democracy, Human Rights and Labour, Uganda

⁶⁹⁹Ibid.

⁷⁰⁰Ibid

⁷⁰¹Ibid

services, it does weaken efforts to eradicate child marriage. The current minimum age of marriage is 18, but 40% of girls are married before they reach 18, higher than the continental average (34%).⁷⁰² A 2004/2005 study found that married women were five times more likely to be infected than women who were never married.⁷⁰³

The Stigma Index illustrates that the workplace is a significant site of HIV-related discrimination. While employment related laws provide some protection for discrimination against workers living with HIV, there are gaps in protection and there is also a need to ensure that employers are aware of their legal obligations.

Recommendations

- Decriminalise consensual same sex sexual relations between consenting adults; urgently repeal the Anti-Homosexuality Law and replace it with legislation that explicitly affirms the human rights of LGBTI persons
- Decriminalise all aspects of sex work by consenting adults
- Revise the current version of the HIV law and in particular revise or remove provisions that allow for compulsory HIV testing, undermine confidentiality of HIV status and test results and that allow for disclosure of HIV status without consent. Revise the law to ensure the full protection for the human rights of people living with HIV and key populations
- Strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials. In particular, training for law enforcement officials is imperative to ensure that they are able to enforce all laws protecting women and children from violence and are sensitised to the rights of key populations such as men who have sex with men

Key data and modes of transmission

According to UNAIDS, around 12.7% (950 000) of adults aged 15 –49 years in Zambia are living with HIV, the majority of whom are women (490 000 women are living with HIV), and there are currently around 30 000 annual deaths from AIDS. There are 160 000 children living with HIV and 670 000 orphans.⁷⁰⁴

Zambia has a generalised HIV epidemic with multiple concurrent partnerships, low condom use, low levels of male circumcision, transactional sex and sexual violence and alcohol abuse cited as amongst the factors driving HIV transmission.⁷⁰⁵

Background to HIV, Law and Human Rights

The ARASA 2009 report identified two major human rights concerns:

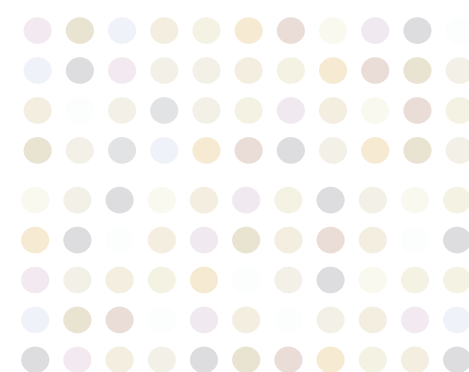
- The report indicated that Zambian prisons have significant problems with over-crowding. HIV prevalence rate in prisons was 27%.
- The report noted that there were no specific laws to protect women from domestic violence and rape and that gender based violence was a barrier to women's ability to seek HIV testing, eMTCT, ART and other HIV-related health care. The report also noted the impact of women's unequal status on their ability to protect themselves from HIV.

Key Human Rights Concerns in 2014

The new National Strategic Framework 2011-2015 adopts a human rights based and gender equality approach to HIV and AIDS. It acknowledges that an enabling legal and policy environment is central to the promotion of a rights-based approach to HIV and AIDS. It recognises a range of key populations and vulnerable populations including women, girls, children, men who have sex with men, sex workers, prisoners, people with disabilities and people who inject drugs and outlines specific strategies such as creating public awareness of stigma and discrimination and addressing the legal barriers that prevent key populations from accessing and utilising services appropriately.⁷⁰⁶

Key HIV and Human Rights issues include:

Stigma and discrimination: HIV-related stigma and discrimination, although it appears to be reducing and there are more people living openly with HIV, is still a matter of concern for affected populations within their families, communities and other sectors.⁷⁰⁷ The recent Stigma Index conducted by NZP+ and GNP+ found evidence of various forms of discrimination including exclusion from places of worship, homes, workplaces, households, health care facilities; discrimination in access to work and services such as health, education and insurance; forced medical procedures; testing



950 000
of adults aged 15-49 years are living with HIV.

Zambian prisons have significant problems with over-crowding. HIV prevalence rate in prisons was 27%.

⁷⁰⁴Available at <http://www.unaids.org/en/regionscountries/countries/zambia/> [Accessed 4 May 2014]

⁷⁰⁵UNAIDS, Country Progress Report, 2012 Available at <http://www.unaids.org/en/regionscountries/countries/zambia/>

⁷⁰⁶Ibid. See also Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

⁷⁰⁷Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

for HIV without voluntary, informed consent or counseling, detention, isolation and quarantine and coerced termination of pregnancy.

The Stigma Index found that access to ART was not a key issue and that over 90% of those surveyed were accessing ART; however it is important to remember that these respondents were identified via their participation in health services.⁷⁰⁸ Other civil society respondents cited the lack of access to health care services, including general health services for the broader population as well as targeted health services for key populations such as men who have sex with men, as an ongoing issue of concern.⁷⁰⁹

Women’s rights: Women and girls constitute about 60% of people living with HIV in Zambia. The high HIV infection rates among women are directly linked to other challenges they face such as inequality, poverty, illiteracy, violence, harmful customary practices and limited access to resources.⁷¹⁰

For women, being widowed by AIDS is exacerbated by their lack of access to property on the death of their spouse; many widows face forcible eviction from their homes and their land by their husband’s family members, traditional authorities and /or neighbours in terms of customary laws and practices, particularly if they refuse to be ‘inherited’ by a male relative of the deceased.⁷¹¹

High levels of sexual violence including harassment, incest, sexual assault, abduction, rape in and outside marriage and defilement as well as various harmful cultural practices such as polygamy; ritual sexual cleansing of widows and widowers; dry sex and the subordination of women which prohibits women from negotiating safe sex, place women at higher risk of HIV exposure.⁷¹² Sexual cleansing, in particular, is a widespread traditional cultural practice throughout Zambia; where the deceased died from AIDS the risk of HIV transmission from the surviving spouse is high. Where children are used in sexual cleansing practices, they are subjected to sexual abuse, HIV infection, other sexually transmitted diseases and psychological trauma.⁷¹³

Women with HIV also report high levels of stigma and discrimination within their families and communities including being forced from their family homes.⁷¹⁴ They also report discriminatory treatment within the health care sector, including reports of coerced terminations of pregnancy and coerced sterilisations.⁷¹⁵ Research in Zambia and other countries in Southern Africa shows that HIV-related stigma and discrimination increases the likelihood of ‘property-grabbing’ for affected widows.⁷¹⁶

Rights of men who have sex with men: Discrimination against men who have sex with men, including denial of access to appropriate services by health care providers⁷¹⁷, is rife. In 2013, the Southern Africa Litigation Centre reported a rise in homophobic hate speech, including from members of local and national government. A prominent LGBTI activist, Paul Kasonkomona, was arrested after appearing on a television programme where he advocated for human rights protections for sexual minorities for an effective response to HIV. Mr Kasonkomona was charged under the Zambia Penal Code for “soliciting in public for an immoral purpose”. Zambian activists have challenged the constitutionality of the arrest and the matter is pending before the High Court.

Rights of sex workers: Sex workers report gross human rights violations;⁷¹⁸ however, due to the high levels of stigma and discrimination very few come out in the open to report violations.⁷¹⁹

Prisoner’s rights: Prisoners are subjected to severe overcrowding, poor ventilation, inadequate sanitation and nutrition, physical abuse, and negligible health services when they become ill. Overcrowding in prisons leads directly to TB

⁷⁰⁸See results of NZP+, GNP+, *The People living with HIV Stigma Index: Zambia, 2012*

⁷⁰⁹Key informant interview, Malala Mwendela, ZARAN, 6 September 2012

⁷¹⁰*Ibid*

⁷¹¹Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012. See also submission by Women and Law in Southern Africa Research and Educational Trust, *Zambia, Africa Regional Dialogue on HIV and the Law*, 4 August 2011. Available at www.hivlawcommission.org

⁷¹²University of Pretoria. *HIV/AIDS and Human Rights in Zambia*

⁷¹³Submission by World Vision Zambia, Keembe Area Development Programme, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷¹⁴Submission by Individual, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷¹⁵See *People Living with HIV Stigma Index: Zambia*; see also HRI, 2009 cited in GCHL, *Regional Issue Brief: Women, HIV and the Law*, 2011

⁷¹⁶McPherson D, *Property Grabbing and Africa’s Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*, 2004 Available at https://www.lawutoronto.ca/documents/ihrp/HIV_mcpherson.docx.

⁷¹⁷Key informant interview, Malala Mwendela, ZARAN, 6 September 2012

⁷¹⁸*Ibid*

⁷¹⁹Submission by Treatment Advocacy and Literacy Campaign, Zambia, *African Regional Dialogue*, Pretoria, 4 August 2011

transmission and can contribute to sexual violence, fuelling the spread of HIV. The prevalence of HIV in Zambian prisons was last measured in 1999 at 27 %; nearly double that of the general adult population (15 %). Although prisoners in recent years have had increased access to HIV testing services and to ART, services are still not adequate and condom distribution is prohibited. The devastating effect of the HIV epidemic in Zambia’s prisons is compounded by a concurrent TB epidemic. TB prevalence in Zambia, among the highest in the world, was estimated to be 0.4 % in the general population in 2007; in Zambian prisons, prevalence was estimated to be between 15 - 20% in 2001. TB isolation cells are in very poor condition and there is limited access to prison-based TB testing or treatment in prisons.⁷²⁰ In 2010 Human Rights Watch, ARASA and the Prisons Care and Counselling Association (PRISSCA) described the Zambian prison system as a “death trap” because of the health risks described above.⁷²¹

Rights of people with disabilities: People with disabilities are vulnerable to HIV because of higher levels of poverty, illiteracy, myths about disabilities, poor or no access to information on sexual and reproductive health and HIV and AIDS, poor access to health care, sexual abuse and the fact that people with disabilities are often left out of HIV and AIDS policies and programming. Even where they are able to access services, people with disabilities are discriminated against – e.g. they are excluded from counselling due to physical barriers or the failure to take their needs into account. When affected by HIV, people with disabilities face ‘double-discrimination’.⁷²²

Children’s rights: Children are vulnerable to sexual abuse and early marriages (although the minimum age of marriage is 16, there is no minimum age in customary law), despite protection from exploitation and abuse within the Constitution, Penal Code and the Juveniles Act. In 2012, UNICEF estimated that 9% of girls were married by 15, and 42% by 18, one of the highest rates of child marriage in the world.⁷²³ The problem is exacerbated by the reluctance of families and the general public to acknowledge the existence of the problem and the lack of data on the issue.⁷²⁴

Workplace rights: Other issues of concern include HIV testing for purposes of employment, which appears to be sanctioned by the Employment Act’s provision for medical testing, as well as HIV testing and refusal to employ applicants to the armed forces by the Zambia Defence Force.⁷²⁵

Legal Framework for HIV and AIDS

Constitution

Zambia is a constitutional democracy and the Constitution is the supreme law. The Constitution of Zambia Act, 1996⁷²⁶ includes a bill of rights. The current Constitution is undergoing a process of review and a technical committee was appointed in 2011 to draft a new Constitution. The draft was supposed to be tabled in Parliament in 2012 but it has remained with the technical committee, despite calls from civil society for the government to set a date for a referendum to adopt the new Constitution.⁷²⁷ In January 2014, the Zambian Watchdog and the Lusaka Times “leaked” a copy of the final draft Constitution. The draft expanded the definition of privacy to include medical information, but removed earlier provisions protecting the rights of marginalised groups. It remains unclear when or whether the new Constitution will be passed into law.

The Constitution of Zambia Act⁷²⁸ protects the equality rights of all people and prohibits discrimination, defined as “affording different treatment to different persons attributable, wholly or mainly to their respective descriptions by race, tribe, sex, place of origin, marital status, political opinions, colour or creed, whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.”⁷²⁹ Protection from discrimination does not apply to some laws however, including laws with respect to adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law and particularly customary laws.

⁷²⁰Submission by Prisons Care and Counselling Association, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷²¹Human Rights Watch, et al, *Unjust and Unhealthy: HIV, TB and Abuse in Zambia Prisons*, April 2010, available at <http://www.hrw.org/node/89819/section/4>

⁷²²Submission by Zambia Disability HIV/AIDS Human Rights Programme, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷²³See: <http://www.girlsnotbrides.org/where-does-it-happen>

⁷²⁴AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

⁷²⁵Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria, *HIV/AIDS and Human Rights in Zambia*, 2004

⁷²⁶Cap 1

⁷²⁷See: <http://www.times.co.zm/?p=19625>

⁷²⁸Cap 1

⁷²⁹Article 23

Although there is no specific mention of HIV or health in the non-discrimination clause, the rights set out in the Constitution should apply equally to people living with HIV and to HIV contexts. For instance in the 2010 case of *Kingaibe and Chookole vs Attorney General* two employees challenged mandatory HIV testing and unfair dismissal by Zambian Air. The Judge in the High Court ruled that the mandatory HIV testing for HIV was unconstitutional.

Current proposals to include better rights protections in the new Constitution will strengthen protection for people living with HIV and members of key populations. It proposes the inclusion of health status as a ground of prohibited discrimination, the expansion of the right to privacy to include health-related information, the inclusion of the right to health as a justiciable right and strengthened protection for women and children’s rights. Also, the draft makes reference to marginalised groups - communities that are unable to participate in the economic and social life of Zambia – and minority groups that are disadvantaged by discrimination because of laws or practices; both of those could be applied to people living with HIV to ensure greater protection for their rights.

National Laws and Policies

Zambia does not have a comprehensive HIV-specific law and there is limited specific provision for HIV in other laws and policies.

The Employment Act⁷³⁰ provides for access to health care for employees and this Act and the Industrial and Labour Relations Act⁷³¹ prohibit discrimination within the working environment. The Industrial and Labour Relations Act prohibits dismissing or denying an employee or prospective employee employment on the grounds of social status. People living with HIV can, in principle, challenge dismissal from employment or refusal of employment before the Industrial Relations Court if dismissal or refusal is based on their HIV status.⁷³² The Citizens Empowerment Act, 2006, which aims to support economic empowerment, specifically prohibits discrimination on the grounds of HIV status in companies defined as citizen empowered companies.

A significant new development for women’s rights is the passing of the Gender Based Violence Act in 2011 which aims to protect women from GBV. It prohibits GBV which is defined to include physical, sexual, economic and psychological violence.⁷³³ This Act should strengthen existing protections such as the Penal Code prohibition against rape,⁷³⁴ defilement of girls below 16 years of age⁷³⁵ and incest,⁷³⁶ as well as the Amendment to the Penal Code of 2005 that prohibits the sexual harassment of children.⁷³⁷ The law unfortunately does not criminalise marital rape and neither does the Penal Code.

The Disabilities Act 3, 1996 and Citizens Economic Empowerment Act, 2006 protects the rights of people with disabilities to equality and non-discrimination. In 2010, the Government of the Republic of Zambia ratified the Convention on the Rights of Persons with Disabilities.

In the health sector, the Public Health Act ⁷³⁸ makes limited provision for HIV although it does provide for HIV to be notifiable in terms of the Public Health Act (Infectious Diseases Regulations). Zambia has a World Trade Organisation (WTO) compliant framework and as a least developed country would be eligible to apply for a waiver regarding implementation of TRIPS in respect of pharmaceutical products; however they have not taken advantage of this flexibility. In 2004 Zambia issued a compulsory license to a pharmaceutical company to manufacture ART, with royalty payment to the patent owners not to exceed 2% and 2.5% respectively.

In 2010, the government announced that it would review child-related legislation to ensure that children are protected from abuse and HIV and AIDS.⁷³⁹ This process appears to still be on-going.

⁷³⁰Cap 268
⁷³¹Cap 276
⁷³²AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007
⁷³³UNAIDS, *Country Progress Report*, 2012
⁷³⁴Section 132
⁷³⁵Section 138
⁷³⁶Section 159
⁷³⁷AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007
⁷³⁸Cap 295
⁷³⁹See: <http://allafrica.com/stories/201002110309.html>

Ratification of International and Regional Human Rights Instruments

Zambia has ratified:

- African Charter on Human and Peoples’ Rights, 1984
- Convention on the Rights of the Child (CRC), 1991
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1985
- Convention on the Rights of people with disabilities, 2010
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1984
- International Convention on Civil and Political Rights (ICCPR), 1984
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2006

Zambia has signed but not ratified the African Charter on the Rights and Welfare of the Child.

Access to Justice and Law Enforcement

Zambia’s recent National Commitments and Policy Instruments Report sets out various mechanisms and services for access to justice and law enforcement in the country including:

- Independent national institutions for the promotion and protection of human rights such as the police, VSU, courts, the Zambia Human Rights Commission and other human rights structures, although funding, relevance and credibility of the Commission remains an issue
- Programmes to educate, raise awareness among people living with HIV concerning their rights
- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV
- Legal aid systems for HIV and AIDS casework
- Programmes to train members of the judiciary (including labour courts/employment tribunals) on HIV and AIDS and human rights issues
- Programmes to educate, raise awareness among people living with HIV concerning their rights
- Programmes designed to change societal attitudes of stigmatisation associated with HIV and AIDS to understanding and acceptance

Civil society organisations have undertaken various initiatives including:

- working with traditional leaders to reduce GBV and harmful gender norms such as sexual cleansing involving women and children⁷⁴⁰
- programmes to reduce stigma and discrimination

“Of those who reported that their rights had been abused and had sought legal redress, over half reported that nothing had happened.”⁷⁴¹

Gaps and Challenges

Zambia has very few HIV-specific provisions in law and no comprehensive law dealing with HIV-related issues. This requires the application of general laws to HIV and AIDS contexts.

In the health sector, the Public Health Act provides for various coercive measures for infectious diseases. For example, a medical or health officer may compel a person to submit to medical examination in respect of any suspected or notified infectious disease; this could be used to compel HIV-positive patients to submit to medical examination.⁷⁴² In terms of access to medicines, Zambia has not taken full advantage of TRIPS flexibilities to increase access to medicines. There is also an inadequate institutional framework to ensure that patents are examined properly and registered, and Zambia

⁷⁴⁰ See MYDJCC, *Zambia and World Vision Zambia submissions to the African Regional Dialogue*, Pretoria, 4 August 2011
⁷⁴¹Stigma Index survey, 2011
⁷⁴²AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

has its patent applications examined by regional bodies such as the Africa Regional Intellectual Property Organisation - not having the local capacity to examine new patents can keep generic competition out for longer periods as companies ‘evergreen’ their products by resubmitting them with minor changes. Furthermore the lack of laws providing for pre- and post-grant opposition to patent applications facilitates ‘ever-greening’.

Women’s rights are not adequately protected in law. Laws such as the Marriage Act and the Employment Act discriminate against women directly or indirectly. The Marriage Act provides non-discriminatory rules for property division between husband and wife for civil law marriages; however the majority of Zambian women are married in terms of customary law.⁷⁴³ The Intestate Succession Act, 1989 protects women from being disinherited where their husbands die intestate; however the Act only applies to land held under statutory law and excludes land held under customary tenure and homesteads. Customary law is protected by the Constitution and also excluded from the application of the discrimination clause. The majority of Zambians die without a will and where the deceased is the husband, the widow has no access to the property and assets left by the husband because these items are considered belonging to the deceased’s family, including land. Local courts administer customary law in the settlement of disputes and are seldom sensitized to human rights issues. This means that many women are dispossessed of their homes, which increases their vulnerability.⁷⁴⁴

High levels of violence against women and girls continue to be an issue of concern.⁷⁴⁵

Criminal laws that criminalise same sex relations, sex work and injecting drug use create barriers to services for key populations at higher risk of HIV and prevents research on their needs:⁷⁴⁶

- The Penal Code⁷⁴⁷ of the Laws of Zambia classifies same sex relationships as unnatural offences and punishable by law. Zambian law declares “carnal knowledge against the order of nature” punishable by 15 years to life in prison and “acts of gross indecency” between same-sex couples are punishable by seven to 14 years imprisonment. Section 158 focuses specifically on ‘indecent practices’ between males. Many are arrested and charged under the Penal Code, but the charges are usually dropped due to publicity, a lack of evidence or the parties are fined and released.⁷⁴⁸
- Soliciting and living off the earnings of sex work is criminalised for men and women by the Penal Code;⁷⁴⁹ however even though sex work itself is not criminalised sex workers are often arrested on charges of loitering.⁷⁵⁰
- Section 19 of the Prisons Act⁷⁵¹ classifies committing sodomy as a major prison offence and acts as an impediment to the provision of condoms in prisons.⁷⁵²
- The Narcotic and Psychotropic Substances Act lists methadone, buprenorphine and naloxone as controlled substances thereby preventing people who inject drugs from accessing opioid substitution therapy, which is a critical component of the comprehensive package for preventing HIV among people who inject drugs. The Act further limits any harm reduction interventions for people who inject drugs and refers to harm reduction as “aiding and abetting”. Evidence-based best practice highlights how such discriminatory laws impact on people’s ability to access effective and friendly HIV prevention, treatment, care and support.⁷⁵³

In addition, it appears that the Gender Based Violence Act, read with the Penal Code, may serve to criminalise HIV exposure and transmission. The Act defines sexual abuse (criminalised in terms of the Penal Code) to include “the engagement of another person in sexual contact, whether married or not, which includes . . . sexual contact by a person aware of being infected with HIV or any other sexually transmitted infection with another person without that other person being given prior information of the infection”.⁷⁵⁴ This broad provision may serve to criminalise a wide range of acts, even those with limited risk of HIV transmission, in the event of non-disclosure of HIV status. This is a concern.⁷⁵⁵

In the employment sector, section 28 of the Employment Act requires that a medical officer should medically examine every employee before he/she enters into a contract of services of at least six months duration to ascertain fitness of employee to undertake work. Although the Act does not mention HIV, it is used as a justification for HIV testing by some institutions.

There are various challenges in access to justice including:

- Many people living with HIV do not know their rights.
- There are limited legal support services for HIV-related human rights violations; government legal aid programmes are overwhelmed and focus on criminal cases.
- The Legal Resources Foundation and Human Rights Commission has tried to address cases of stigma and discrimination; however the Commission is overwhelmed and understaffed.
- The courts are inaccessible and expensive and most people do not know how to use the courts to access justice and feel that the system fails them.⁷⁵⁶ Women in particular feel that the justice system does not protect them from violations such as property grabbing, discrimination and violence.

Recommendations

- Repeal all laws that criminalise consensual sex between adults of the same sex and all laws that criminalise sex work between consenting adults
- Decriminalise possession of drugs for own use and review and amend drug laws to allow for harm reduction and opioid substitution therapy programmes
- Provide for information, training and implementation of protections for women contained in the Gender Based Violence Act
- Criminalise marital rape
- Review Intestate Succession Act
- Improve management of HIV and TB in prisons
- Strengthen protection for people with disabilities in the context of HIV
- Improve access to justice and law enforcement especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials

⁷⁴³GCHL, *Regional Issue Brief: Women, HIV and the Law*, 2011. Available at www.hivlawcommission.org

⁷⁴⁴WLSA, *Zambia, Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷⁴⁵AIDS and Human Rights Research Unit, *Human Rights Protected? 2007*

⁷⁴⁶UNAIDS, *NCPI Report*, 2012

⁷⁴⁷Cap 87

⁷⁴⁸Submission by PRISCCA, *Zambia, Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷⁴⁹Sections 146, 147

⁷⁵⁰Key Informant Interview, Malala Mwondela, ZARAN, 6 September 2012

⁷⁵¹Cap 97

⁷⁵²See submission by PRISCCA, *Zambia, Africa Regional Dialogue on HIV and the Law*, 4 August 2011

⁷⁵³UNAIDS, *Country Progress Report*, 2012; see also Key Informant Interview, Malala Mwondela, ZARAN, 6 September 2012

⁷⁵⁴UNAIDS, *Country Progress Report*, 2012

⁷⁵⁵Key Informant Interview, Malala Mwondela, ZARAN, 6 September 2012

⁷⁵⁶Key Informant Interview, Malala Mwondela, ZARAN, 6 August 2012; Submission by MultiVision Youth Development and Job Creation Centre, Zambia, *African Regional Dialogue*, Pretoria, 4 August 2011

ZIMBABWE

Key data and modes of transmission

According to UNAIDS, 14.7% (1.2 million people) of adults aged 15-49 years in Zimbabwe are living with HIV, the majority of whom are women (7000 000 women have HIV), and there are currently around 39 000 annual deaths from AIDS. There are 180 000 children living with HIV and 890 000 orphans.⁷⁵⁷

A Modes of Transmission study conducted in 2010 shows that the major source of new infections occurs in the 20 - 29 years age group and is low risk hetero-sexual transmission due to low condom use and high sexual networking. There is limited data on key populations generally considered to be at higher risk of HIV such as sex workers, men who have sex with men, prisoners and people who inject drugs, although the Medical Research Council recently approved a study amongst sex workers.⁷⁵⁸

The Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 recognises a number of populations that are considered vulnerable in the context of HIV and AIDS including women and girls, young men and women, orphans and vulnerable children and mobile populations. Zimbabwe's *Global AIDS Response Country Progress Report* 2012 also recognises additional 'most-at-risk populations' including sex workers, cross border traders, men who have sex with men, truckers, internally displaced people, uniformed personnel (soldiers, police, game rangers, customs and immigration officers), prisoners, people with disabilities, survivors of rape and sexual abuse, illegal immigrants, and people who inject drugs.

Background to HIV, Law and Human Rights

The ARASA 2009 report indicated that although Zimbabwe has developed a relatively strong policy framework to address HIV and human rights, key populations such as people who inject drugs, men who have sex with men and sex workers were excluded from protection.

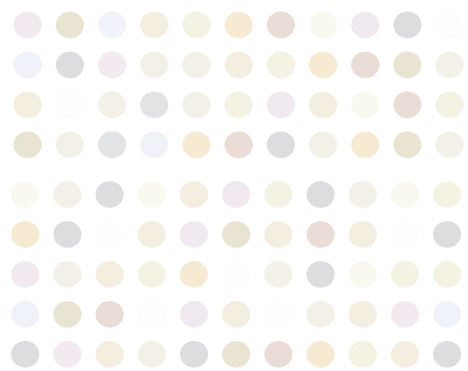
Key Human Rights Concerns in 2014

Zimbabwe remains in a precarious political position. Torture, harassment and victimisation of people who do not support Robert Mugabe's ZANU PF party remains a concern and the government continues to impede civil society from operating freely in the country.

Key HIV and human rights issues in Zimbabwe include the following:

Stigma and discrimination: Ongoing stigma and discrimination against people living with HIV, including within families and communities and the health sector.

Women's rights: The increasing vulnerability of women, particularly poor, rural and marginalised women, to HIV. Women's vulnerability is exacerbated by gender inequality, a number of harmful gender norms as well as GBV in Zimbabwe. Inequality is pervasive



1 200 000
adults aged 15-49
years are living
with HIV

the major source
of new infections
occurs in the
20 - 29 years age
group and is low
risk hetero-sexual
transmission
due to low
condom use
and high sexual
networking

⁷⁵⁷Available at <http://www.unaids.org/en/regionscountries/countries/zimbabwe/> [Accessed 4 May 2014]

⁷⁵⁸UNAIDS, NCPI Report, 2012. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZW_Narrative_Report.pdf

in customary laws and practices and women are treated as minors with limited rights to own and inherit property. Harmful norms that place women at higher risk of HIV exposure include early marriage, female genital mutilation, wife inheritance and polygamy, amongst others.⁷⁵⁹ The National HIV Policy notes that some aspects of GBV are culturally condoned because they are perceived as within the bounds of what is expected of men in their interaction with women in different situations.

Children’s rights: Children under the age of 16 years cannot give consent to HIV testing; they require the consent of a parent or legal guardian for an HIV test. This limits access to HIV prevention services for young people and delays treatment for children without parents or guardians. The minimum age of marriage is 18, but UNICEF reports that 4% of girls are married by the time they reach 15.⁷⁶⁰

Rights of sex workers: Sex workers report gross human rights violations. The experiences of sex workers were documented and confirmed in research by ASWA in 2010.⁷⁶¹ The criminalisation of sex work dehumanizes sex workers. They are highly stigmatised in society and marginalised by family and community members. Extortion, harassment verbal abuse and violence, including beatings, torture, sexual violence and gang rape, are common occurrences at the hands of their clients as well as the police and related authorities and includes violence for refusing unprotected sex. Police also use the presence of condoms as evidence of sex work and a reason for arrest. Sex workers are unable to report complaints of human rights violations since they fear arrest and because law enforcement officials are often the perpetrators. When arrested they report being denied access to medical treatment (e.g. ART), food and bail money and being detained for unnecessarily long periods of time.⁷⁶²

“Police officers force sex workers to have sex with them in exchange for their release from prison. If a sex worker is raped, police won’t take their statement because they say a sex worker cannot be raped because they sell sex and deserve to be punished.”⁷⁶³

Male sex workers are vulnerable not only because of the nature of their work, but also due to criminalisation of sex between men, which means they may be subject to extortion, blackmail and threats based on their perceived sexual orientation or their engagement in same-sex activities. Both male and female sex workers report discriminatory treatment in the health care sector including stigmatisation, denial of services and breaches of their confidentiality rights.⁷⁶⁴ They are unable to disclose their health needs for fear of arrest. This in turn impacts on their ability to seek and access treatment.

Rights of sexual minorities: Sexual minorities are criminalised by law. Organisations of sexual minorities, such as the Gays and Lesbians of Zimbabwe (GALZ) are harassed, raided and their employees are arrested, making it difficult for organisations to continue their work. Members of the LGBTI community report being arrested, beaten and tortured by law enforcement officials and many are forced to work underground. The media frequently presents negative and detrimental images of the gay community. Threats and attacks against LGBTIs continued to emanate from the highest levels of government and during the 2013 election, President Mugabe threatened to behead LGBTI persons.⁷⁶⁵ Societal stigma and discrimination, perpetuated by the political leadership, has resulted in the violations of many of the rights of the LGBTI community. Like sex workers, their criminalised activities make it difficult for them to report violations for fear of further harassment, extortion and arrest. The underground nature of the LGBTI population in Zimbabwe makes it difficult for people to access appropriate health services and for providers to deliver services. Their marginalised status increases their vulnerability.⁷⁶⁶

Legal Framework for HIV and AIDS

Constitution

The new Constitution of Zimbabwe, signed into law in May 2013, is the supreme law of the land. The Constitution states that any law, practice, custom or conduct that is inconsistent with its provisions will be invalid to the extent of the inconsistency. The Constitution contains a declaration of rights that explicitly promotes equality between women and men, and prohibits unfair discrimination on the grounds of nationality, race, colour, tribe, place of birth, ethnic and social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability, economic and social status and whether or not a child is born out of wedlock.⁷⁶⁷ HIV or health status is not included among the prohibited grounds of discrimination. The Constitution also promotes the right of every person to human dignity, personal security and freedom from torture and cruel, inhuman and degrading treatment.

While the Constitution fails to explicitly mention HIV, it provides for a right of privacy with regard to medical conditions⁷⁶⁸ and a right of all to basic health care services for people with a chronic illness.⁷⁶⁹

Human rights activists have indicated that the enactment of a new Constitution has failed to improve human rights in Zimbabwe, largely as a result of ZANU-PF’s failure to implement its provisions.⁷⁷⁰

National Laws and Policies

Zimbabwe does not have a comprehensive HIV-specific law. However, people living with HIV are protected by broad non-discrimination provisions, such as those in the Constitution and the Prevention of Discrimination Act 19 of 1998. Additionally, there are specific anti-discrimination protections in the working environment and in policy.

In the workplace, protection for employees with HIV was provided a number of years ago. The Labour Relations Act protects the rights of all employees to non-discrimination, including on the basis of HIV status.⁷⁷¹ HIV regulations have been enacted in terms of the Labour Relations Act (the Labour Relations Regulations on HIV/AIDS and Employment, Statutory Instrument 202, 1998) to ensure non-discrimination in the workplace, a prohibition on mandatory HIV testing for purposes of employment, protection of the right to confidentiality and protection from unfair dismissals, amongst other things.⁷⁷²

Women have various forms of protection in law. Various laws have been reviewed over the years to improve women’s and girl children’s rights and protections, such as the Legal Age of Majority Act, 1982 that made all Zimbabweans, regardless of sex, majors upon turning 18 years; the Administration of Estates Amendment Act, 1997 which gave inheritance rights to women, including women married in unregistered customary law marriages; the Criminal Procedure and Evidence Amendment Act, 1997 that punishes sexual abuse of minors; the establishment of Victims Friendly Courts to support sexually abused minors to testify against their perpetrators; the Sexual Offences Act, 2000 which protects women from sexual violence including marital rape⁷⁷³ as well as the Domestic Violence Act, 2007 which criminalises all forms of psychological, emotional, economic, physical and sexual violence. The National Gender Policy, 2000 recognises the need to sensitise and create awareness of gender and health issues including HIV, develop gender-sensitive multi-sectoral programmes for the empowerment of women and girls and introduce measures to counter the exposure of women and girls to HIV through traditional and religious beliefs and practices. More recently, the Gender Violence Act, 2011 provides for the punishment of all perpetrators of violence against women, including for marital rape.⁷⁷⁴ In 2012, the Judicial Service Commission established the Multi-Sectoral Protocol on Sexual Abuse to improve the government’s response to child and adult sex abuse and GBV. The government is currently reliant on donor funding to implement the protocol.

⁷⁵⁹AIDS and Human Rights Research Unit, University of Pretoria, Human Rights Protected?, 2007
⁷⁶⁰See: <http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>
⁷⁶¹Submission by ASWA, Africa Regional Dialogue on HIV and the Law, 4th August 2011. Available at XXX
⁷⁶²Submission by ASWA; Female Sex Worker Network of Zimbabwe, Zimbabwe, Africa Regional Dialogue on HIV and the Law, 4 August 2011
⁷⁶⁴Ibid. See also submissions by Sex Workers in Zimbabwe, Zimbabwe; Female Sex Worker Network of Zimbabwe, Zimbabwe; Sexual Rights Centre, Zimbabwe, Africa Regional Dialogue on HIV and the Law, 4 August 2011
⁷⁶⁵Human Rights Watch, World Report: Zimbabwe 2013, available at <http://www.hrw.org/world-report/2014/country-chapters/zimbabwe?page=2>
⁷⁶⁶Submissions by Sexual Rights Centre, Zimbabwe; GALZ, Zimbabwe; Southern African Litigation Centre, South Africa; Africa Regional Dialogue on HIV and the Law, 4 August 2011. Available at www.hivlawcommission.org

⁷⁶⁷Article 56.
⁷⁶⁸Article 57
⁷⁶⁹Article 76
⁷⁷⁰Human Rights Watch, World Report: Zimbabwe 2013, available at <http://www.hrw.org/world-report/2014/country-chapters/zimbabwe?page=2>
⁷⁷¹Section 6(1) in terms of Labour Relations Amendment At 17, 2002
⁷⁷²AIDS and Human Rights Research Unit, Human Rights Protected? 2007
⁷⁷³Section 8(1)
⁷⁷⁴UNAIDS, NCPI Report, 2012 and Country Progress Report, 2012 available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Zimbabwe%20NCPI%202012.pdf>

The courts have also found in favour of the equality rights of women. In *Rattigan and Others v Chief Immigration Officer* the Supreme Court held that the immigration law discriminated against Zimbabwean women as the law allowed automatic citizenship for foreign wives of Zimbabwean men, but did not allow the same for non-Zimbabwean husbands. Following the Rattigan case and the *Ruwodo NO v Ministry of Home Affairs and Others* decision, the government amended the Constitution (14th Amendment), adopting a gender-neutral approach for immigration purposes.⁷⁷⁵

Despite the gains in legal equality, women continue to experience high levels of inequality in society, particularly in rural areas.

In the health sector, the Public Health Act makes no mention of HIV or AIDS. The National HIV and AIDS Policy, 2000 prohibits discrimination against people living with HIV and provides for non-discrimination in access to services and there are various policies and guidelines regarding the provision of access to HIV-related health care services, including guidelines on voluntary HIV testing and counseling, home based care, patient's rights, ART and post-exposure prophylaxis for rape survivors, amongst others. In 2002, the Minister of Justice, Legal and Parliamentary Affairs of Zimbabwe issued a notice declaring a state of emergency on HIV for the purpose of enabling "[t]he State or a person authorised in writing by the Minister to make or use any patented drug, including any anti-retroviral drugs, used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions; and/or to import any generic drug used in the treatment of persons suffering from HIV/AIDS or HIV/AIDS related conditions." Subsequent to this declaration, Zimbabwean companies have been authorised both to manufacture and to import generic antiretrovirals.⁷⁷⁶

Ratification of International and Regional Human Rights Instruments

Zimbabwe has ratified:

- African Charter on Human and Peoples’ Rights, 1986
- African Charter on the Rights and Welfare of the Child, 1995
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1991
- Convention on the Rights of people with Disabilities, 2012
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1991
- International Convention on Civil and Political Rights (ICCPR), 1991
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2008

Access to Justice and Law Enforcement

Zimbabwe reports that it has mechanisms, programmes and services to provide access to justice and enforcement of HIV-related human rights violations including:

- National institutions for the promotion and protection of human rights – the Public Service Commission and the Ombudsman as well as ‘victim-friendly courts’ and ‘victim friendly units’ under the police. There is also a recently established Human Rights Commission, but to date, it is “severely under-funded and largely a symbolic institution” The US State Department concluded that the Commission is currently unable to fulfill its mandate.⁷⁷⁷
- Programmes to reduce HIV-related stigma and discrimination including for health care workers, the media and employers and employees.
- Programmes to educate and raise awareness among people living with HIV and key populations concerning their rights in the context of HIV.
- Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work.
- Legal aid systems for HIV casework.
- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV.⁷⁷⁸

⁷⁷⁵AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

⁷⁷⁶*Ibid.*

⁷⁷⁷Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Zimbabwe*, available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [Accessed on 4 May 2014]

⁷⁷⁸UNAIDS, *NCPI Report*, 2012.

The Office of the Ombudsman has dealt with a few cases tangentially involving HIV but not cases that are reported directly because of HIV or AIDS. Civil servants, for example, have brought cases relating to late or non-disbursement of their pension benefits by their relevant ministries, which affects their ability to access healthcare as they may be living with HIV. In many cases involving complaints about late pension disbursements, there is some measure of success when the Office of the Ombudsman intervenes and approaches the Pensions Office directly to address the problem.⁷⁷⁹

However, given the limited access to justice reported by vulnerable populations such as women, as well as the brutal treatment key populations receive at the hands of law enforcement officials, it appears that there remain many challenges for access to justice, particularly for key populations.

Gaps and Challenges

Other gaps and challenges within Zimbabwe’s legal framework that need to be strengthened include those set out below:

- There is no HIV-specific anti-discrimination protection in law. Protection of the rights of people living with HIV is strong in employment law, but otherwise set out in policy documents and in plans.
- Women do not have equitable access to property and inheritance or adequate access to sexual and reproductive health services.⁷⁸⁰
- Marriage laws are another area of concern. There are only two legally recognised and registered marriages in Zimbabwe - monogamous marriage under Chapter 5:11 and potentially polygamous customary law marriage under Chapter 5:07. Unregistered customary law marriages (which make up more than 50% of all marriages in Zimbabwe) are invalid in law except for purposes of guardianship, custody, access, maintenance and inheritance under customary law.⁷⁸¹ While on paper even women in unregistered customary law marriages have the right to inherit, according to the Administration of Estates Act, 1997, in practice these women face a multiplicity of problems by virtue of the fact that they do not have a marriage certificate and have to rely on the cooperation of their deceased spouse’s relatives to obtain the death certificate for the Master’s Court and are vulnerable to disinheritance through property-grabbing. This then impacts on the economic security of widows, further exacerbating their vulnerability to HIV.⁷⁸² The new Constitution explicitly promotes equality in marriage, during and at the dissolution of the marriage.⁷⁸³ It remains unclear whether the new provisions will assist in removing the discrimination described above.
- Criminal laws contain punitive provisions that may, in their application, further stigmatise and discriminate against people living with HIV and discourage them from testing for HIV and accessing services. The Criminal Law (Codification and Reform Act), section 79 criminalises the wilful transmission of HIV even between husband and wife. The criminalisation provision is exceptionally broad, making it potentially applicable to a wide range of acts. It provides that:

“Any person who, having actual knowledge that he is infected with HIV, intentionally does anything which he knows or ought reasonably to know —

- (a) will infect another person with HIV; or
- (b) is likely to lead to another person becoming infected with HIV;

shall be guilty of an offence, whether or not he is married to that other person, and shall be liable to imprisonment for a period not exceeding 20 years.”

- Criminal law fuels stigma, discrimination, violation of rights and freedoms, confusion and ultimately dislocates prevention and treatment programmes, as is evidenced by court cases brought under this provision. The Magistrates Court in Mbare, Harare, denied bail to a woman alleged to have deliberately transmitted HIV to her husband on the grounds that she would go about infecting people on a whim. The High Court later overturned the decision in April

⁷⁷⁹AIDS and Human Rights Research Unit, *Human rights Protected?* 2007

⁷⁸⁰Submission by Southern African Litigation Centre, *South Africa, Africa Regional Dialogue on HIV and the Law*, 4 August 2011. Available at www.hivlawcommission.org

⁷⁸¹Submission by WLSA, *Zimbabwe, Africa Regional Dialogue on HIV and the Law*, 4 August 2011. Available at www.hivlawcommission.org

⁷⁸²*Ibid.*

⁷⁸³Article 26

2006 and granted bail to the woman citing the principle of innocence until guilt is proven in her favour.⁷⁸⁴ In the case of *S v Kaiboni Mlambo* [02/2005 case] the accused was charged with contravening section 3 (a) and s 51 (1) (b) of the Sexual Offences Act and it was alleged that he had sexual intercourse with a girl below the age of 16 years with actual knowledge of his HIV status and that he deliberately or wilfully transmitted HIV to her. The accused argued that he used a condom and so even if he was HIV positive he took steps to prevent transmission of HIV to the complainant. However, medical professionals gave evidence of having treated the accused and having advised him of his HIV status and on this basis the court found the accused to have had knowledge of his HIV status and to be guilty of acts which had the likelihood to lead another to be infected with HIV and was sentenced to 15 years. In the case *S v ST* [2010 case] (pending), the accused was reported to the police and charged for deliberate transmission of HIV by her sexual partner. She was detained for a period of two days and was told she would only be released if she tested for HIV. The accused was taken by police to a public hospital for testing and was tested without pre-test or post-test counselling.⁷⁸⁵

- The Sexual Offences Act 8, 2001 also imposes a penalty of 20 years for rapists convicted of raping and infecting their victims with HIV. Section 16 also states that where a person is convicted of sexual crimes in the criminal category of rape, sodomy or having sex with an intellectually handicapped person and it is proved that at the time of the offence the convicted person was infected with HIV, whether or not he was aware of his infection, he shall be sentenced to imprisonment not exceeding twenty years. Section 17 provides the court with discretion to order the testing of a sexual offender for HIV. Samples of blood for HIV testing are taken from the accused person and if the accused is found guilty, the court will order testing. If the accused is acquitted, the samples are destroyed without being tested for HIV. The results are used to impose stiffer penalties in a situation where the accused tests positive for HIV. According to section 17(2), the Court may also exercise this discretion in the case of an accused who is merely charged with commission of a sexual offence. Section 18(1) provides that if the presence of HIV antibodies or antigens is found in the sample from a person's body, this shall be regarded as prima facie proof that he or she is HIV positive. Section 18(2) states that if it is proved that a person was infected with HIV within thirty days after committing an offence referred to in those sections, it shall be presumed unless the contrary is shown, that he was infected with HIV when he committed the offence.⁷⁸⁶
- The Miscellaneous Offences Act does not criminalise sex work; however it makes loitering for the purposes of prostitution in a public place an offence.⁷⁸⁷ The effect of this is to criminalise the sex worker and not the client. Part IV of the Sexual Offences Act prohibits pimping and the running of brothels and deals with the suppression of sex work. The Act also criminalises what can be loosely described as fraternizing with sex workers, in that a person who is proved to have either consorted, lived with or was habitually in the company of a sex worker and has no visible means of subsistence, shall be deemed, unless the contrary is proved, to have been knowingly living on the earnings of sex work.⁷⁸⁸
- Consensual sexual relations between men is criminalised by the common law crime of sodomy. In July 2006, the government of Zimbabwe expanded the definition of "sodomy" to include any physical contact between two individuals of the same sex "that would be regarded by a reasonable person to be an indecent act." These laws create a barrier to access to services for men who have sex with men, preventing them from accessing preventive services, information, treatment, care and support, despite their high risk of HIV exposure.⁷⁸⁹
- Young men and women below the age of 16 cannot access HIV testing and counselling on their own because they are considered minors and the legal age of consent to HIV testing is 16 years. In addition, the Child Adoption Act, 2006 allows for HIV testing of children up for adoption.
- In its recent *Global AIDS Response Country Progress Report* Zimbabwe reported that there are plans to review the Public Health Act, Domestic Violence Act, Criminal Law (Codification and Reform) Act, the Sexual Offences Act and the Child Protection Act.⁷⁹⁰

Recommendations

Selected recommendations to strengthen the legal and regulatory response for HIV and AIDS in Zimbabwe include the following:

- Review and repeal laws criminalizing HIV transmission and strengthen anti-discrimination protection in law for HIV and AIDS
- Repeal all laws that criminalise consensual sex between adults of the same sex and all laws that criminalise sex work by consenting adults and allow abuse of key populations by law enforcement officials and others⁷⁹¹
- Decriminalise possession of drugs for own use and review and amend drug laws to allow for harm reduction and opioid substitution therapy programmes
- Improve young people's access to sexual and reproductive health services in the context of HIV and AIDS
- Review laws discriminating against women, recognise unregistered customary law marriages and improve access to justice for women⁷⁹²

Efforts should also be made to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes and programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services, training for law and policy makers as well as work with the judiciary and members of other alternative dispute resolution mechanisms and law enforcement officials.

⁷⁸⁴*Ibid.*

⁷⁸⁵Submission to Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁷⁸⁶AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

⁷⁸⁷Section 4

⁷⁸⁸AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007; UNAIDS, *NCPI Report*, 2012

⁷⁸⁹UNAIDS, *NCPI Report* 2012; see also Sexual Rights Centre, Zimbabwe; Africa Regional Dialogue on HIV and the Law, 4 August 2011

⁷⁹⁰UNAIDS, *Country Progress Report*, 2012.

⁷⁹¹GALZ, Zimbabwe, Africa Regional Dialogue on HIV and the Law, 4th August 2011.

⁷⁹²WLSA, Zimbabwe, Africa Regional Dialogue on HIV and the Law, 4th August 2011

